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LEGISLATIVE REFORM OF WASHINGTON'S TUBERCULOSIS LAW: THE TENSION BETWEEN DUE PROCESS AND PROTECTING PUBLIC HEALTH*

Lisa A. Vincler** & Deborah L. Gordon***

I. INTRODUCTION

Washington law pertaining to tuberculosis (TB) exists to promote the health of its citizens. A tension exists, however, between the goal of protecting public health and the need to respect and protect the personal liberties of affected individuals. Recent amendments to Washington's TB treatment and control law added constitutional due process standards. Thus, Washington's current TB law contains features of both an administrative/public health model and a judicial/due process model. Some public health authorities still are adjusting to the current law, which requires them to incorporate this new individual-focused due process element into the traditional public health approach of providing services based upon the common good.

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* The opinions expressed in this Article are the authors' and are not intended to represent the views of the Washington State Attorney General's Office or the University of Washington.

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This Article examines the tension between protecting public health in light of personal liberty interests in the context of these recent reforms. Legislative reform was initiated based on changes in the nature of TB itself. Part II of the Article briefly examines the nature of TB and its new, multidrug resistant strains as well as its local and global incidence. The transmissibility of TB from a clinical (medical) perspective is discussed because the modes of transmission are critical to determining the nature of the public health risk. The clinical relationship between TB and the human immunodeficiency virus (HIV) is noted, including the contribution of HIV to the rise in the incidence of TB and the spread of multidrug resistant strains. These new TB strains present increased dangers for society because of their resistance to drug therapy and their life-threatening nature.[1]

Part III records and analyzes the legislative history of recent reforms as recommended by the interdisciplinary TB Planning Group (TB Group). This part of the Article also examines the various political influences and legal issues significant in this legislative drafting and rule-making process. Part IV gives an overview of the current law in Washington relating to TB. Part V compares the new law with the law it replaced and with Washington State approaches to other public health issues, including HIV/AIDS[2] and mental illness. Part VI examines federal and state constitutional case law regarding the scope and limitations on the powers of public health officials and agencies to act on behalf of the common good. This part explores the due process standards set forth in these cases.

This Article concludes by recognizing that the changing nature of TB and its air-borne transmissibility create a public health danger that has significant legal implications. Indeed, the "dangerousness" of TB and its attendant clinical and social factors is critical to consider in crafting appropriate legislative, judicial, and public health responses. Society's reasonable safety concerns provide legal justification for intrusion on an

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1. George J. Annas, *Control of Tuberculosis—The Law and the Public's Health*, 328 New Eng. J. Med. 585 (1993).

2. "Human immunodeficiency virus (HIV) is a blood-borne virus transmitted most frequently by unprotected sexual intercourse or the sharing of HIV-contaminated needles and syringes among intravenous drug users (IVDUs). Acquired immunodeficiency syndrome (AIDS) is the end stage of an infection caused by HIV and is always fatal." Spokane County Health Dist. v. Brockett, 120 Wash. 2d 140, 143 (1992); *see also* John M. Karon et al., *Projections of the number of persons diagnosed with AIDS and the number of immunosuppressed HIV-infected persons: United States, 1992–1994*, 41 (RR-18) Morbidity & Mortality Wkly. Rep. 1 (1992) (expanding AIDS surveillance definition to include severe immunosuppression); *Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome*, 36 Morbidity & Mortality Wkly. Rep. 3S (1987).

affected individual's constitutionally protected liberty. The authors conclude that current Washington State TB law successfully provides a reasonable and flexible legal framework balancing due process interests while empowering public health officials to control the spread of this disease and to provide humane and effective treatment.

II. HISTORY OF THE LEGISLATIVE AND REGULATORY REFORM OF LAWS RELATING TO TB

The emergence of multidrug resistant TB and the increased number of TB cases have resulted in changes in public health laws to enable government authorities to effectively treat and control the spread of the disease while incorporating constitutional due process standards.

A. Incentives To Reform: Significant Epidemiological and Clinical Factors

Tuberculosis is an infectious disease caused by a slow-growing and hardy bacterium called *Mycobacterium tuberculosis*.[3] Airborne droplets[4] spread this bacterium which may cause infection by entering the respiratory system and proliferating in the lungs.[5] Skin testing for tuberculosis infection will not be positive until six to eight weeks after initial infection.[6] In most cases, the normal immune response will be successful in eliminating all but a few bacilli and the disease will enter a dormant stage of variable length.[7] The disease is not contagious during this dormant stage if the person has no symptoms of clinically active disease.[8] Only approximately ten percent of persons infected with TB will develop active TB and, of those who do develop active TB, five percent will not develop an active case for as long as fifty years after initial infection.[9]

Multidrug resistant tuberculosis (MDR-TB) occurs in two different ways.[10] MDR-TB strains may develop when an infected person begins

3. Lawrence O. Gostin, *The Resurgent Tuberculosis Epidemic in the Era of AIDS: Reflections on Public Health, Law, and Society*, 54 Md. L. Rev. 1, 13 (1995).

4. *Id.* at 20.

5. *Id.* at 14.

6. *Id.*

7. *Id.* at 13–14.

8. *Id.* at 13.

9. Jody A. Eckler, *Myths & Facts About Tuberculosis*, 25 Nursing 17 (1995).

10. Gostin, *supra* note 3, at 15.

TB treatment and their antibiotic medications kill off the weaker TB strains but the person either fails to take the medications as prescribed or stops taking the medications prior to being fully cured of the disease.[11] These lapses in TB treatment cause stronger TB strains to develop drug resistance.[12] MDR-TB also may be contracted directly from an individual who carries these resistant strains of the disease.[13]

Curing persons who have MDR-TB infections caused by organisms resistant to two or more first-line treatment drugs is difficult and sometimes impossible. MDR-TB results in a decrease in the rate of cure from nearly 100 percent to only forty to sixty percent.[14] The outbreaks of MDR-TB on the East Coast (Florida, New Jersey, and New York) of the United States from 1989 through 1992 were variably resistant to two or more antimycobacterial treatment drugs. In one outbreak, the MDR-TB strain was resistant to seven drugs.[15] Cases of health care workers contracting MDR-TB also have been reported.[16] The increased threat presented by MDR-TB has fueled efforts to update old TB laws across the country to ensure public health departments have legally-valid enforcement mechanisms.[17]

The reemergence of tuberculosis as a public health threat in the United States also arises out of deteriorating social conditions including neglect of existing cases of TB, as well as by the increased resistance to tuberculosis treatment drugs, emergence of HIV/AIDS[18] that compromises resistance to TB, and deterioration of the public health infrastructure.[19] As of 1993, ten to fifteen million people in the United

11. Teri Flowers, *Quarantining the Noncompliant TB Patient: Catching the Red Snapper*, 28 J. Health & Hosp. L. 95 (1995).

12. *Id.* at 95.

13. Gostin, *supra* note 3, at 15.

14. *Id.* at 17.

15. William R. Jarvis, *Nosocomial transmission of multidrug-resistant Mycobacterium tuberculosis*, 23 Am. J. Infection Control 146 (1995).

16. Consuelo Beck-Sague, *Hospital outbreak of multidrug-resistant Mycobacterium tuberculosis infections: Factors in transmission to staff and HIV-infected* patients, 268 JAMA 1280 (1992); *Multidrug-resistant tuberculosis outbreak on an HIV ward: Madrid, Spain, 1991–1995*, 45 Morbidity & Mortality Wkly. Rep. 330 (1996); *see also* Dr. Thomas M. Hooton, Address at Harborview Medical Center's Trauma Care for the 1990s Conference (Apr. 15, 1993) (transcript on file with *Washington Law Review*).

17. Lawrence O. Gostin, *Controlling the Resurgent Tuberculosis Epidemic*, 269 JAMA 255 (1993).

18. *Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome*, *supra* note 2.

19. Charles M. Nolan, *A New Era of TB Resurgence Demands Updated Laws and Regulations*, 1994 Wash. Pub. Health 1; *see also* Hooton, *supra* note 16.

States (or approximately seven percent of Americans) were infected with tuberculosis.[20] The airborne transmission of TB raises significant legal and public policy issues regarding the care and treatment of affected or infectious individuals.[21]

Clinical data regarding the actual risk and transmissibility of TB are somewhat mixed. Some authorities cite clinical data to support characterizing TB as a major threat to health care workers and patients, the homeless, prison inmates, and migrant workers.[22] Other clinical data suggest that an individual's risk of contracting TB through casual contact, even in crowded areas, is minimal.[23] Infection depends on a number of factors. Factors affecting the transmissibility of TB include the severity of the disease, frequency of cough, and level of concentration of acid-fast bacilli in pulmonary secretions.[24] Factors influencing the contraction of TB include close and repeated contact with the source person, poor ventilation, and both non-specific and specific host immunity.[25] Children under the age of five, the elderly, and immunosuppressed persons are at a higher risk for contracting TB.[26] Thus, ascertaining the precise risk presented by any single person with infectious TB is difficult. The consequences of contracting MDR-TB, however, are much greater because the disease may not respond to treatment and may prove fatal.[27] Hence, public health authorities have used the diminished cure rate of MDR-TB to justify increased public health interventions for noncompliant patients.[28]

The incidence of TB globally is staggering. In 1995, TB claimed three million lives worldwide, making it the world's most lethal infectious disease.[29] One reason for the worldwide rapid increase in TB is its linkage with HIV infection.[30] Studies conducted on TB and HIV infection in the United States reveal wide disparities in the rate of

20. Gostin, *supra* note 3, at 12.

21. Gostin, *supra* note 17, at 255.

22. Flowers, *supra* note 11, at 95.

23. Gostin, *supra* note 3, at 21.

24. Richard E. Chaisson, *HIV Infection and Tuberculosis*, 2 HIV 11 (1992).

25. *Id.*

26. Flowers, *supra* note 11, at 96; *Prevention and control of tuberculosis in U.S. communities with at-risk minority populations: Recommendations of the Advisory Council for the Elimination of Tuberculosis*, 41 Morbidity & Mortality Wkly. Rep. 1 (1992).

27. Gostin, *supra* note 3, at 13.

28. Gostin, *supra* note 17.

29. *See TB's Resurgence Calls for New Drugs*, Seattle Post-Intelligencer, Mar. 26, 1996, at A6.

30. Chaisson, *supra* note 24, at 12.

infection in certain ethnic populations and in geographic distributions of infection.[31] In the United States there has been a higher dual morbidity rate from TB and HIV among African-Americans, Hispanics, Haitians, and intravenous drug users; with a stronger association between TB and HIV noted in urban areas in the northeast and in Florida.[32]

Another reason TB began spreading rapidly again is the existence of new multidrug resistant strains.[33] The World Health Organization estimates that 100 million people worldwide carry MDR-TB.[34] After an eight-year surge in new active cases of TB in the United States, however, new cases dropped six percent in 1995 from 24,361 to 22,812.[35] Nevertheless, in some parts of the United States TB rates are actually increasing. Thus, although the overall decrease in new cases in the United States is hopeful, it does not yet mean the disease is fully under control.[36]

Nationally, those who are homeless, recent immigrants, individuals who are HIV positive, institutionalized people, and substance abusers have a higher incidence of TB than the general population.[37] In Washington, recent immigrants from Asian countries that have a high prevalence of TB (such as Vietnam, Korea, Laos, and Cambodia) and from the Philippines and Mexico comprise almost fifty percent of the state's reported cases of TB. Specific groups in the State of Washington at an increased risk for acquiring TB include migrant farmworkers, medically undeserved populations (such as African-Americans, Hispanics, Native Americans, and recent Asian immigrants), HIV-positive individuals, the homeless, and incarcerated persons.[38]

The current treatment for TB varies depending upon the type of TB and whether the patient has other health conditions. Typical TB treatment consists of a three-drug combination taken for six months or a

31. Charles M. Nolan, *Human immunodeficiency syndrome-associated tuberculosis: A review with an emphasis on infection control issues*, 20 Am. J. Infection Control 30 (1992).

32. *Id.*

33. Seattle Post-Intelligencer, *supra* note 29.

34. *Id.*

35. *Id.*

36. *Id.*

37. Susan E. Buskin et al., *Tuberculosis Risk Factors in Adults in King County, Washington, 1988 through 1990*, 84 Am. J. Pub. Health 1750 (1994); Interview with Dr. Charles M. Nolan, Director, TB Control Program, Seattle-King County Pub. Health Dep't, in Seattle, Wash. (Feb. 1996).

38. Buskin et al., *supra* note 37, at 1753.

four-drug combination in areas where MDR-TB is prevalent.[39] However, patients with MDR-TB, HIV/AIDS, or other illnesses resulting in immunosuppression must have multiple drug therapies for at least twelve months.[40] Some public health authorities advocate mandatory treatment until cure for persons with TB.[41] Treatment until cure means that the affected persons would be required to comply with treatment not only during the period of time that they are infectious (approximately two to three weeks) but until they are cured (approximately six to twelve months).[42] Thus, the affected individuals would have mandatory treatment imposed upon them not merely while they are infectious and a direct threat to public health, but beyond this, during a period when they present no immediate threat to public health.[43]

In adopting the new Washington Administrative Code regulations in January 1995, the State Board of Health specifically found that "[p]ulmonary tuberculosis is a life-threatening airborne disease that can be casually transmitted without significant interaction with an infectious person."[44] The Board of Health's findings also mention concerns about development of MDR-TB, stating that a person who begins a course of TB treatment but fails to follow the recommended treatment is highly likely to relapse and develop infectious TB and more likely to have a multidrug resistant strain that is more virulent, more difficult to treat, and more likely to result in fatality.[45]

Washington's current comprehensive strategy for effective control and prevention of TB includes the following components: screening and detection procedures, public health tracking and reporting systems, educational programs for the public and health care providers, improving availability and location of treatment facilities, infectious disease policies and procedures in treatment and confinement facilities, involuntary

39. CDC, *Initial therapy for tuberculosis in the era of multidrug resistance: Recommendations of the Advisory Council for the Elimination of Tuberculosis*, 270 JAMA 694 (1993); *CDC recommends four-drug treatment of tuberculosis in multidrug-resistant era*, 48 Am. Fam. Physician 671 (1993).

40. Flowers, *supra* note 11, at 96.

41. Nolan, *supra* note 19, at 2.

42. Nolan, *supra* note 19, at 2.

43. *Id.*

44. Wash. Admin. Code § 246-170-002 (Supp. 1996). *But see* Gostin, *supra* note 3, at 22 ("Tuberculosis infection is usually transmitted through prolonged contact with a contagious person.").

45. Wash. Rev. Code § 246-170-002.

testing and detainment, removal of cultural and language barriers to education and treatment, and the provision of ancillary social services.[46]

B. Prior Washington State Public Health Laws Related to TB

Legislation related to the control of infectious diseases in Washington State dates back as early as 1891 with the passage of a bill related to the powers and duties of the State Board of Health.[47] That bill gave the Board of Health the authority to "supervise all matters relating to the preservation of the life and health of the people of the state." The bill further provided that the Board of Health "[s]hall have supreme authority in matters of quarantine, and may declare and enforce it when none exists, or may modify, relax, or abolish it when it has been established."[48] This law was revised in 1967 to read: "[The State Board of Health] shall have supreme authority in matters of quarantine, and shall provide by rule and regulation procedures for the imposition and use of isolation and quarantine."[49] Further, all state officials must enforce all rules and regulations adopted by the State Board of Health or be subject to fines.[50]

The Washington Constitution enables local officials to pass rules and regulations concerning the public health: "Any county, city, town or township may make and enforce within its limits all such local police, sanitary and other regulations as are not in conflict with general laws."[51]

The Washington Supreme Court has addressed this grant of authority and noted: "This is a direct delegation of the police power as ample within its limits as that possessed by the legislature itself. It requires no legislative sanction for its exercise so long as the subject-matter is local, and the regulation reasonable and consistent with the general laws."[52]

Thus, from the late 1800s, public health officers in Washington have exercised the broad discretion granted to them by law including taking any necessary measures to protect the public health such as the quarantine of infectious persons.[53] Public health laws have been

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46. *See* Buskin et al., *supra* note 37.

47. Wash. Rev. Code § 43.20.050 (1996).

48. Wash. Rev. Code Ann. § 43.20.050 historical note (West 1994).

49. Wash. Rev. Code § 43.20.050 (1996).

50. Wash. Rev. Code § 43.20.050.

51. Wash. Const. art. XI, § 11.

52. Spokane County Health Dist. v. Brockett, 120 Wash. 2d 140, 146, 839 P.2d 324, 328 (1992) (quoting Lenci v. Seattle, 63 Wash. 2d 664, 667 (1964), and affirming ability of local health department to conduct needle-exchange program).

53. *See, e.g.*, Wash. Rev. Code § 70.28.031 (1996).

expanded and amended several times since their original enactment. For example, in 1891 tuberculosis control legislation was drafted in response to a worldwide tuberculosis epidemic that represented a serious, deadly threat that even up until 1930 took the lives of nearly 90,000 people a year in the United States.[54] The development in the late 1940s and early 1950s of effective TB treatment medications dramatically reduced the threat of tuberculosis.[55] The emergence of multidrug resistant tuberculosis (MDR-TB) in the mid-1980s to the early-1990s and the soaring number of TB cases in general, however, have renewed the threat of tuberculosis to the public health and has stimulated the re-examination of TB control laws resulting in recent legislative reform.[56]

III. THE TB PLANNING GROUP

A. Formation and Meetings

The majority of recent legislative amendments to Washington State's TB laws were passed and public health regulations were reformulated and put into effect in 1994. The legislature also enacted some minor additions to the 1994 reforms in 1995 and 1996. The DOH initiated the TB Planning Group that brought together medical and public health experts, community activists, and representatives of national interest groups to address the control of TB and to propose tuberculosis legislative reform.[57]

The coordinator of the Washington State TB Control Program convened the TB Group on February 22, 1993. The TB Group's charter was to be a "short-term, intense effort that should produce draft legislation."[58] The committee's mission/purpose statement was, "to

54. Kollin K. Min, Comment, *The White Plague Returns: Law and the New Tuberculosis*, 69 Wash. L. Rev. 1121, 1126 (1994).

55. *Id.*

56. *See, e.g.*, Jarvis, *supra* note 15.

57. Interviews with Katherine M. Anderson, then Coordinator, Washington State TB Control Program, in Seattle, Wash. (Feb. 1996) (regarding prior history of contribution made by groups whose work on this issue pre-dated TB Group). The TB Group began its work with a review of draft legislation proposed by a group of persons organized by the American Thoracic Society and American Lung Association that met in 1992. The 1992 group was comprised of members of Public Health Departments, the Thoracic Society, and the American Lung Association. Portions of this group's proposed legislation were incorporated in the legislation recommended in 1994 by the TB Group.

58. TB Planning Group Meeting Minutes (Feb. 22, 1993) (on file with *Washington Law Review*) [hereinafter Feb. 22, 1993 Minutes].

prevent, control, and eliminate TB in a humane and cost effective way in Washington State."[59]

The TB Group's diverse membership included local health officials, private practice physicians, legislative representatives, and representatives of the following: private non-profit organizations such as TB and HIV/AIDS programs, the University of Washington, the American Civil Liberties Union, community clinics, and others with an interest in the control of TB. Seventeen persons attended the first meeting. The membership of the TB Group changed over the life span of the committee; as of March 5, 1993 the group's roster listed twenty-seven persons.

From February until December 1993, the TB Group met regularly and received a variety of input including information from legislative leadership that indicated a reluctance to put detailed due process requirements in the statute. The TB Group focused on the major issues involved in TB control, analyzed the current Washington State program in relation to recommendations from the Federal Centers for Disease Control and Prevention (CDC) and other national organizations for TB programs, considered the TB control programs developed by other states, considered statistical information, analyzed current surveillance programs to determine their ability to generate and review reliable epidemiological data including identifying local treatment and control issues.[60] The TB Group found that the previous TB law failed to address prevention, treatment, and educational measures adequately. Other significant concerns identified included lack of funding and allocation of fiscal responsibility between state and local public health agencies, lack of designated facilities, and lack of certainty about legal issues related to individual due process rights and the scope of public health officers' authority. The TB Group considered the Draft CDC Recommendations for TB Control Programs and several articles from the medical literature detailing the MDR-TB threat to public health.

The TB Group concluded that the critical elements of tuberculosis control were to reduce morbidity, protect the public's health, and eliminate the disease or at least reduce its incidence and its active prevalence through a coordinated statewide approach. This

59. TB Planning Group Meeting Minutes (Mar. 5, 1993) (on file with *Washington Law Review*) [hereinafter Mar. 5, 1993 Minutes].

60. The TB Group began with the presumption that the comprehensive health care reform legislation passed by the Washington State Legislature in 1993 would soon be implemented and have profound and far-reaching effects on all state health care programs. *See* Feb. 22, 1993 Minutes, *supra* note 58.

comprehensive approach would require public education as well as educating private health care practitioners (especially general practitioners), preventing long-term complications, assessing the actual and projected costs of the disease, assuring effective use of resources, reducing outbreaks in institutions, preventing emerging outbreaks of MDR-TB, identifying the source and spread of the disease, and providing expertise.

The TB Group also discussed how to reach target groups, to assure compliance with examination and treatment orders, to coordinate public health services in light of immigration policies, to educate the general public and high risk groups, to deal with persons with dual and triple diagnoses (such as persons with TB and other medical conditions including alcoholism, drug addiction, or HIV/AIDS), and to ensure adequate treatment with new and appropriate medications. Other clinical issues discussed were what research was needed, what would be appropriate follow-up for patients discharged from a health care facility, and the relationship between MDR-TB and HIV. Funding questions discussed included how much money was needed, how to secure that funding, what level of government should be financially responsible for TB control, and what were the roles of public versus private sector health care providers.

The TB Group decided that the following elements were essential to TB control legislation: funding mechanisms, preventive measures, training of health care professionals, the implementation of public educational programs, the development of model treatment standards, a community plan, and the resolution of jurisdictional issues. Specific treatment issues that might be dealt with legislatively included case management, scientific research, the development of rapid diagnosis capabilities, in-patient treatment resources, a treatment protocol for noncompliant persons, and priority setting which would include identifying and targeting high risk populations.

Along with general meetings, the TB Group divided into five working subcommittees: Provision of Services, Reporting, Treatment, Restrictions on Individuals, and Education.[61] Each subcommittee discussed specific aspects of legislative reform and submitted reports to the TB Group. The substance of subcommittees' work was reflected in the eight drafts of proposed legislation that were reviewed and debated by the entire committee.

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61. Mar. 5, 1993 Minutes, *supra* note 59.

B. Reviewing the Draft Legislation

The TB Group's legislation reform recommendations included establishing DOH responsibility for oversight of statewide TB control issues, granting DOH authority to develop practice standards and the process for managing noncompliant patients (focusing on the least restrictive measures necessary to gain compliance including establishing due process provisions for emergency detention), and establishing funding mechanisms.

The major components of the TB Group's proposed legislation clarified reporting requirements, established a significant change in authority and responsibility for TB control in the state, allowed non-licensed personnel to perform skin tests, added practice standards and set minimum levels of services related to TB control, established a TB Advisory Committee to be appointed by the Secretary of DOH, established educational programs and scientific research, created mandatory treatment regimes, developed measures designed to ensure that individuals receive screening and treatment within a context of due process provisions modeled after Washington's mental health and sexually transmitted disease statutes, and, finally, established funding mechanisms and responsibilities.

The TB Group discussed due process issues at its July 23, 1993 meeting. The TB Group made three recommendations: (1) that the wording in Draft Five related to the appointment of a hearing officer should be examined in reference to the "Board of Health" because this language was seen to possibly "cause some problems" in places like Seattle-King County;[62] (2) that the draft should be revised to include "language which clearly allows detention until completion of an appropriate course of treatment;"[63] and (3) that the process to be used when persons released after detention fail to comply with their treatment plan should be clarified.[64]

Funding options and locations of facilities for detention also were discussed at the July 23, 1993 meeting. Three recommendations were made. First, the group recommended that the State pre-designate a minimum number of treatment and detention sites. Second, the group recommended further pursuit of "[i]ssues related to jurisdiction for both

62. TB Planning Group Meeting Minutes 1 (July 23, 1993) (on file with *Washington Law Review*).

63. *Id.* at 2.

64. *Id.*

the health officer and legal action."[65] Third, the group recommended identifying and developing a public health emergency fund at the state level for a broad range of public health emergencies including TB detention with decisions regarding detention placements to be made in partnership between state and local health officers.[66]

The TB Group had a flurry of activities in the final weeks preceding submission of its draft legislation. The TB Group had its last formal meeting on July 23, 1993. Later it had a joint meeting with the Washington State Association of Local Public Health Officials on August 4, 1993. The TB Group's draft legislation was due to the DOH's Legislative & Constituent Relations Office on August 10 and due to the Office of Financial Management on September 3, 1993. A memo dated August 12, 1993 updated TB Group members on recent activities and attached copies of its draft legislation. During this time, the TB Group was informed by the DOH Professional Licensing staff that non-licensed personnel could not perform off-site skin testing and that this issue could not be addressed in administrative rule-making but had to be addressed in statute.

During July and August 1993, some members of the TB Group also met with legislative staff and legal counsel to discuss concerns about draft due process language and the proposal that public health orders be issued prior to every emergency detention.[67] As a result of these meetings, a consensus was reached to submit alternative language on these issues to the DOH Executive Team with an explanation that the due process provisions still were being discussed by the TB Group.[68]

C. *Briefing the Office of Financial Management*

The proposed legislation (Draft Eight) was reviewed by the Office of Financial Management (OFM) on October 14, 1993. OFM noted that the DOH's TB budget for 1993 contained approximately $1.34 million in state and federal funds which were currently being used for surveillance and prevention of TB, HIV-related programs, laboratory upgrades, and research.[69] The OFM's briefing report noted that legal detention

65. *Id.*

66. *Id.*

67. Memorandum from Roxie Schalliol, Washington State DOH, to the TB Planning Group (Aug. 12, 1993) (on file with *Washington Law Review*).

68. *Id.*

69. Department of Health, Immunization, & TB Servs., *OFM Briefing: Proposed TB Legislation*, Oct. 14, 1993, at 1.

proceedings had been instituted in no more than five instances in the previous five years.[70]

D. *Effect of Attorney General Opinion on TB Group*

In October 1993, the TB Group ceased its work, anticipating the issuance of a formal Attorney General's Opinion (AGO) on the power of local health officers regarding TB control. The Chair of the Senate's Health Care Committee requested this formal opinion, which was issued in December 1993. The AGO stated that legislation addressing issues of procedure and due process would provide a "starting point for the court's due process analysis."[71] The AGO also noted that without such statutory guidelines for the examination, treatment, and detention of persons with infectious tuberculosis, the court would be unaware of the legislature's position on how much process was required.[72]

Subsequent to the issuance of the AGO, the Chair of the Senate Health Care Committee conferred with the State Board of Health and expressed his preference that due process issues be dealt with through rule-making by that body instead of through legislative reform.[73] As a consequence, the TB Group withdrew many of its reform recommendations from the proposed legislation. The resulting draft legislation consisted of only two new sections. One section contained the legislative findings concerning the increased risk of TB, recognizing the imperative that local health officials have the authority to act to protect the public health. The second new section mandated that the State Board of Health adopt rules establishing reporting requirements, due process standards, and provide for the training of persons who could test for TB and administer medications.[74]

E. *Reconvening of TB Group and Drafting of Regulations*

The State Board of Health reconvened the TB Group in January 1994 to draft new rules. This included updating Washington Administrative

70. *Id.*

71. 20 Op. Wash. State Att'y Gen. 10 (1993).

72. *Id.*

73. Interview with Katherine M. Anderson, then Coordinator, Washington State TB Control Program, in Seattle, Wash. (Apr. 1996); Interview with Gary Livingston, Coordinator, Washington State TB Control Program, in Seattle, Wash. (Feb. 1996).

74. S. 6158, 53d Leg., Reg. Sess., 1994 Wash. Laws 145.

Code chapters 246-100, 246-170, and 246-271.[75] After public review, the rules submitted for enactment by the State Board of Health reflect the due process content of the legislation initially proposed by the TB Group. Despite some opposition, formal legislative adoption of the new rules occurred on December 14, 1994 and took effect officially on January 24, 1995.[76]

IV. OVERVIEW OF CURRENT WASHINGTON LAWS PERTAINING TO TB: LEGISLATION, REGULATIONS, AND LOCAL HEALTH OFFICER POWERS

Washington's current TB law contains features of both an administrative/public health model and a judicial/due process model. "Administrative model" as used herein means granting broad powers to public health departments to exercise discretion in issuing and enforcing public health orders, including detention powers. "Judicial/due process model" as used herein means requiring public health departments to use the court system for due process hearings for issuance or enforcement of public health orders. The administrative model in Washington law is found in both Washington Revised Code chapters 70.05 and 70.28. The judicial/due process model is found in Washington Administrative Code chapter 246-170. These statutes and regulations are discussed in detail below.

Washington statutory law pertaining to the general powers and duties of local health departments is found in chapter 70.05. This chapter confers broad powers on local health departments to act as necessary and within their discretion to protect the public health. At the local level, the local Board of Health supervises the control and prevention of any dangerous, contagious, or infectious disease within the jurisdiction of the local health department.[77] Local health departments are defined as the county or district that provides public health services to persons within that area.[78] In Washington, there are thirty-three local public health

75. Letter from Dr. M. Ward Hinds, Vice-Chair, Washington State Board of Health, to Representative Dellwo (Jan. 12, 1994) (on file with *Washington Law Review*).

76. Senator Phil Talmadge, then Chair of the Washington State Senate Health and Human Services Committee, expressed his opposition to these draft regulations in writing. Letter from Sen. Talmadge to Dr. M. Ward Hinds, Chair of the State Board of Health (Nov. 29, 1994) (on file with *Washington Law Review*). The letter stated that "the draft rules place unneeded obstacles in the way of public health professionals and so violate our intent when we agreed to pass ESB 6158." *Id.* The rules were adopted as drafted. S. 6158.

77. Wash. Rev. Code § 70.05.060 (1996).

78. Wash. Rev. Code § 70.05.010 (1996).

jurisdictions, of which nineteen are local health departments. Of the nineteen local health departments, seventeen are single-county agencies and two are combined city-county agencies.[79]

The local health officer (LHO) is an individual appointed by the local Board of Health as the health officer for the local health department or as the director of public health for a combined city-county health department.[80] Duties of the LHO include reviewing and determining appropriate action for each suspected case of a reportable disease or condition, or any disease or condition considered a threat to public health, and each reported outbreak or suspected outbreak of disease. The LHO also institutes measures for disease prevention and infection control, including isolation, detention, and quarantine measures necessary to prevent the spread of communicable disease. In carrying out these duties, the LHO may invoke the power of the courts to enforce any measures when necessary.[81] Each LHO has the authority to carry out any additional steps necessary to verify a diagnosis reported by a health care provider, require any person suspected of having a reportable disease or condition to submit to examinations needed to determine the presence of the disease or condition, and to investigate any case or suspected case of a reportable disease or condition or other illness, communicable or otherwise, if deemed necessary.[82] Washington law requires health care providers diagnosing or caring for a person with TB, whether pulmonary or non-pulmonary, to report the case to the LHO or local health department in accordance with the provisions established for Category A conditions and diseases. In addition, health care providers are to report the patient's status to the LHO every three months or as requested.[83]

There is also a specific statute governing TB: Washington Revised Code chapter 70.28 ("TB Statute"). The TB Statute requires all practicing physicians in the state to report to local Boards of Health, in writing, the name, age, sex, occupation, and residence of every person having TB who has been attended by, or come under the observation of, the physician within one day.[84] Medical laboratories that conduct TB

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79. Linda Topel, Northwest Ctr. for Pub. Health Practice, *Welcome to Public Health! A Guidebook for Local Board of Health Members* 12 (1st ed. 1996). For information and requirements regarding combined city-county health departments, see Washington Revised Code chapter 70.08 (1996).

80. Wash. Admin. Code § 246-100-011(23) (1995).

81. Wash. Admin. Code § 246-100-036(1) (1995).

82. Wash. Admin. Code § 246-100-036(3) (1995).

83. Wash. Admin. Code § 246-100-211(1) (1995).

84. Wash. Rev. Code § 70.28.010 (1996).

tests also are required to report cases of TB.[85] This mandatory reporting is the first line public health defense to prevent the spread of TB by notifying the LHO so appropriate public health measures can be taken.

The LHO is authorized to use "every available means" to ascertain the existence of, and to immediately investigate, all reported or suspected cases of TB.[86] In conducting the necessary investigation and crafting interventions, the LHO is given full powers of inspection, examination, treatment, and quarantine or isolation.[87] Whenever an LHO determines "on reasonable grounds" that examination, treatment, or quarantine of any person is necessary for the protection of the public health, the LHO is to set out, in writing, the specific terms or conditions to be followed in the form of an administrative public health order. The affected individual is free, however, to select a licensed physician of their own choosing to conduct any required examination.[88]

If the LHO determines the necessity of quarantine or isolation in a particular case, the LHO must make an isolation or quarantine order in writing, setting forth the name of the person to be isolated or quarantined, the period of time during which the order is to remain effective, the place of isolation or quarantine, and other such terms and conditions as may be necessary to protect the public health.[89] Once this administrative public health order is made, it must be served upon the affected individual. If the individual violates the public health order, then the LHO is required to advise the local prosecuting attorney's office and submit information to the prosecutor about the subject matter of the order.[90] Violation of a public health order is a misdemeanor and, in addition to other permissible general punishments, the court may order the convicted individual "confined until such order of such health officer shall have been fully complied with or terminated by such health officer, but not exceeding six months from the date of passing judgment upon such conviction . . . ."[91] The LHO also is permitted to apply directly to superior court if an individual is refusing to cooperate with recommended public health measures and the LHO has reasonable cause

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85. *See* Wash. Admin. Code §§ 246-100-236, -231 (1995).
86. Wash. Rev. Code § 70.28.031.
87. Wash. Rev. Code § 70.28.031.
88. Wash. Rev. Code § 70.28.031.
89. Wash. Rev. Code § 70.28.031(e).
90. Wash. Rev. Code § 70.28.031(g).
91. Wash. Rev. Code § 70.28.033 (1996).

to believe that the individual has TB.[92] The court then may issue an order requiring the individual to comply with the public health department's order. In such a case, if the individual violates the court order then the individual may be held in contempt for such violation and the court may order additional sanctions.

Public health officials may seek involuntary detention of a person suspected of having TB who refuses to be examined.[93] To obtain a judicial (court) order authorizing detention, the state must show such detention and treatment is necessary to protect the public on the basis of "generally accepted standards of medical and public health science."[94] Orders for examination must be in writing and must include the name of the person to be examined, the time and place of the examination, and other such terms and conditions as may be deemed necessary.[95]

As previously noted, the TB Statute contains a traditional administrative model for public health powers and duties. The statute does not identify the "due process standards" for local public health departments in exercising their authority to involuntarily detain, test, treat, or isolate persons with suspected or confirmed TB. Instead, the 1994 amendments to the statute authorize the State Board of Health to adopt regulations to set out the due process standards.[96]

The legislature amended the TB Statute in 1995 and 1996. One amendment recognizes individual liberty interests by allowing individuals to choose "spiritual means alone through prayer to treat tuberculosis in accordance with the tenets and practice of any well-recognized church or religious denomination. . . ."[97] Thus, affected individuals may decline recommended medical treatment for TB on this basis. However, although the individual may select this type of non-traditional treatment, the LHO still is empowered to take necessary measures to protect the public health. This could result in an extended (perhaps indefinite) isolation period for such an affected person.[98]

The due process standards for local public health departments/districts to follow in compelling individuals to comply with public health orders

92. Wash. Rev. Code § 70.28.035 (1996).

93. Wash. Rev. Code § 70.28.037 (1996).

94. Wash. Admin. Code § 246-170-051(2)(d) (1995).

95. Wash. Rev. Code § 70.28.031(d).

96. These regulations were later enacted in January 1995; for a discussion of these regulations see *infra* part V.

97. Wash. Rev. Code § 70.28.031.

98. Interviews with Katherine M. Anderson, *supra* note 57.

regarding TB are located in Washington Administrative Code chapter 246-170. The regulatory standards contain these judicial/due process elements: adequate notice, an opportunity to be heard, provision of counsel for indigents, right to a judicial proceeding, right to confront and cross-examine witnesses, right to subpoena witnesses, burden of proof on the state/public health department, "preponderance of the evidence" proof standard, and a process to re-petition the court regarding new evidence or a change of circumstances.[99]

V. COMPARISONS BETWEEN CURRENT WASHINGTON TB LAW, PRIOR TB LAW, AND OTHER HEALTH RELATED LAWS

A. Prior TB Law

The most significant difference between the new TB legislation/regulations and the prior law is the creation of due process standards. Under both the previous and current statutory law, the LHO is required to report in writing violations of administrative public health orders for examination or quarantine to the prosecuting attorney. Violation of LHO orders remains a misdemeanor. Potential penalties for violating a public health order include court ordered confinement until full compliance. The court can place the guilty person on probation for a period not to exceed two years, conditioned upon compliance with the terms of the LHO's orders. However, the statute does not contain the due process standards. Instead, the statute grants authority to the State Board of Health to draft the due process standards as rules.[100]

The State Board of Health did develop and enact due process standards in the Washington Administrative Code Chapter 246-170.[101] These regulations provide a detailed judicial/due process mechanism that exists in tandem with broad powers and discretion conferred on local health departments by the statutes[102] (chapter 70.05 and the TB Statute) and the Washington State Constitution.[103]

99. Wash. Admin. Code § 246-170-055 (Supp. 1996).

100. Wash. Rev. Code § 70.28.032 (1996).

101. *See* Wash. Admin. Code §§ 246-170-051, -055.

102. Wash. Rev. Code chs. 70.05, 70.28 (1996).

103. *See* Wash. Const. art. XI, § 11.

B. *Relationship Between Washington's TB Law and HIV/AIDS and Mental Health Laws*

The emergence of the HIV/AIDS epidemic and legislation developed to address that communicable disease significantly influenced recent amendments to the TB legislation.[104] The plight of people with HIV/AIDS and perceptions about the threat and spread of that disease had a dramatic effect on the public's awareness of communicable diseases and the role of government health authorities.[105] The public needed to rely upon government health officials for information and for necessary enforcement measures to protect its general health and safety. Clinical debates occurred as medicine sought to determine the nature of HIV/AIDS, its potential treatments, and its routes of transmission. Political debates occurred as social leaders sought to create new laws and regulations to address that disease and to reassure the public. The privacy and civil rights concerns of affected persons were debated early in the HIV/AIDS epidemic.[106] The public struggled to find a balance between its fears of that new lethal communicable disease and the rights of infected individuals. Governmental public health measures implemented in response to HIV/AIDS sought to balance the need for disease control measures against individual liberty interests including constitutional due process rights.

With the medical community's determination that HIV/AIDS is not transmitted by casual contact, the lawmakers set public health intervention parameters in light of the potential public health risks. This combination of non-casual transmissibility and the liberty and due process concerns together produced the current legal approach of placing explicit limitations on compelled testing, treatment, isolation, or detention of persons with HIV/AIDS.[107]

Unlike HIV/AIDS, however, TB can be transmitted through casual contacts. This difference in transmissibility was significant to lawmakers and is important to consider when comparing the public health interventions developed to respond to these diseases.[108] Unlike the

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104. Interview with Katherine M. Anderson, *supra* note 57; Interview with Gary Livingston, *supra* note 73; Interview with Dr. Charles Nolan, *supra* note 37.

105. Rosemary G. Reilly, *Combating the Tuberculosis Epidemic: The Legality of Coercive Treatment Measures*, 27 Colum. J.L. & Soc. Probs. 101, 103 (1993).

106. *Id.*

107. Wash. Rev. Code ch. 70.24 (1996).

108. In addition to the relationship between TB and HIV/AIDS public health laws there is also a relationship between the diseases themselves. As noted earlier, tuberculosis occurs with increased

response to the HIV/AIDS epidemic in the 1980s, which relied on voluntary behavior-modification strategies, the public health response to treatment of TB has been a traditional public health model of compulsory control.[109] The modes of transmission of HIV/AIDS are a significant reason why Washington's HIV/AIDS law gives less deference to the discretion of public health authorities and contains stringent criteria prior to an LHO isolating or detaining persons on the basis of HIV/AIDS infection. The legislative approach taken in Washington's HIV/AIDS law was studied by the TB Group as it developed its recommendations for updating Washington's TB laws.[110]

Laws relating to involuntary treatment and confinement of the mentally ill were another significant influence on the legislative reform of Washington's TB laws.[111] The power of the state to commit and treat mentally ill persons is specified in the Washington Constitution and also arises from inherent powers generally provided to the courts.[112] Washington's mental health law contains explicit due process standards that, in part, require appointment of an attorney and a court hearing prior to involuntary commitment of an individual. The law recognizes society's immediate safety interests by allowing a limited period of emergency detention prior to a court hearing. Ultimately, the decision whether to commit an individual is based upon a dangerousness standard. Legal standards for the involuntary detention and treatment of the mentally ill were considered by the TB Group as models for new laws enacted in response to the threat of MDR-TB.[113]

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frequency among HIV/AIDS infected persons. Nolan, *supra* note 31. Thus, patients may have both diseases, although LHO intervention measures may be related to only one of the patient's communicable diseases.

109. Reilly, *supra* note 105, at 118.

110. *See* TB Planning Group Meeting Minutes (Mar. 26, 1993) (on file with *Washington Law Review*). Interview with Katherine M. Anderson, *supra* note 57; Interview with Gary Livingston, *supra* note 73. Membership on the committee included persons knowledgeable about mental health commitment and advocates of HIV/AIDS service organizations.

111. TB Planning Group Meeting Minutes (Apr. 21, 1993) (on file with *Washington Law Review*) [hereinafter Apr. 21, 1993 Minutes]; *see also* Wash. Rev. Code ch. 70.24.

112. State *ex rel.* Richey v. Superior Court, 59 Wash. 2d 872, 876–77, 371 P.2d 51, 54 (1962); State *ex rel.* Martin v. Superior Court, 101 Wash. 81, 94, 172 P. 257, 260–61 (1918).

113. Apr. 21, 1993 Minutes, *supra* note 111.

C. *Overview of Public Health Measures for the Control of Sexually-Transmitted Diseases, Including HIV/AIDS*

The public health system relies on health care providers and facilities to report certain contagious diseases to local or state authorities. Two purposes exist for reporting these diseases. One purpose is gathering data to monitor the incidence of communicable diseases. The second purpose is providing a record to ensure that appropriate steps are taken to control the individual's disease and thereby prevent the spread of the disease to others. Before the public health system can function, it first must be aware of the individual's disease status; hence, reporting is critical.

If the individual is unwilling or unable to accept voluntary treatment, then a public health examination, treatment, or detention order may be obtained by a state or local public health officer or their authorized representatives within the respective jurisdiction.[114] Judicial or judicially enforceable public health orders are the ultimate enforcement tools available for protecting the public from the spread of contagious disease. Violation of a public health order is a misdemeanor which is a criminal offense. However, other outreach and enforcement mechanisms are used and may be more effective than imposing criminal sanctions. Many local health departments employ caseworkers who deliver public health services on the streets. These caseworkers may locate persons suspected of carrying an infectious disease, draw blood for testing, counsel them on the control of their disease, help notify their sexual partners, and deliver medications. Caseworkers may offer compliance incentives including vouchers for hot meals and emergency shelter, bus tokens, transportation for medical appointments, and help with other social services.[115]

For each case of sexually transmitted disease (STD), including HIV/AIDS, the health care provider is required to instruct each patient regarding the communicability of the disease and requirements to refrain from acts that may transmit the disease to another.[116] If, after being diagnosed with an STD, there are reasonable grounds to believe that the individual is engaging in conduct that endangers the public health, state and local public health officers have the authority to examine and counsel, or cause to be examined and counseled, a person reasonably believed to be infected with, or to have been exposed to an STD.[117]

114. Wash. Rev. Code § 70.24.024.

115. Nolan, *supra* note 19, at 3.

116. Wash. Admin. Code § 246-100-206 (Supp. 1996).

117. Wash. Rev. Code § 70.24.024.

Detention orders or restrictive measures are available but only as a last resort when other measures to protect the public health have failed, including documented reasonable efforts to obtain the voluntary cooperation of the person believed to be infected with or to have been exposed to an STD.[118] The state or local health officer has the burden of proof to show that reasonable grounds exist for the issuance of the orders or restrictive measures and that the terms and conditions imposed are no more restrictive than necessary to protect the public health.[119]

Detention orders or restrictive measures are issued in the following sequence with the least intrusive measure used first: (1) an order to submit to a medical examination, testing, or seek counseling; (2) an order to obtain medical treatment for curable diseases; and (3) an order to immediately cease and desist from specified conduct that endangers the health of others.[120]

A person is reasonably believed to be infected or to have been exposed to an STD when laboratory test results confirm or suggest an STD, when a health care provider has directly observed clinical signs that confirm or suggest an STD, or when an individual infected with an STD provides information directly about the identity of his or her sexual or needle-sharing contacts. If such information is received from an infected individual, for the LHO to act on this information, it must first meet stringent credibility criteria.[121]

State and local health officers may issue written orders for medical examination, testing, treatment, or counseling only after all other efforts to protect the public health have failed, including reasonable efforts to obtain the voluntary cooperation of the person subject to the order. To meet the burden of proof there must be sufficient evidence to "reasonably believe" that the person has an STD and is engaging in conduct endangering public health.[122]

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118. Wash. Rev. Code § 70.24.024.

119. Wash. Rev. Code § 70.24.024.

120. Wash. Rev. Code § 70.24.024.

121. If such information is received from an infected individual, then the exposure to the STD must have occurred during a period when the disease may have been infectious, the contact must have been sufficient to transmit the disease, and, in the health officer's judgment, the individual is credible and believable. Wash. Admin. Code § 246-100-206.

122. "Conduct endangering public health" for all STDs is defined as anal, oral, or vaginal intercourse; activities introducing blood, semen, or vaginal fluids into a body orifice, a mucous membrane, the eye, or an open cut, wound, lesion, or other interruption of the epidermis; or a needle puncture or penetrating wound resulting in exposure to blood, semen, or vaginal fluids. For HIV and Hepatitis B, "conduct endangering public health " also includes the sharing of injection equipment

Written orders to cease and desist from specified activities may be entered by state or local health officers if the health officer determines three things: the person is engaging in conduct endangering public health; there exists evidence supporting a reasonable belief that the person is infected or has been exposed to an STD; and procedures for a medical examination, testing, or counseling were followed and exhausted.[123] Persons infected with HIV who are engaging in behavior presenting imminent danger to public health are detainable by court order.[124] An employee or volunteer law enforcement officer, firefighter, health care provider or staff of health care facilities may request HIV testing of an individual after "substantial exposure" to that individual's body fluids.[125]

D. *Overview of Washington's Mental Health Involuntary Treatment Act*

Our public health system also includes the laws pertaining to involuntary treatment for persons with mental illness.[126] Legal commentators frequently draw an analogy between involuntary confinement for communicable diseases and involuntary confinement for mental illness.[127]

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and donating or selling blood, blood products, body tissues, or semen. Wash. Admin. Code § 246-100-206.

123. Wash. Admin. Code § 246-100-206.

124. "Behaviors presenting imminent danger to public health" means anal or vaginal intercourse without a latex condom, sharing use of blood-contaminated injection equipment, or donating or selling HIV-infected blood, blood products, or semen by an individual with a laboratory-confirmed HIV infection. Wash. Admin. Code § 246-100-206.

125. Wash. Rev. Code § 70.24.340. "Substantial exposure" means physical contact resulting in exposure presenting possible risk, limited to a physical assault upon the exposed person involving blood or semen; intentional, unauthorized, nonconsensual use of needles or sharp implements to inject or mutilate the exposed person; an accidental parenteral or mucous membrane or non-intact skin exposure to blood, semen, or vaginal fluids. "Exposure presenting possible risk" means one or more of the following: introduction of blood, semen, or vaginal fluids into a body orifice, mucus membrane, the eye, or an open cut, wound, lesion, or other interruption of the epidermis; or a needle puncture or penetrating wound resulting in exposure to blood, semen, or vaginal fluids. Wash. Admin. Code § 246-100-206.

126. *See* Wash. Rev. Code ch. 71.05 (1996); Interviews with Gerald A. Smith, Senior Deputy Prosecuting Attorney, in Seattle, Wash. (Feb. 1996). A person may voluntarily seek treatment for mental illness if he or she is capable of giving informed consent for the recommended treatment. In such instances, the individual's treatment may be privately handled as any other treatment relationship between doctor and patient. The focus of this section is not on such voluntary treatment situations but rather the on involuntary mental health treatment system.

127. *E.g.*, Reilly, *supra* note 105, at 114–15 (referencing State v. Snow, 324 S.W.2d 532 (Ark. 1959), which is an early case making the analogy between confinement for public health reasons due to communicable disease and involuntary commitment for mental illness).

Washington's Involuntary Treatment Act (ITA) for mentally ill persons sets forth a detailed procedural process tied to key terms defined in the statute and regulation and embellished by case law.[128] The involuntary commitment process generally begins with a referral to the local County Designated Mental Health Professional (CDMHP).[129] Individuals may be temporarily detained in the field, but only law enforcement or a CDMHP can actually initiate involuntary commitment proceedings by filing a petition for initial detention and taking the person into custody for evaluation and treatment.[130] The individual must be examined within twenty-four hours[131] and may not be detained more than seventy-two hours unless a probable cause hearing validates continued detention.[132] After the initial seventy-two hour evaluation period, the person may be detained at the probable cause hearing and ordered to receive up to fourteen days of intensive (inpatient) treatment or up to ninety days of less restrictive treatment.[133] The court presiding over the probable cause hearing decides if treatment is in the best interests of the person, then fashions an order meeting those treatment needs.[134] Less restrictive treatment refers to any form of treatment which is less intrusive on personal liberty interests than commitment to a locked psychiatric ward.[135] Examples of common less restrictive treatment measures include the following: medications, outpatient therapy, and residential placement in a specialized mental health halfway house.[136] At the expiration of the fourteen day period of intensive treatment, commitment may be extended only after a new petition for detention is filed by the CDMHP.[137] The required contents of such a petition include a summary of facts supporting the need for continued confinement, affidavits signed by two examining physicians supporting the petition and describing the person's behaviors that support the need for recommended involuntary treatment and confinement in detail, and an explanation of any less restrictive treatments that are alternatives to

128. Gerald A. Smith & John H. Hertog, *Involuntary Commitment*, in *Washington Family Law Deskbook* § 72.3(6) (1991).

129. *Id.*

130. Wash. Rev. Code § 71.05.150.

131. Wash. Rev. Code § 71.05.210.

132. Wash. Rev. Code § 71.05.200(1)(a).

133. Wash. Rev. Code §§ 71.05.230, .240.

134. *In re* J.S., 124 Wash. 2d 689, 699, 880 P.2d 976, 978–79 (1994).

135. Smith & Hertog, *supra* note 128.

136. *Id.*

137. Wash. Rev. Code § 71.05.280.

detention.[138] Unless the detained person waives his or her right to attendance, the person appears in court the day after a petition for a ninety-day commitment is filed. At that time, the person must be informed of their right to be represented by an attorney and their right to a jury trial on the further request for detention.[139] At the ninety-day commitment hearings, the rules of evidence apply and the mental health authorities petitioning for continued involuntary treatment must establish the need for detention by clear, cogent, and convincing evidence.[140] If necessary, mental health authorities can petition for additional involuntary mental health commitment for a maximum time period of another 180 days for each additional court order.[141]

The statute summarizes the legislative intent underlying the ITA as:

> (1) To end inappropriate, indefinite commitment of mentally disordered persons and to eliminate legal disabilities that arise from such commitment;
>
> (2) To provide prompt evaluation and short term treatment of persons with serious mental disorders;
>
> (3) To safeguard individual rights;
>
> (4) To provide continuity of care for persons with serious mental disorders;
>
> (5) To encourage the full use of all existing agencies, professional personnel, and public funds to prevent duplication of services and unnecessary expenditures;
>
> (6) To encourage, whenever appropriate, that services be provided within the community;
>
> (7) To protect the public safety.[142]

The ITA proceedings derive from the State's parens patriae and police powers[143] as well as from constitutional and inherent powers.[144] The ITA

138. Wash. Rev. Code § 71.05.290.

139. Wash. Rev. Code § 71.05.300.

140. Smith & Hertog, *supra* note 128, § 72.6(4).

141. Wash. Rev. Code § 71.05.320.

142. Wash. Rev. Code § 71.05.010.

143. *In re* LaBelle, 107 Wash. 2d 196, 221, 728 P.2d 138, 153 (1986).

144. State *ex rel.* Richey v. Superior Court, 59 Wash. 2d 872, 371 P.2d 51 (1962); State *ex rel.* Martin v. Superior Court, 101 Wash. 81, 172 P. 257 (1918).

contains many procedural and substantive due process safeguards to prevent the inappropriate involuntary commitment of persons. For example, the statute requires that detained persons receive formal notification from the court of their rights to remain silent, to an attorney, and to present evidence and cross-examine witnesses in judicial proceedings. In addition the statute requires that these patient rights be "prominently posted."[145] Also, detained persons have the right to designate and have the court appoint a reasonably available independent physician or licensed mental health professional to conduct an examination of the detainee and provide information in the court proceeding.[146]

Washington's mental health law only permits the involuntary detention of persons on the basis of dangerousness,[147] that is a "likelihood of serious harm"[148] to self or others, or "gravely disabled,"[149] as a result of a "mental disorder."[150] Washington case law also has required an evidentiary showing of "behavior" or a "recent overt act" in order to satisfy the dangerousness standard of "substantial risk."[151]

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145. Wash. Rev. Code § 71.05.370.

146. Wash. Rev. Code § 71.05.470.

147. Smith & Hertog, *supra* note 128.

148. "Likelihood of serious harm" means either:

> (a) a substantial risk that physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on one's self, (b) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm, or (c) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others.

Wash. Rev. Code § 71.05.020(3).

149. "Gravely disabled" means:

> [A] condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety."

Wash. Rev. Code § 71.05.020(1).

150. "Mental disorder" means "any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions." § 71.05.020(2).

151. *In re* Harris, 98 Wash. 2d 276, 654 P.2d 109 (1982).

E. Comparison of Due Process Elements Found in Washington's TB Law, HIV/AIDS Law, and Mental Health Involuntary Treatment Act

1. Detention

If an individual fails to comply with a public health order, the LHO may seek to detain that person consistent with the standard applicable to the individual's condition. Under Washington's TB law, the statute (following the administrative model) provides broad discretion for an LHO to take measures "necessary to protect the public health."[152] However, the TB regulation (following the judicial/due process model) requires an LHO to show all the following elements to obtain a court order: (1) that the person is a suspected or confirmed TB case; (2) the actions taken by the LHO to attempt to achieve voluntary compliance; (3) the nature and duration of the detention or other public health measure requested; and (4) the basis for believing that these measures are necessary to protect public health.[153] The TB regulation does permit involuntary detention on an emergency basis but requires the LHO to file a petition for detention, containing the elements noted above, within one judicial day of such detention.[154]

The detention standard for persons with HIV/AIDS is significantly more stringent, reflecting that HIV/AIDS cannot be transmitted by casual contact as can TB. Thus, for detention of an HIV/AIDS infected person, the LHO first must exhaust all less intrusive means including examination, testing, counseling, and treatment measures and must have "sufficient evidence" to "reasonably believe" the person is engaging in "behaviors presenting an imminent danger to public health."[155]

Under Washington's ITA, commitment is permitted only on the basis of dangerousness (that is "likelihood of serious harm" to self or others or "gravely disabled") due to a "mental disorder."[156] As previously noted, these terms are defined in the statute and limit the application of this law to only those persons whose mental illness severely compromises their ability to function in the world or whose mental illness constitutes a substantial risk.[157] Washington case law adds another element to the

152. Wash. Rev. Code §§ 70.28.005, 031.

153. Wash. Admin. Code § 246-170-051(4) (Supp. 1996).

154. Wash. Admin. Code § 246-170-051(4).

155. Wash. Rev. Code § 70.24.034; Wash. Admin. Code § 246-100-206(6)(d).

156. Wash. Rev. Code § 71.05.150.

157. Wash. Rev. Code § 71.05.020(1), (2), (3).

detention standard, the requirement that such substantial risk is evidenced by behavior such as a "recent overt act."[158] The detention standard applied to the mentally ill is high, but this is justifiable because the loss of liberty is a significant infringement on the individual's constitutional rights.[159] As the Washington Supreme Court stated regarding mental health commitment, "[t]he risk of danger must be substantial and the harm must be serious before detention is justified."[160]

2. *Burden of Proof*

The administrative model as set forth in the TB statute simply provides for entry of a public health order at the discretion of the LHO without mentioning any burden of proof.[161] In contrast, when an LHO enters a public health order to compel a noncompliant person to cooperate with recommended public health measures, the judicial/due process model as set forth in the regulations places the burden of proof on the government health agency. The TB regulation establishes the burden of proof on the LHO to meet the required evidentiary showing by a "preponderance of the evidence."[162] The preponderance of evidence standard is generally understood to mean "more probably true than not true."[163]

In contrast, a higher burden of proof is required for enforcing public health orders against a person infected with HIV/AIDS: it is a "clear and convincing evidence" standard.[164] This burden of proof means a quantum of evidence or degree of proof greater than a mere preponderance, but something less than proof beyond a reasonable doubt.[165] Some commentators suggest this is a standard of "high probability" although

158. *In re* Harris, 98 Wash. 2d 276, 284–85, 654 P.2d 109, 113 (1982).

159. *See id.* at 279, 654 P.2d at 110–11 (citing Humphrey v. Cady, 405 U.S. 504, 509 (1972)).

160. *Id.* at 284, 654 P.2d at 113.

161. Because the statute does not contain a judicial review mechanism, it does not mention the burden of proof. Under the Administrative Procedures Act, however, the standard for judicial review of a final administrative action by an agency is, in its application, like an abuse of discretion standard. Wash. Rev. Code § 34.05.570(3) (1996).

162. Wash. Admin. Code § 246-170-055.

163. *In re* Sego, 82 Wash. 2d 736, 739 n.2, 513 P.2d 831, 833 n.2 (1973); *see also Washington Pattern Jury Instructions* § 21.01 (3d ed. 1989) (stating that to meet burden of proof by preponderance of evidence, fact-finder must be persuaded in considering all evidence that proposition on which party has burden of proof is more probably true than not).

164. Wash. Rev. Code § 70.24.034(4).

165. *Washington Pattern Jury Instructions*, *supra* note 163, § 160.02.

this characterization remains controversial in the Washington courts.[166] The rationale for use of this higher burden of proof seems once again tied to the modes of transmissibility for the disease and also may be influenced in part by the high level of privacy afforded to human sexual behaviors.[167]

The burden of proof for ITA cases differs depending on the type of hearing and the length of time covered by the action or order. The initial detention for evaluation and treatment may occur in two ways: either by a showing of probable cause at a court hearing[168] or by a CDMHP determination that an emergency involving imminent danger exists and detention is necessary pending judicial review within seventy-two hours.[169] For the initial involuntary commitment hearings (petitions for fourteen day commitments), the burden of proof is a "preponderance of the evidence."[170] For continuing involuntary commitment hearings (petitions for ninety or 180 day commitments), the burden of proof is increased to "clear, cogent, and convincing evidence."[171]

3. *Appointment of Attorney*

The TB statutory law is silent about attorney representation and does not specify any appeal mechanism for an individual who wishes to contest the issuance or enforcement of a public health order. This silence is consistent with the TB statute's administrative public health model and the deference given to LHOs' determinations and implementation of necessary public health measures.[172] The TB regulation addresses the right of an individual to legal representation in a hearing to contest a public health order. If the affected person is indigent, the regulation provides for appointment of an attorney at public expense.[173]

If an HIV-infected person is facing a hearing on the enforcement of a public health order, such person is entitled to legal representation because the statute provides, in relevant part, that "[h]e or she may have

166. *See id.* (citing Davis v. Department of Labor & Indus., 94 Wash. 2d 119 127, 615 P.2d 1279, 1284 (1980)).

167. Griswold v. Connecticut, 381 U.S. 479 (1965); State v. Koome, 84 Wash. 2d 901, 530 P.2d 260 (1975).

168. Wash. Rev. Code § 71.05.150.

169. Wash. Rev. Code § 71.05.150(2).

170. Wash. Rev. Code § 71.05.240.

171. Wash. Rev. Code § 71.05.310.

172. *See* Wash. Rev. Code § 70.28.005.

173. Wash. Admin. Code § 246-170-055.

an attorney appear on his or her behalf in the hearing at public expense, if necessary."[174]

In contrast, Washington's ITA law automatically provides for the appointment of an attorney to represent the affected individual, or the individual may privately hire an attorney of his or her own choosing.[175] In addition, the "professional person in charge of the facility"[176] and the court[177] are both responsible for notifying detained persons of their right to legal counsel.

4. Least Restrictive Alternative Principle

Substantive due process is basically a reasonableness test applied to statutes to determine the appropriateness and power of the government to enact such legislation; it also prohibits arbitrary governmental action. In substantive due process adjudication, the least restrictive alternative principle has been an element in the compelling state interest test.[178] Consistent with the least restrictive alternative principle, government should not encroach upon an individual's rights if its goals can be achieved in a less intrusive, restrictive, or costly manner.[179] This principle as applied to a public health situation means that the public health authorities must give full consideration to all acceptable alternative measures that are less restrictive or intrusive on the affected individual's fundamental liberty interests. In considering such alternatives, the government authority may consider the availability of treatment options. This consideration may include a cost analysis.[180] Neither the federal nor state constitutions require that the optimal course of treatment be followed, but rather that the course of treatment is adequate and reasonably based on professional judgment.[181]

Washington's TB law presents two different perspectives. In the TB statute, detention is authorized when the LHO determines detention to be

174. Wash. Rev. Code § 70.24.024(4)(a).

175. Wash. Rev. Code §§ 71.05.460, .300; *see also In re* Quesnell, 83 Wash. 2d 224, 243 517 P.2d 568, 580 (1973).

176. Wash. Rev. Code § 71.05.460.

177. Wash. Rev. Code § 71.05.300.

178. *See* Roy G. Spece, Jr., *The Most Effective or Least Restrictive Alternative as Only Intermediate and Only Means-Focused Review in Due Process and Equal Protection*, 33 Vill. L. Rev. 111, 113 n.2 (1988).

179. *Id.*

180. *In re* J.S., 124 Wash. 2d 689, 700, 880 P.2d 976, 981 (1994).

181. *Id.*

"necessary to protect the public health."[182] The TB regulation requires use of less restrictive measures provided that such measures are "sufficient to protect the public health."[183] The language in the statute (administrative model) and the regulation (judicial/due process model) are similar although the introduction of the least restrictive standard in the regulation is significant. The least restrictive standard still gives deference to the professional judgment of the LHO, however, it does place an additional burden on the petitioning health authority and provides a standard for a court to question and use in reviewing the LHO's recommendation for treatment measures. This itself implies a less deferential legislative attitude to the LHO's recommendations and actions, although as a practical matter, courts are still likely to give significant deference to the expertise of public health authorities within these parameters. In addition, the regulation requires an LHO to "make reasonable efforts to obtain voluntary compliance with requests for examination, testing, and treatment prior to initiating the procedures for involuntary detention."[184] It is unclear from the statute or the regulation if an LHO may use an individual's history of noncompliance as evidence in a current proceeding as a basis for not requiring additional opportunities for voluntary compliance with public health measures.[185]

The STD law also contains a least restrictive alternative standard, but it is more stringent than that in the TB law.[186] The LHO cannot detain an HIV-infected person unless and until all least intrusive measures are first used.[187] This appears to require an affirmative showing by the LHO that these measures were attempted and failed. If this interpretation is accurate, then the LHO would not be allowed to exercise professional judgment that to attempt the least restrictive measures would be inadequate or futile based upon prediction of noncompliance even if the prediction was tied to the individual's past noncompliant behaviors. The

182. Wash. Rev. Code § 70.28.031(e).

183. Wash. Admin. Code § 246-170-055.

184. Wash. Admin. Code § 246-170-051(1) (Supp. 1996).

185. Some TB Group members proposed a regulation containing this phrase "A person . . . who cannot be relied upon to voluntarily submit to appropriate testing, treatment . . . ." TB Planning Group Meeting Minutes (Aug. 30, 1994) (on file with *Washington Law Review*). Other members objected to that phrase. The TB Group examined whether the individual's reliability was at issue and whether the regulation should focus on whether or not a person had voluntarily submitted. The members did agree ultimately that reliability is an issue because the best predictor of future behavior is past behavior and because the LHO should have some discretion to prevent likely noncompliance from occurring. *Id.*

186. *See* Wash. Rev. Code ch. 70.24.

187. Wash. Rev. Code § 70.24.024(2).

practical implications of such a stringent standard are that LHOs are far less likely to use or consider more restrictive measures, including detention, for HIV/AIDS patients who are a risk to the public because the burden of justification is so great.[188]

Washington's ITA law fully incorporates the principle of the least restrictive alternative; however, the terminology used in the ITA is "less restrictive alternative."[189] Consistent with this substantive due process principle, the government must take the least intrusive action required to protect the patient and society in light of the affected individual's constitutionally protected liberty interests.[190] A statutory provision also provides for "conditional release" which itself is a form of less restrictive treatment and patient supervision.[191] The ITA even provides that the court may, if requested, appoint a professional person to seek less restrictive alternative courses of treatment and to testify on behalf of the detained person.[192]

5. *Duration of Detention*

The TB statute limits the duration of detention on the basis of a public health order by requiring release from involuntary detention "as soon as the health officer determines the patient no longer represents a risk to the public health."[193] In contrast, the TB regulation provides an explicit time period that a detention order cannot exceed. For a confirmed case of TB, an initial court ordered detention period is forty-five days.[194] Additional detention is possible but only after a re-hearing, and any additional detention cannot exceed 180 days without additional judicial review.[195]

The lawmakers gave some consideration to the duration of detention time frames based upon clinical treatment periods for TB.[196] In a case involving a noncompliant patient, the time frame itself may be less

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188. Telephone interview with Frank Chaffee, Program Coordinator, HIV Counseling AIDS Prevention Project, Seattle-King County Dep't of Pub. Health (Feb. 1996).

189. Wash. Rev. Code §§ 71.05.230, .240; *see also* Wash. Rev. Code §§ 71.05.290, .320.

190. Addington v. Texas, 441 U.S. 418, 425 (1979); *In re* McLaughlin, 100 Wash. 2d 832, 676 P.2d 444 (1984).

191. Wash. Rev. Code § 71.05.340.

192. Wash. Rev. Code § 71.05.300.

193. Wash. Rev. Code § 70.28.031.

194. Wash. Admin. Code § 246-170-055(2).

195. Wash. Admin. Code § 246-170-055(4).

196. Telephone interview with William L. Williams, Senior Assistant Attorney Gen. & former legal counsel, Washington State Dep't of Pub. Health (June 1996).

relevant than the act of imposing public health measures for a determined period because if the public health measures become unnecessary during the time period of a court order imposing them, then under the TB law the LHO is required to cease the unnecessary measures, including any involuntary detention, testing, treatment, or isolation.[197] There is no similar explicit provision in the HIV/AIDS law, although it is logical to presume the lawmakers would intend, and the LHO would only impose, those public health measures necessary to protect public health.[198] The duration of detention available in situations involving persons infected with HIV, however, is a maximum of ninety days under any court order.[199]

The ITA provides a variety of evaluation, treatment, and detention time periods. The shortest duration is the seventy-two hour hold.[200] After a probable cause hearing, the person may be detained for up to fourteen days of inpatient treatment and ninety days of outpatient treatment.[201] The longest duration involuntary commitment orders are ninety and 180 days.[202] Regardless of the length or presence of a court order authorizing continued detention or court supervised treatment, the ITA requires releasing individuals from involuntary intensive treatment or providing outpatient treatment when, in the opinion of the professional person in charge or the facility or his or her designee, the detained individual no longer presents a danger to self or others or such less restrictive measures are otherwise appropriate.[203]

VI. THE ATTORNEY GENERAL OPINION—SUBSTANCE AND LEGAL ANALYSIS

As noted earlier, one of the goals of the TB Group was to amend the state TB law to address legal concerns regarding individual rights and personal liberty interests versus implementing public health measures to protect the community. In attempting to achieve this aspect of its mission, the TB Group recommended legislation that would have set

197. Wash. Rev. Code § 70.28.032(1)(b).

198. Telephone interview with Frank Chaffee, *supra* note 188.

199. Wash. Rev. Code § 70.24.034.

200. *See* Wash. Rev. Code § 71.05.180. Some commentators have noted the possibility that allowing for weekends and holidays, the initial commitment for seventy-two hours could actually stretch to as much as six days. Smith & Hertog, *supra* note 128, § 72.3(2).

201. Wash. Rev. Code § 71.05.230.

202. Wash. Rev. Code § 71.05.320.

203. Wash. Rev. Code §§ 71.05.260, .340.

forth specific procedural due process guidelines in the TB Statute. As previously discussed, after the TB Group developed its initial legislative proposal, the Chair of the Washington State Senate Health and Human Services Committee requested by letter dated October 28, 1993 a formal opinion from the Washington State Attorney General's Office regarding the current TB statute; the scope of public health officers' authorities to involuntarily detain, test, or treat; applicability to non-infectious, as well as infectious persons; due process requirements; and whether these issues could be handled through administrative rule-making instead of legislation.[204]

The Washington Attorney General opinion (AGO) issued on December 23, 1993 notes that the combination of the specific TB statute[205] and the general public health statute[206] confers broad authority on the LHOs.[207] Section 70.28.031 provides authority for LHOs to order testing and isolation for those reasonably believed to have TB. Section 70.05.070 provides authority for the LHO to detain and treat such persons. The AGO further notes that the statutory language seems to contemplate a process by which an LHO first would issue a public health order for necessary interventions and would not notify the local prosecutor or seek judicial review unless the affected individual violated the public health order.[208] This approach is consistent with a number of other jurisdictions where commitment for TB patients is viewed as a rarely used last resort, occurring only if the patient fails to comply voluntarily with treatment.[209] The AGO specifically mentions that Washington's statutory scheme for public health lacks clarity because it uses a variety of terms to describe individuals subject to its provisions without any cross-reference or explanation of these terms.[210] However, the AGO remarks that as the basic thrust of these statutes is to empower an LHO with broad authority to issue orders necessary for the preservation and protection of the public health, this ultimate purpose should be borne in mind for these provisions to be properly understood.[211]

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204. Letter from Senator Phil Talmadge to Christine Gregoire, Attorney Gen. (Oct. 28, 1993) [hereinafter Sen. Talmadge's Letter] (on file with *Washington Law Review*).

205. Wash. Rev. Code ch. 70.28.

206. Wash. Rev. Code ch. 70.05.

207. 20 Op. Wash. Att'y Gen. 5 (1993).

208. *Id.*

209. *Special Report: Tuberculosis*, AIDS Pol'y & L., Supp. Apr. 1993, at 5–6.

210. 20 Op. Wash. Att'y Gen. 5, 7 (1993).

211. *Id.* at 6–7.

Significantly, the AGO is based upon a public health threat, parallel to a dangerousness standard and predicated on two key factual beliefs. First, the opinion presumes that "TB is an airborne disease that is rather easily transmitted to a person who is in contact with an infectious individual."[212] Second, it assumes that a person subject to the public health powers set forth in chapter 70.05 and the TB Statute "does in fact potentially pose a public health threat."[213] This dangerousness standard is significant because case law establishes that only in the face of society's reasonable concern for "danger" is there legal justification for intrusion on an individual's constitutionally protected liberty interests.[214]

Notwithstanding both the clear legislative intent to authorize broad discretion for LHOs to act as necessary to promote public health and court decisions indicating judicial deference to public health authorities, the lack of due process guidelines in the TB law did raise constitutional concerns. The AGO cites a line of Washington Supreme Court cases establishing the legal parameters for procedural and substantive due process in a variety of factual circumstances where an individual's liberty is at stake.[215] The AGO also notes the Washington Supreme Court recently affirmed its adherence to some aspects of the traditional deference given to public health authorities in *Spokane County Health District v. Brockett*.[216] In *Brockett*, the court held that public health disease prevention measures are "'beyond judicial control, except as they may violate some constitutional right guaranteed to [defendants].'"[217] Nevertheless, the AGO opinion declined to speculate on what level of procedural due process the courts may require of public health departments for TB patient situations. Instead, the AGO points out (as also noted by other scholars) the doctrinal uncertainty surrounding constitutional review of the exercise of public health powers, cautioning

212. *Id.* at 2.

213. *Id.* at 7–8.

214. *See infra* part VII.

215. 20 Op. Wash. Att'y Gen. 8 (1993) (citing *In re* Schuoler, 106 Wash. 2d 500, 723 P.2d 1103 (1986) (regarding involuntary electro-convulsive therapy (shock treatment)); *see also in re* Young, 122 Wash. 2d 1, 857 P.2d 989 (1993); Harper v. State, 110 Wash. 2d 873, 759 P.2d 358 (1988) (regarding involuntary administration of anti-psychotic medications), *rev'd*, 494 U.S. 210 (1990); *In re* Ingram, 102 Wash. 2d 827, 689 P.2d 1363 (1984) (regarding involuntary invasive surgery); Recovery Northwest v. Thorslund, 70 Wash. App. 146, 851 P.2d 1259 (1993) (regarding constitutionality of involuntary alcohol commitment statute).

216. 20 Op. Wash. Att'y Gen. 6–7 (1993) (citing 120 Wash. 2d 140, 839 P.2d 324 (1992)).

217. Spokane County Health Dist. v. Brockett 120 Wash. 2d 140, 149, 839 P.2d 324, 329 (1992) (quoting Kahl v. Chehalis, 45 Wash. 2d 616, 621, 277 P.2d 352, 355 (1954), and affirming ability of local health department to conduct needle-exchange program).

that no uniform and coherent set of criteria exist or have been developed by the courts.[218] In the face of such judicial ambiguity and the legislature's silence on the issue of due process requirements, the AGO concludes that any attempt to determine where the Washington courts will draw a due process line on TB situations is speculative.[219]

VII. FEDERAL AND STATE CONSTITUTIONAL CASE LAW REGARDING POWERS OF PUBLIC HEALTH AGENCIES TO ACT ON BEHALF OF THE "COMMON GOOD"

Despite legislative reform, Washington's statutory law remains silent on what due process is required for the involuntary testing, treatment, or detention of individuals with TB. The Washington Legislature delegated the drafting of due process standards to the State Board of Health.[220] The Legislature provided only two specific statutory guidelines to the Board of Health for this task. One guideline was that the due process standards be developed "for health officers exercising their authority to involuntarily detain, test, treat, or isolate persons with suspected or confirmed tuberculosis under Chapters 70.28.031 and 70.05.070." The other guideline was that a standard be created to "provide for release from any involuntary detention, testing, treatment, or isolation as soon as the health officer determines the patient no longer represents a risk to the public's health."[221]

Constitutional case law, both federal and state, provides little direct guidance for developing due process standards in the context of involuntary treatment and detention of individuals for public health reasons due to infectious disease. The U.S. Supreme Court has not considered the issue of what level of due process must be afforded to persons with communicable diseases.[222] Thus, although public health

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218. Gostin, *supra* note 3, at 97.

219. 20 Op. Wash. Att'y Gen. 10 (1993).

220. Wash. Rev. Code § 70.28.032(1)(b). The Washington State Constitution established the State Board of Health in 1889, making public health a government responsibility in Washington. State law has continued to refine the role, responsibilities, and structure of the public health authorities. In 1921, a State Department of Health was created. The State Board of Health is primarily responsible for addressing issues and making regulations that are principally of local concern and over which the DOH has limited authority. For more information on Washington's public health system and structure, and the relationship between DOH and the State Board of Health, see Thomas L. Milne, *A Separate Department of Health in Washington State: Four Years Before the Mast*, 11 J. Pub. Health Pol'y 305 (1990).

221. *See* Wash. Rev. Code § 70.28.032 (1) (b).

222. Reilly, *supra* note 105, at 129.

commentators generally agree on the need to act to prevent the spread of TB, no clear consensus exists about how to accomplish this goal within the bounds of the law.[223]

The U.S. Supreme Court did address the issue of when persons with contagious disease otherwise are qualified to perform their job duties within the parameters of the Rehabilitation Act of 1973 in *School Board v. Arline*.[224] Because the *Arline* decision rested on statutory provisions regarding equal employment and disabilities, its holding is not directly instructive about due process protections in the face of compelled public health measures. Nevertheless, one aspect of this decision is interesting to note when considering TB isolation and quarantine. The Court's analysis focused on whether the affected individual's condition (TB) posed a significant risk in her employment setting.[225] The *Arline* court articulated a four-pronged test to determine when such a person would pose a significant risk.[226] The test includes the following factors: (1) how the disease is transmitted; (2) how long the carrier is infectious; (3) the severity of the risk; and (4) the probability of disease transmission and the degree of harm caused by the disease.[227]

Although the *Arline* case involves the Rehabilitation Act, the Court's approach in considering the dangerousness standard is analogous to the reasoning needed on a case involving compelled provision of public health measures. Both cases require considering whether such measures are reasonable in light of the nature of the risk and how high the risk has to be to justify deprivation of significant liberty interests. One commentator believes that no matter how impressive the list of procedural due process protections afforded to affected individuals, as a practical matter, the courts will focus only on two factual issues in TB commitment proceedings: first, whether the individual has active TB and, second, the risk of transmission.[228]

Dangerousness and due process standards notwithstanding, a long line of cases supports a broad grant of powers to state government health authorities to take actions necessary to control communicable diseases.[229] This state government power is frequently characterized as a "police

223. Annas, *supra* note 1, at 585.

224. 480 U.S. 273 (1987).

225. *Id.* at 287.

226. *Id.* at 287–88.

227. *Id.*

228. Annas, *supra* note 1, at 586.

229. *See* Sen. Talmadge's Letter, *supra* note 204.

power" because it is an inherent power of the government to act to protect public health and safety.[230] Traditionally, when constitutional challenges have been raised to government police powers to quarantine, courts have upheld the public health mandates expressed through state legislatures.[231] Consistent with this traditional line of reasoning, courts did not overturn public health measures authorized through the legislature unless the measures were found to be arbitrary, oppressive, or unreasonable.[232] In applying a reasonableness review to actions of public health authorities, courts have been deferential in part due to a perception that the legislative and administrative bodies possessed greater expertise and that those bodies were more democratic than the judicial system.[233] Because of these perceptions, when a public health measure was challenged, the judicial review focused on whether a public health risk truly existed, not on how the public health measures impacted individual liberty.[234]

A current difficulty for public health departments and their legal advisors is how to apply these rulings to the present day. Most of these cases arose prior to the 1960s and, hence, prior to more recently developed judicial reasoning on due process and liberty interests. Also, contemporary due process case law stems, not from communicable disease cases, but from other areas such as involuntary mental health confinement. Unlike the traditional broad deference given by the courts to public health authorities in cases involving communicable diseases, in the circumstance of involuntary commitment for mental health treatment, the U.S. Supreme Court has held that such commitment requires a showing that the potential for harm is "great enough to justify such a massive curtailment of liberty."[235] A current uncertainty for public health authorities is what legal standards will be applied by courts to any contemporary public health measure that curtails individual liberty interests: that is, a deferential reasonableness standard or a more stringent scrutiny standard that may question even the underlying medical basis and judgment of the public health authorities.

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230. Annas, *supra* note 1, at 586.

231. John A. Gleason, Comment, *Quarantine: An Unreasonable Solution to the AIDS Dilemma*, 55 U. Cin. L. Rev. 217, 221 (1986).

232. *Id.*

233. Deborah Jones Merritt, *The Constitutional Balance Between Health and Liberty*, in *AIDS: Public Health and Civil Liberties*, Hastings Center Rep., Supp. Dec. 1986, at 2, 3.

234. *Id.* at 4.

235. Humphrey v. Cady, 405 U.S. 504, 509 (1972).

The 1905 landmark case of *Jacobson v. Massachusetts*[236] is cited frequently for the premise that the police power of the states includes the power to act to protect public health and safety.[237] The holding of the U.S. Supreme Court in *Jacobson* was very broad, as the Court acknowledged that in exercising its police powers a state may "enact quarantine laws and 'health laws of every description.'"[238] The *Jacobson* case involved a compulsory vaccination law that required school children to be vaccinated or be sent home. In essence, the court held that the compulsory vaccine was not unconstitutional because even individual liberty interests are subject to the "common good."[239]

Washington courts have developed a line of cases with similar reasoning, acknowledging the extraordinary power of public health authorities to take actions necessary to protect the citizenry.[240] Historically, Washington courts have shown extreme deference to government health authorities on matters of public health. The Washington Supreme Court has ruled consistently that public health statutes are to be liberally construed[241] and the courts should not interfere with actions taken by public health authorities to implement those statutes unless violation of a constitutional right occurs.[242]

In 1992, the Washington Supreme Court issued an opinion regarding the scope of public health authority. This appellate case, *Spokane County Health District v. Brockett*,[243] involved a challenge by a local prosecuting attorney's office to a trial court decision that approved the implementation of a needle exchange program by the local public health authorities.[244] The needle exchange program was initiated to prevent the spread of HIV and other infectious diseases among intravenous drug users by reducing the likelihood that contaminated needles would be used in the community. The prosecutor's office contended that the needle exchange program constituted unlawful distribution of drug

236. 197 U.S. 11 (1905).

237. Reilly, *supra* note 105, at 109.

238. Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905).

239. *Id.* at 26.

240. Spokane County Health Dist. v. Brockett, 120 Wash. 2d 140, 839 P.2d 324 (1992); State *ex rel.* McBride v. Superior Court, 103 Wash. 409, 174 P. 973 (1918); Brown v. Pierce County, 28 Wash. 345, 68 P. 872 (1902); Snohomish County Builders Ass'n v. Snohomish Health Dist., 8 Wash. App. 589, 508 P.2d 617 (1973).

241. *Brockett*, 120 Wash. 2d at 149, 839 P.2d at 329..

242. *Id.* (citing Kaul v. Chehalis, 45 Wash. 2d 616, 621, 277 P.2d 352, 355 (1954)).

243. 120 Wash. 2d 140, 839 P.2d 324 (1992).

244. *Id.* at 143, 839 P.2d at 325–26.

paraphernalia.[245] The court upheld the health department's needle exchange program citing both the sweeping authority given to LHO's by the general statute and specific provisions in the AIDS Omnibus Act.[246]

On one level, the *Brockett* case indicates the court's continuing deferential attitude toward public health authorities and their expertise to determine what health measures are necessary on behalf of the citizenry. In its analysis, the court cites the mandatory duties of LHOs:

> Local health officers . . . enjoy broad authority and are required to:
>
> (1) Take such action as is necessary to maintain health and sanitation supervision over the territory within his jurisdiction;
>
> (2) Control and prevent the spread of any dangerous, contagious or infectious diseases that may occur within his jurisdiction;
>
> (3) Inform the public as to the causes, nature, and prevention of disease and disability and the preservation, promotion and improvement of health within his jurisdiction.[247]

The court further states that it is reluctant to interfere in matters of public health and that "the subject matter and expediency of public health disease prevention measures are 'beyond judicial control, except as they may violate some constitutional right guaranteed to [defendants].'"[248]

The case also indicates however, that its holding may not extend to situations involving compelled treatment or quarantine of individuals. In issuing its opinion, the court notes that "[n]o rights of defendants, guaranteed by the Constitution, have been invaded."[249] Because compelled treatment or quarantine do involve and, hence, "invade," individual liberty interests, the *Brockett* decision offers no guidance as to what level of process is due prior to deprivation of constitutionally protected liberty interests, nor as to how the court will scrutinize the actions of public health authorities in such situations.

The Washington Supreme Court has issued decisions in various factual contexts regarding the substantive and procedural due process rights of individuals not to be subjected to involuntary treatment or

245. *Id.*

246. *Id.* at 155, 839 P.2d at 332 (citing Wash. Rev. Code chs. 70.05, .24 (1996)).

247. *Id.* at 149 (citing Wash. Rev. Code § 70.05.070(2)).

248. *Id.* (quoting Kaul v. Chehalis, 45 Wash. 2d 616, 621, 277 P.2d 352, 355 (1954)).

249. *Id.*

detention and the processes necessary to guard against erroneous deprivation of liberty interests.[250]

This line of Washington cases generally applies substantive due process analysis to situations where state law impinges on a fundamental constitutional right. To withstand constitutional scrutiny, the state law must serve a compelling state interest and be narrowly drawn to serve that interest.[251] This line of cases also defines procedural due process requirements in applying these state laws to affected persons. The procedures required in any particular situation are determined by analyzing several factors such as (1) the nature of the interest that will be affected by the governmental action, (2) the risk of erroneous deprivation of that interest through the procedures used and the value of any additional procedures, and (3) the governmental interest involved and the burden of additional or different procedures.[252]

These decisions indicate that the court will scrutinize the actions of public health authorities in individual cases of compelled treatment or quarantine to determine whether there is a public risk, whether there are less restrictive measures that reasonably can be implemented to reduce or eliminate the public risk, and to afford the greatest possible liberty to the affected individual. Lest there be any doubt about the court's willingness to substitute its judgment for that of public health officials, consider the court's comments from a mental health commitment case when noting the value of judicial oversight:

> One may question the value of such a judicial finding. What insight can a judge provide for a determination that is ultimately medical? Would not a judicial finding of probable dangerousness simply add another administrative burden with little additional protection for the individual since judges will generally defer to the recommendation of the mental health professional?
>
> While a magistrate may not be any better than a mental health professional at predicting whether a person presents a substantial likelihood of physical harm to herself or others, we do feel a magistrate can play an important role in the pre-detention process. The potential curtailment of liberty requires the intervention of an impartial third party to ensure not only that probable dangerousness exists, but that sufficient investigation has occurred, and that

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250. *See* Sen. Talmadge's Letter, *supra* note 204.

251. *In re* Young, 122 Wash. 2d 1, 26, 857 P.2d 989, 1000 (1993).

252. *Id.* at 43–44, 857 P.2d at 1010 (citing Mathews v. Eldridge, 424 U.S. 319, 335 (1976)).

commitment is the least restrictive alternative. These are uniquely judicial concerns that will ensure the system is not abused.[253]

Public health authorities should consider this judicial perspective before implementing court proceedings to compel treatment, but they should not let fear of a judicial process stymie the exercise of their duties.

VIII. CONCLUSION

Because Washington law has two distinct public health models (administrative and judicial/due process), some local public health departments have been confused over how these legal provisions can be used in tandem.[254] Some LHOs appear uncertain about the scope of their powers without formal court approval.[255] Because the local public health departments receive their legal advice from various sources (a mix of local prosecuting attorneys and private counsel)[256] and because of the potential for variations in response from local law enforcement and local court systems, possible differences in how the current TB law is interpreted and applied are understandable.[257] Overall, public health departments and districts appear cautious about exercising discretionary powers against a noncompliant patient without an authorizing court order. Indeed, in practice the LHOs appear to issue public health orders

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253. *In re* Harris, 98 Wash. 2d 276, 287–88, 654 P.2d 109, 114–15 (1982).

254. Interview with Katherine M. Anderson, *supra* note 57; Telephone interview with Dr. M. Ward Hinds, Snohomish County Health Dist. (Apr. 1996); Interview with Gary Livingston, *supra* note 73; Interview with Dr. Charles Nolan, *supra* note 37; Interview with Gerald A. Smith, *supra* note 126.

255. *Supra* note 254.

256. Interview with Katherine M. Anderson, *supra* note 57; Telephone interview with Dr. M. Ward Hinds, Snohomish County Health Dist. (Apr. 1996); Interview with Gary Livingston, *supra* note 73; Interview with Gerald A. Smith, *supra* note 126.

257. Nolan, *supra* note 19, at 2. This Article notes that a case, *State v. McQuakey*, was argued in Seattle District Court in 1986 that greatly influenced the approach taken by the Seattle-King County Dep't of Public Health. This (non-appellate) case is cited by Dr. Charles Nolan as substantially deterring the Department from using the health officer's quarantine statute, Wash. Rev. Code § 70.28.031, to act against noncompliant infectious patients. *Id.* Dr. Nolan reports that the court held "the state statute authorizing involuntary commitment . . . unconstitutional because it denie[d] the accused patient due process of law." *Id.* at 1. The Article also notes that such a predicament is not encountered uniformly throughout Washington State and that some local and county health officers have not had difficulty using the quarantine statute. *Id.* at 2.

In researching this paper, an attempt was made to locate the *State v. McQuakey* court file through both the King County Superior Court and the Municipal Court systems to no avail. The clerk's office reported that this file was destroyed following completion of its records retention schedule.

in reliance upon their broad statutory powers, but if a patient does not voluntarily cooperate with the public health order, the LHOs initiate the judicial due process procedures set forth in the regulations to seek a court order requiring the patient to comply with public health measures.

Possibly, some of the confusion experienced by public health authorities reflects the philosophies behind each of these two approaches. The administrative model reflects generalized beneficence. In medical ethics, beneficence is described as the duty to assist persons in need; this concept is a touchstone in the medical profession and is a promise in the Hippocratic Oath.[258] In intervening to treat a TB-infected individual, the philosophy of beneficence is that the public health department knows best and is here to help those persons in need whether or not they want help. If such persons do not cooperate, the public health department has the ability to take actions to require cooperation insofar as these public health measures are in the best interests of the public health. In contrast, the judicial/due process model focuses on individual rights. One commentator notes that the modern approach of individualized treatment for TB is a "paradigm shift" for public health authorities;[259] previously public health authorities mainly focused on achieving a "common good" of controlling disease rather than maximizing liberty for each affected person.

Court proceedings are adversarial. An individual's assertion of "rights" may result in a decision that is not a sound or desirable general policy to serve the common good. Hence, case law may stymie the traditional benevolent philosophy of public health authorities by making these officials overly cautious in exercising their legitimate powers. The case law's focus on the judicial/due process model also may result inappropriately in creating public health policy devoid of its traditional guiding principle of doing what is in the best interests of society as a whole.

Public health authorities may be redefining the best approach or method for treating persons with TB. Some public health commentators note that policy can be the mechanism for either structural changes or behavioral changes.[260] Thus, to the extent that public health authorities seek to eradicate TB, they must have a knowledge of potential structural interventions aimed at modifying the physical environment to prevent the

258. Albert R. Jonsen, et al., *Clinical Ethics* § 1.0.1 (3d ed. 1992).

259. Nolan, *supra* note 19, at 3.

260. Carol W. Runyan, *Progress and Potential in Injury Control*, 83 Am. J. Pub. Health, 637, 638 (1993).

disease. To provide effective intervention and treatment measures, public health authorities also must develop a deeper understanding of the role of behavior in the occurrence and control of TB. This requires both individualized treatment plans to modify the behaviors of TB-infected persons and an adequate public health infrastructure. When developing an individualized treatment plan, a basic concern is what can be achieved through voluntary means as opposed to compelled measures; in short, the question is whether to use a carrot (incentive) or stick (enforcement).

The incentives approach means that the local health department provides sufficient motivating factors so that the affected individual voluntarily chooses to comply with public health orders. The TB regulation requires an LHO to attempt to achieve an individual's compliance through voluntary means prior to resorting to imposed public health measures, as a petition for detention must specify actions taken by the LHO to obtain voluntary compliance.[261] Thus, LHOs have developed a variety of incentives for treating TB patients. Some examples are providing housing for affected persons and their families, providing meals, and providing economic rewards.[262] In contrast, the ultimate enforcement measure is judicial. The local prosecuting attorney's office may file a criminal action against the noncompliant individual for failure to abide by either a public health order or superior court order.

In sum, multiple issues may impact public health authorities and influence the delivery of services. Prior to the recent TB amendments and regulations, health officers and their legal counsel throughout the State of Washington had no specific due process procedure to follow. This contributed to an inconsistent approach with regard to the control of TB.[263] The full impact of introducing due process standards in the regulation may not be yet known. At present, the existence of both models (administrative and judicial/due process) in Washington's TB law creates ambiguity regarding the scope of the LHO powers and the need to access the judicial system, and results in inconsistent application of the law. These points of confusion may represent merely growing pains as the LHOs and their legal counsel sort out the available options under the new law. As LHOs gain familiarity with the new TB law, they may find that it provides them with greater overall flexibility to fashion

261. Wash. Admin. Code § 246-170-051 (4)(b) (Supp. 1996).

262. Sometimes these arrangements are made at local motels with proper ventilation systems, but one health department in Yakima, Washington actually purchased a travel trailer for such housing needs. Interview with Dr. Charles Nolan, *supra* note 37; Telephone interview with Dr. Diana Yu, Thurston County Health Officer (Apr. 1996).

263. 20 Op. Wash. Att'y Gen. 10 (1993).

individualized treatment plans and then, if voluntary compliance fails, to implement a judicial mechanism to compel compliance with necessary public health measures. This flexible range of public health powers updates Washington's approach to TB to incorporate constitutional standards. Recognizing that many TB-infected persons have other contributing personal, social, and medical problems (such as HIV/AIDS, substance abuse, homelessness, and poverty), some commentators argue that it is a mistake to treat TB as an isolated issue.[264] Accordingly, an ideal individualized treatment plan will offer tailored compliance incentives to help the whole person and will address other conditions that may place the individual at higher risk for re-contracting TB or for failing to comply with recommended treatment.[265] The idea that TB cannot be treated effectively and eradicated in isolation from other problems is not new.[266] Perhaps the recent changes in Washington's TB law will spur greater attempts to comprehensively treat not only this disease but also its root causes. With its emphasis on voluntary individualized treatment plans, Washington's new law may inspire public health authorities to create new comprehensive and humane intervention strategies to treat individuals infected with TB. These public health strategies to address the cause of the epidemic one individual at a time may offer the best means and hope for eradicating this disease.[267] Washington's new TB law gives public health authorities the necessary tools within a flexible legal framework to act to ensure individual due process while protecting the public health.

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264. *See* Annas, *supra* note 1.

265. Nolan, *supra* note 19, at 3.

266. Lee B. Reichman, *Fear, Embarrassment, and Relief: The Tuberculosis Epidemic and Public Health*, 83 Am. J. Pub. Health 639 (1993) (commenting that in 1962 Dr. F.L. Soper of Office of Surgeon General noted that eradication of tuberculosis would require solving many other problems (such as psychological, administrative, educational, and financial)).

267. *See* Annas, *supra* note 1, at 587.