SARS: THE IMPACT ON STATE AND LOCAL JURISDICTIONS[1]

Testimony of the Center for Law and the Public's Health
Georgetown and Johns Hopkins Universities
Prepared for the
Permanent Subcommittee on Investigations
U.S. Senate

Senator Norm Coleman, Minnesota
Chairman

May 21st, 2003

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[1] This document is based, in part, on Gostin, LO, Hodge, JG. *The Model State Emergency Health Powers Act - a brief commentary*. Seattle: Turning Point Statute Modernization Committee, 2002; 1-42. The presenter acknowledges the work of James G. Hodge, Jr. in the preparation of this statement. See Lawrence O. Gostin, *Public Health Law in an Age of Terrorism: Rethinking Individual Rights and Common Goods*, 21 HEALTH AFFAIRS 79-93 (2002); Lawrence O. Gostin, Jason W. Sapsin, Stephen P. Teret, Scott Burris, Julie Samia Mair, James G. Hodge, Jr., Jon S. Vernick, *The Model State Emergency Health Powers Act: Planning and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, 288 JAMA 622-628 (2002). See also, Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint* (University of California Press and Milbank Memorial Fund, 2000).

Executive Summary

The spread of SARS in the U.S. presents significant challenges for tribal, state, and local public health authorities. Laws at each level of government may facilitate the planning, preparation for, response to, and prevention of existing and future SARS cases. Ideally, public health laws authorize government to employ proven powers while respecting individual rights. As such, laws are tools for improving public health outcomes.

However, there is considerable variation among existing public health laws, particular at the state and local levels. These laws may be antiquated, inconsistent, and fragmented. They may not reflect the most current scientific, ethical, and legal norms or standards for public health practice. Such laws may limit or actually interfere with effective communicable disease controls. Not surprisingly, calls for state public health law reform have emanated from federal and state authorities.

At the request of Centers for Disease Control and Prevention (CDC), faculty at the *Center for Law and the Public=s Health* developed the Model State Emergency Health Powers Act (MSEHPA) in 2001. Introduced in whole or part in 39 states and passed in 22 states (and D.C.), MSEHPA provides a structured, balanced approach to using law to control communicable diseases, the spread of which may constitute a public health emergency. Additional work on a larger ATurning Point@ project to develop a comprehensive model state public health law is ongoing. Upon completion in late 2003, this model law will provide a comprehensive, structural approach for states considering extensive reform. These existing and future public health law reforms will help improve our national public health system, and its ability to control new and emerging threats like SARS.

Introduction

There is perhaps no duty more fundamental to American government than the protection of the public=s health. Protecting communal health is the quintessential goal of federal, tribal, state, and local public health authorities. Yet, in the last decade alone, novel threats to the public=s health have emerged. Beginning in 1999, West Nile Virus (WNV) began to spread across the nation through mosquitoes carrying the virus from infected birds. Thousands of persons have been infected, and several deaths (particularly among older persons) occurred. In the ensuing weeks following the terrorism of September 11, 2001, public health and law enforcement officials discovered that some person or group had intentionally contaminated letters with potentially deadly anthrax spores. These letters were mailed to individuals in government and the media in several states and the District of Columbia. Thousands of persons were tested for exposure, hundreds were treated, and five persons died from inhalational anthrax.

In 2003, severe acute respiratory syndrome (SARS) has emerged as another serious threat to public=s health in the United States. Unlike WNV and the anthrax exposures, persons infected with SARS may transmit the disease to others through close human contact. Other potential modes of infection are being investigated. To date, the CDC reports 348 cases of SARS in the U.S., of which 65 are listed as probable. No deaths from the disease have occurred domestically, although the World Health Organization conservatively reports 643 deaths worldwide among 7,864 cases.

The underlying challenge for the U.S. public health system concerning an emerging, infectious disease like SARS is to prevent new or recurring infections, as well as reduce morbidity and mortality, to the fullest extent possible. From an epidemiological perspective, this can be difficult. SARS is communicated from person to person. Persons who have been infected may acquire the disease again [although public health professionals are investigating this potential for reinfection]. There is no cure or

vaccine for SARS. Effective treatment is lacking. In less than 6 months, SARS has spread to 30 countries, largely through persons who have traveled from infected areas. Even if the disease is largely controlled for a specified period of time, it has the potential to flare again if adequate precautions are not taken, especially in larger urban centers that have a regular influx of foreign travelers or returning passengers from foreign destinations.

For these and other reasons, SARS has become a dominant focus of the nation=s public health system. The CDC, under the outstanding leadership of Julie Louise Gerberding, MD, MPH, has performed admirably in keeping SARS under control. State and territorial health officers, as well as city and county health officers, have similarly responded in a professional manner. The response of state and local health officials has been all the more remarkable given the continuing shortage of funds for public health preparedness. Even with the influx of additional resources for bioterrorism, states and localities still need substantial support for all the aspects of a strong public health infrastructure, including laboratories, surveillance, data systems, and workforce. The need for a strong public health infrastructure at the state and local level has been a message consistently stated by the CDC and Institute of Medicine.

Federal, tribal, state, and local public health authorities have effectively utilized modern epidemiologic surveillance and investigations to build knowledge about the diseases, project its potential spread, and identify at-risk persons. In collaboration with the private sector (e.g., physicians, health care workers, hospitals, and primary care institutions), public health authorities have worked diligently to apply a range of measures to slow, detect, and eradicate the spread of SARS from person to person. Persons with known cases of SARS have been voluntarily isolated from others to prevent infection. Close contacts of infected persons have been asked to limit their exposure to others and engage a series of hygienic practices. Individuals entering the country [especially from known infected areas] have been

targeted for potential screening or provided information about SARS. Places where SARS may have contaminated surfaces or other things which humans may come into contact have been temporarily closed for decontamination.

The practice of these and other public health measures in response to SARS rely upon existing and new legal powers at the federal, state, and local levels. Through an Executive Order, President Bush has included SARS among a short list of diseases that the Department of Health and Human Services (HHS) may employ limited quarantine or isolation measures. Federal, state and local public health authorities have utilized existing laws to monitor SARS through ongoing surveillance, investigate factors leading to the spread of the disease, determine contacts of SARS "cases," and implement quarantine and isolation measures. A foreign tourist in New York City was involuntarily detained in a hospital for days because of suspected SARS symptoms. College roommates of a suspected SARS case in Minnesota were voluntarily quarantined for 3 days. A twelve-year old boy who likely contracted SARS from a trip to Toronto has been isolated in Florida. Local authorities in Wisconsin charged a man with failing to cooperate with a public health investigation of SARS. These and other examples of SARS-related legal responses are not new to epidemic diseases. As a health official with the Wisconsin Division of Public Health recently stated, "The ideas of isolation, quarantining, closing buildings, prohibiting public gatherings have been around since the early 1900s. . . . Those are the basic tools."[2]

Need for Public Health Law Reform

Law has long been considered an essential tool for improving public health outcomes, especially among state and local governments that have traditionally been the repositories of public health powers.

[2] Associated Press, *Milwaukee: State Ready for SARS, Officials Say*, ST. PAUL PIONEER PRESS, 4/29/03, 1B.

Statutory laws and administrative rules generally guide the activities of public health authorities, assign and limit their functions, authorize spending, and specify how authorities may exercise their delegated authority. Laws can establish norms for healthy behavior and create the social conditions in which people can be healthy.

However, obsolescence, inconsistency, and inadequacy in existing state public health laws expose flaws and can render these laws ineffective, or even counterproductive. State public health statutes have frequently been constructed in layers over time as lawmakers responded to varying disease threats (e.g., tuberculosis, polio, malaria, HIV/AIDS). (To date, no state has legislatively sought to amend its public health powers in response to SARS, although there have been administrative changes in New York City). Consequently, existing statutory laws may not reflect contemporary scientific understandings of disease (e.g., surveillance, prevention, and response) or legal norms for protection of individual rights. Administrative regulations may supplement existing statutes with more modern public health approaches, but also be limited by original grants of delegated rule-making authority. Existing public health laws may pre-date vast changes in constitutional (e.g., equal protection and due process) and statutory (e.g., disability discrimination, privacy, civil rights) law that have changed social and legal conceptions of individual rights. Public health authorities acting pursuant to these provisions may be vulnerable to legal or ethical challenges on grounds that their actions are unconstitutional or preempted by modern federal or state laws.

The independent evolution of health codes across states, tribal authorities, and locales has led to variation in the structure, substance, complexity, and procedures for detecting, controlling, and preventing disease. Without a coordinated, national public health system, disease detection and reporting systems, response capabilities, and training capacity differ extensively among jurisdictions. These differences could hamper coordination and efficient responses in a multi-state public health

emergency (perhaps involving a large outbreak of SARS). Confusion and complexity among inconsistent state public health laws may create ambiguities that also prevent public health authorities from acting rapidly and decisively in an emergency. Public health authorities may be unsure of the extent of their legal authority, the chain of command during an emergency, or the proper exercise of existing legal powers.

Reforming current state public health laws is particularly important to strengthen key elements of public health preparedness:

Planning, Coordination, and Communication. Most state statutes do not require public health emergency planning or establish response strategies. Essential to the planning process is the definition of clear channels for communication among responsible governmental officials (e.g., public health, law enforcement, emergency management) and the private sector (e.g., health care workers and institutions, pharmaceutical industry, NGO=s). Coordination among the various levels (e.g., federal, tribal, state, and local) and branches (e.g., legislative, executive, and judicial) of government is also critical. State public health laws can implement systematic planning processes that involve multiple stakeholders. However, many public health statutes not only fail to facilitate communication, but may actually proscribe exchange of vital information among principal agencies due to privacy concerns. Some state laws even prohibit sharing data with public health officials in adjoining states. Laws that complicate or hinder data communication among states and responsible agencies could impede a thorough investigation and response to public health emergencies.

Surveillance. Ongoing, effective, and timely surveillance is an essential component of public health preparedness. As with SARS, early detection could save many lives by triggering an effective containment strategy that includes reporting, testing, partner notification, and isolation or quarantine. Some existing state laws may thwart effective surveillance activities. Many states do not require

immediate reporting for all the critical agents identified by the CDC. At the same time, states do not require, and may actually prohibit, public health agencies from monitoring data collected through the health care system. Private information that might lead to early detection (e.g., unusual clusters of fevers or gastrointestinal symptoms) held by hospitals, managed care organizations, and pharmacies may be unavailable to public health officials because of insufficient reporting mechanisms or health information privacy concerns.

Managing Property and Protecting Persons. Authorization for the use of coercive powers are the most controversial aspects of public health laws. Nevertheless, their use may be necessary to manage property or protect persons in a public health emergency. There are numerous circumstances that might require management of property in the interests of protecting the public=s health C e.g., decontamination of facilities; acquisition of vaccines, medicines, or hospital beds; or use of private facilities for isolation, quarantine, or disposal of human remains. Consistent with legal fair safeguards, including compensation for takings of private property used for public purposes, clear legal authority is needed to manage property to contain serious health threats.

There may also be a need to exercise powers over individuals to avert significant threats to the public=s health. Vaccination, testing, physical examination, treatment, isolation, and quarantine each may help contain the spread of infectious diseases. Although most people will comply with these programs during emergencies for the same reason they comply during non-emergencies (i.e., because it is in their own interests and/or desirable for the common welfare), compulsory powers may be needed for those who will not comply and whose conduct poses risks to others or the public health. These people may be required to yield some of their autonomy or liberty to protect the health and security of the community.

Recommendations for Public Health Law Reform

The federal Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), and the Institute of Medicine (part of the National Academy of Sciences chartered by the U.S. Congress) have each cited the need for public health statute reform. In its November 2002 report, *The Future of the Public=s Health in the 21st Century*, IOM noted that Apublic health law at the federal, state and local levels is often outdated and internally inconsistent.@ IOM recommended HHS appoint a national commission to provide guidance to states in reforming their laws to meet modern scientific and legal standards.

Threats of bioterrorism and emerging infectious conditions like SARS have vaulted the state public health law reform to national prominence. Faculty at the *Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities* have led two important initiatives to reform public health laws. Following the anthrax attacks in October, 2001, CDC asked the *Center* to prepare draft legislation that states could use in reviewing their existing laws related to response to bioterrorism and other potentially catastrophic public health emergencies. *Center* faculty drafted the **Model State Emergency Health Powers Act** (MSEHPA) in collaboration with national entities (i.e., National Governors Association, National Conference of State Legislatures, Association of State and Territorial Health Officials, National Association of County and City Health Officers, and the National Association of Attorneys General). MSEHPA presents a modern synthesis of public health law for controlling infectious diseases during emergencies that balances public health needs with the rights and dignity of individuals. The Act was completed in December, 2001, and is available at the *Center=s* website [www.publichealthlaw.net] (a copy of the Act is available at http://www.publichealthlaw.net/Resources/Modellaws.htm. MSEHPA has been widely used by state and local law- and policy-makers, health officials, and representatives in the private sector as a guide for considering reforms of existing legal protections. The Act has been introduced in whole or part through

legislative bills or resolutions in 39 states, and passed in 22 states. The National Conference of State Legislators has developed a check list of powers based on the Model Act, which has been used in virtually all states.

Although MSEHPA was drafted as a stand-alone model act, it was previously conceived as part of a larger, multi-year project convened by the *Turning Point Public Health Statute Modernization National Collaborative*, [www.hss.state.ak.us/dph/APHIP/collaborative] (hereinafter ANational Collaborative@) to develop a **Model State Public Health Act**. Many of the provisions of MSEHPA are part of this larger model act. The purpose of the National Collaborative is to transform and strengthen the legal framework for the public health system through a collaborative process to develop a model state public health law. Through intensive research and consensus building among national, state, and local experts and public health representatives, the **Model State Public Health Act** shall provide legislative language concerning public health administration and practice by public health agencies at the state and local levels. The National Collaborative, comprised of a multi-disciplinary panel of experts in public health, law, and ethics, has already developed various portions of the multi-chapter, comprehensive model public health act for states. The Turning Point Model Act is scheduled for completion later in 2003, but has already been referred to or introduced in part through a state resolution in Hawaii and a comprehensive reform bill in North Carolina.

Improving Emergency Public Health Responses Through Law: The Model State Emergency Health Powers Act

MSEHPA provides a modern illustration of a public health law for controlling infectious diseases like SARS during emergencies that balances the needs of public health with the rights and dignity of

individuals. Though developed quickly following the anthrax exposures in the Fall 2002, the Act's provisions and structure are based on existing federal and state laws and public health practice. Existing state public health laws were used as model approaches for key areas in the Act.

MSEHPA includes a modern series of legal provisions that equip public health authorities with necessary powers to respond to catastrophic public health emergencies while also respecting individual and group rights. The Act vests state and local public health authorities with modern powers to track, prevent, and control disease threats resulting from bioterrorism or other public health emergencies. These powers include measures (e.g., testing, treatment, and vaccination programs; isolation or quarantine powers; and travel restrictions) that may infringe individual civil liberties (e.g., rights to due process, speech, assembly, travel, and privacy). However, the exercise of these powers is restricted in time, duration, and scope. Coercive public health powers, particularly isolation and quarantine, are exercised on a temporary basis, only so long as reasonably necessary, and only among persons who justifiably may pose risks to others because of their contagious conditions. In addition, the dignity of individuals is respected. For example, their rights to contest the coercive use of public health powers, even during an emergency, are secured.

Although some have suggested that MSEHPA sets forth new and expansive powers for public health authorities, this is actually not the case. The Act does not create new powers for public health authorities; each of the Act's provisions are based on existing theory and practice of public health law. Rather, MSEHPA organizes and modernizes these legal powers to facilitate a coordinated approach to public health emergency response.

Central Purposes. MSEHPA addresses each of the key elements for public health preparedness discussed above. Among its central purposes, the Act:

A. Sets a high threshold definition of what constitutes a Apublic health emergency@ [Article I];

B. Requires the development of a comprehensive public health emergency response plan that includes coordination of services, procurement of necessary materials and supplies, housing, feeding, and caring for affected populations, and the administration of vaccines and treatment [Article II];

C. Authorizes the collection of data and records and access to communications to facilitate the early detection of a health emergency [Article III];

D. Vests the power to declare a public health emergency in the state governor, subject to appropriate legislative and judicial checks and balances [Article IV];

E. Grants state and local public health officials the authority to use and appropriate property to care for patients, destroy dangerous or contaminated materials, and implement safe handling procedures for the disposal of human remains or infectious wastes [Article V];

F. Authorizes officials to care and treat ill or exposed persons, to separate affected individuals from the population at large to prevent further transmission, collect specimens, and seek the assistance of in-state and out-of-state private sector health care workers during an emergency [Article VI];

G. Requires public health authorities to inform the population of public health threats through mediums and language that are accessible and understandable to all segments of the population [Article VII]; and

H. Authorizes the governor to allocate state finances as needed during an emergency, and creates limited immunities for some state and private actors from future legal causes of action [Article VIII].

Public Health Emergencies. Most of the public health powers granted to state and local public health authorities through MSEHPA are triggered by the governor's declaration of a public health emergency in response to dire and severe circumstances. A declared state of emergency terminates as

soon as the health threat is eliminated, or automatically after 30 days, unless reinstated by the governor or annulled through legislative or court action. Bioterrorism events involving intentional efforts to spread infectious diseases may present a scenario for a declaration of emergency. Public health emergencies can also arise through the spread of emerging infectious diseases, like SARS, through unintentional means. MSEHPA covers either scenario under its inclusive definition of what constitutes a "public health emergency," summarized as (1) the occurrence or imminent threat of an illness or health condition, caused by bioterrorism or a highly fatal biological toxin or novel or infectious agent (that was previously controlled or eradicated) that (2) poses a high probability of a significant number of human fatalities or incidents of serious, permanent or long-term disability in the affected population.

Some civil libertarians and others have objected to the Act's emergency declaration. They view the declaration of a state of emergency as an authorization for public health authorities to do virtually anything to abate the existing threat. This includes infringing individual rights in the interests of protecting public health. Indubitably, during an emergency, certain civil liberties may need to be restricted as compared to the exercise of these rights in non-emergencies. Yet, the Act specifically protects individual interests from authoritarian actions in government. The governor of a state may be empowered to declare a state of public health emergency, but the legislature, by majority vote, may discontinue the declaration at any time. Similarly, courts may review whether a governor=s actions fail to comply with the standards and procedures in MSEHPA. Thus, each branch of state government has a role in sustaining an emergency declaration consistent with constitutional principles of checks and balances.

Furthermore, the provisions of MSEHPA better protect individuals than most existing state laws. Under the Act, a public health emergency is viewed as a distinct event that requires specific governmental responses. The Act sets a very high threshold for the declaration of a public health emergency and further conditions the use of a defined and limited set of powers on the declaration and continuation of the emergency status. In many state public health laws, however, there are no definitive statutory criteria for the declaration of a public health emergency. Rather, existing state emergency management laws may be used to broadly address public health emergencies. Declaring a general state of emergency in response to a bioterrorism event may allow government to act in indeterminable ways to address the public health threat. Lacking effective statutory guidance, public health authorities may have to rely on existing, antiquated statutory laws, or regulations that are hastily created in specific response to potential or unknown threats.

Information Sharing and Surveillance Measures. MSEHPA enhances existing state surveillance and reporting practices to facilitate the prompt detection of a potential or actual threat by requiring:

- **$** Health care providers to report cases of bioterrorist-related or epidemic diseases that may be caused by any of the infectious agents listed in federal regulations or other non-listed agents;
- **$** Coroners and medical examiners to report deaths that may have resulted from an emerging or epidemic infectious disease or from a suspected agent of bioterrorism;
- **$** Pharmacists to report unusual trends in prescriptions for antibiotics and other medications used to treat infectious diseases in addition to substantial increases in the sale of various over-the-counter (OTC) remedies; and
- **$** Veterinarians or veterinary laboratories to report animals having or suspected of having any diseases that may be potential causes of a public health emergency.

Reports are to be made within 24 hours to the appropriate health authority, and should contain identifying information about the reporter and subject of the report. Upon receiving a report, public health officials can use the information to ameliorate possible public health risks. They may contact and interview individuals mentioned in the report and obtain names and addresses of others who may have been in contact or exposed to the individual. The Act encourages the sharing of this data among public safety and emergency management authorities at the federal, state, local, and tribal levels to prevent, treat, control, or investigate a public health emergency. To protect individual privacy, officials are restricted from sharing any more information than necessary to control or investigate the public health threat. Stricter regulations in the Act govern access to the medical records and charts of individuals under quarantine or isolation where individual privacy interests may be heightened.

Managing Property. Once a public health emergency has been declared, MSEHPA allows authorities the power to seize private property for public use that is reasonable and necessary to respond to the public health emergency. This power includes the ability to use and take temporary control of certain private sector businesses and activities that are of critical importance to epidemic control measures. To safely eliminate infectious waste such as bodily fluids, biopsy materials, sharps, and other materials that may contain pathogens or otherwise pose a public health risk, authorities may take control of landfills and other disposal facilities. To assure safe handling of human remains, officials may control and utilize mortuary facilities and services. They are also authorized to take possession and dispose of all human remains. Health care facilities and supplies may be procured or controlled to treat and care for patients and the general public.

Whenever health authorities take private property to use for public health purposes, constitutional law requires that the property owner be provided just compensation. That is, the state must pay private owners for the use of their property. Correspondingly, the Act requires the state to pay just compensation to the owner of any facilities or materials temporarily or permanently procured for public use during an emergency. Where public health authorities, however, must condemn and destroy any private property that poses a danger to the public (e.g., equipment that is contaminated with anthrax spores), no compensation to the property owners is required although states may choose to make compensation if they wish. Under existing legal powers to abate public nuisances, authorities are able to condemn, remove, or destroy any property that may harm the public=s health.

Other permissible property control measures include restricting certain commercial transactions and practices (e.g., price gouging) to address problems arising from the scarcity of resources that often accompanies public emergencies. MSEHPA allows public health officials to regulate the distribution of scarce health care supplies and to control the price of critical items during an emergency. In addition, authorities may seek the assistance of health care providers to perform medical examination and testing services.

Protection of Persons. Section 601 of MSEHPA states: "During a state of public health emergency, the public health authority shall use every available means to prevent the transmission of infectious disease and to ensure that all cases of contagious disease are subject to proper control and treatment." MSEHPA allows public health authorities to ask any person to be vaccinated or submit to a physical exam, medical testing or treatment, or provide a biological sample. Each of these measures may be needed to assist the individual and evaluate the epidemiologic consequences of an emerging

condition during an emergency. These measures may be taken without any form of due process (e.g., right to a hearing) because individuals are free to choose to participate or not. Any person who may be impacted by the declaration of the public health emergency that gives rise to systematic vaccination or testing programs may challenge the basis for declaring the emergency in court.

Although participation in vaccination, testing, or treatment programs is voluntary, those who choose not to participate and whose contagious condition may pose risks to others may be subject to isolation or quarantine measures. The Act's quarantine and isolation provisions may be used to limit the freedom of individuals exposed to or infected with a contagious disease, respectively, to circulate in the general public. Quarantine and isolation are classic public health powers. During non-emergencies, their practice is typified by limiting the transgressions of a very small number of persons whose behavior may lead to infecting others with a serious, contagious disease (like SARS) or other potential harms. During a public health emergency, where potentially thousands of persons are exposed or infected with a contagious disease, the use of quarantine or isolation powers may be widespread to protect community populations.

MSEHPA attempts to balance the welfare and dignity of individuals with communal interests in implementing quarantine or isolation measures. Accordingly, public health authorities must: (1) use "the least restrictive means necessary to prevent the spread of a contagious or possibly contagious disease to others." Arbitrary or discriminatory quarantines will not satisfy this standard; (2) maintain safe, hygienic conditions for persons in isolation or quarantine that minimize the risk of further disease transmission; (3) provide adequate food, clothing, medication, health care, means of communication, and other necessities; and (4) adhere to strong due process protections for affected individuals.

Except where failure to quarantine or isolate persons immediately may significantly jeopardize the health of others, public health officials must obtain a court order before implementing these measures. The court can approve the use of isolation or quarantine only if the public health authority can show the measures are reasonably necessary to prevent or limit the transmission of a contagious or possibly contagious disease to others. Persons or groups subject to quarantine or isolation must receive written copies of orders accompanied by an explanation of their rights. They are entitled to be represented by counsel at individual or collective hearings to challenge the order generally or the conditions, terms, and treatment of their confinement. Even in cases of immediate quarantine or isolation, a court order must promptly be sought as soon as possible.

Private sector HCWs are encouraged to assist in vaccination, testing, examination, treatment, quarantine, and isolation programs. The Act allows public health authorities to condition future licensing status of in-state HCWs on their providing assistance (where possible), and to waive licensing requirements for out-of-state HCWs who are willing to help. Thus, the Act does not compel any private HCW to participate in public health measures during an emergency. It does provide some strong incentives to encourage participation because of the critical role of private sector HCWs during a public health emergency.

Health Information Privacy. In the events leading to or during a public health emergency, MSEHPA envisions the need for a wide variety of federal, state, and local actors in the public and private sectors to share information that may relate to an individual=s health status. Private sector HCW=s may need to report identifiable health data to local public health authorities who may need to share this data with state and federal authorities to respond to a potential threat. Although there is a

strong need to share such data for public health purposes, MSEHPA respects the privacy interests of individuals concerning their health data. The Act (1) limits the amount of information that may be conveyed to that which is necessary to respond to the public health emergency; (2) limits access to such data during an emergency to those persons having a legitimate need to acquire or use the information to provide treatment, conduct epidemiologic research, or investigate the causes of transmission; and (3) prohibits most disclosures outside the public health context.

Additional privacy protections originally set forth in the *Model State Public Health Privacy Act* [www.critpath.org/msphpa/privacy.htm] and to be replicated in the comprehensive **Model State Public Health Act** supplement the provisions of MSEHPA.

Conclusion

Preparing for existing and future public health threats like SARS in the United States requires a strong national public health infrastructure. Federal, state, tribal, and local public health authorities must collaborate with public and private sector partners in preparedness planning and emergency responses. Working to improve public health detection, prevention, and response capabilities requires effective training, additional resources, use of existing and new technologies, and public health law reform. Inadequacies in existing state public health laws can fail to authorize, or may even thwart, effective public health action. Law reform is needed to improve public health planning, detection, and response capabilities.

MSEHPA (and a forthcoming comprehensive model public health law) present a modern statutory framework of public health powers that allows public health authorities to better plan, detect, manage, and control public health emergencies. The provisions of the Act are balanced against the need

to safeguard individual rights and property interests. Reaching this balance is not easy. Tradeoffs are inevitable. Legal reform may not be a panacea for the unforeseeable conflicts between individual and community interests that may arise from emerging threats like SARS. There continue to be sharp debates about the extent to which the state should restrict individual rights to safeguard the public=s health and safety. Finding an acceptable balance that allows government to fulfill its duty to protect the public=s health while respecting individual rights is a worthy goal. Ultimately at stake is the health of each individual, protected through a public health system that relies upon each person=s contribution to the larger whole.

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