Little Hoover Commission
Public Hearing on Public Health Infrastructure
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Testimony of James B. Simpson

I am the General Counsel of the Public Health Institute and a lecturer in health law at the UC Berkeley School of Public Health. I have been asked to testify about to a particular aspect of California's public health infrastructure, namely the legal structure and authority of state and local public health agencies in California.

Public health is a very broad field. Public health agencies provide direct services to the public, operate regulatory programs, collect data, conduct research, and undertake mass communications and social marketing initiatives. Public health covers such diverse topics as protection of the public water supply, food safety, childhood immunization, mosquito control and prevention of sexually-transmitted diseases. However, the primary function of public health has historically been the prevention and control of communicable disease. My testimony will focus on this area.

Public health laws are not an ordinary topic of general interest or concern. However, there has been a broad awakening of interest in the public health system in the wake of the anthrax incidents last September, and part of that attention has been directed toward the legal infrastructure of public health. For example, Prof. Lawrence O. Gostin and colleagues at the Georgetown University Law School's Center for Law and the Public's Health disseminated a Model State Emergency Health Powers Act (MSEHPA) last fall for consideration by state legislatures and other interested persons. This initiative was supported by the U.S. Centers for Disease Control and Prevention (CDC). Legislation to adopt the MSEHPA in whole or part has been introduced in 33 states. A version of the Model Act was introduced in California as AB 1763 (Richman). I have included with my written testimony a recent report from the Center for Law and the Public's Health on the status of MSEHPA and the ongoing need for public health law reform.[1]

Communicable disease control measures are not ordinarily the subject of litigation. California has been largely free for many years from the kind of infectious disease outbreaks that require public health officials to unleash their full coercive powers. In addition, members of the public and health care providers are usually willing to comply voluntarily with public health agency directives. However, over the years there have been numerous court decisions in California dealing with communicable disease control. An appendix to my written testimony contains copies of a pair of decisions (Wong Wai v. Williamson and Jew Ho v.

[1] Since this document is in draft, the Center has asked that it not be cited in its present form without the author's permission.

Williamson) dealing with an outbreak of bubonic plague in San Francisco in 1900, and a 2002 California appellate court ruling (Souvannarath v. Hadden) on isolation of a noncompliant individual with multidrug resistant tuberculosis. These decisions are instructive in creating an overall picture of public health law in California. I will refer to them in my testimony.[2]

I am going to talk about public health law in California from three different perspectives: the authority of public health agencies and officials, legal constraints on the exercise of that authority, and the duties of public health agencies and officials.

I. THE AUTHORITY OF PUBLIC HEALTH AGENCIES

Public health is an exercise of the police power of the state. The police power is the natural authority of sovereign governments to enact laws, promulgate regulations and take actions to protect, preserve and promote public health, safety and welfare.[3] As a legal principle, the police power is a creature of common law-the tradition of judicial lawmaking that stretches from medieval England to the present day. In political theory, it describes the conditions under which the sovereign may legitimately intrude upon a person's autonomy, privacy, liberty or property.

Courts throughout the United States have held that the police power provides inherent authority on the part of the state (delegable to local government) to institute measures to protect the health of the public. The courts have made it clear that the scope of the public health police power should be interpreted broadly, and that the judiciary should defer to the judgment of public health officials regarding the appropriate methods of public health intervention.[4] The public health police power is indelibly present in California law.

The California legislature has codified the public health police power in statute. Ca. Health and Safety Code sec.120175 provides that:

> *"Each [local] health officer knowing or having reason to believe that any case of the diseases made reportable by regulation of the [Department of Health Services], or any other contagious, infectious or communicable disease exists, or has recently existed, within the territory under his or her*

[2] The versions of these decisions contained in the appendix were extensively edited from the original published opinions for instructional use by public health graduate students, including reorganizing paragraphs, deleting extraneous material, and rewording for clarity. They should not be cited or quoted. Citations to the published opinions are included in the appendix.

[3] See, e.g. Gibbons v. Ogden 22 U.S. 9 (9 Wheat.) 1 (1824) (police power is an "immense mass of legislation, which embraces everything within the territory of the state, not surrendered to the general government… Inspection laws, quarantine laws, health laws of every description… are components of this mass."

[4] The Wong Wai and Jew Ho decisions affirm these principles.

jurisdiction, shall take measures as may be necessary to prevent the spread of the disease or occurrence of additional cases."

Sec. 120140 provides that:

"Upon being informed by a health officer of any contagious, infectious, or communicable disease, the Department [of Health Services] may take measures as are necessary to ascertain the nature of the disease and prevent its spread." [5]

From a legal perspective, statutes like these give broad and almost unlimited discretion to public health agencies. It is critical that these agencies be able to tailor communicable disease management strategies to the specific (and often rapidly evolving) conditions of individual outbreaks. However, the law books give public health officials little in the way of practical guidance or reassurance about the legitimate scope of their authority.

California does have various statutes that grant more narrowly-defined powers to local health officers and DHS to respond to particular problems. For example, in addition to the all-purpose communicable disease control statutes quoted above, there are specialized laws relating to vital statistics (Ca. Health and Safety Code sec. 102100), mortality and morbidity surveillance (Ca. Health and Safety Code sec. 100330 et seq.), childhood immunization (Ca. Health and Safety Code sec. 120325 et seq.), sexually transmitted disease (Ca. Health and Safety Code sec. 120500 et seq.), HIV (Ca. Health and Safety Code sec. 120775 et seq.) and tuberculosis (Ca. Health and Safety Code sec. 121350 et seq.). These provisions were enacted over a period of many years. Although there was a general reorganization and recodification of the Health and Safety Code several years ago, these laws are still somewhat scattered and difficult to relate to each other.

California's Emergency Services Act (Gov't. Code 8550 et seq.) provides an independent source of authority for public health measures in certain dire circumstances. Under the Act, the Governor may declare a state of emergency in an area or areas of the state on the basis of "conditions of disaster or extreme peril to the safety of persons and property within the state caused by conditions such as air pollution,… epidemic,… plant or animal infestation or disease,… or other conditions... by reason of their magnitude… beyond the control of the services, personnel, equipment, and facilities of any single[local government]." (Gov't. Code sec. 8558).

[5] See also Ca. Health and Safety Code sec. 100170 (DHS may commence and maintain all proper and necessary actions and proceedings to protect and preserve the public health) and sec. 120145 (DHS may quarantine, isolate and disinfect persons, animals, houses, rooms, other property, places, cities, localities whenever necessary in its judgment to protect or preserve public health).

In a declared state of emergency the Governor has the right to exercise the entire police power of the state. (Gov't. Code sec. 8627). However, city and county health officers retain the authority to take "any preventive measure that may be necessary to protect and preserve the public health from any public health hazard." (Gov't. Code sec. 101040, 101475). The Emergency Services Act gives the Governor a number of broad powers, including the authority to issue orders and regulations which have the force and effect of law (Gov't. Code sec. 8567), suspend regulatory statutes and state agency rules and regulations (Gov't. Code sec. 8571), commandeer private property or personnel (Gov't. Code sec. 8572), and make expenditures from any funds legally available to deal with the emergency (Gov't. Code sec. 8645). The Act does not appear to automatically suspend existing laws and regulations, such as the basic public health statutes described above. It does not suspend constitutional guarantees of individual rights in the federal or state constitutions.[6]

Observations and Recommendations:

1. California law provides an adequate legal basis for the kind of government response that would be necessary in the event of a bioterrorist attack.

2. The ability of public health officials to respond to bioterrorism or other significant communicable disease outbreaks could be improved if: (a) the public health-related provisions of the Health and Safety Code were systematically reorganized and updated; (b) some of the implied or unstated powers and authorities of public health agencies were expressly set forth in the statutes.

II. LEGAL RESTRAINTS ON PUBLIC HEALTH AGENCIES

The public health police power has the potential to significantly affect the lives and affairs of private individuals. Isolation, quarantine, compulsory testing, treatment and immunization are prototypical examples of government intrusion into constitutionally-protected individual interests.

The primary sources of legal restraint on the exercise of public health powers are the due process and equal protection provisions of the federal and state Constitutions. The Wong Wai and Jew Ho decisions graphically depict the balance between public health and civil liberties. In 1900, the San Francisco Board of Health responded to a threatened epidemic of bubonic plague by prohibiting persons of Asian descent from leaving San Francisco unless they submitted to

[6] The Emergency Services Act also authorizes local governing bodies (and designated local officials) to declare local emergencies. (Gov't. Code sec. 8630). The grounds for declaration of local emergency are the same as for a state of emergency. In a local emergency, the local governing body is authorized to promulgate orders and regulations necessary for protection of life and property (Gov't. Code sec. 8634), including curfew. City and county health officers have the authority to take "any preventive measure that may be necessary" in a local emergency, just as they do in a gubernatorially-declared state of emergency. (Gov't. Code sec. 101040, 101475).

vaccination. In Wong Wai a federal trial court enjoined enforcement of the mandatory quarantine and vaccination program on the grounds that it deprived Asians of their constitutional right not to be deprived of their life, liberty or property without due process of law. It said that although public health measures will generally be upheld, even if they prove inconvenient or burdensome to some individuals, they must have a reasonable relationship to the actual problem confronting health officials. In the case at hand, the court concluded that there was no evidence of actual exposure to disease to justify quarantining the Asian population, and in any case individuals who have previously been exposed to a disease should be treated, not vaccinated.

The day after the ruling in Wong Wai, San Francisco health officials acting on fresh reports of cases in Chinatown quarantined the entire district, except for certain non-Chinese homes and businesses. In Jew Ho v. Williamson, the court enjoined enforcement of the quarantine on the grounds that it deprived Asians of their constitutional right to equal protection. It said that although quarantine is a well-recognized technique of infectious disease control, it must be narrowly tailored to prevent the spread of disease. In the case at hand, the quarantine was overinclusive because it confined uninfected persons with potentially infected cases, and underinclusive because it excluded non-Chinese residents.

Several other constitutional provisions have been held to restrain the exercise of the public health police power, e.g. the procedural aspects of the due process clause (requiring notice and a hearing before an impartial magistrate, or other appropriate procedures, before the government can deprive individuals of life, liberty or property), the takings clause (prohibiting the government from seizing private property for public use without compensation), the first amendment (freedom of speech and association), and the fourth amendment (freedom from unreasonable search and seizure).

Consistent with the California statutes' broad-brush approach to public health authority, state public health laws don't ordinarily set forth restrictions on the exercise of public health police power. However, some more recent statutes incorporate procedural due process provisions. For example, the provisions for isolation and treatment of non-compliant tuberculosis patients set forth in California's TB control law prescribe detailed notice and hearing procedures based on contemporary procedural due process jurisprudence.

Public health officials need to be familiar with the constitutional and statutory restraints on the exercise of public health police powers. Souvannarath v. Hadden exemplifies what can happen when public health officials don't have sufficient training and skill to understand and comply with public health statutes. In that case, county tuberculosis control officials detained a non-compliant patient in the county jail for ten months. They failed to provide her with any written

explanation of her legal rights, or the appointed counsel and judicial hearing she was entitled to under the California TB control law. The Court of Appeal upheld a lower court order directing the county to comply with the law and desist from placing noncompliant TB patients in the county jail. Responding to county officials' explanations that they were unaware of the legal technicalities, the court said that although public health officials are not lawyers, they must understand the basic provisions of the laws which govern the exercise of their offices and duties.

Observations and Recommendations:

1. The threats posed by emerging communicable diseases and bioterrorism are unpredictable and potentially severe. It would be unwise as a matter of public policy to burden public health officials with overly-prescriptive statutory limitations on their ability to respond. However, as an element of a general review of California public health laws, it would be appropriate to consider codifying basic procedures for assuring the fair and equitable administration of compulsory public health powers.

2. Local public health officials need to be trained in the basic concepts of public health jurisprudence and the specific requirements of California law. In addition, public health officials would benefit from increased access to legal services to assist them in the performance of their functions.

III. DUTIES OF PUBLIC HEALTH AGENCIES

The fact that public health officials possess police power doesn't automatically mean that they have the responsibility to take any particular steps to protect the public's health. The Legislature has gone beyond merely granting public health officials the police power and given them a number of specific duties, but the affirmative nature of these obligations is often diluted by being expressed in discretionary terms.

The Legislature has assigned cities and counties the front-line responsibility to protect public health. County Boards of Supervisors have an all-purpose duty to "take measures as may be necessary to preserve and protect the public health in the unincorporated areas of the county." (Ca. Health & Safety Code sec. 101025) . The governing bodies of cities have a similar duty. (Ca. Health & Safety Code sec. 101450). County and city health officers have a duty to enforce and observe county and city orders and ordinances pertaining to public health. (Ca. Health & Safety Code sec. 101030, 101470). They also have a duty to enforce DHS quarantine and other orders and regulations, and a duty to enforce state statutes relating to public health. (Id.).

The Legislature did not give the Department of Health Services the same all-purpose responsibility to protect public health. However, it authorized DHS to advise local health authorities, and directed it to control and regulate their action when in its judgment the public health is menaced. (Ca. Health & Safety Code sec. 100180). DHS has several specific responsibilities with respect to communicable disease control, including examining the causes of communicable disease in man and domestic animals (Ca. Health & Safety Code sec. 120125), investigating the sources of morbidity and mortality (Ca. Health & Safety Code sec. 100325) and establishing a list of diseases which local health officers must report to the department (Ca. Health & Safety Code sec. 120130).

Observations and recommendations:

1. One of the findings of the TOPOFF exercise (May 2000 bioterrorism response exercise conducted by the U.S. Department of Justice in Denver, CO) was that the lines of authority and mechanisms for coordination between federal, state and local officials in public health, public safety and emergency preparedness agencies were complicated, confusing and unclear to participants. It is likely that similar problems would surface in California in the event of a bioterrorist attack. Although resolving issues of intergovernmental jurisdiction and authority are questions of public policy, the structure of California public health laws should contribute to clarity and transparency, and not be unclear or ambiguous as to the allocation of authority. For example, California law should specify the lead agency with principal responsibility for responding to a bioterrorism event or other major communicable disease outbreak, and provide explicit directives and procedures for cooperation and coordination by other government agencies.

THE MODEL STATE EMERGENCY HEALTH POWERS ACT -

BRIEF COMMENTARY

Commentary Sponsored by the
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THE MODEL STATE EMERGENCY HEALTH POWERS ACT - BRIEF COMMENTARY

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Appendix 3: The Model State Emergency Health Powers Act (as of December 21, 2001)

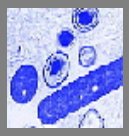
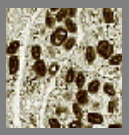
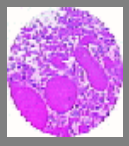
Introduction

There is perhaps no duty more fundamental to American government than the protection of the public=s health. Beginning on September 11, 2001, the state=s obligation to safeguard public safety took on new urgency. The destruction of the World Trade Towers in New York City and a portion of the Pentagon in Washington, D.C. resulted in a staggering loss of lives (2,600 - 2,900) and exposed the country=s vulnerability to catastrophic acts of war. In the ensuing weeks of the Fall, 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. To date, the persons responsible for disseminating anthrax through the mail have not been identified. Government officials predict the potential for additional bioterrorism attacks as the Awar on terrorism≅ continues.

The anthrax exposures confirmed weaknesses in the nation=s public health system and fueled apprehension among government officials and the public about future bioterrorism attacks. Seventy percent of the public believes a subsequent biological or chemical attack on the United States will occur in 2002. Fears of bioterrorism and emerging infectious diseases are justifiable. Many groups or individuals may have access to and use biological agents as weapons to inflict harm on a population-wide basis. Multiple infectious agents (e.g., smallpox, tularemia, plague, viral hemorrhagic fever, anthrax), including genetically-enhanced agents, may be used. Table 1, below, summarizes what bioterrorism experts suggest to be the five deadliest biological agents suitable for bioterrorism attacks.

Table 1 - The Deadliest Five Biological Agents

The Deadliest Five

	Description	*Symptoms*	*Fatality Rate*	*Treatment*
 (Inhalational) Anthrax *Bacillus anthracis*	Inhaled spores germinate and release toxins, causing swelling in chest cavity. Possible blood and brain infection.	Fever, fatigue, and malaise, starting within two to 46 days; progresses to chest pain, cough, rapid deterioration of health.	Kills more than 85 percent of those it infects, often within one to three days after symptoms appear.	Antibiotics (preferably ciprofloxacin) should be given before symptoms appear. Vaccine available, though not to civilians.
 Smallpox *Variola Virus*	Very contagious, airborne disease.	About 12 to 14 days after infection. Fever, aches, vomiting, rash of small red spots that grow into larger, painful pustules covering the body.	Fatal in 30 percent of unvaccinated patients.	No treatment. U.S. has vaccine for about 6 million people. Only a fraction of those vaccinated before 1972 still protected.
 (Pneumonic) Plague *Yersinia Pestis*	Natural, flea-borne form causes bubonic plague. Gravest threat is posed by aerosol, leading to pneumonic plague.	High fever, headache, and bloody cough; progresses to labored breathing, bluish-grayish skin color, respiratory failure and death.	If untreated, a person with pneumonic plague will almost always die within one to two days after symptoms begin.	Various antibiotics including streptomycin and gentamicin. Isolate patients.
 Viral Hemorrhagic Fever	Highly infectious RNA viruses including Ebola, Marburg, Lassa, and dengue fever. Spread by rodents, ticks, mosquitoes.	Vary from one type of HFV to the next. include fever, muscle aches, exhaustion, internal bleeding.	Varies. Death rate from dengue is as low as 1 percent. Ebola fatality rates have reached 90 percent.	Mainly supportive therapy. Anti-viral drug ribavirin useful in treating some viruses but not others (Ebola, Marburg).
 (Inhalational) Botulism *Clostridium botulinum*	Produces toxin that blocks nerve signals, inhibits muscle movement. Weapon would most likely aerosolize toxin.	Difficulty swallowing food, mental numbness, muscle paralysis, possible breathing failure.	Inhalational form: Difficult to say since only a handful of cases have been recorded.	Patients with respiratory paralysis should be placed on ventilator. Antitoxin given early may prevent progression.

Source: Centers for Disease Control and Prevention/U.S. Army Military Research Institute of Infectious Diseases.

Bioterrorists may infect individuals through multiple routes: (1) intentional spread of contagious diseases through individual contact; (2) air-borne dissemination of some infectious agents; or (3) contamination of transportation systems, buildings, or other public places, as well as water, food, controlled substances, or other widely distributed products. The knowledge and equipment needed to manufacture biological weapons is easy to obtain and conceal. Concentrations of people in large urban centers, as well as modern rapid transit systems, facilitate the spread of infectious diseases.

Public health authorities and the private sector (e.g., health care workers and primary care institutions) may lack the infrastructure, resources, knowledge, coordination, and tools to effectively respond to intentional and possibly mass exposure to infectious disease. For many of the most serious agents of bioterrorism, there is inadequate technology for detection, testing, vaccination, and treatment. Prior to September 11th, federal and state public health authorities had allocated limited resources and engaged in limited planning for a major bioterrorism event. Congress authorized the spending of over $500 million early in 2001 for bioterrorism preparedness through the Public Health Threats and Emergencies Act. Most agree that additional commitments to improve surveillance of unusual diseases or clusters, train health care workers, increase existing vaccination and treatment supplies, and collaborate across state boundaries are needed to improve the public health infrastructure. The federal Office of Public Health Preparedness and the Centers for Disease Control and Prevention (CDC) have begun to distribute nearly a billion dollars of federal aid to states to better plan for, prepare, and respond to bioterrorism.

For state and local public health agencies that may find themselves on the front-line of defense to a bioterrorism event, planning is essential. As part of its distribution of federal funds to states, CDC requires states to prepare systematic response plans. Many states had not previously addressed bioterrorism in their emergency response plans. Advance planning is key, but it presupposes that public health authorities are legally empowered to respond to potential or actual bioterrorist threats. Some

states had passed laws or regulations (e.g., Colorado) to address bioterrorism before September 11th. In many states, however, modern legal standards for bioterrorism response are absent, antiquated, fragmented, or insufficient.

Following the September 11, 2001 attacks on the World Trade Center and Pentagon and the dispersal of anthrax in October, the CDC asked the *Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities* 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. On that basis, the *Center* drafted what it terms the **Model State Emergency Health Powers Act** (MSEHPA).[1] The Act reflects its authors' professional judgement regarding statutory provisions states should have in place for that purpose. The Act was developed in collaboration with members of national partners (i.e., National Governors Association, National Conference of State Legislatures, Association of State and Territorial Health Officials, National Association of City and County Health Officers, and the National Association of Attorneys General). It 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 also included with this report, *see* **Appendix 3: The Model State Emergency Health Powers Act**).

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[1]. We would like to thank our faculty colleagues at the *Center for Law and the Public=s Health* who worked together as a committee in drafting various parts of the MSEHPA: **Stephen P. Teret**, Professor, Johns Hopkins Bloomberg School of Public Health, Director, *Center for Law and the Public=s Health*; **Scott Burris**, Professor, Temple Law School, Associate Director, *Center for Law and the Public=s Health*; **Jon Vernick**, Associate Professor, Johns Hopkins Bloomberg School of Public Health, Associate Director, *Center for Law and the Public=s Health*; **Julie Samia Mair**, Assistant Scientist, Johns Hopkins Bloomberg School of Public Health, Affiliate Faculty, *Center for Law and the Public=s Health*; and **Jason Sapsin**, Assistant Scientist, Johns Hopkins Bloomberg School of Public Health, Affiliate Faculty, *Center for Law and the Public=s Health.*

The 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. As of June 1, 2002, it has been used by most states in assessing their existing laws regarding public health emergencies and it has been introduced in whole or part through legislative bills or resolutions in 33 states, and passed in 15 states (for more information, *see* **Appendix 1: The Model State Emergency Health Powers Act - State Legislative Activity**).

An essential challenge to drafting the MSEHPA was to create a modern series of legal provisions that equip public health authorities with necessary powers to respond to catastrophic public health emergencies (including bioterrorism events) 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 the 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**. 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 (for more information on the content of the larger model act, *see* **Appendix 2: The Model State Public Health Act - Preface**). Many of the provisions of the MSEHPA will become part of the larger model act, which is scheduled for completion in 2003.

In this brief report, we first explain the need for public health law reform to better prepare for bioterrorism and other public health emergences. We further describe the process and content of the MSEHPA, including discussion of the ways that the Act balances individual liberties and public health during times of public health emergencies.

The Need for Public Health Law Reform

Law has long been considered an essential tool for improving public health outcomes, especially among state governments that have traditionally been the repositories of public health powers. 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). 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 territories 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 (a likely scenario with modern bioterrorism threats). 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 in key variables for 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 expression 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. In many bioterroristic threats, the dispersal of pathogens may not be evident. Early detection could save many lives by triggering an effective containment strategy that includes testing, vaccination, treatment, and, if needed, isolation or quarantine. Existing state laws may thwart effective surveillance activities. Many states do not require timely reporting for the most dangerous agents of bioterrorism (*see* **Table 1**, above). Most 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 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 a public health emergency X 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. In the recent anthrax attacks, public health authorities had to close various public and private facilities for decontamination. 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 a serious health threat.

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.

The Model State Emergency Health Powers Act

Process/Input. The MSEHPA provides a modern illustration of a public health law for controlling infectious diseases 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. Principal drafters at the *Center for Law and the Public=s Health* turned first to existing state public health laws for language that presented a model approach to key areas in the Act. Many provisions of the Act denote the existing legislative source for all or part of their content (*see* **Appendix 3**, below, for a complete copy of the MSEHPA).

Although some have suggested that the 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, the MSEHPA organizes and modernizes these legal powers to facilitate a coordinated approach to public health emergency response. A rough Aindex≅ for the MSEHPA was derived from the work of experts in law, public health, emergency management, and national security who convened at the Cantigny conference center (outside of Chicago, Illinois) prior to September 11th to examine potential policy dilemmas underlying a bioterorrism event. An earlier draft of the model act was vetted and critiqued through national partners and heads of government agencies, legislators, public health officials, legal practitioners, scholars, non-governmental organizations, and members of the general public. The existing draft of the Act was also vetted through the National Collaborative.

Central Purposes. The MSEHPA addresses each of the key variables for public health preparedness discussed in the section above (*see* **The Need for Public Health Law Reform**). Among its central purposes, the Act:

- Sets a high threshold definition of what constitutes a Apublic health emergency≅ [Article I];
- 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];
- Authorizes the collection of data and records and access to communications to facilitate the early detection of a health emergency [Article III];
- Vests the power to declare a public health emergency in the state governor, subject to appropriate legislative and judicial checks and balances [Article IV];
- 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];
- 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];
- 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
- 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].

Table 2, below, summarizes the specific sections of the MSEHPA.

Table 2 - MSEHPA Legislative Specifications

ARTICLE I TITLE, FINDINGS, PURPOSES, AND DEFINITIONS

Sec.	Title and Brief Description
∋ 101	**Short title** - provides a short title for the Act.
∋ 102	**Legislative findings** - provides a sample set of findings underlying the need for protecting the public health in an emergency.
∋ 103	**Purposes** - summarizes the purposes of the Act, namely to provide the Governor, public health authority, and other state and local authorities with the powers and ability to prevent, detect, manage, and contain emergency health threats without unduly interfering with civil rights and liberties.
∋ 104	**Definitions** - provides key definitions, including Apublic health emergency,≅ Abioterrorism,≅ Apublic health authority (PHA),≅ and Apublic safety authority.≅

ARTICLE II PLANNING FOR A PUBLIC HEALTH EMERGENCY

Sec.	Title and Brief Description
∋ 201	**Public Health Emergency Planning Commission** - authorizes Governor to establish a Commission to begin planning for a public health emergency.
∋ 202	**Public Health Emergency Plan** - within six months of enactment of the Model Act, the Commission shall develop a comprehensive detection and response plan involving the PHA, public safety agencies, and others. The plan shall be reviewed and revised annually.

ARTICLE III MEASURES TO DETECT AND TRACK PUBLIC HEALTH EMERGENCIES

Sec.	Title and Brief Description
∋ 301	**Reporting** - requires health care workers, coroners, pharmacists, veterinarians, laboratories, and others to make written or electronic reports of suspect illnesses or conditions to the PHA to detect a potential serious threat to the public=s health.
∋ 302	**Tracking** - requires PHA to investigate and track potential serious threats to the public health.
∋ 303	**Information sharing** - authorizes public health and safety authorities to share information within limits to detect and respond to serious public health threats.

ARTICLE IV DECLARING A STATE OF PUBLIC HEALTH EMERGENCY

Sec.	Title and Brief Description

Sec.	Title and Brief Description
∋ 401	**Declaration** - Governor can declare a state of public health emergency under a set of criteria and in consultation with the PHA or others.
∋ 402	**Content of declaration** - requires Governor to issue an executive order.
∋ 403	**Effect of declaration** - triggers the public health and other response mechanisms in the Act, including a series of emergency powers.
∋ 404	**Enforcement** - allows PHA to seek assistance of public safety authority.
∋ 405	**Termination of declaration** - requires termination of the declaration of a state of public health emergency by executive order within 30 days, unless renewed by Governor; allows state legislature to terminate declaration at any time via majority vote in both chambers.

ARTICLE V SPECIAL POWERS DURING A STATE OF PUBLIC HEALTH EMERGENCY: MANAGEMENT OF PROPERTY

Sec.	Title and Brief Description
∋ 501	**Emergency measures concerning facilities and materials** - allows PHA to close, evacuate, or decontaminate any facility or material that poses a danger to the public health without compensation to the owner.
∋ 502	**Access to and control of facilities and property** - allows PHA broad access and use of private facilities or materials during a public health emergency with compensation to private owners in the event of a taking.
∋ 503	**Safe disposal of infectious waste** - sets rules for the safe disposal of infectious waste to prevent the spread of an illness or health condition.
∋ 504	**Safe disposal of human remains** - provides guidelines for the safe disposal of human remains that may pose a public health threat, including use of private facilities as needed.
∋ 505	**Control of health care supplies** - authorizes PHA to procure, obtain, and ration needed health supplies (e.g., anti-toxins, serums, vaccines, antibiotics, and other medicines), as well as control their distribution during a public health emergency.
∋ 506	**Compensation** - provides compensation for private owners whose property is taken during a public health emergency. Compensation does not occur if the public health agency is exercising police powers (e.g., a nuisance abatement), but only if there is a Ataking≅ of property.
∋ 507	**Destruction of property** - requires some civil procedures prior to the destruction of property where possible.

ARTICLE VI SPECIAL POWERS DURING A STATE OF PUBLIC HEALTH EMERGENCY: PROTECTION OF PERSONS

Sec.	Title and Brief Description
∋ 601	**Protection of persons** – generally authorizes PHA to use every available means to control a threat to the public health during an emergency.
	Medical examination and testing - allows PHA to perform physical examinations and/or tests as

Sec.	Title and Brief Description
∋ 602	necessary for the diagnosis or treatment of individuals during an emergency. Persons who refuse may be isolated or quarantined.
∋ 603	**Vaccination and treatment** - PHA may require the vaccination of persons to prevent the spread of an infectious condition. Persons who refuse may be isolated or quarantined.
∋ 604	**Isolation and quarantine** - empowers PHA to implement mandatory isolation (for infected persons) or quarantine (for exposed persons) measures for a limited period of time and consistent with a series of conditions and principles.
∋ 605	**Procedures for isolation and quarantine** - outlines provisions for temporary isolation and quarantine measures, including notice, relief, recorded proceedings, appointment of counsel, and consolidation of claims, if and when possible.
∋ 606	**Collection of laboratory specimens; performance of tests** - authorizes collection of lab specimens and performance of tests on living or deceased animals or persons and permits sharing information with public safety authorities to facilitate criminal investigations related to the public health emergency.
∋ 607	**Access to and disclosure of protected health information** - allows access to records of persons under care of the PHA to persons with a need to know, but prohibits many disclosures of identifiable data outside the public health or safety setting without written, specific informed consent.
∋ 608	**Licensing and appointment of health personnel** - requires in-state health care providers to assist with emergency treatment and preventative measures authorized by the Act, lifts licensing requirements to encourage out-of-state health care workers to participate in a public health emergency, and authorizes qualified individuals to assist with duties of state medical examiner and coroners.

ARTICLE VII PUBLIC INFORMATION REGARDING A PUBLIC HEALTH EMERGENCY

Sec.	Title and Brief Description
∋ 701	**Dissemination of information** - requires PHA to inform the population of threats to the public health during a state of public health emergency. Information shall be provided in multiple languages (where needed) and in a medium that is accessible to all parts of the population.
∋ 702	**Provision of access to mental health support personnel** - mental health personnel shall be made available to address psychological responses to the public health emergency.

ARTICLE VIII MISCELLANEOUS

Sec.	Title and Brief Description
∋ 801	**Titles** - titles and subtitles in the Act are instructive, not binding.
∋ 802	**Rules and regulations** - allows PHA to create administrative regulations or rules to further the purposes of the Act.
∋ 803	**Financing and expenses** - authorizes Governor, within specific limits, to transfer state funds to respond to a public health emergency without specific legislative authorization. Funds shall be repaid to existing state accounts as soon as possible. Expenses for a public health emergency shall be authorized by the Governor, but shall not exceed a predetermined cap.

Sec.	Title and Brief Description
∋ 804	**Liability** - creates general immunity for Governor, PHA, and other state executive agencies or actors for their actions during a public health emergency. Some private actors are also statutorily immune in specific circumstances.
∋ 805	**Compensation** - requires compensation for private property that is lawfully taken or appropriated by a PHA during a public health emergency in the amount of and pursuant to procedures typical of a taking proceeding in non-emergency situations.
∋ 806	**Severability** - the provisions of the Act are severable; if any provision is rendered invalid, other provisions remain.
∋ 807	**Repeals** - a placeholder for specific state laws which the Model Act repeals.
∋ 808	**Saving clause** - state laws that do not conflict with the Model Act, or that provide greater protections, continue to have effect.
∋ 809	**Conflicting laws** - as a model state law, the Act cannot preempt any federal law or regulation, but does preempt inconsistent state laws.
∋ 810	**Effective date** - the Act takes effect upon passage by the legislature and signature of the Governor.

Public Health Emergencies. Most of the public health powers granted to state and local public health authorities through the 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 through unintentional means. The MSEHPA covers either scenario under its inclusive definition of what constitutes a Apublic 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.

Under this definition of public health emergency, it is inconsequential how an emerging infectious condition arose in the population. The potential that such infectious conditions may severely impact the morbidity and mortality of populations within a proscribed period of time is the key factor toward the declaration of an emergency.

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 the 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 the 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. The 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 35 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, the 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. The 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 the MSEHPA states: ADuring 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.≅ The 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 (e.g., tuberculosis) 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.

The 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 Athe 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.

These procedural safeguards protect individuals from arbitrary or unjust detention. Even with such protections in place, the psychological toll on society occasioned by isolation and quarantine should not be underestimated. The MSEHPA recognizes the need for mental health support, and requires that public health authorities provide information about and referrals to mental health support personnel to address psychological problems arising from the public health emergency.

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, the 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. For example, private sector HCW=s may need to report identifiable health data to public health authorities who may need to share this data with law enforcement officials to respond to a potential bioterrorism threat. Although there is a strong need to share such data for public health purposes, the 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 the MSEHPA.

Conclusion

Preparing for existing and future bioterrorism events in the United States requires federal, state, tribal, and local public health authorities to collaborate with law enforcement and emergency management personnel to strengthen the national public health infrastructure. 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 fail to authorize, or may even thwart, effective public health action. Law reform is needed to improve public health planning, detection, and response capabilities.

The MSEHPA presents a modern statutory framework of public health powers that allows public health authorities to better plan, detect, manage, and control public health emergencies. These provisions of the Act are balanced against the need to safeguard individual rights and property interests. Balancing individual rights with the interests of the community in protecting the public health during emergencies is not easy. 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. Reaching an acceptable balance that allows government to fulfill its duty to protect the public=s health while respecting individual rights is important. Legal reform may not be a panacea to the unforeseeable conflicts between individual and community interests that may arise during an emergency, but it presents an opportunity for resolving some of the difficult legal and ethical issues that history and experience suggest we will face.

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Appendix 1: The Model State Emergency Health Powers Act - State Legislative Activity

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THE MODEL STATE EMERGENCY HEALTH POWERS ACT
STATE LEGISLATIVE ACTIVITY

As of June 1, 2002

STATE	LEGISLATIVE STATUS UPDATE
AL	An Executive Order (2002 Ala. E.O. 2) establishing the Office of Homeland Security for Alabama and the Alabama Defense Security Council was introduced on 11/01/01. One component of their mission is to coordinate state efforts to ensure public health preparedness for a terrorist attack, including reviewing vaccination policies as well as the adequacy of vaccine and pharmaceutical stockpiles and hospital capacity.
AK	State health officials have circulated the model act widely for review and consideration. The legislature has been asked by Gov. Knowles to appropriate additional funds for anti-terrorism activities in January 2002. Additional legislative activity concerning the model act may soon follow.
AZ Intro Passed	On February 4, 2002, Senator Sue Gerard introduced S.B. 1400, amending several sections of state code in response to public health emergencies. Several provisions are related to similar text in the Model Act. The bill passed the Senate, and the legislative session ended on May 23, 2002, without further action by the House. On April 9, 2002, House Bill 2044, which set standards for the board of dental examiners, passed the House and was transmitted to the Senate. In the Senate, the bill was amended to include bioterrorism and surveillance provisions similar to those in the Model Act. The bill was signed by the Governor on May 23, 2000.
CA Intro	A version of the Model Act has been introduced by Assemblyman Keith Richman, R, on January 8, 2002. See Assembly Bill 1763. It was referred to Committees on Health and Government Organization on Jan. 14, 2002, and on April 9, 2002, the bill will be heard in the Assembly Health Committee. On April 22, 2002, the bill was re-referred to the Committee on Appropriations.
CT Intro	Members of the Connecticut General Assembly have closely examined and studied the Model Act. To date, however, no Member has introduced a bill based on its provisions. On February 13, 2002, the Joint Public Health Committee introduced a bill in the General Assembly that includes many provisions similar to those in the Model Act. On May 3, 2002, the bill passed the House and was sent to the Senate and tabled for the calendar on May 4, 2002. The legislative session ended on May 8, 2002, without further action by the Senate.[2002 CT H.B. 5286]

DE Intro	A bill based on the Model Act was introduced January 16, 2002, by Rep. Maier (2001 DE H.B. 377), and passed the House on May 2, 2002. The bill was referred to the Senate Health & Social Services Committee on May 7, 2002.
FL Intro Passed	Several bills have been introduced that express the legislature=s intent to enact legislation authorizing the Fla. Dept. of Health to coordinate the state=s response to bioterrorism and to respond to threats of bioterrorism and events that endanger the public=s health. 2002 FL SB 1262; 2002 FL SB 1264. SB 1264 passed the Senate but died in the House. SB 1262 passed both houses and was signed by the Governor on May 23, 2002.
GA Intro Passed	Governor Roy Barnes= bill on Public Health Emergencies was introduced as Senate Bill 385 on February 4, 2002 by Senate sponsors Thompson, Stokes, and Tanksley. An amended version of the bill passed the Senate on Feb. 18, 2002 and was referred to the House Committee on Judiciary on Feb. 26, 2002. On April 5, 2002, the bill passed both Houses and was signed by Gov. Barnes on May 16, 2002.
HI Intro Passed	A bill based on the Model Act was introduced in the House on January 24, 2002 by Rep. Say (2001 HI H.B. 2521) and in the Senate on January 23, 2002 by Sen. Bunda (2001 HI S.B. 2779). House Bill 2521 passed both houses and was transmitted to the Governor on May 8, 2002. Senate Bill 2779 passed the Senate on March 5, 2002 and was referred to three House committees on March 12. The legislature adjourned on May 2, 2002, without taking further action on this bill.
ID Intro	House Bill 517 amends existing law to revise the Governor=s powers in disaster emergencies respecting the quarantine of persons and animals and controlling modes of transportation and destinations. HB 517 passed the House on Feb. 2, 2002 and was referred to the Senate Committee on State Affairs on Feb. 26, 2002. The legislative session ended on March 15, 2002, without further action taken on the existing bill.
IL Intro	Sen. Madigan introduced Senate Bill 1529, (2001 S.B. 1529) a virtual replication of the Oct. 23 version of the Model Act, to the Illinois Legislature on Nov. 13, 2001. SB 1529 was introduced and referred to the Senate Committee on Rules on November 13, 2001. Another version of the Model Act was introduced January 18, 2002 by Rep. Feigenholtz (2001 IL H.B. 3809). House Bill 3809 was referred to the House Committee on State Government Administration on Feb. 13, 2002. The bill will be amended to allow the state Emergency Management Agency to share powers with the state Department of Public Health during emergencies. House Bill 3809 was re-referred to the Rules Committee on April 5, 2002, but has subsequently been dropped.
KS Intro	Senate Bill 597 would provide the Governor and other officials with many of the same authorities during a Adisaster emergency≅ as those granted by the MSEHPA during a Astate of public health emergency.≅ SB 597 applies to all states of Adisaster emergency≅ whether they are caused by terrorism or natural events. The bill was referred to the Senate Judiciary Committee on Feb. 14, 2002, and died in committee on May 31, 2002, when the legislative session ended.
KY Intro	Representative Steve Nunn, R, introduced House Bill 370, An Act Relating to the Model State Emergency Health Powers Act [available at http://162.114.4.13/2002rsrecord/hb370.htm] on January 16, 2002. This bill is a virtual reproduction of the Model Act. The bill was assigned to the House State Government Committee on 1/17, instead of the Health and Welfare Committee [where it may have received stronger initial activity, including an early hearing]. Despite working closely with the Health and Welfare Committee to provide technical assistance, HB 370 was withdrawn on Feb. 25, 2002. A bill that calls for assessment and strengthening of strategies to combat an act of bioterrorism was introduced Jan. 8, 2002. [KY HB 88]. The bill also requires the public health authority to address the

	needs of education for health care workers, laboratory and communication capabilities, and reporting and surveillance in the event of a bioterrorism event. This bill passed the House on Jan. 24 and was re-referred to the Senate committee on Appropriations and Revenue on April 2, 2002. The legislative session ended on April 15, 2002, without further action taken on the existing bill.
ME Intro Passed	House Paper 1656, which includes many provisions of the Model Act, was introduced March 11, 2002 and referred by the House to the Joint Committee on Health and Human Services and the Joint Committee on Judiciary. The Senate concurs with the House=s references. (2001 ME H.P. 1656). On April 4, 2002, LD 2164 [as the bill was renumbered] passed both Houses and was signed by the Governor on April 11, 2002.
MD Intro Passed	On January 18, 2002, several Senators (including Senator Hollinger) introduced S.B. 234, entitled AAn Act concerning Catastrophic Health Emergencies - Powers of the Governor and the Secretary of Health and Mental Hygiene.≅ Several of the Act=s provisions are based on the Model Act. SB 234 passed both Houses and was signed by the Governor on April 9, 2002. SB 239, entitled the AMaryland Emergency Management Assistance Compact,≅ and SB 240, AAn Act concerning State Government - Access to Public Records - Public Security Documents≅ also passed both Houses and were signed by the Governor on April 9, 2002. The latter bill allows for the restriction of vulnerable governmental information that could be used for the purposes of planning or executing a terroristic attack. House Bill 303 grants special powers to and places responsibilities on the Governor, health officers and the Secretary of Health and Mental Hygiene under specified circumstances. This bill passed both Houses and was signed by the Governor on April 9, 2002. House Bill 296, based on the Model Act, grants special emergency powers to the Governor and the Secretary of Health and Mental Hygiene whenever an imminent threat of extensive loss of life or of serious disability exists. This bill has passed both Houses and was enrolled April 5, 2002. On May 15, 2002, the Governor vetoed House Bill 296, but the cross-filed bill Senate Bill 234 (referred to above) was signed.
MA Intro	Sen. Moore introduced a version of the Model Act, (2001 Mass. S.B. 2173), aka AThe Massachusetts Emergency Health Powers Act,≅ on Nov. 8, 2001. A subsequent version of the Model Act was introduced November 26, 2001, by Sen. Moore (2001 Mass. S.B. 2194). SB 2173 and SB 2194 were both referred to the Senate Ways and Means Committee on Nov. 26, 2001. On Jan. 15, 2002 the Governor announced the creation of a new Bioterrorism Council led by the Director of Commonwealth Security (2001 MA S.B. 2).
MN Intro Passed	Rep. Thomas Huntley has introduced the Minnesota Emergency Health Powers Act, a version of the Model Act, on January 4, 2002. (2001 MN H.F. 2619). It was referred to the Committee on Health and Human Services Policy January 29, 2002. The same version of the Model Act was introduced in the Senate on February 4, 2002 by Sen. Hottinger (2001 MN S.F. 2669) [http://www.revisor.leg.state.mn.us/unoff/house/ccr/ccrhf3031.html]. On March 26, 2002, SF 2669 was substituted with HF 3031, introduced by Rep. Mulder on Feb. 7, 2002 (2001 MN HF 3031). An amended version of HF 3031 passed the House on March 22, 2002, the Senate on April 3, 2002. The Governor signed the bill on May 22, 2002, and it will go into effect on August 1, 2002. A summary of the Act is available at: http://www.house.leg.state.mn.us/hrd/bs/82/HF3031.html.
MS Intro	A version of the Model Act was introduced in both the House [January 21, 2002 by Rep. Watson , 2002 MS H.B. 1348] and the Senate [on January 21, 2002 by Sen. Furniss, 2002 MS S.B. 2737]. HB 1348 was referred to the Judiciary and Appropriations Committees Jan. 21, 2002 and died in committee on Feb. 5. SB 2737 passed the Senate on Feb. 13, 2002 and was referred to the House Judiciary and

	Appropriations Committees but died in committee on March 5, 2002.
MO Intro Passed	A version of the Model Act was introduced January 9, 2002 by Sen=s Singleton and Sims (2002 MO S.B. 712). It passed the Senate on Feb. 20, 2002 and passed the House on May 16, 2002. It was delivered to the Governor on May 28, 2002. Another version of the Model Act was introduced in the House [on January 31, 2002, by Reps. Barry & Reid (2002 MO H.B. 1771)] and the Senate [January 22, 2002 by Sen. Dougherty (2002 MO S.B. 1000)]. This version does not follow the Model Act as closely as the Singleton/Sims version. HB 1771 was referred to the House Committee on Children, Families, and Health on Feb. 14, 2002. On April 4, 2002, a public hearing was held on HB 1771. SB 1000 was referred to the Senate Health and Welfare Committee on Jan. 28, 2002. On January 9, 2002, Sen. Gross introduced a bill to create a AGovernor=s Expert Emergency Epidemic Response Committee≅ to develop a plan concerned with the public health response to acts of bioterrorism. (2002 MO S.B. 854). SB 854 was referred to the Committee on Pensions and General Laws on March 11, 2002. On March 1, 2002, Sen. Rohrbach introduced a bill based on the Model Act that would expand the applicability of the emergency powers of the Governor to acts of bioterrorism. The bill was referred to the Senate Committee on Pensions and General Laws on March 12, 2002, and a hearing was conducted on March 20. (2002 MO S.B. 1280).
NE Intro	On January 22, 2002, Senator Pam Brown of Omaha introduced a version of the Model Act in the Nebraska Legislature as LB 1224 [www.unicam.state.ne.us]. Senator Jensen. The bill was referred to the Health and Human Services Committee on January 25, 2002. A hearing on the bill was scheduled for Feb. 13, 2002, and indefinitely postponed on April 19, 2002.
NH Intro Passed	A bill based on the Model Act was introduced in the House on February 14, 2002. It was referred to the Committee on Health, Human Services and Elderly Affairs. An amended version of the bill was presented to the House on March 21, 2002. The bill passed the House and the Senate and was signed by the Governor. [2001 NH H.B. 1478]. On Feb. 14, 2002, a concurrent resolution was introduced that cites the CDC=s recognition of the critical importance of public health organizations in responding to bioterrorism. The resolution was adopted by the Senate on March 21and by the House on April 17, 2002. [2001 NH S.C.R. 3].
NJ Intro	The New Jersey Public Health Emergency Study Commission was established on November 8, 2001, (per 2000 Bill Text NJ A.B. 3802) to study, evaluate, and develop recommendations re: the state of preparedness and the development and utilization of available resources to respond to a ph emergency in the event of an attack employing biological or chemical weapons, or a ph emergency created by an outbreak of disease, a natural disaster, or other causes not related to terrorist actions. A bill based on the Model Act was introduced in the Assembly on Feb. 11, 2002, and in the Senate on Feb. 21. [2002 NJ A.B. 1773]; [2002 NJ S.B. 1042]. On Feb. 28, 2002 Sen. Matheussen introduced the APublic Health Preparedness Act≅ that would allow the Commissioner of Public Health to provide comprehensive Statewide planning, coordination and supervision of all activities related to public health preparedness for, and response to, a public health emergency. [2002 NJ S.B. 1223]. The same bill was introduced by Rep. DiGaetano in the General Assembly on Feb. 4, 2002. [2002 NJ A.B. 1746]. (Similar to 2000 NJ A.B. 4060 introduced Dec. 20, 2001).
NM Intro	A joint memorial was introduced by Rep. Dede Feldman for the Legislative Health and Human Services Committee and the Legislative Health Subcommittee and adopted on Feb. 13, 2002. The memorial specifically cites the MSEHPA and creates a working group to evaluate existing law and

Passed	make recommendations for state preparedness. [2002 NM S.J.M. 62]; [2002 NM HJM 34]. An act that allows the public health authority to quarantine individuals infected with a Athreatening communicable disease≅ was introduced on Jan. 22, 2002, and enacted March 5, 2002. [2002 NM HB 195].
NY Intro	On November 20, 2001, Assemblyman Robin Schimminger introduced Assembly Bill 9508 [SB 5841] that replicates many of the Model Act=s provisions [assembly.state.ny.us/leg/?bn=A09508]. Assembly Bill 9508 was amended in committee and presented to the General Assembly on March 5, 2002. Senate Bill 5841 was also amended in committee and presented to the committee on March 4. A committee hearing was held on March 14, 2002 in NYC.
OK Intro	The Oklahoma House of Representatives passed HB 2765 [An Act relating to the Catastrophic Emergency Health Powers Act] on March 6, 2002. (SB 1659) [http://www2.lsb.state.ok.us/2001-02hb/hb2765_cs.rtf]. HB 2765 and SB 1659 passed both houses with amendments. On May 23, 2002, the measures presented by the conference committee failed in the House. The House passed a bill making bioterrorism illegal on March 6, 2002. The definition of Abioterrorism≅ is taken directly from the Model Act. [2001 OK H.B. 2764].
PA Intro	A version of the Model Act was introduced by Rep. Sturla on December 21, 2001 [2001 PA H.B. 2261]. The bill was referred to the Committee on Veterans Affairs and Emergency Preparedness on January 2, 2002. A bill that would give county health departments authority to plan for and respond to public health emergencies was introduced by Rep. Santoni on Feb. 12, 2002. It was referred to the Committee on Health and Human Services on Feb. 13, 2002. [2001 PA H.B. 2371] On March 11, 2002, Sen. Orie introduced a bill based on the Model Act. It was referred to the Senate committee on Public Health and Welfare on March 11, 2002. [2001 PA S.B. 1338].
RI Intro	A version of the Model Act was introduced by Rep. Henseler and referred to the House Committee on Health, Education and Welfare on February 5, 2002. On May 29, 2002, the committee recommended passage, and the bill was placed on the House calendar. [2001 RI H.B. 7357]. Another similar version based on the Model Act was introduced by Rep. Dennigan in the House the same day and referred to the Committee on Finance. [2001 RI H.B. 7563] A bill entitled ARhode Island State Emergency Health Powers Act≅ and based on the Model Act was introduced by Sen. Tassoni on March 7, 2002. It was referred to the Senate Committee on Health, Education & Welfare on the same date. On May 29, 2002, the committee recommended passage, and the bill was placed on the Senate calendar. [2001 RI S.B. 2865]. House Bill 7305 and Senate Bill 2304 would allow the Governor to Adeclare a health emergency and take action to prevent the introduction and epidemic, contagious or infectious disease in the state.≅ The House bill was referred to House Committee on Health, Education and Welfare on Feb. 2, 2002 and scheduled for a hearing and/or consideration on March 27, 2002. The S. Bill was referred to the Senate Committee on Health, Education and Welfare on January 29, 2002.
SD Intro Passed	On Feb. 25, 2002, South Dakota enacted a bill that defines a Apublic health emergency≅ and gives the secretary of health, with the consent of the Governor, the power to declare a state of public health emergency. The bill also requires that certain specifications be included in the declaration, consistent with the language of the Model Act. [2002 S.D. H.B. 1304]. On Feb. 27, 2002, South Dakota enacted a bill to revise the Governor=s emergency powers in the event of a terrorist or bioterrorist attack. While not including all the provisions of the Model Act, the

	bill grants powers to the Governor that are specifically addressed in the Model Act. [2002 SD H.B. 1303].
TN Intro Passed	On January 17, 2002, Representative Bowers and Senator Dixon introduced a bill that is based on the Model Act. (2001 TN S.B. 2392; 2001 TN H.B. 2271). Senate Bill 2392 was passed by the Senate on April 3, 2002. On April 10, 2002, House Bill 2271 was substituted with Senate Bill 2392, and Senate Bill 2392 was passed by the House on April 25, 2002. Senate Bill 2392 was signed by the Governor on May 22, 2002.
UT Intro Passed	A version of the Model Act was enacted on March 18, 2002 [2002 UT H.B. 231].
VT Intro	A bill including provisions based on the Model Act was introduced on March 12, 2002 [2001 VT S.B. 298]. This bill was passed by the Senate on April 16, 2002, and passed the House on May 16, 2002. On May 23, 2002, S.B. 298 was referred to a conference committee.
VA Intro Passed	House Bill 882 would create a bioterrorism unit within the VA Dept. of Health, although the duties of the unit are not consistent in substance or language with the duties of the APublic Health Emergency Planning Commission≅ or other provisions of the MSEHPA. H.B. 882 was referred to the Committee on Appropriations on January 31, 2002. On February 8, 2002, the house voted for the bill to be continued to 2003 in Appropriations. Virginia passed a bill requiring physicians and laboratory directors to report diseases that could be caused by a bioterrorism within 24 hours of diagnosis or identification. This bill was signed by the Governor on April 7, 2002, and will become effective July 1, 2002.
WA Intro	A bill was introduced January 30, 2002, by Rep. Schual-Berkeem creating an Aemergency management council≅ similar to the ACommission≅ described in the Model Act. (2001 WA H.B. 2854). This bill passed the House on Feb. 16, 2002 and was approved by the Senate Committee on Health and Long-term Care on March 1, 2002. House Bill 2854 was returned to the House Rules Committee on March 14, 2002. The legislative session ended on March 14, 2002, without further action taken on the existing bill.
WI Intro	Senator Rosenzweig and legislative and executive counsels have throughly reviewed and compared WI state law concerning provisions of the Model Act. Proposals for some amendments/editions to existing state law are under consideration by a legislative committee. A bill based on the Model Act was introduced February 25, 2002, and referred to the Committee on Public Health.[2001 WI A.B. 849, 850]. On March 26, 2002, A.B. 849 failed to pass. Assembly Bill 850 passed the Assembly on March 7, 2002 and was referred to the Senate Committee on Health, Utilities, Veterans, and Military Affairs on March 8, 2002. The legislative session ended on May 30, 2002, without further action taken on the existing bills.
WY Intro	On February 12, 2002, Senator Scott introduced a bill to amend the Wyoming Emergency Management Act based on portions of the Model Act. The bill was amended and adopted by the Senate on February 28. On March 1, it was presented to the House Committee on Minerals, Business and Economic Development. [2002 WY S.F. 67]. The legislative session ended on March 13, 2002, without further action taken on the existing bills.

Intro B **States that have introduced a legislative bill or resolution based in whole or part on the Model Act**

Passed B **States that have enacted a legislative bill or resolution based in whole or part on the Model Act.**

Appendix 2: The Model State Public Health Act - Preface

Turning Point Public Health Statute Modernization National Collaborative

The Model State Public Health Act

[http://www.hss.state.ak.us/dph/APHIP/collaborative]

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THE MODEL STATE PUBLIC HEALTH ACT

PREFACE

As of 6/1/02

The purpose of the Turning Point Public Health Statute Modernization 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 public health representatives, the MODEL STATE PUBLIC HEALTH ACT (hereinafter AAct≅) presents a comprehensive, model state law that sets forth statutory language concerning public health administration and practice for consideration by existing public health agencies at the state and local levels. The Act=s provisions are consistent with modern constitutional, statutory, and case-based law at the national and state levels, and reflect current scientific and ethical principles underlying modern public health practice.

The Act is presently divided into ten (10) Articles with various Sections [*see* Table of Contents below]. It utilizes a systematic approach to the implementation of public health responsibilities and authorities. The Act focuses on the organization and delivery of essential public health services and functions based on their definition in *Public Health in America*. CITE? It establishes a fundamental mission for state and local public health agencies that is carried out in collaboration with various actors within the public health system. Much of the substance of the Act focuses on the traditional powers of

public health agencies. These powers, however, are framed within a modern public health infrastructure that seeks to balance the protection of public health with respect for individual rights.

Though comprehensive, the scope of the Act is limited in the following ways:

- The Act does not cover some distinct areas of law despite their strong public health relevance. For example, the law relating to mental health, alcohol and substance abuse, and regulation of health care industries are not specifically addressed. Some key issues that are not typically within the domain of public health are touched upon. Thus, while environmental protection is not covered in the Act, environmental health services (*e.g.*, public water supplies, hazardous wastes, vector controls, and indoor air pollution) are addressed in ∋ 6-102.

- Correspondingly, the Act does not include model provisions for all existing laws that impact the public's health (*e.g.*, seat belt provisions, DUI laws, and tobacco control regulations).

- Nor does the Act include extensive language concerning areas of the law that are traditionally covered elsewhere in state statutes (*e.g.*, tax provisions, administrative procedures, disabilities protections). Rather, the Act attempts to incorporate these provisions by reference.

- As a model statutory law, the Act does not specify regulatory details underlying public health practice. These details are left to the discretion of executive agencies through the promulgation of administrative regulations authorized by the Act.

The organizational content of the Act is summarized as follows [*see* the text of the Act itself for precise language and comments].

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Appendix 3: The Model State Emergency Health Powers Act (as of December 21, 2001)

- To be provided -

Court of Appeal, Fifth District, California.

SOUVANNARATH
v.
HADDEN et al..

Jan. 3, 2002.

Hongkham Souvannarath was detained in the Fresno County jail from July 30, 1998 to May 27, 1999 pursuant to an Order of Quarantine and Isolation. The detention was based upon Souvannarath's noncompliance with the plan prescribed to treat her multi-drug resistant tuberculosis. After her release, Souvannarath sought a court order directing Fresno County to comply with the state TB control statutes and desist from placing noncompliant TB patients in the county jail.

TB patients who refuse treatment or who do not comply with an ordered treatment program may be detained. In Fresno County, a detainee is first taken to the chest clinic at University Medical Center (UMC) to determine if he or she is infectious. Patients found to be infectious are retained at UMC. Patients found not to be infectious and not to have other health concerns such as mental illness or substance abuse are detained in the county jail, where treatment is provided through or at the chest clinic.

Souvannarath is Laotian and speaks little English. She was diagnosed with TB in January 1998. A month later she was found to have multi-drug resistant TB, which required the intravenous administration of medication and treatment at the chest clinic. In July 1998, County concluded Souvannarath was not complying with the ordered treatment program.

On July 23, 1998 County served Souvannarath with a Notice and Order for Examination, in English, and told her she was required to appear at the chest clinic on July 28 or risk being detained for continued noncompliance. Souvannarath failed to appear at the chest clinic on the 28th. As a result, the County Health Officer, in consultation with the Division Manager of the County Health Services Agency and the County TB Control Officer, signed and issued an Order of Quarantine and Isolation, dated July 29, 1998, which directed that Souvannarath be detained in the county jail until she completed the prescribed course of treatment, which might extend for two years. The order did not state any specific reason for the detention nor did it contain a statement of Souvannarath's rights under the state TB control laws to request release, to a hearing, and to court appointed counsel.

On July 30, 1998, Souvannarath was taken at gun point to the county jail, after being told she was being taken to the hospital. When she arrived and recognized the jail, she refused to get out of the County van until she was told she would be carried in bodily if she did not submit voluntarily. She was crying, as were her two daughters who had ridden in the van with her. She was strip-searched and forced to undress. She was initially housed in a safety cell for three days, because a Hmong officer mistranslated her Laotian comment that she was afraid to die as a suicide threat. The safety cell had no water, heat, light, bed or toilet. Thereafter, she was housed in the infirmary, where she was expected to clean up after other present inmates

and was threatened by some of them. Ultimately, she was placed with the general inmate population.

Souvannarath ate the same food as the general population inmates. Only one guard occasionally provided translation services. She was unable to communicate her needs to jail personnel. All during her incarceration, Souvannarath was ill, sometimes more so than others. Souvannarath was subject to the same restrictions as those imposed upon all jail inmates. She was allowed visits for a half hour twice weekly. A glass security barrier separated her from her family, who visited on each permitted occasion. She was allowed to make only collect, surcharged telephone calls. She was handcuffed and shackled at her wrists, ankles and waist whenever she was taken from the jail to outside locations, such as the clinic or the hospital. When she was in the hospital, she was chained to a bed.

On May 17, 1999, after the Fresno County Counsel's Office became involved in the matter, Souvannarath was served with a new notice of detention and her case was set for hearing on the superior court's calendar by means of a County petition for an order of continued detention. The new notice was intended to correct the documentary and procedural errors inherent in the original notice and the prior handling of Souvannarath's case. Counsel was appointed for Souvannarath. At a May 27, 1999 hearing, the parties agreed that Souvannarath would be released from jail and placed on electronic monitoring. She was later threatened with rearrest when negotiations broke down between County and Souvannarath's counsel concerning when and who she was to see for medical treatment. At a review hearing on July 19, 1999, the parties stipulated to Souvannarath's unconditional release from detention.

After the county counsel's office became involved in Souvannarath's case, the Department developed new forms for use in civil detention cases under the TB control laws. These new forms were intended to both comply with the provisions of such laws regarding the content of required notices and other documents and papers and to ensure County's future compliance with the procedures directed by those laws.

STATE TB CONTROL LAWS

California's Health and Safety Code 121350 et seq. , enacted in 1995 (S.B. 1360) deals specifically with TB control. Section 121365 requires each local health officer to investigate all active cases of TB in his or her jurisdiction. It allows the local health officer to issue orders for examination, detention in a health facility or other treatment facility, and for a prescribed course of treatment.

Section 121366 allows a local health officer to place a noncompliant TB patient subject to a section 121365 detention order "in a hospital or other appropriate place for examination or treatment." Though such a placement may be ordered by the local health officer without prior court authorization, the statute imposes a number of conditions and restrictions upon a detention, as follows:

> "[W]hen a person detained pursuant to subdivision (a), (d), or (e) of Section 121365 has requested release, the local health officer shall make an application for a court order authorizing the continued detention within 72 hours after the request or, if the 72-hour period ends on a Saturday, Sunday, or legal holiday, by the end of the first business day following the Saturday, Sunday, or legal holiday, which application shall

include a request for an expedited hearing. After the request for release, detention shall not continue for more than five business days in the absence of a court order authorizing detention. However, in no event shall any person be detained for more than 60 days without a court order authorizing the detention. The local health officer shall seek further court review of the detention within 90 days following the initial court order authorizing detention and thereafter within 90 days of each subsequent court review."

Section 121367 directs that an order issued under section 121365 must contain the following, among other things:

1. A statement of the legal authority under which the order was issued,
2. An individualized assessment of the circumstances or behavior upon which the order was based,
3. A description of the less restrictive treatment alternatives attempted or considered and the reasons why such alternatives were either unsuccessful or rejected,
4. A statement of the period of time during which the order will remain effective,
5. A notice that the person detained may request release and that detention may not be continued for more than 5 days in the absence of a court order if release is requested,
6. A notice that the local health officer is required to obtain a court order authorizing the detention within 60 days after commencement of the detention and thereafter seek court review of the detention at 90 day intervals,
7. A notice that the detainee has a right to counsel, either retained or provided.

The section also requires that the order be accompanied by a separate notice which tells the detainee about the right to request release, the five-day limit on the detention in the absence of a court order, and the right to counsel, as well as the right to select not more than two individuals to be notified of the detention by the local health officer.

In 1997, section 121358 was added to Chapter 1 of Part 5; it reads:

"(a) Notwithstanding any other provision of law, individuals housed or detained through the tuberculosis control, housing, and detention program *shall not reside in correctional facilities*, and the funds available under that program with regard to those individuals shall not be disbursed to, or used by, correctional facilities. This section shall not be interpreted to prohibit the institutionalization of criminals with tuberculosis in correctional facilities.
"(b) The department shall work with local health jurisdictions to identify a detention site for recalcitrant tuberculosis patients appropriate for each local health jurisdiction in the state. The department shall notify all counties of their designated site by January 1, 1998." (Emphasis added.)

MOOTNESS

At the trial court hearing, the parties stipulated that the forms and notices under which Souvannarath's detention was authorized did not comply with the state TB control statutes, but that prior to the hearing, the county had changed its forms and notices to bring them into compliance. This included a fax form to be used by the chest clinic to notify county counsel of the potential issuance of the detention order, a fax form for the clinic to notify county counsel of the detainee's request for release, and various other forms. The County argues that as a consequence of these changes, Souvannarath's petition is moot, and this case should be dismissed.

Generally, a court is not obligated to decide issues that have become academic by virtue of some subsequent event. However, we believe that the issues raised by the petition were not restricted to the technical adequacy of the County's forms, notices and inter-office communications.

We pointed out earlier that section 121366 requires that detention cannot exceed the initial

60 days without court authorization, whether or not the detainee requests release, and cannot exceed 5 days without court order when the detainee requests release. The statute without ambiguity puts the burden upon the local health officer to timely obtain the necessary judicial authorization. This requirement of judicial review is not something unique to the TB control statutes or peculiar to the Health and Safety Code. It is a manifestation of the fundamental principle of due process-a hallmark of the constitutional government of this state and the nation. Due process requirements include notice and a meaningful opportunity to be heard.

Despite the clear directions regarding the necessity for judicial authorization in section 12367 and the underlying core notion of due process embedded in the more than 200 years of this nation's history, the County held Souvannarath against her will in the jail for some ten months, not only without court approval but without even seeking court approval.

The explanation for this event is found in the testimony of the public officials involved in the detention. The Health Officer testified that he did not consider the legal ramifications of his order. The TB Control Officer did not acknowledge in his testimony that continued detention, whether beyond five days or 60 days, was not within the authority of the County. He told an attorney who inquired about Souvannarath's case that she was being detained pursuant to "state law" and that she would be held until her treatment was complete. He did not mention to Souvannarath's sons the statutory procedures requiring court authorization in periodic court review, even if he was aware of these provisions. The Division Manager testified that she did not "dwell into people's legal issues" and did not know about "due process" which she believed fell within the realm of "legal assistance." Although she testified that the Department's then-current policy was to converse with the County's legal team when considering a detention, she also characterized "legal advice" as simply the provision of forms. She exhibited little or no knowledge of the conditions attached to the Department's authority to detain under the TB control statutes and no knowledge of any requirement for timely judicial authorization of the detention. She asserted that the Department "just…follow[ed] state laws," but never said anything that reflected any knowledge on her part about "state law" or about the fact that the Department was in violation of it in detaining Souvannarath without court authorization.

We appreciate that these officials are medical professionals and not lawyers. However, as public officials they must be held to know the basic provisions of the laws which empower them and govern the exercise of their particular offices and duties.

In addition, although appellants at the hearing introduced the two new fax forms prepared for use by the chest clinic in notifying county counsel of certain events in potential or actual detention cases, there is no evidence that the chest clinic either used such forms properly in cases subsequent to Souvannarath's or had ever been trained to use such forms. It is one thing to adopt adequate forms and systems, but it is quite another to implement them consistently in accord with pertinent statutory mandates. There was no evidence that any responsible person at the chest clinic had been instructed in the use of the faxes or in the requirements of section 121366 regarding the necessity of judicial authorization for a continued detention, and there was no evidence that appellants had

in place any means by which to monitor the chest clinic's use of the faxes. As we have explained, none of the health officials presumptively responsible for supervising the chest clinic's activities possessed as of the time of the hearing… any knowledge of the contents of, or the scope of their responsibilities under, the relevant statutes, including section 121366.

USE OF JAIL FACILITIES

The County contends that section 121358 does not prohibit the use of the jail to detain noncompliant TB patients because the statute was intended to have nothing more than a fiscal effect. According to appellants, the goal of the statute, to discourage counties from using jails to house TB detainees by withdrawing state funding from the counties for such use, was effectuated because no state funds were used to support the detention of TB patients, including Souvannarath, in the Fresno County jail.

We need go no further than the words of the statute. Section 121358 states without qualification or condition that persons "housed or detained through the tuberculosis control, housing, and detention program *shall not reside* in correctional facilities." The words "shall not" are as unambiguous as any two contiguous words in the English language can be and they cannot rationally be misunderstood.

The clause in section 121358 which prohibits the use of state TB funding to support jail detentions does not overcome the clause which prohibits jail detentions or compel a construction of the statute which makes such detentions elective at the county level. The County wants us to read the statute as if it contained only the prohibition against the use of state money to support jail detentions. But the statute obviously is not so written. Instead, the jail detention ban exists, at the forefront of the section. The subsequent funding ban is linked to the jail detention ban by the conjunction "and," which commonly means "along with" or "together with" (Webster's Third New Internat. Dict. (1986) p. 80). This grammatical structure means the jail prohibition must be given at least equal dignity with the funding prohibition.

The last sentence of subdivision (a) supports this construction; it requires that section 121358 "not be interpreted to prohibit the institutionalization of criminals with tuberculosis in correctional facilities." This explanatory provision would appear to be superfluous if the Legislature did not intend to forbid jail detentions of noncompliant TB patients when done at county rather than state expense. If the Legislature found it necessary to point out that a certain type of TB patient--i.e., one who is also a criminal--was not subject to a prohibition against jail detention contained in subdivision (a) of the section, then the Legislature must have thought it included in subdivision (a) of the section a prohibition against jail detention that applied to another type of TB patient--i.e., one who is not also a criminal.

Moreover, we can perceive in the funding provision a rational legislative aim not inconsistent with the purpose or effect of the jail provision. The Legislature could reasonably have determined that the express withdrawal of state funding was an emphatic means by which to insure that counties would not be tempted to disregard the jail ban for purposes of expedience or economy.

The reference in the statute to "the tuberculosis control, housing, and detention program" does not, as County asserts, restrict the application of section 121358 to only "state" DHS tuberculosis control schemes, nor does it

distinguish between the "state" program and the County's purported "local" program, authorized, in the County's view, by the grant in sections 121365 and 121366 to local health officers, as opposed to a state officer, the discretion to select the appropriate place to detain and treat recalcitrant TB patients.

First, it is nonsense to postulate that the Legislature inserted, into the TB control statute a section, 121358, which was and is entirely irrelevant and inapplicable to everything else contained in the TB control statute. As we explained earlier, the TB control statute sets up a two-level, statewide program for TB control, with the state as the "lead agency" charged with the administration of state funds made available for the care of TB patients. The local health officer, however, is given responsibility to carry out the mandates of the TB control statutes and to implement at the county level the state's TB control program, including the detention and housing of noncompliant patients. The Legislative declaration found in section 121360 itself reflects that the counties are the intended focus for the implementation of the statewide program; the declaration states in relevant part that "all proper expenditures that may be made by any *county*," pursuant to the TB control statute, are "necessary for the preservation of the public health of the *county*." If there is in effect any separate "state" DHS tuberculosis program authorized by the Legislature, it is nowhere the subject of the TB control statute.

Second, section 121358 commences with the words "Notwithstanding any other provision of law." This phrase has a special legal connotation; it is considered an express legislative intent that the specific statute in which it is contained control in the circumstances covered by that statute, despite the existence of some other law which might otherwise apply to require a different or contrary outcome. Thus, although a local health officer may have been granted broad general discretion under the state TB control statute to select the place of detention for noncompliant TB patients, that discretion was intended by the Legislature to be circumscribed by the flat prohibition against jail detention contained in section 121358.

If there were any ambiguity in section 121358--and we do not find any--it would be resolved by the legislative history of the statute. [Discussion of legislative history omitted-Ed.]

It is not within this court's power to release appellants from their statutory obligations simply because the task given them by the Legislature proves difficult or costly in Fresno County. Here, by the language and legislative background of the statute, the Legislature unmistakably intended to prohibit the use of jails as TB detention facilities even though the restriction might place a burden on a particular county to identify and fund a different housing option. Subdivision (b) of the statute specifically acknowledges and addresses this burden by placing a corresponding duty upon DHS to work with the local health officers to identify proper placements for noncompliant TB patients. (§ 121358, subd. (b).) The trial court did not err in finding that appellants violated section 121358 by placing Souvannarath in the county jail.

Note: This is an edited version of a court decision intended exclusively for use in educational settings. Several sections have been extensively edited and/or modified for a non-legal audience. Do not cite this version or use in legal proceedings. The officially reported version may be found at 103 F. 1.]

Circuit Court, N.D. California.

WONG WAI
v.
WILLIAMSON et al.

May 28, 1900.

MORROW, Circuit Judge.

This action is brought by a subject of the emperor of China residing in San Francisco against the San Francisco Board of Health. On May 18, 1900, the board adopted a resolution requiring the inoculation of all Chinese residents of San Francisco with the Haffkine Prophylactic and prohibiting them from leaving the city until they submit to inoculation. The resolution does not apply to any of the inhabitants other than Chinese or Asiatics, and the inhabitants other than Chinese or Asiatics are permitted to depart from and return to the city without being subject to the inoculation imposed upon the Chinese inhabitants. This restriction, it is alleged, discriminates unreasonably against Chinese residents, confines them within the territorial limits of the city and county, and deprives them of their liberty, causing them great and irreparable loss and injury. The plaintiff sues on behalf of the 25,000 persons of the Chinese race now residing in San Francisco. He seeks an injunction prohibiting enforcement of the resolution.

The Haffkine Prophylactic is a poisonous substance compounded from living bacteria of the bubonic plague that it is administered to human beings by hypodermic injection into the tissues of the body. It produces a severe reaction, and causes great pain and distress, a sudden and great rise of temperature, and great depression which sometimes continues, increasing in severity, until it causes death. The only purpose for which such inoculation is claimed to be effective or useful is to prevent persons from contracting the bubonic plague if exposed thereto after having been so inoculated. The plaintiff alleges that there is not now, and never has been, any case of bubonic plague in San Francisco or in the state of California.

The conditions of a great city frequently present unexpected emergencies affecting the public health, comfort, and convenience. Under such circumstances, public health officials should be clothed with sufficient authority to deal with the conditions in a prompt and effective manner. Public health measures that have a uniform operation and are reasonably adapted to the purpose of protecting the health and preserving the welfare of the inhabitants of a city are constantly upheld by the courts, however inconvenient they may prove to be, and a wide discretion has also been sanctioned in their execution.

However, measures to protect the public health must have some relation to the end in view. Personal rights and those pertaining to private property will not be permitted to be arbitrarily invaded under the guise of the police power.

The Board of Health's resolution cannot be sustained. It is not based upon any established distinction in the conditions that are supposed to attend this plague, or the persons exposed to its contagion, but is boldly directed against the Asiatic or Mongolian race as a class, without regard to the previous condition, habits,

exposure to disease, or residence of the individual. The only justification offered for this discrimination was a suggestion made by counsel for the defendants in the course of argument that this particular race is more liable to the plague than any other. No evidence has, however, been offered to support this claim, and it is not known to be a fact.

There is, however, a further and a more serious objection to these regulations adopted by the defendants. It appears from the instructions of Dr. Walter Wyman, the supervising surgeon general of the marine hospital service, that the Haffkine Prophylactic is not designed as a preventive after a person has been exposed to the disease. On the contrary, its administration under such a condition of the human system is declared to be dangerous to life. It is administered for the purpose of preventing contagion from exposure after inoculation, and for that alone. A person about to enter an infected place should therefore secure this treatment, but a person departing from an infected place should not be so treated. For the latter contingency Dr. Wyman prescribes another and very different remedy, namely, inoculation with the Yersin Serum. His instructions state that: "The Haffkine material should be used as a preventive on persons before their exposure, while the Yersin treatment may be used either before or after exposure, or while a person is suffering with the disease. The Haffkine material should not be used on suspects held in quarantine, or on persons who have been definitely exposed to the plague, but is applicable to persons who are liable to be brought into contact with plague, and before such possible contact, as quarantine officers and attendants, health officers and employes, and persons in a community where there is danger of the introduction and spread of the disease."

It therefore appears that the administration of Haffkine Prophylactic to Chinese persons departing from San Francisco has no relation to the public health of the inhabitants of this city, and cannot be sustained by any such claim on the part of its board of health. An injunction will issue as prayed for in the bill of complaint.

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Circuit Court, N.D. California.

JEW HO
v.
WILLIAMSON et al.

June 15, 1900.

MORROW, Circuit Judge

On May 29, 1900 The San Francisco Board of Health adopted the following resolution:

"Whereas, it has been reported by Drs. Kellogg, bacteriologist to the board of health, Montgomery, of the University of California, Ophulf, of the Cooper Medical College, and J. J. Kinyoun, of the U.S. Marine Hospital Service that bubonic plague exists in the Chinatown district and that nine deaths have occurred. Now, therefore, be it resolved that the health officer is hereby instructed to place in quarantine until further notice that particular district of the city bounded north by Broadway, northeast by Montgomery avenue, east by Kearney, south by California, and west by Stockton streets. The chief of police hereby requested to furnish such assistance as may be necessary to establish and maintain the quarantine."

The plaintiff Jew Ho resides at No. 926 Stockton street, within the limits of said quarantined district. He operates a grocery store at his place of residence. A great number of his customers reside outside the quarantined district and are prevented from patronizing his store. The plaintiff alleges that although the resolution is in general terms and purports to impose the same restrictions upon all persons in the quarantined district, it is actually only enforced against persons of the Chinese race and nationality. He alleges that there is not now, and never has been, any case of bubonic plague within the quarantined district, nor any germs or bacteria of bubonic plague, and that other diseases caused the illness and death of the persons claimed to have died of the bubonic plague. He also alleges that the defendants have failed to quarantine the houses said to be infected from the remainder of the district and failed to quarantine or otherwise isolate the persons alleged to been exposed to the danger of contagion, and therefore likely to transmit the germs of bubonic plague, from the other residents of the district. He alleges that the quarantined district includes an unreasonably large and populous district, namely 12 blocks containing more than 15,000 persons, thereby increasing rather than diminishing the danger of contagion and epidemic. He alleges that the action of the defendants in confining and imprisoning him and other Chinese residents within the limits of said quarantined district is a purely arbitrary, unreasonable, unwarranted, wrongful, and oppressive interference with the personal liberty of Chinese residents, and with their right to the pursuit of their lawful business, depriving them of their rights to equal protection of the laws.

The purpose of quarantine is to prevent the spread of diseases among the inhabitants of localities. The more densely populated the community, the greater danger there is that the disease will spread, and hence the necessity for effectual methods of protection. To accomplish this purpose, persons afflicted with such diseases are confined to their own domiciles until they have so far recovered as not to be liable to communicate the disease to others. The object is to confine the disease to the smallest possible number of people; and hence when a vessel in a harbor, a car on a railroad, or a house on land, is found occupied

by persons afflicted with such a disease, the vessel, the car, or the house, is cut off from all communication with the inhabitants of adjoining houses or contiguous territory, so that the spread of the disease may be arrested at once and confined to the least possible territory. This is a system of quarantine that is well recognized in all communities, and is provided by the laws of the various states and municipalities.

It must necessarily follow that, if a large section or a large territory is quarantined, intercommunication of the people within that territory will rather tend to spread the disease than to restrict it. If you place 10,000 persons in one territory, and confine them there, as they have been in prisons and other places, the spread of disease becomes increased and the danger of such spread of disease is increased, sometimes in an alarming degree, because it is the constant communication of people that are so restrained or imprisoned that causes the spread of the disease. If we are to suppose that this bubonic plague has existed in San Francisco for some time and that there has been danger of its spreading over the city, the most dangerous thing that could have been done was to quarantine the whole city, as to the Chinese, as the Board of Health initially sought to do. The next most dangerous thing to do was to quarantine any considerable portion of the city, and not restrict intercommunication within the quarantined district. The quarantined district comprises 12 blocks. It is not claimed that in all the 12 blocks of the quarantined district the disease has been discovered. There are, I believe, 7 or 8 blocks in which it is claimed that deaths have occurred on account of what is said to be this disease. In 2 or 3 blocks it has not appeared at all. Yet this quarantine has been thrown around the entire district. The people therein obtain their food and other supplies, and communicate freely with each other in all their affairs. They are permitted to go from a place where it is said that the disease has appeared, freely among the other 10,000 people in that district. It would necessarily follow that, if the disease is there, every facility has been offered by this species of quarantine to enlarge its sphere and increase its danger and its destructive force. The court must hold that this quarantine is not a reasonable regulation to accomplish the purposes sought. It is not in harmony with the declared purpose of the board of health or of the board of supervisors.

There is another feature of this case that has been called to the attention of the court, and that is the discriminating character of the quarantine. The plaintiff has called our attention to the fact that although the quarantine is supposed to be bounded by streets, in practice the operation of the quarantine is such as to run along in the rear of certain houses with certain houses excluded while others are included. For example upon Stockton street, in the block numbered from 900 to 1,000, there are two places belonging to persons of another race, and these persons and places are excluded from this quarantine, although the Chinese similarly situated are included, and although the quarantine, in terms, is imposed upon all the persons within the blocks bounded by such streets. The evidence here is clear that this is made to operate against the Chinese population only, and the reason given for it is that the Chinese may communicate the disease from one to the other. That explanation is insufficient.

There is still another feature of this case, namely whether or not the bubonic plague has existed in this city, and whether it does now exist. Several reputable physicians, including members of the Board of Health, have testified that there have been 11 deaths in the

quarantined district which on autopsy have disclosed some of the symptoms of the bubonic plague. But there has been no living case under the examination of the physicians from which a clinical history has been obtained, and it does not appear that there has been any transmission of the disease from any of those who have died. From all of which the court infers that the suspected cases were not contagious or infectious, or, if contagious and infectious, they were but sporadic in their nature, and had no tendency to spread or disseminate in the city. If it were within the province of this court to determine this issue, I think, upon such testimony as that given by these physicians, I should be compelled to hold that the plague did not exist and has not existed in San Francisco. But this testimony is contradicted by the physicians of the board of health. They have furnished the testimony of reputable physicians that the bubonic plague has existed, and that the danger of its development does exist. In the face of such testimony the court does not feel authorized to render a judicial opinion as to whether or not the plague exists or has existed in this city. Indeed, that is one of the questions that courts, under ordinary circumstances, are disposed to leave to boards of health to determine, upon such evidence as their professional skill deems satisfactory. If they believe, or if they have even a suspicion, that there is an infectious or contagious disease existing within the city, it is unquestionably the duty of such boards to act and protect the city against it, not to wait always until the matter shall be established to the satisfaction of all the physicians or all the persons who may examine into the question. It is the duty of the court to leave such question to be determined primarily by the authority competent for that purpose. So that in this case the court does not feel at liberty to decide this question, although, as I have said, personally the evidence in this case seems to be sufficient to establish the fact that the bubonic plague has not existed, and does not now exist, in San Francisco.

It follows from the remarks that I have made that his quarantine cannot be continued. It is unreasonable, and its discriminatory enforcement contravenes the equal protection provisions of the fourteenth amendment of the constitution of the United States. However, I will permit the Board to maintain a quarantine around such places as it may have reason to believe are infected by contagious or infectious diseases. The general quarantine of the whole district must not be continued.