17-1558

IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

Liberian Community Association of Connecticut, on behalf of themselves and those similarly situated, Louise Mensah-Sieh, on behalf of herself and her minor children B.D. and S.N., on behalf of themselves and those similarly situated, Victor Sieh, on behalf of themselves and those similarly situated, Emmanuel Kamara, on behalf of themselves and those similarly situated, Assunta Nimley-Phillips, on behalf of themselves and those similarly situated, Laura Skrip, on behalf of themselves and those similarly situated, Ryan Boyko, on behalf of themselves and those similarly situated, Esther Yalartai, on behalf of themselves and those similarly situated, Bishop Harmon Yalartai, on behalf of themselves and those similarly situated, Mary Jean O, on behalf of themselves and those similarly situated,
Plaintiffs-Appellants,

Nathaniel Sieh, on behalf of themselves and those similarly situated,
Plaintiff,

v.

Dannel P. Malloy, Governor, Raul Pino, Commissioner of Public Health, Jewel Mullen, Former Commissioner of Public Health,
Defendants-Appellees.

On Appeal from the United States District Court for the District of Connecticut – Honorable Alfred V. Covello
Case No. 3:16-cv-00201 (AVC)

Brief of Amici Curiae in Support of Appellants and Reversal

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rules 26.1 and 29(c) of the Federal Rules of Appellate Procedure, *Amici Curiae* state that they are not-for-profit non-stock hospitals and health systems. *Amici* either have no parent corporations, or if they do, the parent corporations are also not-for-profit non-stock corporations.

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STATEMENT OF INTEREST OF AMICI CURIAE[1]

Amici Curiae are Connecticut hospitals and health systems involved in the front lines of patient care, including during times of public health emergencies.

Amicus Yale New Haven Health System ("YNHHS")[2] is Connecticut's second-largest employer with over 24,000 employees and nearly 7,000 medical staff. Through Bridgeport, Greenwich, Lawrence + Memorial, Westerly and Yale New Haven Hospitals, and their affiliated organizations, YNHHS provides access to high-quality, patient-centered care from primary care to the most complex care available anywhere in the world.

YNHHS was directly affected by Defendants' quarantine policy in response to the 2014 Ebola outbreak. Not only did Yale New Haven Hospital provide monitoring and care to one of the plaintiffs quarantined

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[1] This brief is filed pursuant to Fed. R. App. P. 29(a)(2). Plaintiffs and Defendants consent to the filing of this amicus brief. No party's counsel authored this brief in whole or in part and no party or party's counsel contributed money intended to fund preparation or submission of this brief. No person other than the *Amici* or their counsel contributed to the preparation and submission of this brief.

[2] Yale New Haven Health System is a d/b/a for *Amicus* Yale New Haven Health Services Corporation.

during the crisis (Plaintiff Boyko), but the Hospital was for a time required to quarantine this individual on-site and to expend hospital resources in connection with a quarantine that was medically unnecessary and scientifically unjustified.

Amicus Hartford Hospital, founded in 1854, is one of the largest teaching hospitals and tertiary care centers in New England. The 867-bed regional referral center provides high-quality care in all clinical disciplines.

Amicus The Hospital of Central Connecticut is a 414-bed, 32-bassinet, acute-care community teaching hospital with campuses in New Britain and Southington providing comprehensive inpatient and outpatient services in general medicine and surgery and a wide variety of specialties.

Amicus Backus Hospital has provided quality health care to residents of Eastern Connecticut since 1893. Licensed for 233 beds, Backus Hospital is the only trauma center in Windham and New London Counties.

Amicus MidState Medical Center, with a history dating back to the 1800s, is a 156-bed acute care hospital located in Meriden, Connecticut, with satellite offices in Cheshire, Wallingford and Southington, that provides a broad spectrum of services.

Amicus Windham Hospital is a 130-bed acute care hospital committed

to excellence in quality and service which has served 19 communities in Eastern Connecticut for more than 80 years.

Amicus Saint Francis Hospital and Medical Center is the largest Catholic not-for-profit hospital in New England. Licensed for 617 beds and 65 bassinets, Saint Francis is a major teaching hospital and has provided high-quality patient care to individuals in north central Connecticut since 1897.

Amicus Johnson Memorial Hospital is a 92-bed hospital that has been an anchor healthcare institution in north central Connecticut for 104 years. Johnson Memorial Hospital is a Catholic not-for-profit institution.

Amicus Saint Mary's Hospital is a Catholic, not-for-profit, acute care, community teaching hospital that has served Greater Waterbury for more than 100 years. Licensed for 347 beds, Saint Mary's is designated as a Level II Trauma Center, offers award-winning cardiac and stroke care and houses the region's only pediatric emergency care unit.

Amicus Bristol Hospital, founded in 1921, is the leading health provider for people who live and work in the Greater Bristol area. With 154 licensed beds, Bristol Hospital has earned national recognition for its commitment to providing outstanding patient care and offers a complete

range of patient services including a first-rate emergency center that cares for more than 40,000 patients each year.

Amici Western Connecticut Health Network, Inc. is a premier, patient-centered health care organization serving residents of Western Connecticut and adjacent New York. The organization is anchored by three nationally recognized hospitals, Danbury Hospital, New Milford Hospital and Norwalk Hospital, and their affiliated organizations. The continuum of care offered includes numerous medical practices and sub-specialties across the region, home health care services, and a nationally renowned biomedical research institute.

Amici have an overarching interest in ensuring that Connecticut's responses to outbreaks of infectious disease are appropriately tailored to the public health risk and medically and scientifically justified. Stopping the spread of infectious diseases like Ebola is a core part of *Amici*'s mission. The best way to combat such diseases and protect American lives is at its source, and this requires sending public health workers (including, potentially, employees of *Amici*) to affected areas, such as Liberia. But unjustified quarantine policies deter public health workers from traveling to affected areas due to concerns that they will be subject to lengthy

quarantines upon returning to the State of Connecticut. When workers are dissuaded from volunteering, the ability to stop the spread of disease is compromised, raising the risk that a localized epidemic thousands of miles away will become a global epidemic hitting close to home. Unnecessary quarantines thus undermine public health rather than protecting it.

In addition, such policies may directly impair the functioning of hospitals whose staff are unable to return to work after traveling abroad to provide public health services and instead must spend weeks in isolation, potentially disrupting the provision of health services domestically. Unnecessary quarantines also contribute to public panic, misconceptions about how disease spreads, and to distrust of the health care system, which can prompt both over and underutilization of health care.

Finally, future outbreaks of infectious disease in the U.S. and abroad are inevitable. Thus, obtaining legal clarity on the appropriate standards governing quarantine is essential.

ARGUMENT OF AMICI CURIAE

In order to accomplish their purpose and to avoid harming public health interests, quarantines should be evidence-based and should be employed only when they are the least restrictive means for safeguarding public health. The quarantines of Plaintiffs Boyko, Skrip, and the Mensah-Sieh family were not medically or scientifically justified as there was no reason to believe that Plaintiffs could spread the Ebola virus. Quarantines like the one challenged here – which are motivated by panic, rather than sound science – are counterproductive. They not only infringe on important liberty interests of those quarantined and impose unnecessary burdens on the health care system, but they may also lead to the greater spread of disease rather than containment.

The district court decision in this case declined to address the merits of the important legal issues raised in this case and instead concluded that the Defendants had qualified immunity from suit. Such a ruling does not provide the necessary predictability or the clear and consistent guidelines that *Amici* as health care institutions need. Hospitals and other health care institutions need a reliable guide for the management of operations, particularly in times of health crises, such as quarantines. Thus, *Amici*

urge this Court to address the merits of the legal claims raised and to reverse.

I. Plaintiffs' Quarantines Were Not Medically or Scientifically Justified.

A. Ebola Is Transmitted Only By Direct Contact With the Bodily Fluids or Tissues of a Symptomatic Individual.

Ebola transmission occurs in very limited circumstances.[3] Since the emergence of Ebola in 1976, medical professionals and scientists have studied the disease and its transmission extensively and built up a considerable knowledge base.[4] Based on forty years of Ebola research and study, experts have determined that person-to-person Ebola transmission requires direct contact with the bodily fluids or tissue of an infected

[3] *Ebola Characteristics and Comparisons to Other Infectious Diseases*, The Henry J. Kaiser Family Foundation (Oct. 21, 2014), http://kff.org/infographic/ebola-characteristics-and-comparisons-to-other-infectious-diseases/(last accessed July 6, 2017).

[4] Centers for Disease Control and Prevention, *Interim Guidance for Managing Suspected Viral Hemorrhagic Fever in U.S. Hospitals* (May 19, 2005); Amy L. Hartman et al., *Ebola and Marburg Hemorrhagic Fever*, 30 Clinics in Laboratory Med. 161, 171-173 (2010); Linda Meyers et al., *Ebola Virus Outbreak 2014: Clinical Review for Emergency Physicians*, 65 Annals of Emergency Med. 101 (Oct. 23, 2014); American Civil Liberties Union & Yale Glob. Health Justice P'ship, *Fear, Politics, and Ebola: How Quarantines Hurt the Fight Against Ebola and Violate the Constitution*, 11-12 (2015).

individual in the later stages of the disease or after death.[5] Thus, while Ebola is very lethal, it is not easily transmittable. Ebola cannot be transmitted via the air or water and cannot be transmitted by an asymptomatic individual because such persons do not have a sufficiently high viral load.[6]

There has never been a documented case of Ebola transmission from an asymptomatic individual.[7] The risk of transmission based on simply being in the vicinity of potentially infected, but asymptomatic, individuals is effectively zero.

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[5] Jeffrey M. Drazen et al., *Ebola and Quarantine*, 371 New Eng. J. Med. 2029 (2014). *See also*, Centers for Disease Control and Prevention, *Interim Guidance for Managing Suspected Viral Hemorrhagic Fever in U.S. Hospitals* (May 19, 2005).

[6] Drazen, *supra* note 5 ("[T]ransmission arises from contact with bodily fluids of a person who is symptomatic — that is, has a fever, vomiting, diarrhea, and malaise. We have very strong reason to believe that transmission occurs when the viral load in bodily fluids is high, on the order of millions of virions per microliter. ... Therefore, an asymptomatic [individual] even if he or she were infected, would not be contagious."). *See also* Centers for Disease Control and Prevention, Transmission of Ebola (Ebola Virus Disease) (2014); Gillian K. SteelFisher et al., *Ebola in the United States — Public Reactions and Implications,* 373 New Eng. J. Med. 789 (2015).

[7] Indeed, a study of over 700 Liberian Ebola patients found that none had contracted Ebola from an individual whose only potential symptom was a fever. D. Chertow et al., *Ebola Virus Disease in West Africa – Clinical Manifestations and Management*, 371 New Eng. J. Med. 2054 (2014); American Civil Liberties Union, *supra* note 4, at 12.

In August 2014, the Centers for Disease Control and Prevention ("CDC") provided guidance for managing asymptomatic travelers arriving from West Africa. In accordance with the scientific consensus, the CDC recommended no movement restrictions for individuals that had not had direct contact with the bodily fluids of an Ebola-symptomatic individual. The CDC recommended only self-monitoring or active monitoring.[8]

B. Quarantine of Plaintiffs (Boyko, Skrip, and Mensah-Sieh) Was Not Reasonable or the Least Restrictive Alternative For Protecting Public Health.

Plaintiffs Boyko and Skrip were public health students who had traveled to Liberia to assist the Liberian Ministry of Health and Social

[8] In October 2014, the CDC made certain revisions to its guidance, focused on individuals involved in direct patient care in areas with widespread Ebola outbreaks. However, even these individuals, who were at high risk of contacting the bodily fluids of infected individuals, were not subject to quarantine under the revised guidelines. And the CDC's October guidance continued to recommend that for individuals like Boyko and Skrip, who were not involved in patient care and had no close contact with Ebola-symptomatic individuals, there should be no movement restrictions. These individuals should engage in self-monitoring or active monitoring depending on the circumstances. The CDC's October 2014 guidance defines "self-monitoring" to mean that a person checks their own temperature twice daily and monitors themselves for other symptoms; "active monitoring" involves the monitoring of a person by a health department to check if an at-risk person has developed a fever or other Ebola symptoms.

Welfare with data analysis of the outbreak. Compl. ¶ 44. They were not involved with caring for Ebola patients nor did they otherwise interact with Ebola-symptomatic individuals. *Id*. 47.

Prior to departing Liberia, due to travel insurance requirements, Boyko was tested for Ebola. *Id*. ¶ 51. He received confirmation on October 6, 2014 that he tested negative for the virus. *Id*. ¶ 53. He and Skrip returned to the United States on October 11, 2014. *Id*. ¶ 55. Upon arrival, they were both screened for Ebola pursuant to CDC guidelines at John F. Kennedy International Airport and permitted to enter the country. *Id.*

Thereafter, they self-monitored by taking their temperatures multiple times daily per CDC guidance. *Id*. ¶ 57. On October 15, 2014, Boyko developed a low-grade fever, *id.* ¶ 58, a common occurrence during flu season. Out of an abundance of caution, he was transported to Yale New Haven Hospital, where his fever resolved. *Id*. ¶ 59, 62. There, his blood was drawn and sent to a Massachusetts lab for testing. *Id* ¶ 61. On October 16, the lab reported a negative test result for Ebola. *Id*. ¶ 64. Notwithstanding the negative test result, in an atmosphere filled with panic, defendants issued an order requiring the Hospital to isolate Boyko on its premises for twenty-one days. *Id*. ¶ 65. This order would have

required the Hospital to expend substantial resources to house and care for an individual who was neither ill nor contagious.

On October 17th, a CDC laboratory test confirmed that Boyko was negative for Ebola. *Id*. ¶ 66. While physicians at Yale New Haven Hospital felt that there was no medical or scientific reason to quarantine Boyko, *id.* ¶ 67, Defendants nevertheless thereafter replaced the isolation order with a new quarantine order requiring Boyko to remain in quarantine at his home until October 30. *Id*. ¶ 68. That same day, defendants also notified Skrip – who had never come into contact with an Ebola-symptomatic individual and who had never shown any signs of Ebola infection— that she too was required to be quarantined at home until October 30. *Id*. ¶ 72. Contrary to CDC guidance, the basis for the quarantine orders appears to have been merely that Boyko and Skrip had traveled to a country where there was an Ebola outbreak. J.A. 74-79 (quarantine orders).

The situation of the Mensah-Sieh family was similar. They arrived in the United States on October 18, 2014 from Liberia after having received approval to immigrate to this country, which approval included required medical tests. Id. ¶ 98-102. They entered the country through John F. Kennedy International Airport, where they were screened and had their

health forms reviewed, and were cleared to enter the country. *Id*. ¶ 101-105. Two days later, they were orally advised that they were subject to quarantine for 21 days. *Id*. ¶ 111. Contrary to CDC guidance, the only basis for this quarantine order appears to have been the fact that the family traveled to the United States from Liberia.

The Plaintiffs' lack of symptoms indicating contagiousness, lack of high-risk contacts, and prior health testing and screening provided no reasonable basis for subjecting the Plaintiffs to quarantine as a measure to prevent the spread of the disease. First, based on the established scientific knowledge about how Ebola is transmitted, there was no reason to believe that any of these individuals had contracted the Ebola virus as none had contact with the bodily fluids or tissues of an Ebola-symptomatic individual. Moreover, even if they had the virus (which they did not), as discussed above, they could not have been contagious while asymptomatic.

Monitoring of these individuals was sufficient to eliminate any public health risk and therefore was an effective and less restrictive alternative to quarantine.[9] Quarantine served no public health purpose in these instances

[9] Drazen, *supra* note 5("[F]ever precedes the contagious stage, allowing [individuals] who are unknowingly infected to identify themselves before

and thus was unreasonable. The quarantine of these individuals appears to have been based on fear or political pressure, rather than science.[10]

On October 27, 2014, after facing serious criticism of their policies, Defendants revised their quarantine guidelines. Compl. ¶ 35-36. Under these revised guidelines, asymptomatic travelers arriving from affected areas were subject to active monitoring, though quarantine remained an option based on an individualized assessment. *Id*. At that same time, CDC guidance continued to recommend that no asymptomatic individuals be quarantined (regardless of potential exposure) and recommended "no travel restrictions" at all for individuals like Plaintiffs, who had been in affected regions but had no contact with Ebola-symptomatic individuals. *Id*. ¶ 35. Notwithstanding the revisions of their internal policy (which was still more conservative than the policy recommended by the CDC),

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they become a threat to their community."); Craig Spencer, *Having and Fighting Ebola — Public Health Lessons from a Clinician Turned Patient*, 372 New. Eng. J. Med. 1089 (2015) (explaining that monitoring provides adequate method for identifying illness in time to permit isolation or quarantine without risk of spreading infection to others).

[10] John D. Kraemer et al., *Analyzing Variability in Ebola-Related Controls Applied to Returned Travelers in the United States*, 13 Health Security 295, 300 (Sept. 1, 2015) (noting that restrictive state quarantine policies appeared to be motivated, at least in part, by political pressures).

Defendants maintained the quarantines over Plaintiffs without any additional review. *Id.* ¶ 36.[11]

II. Unjustified Quarantines Undermine Public Health.

Quarantines that are not grounded in evidence-based science and medicine undermine public health. Most critically, they may jeopardize efforts to halt the spread of infectious disease at its source. As an editorial in the New England Journal of Medicine argued, the Ebola quarantines in 2014 were "more destructive than beneficial" because they "impede[d] essential efforts to stop these awful outbreaks" by adding "barriers making it harder for volunteers to return to their community." Jeffrey M. Drazen et

[11] To the extent that prior case law has suggested that quarantines of individuals not proven to be contagious is acceptable under some circumstances, these cases are distinguishable on medical grounds (in addition to the grounds identified in Appellants' Brief). Both *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11, 25 (1905) and *U.S. ex rel. Siegel v. Shinnick*, 219 F. Supp. 789, 790-91 (E.D.N.Y. 1963) involved small pox, which can be transmitted by air, reducing the ability of an individual to know whether he or she may have been exposed. Ebola, by contrast, requires actual contact with the bodily fluids or tissues of an infected individual, most typically when someone is caring for someone with overt symptoms of Ebola or preparing their bodies after death. Here, plaintiffs had no such contact. Moreover, even under *Shinnick*'s formulation, quarantine is not to be substituted for monitoring unless the risk to public health is "exceptionally serious." *Shinnick*, 219 F. Supp. at 791. Here, the risk certainly was not "exceptionally serious," it was negligible or nonexistent.

al., *Ebola and Quarantine*, 371 New Eng. J. Med. 2029 (2014). Public health volunteers are crucial to the effort to fight Ebola and similar outbreaks.[12] Volunteers and volunteer organizations reported drops in recruitment, difficulty finding and assigning volunteers to the affected areas and scheduling difficulties for volunteers in light of the potential 21 day quarantine following their return.[13] Volunteers, and their employers like *Amici*, would either have to account for the possibility of a 21 day quarantine for returning workers by shortening their assignment in affected countries or extending necessary leave following return, or by risking the possibility that workers would be unable to return to work as

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[12] Mark A. Rothstein, *From SARS to Ebola: Legal and Ethical Considerations for Modern Quarantine*, 12 Ind. Health L. Rev. 227, 256 (2015); Greg Botelho, *Should Health Care Workers Who Treat Ebola in Africa Be Quarantined?*, CNN, (Oct. 26, 2014), http://www.cnn.com/2014/10/24/health/ebola-travel-policy/; American Civil Liberties Union, *supra* note 4, at 31; Editorial Board, *The Dangers of Quarantines: Ebola Policies Made in Panic Cause More Damage*, N.Y. Times, Oct. 27, 2014.

[13]Botelho, *supra* note 12; American Civil Liberties Union, *supra* note 4, at 31; Kristi L. Koenig, *Health Care Worker Quarantine for Ebola: To Eradicate the Virus or Alleviate Fear?*, 65 Annals of Emergency Med. 330 (2015); Christie Duffy, *Ebola Volunteers Down After Quarantine Rules Imposed*, NJTV News, (Nov. 19, 2014), http://www.njtvonline.org/news/video/groups-blame-ebola-quarantine-for-fewer-volunteers/; *Ebola: Quarantine Can Undermine Efforts to Curb Epidemic*, Doctors Without Borders (Oct. 27, 2014), http://www.doctorswithoutborders.org/article/ebola-quarantine-can-undermine-efforts-curb-epidemic.

scheduled due to the imposition of quarantine. *Id*. When unjustified quarantine policies dissuade public health workers from volunteering, or diminish their ability to volunteer, they impede, rather than enhance, the chances of containing the disease.

Additionally, unnecessary quarantines may discourage individuals from reporting their own or others' symptoms or recent contact with infected persons, potentially risking the further spread of the disease.[14] In response to unfounded policies and unnecessary quarantines, individuals with potential exposure may travel outside of monitored routes, deny or minimize disclosure of potential exposure, and avoid diagnosis and isolation when experiencing symptoms that could indicate infection.[15] Thus, unjustified quarantines can have exactly the opposite of the intended effect—enhancing the spread of disease rather than containing it.

The unnecessary and unjustified imposition of quarantines also can create public confusion, panic, and anxiety, as well as promote distrust of

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[14] Eang L. Ngov, *Under Containment: Preempting State Ebola Quarantine Regulations*, 88 Temp. L. Rev. 1, 30-31 (2015).; Ramin Asgary et al., *Ebola Policies That Hinder Epidemic Response by Limiting Scientific Discourse*, 92 Am. J. Trop. Med. & Hygiene 240 (2015).

[15] Asgary, *supra* note 14, at 241.

public health officials and public health measures.[16] Public confusion and panic have the potential to both flood public health institutions like hospitals with patients suspecting they have been infected as well as cause the public to fear these institutions, especially those known to have treated quarantined or isolated individuals (and therefore potentially cause individuals to avoid seeking needed health treatment), due to poor understanding of the methods and likelihood of transmission of diseases like Ebola.

Unnecessary quarantines also pose a burden on health system resources. The Boyko situation is a perfect example. The Defendants here initially indicated an intent to require Yale New Haven Hospital to isolate Boyko on-site for 21 days – which would have been an extraordinary burden on that hospital – for no medical purpose. While the Defendants later imposed quarantine at Boyko's home instead, the incident underscores the need to have quarantine policy grounded in evidence-

[16] Rothstein, *supra* note 12, at 252, 256, 261, 272; Lisa Rosenbaum, *Communicating Uncertainty – Ebola, Public Health, and the Scientific Process*, 372 New Eng. J. Med. 7 (2015); Leslie E. Gerwin, *The Challenge of Providing the Public with Actionable Information During a Pandemic*, 40 J. L. Med. & Ethics 630, 642 (2012); Richard Pérez-Peña, *Alarmed by Ebola, Public Isn't Calmed by "Experts Say,"* N.Y. Times, Nov. 1, 2014, at A19.

based medicine, not fear.

In the wake of the 2014 quarantines, federal officials as well as numerous public health, medical, and scientific experts spoke out against the unnecessary quarantines of asymptomatic individuals in the U.S. Among these were the American College of Emergency Physicians, the Infectious Diseases Society of America, and Society for Healthcare Epidemiology of America, the Centers for Disease Control, the Council of State and Territorial Epidemiologists, the New England Journal of Medicine, the Annals of Emergency Medicine, the New York Times, the Johns Hopkins School of Public Health, the Journal of the American Medical Association, Doctors Without Borders, and the White House.[17]

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[17] Drazen, *supra* note 5; Benjamin Bell, *Infectious Disease Specialist Dr. Anthony Fauci Rejects Mandatory Quarantine*, ABC News, Oct. 26, 2014; Assoc. for Prof'ls in Infection Control and Epidemiology, *Joint Statement: Leading Infections Disease Medical Societies Oppose Quarantine for Asymptomatic Health Care Personnel Traveling from West Africa* (Oct. 31, 2014); Alice Park, *Ebola Quarantines 'Not Grounded on Science,' Say Leading Health Groups*, Time, Oct. 27, 2014; Betsy McKay et al., *CDC Rejects Mandatory Ebola Quarantines*, Wall St. J., Oct. 27, 2014; Editorial Board, *The Dangers of Quarantines: Ebola Policies Made in Panic Cause More Damage*, N.Y. Times, Oct. 27, 2014; Koenig, *supra* note 13; The White House, *President Obama Provides an Update on the US-led Response to Ebola* (Oct. 25, 2014), https://www.whitehouse.gov/ebola-response; Centers for Disease Control and Prevention, *Ebola (Ebola Virus Disease) Fact Sheet* (June 5, 2015), http://www.cdc.gov/vhf/ebola/pdf/ebola-factsheet.pdf; *IDSA Statement*

Quarantines that are not grounded in scientific evidence not only burden core liberty interests of those quarantined, but do damage to the greater public health. They are not the least restrictive alternative, nor are they reasonable.

III. This Court Should Address the Merits of the Claims Asserted.

The Defendants have argued that they are shielded by qualified immunity because their actions did not violate clearly established law specific to quarantines. The District Court accepted this argument and therefore never reached the merits of the Plaintiffs' claims. The *Amici* disagree that qualified immunity applies here, for the same reasons discussed in the brief of Appellants at 26-47. But even if the Court ultimately concludes that qualified immunity is available due to a lack of caselaw directly on point to these factual circumstances, the Court should

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on Involuntary Quarantine of Healthcare Workers Returning from Ebola-Affected Countries, Infectious Diseases Society of America (2014), http://www.idsociety.org/2014_ebola_quarantine/; *SHEA Supports Evidence-Based Measures to Prevent Ebola Transmission, Opposes Mandatory Quarantine for Healthcare Personnel,* Society for Healthcare Epidemiology of America, (Oct. 26, 2014),https://www.shea-online.org/index.php/journal-news/press-room/press-release-archives/223-shea-supports-evidence-based-measures-to-prevent-ebola-transmission-opposes-mandatory-quarantine-for-healthcare-personnel.

first address the substance of the constitutional claims asserted.

In *Saucier v. Katz*, 533 U.S. 194 (2001), the Supreme Court mandated a two-step sequence for resolving government officials' claims of qualified immunity. Courts were first directed to ask whether the officer's conduct violated a constitutional right and only after answering that question to determine whether the right was clearly established. This framework ensured that constitutional questions would not go forever unanswered by courts deferring the issue under the guise of qualified immunity.

In *Pearson v. Callahan,* 555 U.S. 223 (2009), the Supreme Court held that the *Saucier* protocol was not mandatory, but recognized that it is nevertheless "often beneficial." *Id*. at 236. As the Court acknowledged, "the two-step procedure promotes the development of constitutional precedent and is especially valuable with respect to questions that do not frequently arise in cases in which a qualified immunity defense is unavailable." *Id*. That is precisely the case here. Quarantines are undertaken by state actors in an official capacity at times of public health emergency and are of limited duration, making obtaining meaningful judicial review at the time unlikely. Moreover, judicial review now – when panic has subsided and the dust has settled – is a far better forum for

consideration of these important issues.

Hospitals and healthcare providers like *Amici* require clear guidance in order to plan for future public health emergencies. For example, unjustified quarantines of returning healthcare workers who volunteer to fight contagious diseases abroad have the potential to throw hospital call schedules into havoc. Indeed, hospitals may simply be unable to support employees wishing to volunteer if the outcome is likely quarantine (and thus, inability to return to their jobs caring for patients) upon their return. But volunteers are essentially to containing contagious diseases like Ebola. Thus unjustified quarantines can have exactly the opposite of the intended effect: hampering efforts to contain the disease.

The Court can and should address the merits of these critical legal issues now – in advance of the next epidemic.

CONCLUSION

Quarantines should be used by public health officials only when medically or scientifically justified and appropriately tailored to the public health risk without unduly burdening individual liberty. There was no scientific basis to believe that Plaintiffs were contagious. Therefore, the quarantines of Plaintiffs were neither reasonable nor the least restrictive

means of protecting public health.

Respectfully submitted,

Dated: July 12, 2017

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) and Local Rule 29.1 because this brief contains 4,454 words.

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared with a font size of 14 point Book Antiqua, a proportionally spaced typeface, using Microsoft Office Word 2013.

Dated: July 12, 2017

By: /s/ Kim E. Rinehart
Kim E. Rinehart