Pandemics and Public Health Emergencies: Lessons from the 1918 Flu

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I. INTRODUCTION

Public health law scholars are currently grappling with state and community responses to pandemics, bioterrorist attacks, and other public health emergencies. However, this burgeoning scholarship lacks a historical perspective. This article helps to fill that gap by examining the worst epidemic in American history — the 1918 influenza outbreak. During the epidemic, states and localities employed the same emergency health measures that commentators debate today. Close examination of these responses to the 1918

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2 Quarantine and isolation, along with a dose of vaccinations, were the emergency health measures de jure in 1918. See infra Part III. Today, Gostin suggests that a significant threat, like a bioterrorist attack, may justify the government exercising "a set of powers that interfere with personal and proprietary interests: vaccination, treatment, and quarantine, as well as nuisance abatements and takings of private property." See Gostin, supra note 1, at 1108. In fact, Gostin incorporated these health powers into the Model State Emergency Health Powers Act, which he and a team of scholars and policy makers crafted. See THE MODEL STATE EMERGENCY HEALTH POWERS ACT § 604 (Center for Law and the Public Health at Georgetown and John Hopkins Universities, Draft for Discussion 2001), at http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf. A majority of states have now adopted some version of the model act. See Center for Law and the Public Health: Model State Public Health Laws, at http://www.publichealthlaw.net/Resources/Modellaws.htm. For a defense of the act and its balancing of state power and civil liberties, see generally Lawrence
flu can inform the present debate and offer lessons for handling future pandemics and public health emergencies.

This article offers for the first time a systematic narrative of several states’ and localities’ public health law approaches to the 1918 flu. Building on Professor Lawrence Gostin’s and others’ work, it introduces a framework that links each of these responses to a corresponding public health or political theory. The article calls these broad theories: public health elitism, public health liberalism, and public health communitarianism.

Generally speaking, public health elitism provides that experts’ risk assessments should guide responses to public health emergencies and the public should defer to the experts for as long as the emergency lasts. Public health liberalism favors responses to emergencies that weigh individual liberties more heavily than does a cold utilitarian risk assessment. Public health communitarianism, on the other hand, believes that responses are best informed by community, not individual, values. The purpose here is not to add to the fine grain literature on political theory. This article scales down the theories to fold them more neatly into the public health law framework introduced here.

This historical, legal, and theoretical examination shows that the states’ and localities’ approaches differ in important ways that can elucidate discussions on theory and public health decision making today. For example, in Arizona during the 1918 epidemic, local government and state courts fell back on traditional public health elitism. Law enforcement was one of the government’s primary means to communicate the severity of the

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Public health law is an undertheorized field in many ways, leaving it with no uniform lexicon. Thus, while this article draws from others’ discussions on theory and public health, others may convey the same concepts with different language. The labels here are chosen largely for simplicity and clarity.

The four states discussed – Arizona, New Jersey, Idaho, and North Carolina – not only differ in responses to the 1918 flu but also population. According to the 1920 census, Arizona's population was 334,000, New Jersey's was over 3.1 million, Idaho's was 432,000, and North Carolina's was nearly 2.6 million. See U.S. Census Bureau, Statistical Abstract: Historical Statistics, Resident Population by State, available at http://www.census.gov/statab/hist/HS-04.pdf.

See infra Part IV.
epidemic. Perhaps vindicating some of Gostin’s more liberal critics, individual rights were brushed aside. Remedies in court were hard to find. Nonetheless, while the government flexed its muscles, the power structure in Arizona remained clear and the enforcement efforts robust.

The same cannot be said for New Jersey, where local governments showed off their liberal and/or libertarian stripes. Many New Jersey cities were delinquent in enforcing public health measures, such as the closing of saloons and theaters. Newark’s mayor, who favored less liberty-infringing health measures, was the biggest culprit of this arguable nonfeasance. His efforts to champion individual rights caused an acute, albeit short-lived, crisis over the proper hierarchy of power in New Jersey state government. As that political drama unfolded, lives may have been at stake. Recent scientific studies have showed that delays in enforcing quarantines and public closures during a flu epidemic can cause infection rates to double in a matter of days. Later, as the epidemic waned, the judges on the New Jersey Supreme Court, in contrast to their brethren in Arizona, undermined the state’s powers with a crafty reading of a public health law.

Perhaps most revealing, though, was the communitarianism in Idaho. The current public health scholarship has accepted by and large that communitarianism is both more agreeable to government intrusion than liberalism and less likely to produce coercive government acts than public health elitism. The idea is that the government’s exercise of power is more acceptable because it is derived from the community’s “moral voice.” Ultimately, however, the 1918 flu shows that communitarianism, in the midst of a catastrophe, can exacerbate what local government law refers to as the problem of “localism.” So far, this side of communitarianism has been overlooked in the public health literature.

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6 See infra Part V.
7 A somewhat more modern analogue of this public health and civil liberties issue can be seen in the regulations that targeted gay bathhouses in the 1980s. See generally Note, The Constitutional Rights of AIDS Carriers, 99 HARV. L. REV. 1274, 1284-85 (1986).
8 See infra Part VI.
Finally and most importantly, North Carolina’s approach to the 1918 flu adds some fluidity to the three-part theoretical framework. North Carolina followed and encouraged public health elitism during the deadly autumn wave. However, a few months later, after that wave had rescinded but as another wave was gaining strength, the state created room for public health communitarianism and deliberative democracy to take hold. The potential to stagger public health elitism and communitarianism in this way has been lost in the current public health law debate. However, as North Carolina shows, this bifurcated response may have its merits.

This article proceeds as follows. Part II outlines public health law scholars’ treatments of the three theories in the framework applied here: public health elitism, public health liberalism, and public health communitarianism. Part III.A sketches a brief history of public health law and powers leading up to 1918. Part III.B follows with an overview of the 1918 epidemic. Part III.C is a brief note historicizing local government law. Part IV then uses Arizona as an example of public health elitism, followed by Part V’s look at New Jersey as an example of public health liberalism and Part VI’s commentary on Idaho’s public health communitarianism. Part VII discusses North Carolina’s response to the epidemic, which does not fit any particular theoretical framework set forth in the public health law literature. The article concludes by marshaling the evidence to highlight how it can best inform the present public health law discussions on responses to pandemics and other emergencies.

II. PUBLIC HEALTH AND POLITICAL THEORY

This Part discusses the three theories that have framed recent public health law scholarship. The purpose of this Part is not to add to the understanding of these theories. Rather, it is to convey how leading public health scholars conceive of them and their relation to public health law.

9 See infra Part VII.
10 This article is largely descriptive. Prescriptive claims are limited to the conclusion.
A. Public Health Elitism

Elite theory is a branch of political theory, which holds that a group of society’s elite – economic, political, and military – exercise power and shape policies. One implication of elite theory is that elections are irrelevant because power will always accrue to the elites. C. Wright Mills introduced elite theory on the first page of his seminal 1956 book *The Power Elite* with the following:

>The powers of ordinary men are circumscribed by the everyday worlds in which they live, yet even in these rounds of job, family, and neighborhood they often seem driven by forces they can neither understand nor govern. . . . [However,] some come to occupy positions in American society from which they can look down upon, so to speak, and by their decisions mightily affect the everyday worlds of ordinary men and women.

When applied to a public health emergency, elitism lacks the ineluctable and conspiratorial feel. The idea is that, during the emergency, a group of experts are in the best position to make the risk assessments and determine the protective (often coercive) measures necessary to protect the public’s health. These experts, typically appointed members of the local board of health, are largely insulated from direct electoral politics. Public health elitism tracks Gostin's theory of public health, which grants "responsible state actors with the powers they need to detect and contain a potentially catastrophic disease outbreak . . . ." To critics who argue that government officials may abuse their power, Gostin responds that the proper recourse is not to strip public health officials of their power but to provide "safeguards to prevent officials from acting outside the scope of their authority."

This elitist approach to public health is rooted in American history and tradition. It has two distinct forms of justifications.

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13 Gostin, supra note 2, at 5.
14 Id. at 25.
15 See infra Part III.A.
As described by public health scholar Bruce Jennings, one is that “the public cannot understand the scientific facts, the medical rationale for the intervention, or the public interest served.”\textsuperscript{16} The second, and the one Jennings thinks does more work, is that the government operates from the assumption that “the liberty being limited (the desired behavior being foregone) by the intervention indicated by public health knowledge is too immediately important or too intensely desired to be amenable to reasonable public dialogue and consensus building.”\textsuperscript{17} Both assume that time is of the essence; that is, the public could gain the requisite understanding or rationalize the loss of liberty, but not fast enough for the government to respond to the emergency adequately. Ultimately, Jennings argues, these justifications have led public health “toward a kind of constitutional elitism (the experts should decide) and civic privatism (let’s let the experts decide).”\textsuperscript{18} This, in turn, exacerbates tendencies to enact coercive and paternalistic laws during public health emergencies.

Leading public health scholar Professor Wendy Parmet observes that a traditional public health perspective has three traits that differentiate it from liberal and communitarian political theories.\textsuperscript{19} First, “the health of a population is an objective good, measurable by an objective criteria (i.e., morbidity, longevity, etc.), and not simply a matter of individual choice and preference.”\textsuperscript{20} This objectivity distinguishes it from liberal thought, which assumes that preferences are subjective. Thus, “from a public health perspective, the protection of public health may be seen as justifying actions that liberals would decry as paternalistic.” Second, and similarly, public health relies on empiricism, not mere observation.\textsuperscript{21} Finally, public health emphasizes populations. “Public health,” Parmet notes, “in contrast to utilitarian liberalism, but in accord with communitarianism, takes populations as the primary unit of analysis and concern.”\textsuperscript{22}

\textsuperscript{16} Jennings, \textit{supra} note 1, at 1254.

\textsuperscript{17} \textit{Id}. at 1251.

\textsuperscript{18} \textit{Id}. at 1251.

\textsuperscript{19} See Parmet, \textit{supra} note 1, at 1233-37.

\textsuperscript{20} \textit{Id}. at 1234.

\textsuperscript{21} \textit{Id}. at 1235.

\textsuperscript{22} \textit{Id}. at 1236.
B. Public Health Liberalism

Liberalism includes many (sometimes competing) doctrines and schools of thought. Universally, it emphasizes individual rights and liberty. Disagreements within the overarching theory center on the scope of those individual rights. A common limiting principle is the mantra “do no harm to others” and the Rawlsian difference principle, which measures actions by how they affect society’s worst off.

Liberal theory, as Gostin describes, maintains that “government should remain neutral about the meaning of a good life.” The implication is that it rejects the assumption in public health elitism that the public good should be maximized based on an objective measure of health. To that end, Jennings suggests that, in the liberal tradition, risk is a normative function that depends on subjective values and interests and not on “balancing things external to the person.” Liberalism, Jennings says, demands special reasons for coercive action that are “grounded in the protection, preservation, and promotion of the interests of individuals, as individuals themselves define those interests.”

One clash between public health elitism and liberalism, Parmet notes, is that some liberals are deeply skeptical of the a priori assumption in public health elitism that “health is the highest goal” for individuals. In the end, public health authority is illegitimate under liberalism if it ignores these individualized values.

Liberalism includes the libertarian school of thought, which offers the sharpest challenge to robust emergency powers for states. Gostin comments:

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23 See generally Gerald F. Gaus, Contemporary Theories of Liberalism: Public Reason as a Post-Enlightenment Project (2003). The presentation of liberalism in this article is necessarily simplified. The purpose here is not to engage with the nuances of liberalism but rather to view liberalism in terms that let it fit as neatly as possible into the public health framework introduced later in this article.


25 Gostin, supra note 1, at 1142.

26 Jennings, supra note 1, at 1247.

27 Id. at 1244.

28 Parmet, supra note 1, at 1226-27.
The libertarian critique is notable for its characterization of personal interests as “rights,” with its exaggerated absoluteness, its hyperindividualism, its insularity, and its silence with respect to personal, civic, and collective responsibilities. It is distinctly anti-government and anti-regulation in tone.

Restrictions on liberty like isolation and quarantine are unnecessary. These libertarians claim that voluntariness is virtually always preferable to coercion and that “trade-offs” between personal rights and common goods are not required.29 Ultimately, however, Gostin submits that, while liberals generally and libertarians more specifically condemn paternalism, they “concede the legitimacy of state authority to prevent a significant risk of harm to others.”30 Liberalism may not cede the risk assessment to public health experts. Nonetheless, liberals may appear pliant to coercive government action when the risk is significant and the government’s actions are necessary to ensure that individuals do not harm others.

C. Public Health Communitarianism

Communitarianism encompasses a group of philosophies that are markedly distinct from individualism.31 While not always at odds with liberalism, communitarianism aims to shift the focus from individuals to community (an admittedly imprecise term), which it holds is undervalued in liberalism. Communitarianism places individuals within communities and only weighs their interests with respect to their relationships with those

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29 This is based on the claim that coercive measures hurt public health by sending “an epidemic underground, so that people avoid health care and public health professionals.”

30 Gostin, supra note 1, at 1158.

31 Many scholars have been called communitarian. Some eschew the label. Among those that embrace, and indeed helped raise it to prominence is Amitai Etzioni, who is also one of its most prolific writers. For two important treatments of communitarianism by Etzioni, see SPIRIT OF COMMUNITY (1993) and HOW PATRIOTIC IS THE PATRIOT ACT: FREEDOM VERSUS SECURITY IN THE AGE OF TERRORISM (2004). For a more legal and rights-based perspective on communitarianism, see MARY ANN GLENDON, RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE (1991).
According to Michael Sandel, "community describes not just what they have as human beings but also what they are, not a relationship they choose, as in voluntary association, but an attachment they discover, not merely an attribute but a constituent of their identity." Public health typically has high standing in communitarian thought because health is essential to communities. For communitarians, Gostin notes, public health “becomes a transcendent value because a basic level of human functioning is a prerequisite for engaging in activities that are critical to communities.” Important in this conception of health and community is the idea that only collective action can secure the public health. Individuals alone are powerless to ensure acceptable levels of health – this is particularly true when confronting infectious diseases. Gostin argues that, during a public health emergency, communitarians would insist that government act in the public good and operate under the assumption that “everyone would be better off if each person ceded a small amount of liberty to achieve a safer and more secure population.”

While communitarians may willingly yield more power to the government than liberals would, Parmet points out that “[s]ome communities may well place a high priority on health and security and a low value on individual autonomy.” These communitarians would bristle at public health elitism since it would not capture a community’s “moral voice.” Parmet states: “the very concept of delegating extraordinary powers to ‘public health experts,’ and trusting these experts to revise or suspend all laws, seems at odds with, at least in spirit, the type of civic deliberation endorsed by communitarians.” Notably, communitarians hold that

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32 See Parmet, supra note 1, at 1230.
34 Gostin, supra note 1, at 1157.
35 Id.
36 “Moral voice” is a thematic term used by Etzioni in Spirit of Community. Its basic premise is that reason and virtue within a community produce a “moral voice” that should form the foundation of political and civic action.
37 Id. at 1232.
communities should find their values through deliberative and participatory forms of democracy. “If community safety and security are important (and they are) for communitarians,” Jennings maintains, “it is because they are preconditions for deliberative-democratic decision-making to function institutionally.”

In sum, communitarians may appear more willing to cede power to the government than do liberals, but they expect that power to be exercised in concert with the community’s expression of its values. Furthermore, communitarians may be more comfortable if that power is exercised by local government. The communitarian subsidiary principle "asserts that the groups closest to the problem should attend to it, receiving support from higher level groups only if necessary." Finally, perhaps during an epidemic, the communitarian willingness to cede power to the government is greater because the anti-social effects of the disease threaten the constituent identity that Michael Sandel described above.

III. THE HISTORY OF PUBLIC HEALTH LAW AND THE 1918 EPIDEMIC

The purpose of this Part is to provide useful background information before delving into specific examples and applying them to the theoretical framework laid out above. Part III.A will briefly sketch the state of public health powers before the epidemic. Part III.B will follow with an overview of the 1918 flu epidemic. Part III.C offers a brief note on local government law.

A. Public Health Law Pre-1918

In the 1824 case Gibbons v. Ogden, Chief Justice Marshall declared in dictum that a state has the power “to provide for the health of its citizens” through “[i]nspection laws, quarantine laws,

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38 Jennings, supra note 1, at 1255.
40 22 U.S. 1 (1824).
Quarantine and medical isolation were the public health measure of choice in the nineteenth century.\(^{42}\) When yellow fever or small pox outbreaks popped up, local authorities would turn to these coercive measures.\(^{43}\) Oddly, while scholars debated the constitutionality of various state powers, quarantine received little scrutiny.\(^{44}\) “Since quarantine was clearly designed to protect the public from disease, it was easily assumed to be a proper exercise of the police power,” Parmet comments.\(^{45}\) The Maine Supreme Judicial Court’s conception of state public health powers in 1875 is telling:

> It is unquestionable, that the legislature can confer police powers upon public officers, for the protection of the public health. The maxim *salus populi supreme lex* is the law of all courts and countries. The individual right sinks in the necessity to provide for the public good.

As the turn of the century neared, quarantine and medical isolation began to fade from public consciousness. Modern medicine had emerged with more effective and less coercive ways – mostly vaccinations and antibiotics – to respond to infectious diseases. Germ theory and bacteriology dominated medical science by the 1880s. Within a few decades life expectancy nearly doubled in some parts of the country.\(^{46}\) As W.T. Sedgwick, a Massachusetts bacteriological researcher, noted in 1912: “[B]efore

\(^{41}\) Id. at 203.
\(^{42}\) See Lawrence O. Gostin, Scott Burris & Zita Lazzarini, *The Law and the Public’s Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59, 102 (1999). They noted that, "[a] reliance on coercive reactive control methods – particularly nuisance abatement, quarantine, and isolation – can be said to form the deepest layer of American disease control law . . . ." *Id.*
\(^{43}\) See id.
\(^{44}\) See Wendy E. Parmet, *Aids and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53, 59 (1986); see also Kevin Outterson, *Health Care, Technology and Federalism*, 103 W. Va. L. Rev. 503, 504-10 (discussing the development of health law in the U.S. as "the Court began to grapple with health regulation in the interstate context, concomitant with the growth of the nation's commerce").
\(^{45}\) Id. at 60.
1880 we knew nothing; after 1890 we knew it all."\footnote{47} Thus, increasingly, the public turned to physicians to protect their health. Parmet explains that the suddenly-exalted position of physicians in society altered the public health landscape. Now, public health officials were secondary players whose jobs included restricting liberties when necessary and providing access to the medicine for the poor.\footnote{48} With acute epidemics fading from sight, disease became the province of private physicians.\footnote{49}

These medical breakthroughs, coupled with the emergence of the administrative state, also spurred the creation in 1912 of the modern United States Public Health Service (PHS).\footnote{50} In its early years, the agency’s authority was weak and its funding scarce. Nevertheless, its founding was a crucial step in coordinating public health efforts among the states. For example, while the PHS lacked the authority to direct state activity during the 1918 epidemic (and it still lacks such authority today), messages bearing the office’s imprimatur carried weight with state authorities besieged by the death and sickness at hand.\footnote{51}

The improved system to combat infectious diseases, however, did not immediately affect constitutional norms regarding public health powers. The courts continued to uphold coercive state actions. In 1902, a local health board in Louisiana issued a quarantine order that kept a French cargo ship at bay. The order rested merely on the premise that foreigners on board the ship were more likely to carry infectious diseases than the locals were. The Supreme Court upheld the order in \textit{Compagnie Francaise De Navigation A Vapeur v. Louisiana State Board of Health},\footnote{52} stating:

\begin{quote}
\textit{\ldots}
\end{quote}

\footnote{49} Parmet writes: \textit{\ldots} Public health officials played a secondary role, which focused significantly upon restricting liberties or providing treatments to those individuals who otherwise lacked access to the private medical market. \textit{Id.}
\footnote{50} While the Public Health Service existed before 1912, it was known by different names and had different or uncertain duties. \textit{See The History of the Commissioned Corp}, at http://www.usphs.gov/html/history.html.
\footnote{51} See infra Part II.B.
\footnote{52} 186 U.S. 380 (1902).
“That from an early day the power of the states to enact and enforce quarantine laws for the safety and the protection of the health of their inhabitants has been recognized by Congress, is beyond question.”53 Three years later, the Court handed down the landmark decision *Jacobson v. Massachusetts*.54 The case, which upheld a compulsory small pox vaccination law for Massachusetts students, has become the leading authority for public health police powers generally, including quarantines, thanks to the Court’s umbrella holding: “Upon the principle of self-defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members.”55

While the judiciary was (and is) reluctant to second guess states’ public health risk assessments and the reasonableness of their responses, courts have not ceded all oversight. As Professor Kevin Outterson puts it, "[t]he police power of the state will ordinarily be upheld unless the regulation bears no real or substantial relationship to public health, public morals or public safety, or is arbitrary or oppressive and invades fundamental rights."56 One example of where the state went too far is *Wong Wai v. Williamson*,57 in which a federal appeals court in California struck down a San Francisco city ordinance that required all Chinese residents to receive inoculations against bubonic plague before leaving the city. The inoculation was risky, possibly causing death. The city had argued that the law was necessary because Chinese residents were particularly susceptible to the disease.58 Without addressing the merits of the science, the Court

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53 *Id.* at 387. The only real challenge to the law seemed to be whether it violated the Commerce Clause. The Court noted that this was a public health, not commercial, act. It concluded that until Congress created a general quarantine system, that power remained with the states. *See id.* at 391-92.
54 197 U.S. 11 (1905).
55 *Id.* at 27. For a discussion of *Jacobson* and the history of public health law at the time, see Michelle A. Daubert, *Pandemic Fears And Contemporary Quarantine: Protecting Liberty Through A Continuum Of Due Process Rights*, 54 BUFF. L. REV. 1299 (2007).
56 Outterson, *supra* note 44, at 508.
57 103 F. 1 (N.D. Cal. 1900).
58 *Id.* at 3.
invalidated the law because its patent discrimination violated the Equal Protection Clause of the Fourteenth Amendment.59

Of course, there were also interstate commerce and economic due process restrictions on state power.60 Brimmer v. Rebman61 establishes that a state's public health regulations could not burden other states. More pertinent to the quarantine powers adapted in the 1918 flu is Louisiana v. Texas.62 In that case, reports of yellow fever in New Orleans led Texas to order a quarantine.63 Louisiana charged that Texas's aim was not to protect the public's health but to gain a commercial edge over its neighbor.64 While the Court threw out the case on Eleventh Amendment immunity grounds,65 it expressed disapproval of Texas's meddling in interstate commercial affairs.66 Most famously, though, states had to contend with economic due process restrictions on public health measures, as shown in Lochner v. New York.67

And this was roughly the state of public health and public health law when the Spanish influenza arrived in the United States in 1918. The state officials had broad powers68—short of overt

59 Id. at 9-10. The court stated: “[Chinese people] are denied the privilege of traveling from one place to another, except upon conditions not enforced any other class of people . . . . As the case is here presented, how can the court deny them this right?” For a general discussion on the risks of government abuse of quarantine powers, see Carrie Lacy, Abuse of Quarantine Authority: The Case for a Federal Approach to Infectious Disease Containment, 24 J. LEGAL MED. 199 (June, 2003).

60 See generally Outterson, supra note 44, at 507-10.

61 138 U.S. 78 (1891) (striking down on interstate commerce grounds a Virginia statute that imposed a tax on fresh meat sold more than one hundred miles from where it was slaughtered).

62 176 U.S. 1 (1900).

63 See id. at 20.

64 See id. at 22.

65 See id. at 16, 22-23.

66 See id. at 23 (Harlan, J. concurring) (“Texas authorities have gone beyond the necessities of the situation and established a quarantine system that is absolutely subversive of all commerce between Texas and Louisiana, particularly commerce between Texas and New Orleans.”).

67 See 198 U.S. 45 (1905).

68 At the federal level at least, government officials' powers were even stronger because World War I was ongoing. For example, the Supreme Court upheld in 1919 the Espionage Act, later amended by the Sedition Act, which
discrimination and violations of contemporary due process and interstate commerce jurisprudence – to respond to health emergencies, but as a whole they were dealing with endemic conditions and not the epidemics that had plagued cities and towns decades earlier. Physicians, it was thought, could now handle epidemics.

**B. The Spanish Influenza**

The 1918 influenza epidemic – known as the Spanish influenza – was the greatest public health crisis in American history. It killed about 675,000 in a population of just over 100 million. One in ten people contracted the flu during the epidemic. Millions likely stayed home from work and avoided public places. Major sectors of the wartime economy were crippled. What’s more, the virus targeted and killed otherwise young and healthy Americans at far higher rates than typical seasonal strains of the disease. Fleets of soldiers preparing to ship off to fight in World War I were stricken in devastating numbers. Fortunately for American forces, the influenza swept through Axis forces with criminalized communications deemed harmful to the government’s war effort. See Abrams v. United States, 250 U.S. 616 (1919).

The name “Spanish influenza” arose because the Spanish newspapers were the first to report on the disease. The epidemic did not originate in Spain, though. Spain was not fighting in World War I, so its press did not suffer from the same war-time censorship common in most other countries. Thus, it spoke freely of this mysterious disease that was killing thousands, while other nation’s newspapers, including those in the United States, buried the stories. See John M. Barry, The Great Influenza: The Epic Story of the Deadliest Plague in History 171 (2004); Alfred W. Crosby, America’s Forgotten Pandemic: The Influenza of 1918, 26 (1989).

See Barry, supra note 69, at 228. The exact numbers are unknown because of diagnosis and reporting complications. For example, most states did not make influenza a reportable disease until well into the epidemic. Moreover, most people who died as a result of the flu, technically died from pneumonia, and the cause of death was recorded as such. It is also worth noting that the 675,000 number is an undercount in the sense that the flu caused thousands to have health complications that would hasten their deaths in the subsequent years.

See id.

See Crosby, supra note 69, at 21.

See id.
equal damage.\textsuperscript{74}

The leading theory holds that the Spanish influenza first appeared in the United States in a Kansas farming town.\textsuperscript{75} In the spring of 1918, a young Kansan with the virus then headed off to a nearby army base. From there, the flu hopped from army base to army base. In the fall of 1918 it leapt into the civilian populations in Boston and then Philadelphia.\textsuperscript{76} While it shocked the east coast, it was also riding the rails and following the pioneer trails westward.\textsuperscript{77} Despite this traceable trajectory, the disease infected and killed in unpredictable waves. It plagued most of the country for weeks in the autumn, left families alone for the December holidays, and then reared back in the new year.\textsuperscript{78}

Public health officials and governments at every level were, by and large, helpless to treat people. The newly formed United States Public Health Services was unprepared for anything of the flu’s magnitude.\textsuperscript{79} The agency lacked the funds, the interagency and intergovernmental network, and the medical expertise to respond properly.\textsuperscript{80} State and local public health boards were similarly overwhelmed. In many major cities, essential government services broke down. Layers of filth covered the streets and garbage piled up. Bodies rotted away in homes, endangering morale and public health. City morgues, cemeteries, and coffin makers could not keep up with the death toll.\textsuperscript{81}

The nation turned to its medical giants – the men and women who had harbored in the new era of pathology that could prevent and treat the infectious diseases, which had consumed public health efforts in the late nineteenth century.\textsuperscript{82} In 1918, the top scientists

\textsuperscript{74} See id. at 25.
\textsuperscript{75} See BARRY, supra note 69, at 169. There are other, less popular, theories that Barry discusses as well.
\textsuperscript{76} See id. at 169-99.
\textsuperscript{77} See Crosby, supra note 69, at 63.
\textsuperscript{78} See id. at 64.
\textsuperscript{79} See id. at 49. The Public Health Service was established in 1912. For a brief sketch of its history, see GOSTIN, supra note 47, at 10.
\textsuperscript{80} See id. at 19.
\textsuperscript{81} For the most vivid description of this collapse, see BARRY, supra note 1, at 326, where he discusses the what happened in Philadelphia, the city hardest hit by the epidemic.
\textsuperscript{82} See GOSTIN, supra note 47, at 10.
holed up in labs and scrambled to isolate the cause of the influenza and find its Achilles’ heel. At any sign of success, a vaccine was rushed into production. Cities and large employers ordered crate loads of the latest vaccinations. Thousands were injected, but none of the vaccines worked.83

Mostly though, the government fell back on traditional public health measures: quarantine and isolation.84 Surgeon General Rupert Blue, the head of the U.S. Public Health Service, had hoped to steer clear of these coercive actions. Initially, on September 13, he recommended bed rest for flu-like symptoms.85 As reports came in that 1,000 were dead in Massachusetts, Blue told the public to avoid needless crowding and sneezing.86 After Philadelphia recorded three hundred flu-related deaths in one day in early October, the surgeon general relented. He issued a bulletin that advised all public health boards to ban public gatherings and close churches, theaters, saloons, and the like.87 He did not have the power to make his recommendations mandatory. The states, through their constitutional police powers, retained that authority.88

83 See CROSBY, supra note 69, at 100-01.
84 The two are actually distinct concepts in public health, although they are often confused popularly. The Model State Health Emergency Powers Act, supra note 2, defines isolation as “the physical separation and confinement of an individual or groups of individuals who are infected or reasonably believed to be infected with a contagious or possibly contagious disease from non-isolated individuals, to prevent or limit the transmission of the disease to non-isolated individuals.” Id. at § 104(h). It defines quarantine as the “physical separation and confinement of an individual or groups of individuals, who are or may have been exposed to a contagious or possible contagious disease and who do not show signs or symptoms of a contagious disease, from non-quarantined individuals, to prevent or limit the transmission of the disease to non-quarantined individuals.” Id. at § 104(o).
85 See id. at 46.
86 See id.
87 See id.
88 This was generally not a controversial point. The Supreme Court had long recognized strong public health and police powers for the states. The basis was laid in 1824 in Gibbons v. Ogden, 22 U.S. 1, where the court stated that quarantines and public health laws can be “most advantageously exercised by the states themselves.” However, there was some dissension among the scholarly community over whether the states could then in turn delegate legislative police powers to the local boards of health, as most did; although this was mostly a formalistic semantic argument—over powers properly considered
Some balked at implementing fully the surgeon general’s wishes. However, many states and local health boards complied. Some went further. As news of the epidemic mounted, a few cities and towns ordered their citizens to wear face masks and criminalized spitting on streets. Many more medically isolated flu patients in hospitals (that had the space) or in their homes until they were dead or the symptoms had passed. Large signs reading “INFLUENZA” dotted the landscapes in front of homes across the country.

Once the flu entered the U.S. it would sweep through every region. The same held true in Europe and elsewhere. The only country that kept the disease from crossing its borders was Australia. When word reached Australia that the deadly infectious disease was sailing across the globe, the island nation instituted a strict marine quarantine of ships for several months that literally kept the Spanish influenza at bay.89

C. Local Government Law Circa 1918

Before discussing the various localities’ responses to the epidemic, it is worth placing local government law in historical context. The flu arrived at the end of the municipal government movement, which led states to devolve power to cities in much of the country. Champions of municipal power like Frank Goodnow envisioned administrative cities – technocratic, efficient, and sans corruption – that delivered services to property owners free of state constraint and dirty politics.90 Nonetheless, even Goodnow insisted that the state’s power was paramount for matters that transcended local concern91 – an inevitably broad category that

“legislative” – which was characteristic of administrative law at the time. See Walter Carrington, Delegation of Power to Boards and Commissions, 6 VIRGINIA L. REGISTER, 801 (1921).

89 See BARRY, supra note 69, at 375.


91 Goodnow wrote in his leading treatise on municipalities that as soon as the “municipal corporation” exercises “powers of concern to the people of the state as a whole, it becomes necessary for the guardian of the people as a whole to see to it that these powers are exercised uniformly and efficiently throughout the state.” FRANK J. GOODNOW, MUNICIPAL HOME RULE 18-19 (1897) (quoted in Barron, supra note 16 at 2306 n. 191). While Goodnow’s was not the only
must include a deadly epidemic spreading without regard for city boundaries.\textsuperscript{92} Generally then, in 1918 localities were empowered (and expected) to respond to the flu, but the states could limit and override that power. Moreover, courts typically shared the view of limited power for localities. Dillon's Rule was a well established canon of interpretation that called for strict construction of states' delegations of power to localities.\textsuperscript{93}

IV. PUBLIC HEALTH ELITISM: ARIZONA

On October 10, 1918, Dr. Orville Harry Brown, Arizona state superintendent of public health, sent telegrams to the local boards of health or city health officers advising them to report all cases of influenza to his office, isolate all flu patients, and generally follow Surgeon General Blue's advice on closures and bans on public gatherings.\textsuperscript{94} Most complied with Brown's request. They closed schools, churches, theaters, and saloons and banned public gatherings. Enforcement of these provisions was strong and immediate.

While most states lacked Arizona's wild west manners, the pattern of delegation to local or county authorities, followed by their compliance with and enforcement of Blue's and their state health chief's requests, occurred in many places throughout the country.\textsuperscript{95} This response was the model of choice in October 1918 and a model that largely fits into the rubric of public health elitism. Arizona serves as a good example to deconstruct public health elitism during the epidemic for two reasons. First, its extreme and committed enforcement of the public health measures paints a vivid picture of the potential for abuse and the problems of relying

\textsuperscript{92} See Gerald E. Frug, \textit{The City as a Legal Concept}, 93 Harv. L. Rev. 1057, 1117. Frug maintains that, because "any local action can be seen as frustrating state objectives and any governmental action restricts individual liberty," there is very little that remains "purely local." \textit{Id}.

\textsuperscript{93} See Gostin et al., supra note 42, at 104, n. 179.


\textsuperscript{95} See BARRY, supra note 69.
on coercion instead of public cooperation. Second, Arizona court cases echo the typical justifications of public health elitism, while also showing the difficulties of establishing limits to that power.

A. Enforcement by Citizens Committees

Citizens committees in Arizona eagerly enforced the public health measures. Citizens committees had formed throughout the country during World War I at the government’s behest. They consisted of a community’s elite members, and their primary goal was to encourage, and often pressure, Americans to support the war effort, mostly through buying government liberty bonds. The committees in Arizona had proved particularly ruthless in keeping the war and the wartime economy going strong. The Phoenix Citizen Committee hung in effigy those who refused to buy bonds. Another committee put 1,221 striking miners in cattle and boxcars and abandoned them without food or water on a railroad siding in the desert across the New Mexico border.

When the flu hit, these committee members were deputized. They turned their patriotic zeal to the flu and its corresponding public health orders. They arrested coughers for not covering their mouths in public. They stopped traffic, intimidating those who were not traveling for business. And when rumors spread that dogs were spreading the flu, they killed dogs. When Arizonians challenged the public health measures and their arrests or fines, they faced an unwelcoming court system that deferred to the public health experts on these matters.

B. The Arizona Supreme Court

Some in the town of Globe, Arizona bristled at the public health orders. The owner of one theater refused to honor the laws, and he fired up his movie projector as usual. He quickly found

96 See id. 349-351.
97 See id.
98 See id.
99 See id.
100 See id.
101 See Alden v. State, 179 P. 646, 647 (1919).
himself in jail for “willfully, maliciously, and unlawfully conducting and carrying on a moving picture show at Globe, in violation of the published rules . . . to prevent the spread of Spanish influenza.” The theater owner filed a writ of habeas corpus challenging his detainment. He argued that the local board of health lacked the constitutional power to close his business. The superior court denied the writ; the Arizona Supreme Court took the appeal.

On March 14, 1919 the Arizona Supreme Court released its decision in that case – *Alden v. State* – and a related case – *Globe School District v. Board of Health of City of Globe*. In *Alden*, the court simply declared the appellant’s arrest legitimate and it referred readers to its more comprehensive analysis of the relevant public health law in *Globe*. Globe health officials, purportedly under their powers to regulate public nuisances, had issued a fairly standard order banning the congregation of two or more people at schools, theaters, and other public gathering places. Violation of the order was a misdemeanor.

The dispute in *Globe* arose after the local school district wanted to keep the classes up and running, despite conceding that there was “in the city of Globe an epidemic disease known as Spanish influenza, with which several thousand people in that vicinity have been afflicted, and of which a large number of persons have died, and . . . the belief is prevalent that the same [disease] is spreading.” The school district argued that eighty percent of its students were influenza-free and ready to sit at their desks. Moreover, it asserted, nurses were on hand to diagnose and respond to flu-like symptoms as soon as they arose – responsive health care that was likely unavailable to the children outside the school system. The school district attacked the public health law on three grounds: (1) it was unreasonable for the board of health to

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102 Id.
103 See id.
104 179 P. 646 (1919).
105 179 P. 55 (1919).
106 See *Alden*, 179 P. at 647.
107 See *Globe*, 179 P. at 56.
108 Id.
109 See id.
treat the school’s operations as a public health nuisance; (2) more broadly, the board of health lacked the authority to create the law; and (3) the resolution was void for vagueness because it did not establish an end date for the closing order.  

The court handled the first argument in short order. In the early twentieth century, a formalistic approach to administrative law and the non-delegation doctrine was alive and well. The Arizona Supreme Court was troubled that the board of health had gone beyond clear executive enforcement powers and exhibited legislative tendencies by defining what constituted a public nuisance. Siding with the administrative law formalists, the court held that the board did not have the power to define “what is or is not a nuisance.” That, the court said, was a legislative, not an executive, power. It then declared void all portions of the resolution that defined nuisance.

The court, however, was not about to hamstring the public health effort during a brutal epidemic to score points in a war over legal doctrine. Alternative grounds for the board’s authority had to be found. The court delved into the issue of whether the board of health had the power to determine if an emergency existed. Before the New Deal, whether an agency (as opposed to the judiciary in de novo review) had the power to determine jurisdictional facts -- facts that are condition precedents to the operation of a statutory scheme -- was a hot issue. While the court's stance on the

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110 See id.
111 For a sense of that debate at the time and it how it relates to the flu epidemic, see generally Walter Carrington, Delegation of Power to Boards and Commissions, 6 VIRGINIA L. REGISTER, 801 (1921). The leading case on the issue at the time was United States v. Grimauld, 220 U.S. 506 (1911), in which the Supreme Court, in the words of Professor Farina, "followed the well-established course of emphasizing that legislative power could not be delegated but noting that not all power delegated was legislative in nature." See Cynthia R. Farina, Statutory Interpretation and the Balance of Power in the Administrative State, 89 Colum. L. Rev. 452, 482 (1989). For a discussion on the Supreme Court's treatment of the non-delegation doctrine in the late nineteenth century and early twentieth century, see id. at 478-87.
112 Globe, 179 P. at 57
113 See id.
114 See id.
non-delegation doctrine is reminiscent of a bygone era, its treatment of jurisdictional facts would prevail over the next two decades. The court, digging into the board’s enabling statute, parsed the language to hold:

Boards of health are granted power within their jurisdiction to make rules and regulations to facilitate the enforcement of the health laws, and in exercising such powers they may adopt such measures as are reasonable to carry out such health laws according to the spirit and intent of the Legislature.

... Incident to such powers, the local boards of health are granted the power to determine the fact whether the emergency exists for the making of rules and regulations and the adoption of health measures, but such powers are administrative – not legislative. The court, in its most poetic passage, continued: “Necessity is the law of time and place, and the emergency calls into life the necessity for the operation of law.” The court then delivered the crushing blow: during an emergency, it said, the boards of health have “a power superior to that given the school administration officials.”

The Globe opinion concluded with a brief two paragraphs on the extent of that health power. It held that boards of health could enact reasonable regulations “during the existence of said disease in epidemic form . . . and no longer.” It did not examine whether the measures at bar were reasonable. Nor did it discuss how to determine, and who would determine, when the epidemic was over and the board’s powers limited once again.

Ultimately, the court’s analysis in Globe reflects a public health elitism approach. The liberal theory undergirding Alden’s and the school district’s arguments held no sway. Most importantly, the

116 In 1938, Dean Landis said that the issue of providing de novo review to constitutional or jurisdictional facts was “the most disputed field of judicial review over administrative action today.” JAMES M. LANDIS, THE ADMINISTRATIVE PROCESS 140 (1938); see also HORWITZ, supra note 90, at 214 (discussing the rise of the administrative state).


118 Id.
119 Id.
120 Id.
121 Id.
court declared that during a public health emergency other public bodies must bow to the board of health. Even judges, it seemed, would permissively juggle their legal principles to avoid getting in the way of the health experts.

C. Limits to Public Health Elitism in Tucson

On November 17, Dr. Meade Clyne, Tucson’s health officer, called a meeting with the members of the city’s board of health. They were dismayed with the lack of progress in combating the epidemic and wanted to beef up the city’s response. There was nothing left to implement from Surgeon General Blue’s recommendations. Elsewhere, however, the mayor of San Francisco had been boasting that an ordinance requiring residents to wear face masks was responsible for his city’s relatively low infection rates. Impressed, Clyne and the board of health decided that “masks should be worn in any place where people meet for the transaction of necessary business.”

The Tucson public picked up their masks, and the police looked to round up violators. Enforcement, though, was difficult because the law did not mandate mask wearing on public streets. So a few days later, the board of health amended the law to state: “no person shall appear in any street, park, place where any business is transacted, or in any other public place within the city of Tucson, without wearing a mask covering both the nose and mouth.” The police hit the streets with vigor, even deploying

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122 See Luckingham, supra note 94, at 194.
123 Id. In the hopes of curtailing the crowding that the flu seemed to enjoy, the board also declared that businesses “shall not, at any time, permit more than one customer to every 500 square feet of floor space.” Id.
124 Following the order, the Red Cross spurred into action and made 2,300 masks in twenty-four hours. A local newspaper bragged that “the public will be offered, no doubt, positively the latest thing in masks.” Another described “a nifty California mask,” of pliable gauze that folded over the contours of the nose. Id.
125 See id.
126 Id. The order applied to both children and adults. Some newspapers lamented that only one’s home was no safe from the reaches of the board of health. Id.
plain clothes officers.\textsuperscript{127} Within a few days it seemed that Tucson residents were complying with the board’s directive. By the end of November, however, the autumn wave of the influenza was on the wane and reports of new cases were declining. The ban on public gatherings appeared excessive in light of the reduced risk. The board of health convened once again, this time to lift the bans on public gatherings; but it kept the face mask order in place, making just one amendment to exempt students in schools.\textsuperscript{128} On the first day of December 1918, theaters and churches in Tucson opened and masked Arizonians filled the seats.

Problematically for the board, though, lifting the ban on public gatherings had sent a health expert-endorsed message that the air was now safe to breathe. Residents soon began ignoring the mask law. Dejected from the now common sight of people’s faces and noses uncovered, the board of health held another December meeting. It reaffirmed the mask ordinance, and the police pledged to enforce it.\textsuperscript{129}

Dozens were arrested. On December 17, a local judge found eight guilty of violating the ordinance.\textsuperscript{130} They offered various excuses, but the judge showed no leniency and fined them.\textsuperscript{131} But many violators were undeterred. Fed up with the masking law, a prominent banker and civic leader, John Mets, vowed to fight it in court.\textsuperscript{132} He boasted publicly that he had been arrested so many times for not covering his face that he had lost count. He preached that the masks were ineffective (a point modern science agrees on) and clearly unpopular. He flashed his worldliness by explaining that he had recently returned from the east coast, where masks were nowhere in sight. So, after another arrest, Mets challenged the validity of the law in the Tucson Superior Court.\textsuperscript{133} Mets attacked the law as unreasonable and invalid under equal

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\textsuperscript{127} Id.
\textsuperscript{128} See id. at 195.
\textsuperscript{129} See id. at 196.
\textsuperscript{130} See id. at 198.
\textsuperscript{131} See id.
\textsuperscript{132} See id. at 199.
\textsuperscript{133} See id.
protection principles because of the exception for school children.\textsuperscript{134}

Judge Pattee issued his opinion on December 21.\textsuperscript{135} The appellate judge refused to consider the reasonableness of the law; that was for health experts. “I could not see how a person not a physician could reach a basis for determination,” he wrote.\textsuperscript{136} While it clearly would be unreasonable if the board of health mandated “wearing a gunny sack over the head or a suit of armor,” Judge Pattee continued, he would not accept responsibility for determining the reasonableness of the health measure at bar.\textsuperscript{137} The judge bit on the equal protection angle, however, and voided the law because it was underinclusive.\textsuperscript{138} While the board of health could have fixed the validity of the law by removing the school exemption, it instead let the law expire at the judge’s hands. On Christmas Day, the board issued an advisory warning for holiday crowds but took no further action.\textsuperscript{139}

This episode reveals two important limits to public health elitism. First, when public health experts are out of touch with popular will for too long, it can create a fissure that even robust law enforcement cannot fix. A Tucson newspaper commented at the time: “No matter how many citizens the city authorities might have taken to the lock-up, nor how many fines they imposed, they never could have brought about the general observance of masking.”\textsuperscript{140} The board of health responded to this popular disagreement only with muscle and not also with the softer forms of communication to promote public cooperation. This was a fatal mistake. Communication, Gostin writes in his leading book on public health law, is essential because public health is fundamentally a “battleground of ideas” over human behavior. As

\textsuperscript{134} See id.
\textsuperscript{135} The opinion is not available in any reporter. It may be available at the Tucson courthouse archives. However, I have not had the opportunity to go there. This account of the opinion is from Luchingham’s research. See supra note 94 Luckingham pieces together his account from newspaper archives.
\textsuperscript{136} Id. at 201.
\textsuperscript{137} Id.
\textsuperscript{138} See id.
\textsuperscript{139} See id.
\textsuperscript{140} Id. at 202 (quoting Good Riddance, TUCSON CITIZEN, Dec. 24, 1918).
public health scholars James Childress and Ruth Gaare Bernheim put it: “A stronger public that deliberates, collaborates, partners, and most importantly, expects government officials to provide explicit public justification for their actions... will be more likely to foster its members’ voluntary participation and trust.”

The second notable point from the Tucson episode is that even courts espousing public health elitism rhetoric may prove willing to limit state public health powers. The Tucson judge explicitly maintained that public health experts ought to decide the efficacy of health measures and risks during an emergency. Yet, turning to equal protection principles, he was willing to assess whether a health protective measure was well-tailored – not by asking whether it was the least restrictive means necessary (that requires an assessment of health risks beyond the judge’s comfort zone) but by determining whether it was applied equally to different groups.

This equal protection discussion illuminates a dialogue between Gostin and Jennings on the role of courts in a public health emergency. Courts, Gostin says, should check executive power by asking whether public health measures are “well-targeted.”141 Jennings replies that there are two relevant conceptions of “well-targeted.” It can mean “efficient and effective at neutralizing or controlling the risk,” or it can mean “justly, fairly, or equitably targeted.”142 The Arizona court, it seems, sidestepped the first definition and embraced the second. Perhaps that is the role of courts under a public health elitism regime.

V. PUBLIC HEALTH LIBERALISM: NEW JERSEY

In Arizona, officials actively enforced the health measures that Surgeon General Blue recommended, and some places like Tucson went beyond the template of quarantine, medical isolation, and public closings. In New Jersey, by contrast, many localities thought the coercive health orders were ill-suited to them. Few elected officials, though, challenged the state board of health and Blue’s recommendations as openly and antagonistically as Mayor Charles Gillen of Newark. In October 1918, he established himself...

141 See Gostin, supra note 1, at 1161-64.
142 Jennings, supra note 1, at 1248.
as responsive to individuals’ concerns and, in turn, a champion of their rights. He would raise the ire of state officials by launching a liberal attack on the predominant public health elitism of the time. In an unrelated case, the New Jersey Supreme Court would later seem to embrace the same liberal philosophy that animated Gillen. No other state would demonstrate liberalism with as much flare as New Jersey.

\textit{A. Newark’s Champion of Liberal Rights}

In the fall of 1918, Newark factories were churning for the war. An influx of laborers to the city had led to an acute housing shortage and overcrowding, a welcoming condition for influenza.\textsuperscript{143} The first flu case was reported in Newark on September 25.\textsuperscript{144} Certainly aware of the flu's prior impact in other cities, Mayor Gillen, who was also Commissioner of Public Safety and could exercise the public health powers that coincided with that title, called a meeting with a group of civically-engaged Newark physicians to discuss the disease.\textsuperscript{145} They agreed to form a local department of health to mobilize resources against the flu. The first step was an educational campaign on how to prevent the flu and treat its symptoms. As a result, public health pamphlets and posters sprung up across the city. They advised avoiding crowds, covering coughs and sneezes, and wearing warm clothes. School officials and employers were asked to send home people exhibiting flu-like symptoms.\textsuperscript{146} In contrast to Tucson, police were not enlisted to enforce these recommendations. The mayor’s style was instead the soft paternalism of public communication and cooperation.

But, while the mayor’s precautions were sound, the strain of influenza present in 1918 was virulent enough to overcome them all. By mid-October, Newark was reporting fifty to seventy deaths per day from the flu or flu-induced pneumonia.\textsuperscript{147} The death rate

\textsuperscript{144} See \textit{id}. at 249.
\textsuperscript{145} See \textit{id}.
\textsuperscript{146} See \textit{id}.
\textsuperscript{147} See \textit{id}. at 250.
outpaced the grave diggers’ shoveling. Corpses piled up. On October 10, the New Jersey Board of Health followed Surgeon General Blu’s advice and decreed a ban on all public gatherings. Newark Mayor Charles Gillen, favoring less coercive measures, disliked the broad order. Nonetheless, he followed it and that day ordered all school, churches, theaters, dance halls, arenas, and saloons closed indefinitely. Newark’s streetscape quickly turned gloomy. Main street businesses shuttered. Pedestrian sidewalks emptied. It seemed only life insurance offices were doing brisk business.

After the October 10 order, Mayor Gillen still searched for less coercive ways to help Newark residents. With the Newark hospital overflowing, he applied to the county to help treat the skyrocketing number of sick; but it too was overwhelmed and offered nothing in response. So the mayor bought an abandoned warehouse for the city and converted it into a staffed hospital. He created an emergency relief committee, disinfected public conveyances daily, and encouraged private philanthropies to solicit funds to help the city.

For this article’s purposes, one of the mayor’s most important characteristics was his malleability and suggestibility. When some physicians claimed that liquor was good for the flu, he allowed saloons to sell bottled goods on a doctor’s prescription. However, whenever possible, the mayor declared, saloonkeepers had to sell the liquor through the side door and not let people congregate inside. The *Newark Evening News* derided the “side door” proclamation as unenforceable. The newspaper proved right: the side door rule was widely ignored. Instead, many

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148 See *id.* Galishoff observes: “Since coffins were in short supply, and consequently expensive, many families buried their dead in rude pine boxes improvised and constructed in the homes of the bereaved. As it was believed that corpses were a source of infection, public funerals for influenza victims were prohibited by the health authorities.” *Id.*

149 See *id.* at 251.

150 See *id.*

151 See *id.* at 252.

152 See *id.* at 253.

153 See *id.* at 254.

154 The mayor, in a hot-headed moment, actually threatened to close the newspaper. *See id.*
saloons opened their front doors and let the throngs of customers inside. The mayor, it seems, did not push for strict enforcement of the rule.\textsuperscript{155} The healthy liquor business led one newspaper to irk the mayor by printing that he was out to win the “saloon vote” in the upcoming November election.\textsuperscript{156}

Angered by the special treatment for saloons and the sights of busy bars on Sundays, church leaders protested the ban on their operations. On October 19, the mayor capitulated and crafted an equivalent “side door” proclamation for churches. He allowed them to have mediation and prayer in churches but not full-scale services. Once again, the rule was ignored by some, and clergymen held full services as usual.\textsuperscript{157}

Finally, tired of carving exceptions into the ban for various constituencies, Mayor Gillen declared on October 21 that the state closing order no longer applied in Newark.\textsuperscript{158} The New Jersey Board of Health fired off telegrams insisting that the ban was still in effect and that Gillen did not have the authority to lift it.\textsuperscript{159} Gillen responded with an impassioned speech, in which he called the ban foolish. It made no sense to Gillen that crowded factories stayed open around the clock to meet wartime demands but theaters and public places with better ventilation were off limits.\textsuperscript{160} Moreover, he said, it needlessly “scared people who were slightly afflicted into a serious illness.”\textsuperscript{161} Gillen pointed out that cities throughout New Jersey were not enforcing the measures either, and he complained that the state board of health was picking on Newark. Finally, throwing down the gauntlet, he insisted that he had the power to reopen Newark businesses.\textsuperscript{162}

To end the face-off, the Newark city commissioners could have removed Gillen from office or placed the public health enforcement under their jurisdiction. They, however, did not want

\textsuperscript{155} See id. at 255.
\textsuperscript{156} As Galishoff notes: “The accusation was of some consequence, since prohibition was an important political issue in Newark.” Id.
\textsuperscript{157} See id.
\textsuperscript{158} See id. at 256.
\textsuperscript{159} See id.
\textsuperscript{160} See id.
\textsuperscript{161} Id.
\textsuperscript{162} See id.
to take the heat for reinstating the coercive measures, and they refused to act.163 The political mess ended on October 26 when the state declared that the epidemic had passed, and it lifted the ban.164 This was earlier than other nearby states and cities lifted their bans.165 Seemingly, Gillen’s actions influenced the decision.

This article takes no stance as to whether Gillen’s championing of civil liberties and the early end of the coercive public health measures was good. There are two pressing points though. First, as a matter of municipal law, Gillen was wrong. Cities are subsidiary entities whose power is derived from the states.166 Newark had established a commission form of government in 1917 with fairly broad powers, after the state legislature had passed the Walsh Act giving localities the power to create their own charters.167 However, the local charter-making authority did not give localities powers superior to New Jersey’s.168 While the municipal reform movement had led states to grant localities broad powers and autonomy, local powers always fell behind the state's power for matters of “state concern” and matters that went beyond the “purely local.”169 A deadly epidemic is in no way “purely local.” Thus, Gillen’s power was secondary to the state’s authority. Second, Gillen’s antics may have costs lives. Recent studies have shown that, during the 1918 flu, when “restrictions were introduced too late or lifted too early, success rates declined substantially.”170 Of course, in the midst of the epidemic that was

163 See id. at 257.
164 See id.
165 Consider, for example, that Philadelphia and Washington, D.C. did not lift their quarantine measures until about a week later. See Crosby, supra note 69.
166 See, e.g., Gerald E. Frug, City Making 3 (1999) (“American law treats cities as subdivisions of the states, and the states have organized them in a manner that has helped separate metropolitan residents into different, sometimes hostile, groups.”).
169 See text accompanying notes 90-93.
not known. People in New Jersey and New York appeared to be dying regardless of how strict public health measures were. The mayor of Newark chose to err on the side of individual rights – or, more cynically, political expedience – instead of public health.

B. The New Jersey Supreme Court

The New Jersey Supreme Court showed none of the trademarks of the public health elitism that animated the Arizona courts. It viewed through a liberal lens the one case it heard on public health enforcement during the flu.

In that case, Paterson, New Jersey’s health board had not issued a flu-specific order, but had instead relied on a general, previously extant health law that made it a violation to operate a business dangerous to human health. On October 12, 1918, a Paterson saloonkeeper was charged with and convicted of violating the health law because he “had people congregated and invited people to congregate in his saloon, . . . [which was] dangerous to human life and health, there being an epidemic of influenza in the city of Paterson.”

The state supreme court dismissed the charges. It then chastised the prosecution for sloppy work: the prosecution had not clearly established how many people had “congregated” at the saloon. Turning to the dictionary definition of “congregate,” the court stated: “The charge, therefore, is simply that ‘people’ (as few as three perhaps, and we have no proof that there were more) came together at the instance of Clayton in a saloon, of unknown dimensions, with unknown facilities of ventilation, on October 12th, and while influenza was in a general way epidemic in the town.”

The court continued by turning to clear statement principles to poke holes in the prosecution’s argument:

171 The regulation states: “That whatever is dangerous to human life or health . . . are declared to be nuisances and are prohibited.” (quoted in Board of Health of City of Paterson v. Clayton, 106 A. 813, 813 (N.J. 1919)).
172 Id.
173 See id.
174 Id.
It may be freely conceded that epidemics of contagious and infectious disease may be, and have been, so severe and dangerous as to justify the most drastic rules against personal contract of individuals, but there is nothing in the complaint to show that such conditions prevailed in this case, and if they did prevail, the ordinance is not such a rule as to meet the emergency, and as we have said, does not support the complaint, which under well-recognized rules must be taken at the minimum of the facts charged.\textsuperscript{175}

While the Arizona Supreme Court had set out to find a statutory peg to uphold the board of health’s powers, here in New Jersey the court set out to puncture the state’s public health powers. The court appears to have followed Dillon’s Rule,\textsuperscript{176} a local government version of the clear statement rule in modern administrative law. As Cass Sunstein has explained, the clear statement rule promotes accountability and deliberation by forcing the legislature “expressly to deliberate on an issue and unambiguously set forth its will.”\textsuperscript{177} Certainly, the lack of clarity in the ordinance at issue in Paterson differentiates it from the ordinance at bar in \textit{Globe} and \textit{Alden}. Nonetheless, the court could still have deferred to the agency, as the Arizona court did, to determine whether conditions "dangerous to human health" were present, thus triggering the statutory authority. As Professors William Eskridge and Philip Frickey have theorized, ultimately, clear statement rules allow courts “to override probable congressional preferences in statutory interpretation in favor of norms and values favored by the Court.”\textsuperscript{178} The New Jersey court’s liberal norms were on display in this case.

The ruling for the Paterson saloonkeeper was in June 1919, after the epidemic was over. It has not been cited in any significant way and likely has no value as precedent. The primary effect of the court’s liberal decision was thus to exculpate the saloonkeeper. Nonetheless, it is a good example of a liberal court unwilling to

\begin{footnotes}
\item[175] \textit{Id.}\textsuperscript{.}
\item[176] See supra, text accompanying note 93.
\end{footnotes}
cede all risk-assessment duties to public health experts. Remember Jennings’s dual conception of “well-targeted.”179 The New Jersey Supreme Court, it seems, went further than simply asking whether the law was “justly, fairly, or equitably targeted” – as the Tucson court seemed to do. Instead, it aspired to determine whether the health law was “efficient and effective at neutralizing or controlling the risk” – a mission that protects individual liberty more robustly.

VI. PUBLIC HEALTH COMMUNITARIANISM: IDAHO

Liberals have charged advocates of communitarianism with defending their theory through nostalgic arguments that evoke the small town lifestyles of yesteryear.180 Thus, it is in some ways apt to shift from urban New Jersey to Idaho’s pioneer communities when discussing communitarianism. The flu reached Idaho in the first week of October 1918. Governor Moses Alexander followed Surgeon General Blue’s recommendations and issued a statewide order that banned public gatherings.181 Nonetheless, it was the state’s small communities and not its executive that would set the agenda during the epidemic. These small farming and mining towns exhibited the participatory and deliberative democracy that communitarians long for. However, while these processes legitimated government action, they also gave rise to the problem of localism – a sort of “us versus them” mentality that local government law scholars say can plague governance. This underbelly of communitarianism has been overlooked in the public health literature.

A. The Quarantine War in Challis

179 See supra text accompanying note 142.
As the flu raged in Idaho in late October and early November,^{182} some pioneer communities in Idaho took matters into their own hands, leading to the controversial “Quarantine War” in Challis, Idaho. Challis was a farm and stock-raising town with a population of four or five hundred.^{183} While it was fifty miles from the nearest railroad station in Mackay, newspaper reports told of similarly far-flung regions stricken with the disease. Hoping to avoid that fate, Challis residents gathered to discuss their options. They decided they would post guards outside their town to keep people from bringing in the flu via the mountain divide between Challis and Mackay. The guards would lock up in quarantine or turn away anyone who attempted to enter.^{184}

Thus, two hunters making their way down the road to Challis soon found themselves in jail. The town refused to release them, so they sent a habeas corpus appeal to the state district court. The court issued the writ, but the town still refused to release them.^{185} District Judge F.J. Cowan took umbrage and decided to investigate the matter personally. So he, along with a representative from the U.S. Department of Justice, headed to Challis. But upon their arrival, about half of the town had gathered to block their entrance. The judge turned to the local sheriff for help.^{186} Instead, the sheriff deputized all citizens within earshot, and the judge was turned away.^{187}

Judge Cowan sent a request for support to Governor Alexander, who promptly passed the sticky issue to the attorney general. The

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^{182} The *Idaho Observer* ran full page spreads warning of the danger and providing graphics on how readers could fashion face masks to protect them from the flu. In the first three weeks of October, thousands were stricken. Some southeast counties had infection rates above fifteen percent and mortality rates of fifty percent. See [http://www.pandemicflu.gov/general/greatpandemic.html#id](http://www.pandemicflu.gov/general/greatpandemic.html#id). The flu truly exploded, however, after November 7. Responding to report of armistice in World War I, crowds disregarded the ban on public gatherings and took to the streets to celebrate. While the report was a false alarm -- the official armistice was on November 11 -- the deadly disease took the opportunity to spread to thousands more.


^{184} See id.

^{185} See id. at 25.

^{186} See LEONARD ARRINGTON, HISTORY OF IDAHO VOL. 2, 1-21 (1994).

attorney general’s office replied with a letter making several points. First, Idaho did not have armed forces available to send to Challis. Second, Challis had to allow state and county officials to pass along the mountain divide without interference. Yet, the attorney general said, the quarantine order was legal given the health emergency. What’s more, Challis had the right generally to exclude people, including Judge Cowan, from its borders. Finally, the attorney general declared that the Challis sheriff should release the hunters, but since no one could reach the sheriff within the town borders (the quarantine being in effect), nothing could be done. The message was clear – communities had broad powers to curb individual rights and handle the public health crisis as they saw fit.  

Idaho towns by and large sided with Challis in the “Quarantine War.” Several even copied the Challis approach. The state executive was powerless to control the trend. After one county established Challis-inspired guard duties at all points of entrance, Governor Alexander’s secretary noted: “It is impossible to get into the county, but easy to get out.”

In a postscript to the “Quarantine War,” Judge Cowan got his revenge. After the their release, the two hunters filed an action to remove the Challis sheriff from office for nonfeasance during the epidemic, which they had standing to do as residents of the same county. In a 3-1 decision, the Idaho Supreme Court declared that the sheriff “cannot usurp the functions of courts in this manner, and escape the consequences of [his] wrongful acts” and removed him from office.

B. Localism and Social Cohesion

The Challis Quarantine War was on a smaller scale what Oren Gross, writing from a national constitutional law perspective, sees as a rally around the flag effect that accepts coercive government

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188 See id.
189 See id.
190 Id.
191 Archbold et al. v. Huntington, Sheriff, 201 P. 1041, 1045 (Idaho 1921).
action because it is aimed at “others.” For local government law, this attitude toward others is call localism. Professor Richard Briffault defines localism as “reifying] local borders, using invisible municipal boundary lines to delimit the range of local concern and the proper subjects of local compassion and treating the creation and maintenance of local borders as a basic right.” These local borders, Briffault continues, needlessly “become a focus of sentiment and symbolism and create a powerful legal bulwark for the preservation of local interests.” Professor Gerald Frug explains the problem is that “local government law fuels a desire to avoid, rather than to engage with, those who live on the other side of the city line.”

The localist mindset is particularly harmful when combating a virulent disease that can spread across the entire country in days. Therefore, not only does localism lead communities to discount the rights of outsiders, but it may also hurt broader public health efforts. However, local deliberative and participatory democracy during an epidemic is not always so myopic. The problem with Challis’s decision, it seems, is that panic and fear overrode reason. Challis’s response represents an interesting flip

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194 Id.
196 Elizabeth Cooper has argued this point in regard to communitarian treatment of people who are different within that community. Communitarianism, she says, “is problematic in that the communities most esteemed by communitarians – including families, religious groups, unions, and neighborhoods – have been historically recognized as being oppressive of outsider groups, including people with disabilities.” Elizabeth B. Cooper, Social Risk and the Transformation of Public Health Law: Lessons from the Plague Years, 86 IOWA L. REV. 869, 918 (2001).
197 See, e.g., Stuart Galishoff, Germs Know No Color Line: Black Health and Public Policy in Atlanta, 1900-1918, 40(1) JOURNAL OF THE HISTORY OF MEDICINE AND ALLIED SCIENCES 22 (1985). Galishoff discusses how white officials in Atlanta came to favor improving sanitation in African-American neighborhoods because “they found that they could not ignore the high morbidity and mortality rates of blacks, since . . . germs know no color line.” Id. at 41.
of Jennings’s observation that people may balk at short-term, liberty-limiting provisions during an emergency because those liberties are “too intensely desired to be amenable to reasonable public dialogue” in the time available. Here, Challis members’ well-being was so intensely desired that it overshadowed a reasoned understanding of civil liberties.

Fairness and objectivity dictate noting that a Challis-style response may have important benefits. First, while infection rates are unavailable for Challis, as discussed above recent research has shown that strict quarantines and medical isolations applied early were successful in reducing those numbers. Thus, it is conceivable that Challis fared relatively well in the epidemic, or at least that their actions had reasonable odds of protecting residents’ health. Second, aside from rates of flu infection, one school of public health has emphasized the health benefits that accrue when people foster community ties and social cohesion. Conversely, health is hurt when these ties disintegrate, as happened in some cities when public spaces were closed and fear and mistrust were pervasive among residents. Therefore, relying on neighbors and community-based decisions may protect these secondary health benefits. Challis certainly exhibited community support, first by meeting to decide on the guard posts and second by rallying around that decision when Judge Cowan came to town. Whether there were more constructive and liberty-respecting ways to promote social cohesion is another matter.

VII. A FOURTH WAY IN NORTH CAROLINA

198 Jennings, supra note 1, at 1254.
199 See Bakalar, supra note 170.
200 See e.g., Peter Gorski, Caring Relationships: An Investment in Health?, Public Health Reports 2000, 115, 144-150 (March 2000) (arguing that greater connectedness to family and community correlates with better health outcomes and explaining the therapeutic powers of relationships); Ichiro Kawachi et al, Long Live Community: Social Capital as Public Health, American Prospect, Dec. 1997, 56 (demonstrating that social cohesion is linked to health).
201 See Kawachi, supra note 200, at 56 (arguing that civic participation correlates with mortality and reports of well-being and health).
In Arizona, public health experts set the agenda. Robust, sometimes abusive, police officers enforced it, and the judiciary made sure it was not selective in its coercive effects. In New Jersey, state public health officials attempted to set the agenda, but some liberal officials bristled and the state supreme court showed no patience for public health enforcement when the health risk was unclear. In Idaho, some small communities met to set their agenda, regardless of how it impacted their fellow Idahoans who lived outside town lines. These three approaches, however, are not mutually exclusive. As an example from North Carolina shows, mixing and matching is allowed.

A. Public Health Elitism First, Communitarianism Second in North Carolina

In the fall of 1918, North Carolina and the head of its state board of health, Dr. Watson Rankin, were besieged with flu cases. With estimated infection rates of twenty percent, North Carolina and its inchoate public health infrastructure were simply overwhelmed. Dr. Rankin asked the federal government for help, but Surgeon General Blue had nothing to offer. He simply suggested that Rankin and North Carolina should “endeavor to organize local available resources.” So the state turned inward to community action and public philanthropy.

In early October, the Governor Thomas Bickett used the North Carolina Council of Defense (NCCD), an organization created to mobilize and inform residents in every corner of the state during World War I, to spread the message that the deadly influenza had stricken North Carolina. Like authorities in most of the country, he and Dr. Rankin followed Surgeon General Blue’s request and recommended to every North Carolina community that they close schools, churches, theaters, and other public gathering places. Again, most complied.


See id.
The major problem, though, was that in 1918 many rural North Carolina counties and towns lacked health departments. Dr. Rankin urged that everyone should “secure the cooperation of your neighbors in petitioning your county board of health to establish a full time health department . . . to organize the people and teach disease prevention.” In Orange County, North Carolina, civic leaders heeded the advice. After a county commissioners meeting on the epidemic, one commissioner noted: “It was realized at this meeting that there was no County Board of Health, and so one was created.” The board of health in turn created an ad hoc system to marshal resources, bring supplies to flu patients, and enforce the public health measures. A similar script played out throughout the state. Historian David L. Cockrell observed that “spontaneous assistance efforts . . . occurred in almost every community in North Carolina.”

Importantly, it seems that most of these new health boards comprised the communities’ civic leaders – that is, the creation of the health boards consolidated public health powers with the local elite. Those leaders then maintained strict public health measures. Thus, public health elitism emerged from this makeshift process of creating a public health infrastructure. However, the public health elitism faded in the first week of 1919. The deadly autumn wave of the flu had passed, and local boards of health were given the go ahead to lift the quarantine orders. Quickly, public places filled with residents, and schools across North Carolina opened.

However, a new wave of the flu was cresting in early January, and a few school districts were hesitant to open their classrooms. Some would decide whether to open the schools by turning to public health communitarianism to fill the vacuum left when the public health elites lifted the quarantine and effectively abdicated their emergency powers.

204 See id. at 311.
205 Id. at 321.
206 Id. at 317.
207 Id. at 316.
208 See id.
The school district of Lenoir, North Carolina was fiercely divided on whether to open its schools. As factions took shape, the county board of health and the school board called a public meeting to solve the matter. Most notably, the two bodies decided to open voting to all residents in attendance. The next day, *The Charlotte Observer* headline blared: “Lenoir Public Schools Closed Till Next Fall: People So Decide by Vote of 150 to 70 After Bitter Fight. ‘Flu’ the Reason.” The article continued:

The spread of the ‘flu’ during the holiday season caused the county board of health to call a mass meeting to decide on the question of removing the quarantine as to the school. . . . Very few people attended this meeting and those in favor of opening the school circulated a petition to have the school opened on the grounds that this meeting was not representative of the citizens of the school district.

. . .

Considerable agitation and some feeling resulted between the opposing parties. The large margin of victory did not quell the faction seeking to reopen the schools, and it challenged the school district’s decision in court. A sticking point for some was that their children would not advance a grade when the school started in the fall. After the lower court found for the school, the North Carolina Supreme Court took the case. It affirmed, holding that “there was no finding that they [the school trustees] have not been using their best efforts to promote the public welfare, or that they have been arbitrary.”

Most school districts in North Carolina squeezed in a semester of work in early 1919. The residents of Lenoir, though, had met and, through reasoned deliberation and participatory democracy characteristic of communitarianism, decided to keep the schools shuttered. The North Carolina court system simply respected the town’s wishes.

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209 The court in the subsequent legal battle put it this way: “There was considerable agitation in the town, both pro and con, as to opening the school.” *Dula v. Board of Graded School Trustees of Lenoir*, 99 S.E. 193, 194 (North Carolina 1919).
210 *Charlotte Observer*, Jan. 9, 1919, p. 11.
211 *Id.*
212 *Id.*
213 *Dula*, 99 S.E. at 194.
B. Room for More than Public Health Elitism

In both Challis, Idaho and Lenoir, North Carolina some felt their rights had been trampled on, and they turned to the courts; however, in Lenoir, the losing side had been listened to in a reasoned manner. Time was a key factor in making Lenoir’s brand of communitarianism more palatable than Challis’s. Challis residents responded to the flu when it was at its fall peak in Idaho. In contrast, by January 1919, the residents of Lenoir had already lived through a few months of the epidemic and had experienced a brief respite from its rampage. At that point, when they met as a community to decide how to go forward, they had a sense of the risks from the virus and the toll of liberty-limiting health orders. They were thus well-situated to balance the community’s values concerning health and access to a public education. Public health experts did not need to make that calculation for them.

North Carolina’s approach, it turns out, lends credence to one of Jennings’s intuitions. He maintains that expert-based decision making and community-based deliberative reasoning “are symbiotic and mutually reinforcing.” Each, Jennings says, “is seriously flawed and incomplete without the other.” Jennings pushes for a political process and public health policy that is “institutionally rich and commodious enough to incorporate both” models. When Jennings wrote that a couple years ago, his assertions lacked a clear roadmap for how these two modes of reasoning can coexist during a public health emergency. Lenoir, North Carolina provides a historical example to help remedy that.

VIII. CONCLUSION

The analysis in this article has several limitations. The primary limitation stems from the nature of synthesizing complex, messy political decisions and then placing them within a post hoc framework. Inevitably, responses to public health emergencies

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214 Jennings, supra note 1, at 1251.
215 Id.
216 Id.
will not always fit neatly into the model, and these responses may not always appear so starkly different from each other. For example, consider that Newark’s mayor exhibited some public health elitism tendencies before brandishing his liberal bona fides.  

That said, there are several valuable points to take away from viewing the 1918 influenza epidemic through the lens of the public health law framework presented in this article. First, this framework highlights localism – an overlooked potential downside of communitarianism in an epidemic or emergency. Public health scholars generally assume that communitarians are more amenable than liberals to coercive government actions taken in the name of the public good. However, as the Challis Quarantine War shows, public officials may need also to restrain a community from going too far by infringing on the liberty of outsiders and fostering distrust among communities in the midst of a crisis.  

Second, combining the framework in this article with a historical approach reaffirms a couple previous public health law observations. That is, as shown by the episodes in Newark, some liberal challenges to public health efforts may needlessly create political tensions and cost lives by delaying or prematurely ending valuable health measures. The corollary to this observation is that a strong and quick public health elitist response may best preserve order and health in an emergency. However, such strong approaches may step on individual liberties and become harder to enforce as citizens become weary of the coercive behavior.  

Finally and most importantly, this article shows that shifting in the midst of an emergency from a public health elitism-inspired approach to one infused with more communitarian characteristics may best serve the public good. Consider that in Tucson, after the first wave of the epidemic had passed, the city health board insisted on maintaining its order that citizens wear masks. This action eventually led to open hostility to the city’s public health efforts. However, in Lenoir, North Carolina, after the first wave of the

217 See infra Part V.A.
218 See infra Part VI.A.
219 See infra Part V.A.
220 See infra Part IV.C.
epidemic, residents were free to hold a forum on whether to retain the public health order closing schools.\textsuperscript{221} While about one-third of the town was unhappy that the schools remained closed, that group had the chance to make its case before fellow citizens, who at that time of the decision were well-versed in both the disease’s potential to cause harm and the costs of temporarily sacrificing liberties.\textsuperscript{222} Ultimately then, this historical perspective suggests that public health officials may be best situated to assess in the first instance the risks of a disease or health emergency. However, as citizens have more time to consider the public health crisis and its consequences, they may prove to have the best vantage point from which to deliberate and balance between their health and their freedoms.

This implicates one of the central inquiries that Professor Gostin has addressed in his work: "under what circumstances power can be exercised – the standards, processes, and safeguards that fetter, but do not obviate, government power."\textsuperscript{223} Gostin's public health elitism-related theory, which has influenced most states' emergency laws,\textsuperscript{224} posits that, "[a]ssuming the government's intervention is well targeted, the significant risk scenario unequivocally justifies the exercise of state power."\textsuperscript{225} He describes a significant risk scenario as follows:

An agency limits liberty to avert a reasonably tangible and immediate prospect of harm. The government has detailed knowledge of the nature of the risk (e.g., the pathogen and its modes of transmission), the probability (the chances that the threat will result in harm), and the duration (the period during which the threat persists). Additionally, the state can identify a risk producer (the actor who poses the risk) and the at-risk population (the people who are likely to be harmed).\textsuperscript{226}

For Gostin, here public officials perform the entire risk assessment. In response to critics who argue that this arrangement would grant government too much leeway to infringe on civil

\begin{itemize}
\item \textsuperscript{221} See infra Part VII.A.
\item \textsuperscript{222} See id.
\item \textsuperscript{223} Gostin, supra note 1, at 1141.
\item \textsuperscript{224} See supra note 1, at 1109.
\item \textsuperscript{225} Gostin, supra note 1, at 1109.
\item \textsuperscript{226} Id. at 1135.
\end{itemize}
liberties, Gostin maintains that emergency powers should not be limited but "hedged with substantive and procedural safeguards." One such hedge is the democratic process. Before an emergency occurs, citizens, Gostin says, can help put these safeguards in place through deliberative democratic processes. He suggests open fora, town meetings, government advisory committees, and citizen consultations with public health officials. This public participation would happen in anticipation of a public health emergency.

But this article suggests that there is room to continue these deliberative democratic processes in the midst of a pandemic or other public health emergency. North Carolina in 1918 shows how it is possible for citizens, via a town meeting, to assume public health decision making responsibilities in the middle of an epidemic. Professor Gostin is right to maintain that public health officials must have the power to respond promptly to an emergency. However, there is no reason to assume that they must keep that power for themselves throughout the entire lifespan of an emergency.

So now imagine the dreadful scenario of another pandemic on the scale of the 1918 flu or some similarly baleful emergency. Public health officials huddle together to coordinate a response. They have all read this article. What basic lessons should they take away from it?

First, get moving. A slow response can mean more people will die. If it appears you should implement quarantines and isolation orders, then do it. And do it authoritatively – allowing other officials to disrupt the implementation of these health measures to score political points can also cost lives.

Second, fight localism. If renegade towns are infringing on outsiders' rights and harvesting distrust, stop them. Hopefully threats will suffice; but, depending on the risk posed, national guard troops may be called for.

Finally, when the time comes, devolve your emergency powers to the people. In the case of the 1918 flu, the time between the

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227 Id. at 1162,.
228 See id. at 1162-63.
229 See id.
epidemic's waves provided natural points for residents to assess the situation and express how they favored balancing health risks and civil liberties. Not all public health emergencies will have such clear breaks. Nonetheless, your comparative risk-assessment advantage will continue to wane as the emergency drags on. Do not cling to your power beyond its prime usefulness.