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THE PROCEEDINGS

of The Public’s Health and the Law

in the 21st Century:

Fourth Annual Partnership

Conference

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CDC

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THE PROCEEDINGS
of The Public’s Health and the Law
in the 21st Century:
Fourth Annual Partnership Conference
Dear Society Members and Journal Subscribers:

On June 13-15, 2005, the American Society of Law, Medicine & Ethics, in partnership with the Centers for Disease Control and Prevention and the U.S. Department of Health and Human Services, convened a major conference entitled “The Public's Health and the Law in the 21st Century: Fourth Annual Partnership Conference on Public Health Law.” More than 800 individuals from all the 50 states and many foreign countries assembled in Atlanta, Georgia to engage in both plenary and concurrent sessions devoted to all aspects of public health and the role that law plays in promoting and sustaining a healthier population. The audience was truly multidisciplinary—and included lawyers, members of the judiciary, physicians, state legislative members, public health officers, nurses, bioethicists and academics.

The American Society of Law, Medicine & Ethics acknowledges the creative work of the program planning committee, the plenary session speakers and the concurrent session presenters included in this supplement, and the dedication of the extraordinary conference faculty.

We also extend our special thanks to each of the following for their exceptional support for the conference and the conference proceedings: Julie L. Gerberding, MD, MPH, Director of the CDC; William H. Gimson, MBA; Ed Thompson, MD, MPH; Kathy Cahill, MPH; Deborah Jones; James Marks, MD, MPH; Anthony Moulton, PhD; Richard Goodman, MD, JD, MPH; and other colleagues at CDC for their financial and technical support for planning the conference. Finally, we thank Briana Grovhoug for serving as Editor-in-Chief of THE PROCEEDINGS and for her enthusiastic support for THE PROCEEDINGS and the conference.

Sincerely,
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Dear Readers:

It is my pleasure to present this Special Supplement to the *Journal of Law, Medicine & Ethics*, THE PROCEEDINGS of *The Public's Health and the Law in the 21st Century: Fourth Annual Partnership Conference* held in Atlanta, Georgia on June 13-15, 2005. The conference was co-sponsored by the American Society of Law, Medicine & Ethics and the Centers for Disease Control and Prevention's Public Health Law Program. The program was insightfully shaped by the conference planning committee (see Appendix A) and the many collaborating organizations (see Appendix B) which were integral to the success of this year's event. I would like to extend our sincere appreciation for their invaluable contributions to the conference and to improved public health through law.

This national conference continues to grow in size and scope each year. In 2005, more than 600 took part, drawn from all fifty states, Belgium, Canada, Japan, Korea, Nigeria, and the United Kingdom. Attendees included: federal, state, and local public health leaders, practitioners, and legal counsel; elected and appointed public policy makers; physicians and nurses in public health and clinical practice; emergency management and law enforcement officials; judges and attorneys active in public health and health care; educators and researchers in public health law; as well as students from law schools and schools of public health around the country.

The goal of this conference series is to improve the understanding of law as a public health tool. Focusing primarily on innovative legal tools for improved public health, this year's conference emphasized information that participants can use in day-to-day practice. By taking part in the annual conferences, participants are better able: to explain the critical role law plays in protecting the health of the public and in strengthening the public health system for potential emergencies; to describe practical approaches to applying legal tools to today's top-priority public health issues; to identify and assess scientific and other evidence for law-based public health strategies; and to build partnerships with colleagues across professional boundaries.

THE PROCEEDINGS capture both the spirit and the substance of the conference. Collectively, the session summaries present an accurate record of the conference, yet each summary also retains the individual perspective of the faculty member. Overall, the conference faculty, who reflected the multidisciplinary composition of the conference participants, explored cutting-edge issues at the intersection of public health and the law and presented concrete examples of law as a valuable public health tool, both domestically and internationally.

In the first section of THE PROCEEDINGS keynote speakers discuss significant public health and legal issues that are both cross-cutting and central to the practice of public health and law. After the keynote summaries, a synopsis highlights the special plenary program, "*Jacobson v. Massachusetts* and Public Health Law: Perspectives in 2005" which examined the significance of the landmark 1905 U.S. Supreme Court case for public health on the ruling's centennial anniversary. Immediately following are concurrent session summaries organized around topical tracks: (1) applying law throughout the life stages; (2) partners and powers in public health practice; (3) building public health emergency legal preparedness; (4) strengthening legal and scientific frameworks; and (5) cross-cutting public health and legal issues.

THE PROCEEDINGS were made possible by the valuable contributions of many individuals. I would like to especially thank Benjamin Moulton, Executive Director...
of the American Society of Law, Medicine & Ethics, and Edward J. Hutchinson, Editor and Director of Publications, *Journal of Law, Medicine & Ethics*. Additionally, I would like to thank Richard A. Goodman and Anthony D. Moulton, Co-Directors of the CDC Public Health Law Program, as well as my many dedicated colleagues in the Public Health Law Program. Thank you all for your guidance and legal expertise. Furthermore, I would like to thank all members of the conference faculty for making the commitment to share their expertise and insight with conference participants and with the readers of THE PROCEEDINGS.

Finally, I would like to acknowledge the important contributions made to THE PROCEEDINGS by the student and volunteer authors, from inside the CDC and outside, who served as Writer/Editors of the conference sessions. It has been my distinct pleasure to work with them. They are:

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Special thanks to all for their dedication and commitment to help make this year’s conference another milestone event in public health law.

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It is a pleasure – and a real honor – to be here among so many friends. Now I am not going to presume that I am preaching to the choir. But I do believe that we share a passion for protecting and improving the health of America that our philanthropy and public health and the law are, indeed, singing the same tune, and, more often than not, singing in the same key.

To this physician, philanthropy, public health, and the law are partners on the same path. I am excited about where that path is taking us – and where, together, we are taking the health and safety of the American people. This afternoon I want to share with you my perspective about how similar our missions really are and how, together, we can strengthen the public health system, harness the power of public opinion, and literally transform our society – for the better.

This lecture is named for Gene Matthews – who so cheerfully bears the burden of being a living legend to many of us in public health and in the law. This is a field that can utterly exhaust even the best of us. But Gene has been thriving on the toughest public health challenges for more than a quarter of a century. He literally invented the discipline of population health and the law. Gene has witnessed first-hand the public health emergencies that define our times: AIDS, anthrax, West Nile virus, and SARS. But Gene’s true legacy is how the law and public health today are so inextricably connected. How the law has become the rock-solid foundation of the practice of public health. And how the power of the law helps us protect the public’s health in ways that are equitable, ethical, and lasting. Here is one example fresh from the headlines that tell us how much we really are partners on the same path – even when it takes us to Anchorage.

Last month the Governor of Alaska signed into law a top-to-bottom rewrite of that state’s public health law. The legislation’s based on the model public health law statute so many of you worked on as part of our “Turning Point” public health collaborative. It is hard to believe, isn’t it, but Turning Point’s ten years old. From the beginning, our aim was to transform the public health system by strengthening its infrastructure, developing its leadership, and building out its connections to the broader business, health care, and faith communities. And to think we thought public health was in bad shape then! It seemed inconceivable that round after round of shifting political priorities and devastating budget cuts would weaken the system even more. Let me tell you – if Turning Point did not already exist, we would have to invent it all over again.

Alaska’s a good example why. The state’s capacity to meet emerging health threats was held back by a hodgepodge of outdated laws far better suited to the days of the Yukon gold rush than the 21st century. Enter Turning Point’s Alaska team, led by Deb Erickson of Alaska’s Division of Public Health. Thanks to their relentless advocacy – and Turning Point’s model statute – the state now has new public health laws and badly-needed tools, like mandated quarantines to stop the spread of infectious diseases.

Nationwide, public health agencies and community organizations in 21 states are partners in Turning Point collaborations. They are: (1) developing leaders with a stronger sense of accountability to the public; (2) improving the skills and competencies of public health practitioners; (3) bringing on-line better information technologies; (4) and motivating individuals and communities to lead healthier lives.

This is basic, get-the-job done kind of work. In Nebraska, for example, Turning Point helped the state
expand local health department coverage from 22 to all 93 counties. In New York, Turning Point put together a training program for state and local public health officials that works as well upstate as it does downstate. As for statutory reform – 26 states have passed all or part of Turning Point’s model legislation. Action is pending in four more states. This is a remarkable achievement. You have done your work well. What is happening is that Turning Point teams are just like those “tipping points” everyone is talking about. These teams are opening pathways for philanthropy, public health, and the law to transform how we improve and protect the health of the public – and to do it in ways that go far beyond the traditional notions of what “public health” really is. Actually – the Robert Wood Johnson Foundation has been there before. We had our first close encounter with a public health “tipping point” right after we stepped onto the national stage just over a generation ago.

This is one of my favorite stories about who we are as a foundation and where we came from. Remember the old TV series “Emergency” – Saturday nights 30 years ago? “Emergency” was one of the biggest programs on television and one of TV’s first reality-based shows. The show made heroes of a team of fictional Los Angeles County Fire Department paramedics – Rescue Squad 51. At the time, most communities were unable to react promptly and effectively to trauma events. Tens of thousands of lives were being lost because emergency response was slow, there was no medical equipment on hand – and if there had been, no one knew how to use it. Ambulances were likely to be a hearse, doing double duty because it was the only vehicle around that could take a patient on a stretcher. They called it a “scoop and haul.” No one had two-way radios. Communications from the scene to the hospital were nonexistent. Patients were transported too late – or were taken to the wrong place. If you had a heart attack, you had a 50-50 chance of being dead before they got you to the hospital – which had no advance warning you were on the way.

As a result, trauma was the leading cause of death for all ages between infancy and adults in their late 30s. The government had just declared that personal injury trauma was “the neglected disease of modern society.” Fortunately, “Emergency” caught the nation’s attention. It introduced the terms “paramedic” and “EMS” to the media and the public – and, quickly, the public supported doing something about it. Local physicians set up hometown emergency medical systems. And military medics returning from Vietnam provided an unexpected pool of skilled emergency workers. Now, we were a young national foundation and more than just a bit naïve. But this was an opportu-
change on a scale big enough to significantly improve the health of our people, the quality of life, and the security of our communities. “Security” is exactly the right word – because it captures the common yearning of most Americans today. If anything, the terror of our times makes the right to “security of person” more urgent than ever. It is been said that we are living in an age that is “more anxiety-ridden than any period since the breakdown of the Middle Ages.” No wonder. We live in a global village on a flattened planet where news and information from the other side of the world arrives in a nanosecond – and the people who sent it can show up in person only a few hours later. It is a world that threatens us in ways as old as the Black Plague and as new as September 11, 2001.

Getting ready for this lecture I jotted down just some examples that quickly came to mind. Call it Doctor Risa's ad hoc public health “threat brief.” That new strain of avian flu – H5N1 – could sicken 20% of the world’s population if it mutates to pass among more humans. None of us are immune. It is good you got the news media to finally pay attention to the risk. Tuberculosis infects about one-third of the world’s population. Some two billion people. And do not forget – our global village has wings. An infected passenger on your next flight puts you at risk of exposure. There are other killers, too – much closer to home. Like meningitis. The CDC just recommended that eight million kids entering high school and college get vaccinated against meningitis. Or who you are and where you live. Did you know that African Americans in our big cities are more likely than whites to die in this summer’s heat waves because they do not have central air conditioning or fans where they live?

But it is tobacco that is still the worst threat. Though we have made great gains, nearly 25% of all adults continue to smoke. And now there are troubling signs that the rate of decline among youth is leveling off. With women, one in five still smoke, even after all the publicity that lung cancer is the number one cancer killer of American women. And something we certainly did not see coming. The Justice Department’s stunning concession in the tobacco racketeering trial when it announced it would seek only $10 billion for smoking cessation programs – and not the $130 billion the government’s own experts had recommended. Talk about sabotage! In this company it is probably safe to say – that we are mad as hell! And though it seems like the struggle against tobacco will never end – this fight is not over yet. Not by a long shot.

Oh yes – then there is obesity. And now I am really getting angry. Despite the disinformation coming out of the Center for Consumer Freedom, despite those full-page ads about “hype,” despite all those self-styled op-ed experts who say “there is no problem,” despite all that, obesity really is an epidemic. And it is killing tens of thousands of us every year – no matter how you do the math. Our children are the ones at highest risk. Right now some nine million kids over age six are obese. And if they are still obese as teenagers they have an 80% chance of being obese adults – and a 20% chance of dying too soon. If you want more proof, just go to the nearest shopping mall after school on any afternoon and you will see the adolescent evidence all around you. So – do not tell us that there is no such thing as an obesity epidemic – even though the special interests scorn us as “zealots” and “radicals” from “the twilight zone of fat hysteria.” The public and the press know exactly where the attacks are coming from. So let them vent – while we work together in the public’s interest.

Obesity alert is high. Doctor Gerberding is to be applauded for keeping the obesity alert level on high. Let me remind you what Julie said just ten days ago. She said, “We need to be absolutely, explicitly clear about one thing: Obesity and (being) overweight are critically important health threats in this country… They have many adverse consequences.” Well, good for her! It takes courage to champion the public’s good health on a red hot issue when powerful forces are against you. It reminds me of how C. Everett Koop stood like a rock against the tobacco industry. Now it is our turn to be just as resolute, because if we do not turn this epidemic around soon, the human, economic, and social costs over the next two generations will be devastating. Nothing we are doing to protect the health of the public is as important. Nothing. And please – do not underestimate our ability to succeed. No group has ever protected the health of the American public with more determination and more success than you and your public health colleagues back home.

You would think public health would register pretty high on the public’s scale of appreciation. But you do not, do you? When I ask public health professionals, “What is your biggest complaint?” I always get the same two answers. “We do not have enough money” and “we are not appreciated.” You don’t get no respect! It is like public health’s the Rodney Dangerfield of the health world – “You do not get no respect!” It is hard to understand. Every person in America has a stake in what you do. Yet most people do not even know what you do. I saw one poll that said nearly 60% of registered voters did not have a clue that you protect “the population from disease” and promote “healthy living conditions for everyone.”
In another survey, the huge majority – more than nine out of ten – was not able to come up with an answer when asked, “What do the words ‘public health’ mean to you?” Less than 4% knew enough to think of health education, preventing infectious diseases, immunizations, and healthier lifestyles. The rest were just as uneasy and ambiguous coming up with a definition for public health as is the public health community itself. Nevertheless – the great majority without hesitation said funding public health was more important than building roads, creating missile defense systems, or cutting taxes. There is an important message the public’s actually telling us that we are not communicating to them the right way. We do not tell them enough about our successes. And we do not tell them in terms that are relevant to them. Our own research tells us the public thinks health care is a social contract, a system that serves all of us through a shared set of values like equality, compassion, mutual obligation, social responsibility, and accountability. That sounds just like what the Institute of Medicine (IOM) said back in 1988 when they told us that “public health is what society does collectively to assure the conditions in which people can be healthy.”

This may be a great definition – but it is never taken hold in the public’s mind. Why is that? Why is it that you, of all people, “get no respect?” I think they are four reasons. First – So much of what we all do flies below the radar screen. Until it all hits the fan. The public only knows about you when things are going really bad and the radar screen is all lit up. I am reminded of that just about every time I see Dr. Gerberding testify before Congress. Second – Public health is a community without a constituency. Why else is public health hit so hard when it is time to cut the budget? Think about it. The 2006 federal budget expands the stockpile of vaccines and antibiotics for a bio-terrorism attack. But at the same time it cuts support for the state and local agencies that are supposed to distribute the drugs. That makes no sense. Or take a look at the Healthy People 2010 agenda. Preventing diabetes: Goal Number five.

With 800,000 new cases costing upwards of $100 billion a year, this is an urgent public health priority. But the new budget takes hundreds of millions of dollars away from the one program in the Public Health Service that is dedicated to preventing chronic disease like diabetes.

And answer this for me, will you? Why can’t you get the information systems and technologies, the new lab equipment, and the real-time surveillance and epidemiological systems that every expert says you need – that the IOM 17 years ago said you need – but that no budget ever provides for? Without a loyal and loud national constituency of your own – you are just a wheel without a squeak.

There is a third reason why you “do not get no respect.” Most people equate better health with better medicine. They do not connect the dots between health and prevention and the environment, socioeconomic status, race, risky behavior – even geography and circumstance of birth. Remember the big story last month about the benefits of heart bypass surgery versus stents. This was a typical “better medicine” story. Everybody ran it. But where is the story about the deteriorating health status of a poor neighborhood with no place to shop for food except a convenience store? Where kids do not get proper physical exercise because gangs and drugs rule the playgrounds. Where it is too dangerous to walk to school. And where the health care is not nearly as accessible or as good as they get in the suburbs. This is an important public health story – but no one is telling it.

The harsh truth is that too often the public thinks of you as the provider of last resort for many people whom mainstream society conveniently forgets or shuns altogether. People like the poor, minorities, immigrants; people with stigmatized diseases like AIDS and TB. For this part of your work you should be hailed as heroes. Instead, you sometimes end up stigmatized yourselves for doing exactly what society expects and demands of you. It is no surprise, then, that so many public health workers joke about “no good deed going unpunished.”

There is a fourth “disrespecter” of public health. This is a public responsibility which brings with it government involvement, government spending, and government laws and regulation. That is not a very popular notion in much of America today. Yet, public health is very much a government system – a legitimately intrusive system – that is so chronically neglected that every time the IOM takes a look they find the system to be in disarray and long overdue for an overhaul.

One big reason why is that about 95% of all health spending goes for medical care and biomedical research. No more than two percent is for public health and disease prevention. Ninety-five to two. This is not just counter-intuitive. It is counter to the public’s safety.

Everything we know about population health tells us that behavior and environment – and not lack of access to medical care – cause more than 70% of avoidable deaths. Correcting this imbalance would require big shifts in how government allocates public resources, along with an earth-shaking realignment of the private sector’s economic interests. That is a tough
sell, especially if the public is not sure what you really do, your advocates are few and far between, and government’s role in our lives seems to be in such flux.

Fortunately, we already hold in our hands the power to change the trajectory of these discouraging realities. As we see it, the answer is in what philanthropy and public health and the law can accomplish together. As you well know, the needs are urgent. We supported the recent “Ready or Not” report from Trust for America’s Health that found that after three years and $3 billion dollars in federal spending, states are still struggling with the fundamentals of bio-terrorism preparedness; meanwhile, state, and local agencies remain sharply under-funded and not sufficiently prepared to deal with other serious health threats like cancer, asthma, and obesity. Our strategy is to reverse these deficits so you gain the muscle you need to close this prevention and preparedness gap.

We are old hands confronting some of the most destructive threats – like smoking, substance abuse, and obesity. But that is not enough. It is too narrow. So we have broadened our vision – and our efforts – to help re-engineer the public health system itself from the inside-out. We are using power tools of information technology, leadership development, and accountability. We believe it is key that the next cadre of public health leaders be masters of informatics, committed to collaboration, and comfortably accountable to the public they serve.

There is so much to do. Thankfully, we are not alone. Grantmakers in Health identifies 170 foundations that are spending, collectively, $1 billion a year to help improve what you do and improve the public’s awareness of how you do it. Foundations like the California Endowment, Healthcare Georgia, the Health Foundations of South Florida and Greater Cincinnati, and the Rose Community Foundation of Denver. One state-wide philanthropy in particular sets the bar very high and is doing exactly what we are talking about. It is the Kansas Health Foundation. They are into the level of systems change we need, finding and developing workers and leaders, bringing on-line cutting-edge IT systems, and building up the state’s readiness for the future.

This foundation even pays to educate college journalism students on how to cover public health. Just consider – what better way to change public opinion than to train the very journalists who are telling the public all about you. Makes me think we are ready for another TV show of our own.

Changing public opinion as it may seem daunting, but history says we can convert America’s attitude toward public health from one of disinterest to one of enthusiastic support. Look at the turnarounds in public attitudes about fluoridated water, lead-free gasoline, seat belts, smoking, and second hand smoke. Times do change. My mother grew up right here in Atlanta, and in her day it was unheard of for women to physically exercise. Now there is a Curves on just about every corner. And gyms offer nurseries and day care so today’s mothers can work out without worry. Trust me on this. If we could persuade America to buckle up and to stop smoking, we certainly can turn public opinion into public health’s best friend.

We need to do a better job getting out our story. Tell the public about what you are doing to fight obesity, or how state legislators can modernize public health laws, or how you keep a community safe from disease after a hurricane hits, or who ensures that salad bars make you healthier not sicker, or why drinking water in America does not make you sick. Tell them about real people who make all this happen – like the high school kids who are all pumped up about careers in public health.

There is a wonderful program called Young Epidemiology Scholars, or “YES.” We sponsor it with the College Board. This year 650 amazingly talented students competed for college scholarships ranging from $1,000 to $50,000. The winners produced innovative research, like the impact of condom education on high school students, how auto accidents increase in the fall and spring when the time changes, how socio-economic status affects the prevalence of asthma in a Fresno, California, school district. This year’s Young Epidemiology Top Scholar is Jessica Cohen from Roslyn High School on Long Island. She is 17, president of the honor society, and on her way to Columbia University. You cannot beat her attitude. Listen to what she said about YES: “It is very cool. Exactly like Miss America – except for the fact that it is...epidemiology.” Getting enthusiastic new leaders like Jessica Cohen onto public health’s front lines as soon as possible is essential for the public’s future safety.

There is one more thing we can do right now that is just as essential – make the business case for public health, and make it not just to the government, but to the public, the media, and to business itself. Do not forget that nothing serves business better than a healthy workforce in a healthy community. And a healthy community makes for healthy business. For example, we know that nicotine chewing gums, patches, and inhalers can boost successful smoking cessation rates by about 25% – especially when combined with some form of counseling. And we know that employers see financial benefits from employees quitting in as few as two years. I know that this is a hard message to hammer home. But employers and health
plans are finally taking a fresh look at paying for cessation programs. And Medicare now says it will pay for some kinds of counseling. There are other ways to make the business case, like using the same kind of cost-benefit analysis they teach in business school. For instance, we know that health care costs of pediatric HIV infection may run $100,000 or more over a lifetime. But the cost of treating an infected pregnant woman and her baby is only about $1,000. (That, by the way, is a cost-benefit ratio of 1 to 100.) Here is another example. We know that chronic illnesses like diabetes and cancer cause four out of every five deaths and cost some $750 billion a year in health care expenses and lost productivity. But we can prevent much of this with less costly care management at the outset of the disease, plus weight loss and exercise programs.

And start thinking about partnering with business—even if you are skeptical at first. It makes sense. Public health and business each has what the other needs. Business has capital, space and facilities, human resources, all sorts of services—and influence where you might not. You, on the other hand, have expertise, laboratories, access to vaccines, data and research—and connections deep within the community. If business and public health respond separately in a crisis there is chaos. But, as partners, you will reduce risk, better guard your community and its workforce, and keep your families more secure. It is a win-win all around. Seems to me it is about time to take a CEO to lunch. So—where does all this lead us?

This year is the 100th anniversary of Jacobson v. Massachusetts—the Supreme Court case that put the force of law behind protecting the health of the public. Tomorrow you will hear a lot about the case. Take a look at Justice Harlan’s majority decision. He writes about the same “social compact” Americans are still talking about and believing in today. “Organized society,” he wrote, “could not exist without safety to its members.” This is a familiar theme to Americans. We thrive when we live, as others have said, a life of “mutual helpfulness,” so each may “live well” in a society “held together by our need,” a society that never forgets the character of its members.

We are not alone. Out of African tribal folklore comes a parable that teaches the same lessons. Once upon a time there was a community of mice in a certain African village. And in one house a big, mean cat terrorized the mice. The mice, being clever, built a hole through which they could come and go. It was big enough for the mice, and small enough to keep out the cat. And the mice were very pleased with their teamwork and cooperation. But then—at a gathering of the mice—one mouse said, “The cat can still catch us as we enter and leave the hole. Who is going to tie a bell around the cat’s neck to warn us when it is approaching?” No one answered. Everyone was silent. Everyone was afraid. Ladies and gentlemen. The cat’s at the door. Everyone is silent. All are afraid. But not you. You are the brave ones who bell the cat. You are the ones who make sure the rest of us are safe. You are the ones the community praises. For that we thank you. And for that The Robert Wood Johnson Foundation is proud to work with you, to stand with you, to prevail with you, no matter how long it takes or how big and mean the cat may be.
“Working Towards A Better State of Health”

Arkansas Governor Mike Huckabee

If you would have asked me a couple of years ago, if I would be talking about my personal health today, I would have said no. Two years ago, my personal health wasn’t something I had given a lot of priority to. When a doctor told me that I was digging my own grave with a knife and a fork and that without lifestyle changes I would be dead within a decade, he got my undivided attention. He described to me what that decade would be like and quite frankly as he read the script, I didn’t like the way the play was going to end. What really started as a personal journey also meshed into a very important public policy journey. I want to speak to these issues today.

I don’t have to tell any person in this room about the events of September 11, 2001. We all remember where we were and what we were doing. That singular event changed American lives and certainly altered our course in the way we look at ourselves and how we see ourselves as vulnerable. Since that time and over the past four years, our nation has become focused on preventing bioterrorism. We have spent billions of dollars combating the threat of terrorism. And even though we have not seen another widespread act of terrorism comparable to four years ago, we have remained vigilant, we have spent enormous resources combating the potential of terrorism, and rightfully so. I don’t begrudge the expenditure. But that’s not the only terror that Americans face, there is another terror that is already affecting and infecting more Americans than the bioterrorist attacks. This is the terror of bad health. It has been said that when one has his health, he has everything. People would give every dime for their health. Like the suicide bomber who blows himself up, we in America seem to be on a suicide track. Most of the diseases confronting us today are self-inflicted. I was one of those people bent on self destruction, eating southern fried veggies, fried chicken, fried potatoes, fried everything. We no longer face the same threats of infectious diseases but instead, chronic diseases: cancer, heart disease, stroke, etc. If we can find a way to attack these issues, it would not only have a dramatic effect on the lifestyle of Americans, but also have a direct impact on the economy. We all feel the consequences of bad health.

Months after the events of 9/11, we became paranoid. All of us remember the anthrax scare. I was supposed to speak at a red ribbon rally for an anti-drug group with 8,000 students attending. I could not get in because someone in the stands had seen white powder somewhere, called the police and fearing that it might be anthrax, the whole place was quarantined. It was not too many days later that a lady in Franklin County, Arkansas, went to her mailbox to pick up her mail, saw some powder, panicked, sawed off her mailbox and took it the health department and said she had anthrax. The health department dutifully tested her mailbox for anthrax, and it turned out to be simple dust. The thing that struck me in all of that was that there was this panic among people including those in remote places. Why would a widow in Franklin County Arkansas be targeted for a terrorist attack? We are easily persuaded that people can attack us. Why are we not persuaded that the greatest threat to the U.S. today is the lifestyle that we live that causes us not only to be overweight and under-exercised but also causes us chronic diseases? How do we influence policy makers to shift public policy? How do we find a common ground?

Here are two examples of how we can do this. We can begin by defining our political landscape in a new way. In Arkansas, we introduced legislation to launch ARKids First health insurance program which pro-
vides coverage to more than 280,000 Arkansas children over eight years of age whose parents make too much money to qualify for Medicaid but too little to afford private insurance. This program has reduced the number of uninsured children in Arkansas by about 50%. We did this by spending money on prevention. This has been a lifesaver for single mothers.

Additionally, our state legislature also took the money from the Master Tobacco Settlement Agreement and allocated all of it to public health programs. The state’s public health coalition, called the Coalition for Healthy Arkansans Today (CHART), and I placed a proposal for allocating the state’s settlement funds on the November 2000 ballot. It was overwhelmingly approved by the voters; the legislature then passed legislation appropriating tobacco funds for public health programs. Hopefully all the money coming from this settlement will continue going toward public health programs.

With regards to obesity, Arkansas is the first state to require body mass index (BMI) measurements in schools. There was a little controversy over this, but we assured parents that the measurements would be sent to them in the mail confidentially. These measurements are meant to serve as red flags to parents if their children are obese. Parents are supporting the programs, so are pediatricians. Also, both the political community and the Education Commission of the States that I chair have come together to create a comprehensive database that outlines a policy on student health and nutrition. Currently, nine states have restrictions on the sale of competitive foods in the schools, nine states allow for the employment of physical activity and nutrition specialists, and only twelve states have reporting systems for nutrition requirements. Arkansas is part of each of these named states. The reason I am telling you this is because states like ours, small southern rural states, can implement policies that will have an impact upon the children of our state and there is no reason why other states can’t enact these types of legislation. The fact that we have a generation of kids with obesity problems is a true terror to the nation. Fifteen years ago, Arkansas pediatric hospitals had never diagnosed type 2 diabetes among teenagers; today, they see up to ten cases a week. When these kids are thirty, they will have serious health problems.

We have to address this now because it drains on our prosperity. Let me put this in perspective. When I became governor in 1996, our Medicaid budget was $600 million in a state of 2.7 million people. Currently our Medicaid budget is approaching $3 billion, and we are not unique. The Medicaid budget is eclipsing the education budget. We have to do something.

Our next step is to determine our priorities. It is cheaper to prevent illness than cure it. The American health system is directed toward diagnosis and treatment rather than prevention. For example, health insurance covers quadruple bypass surgery but does not cover a 30-minute session with a nutrition counselor. That’s why in Arkansas, we established the Arkansas Diabetes Disease Management Program which has led to significant cost savings related to managing diabetes while improving overall healthcare in Arkansans. In the department of health, for example, employees get points for healthy behavior. They can get up to three days of paid leave for healthy behavior. Examples of healthy behaviors include wearing seat belts and not smoking. We give employees a reason to be healthy and not a reason to be sick.

Not too long ago former president Clinton asked me to join him in an initiative with the American Heart Association. The Clinton Foundation and I have agreed to be involved in an initiative to combat childhood obesity over a period of ten years. One of the things I have realized is that this is an issue that transcends political barriers. It is one of those rare issues that is not polarizing.

In the early 1900’s the public health community of America came together because it saw itself threatened by infectious diseases and it did the things that made a difference, including cleaning the water and sewer systems as well as developing vaccines. We virtually eliminated the threat of infectious diseases. No one here knows of an American who died of smallpox last year. We just don’t die of those things anymore. What we have to do is help America be as afraid of the consequences of overeating and under-exercising and when we get this concern, we will focus policy in that direction and spend some money to make a better impact on public health. I don’t begrudge money spent to protect our borders, to keep our citizens safe, but I will begrudge the fact that after spending all that money, we don’t spend a single dime on prevention or keeping America healthy. We need to redefine our priorities and focus on prevention.
The Commission of the European Union is the executive body of the European Union, with sole right of initiative in policy development and in drafting legislation for presentation to the European Parliament and the Council of Ministers, which are the lawmaking institutions. During the formation of the new Commission in the summer of 1999, a new Department or Directorate General of Health and Consumer Protection was formed. In addition to health and consumer protection, the Directorate General (DG) was also given responsibility over food safety. Various competences were drawn from other DGs, most notably food processing from DG Enterprise and plant and animal health from DG Agriculture. Transferring these competences away from producer interests to health and consumer interests sent a strong message to the European public during a time when it was coming to terms with the health consequences of various food safety.

The promotion of health and the prevention of disease are good ends in themselves. They are a public good that citizens expect governments to pursue as a priority, second only to public security. Any failure in this public duty will have perilous consequences for politicians. However, measures to promote health and to prevent disease also greatly assist in the creation of another public benefit, the creation of wealth. For instance, it has been estimated that a 10% increase in life expectancy can lead to a 0.35% growth in GDP. Even in the enlarged EU, a life expectancy gap of 13 years exists between some member states. For example, life expectancy at birth for a male in Sweden is 77.4 years and in Latvia it is 64.8 years. This is not just a European phenomenon. Professor Jeffrey Sach’s work for the World Health Organization’s (WHO) Commission on Macroeconomics and Health confirmed that increasing life expectancy increases economic growth rate. He also revealed that as much as half of the growth differential between rich and poor countries is due to ill health and demography.

So how does investing in health and healthcare help economic performance? As an example, the case of Severe Acute Respiratory Syndrome (SARS) has conclusively demonstrated the economic value of effective public health measures. The economic costs of pandemics are measured not in millions, but in percentages of GDP. In addition, the indirect costs of ill health, such as reduced productivity, are very high. One recent study has calculated the lifetime cost of cardiovascular disease in Germany. Direct healthcare costs are estimated at $25 billion; indirect costs in productivity are nearly double, at $48 billion. And this is just the projected cost of one largely avoidable condition. Looking to the U.S., we can see the approaching tide of ill health in a country half the size of the enlarged EU. One study estimates that the direct and indirect costs of obesity, diabetes, and tobacco each top the $100 billion mark annually. According to another survey, mental ill health already accounts for 2.5% of GNP in the U.S.

If ill health continues to affect economic prosperity on this scale, then improving the population’s health must be an economic priority. The health of the population will continue to set the economy’s metabolic rate. Wise investment in health, as in education or infrastructure, is an investment in the productive capacity of the economy. Clearly, the issue of effective investment in health systems preoccupies our governments. But in a world of brilliant technological innovations and rising treatment costs, greater efforts are needed to reduce the avoidable disease burden. Effective prevention and promotion can ease the pres-
sure on treatment. The challenge is to separate out genuine, self-financing investment in health from the escalating current expenditure, which needs to be carefully managed if a good social model is to remain sustainable. By this device, we can confront the policies that often sees health in a negative view: health as an overhead; health as a drain on public finances; health always calculated as a cost, never as a benefit; health as a current expenditure, never as a long-term human capital investment.

These points must be advocated for the benefit of public opinion, policy development, and lawmaking in public health. This may lead to the encouragement of politicians to make laws for the protection of public health even where they may cause restrictions on personal liberty, such as smoking in public places. Although politicians sometimes back away from such measures because of concerns of being accused of promoting the “nanny” society, the encouragement given to a politician by a positive climate of public opinion does wonders for his courage. However, whatever the size of such self-financing investment, it must be carefully targeted, with input from scientists and health economists.

What is the role of the lawmaker in public health? Much of lawmaking in public health comes about following risk analysis. Risk analysis is divided into risk assessment, a scientific exercise, followed by risk management, essentially the role of the lawmaker. The lawmaker is not bound to slavishly follow the risk assessment; the lawmaker, often an elected politician, is entitled to take all relevant factors into account, which may result in fine tuning of the scientific advice. Relevant considerations are proportionate response to risk and sometimes economic impact assessments. However, if legislation is deemed necessary, it should comprehensively deal with the perceived risk and adequately protect the public. But lawmaking is not confined to substantive health policy issues. Institutions must be established, such as the European Food Safety Authority and the European Center for Disease Control, and procedures must be put in place, such as effective rapid alert networks for communicable diseases and food safety.

Lawmaking in public health is a sensitive and sometimes controversial task. There is very little scope for laws addressing the determinants of health, such as personal behavior and lifestyles, which influence people’s health, because of the personal liberty issues involved. The obvious exception is tobacco control. In the EU, legislation was brought forward banning the cross-border advertising of tobacco products. This builds on an existing ban on advertising tobacco products on radio and television by extending it to news-papers and magazines. The legislation also bans sponsorship of sports by tobacco companies, including Formula One motor racing since July 2005. This is a significant victory for public health. The adoption of the bans in 2003 also created a good environment for the negotiations of the Framework Convention of Tobacco Control sponsored by the WHO, which is now law, having been ratified by more than the required 40 Member States.

In many countries of the world, attempts are being made to address the obesity debate by law. However, in most cases there is scope for laws requiring clear labeling on foods, informing consumers of the presence and quantities of ingredients such as salt, fats, and sugars. More controversially, the EU is now attempting to prohibit the making of health or nutritional claims on foods which have inappropriate nutrition profiles. The EU Parliament and the member states are in fundamental disagreement on this issue, and the debate is likely to continue for some time as the law passes through Parliament and the Council of Ministers.

The more the world economic order globalizes, the more we need a world legal order in certain areas. The increase in trade, particularly in food and travel, requires global health responses. World trade has its own legal order, however imperfect, contained in the rules of the World Trade Organization (WTO). Until the adoption of the International Health Regulations (IHR) in May 2005, global governance in health was based on unilateral laws imposed by countries exercising their sovereign rights in respect of their own territories. The SARS epidemic of 2003 showed how this approach was entirely inadequate. In May of 2003, this prompted the WHO’s World Health Assembly to mandate the Secretariat of the WHO to speed the drafting of a revised IHR. Now, the adoption of the IHR by the World Health Assembly marks significant progress in providing a harmonized, global approach to global communicable diseases.

The overall objective of the IHR was to provide for surveillance, transparency, and rapid response, the three fundamental elements required in battling an outbreak of communicable disease. In summary, the IHR requires the 192 members of the WHO to engage in capacity building to respond promptly to a public health emergency of international concern. It establishes a requirement to notify the WHO of a public health emergency of international concern and in Annex II sets out an algorithm for the circumstances and manner in which such a notification should take place. An important provision of the convention is that the WHO can request a member state to provide verification of a public health emergency of interna-
tional concern where the WHO suspects that such a situation exists. The WHO is required to offer collaboration to deal with such an emergency. In the event of failure or refusal of collaboration, and when justified by the magnitude of the public health risk, the WHO is empowered to make all relevant information available to member states and ultimately to the public. The consequences are obvious to both travel and trade, especially in food. States will exercise their sovereign powers to take such measures as they deem appropriate in those circumstances.

The core fundamental power of the IHR is that it brings forward the requirement for surveillance, capacity building, and transparency leading to speed of response. These rules were needed to bring clarity, transparency, and certainty to the situation. In the future, this will substantially reduce the risk of countries failing to disclose, for instance, the existence of SARS or avian influenza. Also, it addresses the concern expressed by a number of countries that the WHO, in issuing the travel advisories in 2003, acted on a doubtful legal base. With the IHR now in place, no doubts arise in relation to the issue of the WHO’s powers.

The most difficult points to resolve in the IHR process touched on issues of sovereignty. Some member states, both developing and developed countries, were overly protective from a sense of national pride. Others were reluctant to share valuable information on grounds of national security. Indeed, during one plenary session, a senior official stated that for him, sovereignty was more important than health. Some states were also reluctant to allow the WHO to act on third-party information, particularly where the informant’s identity remained confidential. However, this critically important provision included in the IHR has remained in place unamended.

Additional observations from the WHO’s development of the IHR include how limited the WHO Secretariat’s power is over member states and that the world is not prepared for a flu pandemic. More financial support is needed. Public health, even in developed countries, does not receive sufficient and proper funding. As a consequence, not enough attention is given to preparedness planning: the manufacture of vaccines and antivirals, stockpiling, and the role of the WHO in planning and management. For instance, during a recent outbreak of avian influenza in Southeast Asia, the need for poultry culling raised questions of compensation to those who own the animals to ensure that they will not hide the existence of the disease, thereby creating further risks for the community. In September, the EU announced the provision of funds to help address this problem.

Probably the most controversial issues surrounding the global governance of public health relate to trade in food and food safety. The role of the WTO in this area is much further developed than the role of the WHO in the general public health area. This is a matter of some concern as the role of the WHO is crucial. However, the Sanitary and Phytosanitary Standards (SPS) agreement provides clear rules relating to trade in food with health protection built into the agreement, allowing for the refusal of importation of food on the grounds of public health concerns. The Codex Alimentarius is the forum for rule making in this area at the WTO and the WTO also provides a dispute resolution mechanism. Much of the controversy on food safety is directed against the European Union – and principally by the U.S. One only has to think of issues such as hormones in beef, genetically modified food and feed, not to mention the precautionary principle. Much of this criticism is unfair and fails to acknowledge that substantial progress has been made in recent years. It also fails to recognize that the EU has its own complaints against the U.S. Indeed, the U.S. operates on the precautionary principle itself, although it is described as the ‘precautionary approach’. However, the important issue is not the existence of trade disputes. The real issue is whether public health is really compromised and therefore what steps should be taken for protection.

More law making is required in this area. For some years a veterinary equivalence agreement has been in place between the US and the EU, but it has not worked well in the past. Recent proposals are likely to create improvements. The purpose of the agreement is to allow the inspectors from one jurisdiction to authorize veterinary procedures in the other jurisdiction where the procedures, although not the same, are equivalent. Inspectors have proved reluctant in the past to exercise the necessary discretion to authorize equivalence; they tend to look for the same. One new proposal to resolve these problems is an exchange of inspectors so that each can become more familiar with the other’s procedures. The current climate is now ripe for these developments. For instance, in the US there is a degree of increasing convergence with Europe, albeit coming from a different political direction of the threat of bioterrorism. US systems for registration of exporters and the prior notification of imports are motivated by a desire to protect American citizens from the threat of deliberately contaminated food and food products. There is a marked similarity to the European system in this regard.

There is also much scope for further harmonization of rules in the Codex Alimentarius. For example, two years ago the establishment of a harmonized approach
in the operation of the much misunderstood precautionary principle was proposed. There is a legitimate place for the operation of the precautionary principle, or as US officials prefer to call it the precautionary approach, although in effect there is not much difference in the minds of officials on both sides of the Atlantic on how it should operate. One further rule harmonizing effect is provided by the opinions of the dispute resolution panels of the WTO. Soon, a WTO panel will give its opinion on the genetically modified food dispute, and a separate panel will offer its opinion on the EU legislation banning the importation of beef containing hormones. The WTO dispute resolution panels have an important contribution to make in determining the role of public health in the international trade in food. This serves as yet another example of the law assisting the protection of public health; however, in this case it is not so much the law makers but those who interpret the law, the lawyers, arbitrators, and judges, who make their valuable contribution. However, those engaged in dispute resolution realize that it is not the most ideal way of making law, and some effort should be made to establish a more coherent approach to law making where health is concerned.

A greater collaboration between the WHO and the WTO should be an essential feature of public health and trade. A suggestion was made elsewhere during this conference that a committee of public health be attached to the WTO. This would create certainty in how the system operates and reduce the number of trade disputes that are referred to the dispute resolution panel of the WTO. As currently structured, the dispute resolution mechanism of the WTO might not be adequate to resolve these kinds of complex disputes. If, for example, the WTO panel were to decide that the EU is not entitled to label genetically modified food, there would be a very strong reaction from European consumers to that issue. Issues of that magnitude should not be dealt with in a dispute resolution mechanism. Rather, the European public's genuinely held concerns, which are not inspired by trade protectionism, regarding genetically modified food must be taken into account. Rather than banning genetically modified food and feed entirely, EU legislation authorizes importation but requires proper labeling so people can make their own choices.

The public's perception of risk is important and any failure to heed it can have serious consequences for politicians when they fail to protect public health. In the autumn of 2000 the second outbreak of bovine spongiform encephalitis (BSE) occurred in Europe. At that time, the EU's Scientific Committee had conducted a geographic risk analysis scientifically predicting findings of the disease in a number of Member States and other countries including the U.S., Canada, and Japan. This resulted in a huge political reaction against those findings. In Germany, the Minister for Agriculture publicly stated that there was no BSE in Germany. Within a matter of weeks, Germany found its first case. When, in addition, it became clear that a number of Member States, including Germany, had previously opposed a Commission proposal to ban meat and bone meal in animal feed (the cause of the spread of the disease), the Minister was required to resign. The Minister for Health's resignation followed. This resulted in the consumption of beef in Germany falling to nearly zero.

At the same time, the incidence of BSE in the UK was running at the rate of about 1,500 per week, but the trend was downwards. Consumer confidence and the consumption of beef in the UK were rising. How was it that 1,500 cases of BSE per week in the UK was creating a situation of rising consumer confidence, whereas just a handful of cases in Germany resulted in a catastrophically negative consumer reaction and in a complete absence of demand for beef? The conclusion was that in the UK, people believed that the scientists had identified the cause of the problem, which was the spread of the disease by the feeding of meat and bone meal. They realized that laws had been put in place to ban the feeding of meat and bone meal to the cattle, and that as a consequence the incidence of the disease was reducing week by week. In order to enhance consumer confidence in public authorities, consumers must be convinced that there is somebody or some entity in charge, that there is a plan and the plan is demonstrably working. If extrapolated across the board to other areas of public health, it is possible to build consumer confidence and to persuade the public that you are operating in a transparent manner.

So what recommendations can be made for the improvement of public health? Research is of critical importance in the area of protection of public health. For example, a company in Europe has developed the mechanisms to be able to answer whether SARS is present on an airplane. Another company has developed the technology to test a small sample of food to detect exactly which pathogens are present by breaking down the molecular structure and testing the DNA. The European Space Agency can monitor the flight of birds to give advice to those who are charged with determining where vaccinations should take place after an outbreak of avian influenza. Experts can now detect where the bird flight has gone and decide that, if there are limited resources to be applied in these circumstances, vaccinations should be applied in specific areas. These are examples of what research
can contribute to public health. Often, research is associated more with health care than with public health, but the issue should remain at the top of the agenda for public health.

The powers of international institutions such as the WHO should be reinforced, or at least these institutions should be encouraged to exercise what powers they have and extend areas of competence to their very limits. There should be more investment in public health. There should be fundamental respect for scientific risk assessment, and it should be followed in all respects. Countries should be more prepared to cede sovereignty or to pool sovereignty to enable something to be done for the benefit of all. The concept of transparency is also of fundamental importance. If citizens believe that something is going on that they have not been told about, it can destroy citizens’ confidence in institutions and this confidence can be extremely difficult to regain. So even at the risk of causing a difficulty at a political level, the disclosure of public health risks and concerns is something that should be done in a transparent manner, creating a climate where citizens feel that there is somebody in charge, that there is a plan, the plan is hoped to work and there are signs that it probably will. Those charged with working the system should faithfully operate the rules and remember that the International Health Regulations allow for confidential reporting of public health emergencies of international concern to the WHO to enable an investigation to be undertaken by the authorities there for the benefit of public health. The people have placed their trust for the protection of their health in the hands of politicians; the health of our politics will be judged by the politics of health.
2005 was the centennial of the U.S. Supreme Court’s 1905 seminal ruling, in *Jacobson v. Massachusetts*, that spoke to the balance between individual rights and protection of the community from infectious diseases and other serious health threats. The 2005 annual public health law conference featured a special plenary program that examined the government’s authority to protect and promote the public’s health as discussed in that decision, through an exploration of the scope and limits of the state’s public health powers, including vaccination.

The program had three parts:

• First, Wendy E. Parmet, JD, Professor of Law at the Northeastern University School of Law, described the historical context for the ruling and the facts of the case (which involved a citizen’s refusal to comply with state-mandated smallpox vaccination), reviewed the principal elements of the ruling, and commented on the enduring importance the ruling has had for law as a public health tool.

• Professor Parmet’s presentation was followed by two intentionally divergent commentaries on the *Jacobson* ruling, one from the point of view of Rev. Henning Jacobson, who objected to compulsory vaccination, and the other from the point of view of the state of Massachusetts. The former was presented by Charity Scott, JD, Professor of Law at Georgia State University, and the latter by James G. Hodge, Jr., JD, LLM, Associate Professor at the Johns Hopkins University School of Public Health and Executive Director of the Center for Law and the Public’s Health.

• Finally, a panel discussed the *Jacobson* ruling and its contemporary implications from three differing perspectives: David E. Nahmias, JD, U.S. Attorney for the Northern District of Georgia; Alfred DeMaria, Jr., MD, State Epidemiologist for the Massachusetts Department of Public Health; and Clifford Rees, JD, former legal counsel to the New Mexico Department of Public Health and, at the time of the session, legal counsel to the New Mexico Department of Finance and Administration.

• The session moderator was Richard A. Goodman, MD, JD, MPH, Co-Director of the CDC Public Health Law Program.

This program was rich and illuminating, reflecting the faculty members’ diverse professional experiences in public health and law, and illuminated the broad tensions that exist between government powers and individual rights as well as specific aspects of that relationship in the context of public health practice and policy.

The entire *Jacobson v. Massachusetts* program was recorded and translated into an enduring educational resource for use in schools of public health and law, and for all who are interested in understanding the significance of the case for public health, both in 1905 and today as well. The CD-ROM “*Jacobson v. Massachusetts* and Public Health Law: Perspectives in 2005” comprises the following suite of materials:

• The recorded, 90-minute program of June 14, 2006, including the full presentations of all six faculty members, with slide presentations by Professors Parmet, Scott, and Hodge.
The “Jacobson v. Massachusetts and Public Health Law: Perspectives in 2005” materials may be downloaded without charge from the CDC’s Public Health Law Program (www.cdc.gov/phlp) and also may be requested on CD-ROM from the Public Health Foundation (www.phf.org) for a nominal fee. All materials are in the public domain. This educational resource was created by a team with members from the CDC Public Health Law Program; the Office of Applied Public Health at the Rollins School of Public Health, Emory University; and the Northeastern University School of Law.

Rather than duplicate the extensive contents of the CD-ROM here, this section of THE PROCEEDINGS presents: a) a synopsis of Professor Parmet’s presentation in which she painted the social and public health context of the Supreme Court’s ruling and summarized the principal elements of the ruling; b) brief summaries of the presentations by other members of the session faculty. The reader is urged to access the “Jacobson v. Massachusetts and Public Health Law: Perspectives in 2005” materials as noted above to learn from the full range of perspectives and insights contributed by the program’s distinguished faculty.

“Jacobson v. Massachusetts and the Maturation of Public Health Law”
Wendy E. Parmet, JD, Professor of Law, Northeastern University School of Law

Historical Context
In 1721, Dr. Zabdiel Boylston, of Boston, Massachusetts, became the first North American physician to administer smallpox variolation, an early practice that entailed significant risks for the recipient and his or her contacts. Dr. Boylston was a Puritan minister who learned the practice from London medical publications. The more effective and safer practice of smallpox vaccination superseded variolation and was widely adopted by the mid-1800’s. In 1950, Massachusetts became the first state to require smallpox vaccination as a condition of admission to school. Both practices initially met with considerable opposition from the medical and clerical communities, followed by growing acceptance—especially as government developed a regulatory regime to address safety concerns—and ultimately by free public clinics.

The Return of Smallpox
Boston and its surrounding towns (including Cambridge) in 1901 were in the center of what has been called “the golden age” of public health. This also was a time of great social change and turmoil as immigration increased and industrialization advanced across the country. The nation was in the midst of intense social, religious, and political changes.

In this protean setting, smallpox—which had waxed and waned over the history of the new Republic—made a new and deeply disturbing reentry. One of the most feared of all diseases, smallpox over the centuries had killed untold millions across the world. Although outbreaks had been contained for the preceding 30 years, the number of smallpox cases began to rise in the Boston area in the late 1890’s and the first years of the new century.

By 1902, smallpox had caused nearly 300 deaths in Massachusetts. Health officials’ concern escalated to the extent that the Boston city board of health dispatched teams of physicians and police officer to administer vaccinations, by force if necessary, and concentrated their attention on neighborhoods populated by recent immigrants and ethnic minorities.

The Cambridge, Massachusetts board of health adopted an ordinance requiring all residents to be vaccinated or to pay a fine of $5. At least four residents resisted the Cambridge ordinance, including a city clerk, a water department worker, and the Reverend Henning Jacobson, a Swedish-born immigrant. While his concerns are not available in the historical record, Rev. Jacobson was known to have reported negative experiences when vaccinated as a young man.

Court Rulings
The four Cambridge resisters were tried and convicted by a lower court in 1902. They appealed to the Superior Court and were convicted again. Two then appealed to the state’s highest court but with the same result. Rev. Jacobson alone appealed to the U.S. Supreme Court in 1904, hinging his case on 14th Amendment guarantees of due process protections and limits on the power of the state.

Seven of the nine U.S. Supreme Court justices ruled to uphold the state’s constitutional authority to mandate smallpox vaccination in this case.

Key Holdings of the Jacobson Decision
The Supreme Court’s ruling had four main parts, as follow:
PLENARY SESSIONS

- The Police Powers – The Court upheld the 14th Amendment limits on the police powers of the state and the authority of the federal courts to review exercise of those powers.
- Balance – The Court viewed individual liberties as emanating from a civil society and held that individuals may exercise their liberties only within the laws that protect the common good. This interpretation of liberty paved the way for later rulings on the constitutional right to privacy.
- Deference to the Legislature – The Court accepted that the “common good” applies to the right of society to protect itself from epidemics and that legislative bodies have authority to choose the means toward that end. Deference to the state (in this case, the Cambridge board of health) was upheld on the ground that the state could demonstrate a reason for its choice of vaccination as the means. The Court recognized, however, that deference to the state could be misplaced, for example, if the medical intervention were cruel or inhuman.
- Constitutional Limits – The Court articulated four standards for legitimate exercise of the police power for public health purposes:
  - Necessity: The public health measures must be necessary to address the identified health threat.
  - Reasonable Means: Moreover, the measures taken must have a reasonable relationship to the goal.
  - Proportionality: The burden the public health measures impose must not exceed, in some reasonable calculus, the benefits they bring.
  - Harm Avoidance: The public health measure should not cause harm to those subjected to it.

Conclusions
The Court’s ruling in Jacobson established foundational public health law and also contributed in important ways to the interpretation and application of constitutional law. Lessons we can learn from the case are that:

- Those who resist deserve public health’s respect. Cambridge public health officials appear to have downplayed adverse effects of smallpox vaccination and to have neglected to engage public opinion, forfeiting the public’s trust and fueling reaction.
- The Constitution and public health laws provide a framework not only for public health interventions but also for productive, social debate.

Panel Commentary
“Jacobson v. Massachusetts: Alternate Perspectives in 2005”
Charity Scott, James Hodge Jr., David E. Nahmias, Alfred DeMaria, Jr., Clifford Rees, and Richard A. Goodman (Moderator)
Charity Scott, JD, Professor of Law, Georgia State University School of Law
Speaking from the perspective of the Rev. Henning Jacobson and the rights of the individual, Professor Scott highlighted the balance between individual liberties and civil rights and state police powers. She described instances in which individual liberties have been compromised for the needs of the many, striking an unequal balance. The lessons learned were analyzed and probed in the context of their legacy.

James Hodge Jr., JD, LLM, Associate Professor, Johns Hopkins Bloomberg School of Public Health, and Executive Director, Center for Law & the Public’s Health
Professor Hodge spoke from the point of view of the attorneys who represented Massachusetts before the U.S. Supreme Court. He noted that the state viewed the case as a “must win” because its outcome was central to the state’s ability to protect the health of its citizens. The state argued that public health practice makes an essential contribution to the citizens of the state and that it is the role and obligation of the state to do what no single person can do to protect the community’s health. The state hinged its argument on the proposition that state powers and individual rights are mutually supportive.

David E. Nahmias, JD, U.S. Attorney for the Northern District of Georgia
In his comments, Mr. Nahmias brought to bear the perspective of a trial lawyer and a U.S. Attorney whose office would defend government actions during a public health crisis. He concluded that the applicability to modern settings of the century-old Jacobson ruling remains an open question. The Supreme Court has relied on Jacobson and other rulings of that era but
the law has evolved in significant ways as more recent cases are establishing new legal grounds. Judges and attorneys who may not be aware of the prevailing public health laws and relevant doctrines need new tools—such as public health law bench books and manuals—to represent their clients effectively and, with respect to judges, to be adequately informed about the legal powers of public health officials at all levels of government.

Alfred DeMaria, Jr., MD, State Epidemiologist, Massachusetts Department of Health

Dr. DeMaria is a senior public health official for the state of Massachusetts, the same state that in the late 1800’s authorized local boards of health to compel smallpox vaccination, leading ultimately to the Jacobson ruling. Dr. DeMaria described the dynamic tension that surrounds attempts to practice public health in a way that is respectful of individual liberties but also is rooted in the science of epidemiology and in calculations of the potentially vast human costs associated with disease epidemics.

Clifford Rees, JD, General Counsel, New Mexico Department of Finance and Administration, and former legal counsel to the New Mexico Department of Public Health

In his comments, Mr. Rees offered the perspective of a practicing public attorney in a state health department dealing with day-to-day applications of public health law. He observed that he had not studied Jacobson in law school or in a professional setting but that it was directly relevant to his practice in public health law. Mr. Rees noted that public health officials face a broader spectrum of relevant legal issues today than their counterparts did a century earlier. These encompass religious beliefs, the concept of medical necessity, and a host of additional legal issues.

Domestic Violence in the Adult Years

John C. Nelson, Ronald B. Adrine, Elaine Alpert, Sara Buel, and Corinne Graffunder (Moderator)

Corinne Graffunder

For a significant portion of our country’s history, domestic violence was treated as a private issue and interventions, particularly legal interventions, were seen as intrusive and inappropriate. Due to the vigilance and determination of hundreds of victims, public health and health care professionals, advocates, and lawyers, dramatic changes have occurred in the public response to domestic violence over the last few decades.

One of the most prominent of these legal changes occurred when Congress passed and President Clinton signed, the landmark Violence Against Women Act (VAWA) of 1994 to enhance the ability of states and territories to address violence against women. States have responded by passing mandatory arrest laws, providing increased funding for victim services, and creating special domestic violence prosecution and police units. Research shows, however, that these efforts are uneven across the states and that implementation varies significantly from jurisdiction to jurisdiction. Laws protecting victims and holding offenders accountable differ, limited numbers of criminal justice personnel are trained to enforce them, and relatively few communities have embraced and implemented the important concept of a coordinated response to reduce domestic violence.

The Centers for Disease Control and Prevention (CDC) estimates there are nearly 2 million injuries and 1,300 deaths attributed to intimate partner violence in the United States each year. As communities and states struggle with this epidemic, many are discovering that domestic violence is a cross-cutting public health problem that requires multidisciplinary, community-wide prevention efforts and responses.

This session explores the strengths and challenges of current legal responses to domestic violence and describes efforts underway to link multidisciplinary professionals and services through the development of community coordinated response systems (CCRs).

John C. Nelson

Physicians would like to discuss a few key ideas related to domestic violence. Violence in adulthood is often learned in youth; therefore, we believe a family lifestyle approach to this topic is necessary. Domestic violence should be examined throughout the entire life cycle of people: children, adolescents, and adults.

We also believe that physicians are in a unique position to identify domestic violence by taking advantage, in the appropriate sense of the word, of the patient/physician relationship. Physicians are on the front line and they are the key to both the prevention of and response to domestic violence. Multiple studies have shown that a female victim of violence would rather share information about a violence situation with her physician than with any other person. A patient’s history is 85% of his or her diagnosis. If a physician does not create and maintain an environment that allows a patient to share information, that physician is most likely missing an important diagnosis. And if a physician does not think of the diagnosis, the physician cannot make the diagnosis.

Physician education, public health activism, and state and federal legislative advocacy are three solu-
tions to help physicians who are on the front lines. In order to improve physician education, the American Medical Association (AMA) developed the Roadmap for Clinical Practice on Intimate Partner Violence in 2002. This guide has received positive feedback. Furthermore, the Journal of the American Medical Association (JAMA) has provided hundreds of violence studies since 1962. However, more research is needed particularly related to the life-cycle of violence; sub-cultural and cross-cultural influences; and the legal and social impact of various physician interventions. Moreover, taking a course related to domestic violence does not equate to competency just as taking a course in ethics does not make one ethical. Educators need proven experience, training, and testing methods related to domestic violence as part of their traditional curriculum. An example is the University of Virginia’s Medical Student Section chapter entitled, “How to Help a Sexual Assault Survivor: What Physicians and Medical Students Can Do.” We need to know what doctors know. As clinicians we know that if a patient who is pregnant comes into an office late in pregnancy with no previous prenatal care, that this situation should raise a red flag. In addition, patient appointment cancellations by someone other than that patient, bruises in unusual places, and various stages of healing should also raise red flags. Physicians need to be trained to be observant and to look for these diagnoses.

There is hope in public health activism. We know that a woman is beaten, raped, or mugged every five seconds, and we know that we can do better than that. We also know that alcohol contributes to domestic violence about 25% of the time. Often, alcohol advertisements target youth who are more likely to become violent at earlier ages when they drink. In response, the AMA supports the Stop America’s Violence Everywhere (SAVE) campaign to help prevent violence at an earlier age. Additionally, through legislative advocacy, the AMA aims to keep violent activities away from youth who spend twice as much time in front of the television than they do in the classroom. The Family Movie Violence Act of 2004 and other initiatives, such as V-Chips, DVD filters, restrictions on violence “role-modeling” in video games, and the Safe and Drug Free Schools and Communities Act of 2002 are examples of our prevention efforts through legislative advocacy. Lastly, the AMA was also among the first to support the Violence Against Women Act and will continue to vote for funding for this program. Despite this advocacy, more qualitative and quantitative research needs to be done with more case studies and proven methodologies to provide greater public awareness. Additionally, better and more physician education opportunities and requirements and a shift in focus from intervention to prevention are needed. Finally, clinicians have the opportunity within the context of the patient/physician relationship, for incredibly intimate information to be shared. As clinicians, we need to be looking for that. The AMA can be part of the solution to help these clinicians understand what is going on through partnerships with other community organizations and leaders. Our patients come to expect us to do that; our profession demands it of us.

Ronald B. Adrine

Many judges are like the proverbial deer in the headlights when given information about domestic violence. It is not something that most judges have been trained to handle. Can one be an activist from the bench without being an advocate? It sounds like a distinction without a difference, but it is entirely possible for a judge to be active on behalf of justice without advocating for any particular individual or cause within the judicial system. Making that distinction is impossible for some judges and very difficult for others. The oath of office requires that we administer justice fairly and impartially without regard to person. Trying to decide how this is accomplished without appearing to be partial is a struggle for most judges.

Violence exists in many interpersonal relationships involving men and women. Consequently, much of the violence that we see is random violence, not the instrumental violence that existing laws were put on the books to address. The domestic violence laws deal with a very specific kind of violence that happens within those interpersonal relationships. Classic domestic violence is employed to obtain other ends not just as an end, in and of itself.

Generally speaking, classic domestic violence is used as a means to control the behavior of the person against whom it is directed, or to control the behavior of some third person who cares about the well being of the victim of the violence. We often find survivors of domestic violence that have a very different idea of what constitutes an appropriate resolution to their situation. Their view often differs radically from the view held by a majority of those of us in the legal and medical professions, who have not experienced what they are going through. Getting into a violent situation or an abusive relationship was, for them, a process; getting out, will be the same. What we want and what survivors want, by way of outcomes, are not necessarily the same.
So, why should judges be concerned? Domestic violence negatively impacts many of society’s worst problems including: homicide, suicide, rape, child abuse, substance abuse, juvenile delinquency, and homelessness. The lowest common denominator to all of these ills is that the individuals that commit these offenses have either witnessed or have been victims of violent interactions in their homes. Therefore, if we can positively impact the incidence of violence that occurs in homes, not only will we impact what our medical professionals see as health care providers, but also what we see as judicial interveners.

So, why should judges in particular be concerned? What is happening out there is negatively impacting judges’ dockets. If we can do something that has a positive impact on domestic violence, it makes our work easier. And, we are in a unique position to accomplish this. When a judge speaks, everyone down in the justice system listens. If a judge treats domestic violence as if it is not criminal activity, then the police, prosecutor, and, in essence, even the advocates will know that bringing a domestic violence case to court is not going to end up with a good result. Hence, the court’s position and the court’s attitude permeate every other aspect of dealing with domestic violence in the judicial system. Ultimately, the question is who controls the proceedings? Is it the domestic violence perpetrator or is it the judge? Have we allowed an unofficial, but highly effective diversion program to come into existence in the court room where we cede control to the abusers? Have we made it possible for the wrongdoers to control the process, simply by continuing to exercise the same control that they have always exercised over their victims?

We need to ask ourselves why did the justice system face such problem when dealing with these issues in the past, and in some instances, why do we still have such a hard time coming to grips with many of the problems presented by domestic violence today?

By focusing on the victim and not the perpetrator, in the past, we gave control to the person who committed the offense. Additionally, in many instances, we tried to imprint our own desired outcomes and attitudes on domestic violence situations. When a victim did not complete the steps we felt were appropriate, we became angry, which resulted in prosecutors, law enforcement officers, and even some advocates viewing victims as “the problem,” when, in essence, the victim was probably in the best position to assess what was necessary to enhance his or her ability to remain safe.

Past justice system efforts, therefore, were frequently ego driven, or all about us and not really about safety or justice. In addition, domestic violence was seen as “just” a justice problem when, in reality, it was and is a societal issue that demands societal solutions. The medical and judicial pieces are only two of many pieces of a much larger puzzle that has to be solved if we are going to do anything to effectively resolve this problem.

We are only now beginning to come to grips with the fact that we all have a role to play, which is the single most important aspect of getting good results. In those communities where the community has come together to form coordinated efforts to deal with domestic violence, we see drastic reductions in the number of domestic violence related homicides that occur. Those communities are thinking creatively in ways that communities failed to consider in the past. They are constructing the connective tissue necessary to bind domestic violence in such a way as to eliminate it as a threat to our general well being.

What, then, is the appropriate role of the court in addressing domestic violence as an issue? Well, we can serve as catalysts. We can be active participants, where we think that it is our appropriate role. And where we do not see active participation as our appropriate role, we can become information resources and take on educating our colleagues and others, as well as the general public about what the courts, prosecutors, police officers, and advocates can do in domestic violence cases, and as importantly, what their limits are.

It is not possible for an individual to be a good judge and remain impartial about justice. Some courts are uncomfortable with this statement, because judges are sworn to be impartial. Some judges fear political repercussions, from, for example, father’s rights groups which see any level of judicial activism in this area of the law as impeding impartibility. Some judges fear that such perceptions of partiality, real, or imagined, could crystallize into real opposition during any bid for re-election. Many feel that they are already overworked and, of course, underpaid. Lastly, some judges dislike the issue and/or the advocates. Courts who find themselves paralyzed in this way fail to realize that the decision not to act is still a decision, and one that can have direct and dire consequences for a community looking to its judiciary for leadership in an area where it has particularized experience, education, and power to bring about change.

So, ethically, what can judges do? We can set the tone and establish consistent evidentiary standards so that prosecutors, law enforcement agents, probation officers, defense attorneys, and even the general community can know what they can expect from the court in domestic violence cases. We can establish clear
expectations of how people will be treated when they come to the courthouse door, because in many instances, the judges do not know what happens to someone before they arrive in, and once they walk out of, the courtroom. Unless you know what is going on, certainly you cannot address it.

We can question inappropriate prosecutions. We can underscore the appropriate message by discussing how seriously we view domestic violence cases. We can ensure fairness for everybody who comes within our ambit; seek enhancements of victim’s safety; and hold everyone convicted of domestic violence fully accountable so that the message goes back into the general community: this type of criminal behavior, as all others, will not be tolerated. The rest of the courthouse needs to make sure that the volume of paper work associated with pursuing domestic violence litigation is not discouraging people from entering the judicial system. We can guarantee that the facilities where we are housed, themselves, are safety conscious so that those who are accused and those alleged to be their victims are separated. We can make sure that our personnel are trained so that they become more considerate and more understanding of the emotionally wrenching and disorienting crisis in which survivors of domestic violence find themselves. We can make interagency referrals and establish protocols as to how that happens and streamline our paper chase. We can research exactly what domestic violence victims are being told by our clerks and how many domestic violence calls in our jurisdictions result in dual arrests. We can arrange for speaking engagements just to talk about what our courts do so that the community becomes more aware of the court’s powers and limitations. We can find out if our orders to remove guns under the federal law or state law are actually being carried out, and we can monitor batters programs within our communities. In Cleveland, a Domestic Violence Coordinating Council began in 1994 and we have attempted to bring all players including defense attorneys together to discuss domestic violence issues. Some of the Council’s accomplishments include the establishment of a domestic violence fatality review and protocols for all of the agencies that interact with the court to make sure that we share information in an effective and efficient way.

Lastly, the judicial oath of office not only anticipates, but also encourages that we be proactive. We have an obligation to do justice, and in order for us to do that, we have to reach out across all lines to identify first responder allies in the community including those within the public and private health care sectors. Victims and survivors are most likely to go to these first contact allies before they come to those of us in the justice system, so by partnering with these allies we can increase, expand, and tailor the provision of service to those people who find themselves caught in the horrific cycle of an abusive relationship.

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**Elaine Alpert**

The connection between health care and the judicial system is critical. Having health care involved is important because we have direct access to survivors. In addition, physicians also understand health and mental health issues and bring respect and intellectual rigor to both public health and advocacy efforts. Health care involvement also strengthens the collaborative community response. Survivors trust their health care providers and both testimonial and research data consistently prove that they do want to be asked about domestic violence. Health care providers play both the private or individual role and the public or advocacy role in the issue. The individual role can be summarized as RADAR, which stands for “R”emember to ask, “A”sk directly, “D”ocument findings, “A”ssess for dangerousness, and “R”eview options and refer as appropriate. In terms of our public or advocacy role, we are respected in the community; valued on the domestic violence/ child protection team; serve as change agents in public health; and are a key link in fostering primary and secondary prevention. The Family Violence Prevention Fund promulgated four guiding principles of intervention: safety for all, survivor autonomy, offender accountability, and changing social and cultural norms. We have to ask if what we are doing, saying, or recommending follows these four principles in order to ensure that the survivor is put in a position where he or she can make better, more informed decisions that relate to his or her life under his or her terms without being blamed. Every time a physician places a domestic violence awareness poster in his or her waiting room, he or she is actually changing the concept of what the health care system does.

The public health approach is prevention-focused, science-based, and advocacy-oriented. In 1958, Sir Geoffrey Vickers stated that, “An issue becomes a public health issue when it transforms from the realm of the given to the realm of the unacceptable.” And really, our consciousness surrounding the issue of domestic violence has transformed from something that just happens to something that is unacceptable. Family violence is an important public health problem, because it is prevalent, disproportionately affects young people, and adversely affects both individuals
and families and communities and society in a similar way. It also costs a lot of money due to lost years of productive life, missed days of work, health care direct costs, and legal costs. Certain types of family violence are more prevalent in the United States than in other places in the world, and family violence is amenable to other public health interventions, particularly those related to education, social norms, legislation, and advocacy. Ultimately, the mark of something being a public health issue is that it is preventable. We can prevent domestic violence, and every day we do not work to prevent it, we are part of the problem. The steps of public health clearly apply to family violence very well as we have (1) worked to define and describe the problem; (2) identified the risk factors for both victims and perpetrators; (3) developed, implemented, and evaluated interventions particularly with the Centers for Disease Control and Prevention (CDC); and finally, (4) disseminated models that work and attempt to understand how we need to readapt these models for different populations.

That said, there are several challenges. First, we need to implement universal inquiry. Every person should be asked about violence in their background as a routine part of medical care and this does not occur due to several reasons. These include time constraints on physicians, reimbursement challenges, the rarity of trauma-informed care which helps develop respect and rapport, privacy and confidentiality issues that allow both parents to view a child’s record, and the United States Preventive Task Force (USPTF) that stated that there is “insufficient evidence” to recommend for or against screening. Other current challenges are related to assessment and intervention: what do we do when a patient discloses; how do we work as an effective team; and how do we connect with a valiant, yet inadequate infrastructure? We need health professions education badly, but scholarly training is nearly non-existent. There are very few education scholars and funding is inadequate to support teaching. Other research is needed centered especially on ethical issues and cultural competency. On the horizon, we need to think of lifespan issues, such as the adult effects of child victimization, inter-generational effects, indirect economic and social effects, and health disparities. We will need to focus on men, not just as victims of adult, elder and childhood physical and sexual abuse, but as allies and partners in prevention. In addition, we need to focus on primary prevention; research on firearms and domestic violence; and additional help for health care providers. Physicians, in particular, need help with expert consultation in practice; guidance and support for personal issues; continuing education; and leadership opportunities. Health care providers can be change agents through local or statewide councils; teaching and training opportunities; research and evaluation opportunities; continuing education; being an expert voice for the media; and volunteering for domestic violence and rape crisis hotlines. In fact, we are now doing work that we never thought possible or even dreamed of before.

Sarah Buel

The medical and the legal roles related to domestic violence are parallel, meaning there is a tremendous opportunity to collaborate such that our expertise informs each other’s practices. At some point, we, as the community, have to be the family for domestic violence victims who often do not have a support system. We must “wrap” victims in the services they need, be they legal, medical, and mental health services including finding affordable child care, decent housing, and employment. This desire to identify effective interventions for abuse victims is relevant for all medical disciplines. Initially, we knew it applied to emergency medicine, but now we realize that orthopedics, pediatrics, psychiatry, and virtually every other field also need to be trained. Likewise, in the legal arena, we originally believed this issue only impacted criminal law, but now we see that it affects most areas of law including family, labor, property, estate planning, and torts. Medical doctors need to conduct universal screening; survivors desperately need to be asked if they have been hit or threatened in an intimate relationship. Otherwise, shame, fear of retaliation, and lack of knowledge about resources will probably keep patients from disclosing. Dr. Richard Jones, an obstetrician/gynecologist and former president of the American College of Obstetrician Gynecologists, found that when he conducted universal screening, he identified several victims per week (vs. per year). The Institute for Safe Families (ISF) provides a guide for universal screening that can be kept with each physician. In fact, it is malpractice not to conduct such screenings. All disciplines including medical, legal, social work, psychology, and mental health, need to be trained to implement universal screening. Given that the Federal Bureau of Investigation tells us that one out of every three women in America will be in a violent relationship in their lifetime; there should not be a lack of education. After asking if the patient is being harmed, the second step is making sure to document the injuries, story, and identification of the abuser. Medical providers should say loud and clear, “You do
not deserve to be abused," since many survivors take on that blame. Safety planning is also a critical aspect of our interventions and its omission is malpractice. This includes providing every patient an adult safety plan and every parent and child a youth safety plan.

Model collaborations between medical and legal fields are important as they recognize that the mutual goal of victim safety can often best be achieved together. There are also benefits to a medical facility having a domestic violence program on site, including improved identification and quality of care; compliance with regulatory standards; and increased patient and purchaser satisfaction. As part of the standard of care of intimate partner violence (IPV) victims, physicians must follow IPV screening and intervention protocols, which includes universal screening and referral. Also, we need to address integration into education through the schools of public health, medicine, and law. The American Medical Association and the American Bar Association have had a wonderful, mutually beneficial partnership for many years. Although medical and legal partnerships are advantageous, in the nine states that require providers to report IPV to authorities, the traditional physician/patient privilege no longer applies. Finally, community education is vital. ISF provides awareness posters with men of all different cultures in response to the fact that most batterers need to hear the message from men. Perpetrators need to get the message that real men do not batter their partners; that men can stop family violence; and that men will be held accountable in their community.

Concurrent Sessions

Alan Hinman
States play an important and historic role in assuring high levels of vaccination coverage either through legislative requirements for immunization policies or by authorizing public health agencies to set such policies. Discussed here are current topics in state immunization legislation including non-medical exemptions and restrictions on the provision of certain vaccines. Additional information includes the potential impact of state legislation and policies on vaccination coverage and other immunization goals as well as examples of roles that immunization programs and partners have played in recent state immunization legislation including effective strategies for communicating with state legislators.

Melinda Wharton
School and day care immunization requirements have been an important factor in the prevention of vaccine-preventable diseases in the United States. The U.S. Supreme Court upheld the school immunization requirements in 1922. Current strategies date back to the measles elimination efforts of the 1970’s. During the 2003-2004 school year, every state required immunizations for diphtheria, tetanus, polio, measles, and rubella; 42 states required varicella vaccine; and seven states required hepatitis A vaccine. The goal is to get children vaccinated on time during the early years when they are most vulnerable; rates of coverage among children 19-35 months of age are lower than for school entry, which during the 2003-2004 school year was 95% or higher for all diseases, except for varicella, which was 93.3%.

All states offer medical exemptions to immunizations for medical contraindications to vaccination. Forty-eight states allow religious exemptions and 18 states allow philosophical exemptions. In many states, more families are requesting religious or philosophical exemptions. One reason for this is the fact that the diseases we are using vaccines to prevent are less prevalent and therefore, parents are less concerned. Another factor is that the immunization schedule has expanded and some of the diseases for which children are now being vaccinated are less familiar to parents. Jennifer Rota (2001) found an inverse correlation between the complexity of the exemption process and the frequency that exemptions were obtained. In addition, recent research (Salmon et al, 2005) looked at the actual enforcement arm and found substantial variability in how these exemptions were implemented in schools. School policies associated with an increase in the frequency of exemptions include an absence of written instructions for completing the school immunization requirements prior to enrollment; administrative procedures are making it easier to claim an exemption; and granting philosophical exemptions. In states in which philosophical exemptions are not available, schools interpret religious exemptions very broadly when families feel strongly.

Researchers at Johns Hopkins University have provided a list of guiding principles for creating a nonmedical vaccination exemption provision, which includes the fact that individual freedom and parental autonomy may be limited when they affect the health of others; imposing vaccination on a significant number of families may create a public backlash that undermines support for any school immunization requirements; and conscientious exemptions from school immunization requirements may help to sustain the local community consensus required for immunization programs (Salmon et al, 2005). Based on these principles, a nonmedical vaccination exemption has been proposed that requires a firmly held, bona fide belief; proof of health department-approved vaccine counseling; signed personal statement by the parent; department discretion to reject based on indi-
vidual and community risk; annual renewal; and ongoing central exemption tracking (Salmon et al, 2005).

The second topic of importance is the issue of thimerosal, a preservative found in vaccines since the 1930’s; early on many childhood vaccines contained 12.5-25 mcg mercury in the form of ethyl mercury. In 1999, the Food and Drug Administration (FDA) reviewed mercury in pharmaceuticals as directed by Congress and calculated that some infants may have received mercury exposure from childhood vaccines in excess of one of three federal standards for methyl mercury (not ethyl mercury, the form in vaccines). As a result, the United States Public Health Service (USPHS) and the American Academy of Pediatrics (AAP) urged that thimerosal be removed from vaccines administered to young infants as rapidly as possible. There was no evidence of harm, but it was feasible to accomplish this task versus the much harder task of removing mercury from the environment. A study by the Centers for Disease Control and Prevention (CDC) in 2003 showed no consistent neurodevelopmental abnormalities associated with thimerosal exposure from vaccines, but additional studies were recommended. Several other epidemiological studies have shown no relationship between thimerosal exposure from vaccines and autism. In May 2004, the Institute of Medicine (IOM) reviewed available studies, both published and unpublished, and concluded that scientific evidence does not support an association between vaccines and autism.

Since 1999, almost all childhood vaccinations have been reformulated so that they no longer contain thimerosal as a preservative. In 2004, the Advisory Committee on Immunization Practices (ACIP) recommended the addition of influenza vaccine to the childhood immunization schedule for use in children 6-23 months of age; most influenza vaccine used in the United States includes thimerosal as a preservative, but limited quantities of thimerosal-free vaccine are available. Individuals are now questioning why thimerosal-containing vaccines are once again being recommended for use in young children. During 2005, at least 20 states had thimerosal legislation introduced. Proposed legislation varied in populations covered, amounts of thimerosal prohibited, vaccines affected, and availability of exemptions due to shortages or public health emergencies. These variations greatly influence the impact of such legislation, if signed into law. Issues for state legislators to face include the difficulty of communication issues; complex science that cannot prove the absence of risk; very intense advocacy; and the reality of many unanswered questions about autism and unmet needs of affected families. New vaccines will present many opportunities and challenges. There is a polarized environment surrounding this issue and it is very difficult to find a middle ground. Advocacy groups are well organized, but there remains a social consensus around the value of immunization. Public health officials must learn to communicate the risks and benefits of vaccination more effectively.

Rick D. Hogan

In the 1850’s, the first compulsory smallpox immunization requirements for school children in the U.S. were mandated by the state of Massachusetts. In 1905, the United States Supreme Court handed down the landmark case of Jacobson v. Commonwealth of Massachusetts,3 which laid out the principle of Federalism that “the safety and the health of the people of Massachusetts are, in the first instance, for that Commonwealth to guard and protect.” Jacobson determined the floor of constitutional protection with four elements, which included public health necessity with a demonstrable health threat; reasonable means with a reasonable intervention to achieve an objective; proportionality involving quarantine versus isolation; and harm avoidance through medical contraindication.

Before 1964, the U.S. Supreme Court stated that children must be properly immunized despite religious objection and in 1964, the Arkansas Supreme Court ruled in Cude v. State4 that children must be properly immunized before entering schools despite the religious objections of a parent. In another case, Wright v. DeWitt School District,5 the Arkansas Supreme Court rejected the clear and present danger argument and basically said that you do not have to wait until someone gets ill. In fact, public health officials should start earlier. According to Arkansas law, no child can be admitted to public or private school unless he or she is age appropriately immunized from a number of diseases, as designated by the State Board of Health. However, Arkansas Acts 244 of 1967 established that this provision, “...shall not apply if the parent or legal guardian of the child object thereto on the grounds that the immunization conflicts with the religious tenets and practices of a recognized church or religious denomination of which the parent or guardian is an adherent or member.”

In 1987, a parent challenged Arkansas’ religious exemption, and in an unpublished opinion, the federal court ruled that the statute was constitutional.6 In response, four plaintiffs, Cynthia Boone (Hepatitis B), Daniel McCarthy (all vaccines), Shannon Law

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(Varicella), and Susan Brock (Hepatitis B), on behalf of their children in three separate lawsuits challenged Arkansas’ immunization statutes. McCarthy stated, “God gave us our immune system and people must not defile the body with immunizations.” Boone believed that vaccinating her daughter against Hepatitis B would encourage her to engage in unprotected sex and intravenous drug use. At this time, the religious exemption required a lot of information to prove that an individual belonged to a recognized religion and that the tenants and practices of that church conflicted with immunizations and it had been determined that a philosophical exemption was not valid. In August of 2002, two judges ruled the religious exemption unconstitutional, but they found compulsory immunizations to be permissible. The federal courts held the religious exemptions unconstitutional stating that it violated the Establishment Clause, the Free Exercise Clause, and the Equal Protection Clause. As a result, Arkansas became one of three states with only a medical exemption to immunization requirements.

In comparing Arkansas to other states, we find that four states require an organized, recognized, or established religion to obtain a religious exemption as just as Arkansas formerly required. Fourteen states require genuinely and sincerely held religious beliefs, and 28 states and Washington D.C. merely require an affidavit or form stating opposition to vaccination based on religious grounds. The Boone and McCarthy cases determined that Arkansas’ religious exemption discriminates against nondenominational, nonsectarian individuals with sincerely held religious beliefs as well as churches and denominations that do not have explicit teachings on immunizations but leave such matters to individual religious conscience. Yet, in Jacobson the limits of individual liberty are defined because the U.S. Constitution does not import an absolute right for each person to be freed from restraint and that there are manifold restraints to which every person is necessarily subject to the common good. Courts now hold that states cannot have an exemption based on church doctrine without exempting those who have individual religious beliefs not based on doctrine. In response, the religious exemption in Arkansas now states that, “The provisions of this section shall not apply if the parents or legal guardians of that child object thereto on the grounds that immunization conflicts with the religious or philosophical beliefs of the parent or guardian.” In states offering both religious and philosophical exemptions, the philosophical exemptions will always exceed the combined medical and religious exemptions. As soon as enacted, Arkansas had 403 philosophical exemptions (52.7% of the total). As of today, this number is 728 (66.5% of the total). The number of exemptions has increased from 651 before the new policy to 1,094 after the policy.

School-aged children usually have the highest attack rates for vaccine preventable diseases and infectious school children are a likely source of secondary infections of susceptible household contacts. The indirect effectiveness of immunization in school populations is both recognized and accepted as the vaccination of large numbers of school children indirectly reduces the transmission of disease from infected person to a susceptible population. Herd immunity occurs when the number of immune individuals is high enough that it becomes unlikely that a susceptible individual will have contact with a contagious individual. Epidemics occur even in immunized populations when clusters of susceptible individuals exist and are exposed to a contagious individual. Thus, a population of school children is less protected from vaccine preventable diseases where a school is characterized by high rates of immunization exemptions. In short, we must ask whether surveillance will indicate a higher incidence of vaccine preventable disease and assuming higher rates, whether we will be able to show this is related to the philosophical exemption.

Patricia Segal-Freeman

Thimerosal is used as a preservative to prevent bacterial growth in multi-dose vaccine vials. It contains ethyl mercury and not methyl mercury; both metabolize differently. Thimerosal is found in other medical products and items, such as nose drops, face creams, and fluorescent light bulbs. Proponents of the ban on thimerosal include the local and national network of parents with autistic children, including political figures such as Rep. Dan Burton and Rep. Dave Weldon; alternative medicine practitioners, such as homeopaths and chiropractors; and persons with personal stories with emotional appeal. In 2004, California and Iowa passed bans on thimerosal not including trace amounts (<1 mcg) or the flu vaccine (IA). This year, bans are proposed in 20 states. There are seven probable defeats and the bans in Missouri and Illinois have passed. The majority of the proposed legislation focuses on early childhood vaccines and allows trace amounts. Proposed federal legislation (HR881) would allow only a trace amount of thimerosal in flu shots for children under three and pregnant women during 2006-2007. Other routinely administered childhood vaccines would be included as of July 1, 2006 and flu shots for children under six and pregnant women
would be added in 2007-2008. All vaccines that contain more than a trace amount would be banned as of January 1, 2009. On March 14, 2005, a mandated message by Congress was referred to the House Subcommittee on Health stating that, “The Centers for Disease Control and Prevention (CDC) should incorporate a recommendation against administering a mercury-containing vaccine to pregnant women into its vaccine promotion messages.”

In 2002, the Minnesota Department of Health (MDH) wrote new school immunization rules that added chickenpox and pneumococcal vaccines to the school immunization law. Vaccine opponents were very vocal and in 2003-2004, the Natural Health Coalition and Vaccine Awareness proposed very prescriptive thimerosal legislation that was opposed by MDH and resulted in drastically modifying the bill. This year, proposed Minnesota legislation banning thimerosal in vaccines was brought forth by Mercury-Free Minnesota and the Minnesota Natural Health Coalition. MDH staff opposed the legislation but publicly stated “serious concerns.” The proposed legislation would require that vaccines administered in Minnesota contain no thimerosal beginning July 1, 2005 unless (1) a mercury-free vaccine is not made or (2) the provider cannot obtain a mercury-free vaccine using reasonable effort. If a mercury-free vaccine is not available, then a vaccine containing trace amounts of mercury as defined by the Federal Drug Administration (FDA) may be used. This proposed legislation would have a great fiscal impact costing the MDH $400,000 and the Department of Health and Human Services $584,000 during the first year alone. This cost was a big hurdle for supporters of the bill given the current budget crisis and as a response, they questioned these figures and MDH’s integrity. After several hearings, the legislation is dead for the 2005 session.

Proponents for a thimerosal ban argue that mercury is a known toxin with signs and symptoms similar to autism; mercury in vaccines causes autism in susceptible children; and the medical and scientific communities have conflicts of interest resulting in a conspiracy theory. They also argue that there is anecdotal and circumstantial evidence and given the current controversy, we should err on the side of caution to protect children. Lastly, they state that other countries are banning thimerosal when this is not the case. They have taken the same stand as the U.S.; it is not a ban.

MDH’s arguments against a thimerosal ban are based on science and policy arguments. We believe that public health policy should be based on well-founded science. Hence, given the current body of scientific evidence, this legislation sends the wrong message. In May 2004, the Institute of Medicine’s (IOM) review of all data found no credible evidence linking thimerosal containing vaccines with autism. Numerous large-scale human studies consistently find no association (including the Denmark, England, and Verstraeten-VSD studies). Furthermore, this ban is unnecessary. Due to the American Academy of Pediatrics and the U.S. Public Health Service recommendation in July 1999, all formulations of vaccines in the U.S. recommended for children six years of age or younger are either preservative free, which allows only a trace amount, or free of thimerosal as a preservative by March 2001.

Other arguments, specifically against the Minnesota ban, included the fragile vaccine supply, high cost, and limited provider choice. In addition, the effective date for these policies is too soon, covering all ages was too broad, there will be resulting lawsuits, and it sends the wrong message that vaccines are not beneficial. Key policy questions to ask during these situations include: Who is the focus; what is the cost; are all vaccines included; are there any exceptions; how do they define thimerosal-free; what is the effective date; and what is the message being sent to parents and the public? Minnesota’s success resulted from having support from the governor, commissioner, and state and local health care professionals. In fact, a letter was signed by every major health organization in the state. Similarly, other success factors included the fact that the proposed legislation was all or nothing; proponents’ arguments were not always credible; and the policy had a significant fiscal impact.

9. Silverman, 12 Annals Health L.277 @ 284.
Preventing Sexual Exploitation of Children and Teens

Anthony Iton, Mary Margaret Oliver, Kirk Torgensen, and Stephanie Bailey (Moderator)

Stephanie Bailey
Sexual exploitation of children and teens is a form of abuse whereby perpetrators prey on victims through prostitution, internet predation, and illegal trafficking. Exploitation of children includes prostitution with active pimping, gang, and drug related victimization. Sexual exploitation of young people is both a public health and law enforcement problem.

Strategies to combine resources from law enforcement, public health, and other private and public sector organizations to prevent sexual exploitation of teens are underway and provide a solution to a pressing problem.

Anthony Iton
Sexual exploitation of children and teens is more than just a crime. It is a problem that involves law enforcement, social services organizations, health organizations, and advocacy groups. Originally convened in 2002, the Minors in Prostitution Task Force of Alameda County in Oakland, California focuses mainly on commercial sexual exploitation organized by pimps. Faced with increasingly alarming numbers of sexually exploited youth, the task force implemented a multi-pronged approach utilizing county, city, and community partners to identify key risk factors that may put victims at risk and to reduce such risks.

Frequently, children who have been exposed to sexual abuse or children who have witnessed domestic violence situations in their surroundings become involved in juvenile prostitution. Similarly, a teen runaways, some of whom may not have had supportive home environment, often become involved in juvenile prostitution. Indeed, according to United Nations estimates, there are 300,000 sexually exploited children and youth each year.

By providing community education and utilizing community centered efforts through advocacy groups and choosing to address the problem across all sectors, the task force, comprised of public health officials as well as law enforcement representatives, has made success of getting runaways from the streets into suitable shelters and providing re-education efforts to prevent further exploitation of children.

Mary Margaret Oliver
Sexual exploitation of children is a hidden form of child abuse and thus must be prosecuted vigorously. Prior to 2001, pimping was prosecuted as a misdemeanor in the city of Atlanta. Due to difficulties in gathering concrete data, prostitution was historically viewed as a nuisance or status offense crime. The then Georgia state statutes did not differentiate between adults and minor prostitutes.

Faced with the issue of children being exploited, an approach to targeting pimps was carried out. This required a coordinated strategy involving the Fulton County Juvenile Court, U.S. Attorney’s office, media, and state and local entities to provide an on-going map of the child sex trade in Atlanta.

To address this issue, the Georgia general assembly amended the law to make pimping of minors a felony offense. Furthermore, the Fulton County juvenile court system utilized public, law enforcement, and private resources to counsel runaways who make up a large majority of child prostitutes in Atlanta. The U.S. Attorney’s office for the Northern District of Georgia
prosecuted 13 pimps under a variety of federal 
Racketeer Influenced and Corrupt Organizations
(RICO) Act of 1970 statutes. This was the first time
that the U.S. Attorney’s office had used the RICO
statutes to impose federal sentences for the crime of
pimping. Moreover, increased local media attention to
the plight of runaway children attracted national
attention and aided in law enforcement and preven-
tion efforts.

Recognizing that delinquents were frequently
released from custody only to return to the streets, a
local project called Angela’s House\(^2\) was developed to
treat minor girls and to provide a normalized environ-
ment for their nurture and care. Angela’s House is a
collaborative effort between public and private part-
nerships with grants from the Georgia General
Assembly and private donations from treatment
providers. Additionally, the federal Office of Juvenile
Justice Delinquency Prevention has instituted a five-
year grant in New York City and Atlanta to create a
multi-agency database, with a model treatment and
coordination plan.

A continued focus and interest from political enti-
ties such as legislature is needed to continue to
address cases of child exploitation including female
genital mutilation.

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Kirk Torgensen

Child sexual exploitation and child sexual predation,
while not mutually exclusive, do a lot of harm. Most
perpetrators of these acts use the internet, scouring
web chat rooms and visiting multiple websites to prey
on unsuspecting children. Twelve, 13, and 14 year old
children are frequently lured into a meeting with the
perpetrator where they are abducted or molested.
Perpetrators arrested were more often good standing
members of society from all walks of life.

To protect the public, the Utah Attorney General’s
office has engaged law enforcement to go online and
pose as children to lure offenders. Such efforts have
led to increased arrests of sexual internet predators.
Additionally, a public media campaign targeted
towards the community to educate parents/ care-
givers of the dangers facing minor children, has gone
a long way in creating awareness at the community
level. Also, close coordination between law enforce-
ment, health, and child welfare agencies serves to
limit such web-based sexual predation.

1. For more information on the Alameda County Minors in
   Prostitution Task Force, please visit: http://clerkwebsvr1.oakland
   net.com/attachments/9924.pdf.
2. For more information on Angela’s House, please see: http://
Enforcement of Lead Hazard Remediation to Protect Childhood Development

Anne Evens, Beverly J. Gard, and Mary Jean Brown (Moderator)

Mary Jean Brown
The nation has an ambitious goal from the Healthy People 2010 objectives to eliminate lead poisoning as a public health problem in the United States by 2010. The Lead Poisoning Prevention Branch of the Centers for Disease Control and Prevention (CDC) takes this goal very seriously as do partners at the Environmental Protection Agency (EPA) and the U.S. Department of Housing and Urban Development (HUD).

Childhood lead poisoning is a completely preventable illness. We know what the causes are, how children get it, and how to prevent it. Essentially, the way to prevent it is to control or eliminate sources of lead in the environments around children.

Given enough exposure, children and adults can die from elevated blood lead levels. This happens rarely, but it is not impossible. The last child who died from lead poisoning in the United States lived in Manchester, New Hampshire and she died in April of 2000. However, most children with elevated blood lead levels have levels at or above 10 micrograms per deciliter (Mg/dL). Children who have these elevated levels have no overt symptoms. Sometimes they may be tired or may not be eating properly, but for most children, elevated blood levels occur between 18 and 28 months when these behavior trends may occur anyway. The only way to determine if a child has had too much lead exposure is to do a blood lead test. In many places in the country, blood lead testing is required by law. All areas receiving CDC lead prevention grant funds are required to develop a strategy for their jurisdiction to target children most at risk for exposure and ensure that those children are tested. In addition, any child who is enrolled in Medicaid is required to be tested at 12 and 24 months and older children who have never been tested have to be tested when they are identified. Most children with elevated blood lead levels will have some learning and behavioral problems, and some may have emotional problems.

Dr. Herbert Needleman’s study, looking at 2,000 children in Charlestown and Sommerville, Massachusetts in the late 1970’s, collected two teeth from second graders and ranked children on how much lead was in their teeth. Lead is stored deep in the bones and therefore, teeth can be used to determine historic exposure to lead. He ranked the children by the amount of blood lead levels in their teeth and had their teachers evaluate these children on how they were doing in the classroom. The children with the highest tooth lead levels were doing the least well in all evaluative categories except for hyperactivity. The researchers thought that this may have been due to the fact that second grade teachers may not have wanted to diagnose hyperactivity on a checklist. Children in the higher categories are statistically worse off than children in the lower categories.

Lead poisoning follows a step-wise progression called the dose-response curve, which reveals that the toxic chemical that is examined is the cause of the effects that are seen. Similar studies have been conducted across continents, socioeconomic classes, and racial and language groups and consistently it is found that higher blood levels affect children’s performance in school and their life achievement. New data suggests that even at blood lead levels less than ten we find that children have subtle but significant neurological effects that affect their ability to sit still in a classroom, learn to read, and understand math. We have not yet found a safe blood lead level for children.
As public health professionals, we are population scientists. In a normal population, about 5% of the population has an intelligence quota (IQ) above 120 and about 5% of the population has an IQ below 80. If you shift the population's IQ by five points, which is about what a child with a blood lead level of 20 Mg/dL has lost in his or her life, no one in that lead poisoned population has an IQ above 120 and there is double the number of people with IQ's below 80 (these are children who qualify for special education). Lead poisoning knocks the natural leaders out which is not only a tragedy for an individual child, but also has enormous effects on populations.

In particular, childhood lead poisoning affects those at most risk, which are low income, African American children living in urban areas. The most common source of lead for children is lead paint that has crumbled and contaminates soil or household dust and then becomes ingested. Children absorb lead through the gastrointestinal track (GI) much more effectively than adults. After absorption, lead enters the bloodstream and continues into the brain because barriers between the blood and the brain are not as mature in children as in adults. Once inside the brain, lead affects a child's intellectual development.

Lead poisoning can be prevented by safely removing lead paint hazards through such actions as limiting children's access to soil and household dust; frequently washing hands; increasing dietary iron and calcium as well as overall food intake to decrease the absorption of lead in the GI track; and using chelation therapy to reduce blood lead levels. There is also evidence that children who have elevated blood lead levels and who are given early childhood education, such as Head Start, will actually be able to mitigate some of the effects of those elevated levels. The brain is more plastic than we sometimes think it is and there is an opportunity with good early childhood education to reverse some of the effects of lead exposure. The CDC's lead branch aims to prevent lead poisoning by funding 42 state and local lead programs. Traditionally, programs make sure that children are tested for lead and then intervene by case for children with elevated blood lead levels. The four basic messages are: keep it clean; put barriers between children and lead paint; talk to people about foods that help; and make sure that children get tested periodically. None of these are a perfect solution. As a result of Dr. Needleman's groundbreaking study of the late 1970's, we learned that we have to regulate the abatement process. Many children have high blood lead levels as the result of the work being done to protect them. Now workers wear protective gear, children are removed from the situation, and all of the dust is cleaned up. At the end of abatement, in most places, children are not allowed to return to the house until the dust lead levels are normal. Other methods for lowering blood lead levels have also been tried. Studies examining chelation therapy, removing household lead paint, and educational strategies found that comparisons between the intervention group and the comparison group were not significantly different indicating that these treatment methods might not be that effective.

While it is important to continue to intervene with these secondary methods, since childhood lead levels did go down for both groups, we are trying to push programs in states to focus on primary prevention. This includes intervening before a child's blood lead levels are elevated by identifying high risk communities and incorporating lead poisoning prevention activities into health and community services that reach families at high risk for lead poisoning. Additionally, there are easy remedial housing elements that can be taken care of such as removing chipping paint and replacing older windows. It is better to take care of these situations before children are exposed as we know that there are islands of risk in large urban areas. After examining seven cities we found that 50% of the cases with elevated blood lead levels live in a small number of zip codes and this is fairly uniform across the country. We know where these children live and we know what to do. It is four times more likely to have another lead poisoned child in a house that has had a lead poisoned child in the past if there is not strict enforcement capacity. Thirty-five percent of children live at addresses where a child has been identified in the recent past; 18-20% of these addresses account for the bulk of the children identified in a certain time period; and 40% of these addressed have had some form of federal subsidy. We are observing repeat offender houses that are being federally subsidized. The HUD, EPA, CDC, and state and local partners are working hard to take care of these houses. If we can get these houses taken care of, we will eliminate about 35-40% of the problem in this country. Controlling or eliminating lead hazards in these addresses could save $45,000 in lifetime earnings for the children who move into them over the next ten years. An educated consumer can force some changes to occur. Lead poisoning is a problem that we can and need to fix.

Anne Evans

In Chicago, we have a big problem. We have the largest number of lead poisoned children for any city.
in the nation reported each year due to the fact that we are a large, midwestern city with a lot of older housing. If one lives in a house that was built before 1978, he or she also has a big lead problem and might as well recognize it. In Chicago in 2001, we had neighborhoods where 30% of the children had elevated blood lead levels and if we went down to the block level, we had blocks where half of the children had lead poisoning. A map of failing schools is very consistent with these elevated blood lead level rates.

There are a lot of model ordinances or state laws out there. Chicago has had its lead bearing substances ordinance since 1994 because there are a lot of strong childhood health advocates in the city. There are three important components to this ordinance. First, we require that all properties must be maintained free of lead hazards to achieve primary prevention. We do not want to wait until a child has been lead poisoned to take action. The property owners and their agents are required to maintain their properties free of lead hazards. Second, we have the right to inspect all residential units and child-occupied facilities, such as daycare centers and schools, in the city. We do not have to wait for the authority to inspect or until a lead poisoned child is present, which allows us to target repeat offenders or high risk properties. Third, we have an effective enforcement system. When we find a violation, we are now allowed to use the courts to get that violation remediated. We do that locally through an administrative hearing process and we find it to be very effective for increasing compliance. Prior to having instituted our Lead Court in 1996 and 1997, we would write violations and send them to court and that would give the property owner an extra year before they had to do anything. Currently, we have an 85% compliance rate with the orders that we write. One can target this enforcement to be effective in a way that does not overwhelm a public health agency.

In Chicago, and this is true in many states, it is really the houses built in the 1950’s that are the most hazardous. These account for 600,000 of the 1,100,000 housing units in Chicago. Chicago has 24 lead inspectors, which is considerably more than other locations. If the inspectors could do 4,000 inspections a day, we could get through those 600,000 units. This is not feasible so, we worked with federal partners and received a lot of technical assistance both from the CDC and HUD to really identify the highest risk housing. Based on 2000 estimates, we have identified that there are 88,000 housing units that are the most hazardous to children where low income children are living and are likely to get exposed to lead. We also understand that two thirds of these housing units are multi-family rental properties and a third are single family properties. It is critical to understand ownership patterns when developing lead prevention strategies.

Our strategies to eliminate and control the presence of lead in homes include enforcements (sticks) and incentives (carrots). Our municipal code allows us to levy significant fines and these fines can add up to a significant amount of money. Our enforcement is based on the health department’s building approach with inspections triggered by high risk housing data, complaints, or the involvement of a lead poisoned child. We also have a particular strategy for repeat offenders. We have worked to identify those properties which are poisoning multiple children over time and use both stepped up local enforcement and the Lead Disclosure Law (Section 1018) enforcement by the HUD/USEPA with these cases. Finally, we are trying to ensure that our publicly funded properties do not poison kids, so we are working with sister city agencies to assure that all Section 8 and Community Development Block Grants (CDBG)/HOME Investment Partnership (HOME) funded units are lead-safe as well as all other federally assisted programs.

The Lead Disclosure Law (Section 1018) requires individuals to disclose any knowledge of lead hazards during every real estate transaction. This law was created in 1992, but enforcement began more recently. The reason that this law is so important is that it allows the HUD and EPA to have the authority to seek civil money penalties of $10,000 per violation with the potential for multiple violations per transaction. This law is enforced through the leverage of these fines. If owners are willing to abate their properties, the fine will be reduced as long as the money is used to fix the problem. Business owners see the value of applying that money back into their own buildings to address their lead hazards rather than writing a check to the U.S. Treasury. Chicago cases have been jointly enforced by the federal, state, county, and city agencies and this has become a good way to collaborate. It is also really effective to talk to the property owners with four government agencies in order to enforce change. Because the process involves a lot of lawyers, it does take a long time (it took two years to get the first settlements).

Owner incentives (carrots) are also very important as well. First, there is education. A lot of property owners do not know that their properties contain lead-based paint nor do they consider themselves in business. Property owners need to know that if their property is pre-1950, they have a lead problem while if their property is pre-1978, they are likely to have a
lead problem. The important carrot is a financial incentive. We have been fortunate to approve a property tax benefit, which reduces a property owner’s tax assessment by one half for a period of ten years if he or she keeps their rent affordable and abates lead hazards. We also use the federal grant and matching grant funds that are made available for lead abatement through the HUD as well as some local money to assist property owners. The goal is to make a property lead-safe for families in an affordable manner. We want to ensure that families remain at their homes rather than setting up a situation where families relocate to other leaded homes.

In 2004, we inspected 1,140 homes with a very high compliance rate and 1,039 of these inspections were due to our administrative hearing process. We also began doing a quarterly database matching between Section 8 and the health department to identify hazardous housing and have reduced the lead poisoning rate by 50% in these communities. Public housing units have also been addressed primarily through demolition as part of a larger city transition plan. Through Section 1018 enforcement, we have been able to target 8,700 units since the year 2000. Today more than 5,000 units have been abated; 3,100 units are in the process; and 108 units resulted in fines (no abatement). An additional 5,000 units are generated each year as a result of the compliance with the lead-safe housing rule in publicly funded properties. We have been relatively successful in getting lead hazard control grant funds for low-income owners ($8.6 million). Due to effective enforcement, we now have some property owners coming to us stating that they would like to address their lead hazards. In 2004, there were 962 housing units made lead-safe proactively by private landlords. Lead poisoning rates are declining both in the city overall and in the highest risk neighborhoods. Although the rates are still too high in these neighborhoods, progress is being made. It is important to understand that a strong primary prevention, regulatory framework requires that properties be maintained lead-safe, which gives health departments the right to an inspection, and includes an effective enforcement mechanism. Partnership is critical and in lead abatement, it is extremely critical. The City of Chicago Lead Committee includes representatives from all sectors. Strong advocates are important and needed to push the agenda forward. Lead-Safe Chicago includes over 150 community based organizations including housing groups, child advocates, universities, property owners, and government agencies. Lead-Safe Illinois is a statewide task force which includes Lead-Safe Communities all over the state. Lead poisoning is a problem that we can fix and is a problem that we absolutely have to fix. There are so many social problems that affect a child’s school performance and their ability to succeed in life, and this is one circumstance that we know how to fix.

**Beverly J. Gard**

Administrative rulemaking directed on reducing blood lead levels has existed both federally and at the state level since 1988. In 1997, the Indiana Department of Environmental Management (IDEM) established a children’s health initiative including lead prevention efforts and by the next year, had launched “2000 Families by 2000” to train 200 risk assessors to conduct 2000 risk assessments. In 2003, the attorney general joined an agreement with paint manufacturers to put warning labels on paint cans about the risk of lead paint exposure.

Indiana’s legislative history concerning lead began with *The House Enrolled Act (HEA) 1181 of 1997.* This law directed IDEM to adopt EPA lead-based paint activities and lead licensing rules and gave the Indiana State Department of Health (ISDH) broad coordination responsibilities. Next, Senate Bill 320 was introduced in 2001 to the Indiana legislature. This proposed bill would require social security numbers; extend lead abatement license duration from one to four years; establish a clearance examiner license; prohibit dangerous work practice on pre-1960’s homes and child facilities; require exterior clean up of these homes; and direct the Air Pollution Control Board (APCB) to revise their rules. SB 320 did not pass the Indiana Senate conference committee because Indiana state legislators were and are concerned about individual property rights infringement and because this law asked for social security numbers.

Later in 2001, the Indiana legislature introduced the HEA 1171, similar to the SB 320, but dropped the social security number requirements and instead of extending licenses for a period of four years it extended them for a period of three years and had provisions for refresher courses. This legislation also required the reporting of childhood blood lead tests, which continues to be a problem. The Indiana legislature also started requiring information sharing of blood lead test results collected after January 1, 1990 between health agencies, families, and Social Services Agency (FSSA) because it found that the information may have been collected and might eventually get shared, but there was no direct manner of sharing the information to perhaps do an intervention that would
make a difference. It also required that the information collected after July 1, 2002 is shared between the health agencies, FSSA, and local housing agencies. In 2003, Senate Act 367 expanded the blood lead test reporting to include all tests not just tests on children and it added an annual reporting requirement. Senate Bill 367 was a very comprehensive piece of legislation, which was meant to refine a number of things that we had done presently.

In a 2004 report, the ISDH found that Indiana was only able to identify that 8% of Medicaid children were actually being reported as being tested. That was down from 8.9% in 2003 and 11% in 2002. As a result of those low test rates, the Indiana legislature passed the Senate Enrolled Act (SEA) 538 in 2005 to develop measures and report performance incentives to improve Medicaid blood level testing rates. This act also required the ISDH to adopt rules regarding the case management of lead poisoned children and to determine whether case management was being paid for either at the local level or through funds designated for some other purpose. This law also mandated that labs report blood lead test results electronically, if they submit more than 50 test reports a year. Currently, about 40,000 test results are reported annually in Indiana. In the previous calendar year, about 14,000 of those were submitted manually and not electronically, which is a huge problem. It takes time and increases reporting error rates. Electronic submissions will amplify cost savings, improve the reliability of these results, and increase the number of results retrieved. Also, Indiana is expanding its information sharing for data collected after January 1, 1990 to include the HUD. This aspect only requires that information be disclosed that is necessary to determine the prevalence of lead poisoning, which confronts the issue that legislators face, confidentiality of individual information. Additionally, the HEA 538 also expanded information sharing for data collected after July 1, 2002 to include federal agencies that administer housing programs and again, it limits the sharing to the extent necessary to ensure that the children are protected from lead poisoning. It also mandated ISDH to submit an annual report by March 15th of each year for the previous year on ten categories. Some of these categories include a count of the days it took to confirm a test, assessments done for children identified as lead poisoned, housing units for assessments identified for lead hazards, housing units ordered to eliminate lead hazards, children tested, children with results greater than 10 Mg/dL, confirmatory tests done, actually lead poisoned children tested at less than 10 Mg/dL, and housing units where lead hazards had been eliminated. This will be a comprehensive report that is going to help us move forward in the future.

One challenge associated with the SEA 523 included data sharing with our environmental agency. In the legislation, we required that data be shared that had never been shared before. This required IDEM to give notice of potential legal action if they had information about lead hazard specific sites that were not being abated. In the past, however, the statute never required them to get that information. When this legislation was filed, IDEM became upset in part due to the new prioritization required with the new administration. IDEM estimated that there would be thousands of cases for them to litigate. An advocacy group, Improving Kid’s Environment, negotiated with our attorney general’s office and as a result, the attorney general’s office will now take care of these cases after the property owners have been given adequate notice and there is a well documented lead hazard. As a result of that commitment from the attorney general’s office, the legislation did not require that this information be given to IDEM. Their responsibilities would continue as before, but they would not handle the enforcement actions.

The fiscal constraints that states have are another real challenge particularly with these programs which involve so many different state and local agencies. States are going to have to begin to make a stronger commitment to financial resources. States, and this includes Indiana, do not have the money to meet the match for federal funds. Getting lead prevention programs implemented at the state and local levels are Indiana’s next challenge.

It is also important to have the support of advocacy groups and other legislators. Improving Kid’s Environment has an annual lead-safe conference every year and has done a lot of work with retail establishments to train them on educating customers. We have been fairly successful due to their assistance in the general assembly. Certainly, victims can also be strong advocates and having their testimony truly helps.

For Indiana, the next steps are more administrative than legislative. ISDH and FSSA must develop systems to comply with the provisions of the new statute which includes the report, the incentives for compliance with lead testing, and a system to provide reimbursement for case management investigation of lead poisoned children. FSSA will also need to establish performance standards for blood level testing for managed care and then set up those performance incentives. ISDH needs to assess compliance for lab
reporting requirements and take enforcement actions for noncompliance. IDEM must enforce rules for abatement and non-abatement projects, which will be the biggest challenge statutorily due to dealing with our environmental agency. It will continue to utilize the attorney general’s office. The general assembly is going to have to make controlling lead poisoning more of a priority with funding. Programs also need an overall coordinator to work with all state and local agencies rather than someone under the department of health. Lastly, state and local agencies need to be more aggressive in pursuing the HUD funds to reduce lead hazards.

3. The Residential Lead-Based Paint Hazard Reduction Act (also known as Title X), 42 U.S.C. § 4852d (2005).
Scott Grosse
Newborn screening seeks to prevent death or disability through early identification and treatment of metabolic and other heritable diseases. Because proposed disorders vary in incidence and the frequency and preventability of adverse outcomes, screening needs to be assessed for each disorder. In this country newborn screening is a state responsibility, and each state specifies by law or regulation the disorders for which newborn infants are to be screened. Since the late 1990’s, advocacy groups and experts have called for infants to be tested for the same disorders regardless of state of birth. Recently, the American College of Medical Genetics (ACMG) called for the adoption of a uniform core screening panel of 29 disorders. The ACMG’s recommended panel may differ from established criteria currently in use in different states. States who wish to expand their newborn screening panels need to weigh scientific evidence and legal and ethical concerns as well as the new national recommendations.

In 1998, Massachusetts was the first state to consider expansion of newborn screening to include the new technology of tandem mass spectrometry. A 2001 article in Public Health Reports by Atkinson and colleagues provides a discussion of that experience.1

Mary Ann Baily
To be ethical, decision-making for newborn genetic screening must be evidence-based, take the opportunity cost of the newborn screening (NBS) program into account, distribute the costs and benefits of the program fairly, and appropriately respect human rights.

In newborn screening policy, cost is an ethical issue because newborn screening uses pooled resources that have an “opportunity cost,” such as there are always other uses for the resources that would improve the length and quality of life. When policymakers make decisions, they must be good stewards to ensure that the benefits are worth the costs and to consider the fairness of the distribution of benefits and costs across individuals. Since information about the existence, size, and distribution of the benefits and costs of screening is so critical to evaluation of opportunity cost and fairness, to be ethical, policy decisions must be based on evidence.

Newborn screening programs must also respect American beliefs about the rights of individuals to make decisions about medical treatment, research participation, and the use of their personal information and body tissues such as blood samples. Since children cannot make their own decisions, determining how to do this can be controversial. Policy decisions raise difficult ethical issues relating to consent to screening, confidentiality, and the use of blood samples for research and quality improvement.

The current policy process is not structured to meet the above ethical requirements. The recent Health Resources and Services Administration (HRSA) funded ACMG Report2 was intended to develop recommendations for a uniform panel of tests to be included in state NBS panels and also lay the foundation for a more rational and ethical decision-making process. Unfortunately, both the recommendations and the process are flawed because of problems relating to the working group’s composition, the methodology it used, the process of developing and disseminating the report, and the report’s substantive content.
In 1998, Ohio had a screening panel of five disorders which included: phenylketonuria (PKU), homocystinuria, galactosemia, congenital hypothyroidism, and hemoglobin disorders. Based on widespread interest from state clinical experts, public, private, and political groups, the state of Ohio considered adding three more disorders to the newborn screening (NBS) panel. Although, outsourcing of testing to private and other state labs was briefly considered, Ohio began implementation of a centralized program utilizing an integrated system to connect babies, parents, hospitals, and physicians with the health departments and regional children’s hospitals.

In considering expansion, Ohio’s NBS Advisory Council created state-wide criteria specifying what disorders to include in expanding newborn screening. This criteria included disorders: (1) that cause disability if diagnosis, treatment and early intervention are delayed; (2) that increase incidence, mortality and morbidity; (3) without potential for successful treatment; (4) when treated that would provide benefits to children and society; and (5) that are balanced with costs associated with false positives. Additionally, the availability of tandem mass spectrometry in the late 1990’s presented an opportunity to dispel with single tests for each disorder, and instead to utilize one test to detect multiple compounds at one time thereby detecting many potential disorders. Expansion of newborn screening, however, does not come without cost. Though tandem mass spectrometry acquisition costs are one-time purchases and manageable, the non-analytic costs such as follow-up testing for all screen positive infants and education of parents and health care providers in some cases may exceed $1,000 per child. Additionally, intangible costs due to parent distress in the cases of false positive results must be taken into account.

During 2001 and 2002, Ohio expanded newborn screening using tandem mass spectrometry, with seven disorders added to the mandatory panel and a separate voluntary panel for 16 additional disorders, thereby increasing the total disorders potentially screened to 28. Because almost all parents opted for the voluntary panel, in August 2004, the two panels were combined into a single mandatory panel.

Seeking to address the national lack of uniformity in screening programs, the Health Resources and Services Administration (HRSA) contracted with the American College of Medical Genetics (ACMG) to develop a decision-making tool based on criteria for assessing conditions for their appropriateness for newborn screening and to use this tool to develop a model uniform panel of conditions that could be recommended to the states. The ACMG work group used a best evidence model to develop the decision-making tool and select the uniform condition panel. In early 2005, the report from the HRSA/ACMG contract was accepted and recommended to the Department of Health and Human Services (DHHS) secretary Michael Leavitt by a federal Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children. This Advisory Committee was authorized under Title XXVI of the Children’s Health Act of 2000 to issue recommendations to enhance, expand, or improve the ability of programs to reduce mortality or morbidity in newborns and children from heritable disorders. The Advisory Committee is also addressing problems of analytic quality, results interpretations, follow-up services, education, and outcome data collection.

Lessons learned from Washington state’s efforts at expansion of newborn screening included: developing a criteria for selection of disorders; convening a newborn screening advisory committee; and keeping the process open and transparent.

In developing criteria for selection of disorders, consideration of the prevention potential and medical rationale is needed. This approach required weighing several factors including: identifying a condition that provides a clear benefit to the newborn while preventing a delay in diagnosis and prevention of a developmental impairment or preventing illness or death. The newborn screening committee also considered the availability of a viable treatment for evaluation and care after diagnosis and treatment.

Additionally, a public health rationale was utilized. This approach required looking at the nature and the prevalence of the condition to justify population-based screening rather than risk-based screening. Furthermore, the use of available technology to provide timely, sensitive tests adapted to mass screening was considered and compared to a cost effectiveness approach to determine whether or not the benefits of such tests justify the costs of screening.

In an effort to keep the process open and transparent, the newborn screening committee was comprised of a multi-section of public and private groups including parents, state hospital and nursing associations, state board of health, the March of Dimes, the State Board of Health, and local public health officials.
Fatty acid oxidation disorders are a group of inherited metabolic conditions that impair fatty acid metabolism. Each fatty acid oxidation disorder is associated with a specific enzyme defect in the fatty acid metabolic pathway and affects utilization of dietary and stored fat. An example is a medium chain acyl-CoA dehydrogenase deficiency (MCAD). In the early to mid 1990's Tennessee did not screen for MCAD in newborns because the Tennessee Genetic Advisory Committee (GAC) concluded that there was insufficient data to warrant screening for the disorder. In 1998, a letter from parent advocacy groups to a state senator urging adoption of mass spectrometry (MS/MS) to screen for MCAD did not lead to the inclusion of MCAD in newborn screening. At that time, GAC decided against adopting MS/MS because several of the diseases detected have no known treatment and therefore did not meet all the screening criteria.

After monitoring the Massachusetts pilot study in 2000 as well as other pilots, the Tennessee Department of Health and the GAC decided that a change in policy was not warranted in light of concerns about the rarity and lack of treatment for many disorders identified by MS/MS, particularly in light of the high costs of this technology. However, later in 2000, the GAC recommended that MCAD be added to the panel for newborn screening. In 2001, Tennessee noted the report in MMWR\(^6\) of the impact of parent advocacy groups despite limited data in medical literature. In 2002, Mississippi (for whom Tennessee used to perform newborn screening) introduced a bill requiring screening for all disorders detectable by MS/MS.

Eventually, Tennessee decided to require MS/MS detection of disorders including MCAD and the state began screening in early 2004, reporting 50 disorders by the summer of the same year. The impact of MS/MS screening in Tennessee includes an enormous increase in presumptive positives and false positives. The experience in Tennessee demonstrates that long-held ethical and policy standards for newborn screening have come under fire as a result of changes in technology and parental advocacy.

Alcohol-Impaired Drivers: Reducing the Risk for Children

Ruth Shults, Nick Ellinger, Thomas Wyss, and Linda L. Chezem (Moderator)

Reducing injuries from motor vehicle crashes is a priority at the Centers for Disease Control and Prevention (CDC). Motor vehicle crashes are the leading cause of death among children after the first year of age until adulthood. On average, each day one child passenger under the age of 15 years dies and about 50 children are injured in alcohol-related crashes in the U.S. Twenty-five percent of all child passenger deaths involve at least one drinking driver. Two-thirds of fatalities occur among children riding in the same car as the drinking driver; only about 1/3 of the deaths occur to children who are struck by a driver who has been drinking.

During the past 20 years, there has been about a 50% decline in child passenger deaths involving drinking drivers. The rate of decline has slowed since the 1990’s as per the National Highway Traffic Safety Administration’s (NHTSA) Fatality Analysis Reporting System.

About 265 children die each year in crashes while riding with a driver who has been drinking. Sixty percent of these crashes occur during day and evening hours (from 6 a.m. to 9 p.m.). Most of the children who die in these crashes (70%) are not using any type of occupant restraint. The higher the driver’s blood alcohol content (BAC), the less likely the child will be restrained.

While it is unknown whether most of the drivers are the parents of child passengers, most drivers are old enough to be the child’s parent. Sixty-five percent of the drivers are male. The drinking drivers are about six times more likely to have had a previous DWI (driving while intoxicated) conviction than drivers who have not been drinking and are involved in a crash in which a child is killed. The median BAC for the drinking drivers is 0.13%, which is well over the legal limit of 0.08%. These two points, the high DWI conviction rate and the high BAC levels, suggest that many of these drivers may have a serious alcohol problem. Sixty-eight percent of drivers survive the crash, which suggests that many of these crashes are survivable and at least some of the children may have survived if they had been restrained.

How does the CDC translate these statistics into policy? CDC and other organizations partnered with Mothers Against Drunk Driving (MADD) last year in producing a child endangerment report. The primary purpose of the report was to detail recommendations for legislators, court officials, parents, medical providers, and other interest groups. Some of the recommendations made in the MADD report include: (1) Strengthening child endangerment laws that address transporting children while under the influence of alcohol. These laws currently exist in 38 states. (2) Strengthening enforcement and penalties for violating child restraint laws. Every state has a child restraint law that permits officers to stop cars if they see unrestrained children. Many states have weak enforcement practices, and assess very small fines for violations. In some situations, weak enforcement can send a message that this issue is not a priority. (3) Strengthening protections for children in civil cases involving child custody/visitations. (4) Mandating reporting of convictions of child endangerment to Child Protective Services.

Other potential strategies supported by the CDC include strong enforcement of DWI laws, stronger adult restraint laws, and a lower BAC limit for drivers.
who transport children. Lastly, health care providers can encourage families to adopt a zero-tolerance policy whenever adults are transporting children in cars. Health care providers should also screen adults for alcohol-related problems.

**Nick Ellinger**

In 2003, for the first time ever, the percentage of alcohol-related fatalities of child passengers that were riding with a drinking driver fell below 50%, although that may be a temporary anomaly in the data. In previous years, about 2/3 of all children killed in alcohol-related crashes were riding with a drinking driver. Driving under the influence with children in a vehicle is known as DUI endangerment.

There are 38 states with child endangerment laws: 22 states have increased penalties (a DUI conviction with circumstances causing the offender to receive an enhanced penalty), nine have separate DUI child endangerment statutes (offenders can be charged with child endangerment, DUI, or both), four allow DUI child endangerment to be used as an aggravating factor (no mandatory penalties, but a judge or jury can enhance the sentence), and three “others.” The existence of DUI child endangerment laws does not necessarily mean that they are effective.

State laws are varied. They have different coverage (for example, some protect children from ages 12 and below, others protect children as old as 18), different penalties and different structures. Many of the laws do not focus on the sanctions that have been proven effective and most focus on fines and jail time. For example, Colorado’s law only applies if a child is injured and killed in a crash. Delaware’s law makes the driver do 40 hours of community service and a minimum $230 fine over and above the normal DUI. The punishments that have the least amount of deterrent value are jail time, fines, and community service.

The sanctions that do work are license revocation, ignition interlock devices (which is a device that monitors BAC on a driver’s breath), and impoundment of vehicles for repeat offenders. Unfortunately, there are few states that assign these to DUI child endangerment offenders.

Additionally, some states allow diversion for DUI child endangerment offenders. There is evidence that diversion programs do not work. Before conviction, the judge will mandate some form of treatment in exchange for no record, and no license revocation, which is both a specific and general determent (the fear of license revocation deters both the individual offender and the public as a whole). The negative effects of diversion programs include decreasing the deterrent value of the laws, and undermining the state statutes for repeat offenders.

Not a lot is known about the impact of the laws because this is a new area of inquiry, and the sample sizes are small. It is difficult to break out the fatality and injury data by state. The injury data for alcohol-related offenses is historically very poorly reported.

Other barriers to charging offenders under criminal law include the fact that laws are often so complex that they are not used or law enforcement officers are not aware of them. Additionally, the enhancements can be pled down or off, and there’s not a record for future judges to know that there was a child in the car at that time.

There is some progress being made. New laws have been enacted in Alaska and Montana and things are improving in Georgia, Indiana, and Utah because of the inclusion of more science-based sanctions. In 2005 so far, at least nine states have looked at DUI child endangerment laws.

Of key importance to bringing civil charges against an offender is that if the criminal side does not tell the civil side the details of a situation, it does not exist. In most cases, this involves divorces or separations where visitation makes monitoring problematic. Because most divorce decrees mandate when a parent will have actual custody of a child, a parent who is required to relinquish the child to a former spouse who is intoxicated is forced to either give the child to a drunk driver or be in contempt of court.

There is a need to educate judges and divorce lawyers about including specific provisions into the divorce decree. For example, there should be an affirmative defense to a contempt action, which the person was intoxicated when attempting to pick up the child; this helps parents say no if an intoxicated parent is demanding visitation. Additionally, the civil process must be cognizant of DUI child endangerment and must have sanctions that can be levied against a parent that has committed DUI child endangerment including supervised visitations and tests before custody transfers.

Process participants like law enforcement, prosecutors, and judges need to know about endangerment laws and why it’s important to document the criminal side for the benefit of the civil side. Law enforcement needs to know about child endangerment laws – officers often neglect to take the extra steps necessary to document that there is a child in the car when offenders are taken into custody. DUI child endangerment charges need to be able to be introduced in custody hearings so that if there has been a serious
offense, it can be heard during the discussion of what is in the best interest of the child. And Child Protective Services also needs to be informed.

Enforcement and the perception of enforcement are vital to the efforts to stop impaired driving. In addition to funding, there are two other variables important to a law enforcement presence in a state. First is the legislature or the court system: in ten states, it is still illegal to do sobriety check-points, either because of court decisions or because they have been banned by the legislature. Because of the strong deterrent effect of checkpoints, they can make a large, positive difference in not only DUI child endangerment, but also in decreasing all alcohol-related crashes. The second is the will of the law enforcement leadership. If leadership believes in traffic and DUI enforcement, the rest of the force will follow.

In sum, laws are widespread but good sanctions are not. Currently, enforcement of these DUI child endangerment laws is not aggressively pursued. The civil and criminal sides should learn to communicate with each other better. And important audiences still need to be educated about these issues.

**Thomas J. Wyss**

I have been in the Senate for 20 years, and have known over 400 families who have lost family members to drunk drivers. Additionally, I have been engaged in battles with other legislators who were resistant to enacting laws to combat drunk driving. That resistance may have been due to the fact that those individuals were drinkers themselves, but most importantly, they may have been victims of successful alcohol industry lobbying.

Indiana has seen a number of success stories in recent years. After an 11-year battle, this year Indiana's open container law was passed, which meets the federal legislation. Other success stories include the multiple death/multiple conviction law. Before passage of that statute, if an impaired motorist caused one or six deaths in one incident, the driver was subject to only one conviction. Now, the law allows multiple charges for multiple deaths that occur in a single incident. Another new law makes killing another person in an impaired state (drugs or alcohol) a Class B felony. And already-established laws have been enhanced recently to give law enforcement another bullet in the arsenal to go after drunk drivers.

Indiana also has the most stringent child-restraint laws in the nation. Indiana now requires that children up to age eight sit in a booster seat or fit properly in a seatbelt. Plus, the state requires that up to the age of 16, a child must be seat-belted no matter where they are in the vehicle.

Another success is the Antabuse Alcohol Deterrent Program, which was developed from legislation in 1989. Individuals come into this program if they have two or more convictions for OWI (operating under the influence) in a two-year period. Antabuse is a medication taken several times a week and causes violent illness if alcohol is consumed. Of the program's participants, over 60% receive a satisfactory discharge after being in the program for an average of three years. Since 1989, over 5,100 people have gone through the program. The average person has six drug-related offenses (drugs and/or alcohol), plus three operating a vehicle while intoxicated (OWI). Of the participants who successfully complete the program, the recidivism rate is only 10%; of people who do not satisfactorily finish the program, there is an 80% recidivism rate. Nationally, there has been an insignificant drop, or possibly even an increase, in the number of alcohol-related crash deaths. But in Indiana, because of legislative efforts as well as the cooperation between the courts and law enforcement, there has been a 25% drop in alcohol-related deaths in the same 10-year period.

The enforcement of traffic laws is hindered by different factors. For example, impaired drivers are not stopped if there is no police presence on the roads. Indiana's Council on Impaired and Dangerous Driving is very active with the local law enforcement agencies. The Council provides extra money for police officers to enforce traffic laws during overtime hours, or on their days off. Depending on a state's laws, there is a one in 300 to a one in 1000 chance of being arrested for impaired driving.

Another problem is diversion programs. Diversion programs are established for aberrations in behavior, for example a teenager with a first traffic ticket, or a child who shoplifts on a dare. But in a survey of the 92 Indiana prosecutors, many of them replied that they do have a diversion program. When asked if they ever divert charges of operating a vehicle while intoxicated, they all said 'no.' Asked if they ever pleaded down an OWI to reckless driving, nearly all said 'yes.' When asked if they ever diverted reckless driving, many gave no answer, implying that they did!

In the 1980's and 1990's, MADD was a big force. People think the problem is taken care of now, but obviously that is not true. What is needed are correct laws, more laws, more enforcement of existing laws, and lawyers and judges on our side.
Linda L. Chezem

How do courts deal with family members transporting children, when the drivers are under the influence of alcohol? When can courts intervene? Since civil courts are involved when issues revolve around custody (1/2 of all marriages end in divorce) and paternity (1/3 of children born in the U.S. are born out of wedlock), courts already have jurisdiction of those children’s lives. Courts also have jurisdiction over families (including parents) when a child has been declared in need of services and also when the children are status offenders (truant, runaway, etc.). In Indiana, the non-custodial parent is entitled to reasonable visitation, unless the court finds after a hearing that the visitation might endanger or significantly impair the child’s physical health or emotional development. The courts can give orders in these cases. One approach I have taken is to order a father who was known to drive while intoxicated with his child in the car, to submit to a breath test at the police station prior to taking the child for his regular visit. In that case, I felt that there would be too much emotional damage to the child to prohibit the visit altogether.

The burden of ordering a parent to show that they are sober when they start the visitation is a start. However, there are some problems with that approach. Who is to make the determination of sobriety? Who monitors the process? It is challenging, but it can be done. New technologies are emerging, such as the microchip implant that will be able to detect BAC. That sort of device, while invasive, could pass constitutional muster if a parent refuses all other options.
Scope of Practice for Public Health Professionals and Volunteers

James G. Hodge, Jr., Jeanine K. Mount, Joy F. Reed, and Mary P. Couig (Moderator)

Mary P. Couig

Public health workers face a variety of challenges including preparing for and responding to emerging infectious diseases, large scale industrial accidents, bioterrorism, and natural disasters. In the aftermath of Florida's triple hurricane damage, there was an urgent need for health professionals, especially nurses, to supplement healthcare personnel already responding to the hurricanes. Although states such as Georgia, Texas, and Colorado have developed large databases of nurses, there are legal challenges in the terms of the scope of practice, licensure, credentialing, and liability.

Federal employees and those hired as temporary federal employees, working under their scope of employment, are covered under the Federal Tort Claims Act (FTCA) of 2000 for liability and also are covered for workman's compensation if injured. Health professionals want to know that they will be protected if they volunteer to respond. This session highlights new initiatives to protect health volunteers and specific issues related to pharmacists and nurses.

Prior to September 11, 2001, state and local governments depended on general emergency declarations for authority to respond to emergencies, because existing legal infrastructure typically focused on general emergency responses and not on specific public health events.

After September 11, 2001, federal, state, and local governments systematically reformed their emergency response laws, especially in the areas of licensing, credentialing, and privileging to address public health emergencies. Credentialing evaluates a health professional's general skills and competencies while privileging authorizes a health professional's scope of practice within a specific facility.

Some states, recognizing potential hurdles in emergency management, relax licensing requirements during emergency situations. Although professional licensing is part of a state's regulatory process for health professionals, emergency laws typically waive licensure requirements or allow license reciprocity during declared emergencies.

To address an imminent shortage of volunteer health care professionals needed to meet surge capacity during emergencies, the Health Resources and Services Administration (HRSA) is overseeing state and territorial creation of volunteer registration systems known as the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP). The ESAR-VHP functions as a state-based and state-run system to register and vet in advance health professionals who may be called upon during an emergency. State Emergency Management Assistance Compacts (EMAC) formalize emergency requests among states to provide immunity for responders as agents of a requesting state.

James G. Hodge, Jr.

Any emergency involving mass casualties or injuries inevitably will stretch existing health care and public health resources. Meeting surge capacity during emergencies is one of the most significant challenges for public health planners. Many rely on the efforts of volunteer health professionals to treat patients during emergencies. However, the legal environment implicates the ability of these volunteers to effectively participate, as well as raises multiple issues of concern for the volunteers themselves.
EMAC has been implemented in 48 states.

The Volunteer Protection Act of 1997 seeks to provide some protection to medical volunteers from civil liability. Civil actions that may be brought against medical volunteers include negligence, intentional torts, privacy violations, misrepresentation, discrimination, or breach of contract. Some states have provided additional legal protection from civil liability through immunity and indemnification provisions. Examples of immunity provisions include Good Samaritan laws, governmental (sovereign) immunity, and mutual aid agreements. Additionally, workman’s compensation reform provides employee protection for out-of-state workers during emergencies, although such coverage varies extensively from state to state.

Jeanine Mount

Pharmacists’ roles have traditionally been limited to dispensing drugs and monitoring individual patient therapy. In the last five to ten years, pharmacist education has included an expanded emphasis on public health activities such as disease prevention and health promotion.

Although the pharmacist’s role has seen some expansion, ambiguities remain as to the scope of practice in emergency preparedness. It is recommended that pharmacists should be involved in emergency preparedness. In emergency preparedness, the pharmacist’s role can include medication focused activities such as mass vaccination, ChemPack program, and administering the Strategic National Stockpile. Additionally, pharmacists may be required to conduct health surveillance activities or serve as members of the Medical Reserve Corps. State and local groups, pharmacy boards, and schools of pharmacy are likely places for change.

Current activities to integrate emergency preparedness into pharmacy education are varied. Present efforts are not uniform, although options exist for continuing education and university curricula. The Health Resources and Services Administration (HRSA) is working with the American Association of Colleges of Pharmacy (AACP) to develop a model of an “all hazards” curriculum for pharmacists and pharmacy students.

Joy F. Reed

What is the role of nurses during an emergency? A survey of states to determine the current scope of practice for nurses that might impact their preparedness, found that sources of authority in emergencies including Nurse Practice Acts (NPA), various public health laws, bioterrorism laws, or a combination of all three, present some limitations to nurses.

States wishing to use out-of-state nurses for emergency reasons do so under many circumstances. Some states require nurses to be licensed in the requesting state, others depend on NPA compacts which provide for out-of-state nurses to practice under the supervision of in-state nurses, others take advantage of the Nurse Licensure Compact which allows one nurse to legally practice in any Compact state, while others depend on the reciprocity agreements of the Emergency Management Assistance Compact (EMAC). All in all, these requirements serve to restrict the nurse response in an emergency.

Other concerns which impact the scope of practice include workman’s compensation and liability issues, lack of clarity on what constitutes a “declared emergency” and who should declare such an emergency. Additionally, NPA requirements for licensure in a state, even during emergencies, and NPA restrictions on certain practices needed for a public health response are problematic and do not provide for a seamless system of deploying nurses to needed areas.

Given the wide range of ability for nurses to respond to out-of-state emergencies, there is a need for a seamless system of expanding and ensuring nurses’ scope of practice. State reciprocity compacts and state memoranda of understanding may provide part of the solution for creating a uniform system worthy of responding to a public health emergency, but in some states it may require changes to the statutes regulating nursing practice.

Reducing the Risk of Drugs in Schools: Illegal Use and Medical Management

Timothy Volpert, Anthony Derezinski, and Howell Wechsler (Moderator)

Howell Wechsler
To promote the health of young people, it is important that public health officials, legislators, and legal advisors are informed of the many issues associated with students’ use of drugs, both illegal and legal, while at school. Drug abuse can lead to illness, impaired educational performance, and even death. Likewise, ensuring the availability of prescribed medications during the school day is important for many students with acute and chronic health conditions. Public health officials, legislators, and legal advisors often play a key role at both the state and local level in making policy decisions and passing legislation regarding these issues.

Timothy Volpert
When we discuss the constitutionality of school searches, we are talking about non-criminal searches done in schools by school personnel not criminal searches conducted by the police department. For the most part, there are not relaxed rules for police officers to conduct such searches. Drug testing is a federal case primarily due to the fourth amendment, which states that “the rights for persons, houses, and effects against unreasonable searches and seizures should not be violated, and no warrant shall issue but upon probable cause supported by oath or affirmation.” Particularly, they are describing the place to be searched or the person or thing to be seized. The fourth amendment is not there in order to help the government. It is there to protect the privacy of individual citizens. This is a fundamental assumption that individuals, who are strong proponents of drug testing, sometimes do not understand. The basic rule under the law is that in order for a search to be reasonable under the fourth amendment, one has to have a warrant based on probable cause and exemptions have grown up around this so that in certain circumstances one no longer needs a warrant or probable cause. Courts over the years have developed rules in which they stated that it is basically impossible to develop probable cause in certain circumstances. One primary example is what we call an administrative search, such as in the case in San Francisco where houses were searched for faulty wiring. The government’s need to conduct a search is balanced against the extent of intrusion on an individual’s privacy. There are a series of special needs cases in the last hundred years where a warrant and probable cause requirement under the fourth amendment has shockingly been eroded over time.

In 1984, in *New Jersey v. TLO*, the U.S. Supreme Court ruled that it was very impractical for a school principal to stop and call a lawyer and go to a judge to get a warrant when he or she suspected student drug use. We do not expect school personnel to be lawyers or police officers; we expect them to be educators. Under the fourth amendment, the court states that in order to conduct a search in schools one does not need a warrant, he or she just needs reasonable suspicion.

In 1989, in the Vernonia school district a small, rural school in Oregon had what they considered a severe drug problem. The school tried education and other initiatives in order to solve the problem and as a last resort, they decided to do random urinalysis drug testing. The process was very primitive at this time. A student athlete’s name would be pulled from a hat, and she or he would go in for a urine test. If the stu-
dent tested positive, there were various levels of secondary tests to test for accuracy and necessary hearings. Ultimately if a student tested positive, they would not be allowed to participate in extracurricular sports to various degrees with each offense. A student’s third offense resulted in not being able to participate in sports at all.

What is so unusual about this situation is the question of whether or not the school could conduct a search without any suspicion. School administrators always suspect that students are using drugs. However, there is no reason to expect the individual that is being asked to provide a urine sample has done anything wrong. Requiring someone to provide a sample of urine is a seizure and sending this sample to a laboratory is a search. Can a school ever conduct a search without reasonable suspicion? The plaintiff in Vernonia School District v. Wayne Acton, Wayne Acton, was in seventh grade and had probably never used drugs, and here the school was conducting a search and seizure of him. This was an extreme case. The trial court stated:

The administration was at its wit’s end and a large segment of the student body particularly those involved in interscholastic athletics was in a state of rebellion. Disciplinary actions had reached epidemic proportions. The coincidence of almost three-fold classroom disruptions and disciplinary reports along with the staff’s direct observations of students using drugs or glamorizing drug and alcohol’s use led the administration to the inescapable conclusion that the rebellion was being fueled by alcohol and drug abuse as well as the student’s misperceptions about the drug culture.

The randomness of a program is absolutely essential to its constitutionality. Random refers to selecting a person to be tested by some method where it is impossible to actually select a particular individual. Any time there is a search without suspicion or a warrant, there needs to be protections against choosing specific individuals for testing. Unless the test is random, it is not constitutional. Also, in Vernonia the test was narrowly limited to testing for illegal drugs, which was essential. Further, there were no academic or criminal sanctions in this case, and drug tests were not reflected on a student’s academic record. All that occurred was a loss of participation in sports. If a student tested positive, that student could continue to play sports by enrolling in a drug treatment program. On behalf of Wayne Acton a lawsuit was filed in 1990 arguing that it violated the fourth amendment of the U.S. Constitution and the Oregon Constitution.

Schools need to balance the extent of the privacy intrusion against a need for the search. If the government could search without warrants, there would be no crime. The privacy issue is more difficult to articulate. In Vernonia, the Court stated that due to the terrible drug problem, the government in the form of the school district needed to do something. On the other side was the privacy issue. Inherent with sports is giving up a lot of privacy by being subjected to a medical exam and communal showers. Since athletes have such narrow expectations of privacy, government wins out in the balance. The court ultimately said that the most significant element in the case is that the policy was undertaken in furtherance of the government’s responsibilities under a public school system as guardian and tutor of children entrusted to do its care. When the government acts as a guardian and tutor, the relevant question is whether the search is one that a reasonable guardian and tutor might undertake.

In another case, the Board of Education of Independent School District 92 of Pottawatomie County et al v. Earls et al, the school district decided they needed to test every individual that participates in competitive extracurricular activities. The U.S. Supreme Court applied Vernonia and decided that in Earls the testing did not violate the fourth amendment either. The state of the law today is that if a school has a proper narrowly tailored program with built in privacy protections that are necessary and is testing only those students who voluntarily participate in extracurricular activities, the school is most likely not violating the fourth amendment. Having stated this, every state has its own constitution, and state constitutions can provide greater rights to individuals than the U.S. Constitution. A school must consider not only the U.S. Constitution but also the individual state’s constitution in implementing a drug testing program.

There are other alternatives in drug testing procedures. One alternative is voluntary drug testing. An example is San Clemente High School in California where both a parent and a student must agree to drug testing and waive a student’s fourth amendment rights. This avoids problems for any parent who feels that it violates individual rights. Other alternatives include testing only athletes, testing all students involved in extracurricular activities, and trying to test the entire student body. The problem with testing the entire student body is applying the balance of governmental intrusion and arguing that everyone who comes to school has low enough expectations of privacy. It is also important not to overlook the notion of drug education. There are existing educational pro-
programs including an award winning program called the Atlas and Athena Program. This program was designed initially to keep boys in sports away from steroids and to reduce eating disorders in girls. It has had very good results in reducing drug use among both populations and has received outstanding reviews from federal government agencies. In summary, when a drug testing program is introduced it will result in some form of turmoil. The majority of the people in a school district are going to feel it is a great idea, but there are going to be some parents who will object. When parents object due to privacy rights and having their child forced to give a urine sample, they tend to get very emotional and feelings are very strong. Therefore, when approaching this topic, it is important to consider parental opinion.

Anthony Derezinski

The enactment of education laws that promote the use of prescription drugs, especially those intended to treat chronic diseases, has resulted in schools becoming an integral and major provider of drug provisions in a child’s life, at least for those nine to ten months a year that he or she is in school. Sponsored by the Center for Health and Healthcare, last year’s conference on medical management in schools resulted in a report entitled A Systems Approach to Reducing Risk and Striking the Quality of School Medication Management. Part of the report provided statistics on medical services for students, comparing students in Austin, Texas, and Boston, Massachusetts in 2001-2002. In Austin, there were 543,299 direct student contacts involving medical personnel in schools including 188,519 instances of medication assistance by the schools to students. In Boston, 721,300 contacts including 227,114 incidents of medical assistance. This same report made a very important point discussing communication with medical professionals. Since the primary mission of schools is education and not medical care, this makes it important that schools reach out to medical professionals in their communities for advice and assistance, and it is imperative that the public and private health care system regard schools as partners in the management of medication and other health issues. When problems or risks occur, very often the break down in schools occurs between health care professionals who are treating patients in another context and when that patient comes into a school. Education and healthcare are two very different disciplines. When they converge, creating a synergy that is needed to achieve both the primary aim of education, which is student achievement and of health care, which is healthy kids is of utmost importance.

This is about the creation of sound public health policy. An essential target of this focus is legislators, since most of this issue centers on state legislation. A lot of what we are doing here in different forums is addressing that problem of the hand off and answering the question of how to guarantee continuity of healthcare for those children and to avoid serious miscommunication. A Michigan statute deals with administration of medication to pupils and talks about liability and school employees who are licensed professional school nurses. The major concern in our statutory approach was the understandable reluctance of a lot of people in the schools to provide medications. This statute requires schools to acquire an adult witness when a school employee provides medications. This statute requires schools to acquire an adult witness when a school employee provides medications to a student. Secondly, if one does that correctly, the school has a different standard of immunity, which is called gross negligence and replaces simple negligence. This was passed in 1976, and shortly thereafter, amendments were made to improve it. An amendment was passed stating that the school did not need a witness in a medical, life threatening emergency. A few years later an additional amendment was added to allow nurse professionals who are properly trained to administer medications without a witness. Not only that, but nurses are provided with a higher level of protection meaning they would also have to be grossly negligent in order to be found liable. These protections were the first steps taken in order to encourage medication disbursement.

A second statute, which was passed in 2002, requires that the Michigan State Department of Education review all state policies dealing with provision of medications in schools. It also requires the Department to make available a series of model policies on provision of medications in schools. The statute encourages local school districts to take a look at these model policies but does not mandate them. It also requires local school districts to review their local policies at an open meeting to hopefully encourage them to take the state policies and adopt them. Finally, the last statute deals with the possession of inhalants and states that local school districts can not prohibit students from carrying inhalants to take care of asthmatic problems, if the student has a prescription from a doctor and meets various conditions such as parent notification. If a school follows these procedures, they will receive absolute immunity, but the statement of reasonable belief within the statute injects a different standard which results in not taking away any other immunities.
We are dealing with two other issues in the same statutory framework. One is an amendment that deals with epinephrine auto injector devices (epipens) to treat anaphylactic shock. This law is intended to protect children who can carry epi-pens with them as long as it is prescribed by a physician and that the student has the ability to self-treat. Second is House Bill 4150, which addresses type 1 and type 2 diabetes, and requires schools to train personnel to be able to handle students with diabetes and assist students when they need insulin. First, any school that has one or two people with diabetes must have at least two people trained to help these individuals. Not only that, it also applies to all extracurricular activities where school personnel attend and any other before and after school programs. It is a very intrusive bill and the School Board Association, school nurses, and state departments of education are all opposing it.

Michigan’s state department has now developed model guidelines, policies, and forms covering such issues as overall times, administration, self-administration, training of personnel, signing forms for a trainer, permission forms, daily logs, and warnings for detection of asthma and diabetes. The School Board Associations, as well as the school administrators, are reaching out to discuss these policies. New policies are drafted for school districts in order to ensure that these policies are up to date as required by state law. These policies are in place, but the question is who actually delivers the services. A survey was sent to 4,100 schools in Michigan with a 50% return rate. The survey found that only 16% of schools had full-time health professionals in the buildings. Seven percent of schools had half-time health professionals on site, but most often (about 28%), these health professionals are on site less than ten hours a week. Regarding school nurses, 16% were exclusively on call for emergencies. Sixty-four percent of funding came from general revenues, there was 14% that came from specific funds for at-risk students, and 2% came from other grants. The findings suggest that there are fewer school nurses and more questions of how to implement these policies with non-professional school staff. Finally, while schools need to make sure that non-professional staff are very well trained, it is costly.

We have not heard of a lot of cases involving liability from wrongful provision of medications in schools, but it does happen. The Philip Gonzales case is what parents fear most. Philip had asthma, and his nebulizer, another instrument used to administer medications for asthma, was kept in the school office. When he needed to use the nebulizer, he was assisted by staff. On the day he died, Philip appeared in the school office showing symptoms of a severe asthma. Before effective health care could be rendered, Philip collapsed. The case was tried in front of a jury on a general theory of negligence, and the jury unanimously awarded Mrs. Gonzales $9 million which was later decreased to $2.5 million. The appeal was later upheld, but there was a dead child and the school district lost funds due to the award and legal fees. The major problem was the lack of communication. First, there was an exemption allowing Philip to carry an inhaler with him, but Mrs. Gonzales stated that she was not informed of this exemption, and was not given the written policy itself or a consent form. Secondly, Philip’s condition was not communicated to the school nurse. This is what can happen if a school does not fully implement its policies. It really is a question of how policies are implemented and then, how do these policies clearly work in reality.
Therapeutic Jurisprudence: Using the Law to Improve the Public’s Health

William Schma, Diane Kjervik, Carrie Petrucci, and Charity Scott (Moderator)

Charity Scott

Therapeutic jurisprudence (TJ) is an emerging field in the law generally, and in health law in particular. TJ is being used to analyze different kinds of law: from tort and contract law to criminal law and family law. TJ is a lens through which the effects (both positive and negative) of our laws and legal system can be analyzed and understood.¹

TJ is the study of law as a social force that impacts people’s emotional lives and psychological well-being. Based on the premise that an individual’s interaction with the legal system can have positive or negative side effects, TJ aims to understand how we might maximize the law’s positive, or therapeutic side effects. In this way, law and medicine can be seen to share a common goal: the principle of “above all, do no harm.” Both law and medicine should strive to minimize the harm that our professions inflict on those who come within our systems.

Too often, however, we see how the legal system can negatively impact the people who become involved in it. The process of civil litigation, for example, can negatively impact people both emotionally and financially through its time-consuming and often psychologically draining processes.

What can the law do to encourage therapeutic outcomes after some individual or some institution has caused harm to another individual? One illustration of the positive impact law can have after an injury is the use of law to encourage the wrong-doers to disclose how the harm occurred, to acknowledge their responsibility for it, and to apologize by saying, “I am sorry.”

Many public apologies by government officials or others have been issued in the public health domain, for example. After the forced sterilization of over 60,000 people, predominantly women, in 33 states from 1920-1970, the governments in at least four states have offered a public apology for the wrong that was done. Also, President Clinton offered a public apology for the wrong that was done to the African-American men who participated in the Tuskegee Syphilis Study from the 1930’s to 1972. Similarly, he issued an apology on behalf of the U.S. government for the internment of those of Japanese ancestry during World War II. More recently, the Red Cross in Canada issued a public apology for the tragic disaster of tainted blood that infected and killed a number of Canadians in the 1980’s.

Locally here in Georgia is another example of the promotion of the therapeutic effects of an apology for someone who has been harmed within the health system. Senate Bill 3 was a part of our tort reform measures that passed in February 2005. One portion of the legislation provides encouragement for offers of apology and expressions of sympathy after an adverse outcome in a medical case. In the preamble to the new statute, the Georgia General Assembly acknowledged the positive effect such behavior can have on those affected by an unanticipated outcome from their medical care:

The General Assembly finds that conduct, statements, or activity constituting voluntary offers of assistance or expressions of benevolence, regret, mistake, error, sympathy, or apology between or among parties or potential parties to a civil action should be encouraged and should not be considered an admission of liability. The General Assembly further finds that such conduct, state-
ments, or activity should be particularly encouraged between health care providers and patients experiencing an unanticipated outcome resulting from their medical care. Regulatory and accreditation agencies are in some instances requiring health care providers to discuss the outcomes of their medical care and treatment with their patients, including unanticipated outcomes, and studies have shown such discussions foster improved communications and respect between provider and patient, promote quicker recovery by the patient, and reduce the incidence of claims and lawsuits arising out of such unanticipated outcomes. The General Assembly therefore concludes certain steps should be taken to promote such conduct, statements, or activity by limiting their admissibility in civil actions. [Emphasis added.]

The statute provides that such statements of apology or sympathy shall not be admissible in evidence in a civil lawsuit and shall not constitute an admission of liability. Before Senate Bill 3 was passed, Georgia health care providers were very reluctant to apologize after a medical error occurred to a patient because they feared that the apology could be taken later in a subsequent liability suit as an admission of liability.

An apology can be a positive mechanism for promoting good relations and good will even after a medical error has occurred, and can even improve the overall delivery of health care. According to the Institute of Medicine (IOM), between 44,000 and 98,000 people die each year as a result of errors during hospitalization. Apologies, if done appropriately, can be vital to the effective delivery of health care services because they can both repair the damage in the doctor-patient relationship, and more broadly, they can encourage trust from the larger community in the institutions where the errors were committed. Apologies can also reduce the emotional and psychological drains of litigation on all parties, thus lessening tension among the parties and thereby encouraging earlier resolutions. In essence, by promoting apologies, the law can allow people to get the harm and its causes out on the table for discussion, which benefits not just the immediate parties including the patient, but also allows the health care providers systematically to address the root causes of that error, and thereby avoid future errors from the same underlying problem.

This is just one illustration of how law and the legal system can be used as a mechanism for promoting positive effects in human relations, which is a goal at the core of TJ.

William Schma

I have a different view of the law than many people, much of it inspired by therapeutic jurisprudence (TJ). Christopher Slobogin defines TJ as “The use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects.” In other words, TJ is the study and practice of law as a healing agent.

We encounter serious public health issues in the court system. They involve not only emotional problems but also physical problems, the most notable being the debilitating psychological and physical effects of abuse of alcohol and other drugs. TJ suggests that those of us who are responsible for the courts are responsible for addressing the underlying issues that return people to court repeatedly if we are to discharge our office with integrity.

In spite of this, because TJ is new and represents an unfamiliar view to many it makes some uncomfortable. Misrepresentation of TJ in the media aggravates this. For example, a recent New York Times article on the subject was inaccurately titled. It read: “Judges Turn Therapists in Problem Solving Courts”. This is simply wrong, and not advocated for by any responsible proponent of the practice of TJ. Judges are not therapists and should not practice therapy. They can, nevertheless, be interested in emotional and physical issues in law – the public health issues that affect people who struggle to survive their encounters with the adversarial system. In problem solving courts judges join and partner with therapists, public health officials and social scientists to address the many public health issues in which their roles intersect.

Judith S. Kaye, Chief Justice of the Supreme Court of New York, describes four characteristics of a problem solving or, as she calls them, “hands-on” court. First, the judges in the court see themselves and the courts as problem solvers and believe they can and should play a role in solving human problems. Second, the judges are interested in outcomes and not just process and precedent. Third, the judges recognize the therapeutic potential of the courts’ coercive powers and their ability to both offer opportunity and demand accountability. Fourth, these judges collaborate with other service providers to provide a continuum of care to the persons they affect. In the latter role, courts have the capacity to act as conveners and partnership-centers to cooperate with pertinent agencies in the community. The drug treatment courts that have developed in the last 15 years across the country are a good example of the best practices of these kinds of courts. In them, the recovery of court participants...
is impacted by the participating partners: the treatment and mental health communities; prosecution and law enforcement; defense attorneys; family services; counselors; labor and housing resources; and others as appropriate.

In medical terminology an “iatrogenic effect” describes an adverse consequence for a patient occasioned unintentionally by negative behavior of a medical professional. Likewise, in the legal system, litigants and lawyers can experience a “juridicen effect” through similar actions. A distinct relationship develops between judges, lawyers, and litigants in the courtroom which can significantly impact how people experience it, and how they come out of it. Judges and lawyers need to be sensitive to the principle of “first, do no harm” if they wish to maintain the law’s place as one of the three original healing professions, along with medicine and ministry.

The legal system, especially the criminal side of it, is dominated by a punitive mind-set. Judges and corrections officials are accustomed to demanding certain results or behaviors and resorting to punishment when they are not forthcoming promptly, often with terrible consequences for the individuals. Inevitably, the punitive mind-set does not take the time to understand the underlying psychological, physical, economic, or other social problems that contribute to the perceived failures. As long as the legal system responds unthinkingly to these situations, the individuals will continue to recycle through the system at great personal expense to them and their families and great emotional and economic expense to the community.

An important consideration must be emphasized. The court system is responsible for protecting the due process rights of the community to preserve the social order. To accomplish what the legal system has, over centuries, acquired a set of analytical tools and processes that are effective, dependable, and fair. They must be preserved, and applications of TJ to the business of the courts can never trump due process. Nevertheless, the social order is also enhanced when citizens are healed, when problems are solved, when citizens are successfully removed from the justice system. It is not advanced when people are merely processed and recycled like so many bodies. That breeds disrespect for the law and the legal system.

Bruce Winick, one of the originators of the notion of TJ has stated it correctly: “If those of us involved in law-making, law-applying, and law-related counseling begin to see ourselves as therapeutic agents, we can considerably enhance the potential of law as a helping profession.” To the extent that we do that, law and public health converge and enhance one another and bring healing to an ailing population.

_Diane Kjervik_

I see law as a way to bring the information and power associated with law into nursing. If nurses understand how law affects them and the nursing profession then they are better able to make a change in the law. Essentially, the goals of the nursing profession can be served by the law (Kjervik, 2003).³

Therapeutic jurisprudence (TJ) is a concept that is new to nursing. TJ is the study of the impact of law on health outcomes. It was developed by David Wexler, Bruce Winick and Dennis Stolle (2000)⁴ whose primary focus was the mental health effects of the law.

There are several examples of research studies that demonstrate the use of TJ. Presented here are five examples in subject areas including abortion, malpractice, assisted suicide, welfare policy, and smoking.

In abortion, for example, Bitler and Zavodny (2001)⁵ studied the effect of statutes limiting funding and mandating parental involvement and waiting periods prior to abortion on delay and likelihood of abortion. They found that the women who seek abortions delay the care that they need to get in states where parental involvement and waiting periods are required, but Medicaid funding restrictions do not change the timing of abortions.

In malpractice, Dubay, Kaestner and Waidmann (2001)⁶ studied the effects of malpractice premium levels on prenatal care and infant health. Their results indicated that, “a decrease in malpractice premiums that would result from a feasible policy reform would lead to a decrease in the incidence of late prenatal care by between 3.0% and 5.9% for black women and between 2.2% and 4.7% for white women. Although, [they] found evidence that malpractice liability pressure was associated with greater prenatal care delay and fewer prenatal care visits, [they] did not find evidence that such pressure negatively affected infant health” (Dubay et al., 2001).

In assisted suicide, Ganzini et al. (2002)⁷ studied the effect of Oregon statute allowing assisted suicide on hospice nurses and social workers experiences. They found that 55 of 82 patients were given prescriptions for assisted suicide and they actually used them for this purpose. The greatest motivation for using assisted suicide was that the patients wished to control the dying process.

In welfare policy, Romero, Chavkin, Wise, Hess and VanLandeghem (2001)⁸ studied the effect of The Personal Responsibility and Work Opportunity Recon-
ciliation Act of 1996 on maternal child health in the US. They found that the removal of cash assistance resulted in a decrease in coordination of benefits among the agencies giving care to mothers and persons with substance abuse problems.

In smoking, Daynard (2002) studied the effect of minimal federal oversight of tobacco products based upon values espoused by the U.S. Supreme Court on continuation of smoking habit. He looked at judicial opinions of both federal and state courts and found that there really wasn’t much oversight of the use of tobacco products by the courts. Daynard suggested a new tenet that should be used by the courts, that is Salus populi suprema lex, which means people’s safety is supreme. This concept should be brought into the judicial system and adopted by courts to increase its own commitment to the improvement of health.

TJ can make nurses more visible by bringing them into the healthcare and policymaking arena. Healthcare professionals and attorneys can use TJ to advocate more effectively for clients by knowing the effect of law on health, lobby for changes in the law using data to demonstrate the effect of current policy and conduct research using legal or other empirical research methods with TJ as the framework for analysis.

Carrie Petrucci

As a social work researcher and practitioner, my emphasis has been on program design and program evaluation for criminal justice and social welfare system interventions. From a social welfare perspective, I bring the emphasis on “effectiveness,” which in this context refers to how individuals, families, and communities benefit in positive ways as a direct consequence of a system intervention.

Where does public health fit in the mix? By definition, public health is similarly concerned with overall well-being. When asked to prepare a paper for this conference merging these ideas of public health, law, and social welfare, three questions came to mind: does the legal system impact public health, how can we understand the legal system from a public health perspective, and what do we gain by doing so? These three questions formed the foundation for the theoretical framework that I propose here. This framework is intended to be used to evaluate legal practice as a means towards establishing greater effectiveness in the legal system.

What evidence do we have that the legal system impacts public health? We can look at examples of public health law in areas such as mandatory vaccinations, as has been discussed in the last couple of days. Certainly these laws impact public health on a community-wide basis. But I’m more interested in the impact of the process and outcomes of the criminal justice system, and to some extent, the civil justice system. What evidence do we have that public health is impacted in these areas? Here the links available in the research are less clear, although if we look at the collective lived experience of participants in the legal system, we have some indirect evidence that the legal system impacts public health. So we might look at violence studies, for example, and determine if victims who go through the criminal justice system have enhanced well-being or not. The domestic violence literature has found that arrests can result in more risk of violence for some populations of women and less violence for others.

How can we understand the legal system from a public health perspective? I’ll present a model that merges three different theories to create a way to understand the process and impacts of the legal system from this perspective. First, I’ll discuss a systems approach that incorporates Urie Bronfenbrenner’s ecology of human development (micro, meso, exo, and macro systems), logic modeling (resources, activities, outputs, outcomes), and therapeutic jurisprudence (a legal reform theory that considers how the well-being of those in the legal system is impacted by legal actors, legal rules, and legal procedures). In doing so, we gain five things. First, we preserve the goal of the legal system as a “public good” or public service as we pursue justice. Secondly, we put the individual and community needs back at the center of the legal system, rather than having it solely about legal professionals winning and losing cases. Third, we can emphasize accessibility and meaning from multiple stakeholders including those being acted upon, such as the defendants, the victims and the communities. Fourth, we can also emphasize the responsiveness of the legal system to all of its constituents rather than just the most powerful ones. Finally, we can strive to achieve effectiveness in the legal system. We can determine if those coming through the legal system have positive outcomes or not, and how these positive outcomes ultimately enhance public health. This framework is intended to help us evaluate and hopefully understand an evaluation feedback loop to improve legal practice, specifically in court settings. It is proposed that by improving the effectiveness of the legal process, that we also improve the public’s health.

The table below provides an example of the systems approach, merging these three theories.


Table 1

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Initial</th>
<th>Intermediate</th>
<th>Long-term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Micro / Legal Actors</td>
<td>Process experienced by individuals</td>
<td>Completion data by individual case</td>
<td>Change in psychological, emotional, physical well-being</td>
<td>Change in behavior of defendant or legal actors</td>
<td>Change in condition or status of defendant or legal actors</td>
</tr>
<tr>
<td>Meso</td>
<td>Process as experienced by family, extended family, employment</td>
<td>Completion data</td>
<td>Attitude change or interactions between defendant and family or employers</td>
<td>Change in behavior or interactions between defendant, family, or employer</td>
<td>Change in condition or status related to defendant, family, or employer</td>
</tr>
<tr>
<td>Exo Rules</td>
<td>How rules or procedures are carried out</td>
<td>Completion data by adherence to rules</td>
<td>How rules impact well-being</td>
<td>How rules impact behavior</td>
<td>How rules impact condition or status</td>
</tr>
<tr>
<td>Macro Subculture Belief systems</td>
<td>How broader society responds at policy level</td>
<td>Completion data at policy level</td>
<td>How policy impacts societal attitudes and knowledge</td>
<td>How policy impacts societal behavior</td>
<td>How policy impacts societal condition or status</td>
</tr>
</tbody>
</table>
Media, Law, and the Public’s Health

Toni N. Harp, Maryn McKenna, Nancy Shute, and Dan Rutz (Moderator)

Dan Rutz

This morning we are exploring some of the tensions that exist between the public health community and the media. My background is in media and as a medical correspondent for CNN for 18 years; I have seen things from both the public health and the media side. It is easy to see that there is an uneasy alliance between the media and public health. We need each other but we don’t want to get too cozy about it. As a public health person, I realize the importance of integrating communications in public health. In order for public health to be truly effective, it has to be understood, defined, and explained to the general public. We need the news media to help us do that. Shifting the media’s attention to focus on public health issues can be accomplished by educating reporters on why public health issues are important.

Toni N. Harp

It is an honor to be here and I would like to share with you what I have learned about working with the press. My interest in public health started in the area of sexually transmitted diseases. After learning that chlamydia is a precursor to AIDS, I introduced a bill in the Connecticut legislature on chlamydia to educate our high school students about the disease before they went to college. The bill was introduced and a health writer from the Hartford Courant came to talk to me about it. He thought it was a bizarre bill and it actually earned me my first political cartoon.

Working with the press can also help an issue. Recently, one of our priorities in Connecticut was to implement a report card system on hospital safety. Hospital groups and associations were strongly opposed to this measure. In 2001, a dumbed-down bill was passed and then in 2002, in my district, two women died in a hospital. One of them died in the operating room and both deaths were attributed to errors in the administration of anesthesia. The local newspaper ran the story and it was later picked up by the larger newspaper, the Hartford Courant. The press wondered why the hospitals were not held responsible for these deaths. As a result, the state developed a hospital report card system. This time, the hospital groups and associations did not oppose us, largely because the press had taken up the issue. Without the eye of the press, the ultimate law would have not been as effective. The press is our partner. We should fear them, but also work together. Only then can we find ways to move the public health agenda forward.

Maryn McKenna

I am author of the book, “Beating Back the Devil: On the Front Lines with the Disease Detectives of the Epidemic Intelligence Service.” As a reporter who has been writing about public health, I would like to share my insight into how we report and cover public health issues. I will walk you through two stories about public health that were received differently by the public. The two public health stories are about the anthrax letter attacks in the fall of 2001 and the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003.

The first anthrax letter incident was announced on October 4, 2001. About 60,000 people were evaluated by healthcare professionals to see whether they needed antibiotics or not, and approximately 10,000 people were put on antibiotics. The House of Representatives was shut down and the Senate was closed for three days. The public health system was completely overwhelmed; public health laboratories were swamped with mail samples that needed analyzing. Surprisingly, all of this took place amid an abundance of prior publication and literature on anthrax. Anthrax is not an unfamiliar pathogen.

Contrast that with SARS. We now know that SARS developed in the People’s Republic of China (PRC) in
2002; emerging in October or November. It spread to Hong Kong on February 21, 2003, via one man from one heavily infected area. In less than a month, SARS had gone completely around the globe; more than 8,000 people became ill and 774 died. In the U.S., new public health powers created by presidential executive order were used. However, the reaction to SARS was not paralyzing.

In these two situations, the public felt at risk to different degrees. According to studies from the Harvard Center for Risk Communications, the public does not do a good job in estimating risk. People feel at risk when they perceive themselves to be vulnerable, distrust institutions, lack control, and when the risk feels more present to them. In today’s media culture, a single story can be repeated many times in a 24-hour news cycle. This can increase the perception of risk among the general public.

In the anthrax case, the public felt more at risk than they did with SARS, even though probabilistically, SARS may have been a greater risk to the average American. Why is that? In the anthrax case, the government restricted the flow of information to the media, partly because this was a bioterrorist event. In addition, most of the relatively small numbers of anthrax researchers had grants or contracts from government institutions, which made it very easy for the federal government to impose restrictions on them. The public was confused, felt the situation was uncertain, unfamiliar, and above all, distrusted the institutions.

SARS by contrast was well-handled. The Centers for Disease Control and Prevention (CDC) had daily briefings for about three months. The laboratories responded quickly, publications came out on the web with valuable information. The CDC and others were willing to say, “This is what we know now and it might change and if it does, we will let you know.” So according to the tenets of the Harvard Center for Risk Communication, the public felt more trust and less confusion and thus did not feel as at-risk as in the anthrax attacks.

However, the process of communicating news and risk to the public is becoming more complicated. Here is an example. While SARS was contained to the PRC, the Chinese government stonewalled inquiries from the World Health Organization (WHO) asking about outbreak rumors. Then, on February 9, 2003, a fourth grade teacher in San Francisco was chatting online with someone in Guangdong Province who sent her a note saying that there was a big disease outbreak in that province. The fourth grade teacher knew an epidemiologist and sent the note to him. He in turn posted the note on ProMED-mail, the Program for Moni-

toring Emerging Diseases and an international mailing list run by the International Society for Infectious Diseases. It appeared on February 10, 2003; just a simple note asking if anyone knew anything about the outbreak in Guangdong Province. In less than 24-hours, the Chinese government admitted to the existence of 300 cases of an atypical pneumonia and five deaths.

This example illustrates the power of the non-mainstream media. Another example is the vat blog community now discussing avian influenza. The vast expansion of channels through which health news is communicated to the public is likely to significantly change the public’s perception of public health risk. This is what we should be discussing.

Nancy Shute

How do we rate media coverage of public health issues? How does media coverage affect public health policy and legislation? Tracking the media’s coverage of the flu vaccine shortage story began after the story broke on October 3, 2004. There were 247 stories about the closing of the Chiron plant in the United Kingdom, the next week there were 162 stories, and the week following, 134 stories were published. This volume of stories gradually decreased but continued through late November and early December as the Centers for Disease Control and Prevention (CDC) issued new guidelines which were covered extensively. So in the first three months after this story broke, there was a lot of media coverage. Many activities including congressional hearings where experts from the CDC testified, the Department of Health and Human Services redirection of $100 million into flu vaccine supply issues, and the introduction of several bills in congress to address the problem, none of which were passed, all added to the number of vaccine shortage stories.

The media covered as much of this story as possible. I think we can say that we in the media are getting it. We understand the issues. The media does and can influence public health policy. But public health issues are long-standing, often complex and are sometimes difficult to cover. There is also tremendous competition for news and it is very difficult to get original stories. News is something that is happening now. With this comes a timing issue and there is also a perpetual misperception of risk by the public. Another problem is that we as journalists have our own foibles too, for example, the “eek” factor. A lot of journalists are squeamish about reporting health factors that we ourselves are uncomfortable discussing.
A public health emergency can be classified in one of two contexts. First, a public health emergency can arise primarily from a health or public health impetus, such as human diseases that disrupt society. Second, a public health emergency can be caused by natural disasters, which disrupt communities and infrastructure in ways which affect living conditions – and can lead to major population health issues. Within the last several years, the federal government has been restructuring the emergency management system in order to create a nationally coherent system that can be applied to all states in an event of an emergency. This effort started in response to criticism regarding previous piecemeal emergency preparedness plans, where every state had different plans for different types of disasters. In addition, a national incident management system has also been constructed to facilitate the federal government’s involvement in providing support to states and local communities in an emergency. Program implementation has been facilitated by federal law requiring adoption of the nationally recognized emergency management system by states and communities in exchange for federal financial aid.

Unfortunately, a surprising disconnect still exists between the public health and emergency management communities when declaring an emergency. It is pertinent to understand who has the power and authority to declare an emergency. This includes the president, the secretary of health and human services, and state governors. An emergency declaration must specify broad sweeping statements, like a situation is beyond the manageable capability of states and communities. Upon announcing an emergency, mechanisms must be in place to allow for funding disaster relief allocations. One key issue that still must be addressed between emergency planning officials and the federal government is the amount of federal money that can be spent on preparation and preparedness.

California has dealt with many disasters over the years, which has positioned the state to effectively shape and evolve the legal framework for disaster preparedness. Many disaster relief programs in California were implemented back in the 1950’s, therefore, guidance has been provided throughout the years. It should be noted, however, that exercises, such as table top exercises, do not necessarily drive operational change in emergency response planning. California has not had a significant policy change in recent years because there has not been a catastrophic disaster to test the system.

The lessons learned from previous disasters, however, have allowed California officials time to discuss and reflect upon the systems installed for emergency responses. Going back to the 1950’s, it was very obvious that California’s enormous size required a regionalized emergency response system in order to effectively deal with emergencies. This lead to the development of six mutual aid regions. Mutual aid helps in the management and control of state resources through regional sharing in the event of an emergency. The creator of California’s mutual aid regionalization, Earl Warren, used specific contract language so that participation in the mutual aid system mandated jurisdictional assistance to areas of need.
However, a clause was included to allow for leniency to lending for regions if their resources were going to be exhausted.

In the old system, California applied different plans for different types of disasters in different geographic locations. Today, California utilizes the incident command system, which aims to unify plans and strategies to combat emergencies and disasters. The incident command system is used throughout all levels of government to enforce consistency in emergency planning and implementation, which allows for jurisdictions to have similar organization and minimizes confusion during disasters. Furthermore, some state financial aid is contingent upon adherence to this organizational standardization.

One of the most significant concerns in the past has been the infamous issue of who is exactly in charge during a disaster situation. Since multiple organizations may be involved in the implementation of disaster response programs, much confusion has risen over leadership and command. The incident command system allows for an organizational overview of the players involved and can be used as a tool to help in situations where a cross sectional array of departments are involved. The system shows department responsibilities for different aspects of an emergency, therefore, allowing changes in leadership as an emergency situation progresses.

One final lesson learned has been the need for resource typing and management. California, especially, has a significant amount of resources that must be tracked and managed. For instance, ten years ago in California, if you called for a fire truck under mutual aid, different kinds of vehicles with wheels would appear. Thus, California has gone through a long and time consuming process in identifying and categorizing resources, so that such tools can be used and allocated effectively and efficiently in disastrous situations.

Prior to a declared emergency, there are still many powers local health officers have within their communities. For example, local health officers can conduct epidemiological investigations, examine suspected persons that may be carrying a reportable infectious disease, impose travel restrictions on people with a reportable infectious disease, cancel activities and limit the travel of community members, and even evoke quarantine and isolation laws. If there is a declared emergency, then all of the previously listed powers are included in addition to preventative measures a health officer deems necessary to stop any public health issues.

In addition to the president, secretary of health and human services, and state governors, health officers can potentially have the legal authority to declare a disaster, if granted such power from a legitimate source. A situation where a health officer can declare an emergency regardless is for a hazardous waste accident, although, such incidents are unusual. Post-September 11, 2001, Santa Clara County has experienced a change in coordination between agencies and organizations. There has been an incorporation of national preparedness goals, which has encouraged cooperation. Furthermore, a county wide medical response system has also been implemented, which also facilitates partnerships between organizations at the local level.

Although, positive advancements have occurred in recent years, there are still areas within emergency response management that require more discussion. Communication barriers continue to cause confusion between agencies, which must be reconciled for a coherent emergency response system. For example, there is a major difference between the legal enforcement community’s understanding of surveillance and the public health community’s definition. Another topic that has been discussed includes who exactly has the responsibility to actually enforce quarantine and isolation statutes during an emergency. Additionally, infrastructure concerns as well as including surveillance systems and vaccination distribution centers are major discussion topics. Therefore, much needed emergency response and planning policy work remains in California.

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**Martin Fenstersheib**

At the county or community level, there are two main sources of local authority. The first are state laws granting power to local authorities to control public health related issues. Second, are the state laws that specify responsibilities and powers. In California, there is broad statutory authority, which allows for health officers at the local level to have the power and authority to take control of a situation in order to prevent the spread of a reportable infectious disease. Such actions can be taken because of the broad and sometimes vague legal language of California’s public health system.

**Thomas J. Balint, Jr.**

New Jersey’s Public Health Law was originally enacted in 1887 and despite a number of subsequent revisions, it provides little clear authority to respond to epidemics. The governor is the single command authority under New Jersey’s Emergency Management
The U.S. Department of Homeland Security’s Top Officials 3 Exercise (TOPOFF 3 or T3) was a full scale congressionally mandated exercise to prepare, analyze, and test the emergency response systems of states and countries. Participating parties in the exercise included New Jersey, Connecticut, Britain, and Canada. The exercise was conducted from April 4-8, 2005.

Significant planning and preparation for T3 included a thorough gap analysis of New Jersey’s emergency response powers and statutes, which has become a very valuable assessment tool used by many states and the second by New Jersey post-September 11, 2001. Other preparation activities included: updating New Jersey’s emergency operations plan, conducting legal quasi table-top exercises, and providing education in the form of seminars and advanced distance learning programs. By far, the most significant benefit of the exercise process was exploring legal and operational issues in the absence of an actual emergency, identifying likely issues to arise, and determining solutions to prevent the issues from becoming problems.

In the final days before T3, New Jersey suffered severe flooding caused by the Delaware River and other rivers and streams. This event added a unique twist to the exercise and provided a real-life test to the solutions developed from the legal table-top exercises. Critical issues that the T3 preparation provided quick solutions to included: the process for determining and distributing “boil water” orders and the ability of law enforcement to enforce evacuation orders. In addition to the flood, the T3 scenario specified that pneumonic plague had infected 40,000 people and caused 9,000 fatalities during the week of exercise play.

There were many lessons learned from T3 and many issues were identified that will arise in each public health emergency, including:

1. What is the practical meaning of “red” in terms of the Homeland Security Alert System color coding system? For example, what are the real responsibilities and duties of federal, state, and local governments during red alert as compared to yellow or orange alerts?

2. T3 confirmed that the legal language needs to be clarified regarding actions that officials can take in the event of an emergency. During T3, New Jersey officials ordered all primary and secondary schools closed and converted them into points of dispensing (PODS) for health care services. Travel on highways was also strictly regulated and only allowed essential employees and people seeking medical care to travel on them. Although persons seeking medical care included attendance at pods, the ordered travel restrictions were confusing.

3. The designation of an “essential employee” was also questioned. With upwards of 1/3 of the public health work force either ill or worried well, was the depth of identified essential employees sufficient to provide support in a public health emergency?

4. Areas of concern arose during the exercise regarding the regulation and dispensing of medicine at POD locations. Are pharmacists required to be present at all pill counting’s? Can family members pick up medications for other family members, for example, children? Do first responders get preferential medical distribution and treatment?

5. Questions arose regarding legal and liability issues in terms of mutual aid. For example, would medical care professionals responding from out of state be licensed? Do they have hospital privileges? Also, if federal resources are involved in the emergency response, do they preempt state and local resources?

6. Another concern was patient care versus mass distribution of prophylaxis. Is it even possible to deal with patients on an individual basis when attempting to provide mass prophylaxis to large populations? The federal governments plan to utilize post offices as PODs is premature and requires additional planning.

7. Finally, the last major concern found during T3 was the inadequacy of the Stafford Act, an issue also identified in both T1 and T2. Neither terrorism, absent fire or explosion, nor pandemic/epidemic are eligible for a disaster declaration. Absent a disaster declaration, mental health, and disaster unemployment assistance are unavailable. Hospital-based public health treatment expenses are not covered under the Stafford Act.

T3 provided a great exercise for the state of New Jersey in its disaster preparedness, and the lessons learned can be generalized to a broader audience.
Quarantine Laws and Public Health Realities

Edward P. Richards, Scott Burris, Richard P. McNelis, and Eric Hargan (Moderator)

Eric Hargan

First, a definition of quarantine: quarantine is the restriction of movement of people who have been exposed to communicable diseases. Quarantine can be voluntary or it can be legally compelled. While quarantine can be accomplished in various settings, it usually occurs in hospitals or healthcare facilities. Some modern techniques include “snow days,” self-shielding, and working quarantine, which help limit societal disruption while allowing authorities to slow or stop the spread of disease.

The federal government has quarantine power over persons arriving from foreign countries into the United States or traveling from one state or possession into another. This power was upheld and discussed most recently in the case United States v. Shinnick. The federal quarantine power is located in Section 361 of the Public Health Service Act, 42 U.S.C. § 264. This power is limited to diseases listed in an Executive Order, which was most recently renewed on April 1, 2005, to include pandemic influenza.

States are responsible for intrastate quarantine. In fact, almost all of the plenary and practical quarantine power belongs to the states. However, many of the states have old, broadly worded statutes that may need revision. There is a difference of opinion as to whether these broadly worded laws should be revised or not to include more procedure to follow in imposing quarantine and otherwise reflect modern developments in law, and that is part of what we are discussing here today.

Under Section 311 of the Public Health Service Act, the U.S. Department of Health and Human Services may assist states in establishing and maintaining quarantines, and concurrent jurisdiction is common. Federal resources are limited, though. The Stafford Act provides some assistance in funding disaster recovery efforts and may be available in certain scenarios, but not necessarily.

Quarantine laws are meant to work effectively to disrupt the spread of communicable diseases. However, quarantine actions must be consistent with due process requirements. Laws should allow for federal and state interaction and make sure the actions of state and federal agencies are coordinated. This need for effective cooperation is fundamental, whether or not that entails the revision of existing quarantine statutes and regulations. This pragmatic need is what should inform our discussions on the form quarantines laws should take.

Edward P. Richards

The Constitutional reservation of the police powers to the states gives them broad authority to take emergency actions to protect the public health and safety. The United States Supreme Court has put few restrictions on the police powers when they are applied to protecting the public health from acute threats and none on emergency public health actions. Every state exercised the full range of public health powers, including quarantine, through the 1950’s. Unless the state subsequently weakened its quarantine laws, they are still constitutional.

Several factors drive the push to revise traditional public health laws, including quarantine laws. The first is that legislatures see themselves as factories, with their output measured in laws passed. It is a natural response to public pressure to “do something” about
the threat of bioterrorism and emerging infections to pass new emergency laws. It shows the legislature is doing something and it does not cost anything – in contrast with the costs of any measures which would actually improve public health preparedness.

The second is the pressure to weaken the power of the government to carry out restrictions of persons and property. This comes from both ends of the political spectrum, with liberals wanting to limit quarantine laws and conservatives trying to limit regulation of property.

The third factor is that many states, driven by the tiny minority of cases questioning the due process provisions in traditional public health laws, passed laws, and regulations imposing due process provisions that would be impossible to meet in an emergency. These states do need to revise their laws.

The main criticism of traditional quarantine laws is that they do not provide sufficient due process protections because they do not provide due process review within the statute itself. Yet the courts have made it clear from the earliest cases that the proper due process review for an improper quarantine law is a petition for habeas corpus. This is available though both the U.S. and state constitutions.

The very few courts that have questioned traditional quarantine laws have analogized them to mental health commitment laws. This concern is misplaced: mental health decisions on dangerousness to self or others are inherently subjective and the term of commitment is open-ended. Quarantine orders are based on objectively diagnosable diseases and risk factors and automatically expire with the end of the incubation period of the disease or its treatment. All due process does is increase the cost and delay of the quarantine.

The call for increased due process misses the fundamental problem of reviewing public health decision-making. Even the judge who imposed the most extreme due process requirements on a traditional law recognized that the health department had clearly met its burden and ordered the holding of the plaintiff. This is consistent with administrative law principles that require judges to defer to agency decisions on objective factual determinations and public policy decisions.

It is extremely unlikely that any judge would rule differently, especially in the face of a public health emergency.

It is reasonable to worry about the improper use of quarantine. Many health departments are headed by political appointees with little expertise in public health disease control. In some states there are few or no board-certified public health physicians in any positions of authority. Local and state officials, as demonstrated in the hurricane Katrina evacuation, may behave erratically in a major emergency. Individual rights and community safety would be better protected by assuring that quarantine decisions are made by real public health experts. These decisions could be reviewed by an administrative panel of experts. This could be done quickly and would be much more effective than judicial review. Once this review was completed, there would still be review through habeas corpus.

When drafting new emergency response laws, the legislature should focus on protecting public health. More imagination, not more laws, is needed. The bottom line is that new laws are not a substitute for having sufficient resources and knowing what to do. As importantly, the government must educate the public ahead of time about its plans for emergency actions and the public must accept these plans. The government cannot convince the public to follow its orders with a gun or a law.

Scott Burris

When public health emergencies break out, we need action, not talk. We can look to history to see what happens in real emergencies: when a response works, it is because people took responsibility and then action; failure is usually due to the collapse of any sort of organized civil authority. Because action is essential, courts reviewing emergency measures are even more than usually deferential to public health agencies. Courts do not demand perfect information and will usually support public officials who err within reason on the side of caution. In regard to due process, the courts generally read it into the statute when it is not there, interpreting the law consistently with other laws to make it work. In this sense, Ed Richards is correct: current health law generally gives health officials broad power to respond to emergencies.

He is also correct that questions of practice, rather than statutory language, would be expected to predominate in the early days of an emergency. In regard to a disease such as smallpox, the problem may not be getting people to stay at home. Instead, the problem would be getting people to go to work. This includes judges, who may be reluctant to come to court when a quarantine is in place. The urge to flee or to hide might require little official stimulus and could create problems of its own. On the other hand, we do not want officials in an emergency wasting time debating legal technicalities. One cannot respond effectively to a novel emergency “by the book.”
Is a quarantine the most appropriate public health tool in this sort of environment? A curfew may be an effective, traditional public health mechanism that would work as well as a quarantine. The standards are the same as for a quarantine, but the political gestalt is different, so civil libertarians may be less likely to object to a curfew.

The civil liberties problem with quarantine is not, in my view, the deprivation of liberty as such. Given the need for action, and erring on the side of caution, in an emergency, some people will be confined. I worry instead that this deprivation is applied fairly. We must be particularly cognizant of how due process limits are applied in a quarantine. It may be “easier” to limit the due process rights of a disfavored class, such as minorities or the poor, because of stereotypes about susceptibility to communicable diseases. Consider that famous case of Jew Ho v. Williamson, when health officials in San Francisco managed to gerrymander a quarantine zone that included only Chinese homes. Judicial training and rigorous public health professionalism are means of preventing unfair application of emergency measures. Accountability after the emergency is also crucial.

Compensation, when manageable, should be given to those who have to miss work during a quarantine. Laws that allow people to act quickly are needed. In terms of accountability, it is hard to say that plaintiff lawyers are the answer, because the tort system is so inefficient, but to say there should be no compensation for those affected by quarantines would be going too far. The legislature should consider creating an administrative mechanism that would not lead to endless tort litigation.

Changing laws is not necessity in most places, but because laws are a vehicle for advancing public health agendas, change may be useful in places where there is a change of overall positive reform of health agency powers, duties, and budgets. In reforming quarantine laws, the legislature should consider the curfew option, compensation for those affected by quarantines, and stronger due process protections.

Richard P. McNelis

In Florida, there are 67 counties, and each county has a county health department, which is run by either an administrator or a director. Florida quarantine law is set out clearly in statutes, and not much has changed since the 1950’s.

The directors of the county public health agencies need to be able to exercise discretion, but whenever the state attorneys lose a case, some of that discretion may be lost. It is the job of the state attorneys to maintain the public health officials’ ability to exercise discretion.

Health departments are not businesses or corporations. They maintain public health. Lawyers do not hold lives in their hands the way doctors do and it is not desirable to have medical decisions coming from the bench. That is why Florida prefers to have doctors running the county health departments.

Quarantine is created by increased social distance and laws are a dangerous tool for beating quarantines into shape. However, quarantines are a good tool for things we do not understand, what we call the “works of angry gods.” These can include diseases for which we do not know the incubation periods, for example. If we amend quarantine powers, we risk losing those powers. Quarantine powers are a good tool to keep in health departments’ back pockets. People are entitled to due process regardless of what the legislature does.

A review of articles on quarantines in Florida between 2003 and 2004 brought up stories about hospitals, jails, and ships, as well as issues regarding diseases coming from Asia. One story involved a man and woman who walked into a mini-mart with sores on their faces. The man and woman were unintelligible, so the storeowner called the police. After the police were exposed to the affected man and woman, the fire chief was called, and he ordered a quarantine and barricaded the store. It should be noted that this quarantine order did not come from the health department. We will more often see people on the scene making decisions as to what laws exist. In this case, the fire department did not have authority to order a quarantine.

We do not talk about quarantine laws in Florida often, because we have a lot of power in this state, but a story that illustrates the situation involves a group of men who were on a hunting trip. One of the men asked their guide, “If I see an elk, can I shoot off the back of my horse?” The guide said, “Sure…once.” We can do anything during a quarantine…once.

In Florida, a black letter statute sets forth that a health order will be enforced. Law enforcement officers often take the attitude that they are “defending the perimeter” during a quarantine, but quarantine orders attach to the person, not the place. Also, Florida has interstate resource sharing agreements, but the state is not ready for enforcement of closed borders between states.


4. For a classic case, see: Pauline Varholy v. Rex Sweat, 15 So. 2d 267, 153 Fla. 571 (Fl 1943).


Community and Interjurisdictional Legal Preparedness

Anne M. Murphy, Steven H. Hinrichs, Priscilla Fox, Daniel Stier, and James G. Hodge, Jr. (Moderator)

James G. Hodge, Jr.
Quintessential to public health preparedness efforts in response to emerging infectious diseases, bioterrorism, or other emergencies is the need to address legal issues that relate to interjurisdictional (local, state, regional, and international) exchange and use of resources, personnel, and data across boundaries. Articulating the complex, interjurisdictional legal challenges that underlie effective responses to public health emergencies with potentially catastrophic consequences is not easy. This session is devoted to (1) clarifying policy and practical issues related to these legal challenges, including development and fostering of relationships among multisectoral partners; and (2) identifying existing frameworks, projects, approaches, and tools for improving interjurisdictional legal preparedness, including mutual aid agreements, compacts, and legal checklists.

The Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities has worked extensively on issues concerning community and interjurisdictional legal preparedness. It has recently produced a foundational checklist on Interjurisdictional Legal Coordination for Public Health Emergency Preparedness. Center colleagues have also developed fundamental guidance on the legal and ethical issues concerning the interjurisdictional use of medical volunteers during public health or other emergencies for the Health Resources and Service Administration's Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program. Major cross-boundary legal issues concerning the deployment and use of volunteers include concerns about the scope of emergency declarations, liability of volunteers and hosts, licensing, credentialing, worker's compensation, and privacy.

As summarized below, each of the panelists brings his or her perspectives regarding community and interjurisdictional legal preparedness. Anne Murphy discusses key provisions of the new mutual aid agreement endorsed by most Illinois local health departments. Steve Hinrichs offers insight on the new, ten-state Mid-America Alliance dedicated to developing an interstate agreement for public health emergency mutual aid that is likely to serve as a national model. Priscilla Fox describes the work of the International Emergency Management Group which has developed legal tools to support mutual aid between the New England states and Canada's eastern provinces. And from the Centers for Disease Control and Prevention (CDC), Dan Stier comments on the importance of legal coordination within (and outside) of the U.S.

Anne M. Murphy

The Illinois Public Health Mutual Aid System (IPHMAS) is an intergovernmental, intrastate agreement in Illinois for sharing resources among certified Illinois local health departments. This system of mutual aid is available during events such as bioterrorism or other emergencies. Ninety-three of the 95 certified local health departments in Illinois have agreed to participate in the program.

Over the last several years, there has been a sense of urgency in public health, and the need to implement a statewide intrastate mutual aid program arose after the September 11, 2001 terrorist attacks and the anthrax mailings. Legal staff in the Illinois
The personnel of the member entity remain employees of the aiding member, and each member entity is responsible for paying compensation to personnel, as well as workers’ compensation and occupational disease benefits. In addition, each member entity must maintain its own insurance program and must bear the costs of its own defense. The agreement does not diminish or enlarge the liabilities or obligations of the member entities. In regard to the other member entities, each member entity releases and waives all claims except those involving gross negligence or willful and wanton misconduct.

The Executive Board of the IPHMAS consists of nine representatives from the participating member entities, and the Board facilitates requests for assistance; gathers and analyzes data; disseminates outcome information; and performs the duties set out in the agreement. While the Illinois Department of Public Health is involved in the meetings, it does not dictate policy to the Board, which is an independent legal body created by the agreement.

Steven H. Hinrichs

The Mid-America Alliance (MAA) is an interstate program intended to develop systems for mutual aid and share resources to detect or respond to public health emergencies that do not rise to the level where a governor would declare an emergency under the Emergency Management Assistance Compact (EMAC).

The MAA originated on a bus ride when representatives from the Centers for Disease Control and Prevention (CDC) pointed out the need for aid between states without there being a declaration of emergency. Then an anhydrous ammonia spill in North Dakota and an outbreak of the West Nile Virus drove this point home even further.

The states in the MAA are Montana, North Dakota, South Dakota, Wyoming, Utah, Colorado, Nebraska, Iowa, Kansas, and Missouri. Anticipating that the federal government would be fully occupied in the case of a multi-state, mass casualty event and that no one state has sufficient resources to address all potential scenarios, the MAA was needed. The MAA provides protocols and mechanisms for responding to public health emergencies and establishes pre-event planning for rapid assistance. In large, western states, sometimes the closest help is right across the border.

Four key projects for the MAA are: identifying and negotiating the sharing of assets and resources; providing laboratory surge capacity and connectivity; organizing epidemiological workforce planning for common reportable disease reporting; and preparing a model medical license endorsement act. The MAA first set up an advisory board, established administrative support, and then created a database and directory for distribution. The operational plan for the MAA includes defining a regional all-hazards response sys-
The mutual aid agreement between New England and eastern Canada has a precedent reaching back to the Northeastern Interstate Forest Fire Protection Compact of 1949, which was extended from New York and New England to contiguous provinces in Canada in 1952. Other examples include the 1967 New England Compact on Radiological Health Protection and the United States/Canada Joint Marine Pollution Contingency Plan of 2003. This presentation discusses the mutual aid agreement reached in 2000 between New England and five eastern Canadian provinces. The language of this compact is based on the U.S. Interstate Emergency Management Assistance Compact (EMAC), which provides for mutual assistance between states after disasters. California and Hawaii are the only two states that are not members of EMAC.

The legal authority for international agreements between states and neighboring countries is 42 U.S.C. § 5196a. The statute provides, “The Director [FEMA] shall give all practicable assistance to states in arranging, through the Department of State, mutual emergency preparedness aid between the states and neighboring countries.” Additional legal authority is found in the United States/Canada treaty on cooperation in comprehensive civil emergency planning and management, which was renewed in 1998.

New England governors and eastern Canadian premiers approved the International Emergency Management Assistance Memorandum of Understanding (IEMAC) in July 2000. The United States Senate approved IEMAC on December 18, 2001. The question of whether the agreement needs the agreement of both houses of Congress has been raised, and it would be a good idea to get such approval in order to obviate future problems.

In New England, Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, and Vermont belong to IEMAC, and in Canada, New Brunswick, Newfoundland and Labrador, Nova Scotia, Prince Edward Island, and Quebec are members.

While EMAC requires the declaration of an emergency by a state’s governor, members of IEMAC can request aid without such a declaration. Under IEMAC, resources may be shared in the case of natural disasters, technological hazards, man-made disasters, or civil emergencies that result from resource shortages. Members must formulate mutual aid plans and procedures for implementing the compact, such as inventorying resources and agreeing on procedures for loaning human and material resources. IEMAC has a governing body known as the International Emergency Management Group (IEMG) which meets in work groups, such as the Legal and Credentialing and the Resources Work Groups.

IEMAC was activated, sending aid across the border, in February 2004 for the snowstorm “White Juan” in Nova Scotia and for an outdoor concert in Vermont in August 2004. Federal authority is not needed for such activation.

Legal protections in IEMAC are similar to those in EMAC. Each member of IEMAC must afford personnel of the other members the same powers, duties, rights, privileges, and immunities as their own personnel would have. Personnel from a jurisdiction sending aid continue under the command and control of their regular leaders, but come under the operational control of the jurisdiction that is receiving assistance.

In regard to license reciprocity, if a person holds a license issued by his or her home state or province showing that he or she meets qualifications for professional, mechanical, or other skills, then that person...
is deemed licensed by the requesting jurisdiction, subject to any limitations and conditions prescribed by the requesting jurisdiction.

In regard to liability, a “person or entity of a party jurisdiction” becomes an agent of the requesting jurisdiction for tort liability purposes. Good faith actions, which do not include willful misconduct, gross negligence, or recklessness, will immunize the person from liability. In addition, personnel sent to another jurisdiction under IEMAC “bring with them” their workers’ compensation and death benefits coverage. Ongoing issues for resolution include border crossing, which becomes an issue especially when border security is increased, and communications are hindered, especially because of linguistic and technological challenges.

The use of private sector personnel raises legal issues, especially if the personnel are sent outside of the state. This has not been done under EMAC or IEMAC, but the language of IEMAC might allow this. However, there is generally no procedure for states or provinces to designate private people as government agents. Other legal issues arise with credentialing and privileging of health care personnel. A system for advance registration of health care volunteers is forthcoming in the United States, but it is unclear how this system will be used internationally.

An issue that arises in the liability context is whether a state attorney general would be required to defend out-of-jurisdiction workers who are sued for work they do under IEMAC. Since volunteers are considered agents of the requesting jurisdiction, the attorney general should defend them, but this has not been tested yet.

Article III of IEMAC requires each jurisdiction to provide for the temporary suspension of any statutes or ordinances that impede the implementation of responsibilities under the Compact. We have developed a list of types of laws that might need to be suspended, for each state and province. Examples include labor and employment laws, licensure requirements, scope of practice laws, etc.

Daniel Stier

Considering how intrastate, interstate, and international agreements work is important because diseases do not honor borders. Public health is an international issue and efforts are being put forth along the United States’ borders. An agreement bearing some similarity to the International Emergency Management Assistance Memorandum of Understanding (IEMAC) in the Pacific Northwest has received approval from both houses of Congress. Issues along our borders need to be addressed and approaching the work in smaller pieces may be the key to effective collaboration. An example is the Early Warning Infectious Disease System (EWIDS) project, funded through the Centers for Disease Control and Prevention’s (CDC) cooperative agreements. EWIDS is intended to establish systems for cross-border sharing of epidemiologic and laboratory information to monitor infectious diseases. These systems can be accomplished through agreements between states and provinces operating health alert networks. A lot may be accomplished in short order, but legal issues involving international borders must be resolved.

The U.S. Interstate Emergency Management Assistance Compact (EMAC) agreement is binding. Under Article I, Section 10 of the United States Constitution, states need Congressional approval for binding compact provisions with other countries. When agreements are non-binding, the State Department will sign off on them. States should explore the potential for drafting agreements for sharing information and resources in a non-binding way. According to State Department treaty attorneys, there is a gray area between binding and non-binding agreements, and states could work with the State Department to draft language so they do not need Congressional approval.

Everyone recognizes that there is a need for the sharing of information and lawyers should try to accomplish this under existing law. If that is not possible, then states can craft statutes or get Senate approval. Everyone needs to be on the same page, so we can use law as a tool for protecting public health.

2. More information about the ESAR-VHP project is available through the Center for Law and the Public’s Health at Georgetown and Johns Hopkins Universities website at www.publichealthlaw.net/Research/Affprojects.htm.
The Private Bar: A Force for Public Health

Mary desVignes-Kendrick, Gene W. Matthews, Susan K. Steeg, Susan F. Zinder, and J.A. (Tony) Patterson (Moderator)

Law plays a critical role in protecting Americans from and in dealing with public health emergencies, such as in the anthrax attacks of October 2001, the Severe Acute Respiratory Syndrome (SARS) epidemic, hurricane preparation and relief, and potential pandemic influenza and other infectious disease outbreaks. Law makes equally important contributions to chronic disease prevention, environmental health protection, and prevention of injury and disability.

Beginning in 2001, public health attorneys began working intensively to assess and update health agencies’ “legal preparedness” for public health emergencies. However, health care attorneys have had few opportunities to learn about the legal framework in which their clients – private and public hospitals and other health care organizations – would operate during an acute public health emergency. True community-wide legal preparedness hinges critically on close coordination between public health agencies and health care organizations – would operate during an acute public health emergency. True community-wide legal preparedness hinges critically on close coordination between public health agencies and health care organizations, for example, in quarantine, vaccination, treatment of victims, etc.

Historically, private-sector attorneys have played key roles in the practice of public health at the community level. In 1905, for example, a Chicago lawyer founded the Rotary Club and built the first public restroom in Chicago. Ongoing work continued, however, by the 1950’s major levels of collaborative legal involvement in the practice of public health eroded. In the 21st century, the globalization of travel and communication technology, coupled with human and nature's challenges (for example, hurricanes Katrina and Rita and the tsunami in the Indian Ocean region) have resulted in a reinvigorated level of involvement of private-sector attorneys in public health emergency legal preparedness. Human events such as those witnessed during the September 11, 2001 terrorist attack and biological events, such as SARS and the avian flu, have resulted in heightened attention to the role of the private bar as a force for public health.

Traditionally public health has been seen as primarily a function of the public sector, but new and emerging infectious diseases and other events have underscored the importance of a new public health paradigm. This paradigm seeks to engage both the public and private sectors, because the private sector cannot afford for government to fail and the government cannot afford for the private sector to be ill-prepared. For example, the SARS epidemic, while being managed by several national governments deeply affected the aviation industry (part of the private sector). Indeed, governments have increasingly found itself needing private sector assistance before, during, and after public health emergencies partly due to governments facing multiple budgetary challenges. The regulatory scheme of health care intimately places lawyers at the hub of planning and participation. Additionally, the changing global business environment has now witnessed multi-national corporations seeking to operate in the business of public health. Companies such as Ford, Dell, and General Electric are concerned with employee productivity and are more involved in issues of healthcare delivery.

Traditionally, government, business and individuals have been separated by different goals, agendas, and strategies during normal times when there is no public health emergency. However, in dire times of a public health emergency, the separation becomes marginal as relationships between the three are altered. The government responds to the emergency and may issue
quarantine orders; individuals receive information not only from the media but from their employers; and businesses engage and lead economic recovery efforts.

Recognizing the roles of the public and private health bars is crucial to assuring seamless collaborative work. Each bar’s role is identical since both seek to understand the business, community, and regulatory issues that their clients might face; to anticipate potential risks and issues; and to respond to these risks in hopes of mitigating loss.

So what can be done in pre-emergency stages by both the private and public bar to prepare for public health emergencies? Both the private and public bar should engage in emergency preparedness planning, workforce training, and exercises and drills with emergency response partners. Both should recognize that the standard risk adverse decision making process does not work well during a disaster. Both should examine potential issues such as sick leave policies, liability insurance, compensation policies, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, state privacy laws, quarantine, Good Samaritan laws, the federal Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986, on-call requirements of health care professionals, and a myriad other cross-cutting legal issues. Indeed, recognition of the value of the private bar as partners in the preparedness planning, mitigation, and management of public health emergencies, is a positive step toward seamless integration among the public and private sector.
Judicial Preparedness for Public Health Emergencies

Diane S. Mackey, Kay S. Palmer, Rick D. Hogan, Amy R. Schofield, and Linda L. Chezem (Moderator)

The Arkansas Public Health Bench Book

The Arkansas Public Health Law Bench Book evolved based on a perceived need to prepare judges to make good public health law decisions. Arkansas public health law statutes are old, overlapping, and sometimes contradictory and the judiciary is scattered across many judicial districts, many of them rural, where they do not have law clerks or good law libraries readily available. Even in a state where there is no immediate bioterrorism threat, many public health law questions may arise in a given case including questions of standing, choice of law, venue, and the level of intervention appropriate and authorized by law.

The bench book project was initiated by the Fay W. Boozman College of Public Health and the William H. Bowen School of Law at the University of Arkansas at Little Rock with the cooperation of the Arkansas Department of Health and an extensive network of volunteer attorneys and law clerks. Additionally, the assistance of the Administrative Office of the Courts was also invaluable. The Bench Book planning committee designed a framework for the research so that each substantive legal entry included citations, a brief explanatory annotation, and a link to the actual statute or constitution from which the entry was derived. In drafting the Arkansas Public Health Law Bench Book, the group started with the Public Health Emergency Powers Act as an outline. The committee creating the Bench Book includes health care professionals as well as legal professionals, including judges and law students. The Bench Book focuses on three areas: (1) substantive laws of public health and bioterrorism; (2) procedural steps and forms for acting on public health laws; and (3) additional information for judges. Creation of the Bench Book is estimated to comprise a 2-3 year process. The project is off to a successful start thanks to a strong partnership between the bar, academia, and the judiciary. The completed Bench Book is expected to offer numerous benefits, including more informed public health law decisions, enhanced judicial preparedness for emergency public health lawmaking, and more efficient and effective public health judicial education.

Each state has judicial branch educators responsible for the continuing education of judges and judicial staff, including clerks, reporters, and appellate staff, among others. The judicial branch educators are often located in the administrative offices of the state supreme courts, although some states’ educators are located at universities or in free standing institutions. Educators may be attorneys, but many are not. Arkansas conducts approximately 15-20 judicial education programs annually for over 1,500 individuals. These programs are geographically dispersed throughout the state to allow easier attendee access. Programs are designed to be interactive and are primarily intended to facilitate the exchange of ideas among attendees. Program topics are chosen based on their urgency and uniqueness, and the measure of success is changes in attendees’ behavior.

There are several resources available to support judicial branch education. The JERITT project at Michigan State University houses a collection of program content for judicial education in a national database. The JERITT website also lists the judicial educators for each state. Other resources include: the National Associations of State Judicial Educators, the State Justice Institute, and the National Center for State Courts. There are also national providers of
judicial education, such as the National Judicial College.\footnote{For more information on the National Judicial College, visit: http://www.judges.org.}

*The Public Health Law Bench Book for Indiana Courts*

The judiciary is both the enforcer of government public health policy and the arbiter of conflicts between individual liberties and the public interest. Pursuant to the American constitutional system, public health law is generally the province of state governments. Thus, both the content and effect of public health law varies significantly among states, and it is difficult to generalize a nationally-applicable body of public health law that adequately respects each state’s unique structure and legal intricacies. Importantly, the organization of a state’s judicial system significantly impacts the manner in which public health law cases will evolve and, ultimately, be determined. In recognition of these facts, the Indiana Bench Book is a jurisdiction-specific resource intended for judges to utilize in public health cases.

Several key features about the Indiana Bench Book merit specific comment. First, the Bench Book organizes Indiana public health laws by subject matter (for example, the public health system, searches and seizures, limitations on individual liberties, etc.) in order to facilitate cross-jurisdictional analysis. It is important to note the challenge inherent in defining what constitutes a state’s “public health law.” The Indiana Bench Book focuses on areas in which the government has the power to compel or restrain individual actions. As a result, the Indiana Bench Book does not address in detail many of the administrative functions performed by public health systems, such as licensing, provision of medical services, and Medicare/ Medicaid oversight.

Second, the Bench Book includes federal law where applicable, such as legal principles of privacy and due process developed in the Supreme Court’s Fourth and Fourteenth Amendment jurisprudence, respectively. State constitutional provisions, statutes, regulations, case law, and court rules are also included. Local ordinances were generally excluded for practical reasons, and this should be noted as a potential limitation of the Bench Book. Secondary sources are referenced only in discussions of particularly uncertain and underdeveloped areas of law, such as the extension of the warrant exceptions to certain public health searches and seizures. Analogies to criminal law, while tempting in the absence of a substantial body of modern public health case law, were generally avoided given that public health and criminal law vary fundamentally in both purpose and justification. In those contexts in which the criminal law proved instructive (for example, articulation of standards of proof), its application is clearly noted.

Third, the involvement of practicing public health attorneys was crucial to the successful development of the Bench Book. These attorneys assisted with the extensive legal research necessary to produce an accurate, comprehensive product. Specifically, these attorneys offered helpful “reality checks” on statutory analysis. For example, provisions relevant to public health law practice are often scattered throughout a state’s statutory code. While one statutory provision may appear to address an issue conclusively, practicing attorneys may be aware of a host of related statutes or administrative procedures that are also applicable. Additionally, several practicing attorneys in Indiana provided model orders for inclusion in the Bench Book and offered feedback on the Bench Book throughout its development process.

The Indiana Bench Book is available online at http://www.publichealthlaw.info/INBenchBook.pdf.

2. For more information on the National Associations of State Judicial Educators, visit: http://nasje.unm.edu.
3. For more information on the State Justice Institute, visit: http://www.statejustice.org.
4. For more information on the National Center for State Courts, visit: http://www.ncsconline.org.
5. More information is available on the National Judicial College, visit: http://www.judges.org.
Legal Tools for Cancer Prevention and Control

Paul Silverman, Cynthia Honssinger, and Marice Ashe (Moderator)

In Delaware, there had not been a vigorous effort to coordinate a cancer control program. However, the crisscross of law, public health, and politics has led to increased efforts and success. The statistics in Delaware were grim. Delaware’s five-year average annual age-adjusted cancer incidence rate between 1994 and 1998 was 10% higher than the rate for the United States. In addition, Delaware had the fourth-highest cancer death rate in the nation and cancer rates among African-Americans were much higher than the national average.

One of the key figures in Delaware’s cancer control program is Delaware Governor Ruth Ann Minner. In her campaign, Minner made a promise to fight cancer. Minner lost her husband to cancer and this led to her deep personal commitment. Personal connections and stories have been the key difference between Delaware’s recent efforts and efforts in the past, when voters had a hard time connecting with cancer control initiatives that might have been vague with no emotional appeal. For example, the chair of the cancer council in Delaware was William W. Bowser, a lawyer whose son was a leukemia survivor.

The staff for the cancer council asked hundreds of citizens and experts the following question, “A specific issue that needs to be addressed in comprehensive cancer control in Delaware is...?” The responses were part of a process called “concept mapping,” which is a learning and evaluation tool that creates a visual way to understand and prioritize complex information. The 118 ideas that were generated were evaluated in regard to feasibility and importance and then placed into “go zones.”

This process brought out personal stories that were essential to keep the members of the cancer council on track. For example, Rebecca Wolhar told her story about receiving a cancer diagnosis and then having to wait a week for the surgery to be scheduled and another month for the procedure to take place. Shirley Moore spoke about how her radiation bill alone was $10,000 and for someone already on disability, the bills were a financial tragedy for her family. Nellie Foster put off her annual mammogram because she did not have insurance, but the Screening for Life, Delaware’s Breast and Cervical Cancer Early Detection Program, showed a mass in her breast that turned out to be cancer.

These stories and studies led to a report produced in April 2002, called Turning Commitment Into Action, which aimed to educate the public and legislators about cancer. Among the things that could be done immediately, the report listed improving the quality of cancer care, helping people get services, increasing screening for early diagnoses, and paying for cancer treatment for the uninsured.

As a result, the governor and the legislature focused on funding and approving $5.5 million in both 2004 and 2005. The Advisory Council expanded, becoming the Delaware Cancer Consortium. Action plans were set forth, and the Consortium rolled up its sleeves to implement the recommendations in the Turning Commitment Into Action Report.

Screening for and early detection of colorectal cancer (CRC) increased. The Consortium provided CRC screening for uninsured patients, established a network of CRC screening program coordinators, provided case management to uninsured patients, and added state-funded CRC screening to the federally funded programs.
funded breast and cervical treatment program.

The Consortium took steps toward providing the highest quality of care for every Delawarean diagnosed with cancer. They established cancer care coordinators in every hospital, expanded education to health care providers in end-of-life care, and worked on a credentialing system for health care providers.

In addition to efforts in regard to CRC, the Consortium took steps to reduce tobacco use and exposure. They expanded tobacco awareness and cessation programs; strengthened, expanded, and enforced the Delaware Clean Indoor Air Act of 2002; funded comprehensive tobacco prevention programs above recommended minimums; and advocated for an excise tax increase. The Clear Indoor Air Act was passed before the Cancer Council came into existence, and, like a similar law in California, it bans smoking in all public places where people conve. The excise tax increase will probably go through this year.

A difficult area for the Consortium has been reducing the threat of cancer from the environment. This would involve increasing ambient air quality monitoring; increasing shallow aquifer monitoring; increasing testing of fish for carcinogenic substances; and increasing radon testing and remediation.

Finally, minorities became a focus of the Consortium’s efforts and the Consortium created Champions of Change, an outreach program. Through Champions of Change, the Consortium seeks to eliminate the unequal cancer burden affecting minorities and the poor by reaching the largest disparity and by initiating in-depth studies of cancer health disparities. Many in-depth studies have been done in this area. In addition, the Consortium is looking for ways to pay for cancer treatment for the uninsured. This effort focuses on benefits, eligibility criteria, and people served. In July 2004, a program was put into place to cover all cancer treatment for up to 12 months from diagnosis. The state acts as a payer of last resort and the patient must have been a Delaware resident at the time of diagnosis and cannot have any health insurance. So far, $775,000 has been spent in this program.

The legal basis for these initiatives came from the legislature, which acted quickly to establish the Advisory Council on Cancer Incidence and Mortality in 2001 and the Delaware Cancer Consortium in 2002. It was important that these acts were done right the first time, because mistakes would have impacted cancer control efforts for decades. Governor Minner intends for the Cancer Consortium to transcend her own administration.

In addition, with technical assistance from individuals at Medicaid and legal review from the attorney general’s office, the Cancer Consortium encouraged the Division of Public Health to develop regulations for the Delaware Cancer Treatment Program. This was an exploratory process and many of the members of the Consortium were not lawyers.

Some of the key successful ingredients in Delaware’s cancer control program are high-ranking, credible, passionate leaders; broad-based participation; a focused plan; feasible goals; legislative support and funding; celebrations for success; flexibility; the courageous Delawareans who volunteered their stories; and an honest realization that you cannot do it all.

Cynthia Honssinger

In 2004, Colorado had the second-lowest ranking for tax on the sale of tobacco. The tax at that time was twenty cents per pack. In the early 1990s, efforts to increase the excise tax failed. Then, after the Master Settlement Agreement, advocacy groups began to coalesce and form a strong lobby. Public awareness of the expense of tobacco use was raised and people began to understand that raising the price of cigarettes would prevent kids from smoking.

Therefore, constitutional change in the form of Amendment 35 was proposed. This change was complicated because the Colorado Constitution includes a Taxpayer Bill of Rights, which requires a vote by the people for any tax increases. However, the proposed amendment received 61.38% of the vote, a great victory for tobacco control advocates. This led to a 320% increase in the excise tax and Colorado became 22nd in the country in terms of excise tax. Colorado also increased its smokeless tobacco tax by 20%.

Colorado’s tobacco control program is one of the few that meet the Centers for Disease Control and Prevention’s (CDC) recommendations. However, before the tax increase, the Department of Health and Human Services (DHHS) money had been diminishing and there were questions about whether the tobacco program should be moved out of the state department of health and not be funded by state money, as Colorado was in an extreme budget crisis.

In the first fiscal quarter of 2005, cigarette sales were down 38% and tax revenues were up 160%. The advocates of the excise tax expected a 5% decrease, so these numbers were very encouraging. Advocates hope that the increase in price will lead to a decrease in initiation into smoking, a decrease in pregnant women smoking, as well as an increase in enrollment in prevention and cessation program.

In the 2005 legislative session, when the enabling legislation was passed, three different groups brought
forth different agendas. The framers of the amendment sought a comprehensive tobacco program covering children, youth, and adults. This would emulate what the state had been doing with the Master Settlement Agreement and would minimize executive branch involvement. The governor emphasized preventing children from smoking and he proposed that some of the money go toward a rainy day fund for fiscal crises.

Democrats in the legislature presented a compromise, emphasizing rural healthcare, cardiovascular disease programming, and breast and cervical cancer screening. The compromise legislation, House Bill 1262, set forth where the funds would go. Fifty-one percent would go to preventing and reducing tobacco use among children. The Republican contingent in the legislature felt that adults did not need as much education about the dangers of smoking but that children are still forming their impressions about smoking and need to be educated on the dangers of smoking. Funding also would go to a Health Care Expansion Fund, which is similar to Medicaid. A Primary Care Fund would also be created, and funds would go to tobacco education, prevention, and cessation programs. Finally, funds would go toward eliminating tobacco-related disparities and prevention, early detection, and treatment programs, especially for breast and cervical cancer. None of the funds are to go toward lobbying and while the state health department will benefit from the legislation, it has had to let the political process take care of itself.

Amendment 35 and the enabling legislation has been a success story for Colorado. This program will bear out national trends, achieve the goals of preventing children from smoking, and provide better health care for the population than before.

Marice Ashe
The Public Health Law Program (PHLP) in California promotes innovative public policy solutions to prevent chronic diseases by offering legal technical assistance and by developing model ordinances for public health advocates to use on local policy campaigns. Staff attorneys work with state and local health departments, community-based organizations, local planning departments, schools, elected officials, and municipal attorneys to facilitate the passage of local public health-oriented laws. The premise of the PHLP activities is that by working on public policy initiatives rather than individual solutions to public health problems, health departments can achieve more cost effective programs and better health outcomes. For example, a smoking cessation program with an individualized education and nicotine replacement costs approximately $7,000 per quitter. In contrast, a smoke-free workplace policy leads to nearly nine-times as many quitters as traditional cessation programs and costs less than $800 per quitter.

Tobacco related diseases are a focus of the PHLP. The PHLP’s work on tobacco control demonstrates how a variety of public policy approaches - such as increasing fees and taxes, abating secondhand smoke in workplaces, multi-unit housing, and in outdoor areas, and licensing tobacco retailers - can address problems associated with tobacco addiction.

While tobacco taxes in California already are earmarked in-part for tobacco use prevention, the PHLP drafts model ordinances to increase local fees to supplement state funding to encourage enforcement of tobacco control laws, litter abatement, fire prevention and control, and other problems related to tobacco use. Under California law taxes require a two-thirds vote of the legislative body while fees require only a simple majority vote. Increasingly, local communities are using fees to generate revenues to offset the public harms caused by tobacco use.

The California Labor Code offers near-universal protection from secondhand smoke in workplaces. But there are gaps in coverage under the Labor Code and there are several venues (for example, multi-unit housing, outdoor areas, etc.) in which significant exposure to secondhand smoke can still occur. The PHLP has developed several model ordinances to assist local governments in filling the gaps in the Code and to address areas of exposure beyond those already addressed in the statute. Because California’s tobacco-related laws have explicit non-preemption language, these model ordinances give local governments the ability to offer greater protection to their residents than provided by state law alone.

California’s Labor Code that regulates smoking in workplaces only covers places with “employees,” thus allowing owner-operated businesses and businesses using volunteers (such as bingo parlors) to skirt the worker health protections provided by law. Several establishments have even deemed their employers “part-owners” by issuing $1 stock certificates to the business! The PHLP’s model ordinance broadens the provisions of the Labor Code to include owner-operated businesses and organizations that use volunteers.

The California Labor Code only covers “enclosed” workplaces. The PHLP ordinance expands the coverage provided under the state law to include outdoor worksites including outdoor dining areas, construction sites, and outdoor markets.
Additionally, the state law exempts tobacco shops and smokers' lounges, hotel lobbies, guest rooms, banquet rooms, small businesses, and warehouse facilities. The model ordinance fills these gaps with language that would protect workers in all locations.

The Labor Code only covers "places of employment," so the model ordinance expands smoking bans to all public places where people can be exposed to second-hand smoke. Areas covered by the ordinance include parks, playgrounds, beaches, outdoor recreational facilities, walkways, plazas, bus kiosks, and ticket lines. Furthermore, state law is limited in regard to doorway bans and reasonable distance restrictions. Currently, the law only restricts smoking outside of government buildings and the distance restrictions only apply to main entrances, exits, and windows with no enforcement. The model ordinance expands the reasonable distance restrictions to all buildings, all doors and windows, and outdoor areas where smoking is prohibited. The model ordinance would also call for signs posted in "smoke free areas" and clear penalties and enforcement for violations.

State law currently prohibits smoking in some common areas of multi-unit apartment buildings and condominiums if the building management company has a sufficient number of employees to trigger protections provided under the Labor Code. To date, individual units are not included in the Labor Code's protections and non-smoking tenants can receive significant exposures to secondhand smoke in their homes. The PHLP model local ordinance includes protections from secondhand smoke in all indoor and outdoor common areas and provides for a variety of options to ensure that individual units become smoke-free over time.

The California state law that licenses tobacco retailers relates only to revenue collection and does not address any public health goals related to the sales of tobacco products. Through the efforts by local tobacco control advocates, the state licensing law also contains expressly non-preemptive and local governments are therefore free to establish more rigorous licensing requirements at the local level.

The PHLP model licensing ordinance allows local governments to make a violation of any tobacco law (for example, tax and fee laws, youth sales, posting age restrictions, abiding by self-service display bans, etc.) legal misconduct that can result in a temporary revocation of the license. Since the revocation of a license can have a significant impact on a retailer's business revenues, this provision can add a powerful incentive to the retailer to abide by the panoply of laws related to tobacco sales and gives the local government the ability to enforce the laws against retailers.

Additionally, the model local licensing ordinance requires retailers that have a revoked license to remove all tobacco advertisements from their shops so as to not mislead consumers that tobacco products are available for sale at that location. This in an innovative way to control the advertising of tobacco products that does not trigger First Amendment concerns.

Among the public health goals of the model local ordinance is limiting the introduction of so-called "harm reduction" products that could mislead consumers into thinking that these new products are healthier forms of nicotine. The model ordinance expands the definition of "tobacco products" that are regulated to include any form of new nicotine or tobacco products thereby ensuring that nicotine waters and candies, as well as new delivery devices and other changes by the tobacco industry to traditional tobacco products, are covered under the law.

The PHLP also focuses on chronic diseases related to nutrition and unhealthy eating. As in tobacco control, public health advocates seek to prevent chronic diseases by changing the environmental conditions that promote unhealthy behavior. For example, local policy solutions include land use controls, eliminating sodas and junk foods from schools, and reducing or eliminating junk food marketing to children.

The PHLP model local ordinances include a general plan and zoning code provisions that are designed to increase access to healthy foods; restrict locations of fast food restaurants; require safe sidewalks and bike paths; establish safe routes to school, food, and recreation; create community gardens and farmers' markets; and provide adequate lighting to enhance public safety.

Local governments can eliminate or at least improve competitive food contracts and prohibit commercial messages on school property. Technical assistance and resources and training programs on government contracting and model contract language is available for assistance in improving food offerings in the school environment.

Children see an average of 40,000 television advertisements each year, and these increase in children's exposure to television ads tracks directly to the increase in childhood obesity. The PHLP is developing a series of regulatory options to decrease children's exposure to junk food advertising.

The Public Health Law Program is a constellation of several individual projects. For more information, see the websites of each project. (1) The Buck Tobacco Project works with communities throughout the country to eliminate spit tobacco sponsorship at

A number of states are considering or have passed laws that require hospitals to report how frequently patients contract infections. These new laws are intended to curb the burden of health care associated infections (HAIs). The estimated toll of these infections is significant. An estimated 2 million healthcare acquired infections occur annually in the U.S. resulting in 90,000 deaths and an estimated cost of over $4.5 billion. These new laws offer an opportunity, but also present challenges that may hinder enhanced patient care and safety.

The National Nosocomial Infections Surveillance System (NNIS) was established in the early 1970’s and has grown from 60 hospitals to approximately 300 today representing 42 states. Participation in the system is voluntary and confidential, and current participants have at least 100 occupied beds and at least one infection control professional per 100 beds. Data is collected on inpatients only. The overall goals of the NNIS are: (1) to describe the epidemiology of HAIs in U.S. hospitals; (2) to describe antimicrobial resistance associated with HAIs; (3) to produce aggregate HAIs rates suitable for interhospital comparison; and (4) to promote epidemiologically sound surveillance of HAIs in hospitals to better understand risk factors and prevention strategies.

The NNIS methods focus on monitoring infections in critical care and surgery because there are productive prevention steps that can be taken in these areas. Importantly, the NNIS uses standard definitions for infections, standard protocols for collecting infection information, and standard definitions for denominators so that the data can be analyzed and applied consistently. Definitions and protocols are updated periodically as necessary. Any institution, not only participants, can use data from the NNIS aggregate reports.

The NNIS is intended to be a continuous improvement tool, creating a cycle for success that involves assessing where an institution has a problem and why the problem may exist. A plan to affect change can then be developed to deal with the problem and the results the plan produces should be monitored for progress toward improvement. The hospitals participating in the system have seen decreases in central line-associated bloodstream infection rates between 31-44%, decreases in ventilator-associated pneumonia rates between 26-56%, and decreases in catheter-associated urinary tract infection rates between 30-59% depending on the type of intensive care unit (ICU) analyzed. Key features of success for the NNIS include the standard definitions for events and denominators as well as the specified monitoring protocols for all program participants. Also, the NNIS provides feedback to participants, not only from the Centers for Disease Control and Prevention (CDC) to the participants, but also from system participants to their clinicians. Finally, the NNIS has trained personnel for data collection and for interventions.

Currently, the NNIS system is being improved and has been renamed as the National Healthcare Safety Network (NHSN). The NHSN expands and enhances this model for patient and healthcare personnel safety. The NHSN relies on strategies to minimize the burden of collecting data by streamlining data report-
ing protocols and by increasing capacity for existing electronic data systems to seamlessly collect the required information. The NHSN also includes process measures to analyze how well clinicians are following recommendations, for example, surgical prophylaxis to prevent surgical infections. A recent study suggested that only 50% of over 30,000 surgical procedures included surgical antibacterial prophylaxis at the proper time. Lastly, the NHSN allows all healthcare delivery units to participate, including adult care, long-term care, ambulatory care, and home health settings. Several states considering legislation for public reporting of HAIs have consulted with the CDC about options to conduct surveillance of HAIs. Because of the strengths of the NHSN, this system is being considered to be used by some of these states. The CDC welcomes the opportunity to assist states and facilitate the process for public reporting and prevention of HAIs.

Recently, the Healthcare Infection Control Practices Advisory Committee (HICPAC) released a consensus opinion for public reporting of HAIs. The opinion is a guide to best practices and has been endorsed by the Association for Professionals in Infection Control and Epidemiology (APIC), the Society for Healthcare Epidemiology of America (SHEA), and the Council of State and Territorial Epidemiologists (CSTE). The four main recommendations of the opinion are to: (1) use established public health surveillance methods when designing and implementing mandatory HAIs reporting systems; (2) create a multidisciplinary advisory panel to monitor the planning and oversight of the operations and products of HAIs public reporting systems; (3) choose appropriate process and outcome measures based on the facility type and phase in measures over time to allow time for facilities to adapt and to permit ongoing evaluation of data validity; and (4) provide regular and confidential feedback of performance data to healthcare providers. Systems should not use hospital discharge diagnostic codes as the primary data source for HAIs public reporting, instead, the recommended process measures include central line insertion practices, surgical antimicrobial prophylaxis, and influenza vaccination coverage. Recommended outcome measures are based on frequency, preventability, and the importance of linkage to process measures and include central line-associated laboratory confirmed bloodstream inventions and surgical site infections. Prevention of HAIs is the primary goal of HAIs reporting systems.

Patrick J. Brennan
Pennsylvania’s mandatory public disclosure of HAIs rates is administered by the Pennsylvania Health Care Cost Containment Council (PHC4), an independent agency formed in 1986 under Pennsylvania statute as amended by 35 PA Stat. Ann. §§ 449.1-449.15 (2005), authorized the public disclosure of HAIs in order to address rapidly growing health care costs. The PHC4’s strategy to contain costs is to stimulate competition in the healthcare market by giving comparative information about the most efficient and effective health care providers to individual consumers and group purchasers. Additionally, the PHC4 reinforces the strategy by giving information to health care providers so that they can identify opportunities to contain costs and improve the quality of care they deliver. The composition of the panel reflects a heavy representation of health care purchasers.

The PHC4 is responsible for reviewing hospital and free standing surgery centers. It requires quarterly data transmission of administrative billing charges and all inpatient discharges along with select ambulatory procedures. Acute care hospitals also collect and submit clinical severity data through a mandatory electronic system that permits the use of a risk adjustment tool. The data collected are for the first 24-hours of admission to create admission severity groups, a predictor of mortality at the time of admission. The PHC4 produces a report for each hospital for the discharges by diagnostic related group (DRG) and updates the data quarterly on their website. However, use of the DRG data can lead to complications in the data, as DRGs can be an amalgamation of many different procedures. For example, interventional radiology fell under the vascular surgery DRG. In one hospital, cancer patients were receiving filters in blood vessels to prevent the migration of blood clots from the legs to the lungs and were classified under the vascular surgery DRG. The patients were not dying of complications from vascular surgery, they were dying of cancer, but the PHC4 report suggested that the vascular surgery mortality for the hospital in general was above average. The result was that three of the finest surgeons in the region had a drop off in their referral volume because of the flaw in the system. The PHC4 was reauthorized in 2003 and added nosocomial infections as a required data element in Section 912.21. Although the PHC4 did create a standing advisory panel and technical advisory board, HAIs reporting was highly prescriptive. It required the use of the Uniform Claims and Billing Form (UB92) and covered 13 specific body sites, leaving lit-
tle room for the advisory panels to make adjustments as needed. There were no explicit provisions for denominators, risk adjustment, or what measures would be reported. Furthermore, the act was passed during the summer of 2003, but the provider community was not notified that the data collection would be required in calendar year 2004 until November 2003. Following an appeal by the Hospital Association of Pennsylvania, the PHC4 agreed to slow the implementation requirements of the act. This allowed hospitals to make any necessary infrastructure changes while the two entities worked together to develop regional training programs and joint outreach programs to promote consistent and uniform understanding of the data requirements.

Some observations from the Pennsylvania experience are that the media provided the spark to move legislation forward. The details of how reporting will be carried out are critical, and the devil is in the details. Although, Pennsylvania’s Health Department was not involved in the process and there was a general lack of epidemiologic data. Regulators in Pennsylvania were interested in the total burden of disease because purchasers wanted to know what they were paying for but there was no attention to defining the denominators for the data, risk adjustment methodologies, advanced planning for reporting, or post-mandate refinements. The issue has been contentious and by resisting public reporting, the public viewed healthcare providers as stonewalling.

There are four key differences between the HICPAC recommendations and the PHC4 approach. The PHC4 uses its own methods rather than established public health surveillance methods for collecting HAIs. The advisory panel has a limited role compared to other states that have approved legislation on the issue. The PHC4 focuses on outcome measures only, which require risk adjustment, rather than the process measures in addition to outcome measures recommended by the HICPAC. Process measures are binary and do not require risk adjustment like outcome measures. Finally, the PCH4 provides feedback through the media rather than providing confidential feedback to individual providers.

Durell Peaden, Jr.

When debating the state's malpractice problems, the Florida legislature engaged issues surrounding reporting of adverse instances as a part of a patient safety initiative. The reporting of adverse instances built public interest into access to information from hospitals and physicians. Making healthcare information available to the public became a focal point in a broader initiative to analyze cost drivers in health care. Programs were instituted to make physician prescribing behavior publicly available as well as public reporting of HAIs.

Public interest in full disclosure and transparency of cost drivers for health care is evident in provisions of the Florida legislature's 2005 Medicaid Reform Bill (SB 838). This bill not only redesigns hospital networking, quality issues of physician development, and utilization of managed care, but also requires real-time evaluation of pharmaceutical availability and complications such as nosocomial infections. An additional area of real-time data reporting is the cost of pharmaceuticals. Pharmacies in Florida must individually report the price of the fifty most utilized medications in Florida Medicaid on an internet site. An analysis of the data reveals price variations within communities and even variations within pharmacies depending on the day of the week. Continued public reporting of health care information will be an important part of making health care more effective. Reports of surgical complications, infection rates, and financial costs of hospitalization will be available on public websites by January 2006.

1. Aggregate reports of the data are published at www.cdc.gov/ncidod/hip/surveill/nnis/htm.
3. For more information on The Pennsylvania Health Care Cost Containment Council (PHC4), please visit: http://www.phec4.org/.
5. SB 838 can be viewed at: http://www.fdhc.state.fl.us/Medicaid/long_term_care/sb838.shtml.
In an ideal society, all public health policies would be based on a plethora of sound scientific evidence and would achieve maximum health impact, impose no risk on individuals, and be cost saving. In the real world, these conditions never exist. And, even when these conditions are approximated (such as when a proposed policy is based on scientific evidence, is effective, has minimal risk and is reasonably priced) it may not be adopted because of other concerns such as religious convictions, questions of cost, public perception of risk or any number of other factors. Nevertheless, translating good science into good policy can be one of the most rewarding aspects of working in the field of public health. And it has happened often enough to allow us to make great strides in improving public health over the past century.

Today we will hear from three speakers who will discuss the opportunities and challenges of making public health policy based on science. We will hear the perspectives of a scientist, a lawyer, and a legislator. Each has important lessons to convey about how to be more successful in translating good science into good healthy policy.

Governor Mike Huckabee this morning talked about three questions that he tries to think about in the policy making process: what works in policy, what is feasible, and what would Americans accept?

In principle, science can and does inform policy, especially with respect to Governor Huckabee’s first question. Practitioners and policy makers face a staggering amount of health research and increasingly tight budgetary constraints. Credible and understandable scientific information on what works, how well, for whom and at what cost could help support informed choices and in principle, might help improve outcomes. There is a renewed emphasis on the nature and quality of evidence, and the reporting of that evidence. Policy makers are increasingly asking sophisticated questions about what is the best information, for example, the landmark No Child Left Behind Act of 2002,\textsuperscript{1} includes 111 references to the use of programs founded or proven by “scientifically-based research.”

All of this interest is happening because people would like to know if they are really making an impact. Answering this question is hard because reliable, valid, effectiveness data can be hard to find, difficult to understand, and difficult to assess. We need to figure out a reliable way to obtain, distill, and evaluate evidence about what is known about the relationship of policies and programs and important outcomes like health, illness, function, and cost.

What are our options? A hierarchy of evidence might go from the results of multiple good studies or a formal modeling process down through progressively less reliable options. At a minimum, evidence-based resources should provide: information; an understandable process for describing who participated and how; a systematic process for identifying, evaluating, and summarizing scientific evidence about the outcomes of interventions or policies; and a method for translating the evidence into practice recommendations. Some types of information are more credible than others. One should generally prefer scientific studies over opinions and anecdotes.
There are often concerns that insufficient evidence would be a routine or even insurmountable barrier to program and policy. I am delighted to report that this has not really played out. Convincing scientific evidence has sometimes strengthened the argument for action. For example, in 2001, a systematic review of published studies conducted on behalf of the Task Force on Community Preventive Services found that the 0.08% blood alcohol concentration (BAC) laws are effective in reducing alcohol related motor vehicle crashes. In the same year, the U.S. Congress provided incentives to states to pass such laws. Consequently, the number of states with 0.08% BAC laws increased from 17 to 50, resulting in an estimated 500 lives saved annually. However, it is imperative to note that scientific information is important but it is not enough. Users must use scientific information like effectiveness and cost together with other information, such as needs, values, capacities, and resources. In order for public health practitioners to do a better job of communicating science to policy makers and the public, the following key communication questions should be considered: (1) what information is useful for and used in decision making and how best to provide it? (2) What is the relative importance of scientific evidence in shaping decisions among policy makers? (3) How do you speed up dissemination and adoption? (4) How do you tailor dissemination strategies?

Lawrence O. Gostin

Let me begin with the following academic quote, “Should the government concern itself with public opinion when addressing public health risks such as cancer?” What if public opinion is at odds with all of the best scientific evidence? Suppose the public demands extensive government regulation or even prohibition of a valuable substance or activity when scientific studies indicate that the substance or activity presents little or no risk. The result is a conflict between the goals of a democratically responsive government and an ineffective public health protection program. Because it is impossible to reduce all human risks as publicly perceived or as scientifically justified, a trade-off is often unavoidable. The problem is complicated because the general populace and scientists do not even agree on the meaning of the term risk. So with that, I will look at questions of risks and scientific evidence from four different perspectives. I am going to look at science’s perspective of risk, the legal understanding of scientific evidence, how the lay public looks at questions of risk, and finally I am going to revisit the important question of what we do under circumstances of scientific uncertainty. I will draw a parallel to something common in environmental law, less so in public health law, and that is the relevance of the precautionary principle in matters of public health regulation.

So let me first look at science. Scientists look at three interrelated issues in trying to assess risk: (1) the nature of risk, (2) the probability of the risk materializing, and (3) how severe the harm would be if a hazard in fact did occur. It may be that there is a large probability that harm would occur, but the harm may be small; therefore policy makers may not want to take much notice of that or there maybe improbable harms but the magnitude would be very high. To give one classic example that the Centers for Disease Control and Prevention (CDC) went through about a decade ago is when mothers would ask why they were told that children with head lice were required to be sent home, whereas those with HIV/AIDS were not. The reason is that in one case, the probability is high and the harm is low, and in the other case, the probability is low but the harm is very high. There are different understandings of this. In scientific risk assessment, there is a rough inverse correlation between probability and severity. The easiest case is when you have a high probability and high severity while the hardest case is the reverse. That is why there was political and public consternation over a smallpox vaccine campaign because the probability was very low but the severity of harm if it were to occur was very high. Scientists and politicians, generally speaking, have very different perceptions; unfortunately the CDC was caught in the middle, because they are scientists but also accountable to the polity.

Another nature of risk probability is the duration of the risk. It matters how long the risk occurs, for example, with tuberculosis (TB). One would want to isolate a person with TB during the course of his or her infection, but if he or she is no longer infectious, one would not want to isolate either. So from a scientific perspective, they are interested in the nature of the risk, the probability of the risk, the severity of the harm, and the duration of the risk. This is not that dissimilar from how lawyers sometimes look at risk.

But now I want to transition to how law looks at risk and scientific evidence rather differently from scientists and in fact disturbingly differently. Scientific risk assessors look at the probability that an intervention could have been caused by chance or by the intervention itself, whereas law uses a completely different standard of proof. Law uses clear and convincing evidence or more regularly the balance of probabilities.
For example, is it 50% more likely that an event was caused by a certain cause or not likely? That balance of probabilities makes no sense to the scientist and so, the scientist would get up in court and not know what to say.

Other significant differences have to do with the understanding of biostatistics and epidemiology and this is one of the big problems, say, with mass tort litigation. Normally, the law is comfortable with the following hypothetical scenario: I get in my car, I am driving, somebody runs a stop light, they hit me, we get in court and an eyewitness says I saw X run a stop light and hit Y, which caused the harm to Y. What if you have a case where a toxic substance caused a particular harm or smoking in a particular case caused harm? Scientists might be able to say that in a large population, there is X probability that this substance caused harm Y. Yet, they will never say “caused” because they do not know. What they know is that there is a close association between substance X and harm Y. In law, that will not do. One has to actually prove that substance X directly caused harm Y, to a patient, even in circumstances where there are no eyewitnesses. In this case, epidemiology does not help.

The third gulf between law and science has to do with expert opinion. For the most part, the law tends to accept what the experts say. Unfortunately, there are very few barriers to any expert getting up in court and saying just about anything he or she wants to say, hence the concept of “junk science.” There has been a very long battle in the Supreme Court over the question of when an expert is really an expert. The bottom line is that the Supreme Court has given the judge the gatekeeper role, so the judge basically has very broad discretion in letting in whatever evidence he or she wants to let in. Law and science differ because of the standard of evidence, the idea of causation and epidemiology in mass torts, and the question of expert testimony. Don’t forget that experts are guns for hire; they are paid for their testimony.

Now let me talk about the lay perception. The lay perception of risk is something more than the scientific probability or likelihood of an event. The lay perception also takes into account personal social and cultural values. The question is, when the lay public and scientists differ, what do you do? What do you do if the science is at odds with public opinion? Very often, the public tends to use heuristics, or rules of thumb, to understand risk. What this amounts to is simplifying assumptions. For example, toxic waste is harmful, so all toxic material must be removed; or nuclear power disasters occur therefore, all nuclear power plants must be dangerous and banned, which is why nuclear power has a lot of controversy surrounding it. The public is concerned with some really interesting ways of thinking about risk, one of course is salience. What is salient in the public mind usually through the media is thought of to have a high risk and so if you think of scientifically very low risk, the public perception of it is very high. For example, flesh eating bacteria, mad cow disease, or even bioterrorism. Salience means a lot and the media tends to have a substantial effect on the public’s perception of risk. The public is prepared to accept certain risks that are natural risks but not things that they think are unnatural like nuclear power, cloning, genetically modified foods, etc. They are suspicious of these. The public also prefers voluntarily incurred risks to involuntary risks. For example, people may insist upon the regulation of airlines even though the airline safety record is much better than the driving record, because in the public view, they have no control over flying, as compared to driving.

Finally one needs to point out, in terms of law, science, and the lay perception, there are no easy answers and most of the time, the problems involve risk trade-offs. To reduce one risk, one may have to increase another. One example from the CDC is that in order to reduce the risk of cryptosporidium or other water-borne diseases, you may have to use chemicals in the water which might raise the level of cancer risks. In most situations, you are always balancing one risk over another.

Let me finish by talking about the precautionary principle, or what you do when faced by conditions of uncertainty by way of quoting the Dahi Lama, “Where there are threats of serious and irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradations.” I will end by saying that public health officials at the local, state, and federal levels have my greatest admiration because their job is a difficult one. Public health officials live in a political community, are acting without full scientific evidence, and the failure to move aggressively at an early stage can have catastrophic consequences. But at the same time, actions that prove to be unnecessary will be viewed by the public as draconian and based on hysteria. My only advice is that a major safeguard against this is transparency. Public health officials need to make the basis of their decisions clear and open, they need to honestly acknowledge what they know from science and what they do not know, and they have to be open to reconsideration of public policy based on new scientific evidence.
I often tell people that I have the easiest job in the health field. I do not treat people and I do not live with the laws that I enact because I do not run a hospital or even worry about sales in my line of work. But it also means that I do not bring real-world health professional knowledge and experience to my work. One of my favorite quotes is from Confucius, “To know what you know and to know what you don’t know, that is wisdom.”

I am going to talk about how public health professionals can have an impact on legislators. It is important that you know how to do that and practice it because legislators make laws. Most health laws are made at the state level. If public health professionals do not influence legislators on public health policy, a lot of other people will. You should not be shutting yourselves out of that process.

In dealing with legislators, it is important to assume that they are by and large ordinary people. We come in all shapes and forms, and from a variety of backgrounds. Most people think that the overwhelming majority of legislators are lawyers. This is not true. The overwhelming majority are not lawyers. You should also assume that legislators want to do the right thing and need the right information to guide their decisions. I don’t want to claim that legislators always do what they think is the right thing, but it happens much more often than you might think.

There are enormous obstacles to legislators doing things that are evidence-based, among them are:

1. Lack of information. People often do not know what they do not know; we tend to think we know. Anecdotal information is the most powerful in influencing most people. A good anecdote is impressive and powerful. For example, we all know that George Washington did not chop down the cherry tree but that does not prevent us from believing that he did.

2. Interest groups. For example, the drug industry, manufacturers, and people in other industries who do not want to be told what to do or what not to do. They can oppose and defeat bills or get them passed, and have the ability to contribute to political campaigns and often visit legislators in their offices.

3. Credibility of information. Trying to figure out what information source is credible is a major obstacle. How does a lay observer figure out which messenger is carrying the junk science? I have been doing a lot of work in this legislative session relating to vaccines. Are the anti-vaccine people the peddlers of junk science or are the manufacturers of the vaccines – who are not different from other drug manufacturers – the peddlers of junk science? Lawmakers tend to turn to those whose credibility they trust, and this does not always work in favor of public health.

4. Ideology and religion. These have always dominated American politics. All of us can point to issues where ideology and religion superseded science.

5. Information overload. Too little information is a barrier; conversely, too much information is a barrier too. Lawmakers do not have time to plow through huge amounts of scientific data.

6. Analytical errors. Labels put on proposals, such as the names of victims put on laws (for example, Megan’s Law) tend to obscure the real issues or crimes. For example, we assume that if Megan’s Law had been enacted, Megan would still be with us. Also in New York State, we have Kendra’s Law named after a woman who was pushed onto the train tracks in New York City by a person with a history of mental illness. The aftermath of this included the passing of a law mandating court ordered assisted outpatient treatment. The truth was that the man in Kendra’s case had not refused treatment; he had actually been banging on the doors of the system seeking help and getting turned away. The facts in Kendra’s case had nothing to do with Kendra’s Law but once her name was affixed to it, it drove the bill to enactment.

Legislators need to think clearly about what interventions we are talking about. Take the example of sexual abstinence. It is a very effective way to prevent pregnancy and the contracting of sexually transmitted diseases. But, whether abstinence is an effective intervention is one thing. Whether having school teachers tell teenagers to practice abstinence and whether that is an effective intervention for holding down pregnancy is a very different question. As far as I can tell, having school teachers tell teenagers to abstain is a totally ineffective way to prevent teen pregnancy. But people talk about abstinence education as if they were talking about abstinence itself and focus on the fact that abstinence keeps girls from getting pregnant. Getting policy makers to focus on what interventions they are in fact proposing or discussing and whether that intervention produces the desired outcome is a major obstacle.

How do you overcome these barriers? Tailor your
messages to the legislators’ intellectual capacity, interest, and background as well as interact more with legislators. Provide regular briefings on what you do, what your area of expertise is and what your agency does. These interactions help to develop relationships and credibility that will be invaluable to you when the time comes for you to reach out to them. For example, in New York State, the legislature delayed the enactment of the mandate for the vaccine against chicken pox because a pediatrician who treated the children of a top health policy staff member of the Speaker in the Assembly felt that there was not enough data to support the enactment of the legislation. The staff member had turned to him for advice and the bill ground to a halt. (A year later, the doctor felt the case had been made, and the bill became law.) Other opportunities to interact with legislators include being involved in various associations that do legislative advocacy, such as the National Association of County and City Health Officials (NACCHO) and its local affiliates.

Lastly, focus on education. There are several instances where legislators can be educated on public health issues. For example, every summer, the University of Colorado Medical School runs a few days-long program course on evidence-based medicine, mostly for physicians and other healthcare professionals. The Milbank Memorial Fund pays for about half a dozen state legislators to attend. I have found this to be enormously valuable in my work. If we can create more opportunities like this for formal or informal education of elected officials about public health issues, it will be energetically received by most legislators and can be very effective. Since we’re citing religious authorities, I will close with a line from the Talmud, “The ignorant cannot be righteous.”

1. For more information, please see: http://www.ed.gov/nclb/landing.jhtml.
2. For more information, please visit: http://www.oag.state.ny.us/consumer/tips/megans_law.html.
3. For more information, please visit: http://www.omh.state.ny.us/omhweb/Kendra_web/KHome.htm.
Legal Frameworks for Preventing Chronic Disease

Wendy Collins Perdue, Edward P. Richards, Kathleen H. Acree, and Donna F. Stroup (Moderator),

**Donna F. Stroup**
The application of legal tools, as a means of prevention, has a promising future in the area of chronic diseases. Businesses that provide healthy snacks, wellness centers located in office buildings, healthy urban planning, and regulation intervention are all examples of how steps to prevent chronic diseases through a legal framework can succeed in helping communities to be healthier.

**Wendy Collins Perdue**
Chronic diseases including heart disease, diabetes, asthma, and cancer are among the leading causes of death and illness in the United States. Success in diminishing the number of cases is directly related to preventable risk factors: sedentary lifestyle, diet, obesity, smoking, and air pollution. Individuals’ lifestyle choices are affected by the broader physical, social, and informational environment but law can be used to alter that environment and increase the likelihood that individuals will make healthier choices. Government intervention can provide assistance in creating a legal framework, as well as a physical environment, in which individuals may make private lifestyle choices.

Unhealthy habits are often correlated to the shape or design of the physical environment. Street patterns, destinations within walking distance, street designs, accessibility of parks and recreation areas all affect whether individuals make healthy choices. Many areas are constructed without taking into account the broader public health implications created by the design and the policy choices that are involved with the particular area. Some laws and government actions even contribute to unhealthy physical environments. Zoning that requires single-use zones or large parking lots, street codes that focus on cars and speed rather than pedestrians and bicycles, spending decisions that build more roads and fewer sidewalks are all examples of ways law and government actions can negatively affect the health choices of individuals.

Laws and government actions can also affect nutrition and the food environment. Sometimes government policies fail to include grocery stores in redevelopment plans and instead incorporate fast food outlets creating a deficiency of healthy food options. Many schools have inadequate school food policies thus providing a wide availability of high calorie/low nutrition food. The advertising sector aggressively promotes “junk” food at the expense of our society’s health. Therefore, law and government policies must be altered and directed toward remedying the current inadequacies and inefficiencies to construct an environment that promotes nutrition and healthy eating habits.

To promote exercise, nutritious eating habits, and a healthy lifestyle there are a number of legal tools at governments’ disposal. Governments can use direct regulation by implementing policies such as seatbelt and helmet requirements or by requiring individuals or groups that impact the environment, both the physical and informational, to build and conduct themselves in particular ways. The advantage of governments using direct regulation is that it specifically and directly targets the relevant conduct. In addition, requirements or prohibitions can highlight to the community underlying values and thereby contribute to general health education. The disadvantages are that the method is coercive, regulations can a trigger
backlash of concern about infringement upon personal freedoms, and the monitoring of such regulations can be costly.

Economic incentives or subsidies are another method governments can use to promote, but not require, desired conduct. Examples are taxes on cigarettes, alcohol, and snack foods; higher insurance premiums for overweight individuals; direct subsidies to healthy food manufacturers or preventative health care providers; land use incentives; as well as taxing food advertising that targets children. These strategies encourage desirable conduct without directly coercing groups or individuals. As a disadvantage, the approach can disproportionately affect the poor and benefit the rich. In addition, there can be unintended and unforeseen consequences that, in turn, negatively affect the goals of the original initiative.

Indirect regulation through private enforcement is another approach that can influence certain behaviors. Tobacco litigation, fast food litigation, and malpractice liability are examples of tort law discouraging undesirable conduct. Indirect regulation offers an approach that costs governments less and encourages private industry solutions. In addition, document discovery associated with litigation may increase information about a particular issue. However, such litigation can be long and complex and the approach can produce unintended defensive responses.

Governments can provide general information that encourages healthy behavior and discourages unhealthy behavior. This approach preserves a high degree of individual autonomy, but can increase perceptions that individuals are to blame. Governments can also provide needed facilities and services such as transportation facilities, parks and recreation areas, and schools. The location and design of such facilities are important in encouraging healthy behaviors. By providing services and facilities, governments respond directly to the needs of the community; sometimes, government involvement can be less efficient than private providers and the approach can be costly.

Governments control thousands of facilities and employ millions of workers. Governments can create and provide healthy environments for workers and customers by providing stairs, pedestrian accessibility, healthy food options, prohibiting smoking, and by offering other incentives for healthy lifestyles. Thus, government offices can be a place for developing best practices, in turn, making private industry more receptive to try these practices. A major shortcoming of these programs is that they do not directly impact the majority of citizens.

Lastly, different levels of government may interact with one another to provide incentives in order to promote certain policies, as in the use of funding grants. These grants can be made conditional, for example, when the apportionment of federal highway funds to state governments are provided on the condition that the state enact legislation that declares the legal drinking limit to be 0.08%. This allows a focused, countrywide effort to seek change as opposed to each local government having to pursue such an effort alone. However, this approach can be unresponsive to particular needs and penalize localities with the highest need.

These approaches are tools that can be used to promote healthy lifestyles. The methods may be used separately or jointly and by using these approaches, a broad framework can be created that reflects a government’s choice to promote healthy lifestyles, while allowing individuals to make personal choices within the framework.

Edward P. Richards

Obesity poses unique issues for public health policy makers. Unlike tobacco, where the public health message is a simple “don’t do it”, managing obesity demands that individuals learn to make healthy choices of food, understand calories, and, ideally, increase their levels of physical activity. Also unlike tobacco, whose risks are evenly spread through the population, obesity and its sequella is complicated by race, culture, and genetics. For example, mild to moderate obesity has profoundly different consequences for individual health, depending on whether the individual is predisposed to diabetes. This predisposition to diabetes is more common in minority communities and particularly in American Indians. Are legal strategies that target individuals, such as health insurance surcharges and “fat taxes” appropriate when they will disproportionately affect minority populations or genetically identifiable groups?

Developing effective legal strategies requires viewing obesity in the larger context of public health and policy, because many of the root causes of the increase in obesity are the unintended consequences of legal policies directed at other public concerns. Without a holistic approach to public health policy, legislative approaches to obesity management may fail in their intended purpose and may spawn unanticipated problems.

There are two key considerations in designing public health legal strategies: (1) is the strategy an efficient way to accomplish the objective; and (2) will it have unintended negative consequences?
The first step in developing legal strategies to manage obesity is to reexamine and revise the policies that contribute to it. School districts installed vending machines to make up for shortfalls caused by reductions in tax revenue to support schools. Portion size increases, both at home and in restaurants, were possible because agricultural policy since the 1950's has focused on reducing the cost of food. Fresh fruit and vegetables are relatively more expensive than grains and meat because grain production has been encouraged to support export policy. In many neighborhoods, children do not play outside because of fears of crime. Neighborhoods are not conducive to walking because zoning has encouraged single-use suburbs. Additionally, physical education has been reduced or eliminated in many schools because of cost concerns and because it takes time away from academic work.

As these policies are revised, it is difficult to avoid new unintended consequences. For example, if schools are dependant on vending machine income to support academic programs, laws that ban or limit vending machines in schools should also address the replacement of vending machine income. Laws that prevent the sale of fast food for school lunches should also address the limited cafeteria resources in overcrowded schools that lead to the sale of fast food. Taxes to raise the cost of high-calorie foods will further reduce the ability of the poor to purchase food, and food insecurity is a contributing cause to obesity.

Developing new legal strategies should be driven by the best nutritional science. Obesity is a complex problem and many proposed solutions have little scientific support. While it may be politically attractive to enact laws without waiting for good scientific evidence, intrusive policies that are later shown to be ineffective undermine community support for public health.

Even a well understood strategy, such as collecting better data on the prevalence and severity of obesity, can pose problems when it is added to the responsibilities of an already overworked health department. Many local and even some state health departments have sustained budget cuts over the past several years, especially if limited-use bioterrorism funds are not counted in their budgets. Adding obesity data collections and interventions to a health department’s workload, without fully funding the new activities, will reduce the effectiveness of the department in other areas. While obesity is a very important problem, it should not displace other critical public health activities.

Obesity is a long-term problem that defies short-term solutions. Key strategies to prevent obesity include education in K-12 schools, acculturating the next generation of children to be more physically active, changing long-established land use patterns, and shifting food and agriculture policy to reduce the cost and increase the availability of healthier foods.

Helping individuals who are already obese and suffering from obesity-related sequelae such as diabetes requires providing universal access to high-quality primary care. Current health care policy encourages surgical or pharmaceutical treatment of obesity. This does not address prevention of obesity and it is expensive, as well as potentially dangerous. Yet because such treatments are profitable and easy for the patient, they have a strong constituency that opposes diverting resources to preventive care.

Supporting long-term strategies that are essential to changing the culture basis of obesity, and reforming the health care system to support prevention, requires hard political choices and a long-term commitment of funds and political support. This, ultimately, is the hardest challenge in implementing legal strategies to reduce obesity and encourage physical activity.

**Kathleen H. Acree**

Law is but one of many tools that can be used effectively to promote health and control disease. Childhood immunization laws are excellent national examples, as is the California Water Fluoridation Act. Legally, the clout of state and local health officers is as enormous as it is limited. Under the right circumstances, health officers can close down businesses, enforce quarantines of people and products, levy fines, and revoke licenses. Such powers must be tempered by public information, friendly persuasion, effective warnings and, above all, common sense. Such powers clearly require well-educated, well-trained and experienced public health professional leadership. Unfortunately, as pointed out in the Institute of Medicine's (IOM) report – The Future of Public Health, – the public health workforce at all levels is currently in significant decline.

Public health laws and programs can have unintended consequences. For example, the need for the physicians to remain current on medical advances and procedures has led to required continuing medical education credits to maintain licenses – a worthy cause indeed. However, even here we often see overzealous specific requirements, as for example when CPR certification for all physicians was made an annual requirement. While this undoubtedly provided income to sponsors of such training, there was little evidence of overall benefit, and considerable evi-
dence that the requirement was little more than an annual annoyance to the targeted community. The offending requirement was soon revoked. While unintended consequences should be taken into consideration in the design of new laws, programs, and policies, fear of these consequences should not serve to stifle such development.

Given the goals they are expected to attain, public health agencies at all levels of government are often underfunded, understaffed, overly politicized, and at times unable to officially promote effective public health measures. It is a challenge to work in such environments. New and creative approaches must be undertaken toward both funding staffing and program implementation. Nor is it essential that such programs and funding be placed within public health agencies. Now more than ever, public health professionals must join forces with other groups, taking the time and effort, directly or indirectly, to cultivate and nurture appropriate community connections and coalitions in order to generate the requisite new laws, new programs, new sources of additional funds, or to protect the resources already in hand. For example, the California Fluoridation Project, solely by working with a broad-based constituency which leveraged an additional $15 million from a single foundation, The California Endowment, will have raised the percentage of Californians with access to fluoridated water from 17% to approximately 70% by 2006.

Additionally, more flexible funds are desperately needed; as such funds are more likely to effectively address local needs and priorities. For example, over the past 25 years, the federal Preventive Health and Health Services Block Grant (PHHSBG) has indeed provided public health departments with greater flexibility than that of any of the categorical programs. This has allowed states to establish highly successful programs, more tailored to state needs and better positioned to leverage additional funds from other sources. Over the past five years, California PHHSBG programs have leveraged an additional $111 million for program efforts – a return of four dollars for every PHHSBG dollar invested. Further, a minimal investment of PHHSBG dollars in California ultimately led to the development of the five a Day program, which became the prototype for the national five a day program. Similarly, an investment of PHHSBG funds in early tobacco control activities eventually led to permanent funding through the California Tobacco Control Tax and Health Promotion Act Tax (Proposition 99). The resultant programs have significantly reduced California deaths from cardiovascular disease and tobacco-related cancers, and produced a decline in cancer of the lung and bronchus that is six times that of the rest of the nation.

There is certainly a need for sound scientific underpinnings in any public health action to control chronic disease. The question is how much data is enough, and how severe must the problem be before requiring some action even in the face of less than complete information. Consider the fact that the adverse health effects of tobacco usage were known for some 50 years before the nation launched concerted action against this product. Think of all the lost lives and needless suffering and deaths that occurred in this time frame. With regard to obesity, for the past decade this epidemic has marched inexorably across the nation, followed swiftly by the march of type 2 diabetes. The implications for future health problems, especially among our youth, are mind-boggling. This problem is not just one for the medical care community. Immediate public health action is essential. The public health community cannot afford to stand idly by, nor does it have the academic luxury of waiting for yet another study or one more research project. While the call for additional studies is well founded and should be promoted, there is indeed sufficient available data to begin action now. Social marketing campaigns, passage of school soda bans and/or physical activity requirements, food labeling efforts, a focus on the health effects of the built environment, the work environment, and safety issues adversely affecting physical activity of all these environments are but a few of the areas where public health officials must take action to resolve the public health problems of today.
Shaping Healthy Environments

Victor Colman, Delores M. Pluto, and Angela K. McGowan (Moderator)

Angela K. McGowan
This session considered how legal interventions can aid in creating or shaping a healthy environment. Specifically, it focused on legal issues surrounding the built environment, schools, and potential nutrition and physical activity policies and legal interventions.

Victor Colman
The Washington state story centers on a rare convergence in the chronic disease prevention field: the public, media, policy makers, and public health. This rarity will ultimately diminish, making now the time to act for policy change. Washington serves as an example of policy change and partnerships with its plan centered on policy and environmental change, and it illustrates how a plan serves as a mechanism to legitimize an issue. Washington’s plan had high level goals and objectives and also serves as a current reference tool. The program centered on Washington’s receipt of Steps to a HealthierUS (STEPS) grant from the Centers for Disease Control and Prevention (CDC) for four different communities within the state and a city grant for Seattle/King County. At its core was the element of integration, specifically, fusing the risk factors identified by the STEPS program. Further, the program sought to go beyond the grant’s four steps to look at all issues related to chronic disease resulting in program efforts that engage locals and push innovation. For Washington this resulted in trying different strategies in the area of physical activity.

Multiple efforts at the local level are effective mechanisms to assess a program’s innovation, promise, and feasibility. This dynamic between state and local work is challenging, but there is a limit to what can be accomplished at the local level because of a lack of jurisdictional authority. In some instances, action must be done at the federal level which may or may not offer the state a voice.

The STEPS grant focused on teaching policy skills that targeted a broad spectrum of policy knowledge and function at the local level. In January 2005, STEPS, tobacco prevention, and numerous other local and state chronic disease prevention programs collaborated to develop a comprehensive two day policy development training for local contractors. Because policy development is considered one of the three “core” public health functions (and likely the least understood), it was necessary to talk about both the “why” and the “how” of policy development and provide skills and legitimacy to the concept before implementation. The lessons learned from the experience included: the need for practical training at the local level and defining and differentiating the role of a public health employee from a non-profit employee. Further, understanding was needed regarding appropriateness, the authorizing environment, and the critical role definition. This requires heightened accountability for contractors at the local level because they must integrate the work at the state level, too. In response to the concerns of a large scale training session with no resulting action, a work group formed to determine the next steps, create real expectations, and establish standards.

In late 2004, collective policy development work generated the Nutrition and Physical Activity Policy Leadership Group (NPA-PLG), which channeled its focus on one or two state policy issues to maximize effectiveness. In preparation for the 2005 legislative
session, a think-tank process for policy ideas was used resulting in a “greatest hits” of policy related work, although, a policy vision for what nutrition and physical activity needs to encompass is still pending. This process requires a policy roadmap defining direction for the next three to five years, executing the necessary work, and determining whether the NPA-PLG wants to take on the role of the advocacy arm that pushes ideas forward. It is still uncertain if the group wants to take on that role and the potential challenges. The largest challenge they would face is inviting business to the table and, if invited, the subsequent agenda impact. Within the NPA-PLG, business and food are the two key industries barely present. The necessary work would require additional alliances at the city and county level. Finally, it is necessary to determine the role of public entities in policy development. Often in these work environments, individuals “self censor” because they are not clear about their particular roles and wind up disengaging from the process. A further policy development postscript is that often people focus efforts on policy change and ignore the sometimes more complicated work of implementation. The questions that need to be asked are: is it feasible, who needs to be brought in to carry out the policy work, and who will be on the front lines?

In sum, scattered policy agendas are ineffective for policy change. The top down/bottom up approach is critical because individuals are needed at the local level to drive and move policy makers via coalitions, alliances, and grass roots organizations. There are challenges that remain as illustrated by the overlay of disparities, for example, access to healthy foods in the inner city does not make sense when a supermarket is not available. Accordingly, policy ideas need to target all populations and address sustainable funding. Continuing work is determining what “best practices” look like, and utilizing the public health overlay between prevention, disease management, and planned care. Legitimization of prevention in the health care world is still pending. Policy change is an inherently political process and demystifying the process is critical for the next steps because local health leadership must understand this process and their role in it and the problem must be addressed in its entirety such as not focusing exclusively on children. Work remains and greater resources are needed to bridge research and the outside field, but Washington demonstrated that measured steps to instigate policy development processes in public and private settings can help the overall efforts in chronic disease prevention.

Delores M. Pluto
The need for continued physical activity policy research is simple. The levels of physical activity in the United States have not changed in the past ten years. The more people are told to “get active” the more things stay the same. As tobacco control illustrated, efforts to change behavior require a broader, multi-level approach – not simply going after individuals, but looking at communities, environments, and policy influences.

The Prevention Research Center Program is a Centers for Disease Control and Prevention (CDC) program comprised of 33 funded locations throughout the United States. They are located at schools of public health and/or schools of preventive medicine and each center has either a behavioral or disease focus. The center at the University of South Carolina focuses on policy and environmental support for physical activity and works with a local community coalition to provide technical assistance to change the community environment. Within this program, the CDC has funded five centers as a Physical Activity Policy Research Network (PAPRN).5 The mission of the PAPRN is to conduct transdisciplinary policy research by identifying potential (physical activity) policies, related factors and determinants, describing policy implementation, and determining both intended and unintended consequences. The policy definition is not simply legislation, but rules, regulations, and practices that may become policy. Policies being examined include those that impact physical activity either directly or indirectly through the environment.6

The PAPRN project receiving core funding, centers on active travel to school. For example, Safe Routes to School has defined its effort around transportation based on the “Four E's” of encouragement, education, enforcement, and engineering. The first, encouragement, supports walking to school and is aimed at both children and parents. The rationale is that parents will allow children to walk or bike to school after accompanying them on the route. This allows for both reinforcement of the behavior and identification of safety problems. The education portion teaches bicycle and walking safety, identifying “stranger-danger,” and driver education. The enforcement component requires strong traffic law enforcement. The engineering component examines school location, sidewalk construction, and the cycle lane connection.

A number of policies at the state and local level affect this program. At the federal level transportation funding comes up for review every six years and funding is provided for non-motorized infrastructure.
Federal transportation legislation passed this summer including funding for a safe route to school program. State policies impact walking and cycling to school from a variety of angles. A prime example is school site selection. Currently, many states have minimum acreage requirements and in some cases urban schools cannot be built because there is not enough land. Other districts face concerns about maintaining community schools or consolidating community schools in favor of one big school. For example, in South Carolina some counties have only one elementary school, one middle school, and one high school to serve an entire county. As a result, most children live too far away to walk or bike to school. Additionally, state bus policies only provide busing if the individual lives more than a mile and a half away and large student parking facilities encourages high school students to drive. Several states have attempted to follow California’s policy lead (with varying degrees of success) earmarking a percentage of transportation safety money specifically for school improvements. South Carolina, for example, recently passed a policy which allows school districts to set up teams to look at safe routes to school programs, but the policy allocated no money to the cause.

The PAPRN is conducting a multi-site case study to determine factors that might effect active transportation to school. Each of the five centers has selected a specific school involved in safe route issues, programs, and policies and their respective barriers and enablers. The school district in South Carolina has a local non-profit working with two different schools on improving safe routes. One was successful and one was not, so they will examine the differences both at the school and community level. Interviews will be conducted with principals, school district representatives, land use planners, and others who are, or should be, involved in the effort associated with those particular elementary schools, using a snowball sample to identify key participants. Finally, last year PAPRN received funding under the Robert Wood Johnson Foundation’s Active Living Program for policy case studies. As a network, a proposal was submitted to look at walking trails for each of these five communities. Interviews will be conducted looking at the policies that led to the trails and what was involved in adopting them. The case studies will include trails in urban and rural areas and involving a variety of policies and players.

Panel Q & A Discussion (Angela K. McGowan, Victor Colman, and Delores M. Pluto)
The discussion addressed a variety of issues generated from the presentations including, promotion of walking to school by city planners and real estate developers, retrofitting sidewalks, social impact of restructuring schools, generating a budget/interest in policy issues, the use of scientific evidence to generate concrete land use policies, and what resources (if any) are available to decision makers.

The panelists briefly discussed the role of the real estate industry in promoting walking, introduced the topic of neighborhood gentrification, and Dr. Pluto noted that urban renewal must also provide affordable housing. It further spurred talk about the need for substantive rather than procedural changes and the need to utilize all available powers, for example a public health officer signing off on school site selection. Ms. McGowan, also questioned the audience on whether they had experience with the insurance industry working with the built environment, which was answered in the negative.

Sidewalks, or lack thereof, brought engaging discussion, particularly surrounding the issue of retrofitting. As Mr. Colman pointed out, being risk adverse and assessing true risk must be distinguished to avoid running away from the issue. Dr. Pluto noted that the elderly population in particular is concerned about liability associated with lack of maintenance during winter, but emphasized the need for true risk assessment. Audience members pointed out that controversy stems primarily from retrofitting including concerns that walkers will generate crime and that solutions will not come easy, but do require community involvement to ensure success. More often than not, the focus is centered on “doing it right the first time” in regard to sidewalks.

Regarding the social impact of policy, Dr. Pluto emphasized the need for a multi-disciplinary approach and the balancing act related to desegregation and the efforts to ensure that there are not unintended consequences related to reducing school size and reinstating the neighborhood school, which brings the flavor of the neighborhood with it. Dovetailing into the subject of insurance incentives, Mr. Colman pointed out that monetary incentives come from a program’s history and integrity and the difficulty of making them an initial player. As the talk shifted to “beating down the budget door” Mr. Colman pointed out the need for both intentionality and for stakeholders to work together to tackle issues, by developing coalitions and alliances.

Ms. McGowan also highlighted the panelist’s use of scientific evidence to support their policy work. Specifically, she noted the use of science and evidence based research to craft effective policies. She asked
both the audience and the panelists for examples of both “unusual partners” and relevant policy related research. Mr. Colman emphasized the need for policy making in both the private and public sector and his work focused on compilation of nutrition and physical activity policies categorized at the state, local, and institutional levels and did a cross hatch based on evidence which resulted in a compendium, or policy inventory on the subject. Dr. Pluto noted that although she and her colleagues drew upon the Guide to Community Preventive Services, there is still not a lot of evidence-based research to use. Studies like those of the PAPRN will help contribute to “on the ground work.” In regard to policy evaluation, Dr. Pluto noted that there has been an evaluation of active living by design and that Maine is a leader in the anti-sprawl movement.

Ms. McGowan posed a final prompt to the panelists asking what the panelists’ visions and hopes for the future of their projects and policies included. Final thoughts put forth by the panelists included Dr. Pluto’s comments that education must be combined with incentives to achieve results and the need for the public to have a voice in the process. Mr. Colman pointed out the need for policy development to be truly a core public health function as well as embraced as such by the discipline. In response to a final audience comment, Ms. McGowan also reminded the group that policy examples related to the built environment and land use can be effective stepping stones for expanding the field of public health policy and our greater efforts.

1. Please note that David Goldberg from Smart Growth America was unable to participate in this session. For more information on Smart Growth America, please see: http://www.smartgrowthamerica.org.
2. For more information, please visit: http://www.doh.wa.gov/cfh/steps/npa_ply_gry.htm.
3. Aging is another group that was neglected, but cannot be ignored because of its demographics and the implications for chronic disease prevention. In the future there will be collaboration with AARP and other individuals and organizations.
4. An example is SB 5436 which required all schools to have a policy on nutrition and physical activity by certain dates, but there was no money in the bill. A lot of work was done to find grant money, but none was found for actual grant implementation. Many calls were received for technical assistance, but there was only a limited amount of help available. This raises the question: if they held out for money would they have received better results. The answer remains to be seen because the due date is a few months off, but waiting for the money might have been a better option.
5. The five funded centers are located at the University of Washington, University of South Carolina, University of North Carolina at Chapel Hill, Harvard University, and St. Louis University (the lead center).
6. The primary example of a direct influence on children’s physical activity is requiring PE in schools. An example of a policy that affects physical activity through the built environment is roadway design providing bike lanes, trails, and recreational spaces.
7. Elementary schools were chosen because of the smaller catchments area so it is more likely that children will walk or bike to school.
8. The compendium or policy inventory can be viewed at: http://www.doh.wa.gov/cfh/steps/publications/nutrition_activity_policy_guide_final.pdf.
9. For more information on the Guide to Community Preventive Services, please visit: http://www.thecommunityguide.org/.
Public health law and ethics work together to guide decision making in public health. Public health laws provide broad authority allowing for professional judgment and discretion. Public health ethics involves deliberation about and justification for public health action and guides when and how to use government authority when the law is not determinative. Law and ethics are both fundamental institutions in society, but they are slightly different. Law is a formal institution with statutes, regulations, court decisions, and public proceedings. Ethics is no less a social institution, but it is less formal. There are moral norms, professional codes, and previous cases to draw upon. The goal of public policy ethics, including public health ethics, is public justification.

Ethics is a process that involves exploring, analyzing, and presenting sufficient grounds or reasons for a course of action, especially when the law does not tell you what to do. Ethics appeals to moral norms, ethical principles and professional codes. Ethics is a deliberative process best practiced in groups with reasons presented to others. There are no right answers often times, especially when there is significant scientific uncertainty. Therefore, having collaborative partners with whom to search for and deliberate ethically acceptable options helps to achieve the goal of coming to a well reasoned, publicly justifiable decision.

The objectives for this session are to explore the process of using an ethics framework to guide decision making and to describe the Public Health Code of Ethics promulgated by the Public Health Leadership Society. Then the panel simulates an ethics committee addressing flu vaccine allocation issues to explore the role and usefulness of an ethics advisory committee. Another question we will address is the role of the public health lawyer in ethics discussions.

The ethical analysis of flu vaccine allocation begins with the relevant laws, regulations, and sources of authority. A few states address allocation directly in legislation, some adopting by law a hierarchy of high-risk groups to be treated first. Other states issue executive or emergency orders to guide vaccine distribution. Regardless of the source of authority, the question lurking remains when and how should public health use the authority granted in law? What are the ethical principles and moral considerations that provide justification for a particular option? How should particular stakeholders be engaged and how should the process of public justification take place?

There are several ethical principles to be considered in making public health decisions, but here the panel focuses on utilitarian and egalitarian principles. Utilitarian principles strive to do the greatest good for the greatest number of people. When explicating the principle of utility, one might distinguish social and medical utility. Social utility, which attempts to maximize overall social welfare, can be framed either as broad social utility, or narrow social utility, which would focus on the specific essential roles an individual may play. An example of narrow social utility is vaccination for medical personnel on the front lines. Medical utility seeks to maximize the welfare of persons suffering from or at risk for disease. There are two aspects of medical utility one might consider, medical need versus the probability of a successful outcome. These distinctions may be useful in deliberation to help clarify the goals of a particular allocation.

Egalitarian principles focus on concepts of equality...
and justice. These include treating each person as an equal according to fair procedure in the distribution of goods and burdens. However, identical treatment for all individuals is not required under all egalitarian principles, and fair rationing is permitted. In addition, egalitarian principles do not preclude the use of utilitarian principles. For instance, decision makers might appeal to narrow social utility and fair treatment when providing justification for giving priority to vaccinating medical personnel on the basis of that individual’s social role.

Four prevailing methods were employed for allocation of flu vaccination during 2004–2005 shortages, each with inherent strengths and weaknesses. Priority groups based on risk, a utilitarian approach, were justified by efficient and effective use of available flu vaccine, but required further prioritization of risk groups in the face of scientific uncertainty. The idea of first-come, first-served offered egalitarian fair equality of opportunity but did not account for inequalities in access to service and utilitarian considerations. Another egalitarian approach was lottery, which offered equal opportunity but again failed to address inequality of access to enter the lottery and utilitarian considerations. Finally, priority groups based on social function included health care workers with direct patient contact and were justified by social and medical utility. A related question is, who decides which criteria will be used and who will be vaccinated? As Calabresi and Bobbitt observed, when societies confront tragic choices where fundamental social, cultural, and ethical values are at stake, they must attempt to make allocations in ways that preserve the moral foundations of social collaboration: trust.1 Recognizing the importance of community trust, public health officials are exploring ways to integrate ethical analysis in their day-to-day decision making, such as by establishing informal ethics advisory groups that the panel will model.

**Alan Melnick**

The frameworks for guiding decision making, including the Public Health Code of Ethics, provide structure for the process of discussion, challenge, and deliberation of ethical issues. The Public Health Code of Ethics recognizes several distinctive dynamics of public health. Public health is responsible for maintaining a population-based focus while serving individuals. Also, public health authority is derived from the police powers of the state and functions within that governmental structure. Public health law provides authority to place significant restrictions on individuals; the law describes what public health can do, ethics helps in the process of determining what public health should do. The Code is intended to be a catalyst for making ethical considerations a part of the regular public health decision making process to optimize outcomes.

**Lisa Kaplowitz**

Virginia approached the flu vaccine shortage by delegating much of the decision making for allocation to the 35 local health districts. Localities were successful in communicating with the public about the situation and the priorities in their areas, and vaccine was redistributed from lower to higher need areas. At the end of the process, local health directors agreed that an ethics group would be beneficial to promote transparent, ethical decision making that can be communicated clearly to the public. The ethics group can help to build community trust in the depth and integrity of the decision making process and by involving a broad range of parties. A Pandemic Influenza Advisory Group has been created to support the development of a pandemic flu plan in Virginia.

**Wilfredo Lopez**

A few words of caution are warranted with regard to the functioning of ethics committees in a governmental setting, considering media interests, freedom of information laws, and confidentiality. There are fewer complications for an ethics committee involved in a planning process if it is merely advisory, as opposed to a decision-making body managing an actual case or event. This is especially so if the ethics committee includes outside, non-governmental members. Governmental decision-making bodies invoice a number of laws, such as requirements to announce and conduct meetings publicly in accordance with open meeting laws. The planning process is an appropriate forum for a committee with outside members, allowing for involvement by the members of the public and experts from the community to fully discuss and debate ethical considerations. In contrast, the management of an actual event is best handled by an internal group that can meet quickly to frankly discuss various options. The internal discussions and deliberations can thereby remain confidential, while, of course, the final determinations and documents are available to the public. In this way, when the policy is actually determined and implemented, explanations and justifications can be conveyed clearly and consistently to the public.
The core principles of public health ethics are analogous to many core legal principles. Public health ethics seeks to ensure that advancing the health of the community does not improperly infringe upon individual rights. Referencing the Principles of the Ethical Practice of Public Health, each principle is embedded in the law. Public health law gives government the power to advance public health through the curtailment of civil liberties, while the process of public health ethics provides for the thoughtful balancing of public interest and individual rights. Respect for the individual reflects equal protection, the right to privacy, and substantive due process. Gathering community input for decision making reflects procedural due process. Providing information to the community and obtaining consent for those affected reflects informed consent. Making informed public health decisions reflects rational basis review of decisions to assure there is a compelling need and that less restrictive alternatives are not overlooked. Protecting the disenfranchised reflects equal protection, procedural due process, and informed consent. Protecting the confidentiality of private information reflects the right to privacy. Respect of diverse values, beliefs, and cultures reflects equal protection, freedom of religion, and informed consent.

Lawyers should play a key role in public health ethics discussions. A lawyer is an advocate for the process and rational decision making, and should remind the group that the decision will need to be articulated and defended in a variety of different venues. A lawyer also serves as the subject matter expert on what is legally permitted. Frequently a lawyer is also the voice for individual constitutional rights in the face of public health applying its powers for the good of the community. Finally, a lawyer helps the group to understand the legal latitude that may exist in emergency situations.

Discussion of Flu Vaccine and Drug Allocation Strategies
The hypothetical case discussion centered on a novel influenza strain that emerged from Asia, with relatively high mortality rates. As the outbreak spreads through the United States into populous areas, vaccine development is underway with limited quantities expected to become available within a matter of months. There is also a looming shortage of antivirals that might be effective against the strain. Community concern is fueled by media coverage of the disease, and a range of ethical questions emerge.

Vaccine Issues
Prioritization of persons receiving the initial doses of vaccine will be necessary. Issues will arise, such as:

- What populations should receive the vaccine in the event of a shortage?
- How will decisions be made about sub-groups in each of the priority populations (e.g., how to define a “health care” worker?)
- How will vaccine be distributed to priority groups?
- How will vaccination of priority groups be enforced and will people have to “prove” their rightful membership in a priority group?
- How will security of the vaccine supply be maintained?
- Should the government take over the development of the vaccine?

Antiviral Medications
Because vaccine will not be available when the virus first affects communities, antiviral medications may play an important role in the prevention and control of the influenza, especially during the period before vaccine is available. Issues that will arise include:

- What populations should receive antivirals in the event of a shortage?
- Should antiviral use be recommended for either prophylaxis or treatment, or both?
- Should compliance with recommendations for the use of scarce antivirals be voluntary or should the recommendations be enforced through regulations or statutes that may carry civil or criminal penalties?

Community Communication
Widespread occurrence of a novel influenza strain will create many concerns, including:

- How will government communicate the plan to the community, and how transparent will public health be about the status of development and availability of vaccine and antiviral medications?
- What are the essential services that cannot be stopped in any event (e.g., water, electricity, power plants)?
- What steps will be taken to ensure that essential service workers are prioritized to receive either vaccine and/or antiviral medications?
- At what stage in the outbreak will isolation and quarantine be used as tools to reduce transmission?
Most of these questions arise because the law authorizes public health to take actions, but leaves the design of those actions up to the judgment of public health officials in the given situation. Public health ethics provide structure for the process of discussion, challenge, and deliberation of ethical issues to facilitate thorough consideration of the interests involved in a decision.

Severe Acute Respiratory Syndrome (SARS) was a significant wake-up call for Canada. Although its spread was confined mostly to health care institutions, largely through the dedication of health care workers and the public, this outbreak had significant social disruptions (associated with quarantine) and economic impacts. In Toronto, it caused some 8,500 people to be quarantined, and resulted in over 40 deaths. SARS reminded us of the limitations of science, that is, developing an accurate diagnostic test was not such an easy task. It also reminded us of the importance of social solidarity in our ability to fight public health threats and as it turned out, the most effective tool was an old one and that is the conventional isolation of those infected. SARS and the re-emergence of old foes, such as syphilis and community water-borne disease outbreaks, and new ones, including bioterrorism, forced us to reassess the state of the public health infrastructure at the federal, provincial and local levels.

Over the last decade, there have been many calls to strengthen public health infrastructure in Canada. The last two years in particular have been characterized by many comprehensive reports on the state of the nation's public health system. Most of the reports have been initiated by the federal or provincial governments in response to public health crises. The most recent reports share a common vision for the renewal of Canada's public health system; better federal-provincial and inter-agency cooperation, and public health system improvement. These reports caused the formulation of a multi-pronged federal strategy seeking to:

- Improve collaboration through a Federal/Provincial Public Health Network (The Public Health Network was announced in late April of 2005 and was designed to bring together all partners in public health in an efficient and coordinated manner and will enable more effective public health practice)
- Coordinate and focus efforts on public health through the collaborative development and implementation of national public health goals and targets
- Translate knowledge into practice, via a series of National Collaborating Centres, (The National Collaborating Centres were recently announced and will focus on the determinants of health, public policy and risk assessment, infrastructure and information structures and tools development, infectious diseases, environmental and Aboriginal health) and, finally,
- Create a federal focal point for public health, with a new agency and the position of a Chief Public Health Officer for Canada. (The Public Health Agency was created in September of 2004, and the Government of Canada has created the first-ever position of Chief Public Health Officer of Canada).

Today, the Public Health Agency of Canada provides a federal focus for public health. Furthermore, the agency displays leadership in programs, research, and surveillance related to: emergency preparedness and response to disease outbreaks; prevention and control of infectious diseases, chronic diseases, and injury; and health promotion and community action. In order to increase accountability and independence,
the Chief Public Health Officer heads the Public Health Agency while reporting to the Minister of Health.

Difficulties and sometimes confusion exist due to the complexity of the Canadian legislative framework. *The Constitution Act of 1867* articulates the division of powers between the provincial and federal governments. However, it does not mention exclusive authority to make laws in the matter of “health” or “public health functions” – as a result, all jurisdictions have roles and responsibilities for public health.

Specifically, the provincial governments are in charge of local or private matters, property and civil rights issues, the establishment of hospitals, education, provincial spending power, and municipal institutions. In turn, the federal government is responsible for criminal law, quarantine and marine hospitals, order and good government, federal spending power, navigation and shipping, Indians and lands reserved, trade, and finally, commerce.

New steps that have been taken to improve this complex legislative situation in Canada can be seen in recently announced federal legislation – the new Quarantine Act. The original act was adopted in 1872 and was overhauled in May 2005. The act focuses on airline travel rather than marine travel. Provisions include: establishing quarantine facilities at any location in Canada; taking temporary possession of premises as detention facilities; diverting airlines to alternate sites; collecting and disclosing medical and confidential business information; issuing Emergency Orders prohibiting entry into Canada. Another example of steps taken to improve federal legislation is the proposed Canada Health Protection Act. The act’s focus is on the Food and Drugs Act of 1953, Hazardous Products Act of 1969, and the Radiation Emitting Devices Act of 1969. The Federal Provincial Territorial Public Health Network – a new mechanism for intergovernmental collaboration – has announced as one of its priorities a commitment to harmonize approaches to public health law improvement across the country. This is a positive development, which promises to help improve Canada’s public health legislative infrastructure.

**Jane Speakman**

Progress is being made toward creating a more adequately prepared public health system in Ontario. The creation of the Capacity Review Committee increased funding for local public health units, the newly created Provincial Infectious Disease Advisory Committee, recent amendments to the *Health Protection and Promotion Act* which strengthens the role and the independence of the Chief Medical Officer, and an integrated Public Health Information System are examples of improvements to public health in Ontario post-SARS.

If the provincial government follows through and implements the recommendations in Justice Campbell’s interim reports one can be hopeful and optimistic about the future of public health. Justice Campbell made many recommendations in his second interim report; a few are highlighted in this overview. Justice Campbell supports and recommends an independent role for medical officers of health. The Chief Medical Officer of Health must have primary responsibility for public health aspects of every emergency. Stronger health protection powers are a necessary element in the successful functioning of the public health sector. Physicians’ duty to report infectious diseases, including the timing and the content of these reports, must be clarified and prescribed by statute. The categories of individuals with reporting obligations should be expanded to incorporate a wider array of health professionals. The legislation must reflect the necessity of sharing communicable disease information with medical officers of health. Protection of whistleblowers must also be provided. Quarantine policies and emergency plans need to include compensation packages that are readily operationalized. Justice Campbell also observed that legal preparedness should be an integral part of public health emergency planning and emergency powers should undergo legal, practical, and policy analysis before new emergency management legislation is enacted.

These recommendations highlight some of the steps that must be taken to establish a successful, sustainable, and revitalized public health system. Health professionals must continue to advocate a critical shift in thinking in relation to public health reform and assist in identifying strengths and deficiencies within the public health system. Public health has made many improvements but there is much more work to be done. Evidence of government commitment is absolutely necessary or the momentum for change will fade.

**Elaine Gibson**

A lack of effective information systems hindered the fight against SARS in 2003. The information flow between individuals, primary care providers, public health units, provinces, federal government, international governments, media, and the public proved to be unsystematic and disordered. The cause was a
series of overlapping problems, a number of which are discussed below.

First, workers in the public health system, in hospitals, and in the federal and provincial ministries faced overwhelming and disorganized demands for information. Second, during the SARS epidemic there were one federal and two provincial information systems in use. This resulted in a great deal of overlap and duplication during a time when resources were extremely low. And third, there was no data dictionary. Case definitions were inconsistent, both within a given organization and between different bodies (for example, the definition of a SARS case by Health Canada changed seven times during the SARS outbreak). This meant that different information systems were not necessarily counting the same things, resulting in a great deal of confusion.

What solutions are proposed? Broadly, an information system must be designed and implemented, with due respect for confidentiality of individuals and groups. This system should be designed post haste. Unfortunately, once an outbreak of an infectious disease has surfaced, the time for designing and building such a system has passed. There should be careful consideration given to determining who are the appropriate healthcare system actors that would have access to this system. Within the system, while some degree of flexibility is required in the circumstance of a newly arising infectious disease, there must be relative consistency in case definitions. Inconsistencies exist between jurisdictions due to both public health and information being primarily provincial, producing a smorgasbord across Canada. Collaboration across jurisdictions must be improved to effectively coordinate public health efforts. Data needs to be clarified as to who owns the information so as not to hamper those who need the information with the legal question of ownership. Legislative reforms and data sharing agreements must also be developed in order to provide greater access to information. Neglect and tolerance of imperfect systems must cease and action must be taken toward creating better, more efficient arrangements within the public health sector.
Global migration is an ever-present reality in our mobile international world. Prior to the September 11, 2001 terrorist attacks, U.S. Citizenship and Immigration Services (USCIS) admitted over 1,000,000 immigrants and nearly 50,000-70,000 refugees/asylees per year into the United States. In fiscal year 2002, the number of migrants entering the U.S. declined significantly as the result of tightened security procedures implemented post September 11th. In 2003, USCIS reported that 705,827 immigrants were admitted into the United States. In that same year 28,306 refugees/asylees arrived in the United States.

Immigrants and refugees are often vulnerable populations who have been marginalized from receiving health care services or do not have preventive and treatment health care services in their countries of origin. When immigrants and refugees arrive in the United States, they often have complex health care needs that go unmet as they face a host of additional obstacles to receiving care and adjust to a new environment. Many public health issues have been raised from the local to federal and international levels regarding migration, law, and the public’s health. To effectively address the health needs of immigrants and refugees, a paradigm shift from an exclusionary to inclusionary model for migrant health is necessary.

This session will identify approaches and tools that have proven effective and can potentially be effective in addressing major public health issues raised by immigrant and refugee populations. Panelists will provide perspectives and experiences from federal and international sectors; academic and local community practice sectors; and the state and legislative sectors.

Each year, the U.S. resettles between 50,000-70,000 refugees. The Immigration and Nationality Act delegates authority to the Centers for Disease Control and Prevention (CDC) for monitoring the required overseas medical exam and defines inadmissible conditions. In 1990, immigration laws related to health conditions underwent major revisions. The amendments defined inadmissible conditions as “communicable diseases of public health significance as determined by the Secretary of Health and Human Services.” The CDC is responsible for staffing ports of entry to meet arriving refugees and for notifying and transferring medical information to health departments so that the refugees will have appropriate follow-up and treatment in the U.S. These rules, authorities, and mandated encounters provide the CDC with the unique responsibility and opportunity to improve refugee health.

Proposition 200 was passed in Arizona in 2004 to restrict certain state benefits to only United States citizens and required state and local governments responsible for administering non-federally mandated public benefits to verify the identity, immigration status, and eligibility of each applicant to receive “public benefits.” Any violations of immigration laws had to be reported to authorities, and failure to do so constituted a misdemeanor. However, the term “public benefits” was not defined in the bill and Arizona’s attorney general interpreted it to include only five specific programs. The interpretation by the attorney...
general was challenged in court to expand the reach of the law.

Since the passage of Proposition 200, twenty-eight anti-immigrant bills were introduced into the legislature. Ten passed the House and Senate, and five were signed into law by the governor. One of the laws the governor signed prohibits public funding for day labor centers, where people who want to do day labor can congregate at facilities with water, shade, and restrooms. As these facilities provide opportunities for both citizens and illegal aliens alike, they can no longer receive public funding. Bills that were vetoed by the governor included measures to deny adult education, child care assistance, in-state status for tuition and college scholarships, fee waivers, or financial aid to people not legally present in the U.S. The governor also vetoed a bill to authorize local police departments to enforce federal immigration laws. This bill was opposed by police departments because they had no training in federal immigration law and the bill provided no funding for officer training. An additional bill vetoed by the governor prohibited law enforcement or other government agencies from accepting identification necessary to receive public services unless issued by federal, state, county, city, or Indian Tribe, specifically excluding the use of the Matricula Consular identification card issued by the Mexican government. Although Proposition 200 has had little practical effect on public health programs in Arizona to date, the pending litigation threatens a broad array of services.

Jill Moore

Immigrant benefit eligibility in the U.S. is primarily shaped by Title IV of the Welfare Reform Act of 1996. The Act did four things that have an impact on immigrant health and public health as well as state and local governments. First, the act drew a distinction between U.S. citizens and all others for purposes of public benefit eligibility. Second, the act created a new designation called “qualified alien.” Third, the act set forth the benefit eligibility rules for qualified and non-qualified aliens, which completely barred non-qualified aliens from receiving many benefits that are publicly funded and restricted benefit eligibility for most qualified aliens. Finally, the act gave states the option to take additional steps to address benefit eligibility. States may choose to enact legislation to provide state and local benefits to non-qualified aliens. On the other hand, states also have the option to impose more restrictive eligibility requirements for federally funded programs, including Medicaid, for qualified aliens.

Under the new rules, most qualified aliens have limited eligibility for Supplemental Security Income (SSI) or food stamps and a five-year waiting period for federal means-tested public benefits, which includes Temporary Assistance for Needy Families (TANF), Medicaid, and State Children’s Health Insurance Program (SCHIP). Further, the general rule is that non-qualified aliens are ineligible for publicly funded benefits or services. However, there are some significant exceptions to this rule. Among other things, non-qualified aliens are eligible for emergency Medicaid, short-term non-cash disaster relief, communicable disease tests and treatment, and immunizations that are publicly funded. Additionally, some benefits and services are available to everyone present in the U.S. without regard to citizenship or immigration status. These include ambulance services, emergency medical services, fire services, police, and public transportation.

The Welfare Reform Act creates a direct barrier to immigrants’ health by expressly denying some benefits. It creates several indirect barriers as well. First, eligibility requirements are difficult to understand. Second, immigrants who are eligible for services may be reluctant to apply for them because of concerns about revealing their or their family members’ immigrant status.

The act has created practical problems for state and local governments as well. The most significant of these is the strain on local resources that is created when immigrants are eligible for a service a state or local agency provides, but not eligible for a program that would pay for the service. For example, the Department of Health and Human Services (DHHS) provides funding to local health departments to provide prenatal services and DHHS has determined that non-qualified aliens are eligible to receive these services. Therefore, local health officials cannot inquire about citizenship or immigration status in determining eligibility for prenatal benefits. However, unless the patient is a citizen or qualified alien who has been in the U.S. for five years, the health department cannot access Medicaid to fund most of the care, creating uncompensated care costs.

1. 8 U.S.C. §§ 1101 et seq.
The United States is behind the curve in thinking about trade and public health. Looking into the future, trade and public health are two of the most important topics of discussion.

This is the tenth anniversary of the World Trade Organization (WTO). The WTO, which is based in Switzerland, is not a United Nations (UN) agency. It has 148 members and 630 staff, and its Director General is Supachai Panitchpakdi of Thailand. The WTO represents a formal break with the UN and the WTO establishes trade agreements, develops policies, and encourages cooperation with other agencies.

Among the health-related agreements promulgated by the WTO are the General Agreement on Tariffs and Trade (GATT) which was signed in 1947; the General Agreement on Trade in Services (GATS) which was signed in 1995; the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs) which was signed in 1994; the Agreement on Sanitary and Phytosanitary Measures (SPS) which took effect in 1995; and the Technical Barriers to Trade (TBT) which took effect in 1996.

In regard to product availability, issues arise when a product, such as alcohol or asbestos, is taxed differently from other products or when a product such as firearms is introduced into a market. When a country seeks access to the WTO, members of the WTO can apply pressure to that country to change its trade policies.

Another area where product availability becomes an issue is food and diet. Reports have stated that changes in behavior when new foods are introduced into a market can result in detrimental health choices. While some would say there are no bad foods, fatty and sugary foods are becoming the next tobacco. Issues over food show the tension between trade, commerce, and public health.

With services and providers, this movement can be seen in health providers and in who controls access to water. An example of the change in willingness to regulate can be seen in the example of Methanex, an additive in gas. California found the additive to be harmful to the environment, but because of the North American Free Trade Agreement (NAFTA), the dis-
Trade represents the free market approach to reducing poverty and those in favor of this approach argue that we need privatization of markets. This can be seen in the percentages of net capital now moving between countries, where 82% of trade is between private parties and 9% is between public entities.

Privatization is fueled by globalization, international financial institutions, and a push to overcome corruption and inefficiency. Privatization may be a cause for concern, because the private sector may clash over public priorities. For example, if the population is poor, then investors may not be motivated to enter the market. Privatization may also lead to loss of local development.

Water privatization is a good example of what we know about privatization of previously publicly controlled services. In privatization, the focus is on labor productivity, firm growth, and market valuation, but not on public health. This does not produce a good picture of how these efforts play out over time. Physical access may be improved in poor areas, but such access is estimated indirectly. Water piracy may prevent these numbers from reflecting reality. In addition, non-privatized areas usually already have fairly high rates of access to water, so starting where there is no access to water will allow providers to show statistics of success much more easily. Studies have also shown that child mortality has declined in areas where water access is privatized, but over the long term, the public entities offer comparable services and child mortality rates even out.

Trade can disrupt public health practices and influence shifts in public health, especially in the transfer of food. In addition, the commoditization of goods does not “feel good.” It feels disturbing to put control of water access in private hands. Barriers to increased awareness to the effects of trade on public health are institutional resistance, lack of resources and coordination, and lack of balanced advocacy.

The World Health Organization (WHO) recommends training, compliance counseling for SBT and TBT, more interaction between public health and trade, and health impact assessments. It should be noted that, in their recent report on the future of the WTO, the WTO did not mention the WHO, whose offices are just down the street from the WTO. It is not enough to say trade is a problem for public health.

The WHO thinks trade is a problem, but we cannot ignore trade. Trade is not going away. How it affects public health will depend on the participation of public health officials in the debate.

**Ann Marie Kimball**

Public health’s core mission is to protect populations from infectious diseases. However, despite the enormous range of global trade, there is no working group on health at the World Trade Organization (WTO). It should be noted that trade is good for some regions, especially the Asian Pacific region, where even non-market economies such as China and Vietnam have seen positive results from trade. Therefore, when discussing the effects of trade on public health, we need to specify the effects region by region.

The world population has reached unprecedented levels, but the world urban population is mostly centered in developing countries. Access to water and sanitation in those areas is uneven, with about 1 billion people short on water and 2 billion people short on sanitation.

Uncontrolled urbanization plus globalization of travel and trade can equal huge risks. This can be seen in the agricultural poultry industry. Pathogenic influenza led to the deaths of millions of chickens and, as a result, millions of dollars. The intensification of poultry agriculture in poor sanitary environments can lead to high risks because disease in those areas is difficult to control. In a pandemic, the primary level of microbial traffic is at the point of emergence. The secondary level is by local extension, and the tertiary level is in geographically dispersed clusters.

Trade-related infections emerge coincidently with ramping up production for global market demands, increased efficiencies mandated by tariffs, or innovations in product manufacturing. Reducing tariffs increases market access and increases competition. In the case of HIV/AIDS, transmission was amplified through global trade. In addition, a description of infection can cause disruption in travel and trade, which can be extremely expensive.

Poultry exports from East Asia increased 25 fold in the decade preceding 2000. This was a result of a need for high-protein food, and much of the poultry was eaten fresh in the region. Now there is a need to restructure the poultry industry, but we do not have the metrics to measure successful restructuring. There is now active surveillance in place for avian influenza. While there is a high human mortality rate for avian influenza, the disease does not transfer from human to human very well. The threshold of this pandemic is not yet known. However, even in the best situation, the risks associated with avian influenza are high.

Other examples of diseases being transmitted as a result of ramping up, consolidation, advances in pro-
cessing, and pooling of biological materials in processing include HIV/AIDS in the Factor VII global market, *E. coli* 0157:H7 in beef, and bovine spongiform encephalitis (BSE or “mad cow”), in beef. BSE transmission may have been related to changes in rendering and increased efficiencies that were needed as a result of GATT pressure on beef tariffs.

Among the “tools of the trade” are agreements such as the General Agreement on Tariffs and Trade (GATT), the Technical Barriers to Trade (TBT), and the Agreement on Sanitary and Phytosanitary Measures (SPS), which have interactions with emergence paradigms. The GATT’s commitment to tariff reduction may lead to enhanced efficiency. In addition, both TBT and SPS mandate notification of urgent trade restrictions, and human health concerns are the leading rationale for notification in both cases. In the case of BSE, notification practically stopped beef export from Great Britain. The notification may be a smokescreen, though, given the high number of notifications each year. Also, the World Health Organization (WHO) is not given access to the information in the notifications.

Can public health pull the brakes on the global express? Local systems for isolation, quarantine, and epidemiological investigation and control are weak. Other options are recall of products and trade restrictions, but these are in doubt. While the WTO already has a committee on the environment, the WTO also needs a committee on health. Remedies for microbial traffic can start with national and local public health agencies and then move to the WHO and WTO.

In the new International Health Regulations (IHR), which create a positive obligation to create capacity within countries and a mechanism for declaring public health emergencies, there is no mention of trade or contact with the WTO. The regulations, which will be implemented in 2007, will seek to enfranchise poor countries to establish public health infrastructures.

The future of world trade still raises questions. Will the mandates for “safety nets” in countries in the IHR be realized? Can these measures mitigate risks? Will product alerts through urgent measures reach the WHO in a timely manner? Can the WTO and WHO work together on secondary prevention? Currently, there is little operational discussion between the two parties. Finally, will it take a pandemic to get a standing committee on health at the WTO? Eventually, both sides, trade and public health, must come together.

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**David P. Fidler**

Over the past ten years, the World Trade Organization (WTO) dominated the relationship between public health and international trade. But what does the next decade portend? Analyzing this question involves looking at three areas: (1) potential developments within the WTO; (2) the proliferation of bilateral and regional trade agreements; and (3) the implementation of the new International Health Regulations (IHR).

*Potential developments within the WTO.* In the next decade, the trade-health relationship is intertwined with the fate of the Doha Development Agenda, the failure of which may mean that poverty and its attendant public health problems will become even more entrenched. Thus, the Doha Development Agenda itself is important from a public health perspective.

In terms of specific WTO agreements, potential developments with the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs), the Sanitary and Phytosanitary Measures (SPS) agreement, and the General Agreement on Trade in Services (GATS) may have the most importance in the next ten years. Concerning intellectual property, one development to monitor is whether any countries take advantage of the third-party compulsory licensing mechanism established in 2003 (the so-called Agreement of the Implementation of Paragraph 6 of the Doha Declaration). To date, no countries have utilized this mechanism, even for anti-retrovirals. Another area to watch is what impact the WHO Commission on Intellectual Property Rights, Innovation, and Public Health will have on the controversies surrounding intellectual property rights and public health.

Certain developments concerning the SPS Agreement might be worth watching. In particular, the upcoming decision expected in the *EC – Biotech* case, filed by the U.S. against the EC’s regulations on genetically modified organisms, may be seminal for how the SPS Agreement is interpreted and applied in the future.

Finally, the potential liberalization of trade in services under GATS is important. Negotiations on such liberalization continue as part of the Doha Development Agenda, and how negotiations deal with health-related services will be critical. In addition, new case law under GATS may also be forthcoming in the next ten years. The recent decision in the *US – Gambling* case, although not involving public health, has implications for public health, especially with respect to specific commitments on market access.

*Proliferation of regional and bilateral trade agreements.* The “next wave” in the trade-public health
relationship may be affected most by the proliferation of regional and bilateral trade agreements. Instead of a multilateral system, a complicated “spaghetti bowl” of preferential trading arrangements is emerging. The spaghetti bowl also includes approximately 2,000 bilateral investment treaties that regulate foreign direct investment.

How does this spaghetti bowl of regional and bilateral agreements affect public health? So much attention has been focused on the WTO that, with some exceptions, the public health community has been slow to appreciate the proliferation of regional and bilateral agreements represents. The impact on public health of these regional and bilateral agreements could be significant in each area of the trade-public health relationship, including intellectual property rights, SPS measures, services, and the manner in which disputes are settled.

The Central American Free Trade Agreement (CAFTA) provides an illustration. A number of public health experts have argued that CAFTA represents a threat to public health in the CAFTA nations (United States, Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, and Nicaragua). Analytically, assessment of the impact of agreements such as CAFTA on public health could start by evaluating their rules against relevant WTO agreements because public health’s familiarity with the WTO provides a baseline for thinking about what’s in the spaghetti bowl.

Crudely, CAFTA’s rules on trade in goods, SPS measures, technical barriers to trade, and general exceptions for measures that protect human health more or less track what’s in WTO agreements. CAFTA differs from WTO rules in three areas: protection of intellectual property rights, trade in services, and dispute settlement. CAFTA contains provisions that require greater protection of intellectual property rights than TRIPS. In terms of services, CAFTA differs from GATS in that it applies market access and national treatment obligations on CAFTA states parties, except for non-conforming measures the parties list in an annex. This means that CAFTA’s liberalization of trade in services is more aggressive than GATS. Finally, CAFTA creates its own dispute settlement mechanism that could be used instead of the WTO. This creates another dispute settlement system public health experts have to monitor for decisions that may impact health policy.

This focus on CAFTA suggests that the implications of regional and bilateral agreements are complex and cannot be summarized by “sound bites.” The bottom line is, however, that these regional and bilateral agreements constitute an important topic on which more public health attention is needed.

The new International Health Regulations (IHR).

The new IHR, adopted in May 2005, will affect the trade-health relationship. The new IHR attempt to balance trade and health interests as did the old IHR, but the new IHR are radically different and more demanding. What needs to be watched in the next decade is whether the radical transformation the new IHR represents is actually implemented in a way that maximizes synergies between public health and trade.

The past decade was one in which public health had to adjust to the WTO. The way in which the WTO altered the relationship between trade and public health had the ironic effect of making public health more politically important than it had been in the past. The next decade will be different as public health will have to continue to deal with the WTO but also swim in the spaghetti bowl of regional and bilateral agreements. The new IHR adds another regime to the mix in terms of the future relationship between trade and public health.

The Holy Grail of this relationship has, of course, been policy coherency between trade and public health. Achieving such coherency will prove difficult; and public health still does not have the muscle that trade possesses, placing a greater burden on public health to understand, influence, and manage international trade agreements in a way that shapes them, as much as possible, into vehicles for better public health.

The Emerging Role of State Attorneys General in Public Health Emergencies

Cynthia Honssinger, Robert Ianni, and Jeff Milsteen (Moderator)

Jeff Milsteen
The two panel members here are eminently qualified to discuss the session's topic. The topic, the "emerging role" of attorneys general underscores the fact that public health and emergency management are new areas for attorneys general. While true, this is surprising because attorneys general represent all of the state players who would be participating in a public health emergency.

The two panelists are Cynthia Honssinger, the Chief Deputy Attorney General for Colorado. She has been in this position for only a few months but has a great deal of experience in government and public health in particular. She previously served as the Chief Counsel to the Colorado Governor and prior to that was Director of Legal and Regulatory Affairs for the Colorado Department of Public Health and Environment. She also served as Deputy Executive Director for the Department of Public Health and Environment in 2003. She is also a founding member of the Public Health Law Association and currently serves on its board of directors. She also supported the foundation of the Centers for Disease Control and Prevention's Public Health Law Program.

The second panelist is Robert Ianni, with the Michigan Attorney General's office, where he has served for over 30 years. He has practiced in areas from insurance and banking to criminal law, and has been the AG's Emergency Management Coordinator for 15 years – one of the few in an attorney general's office. In 2004, he was appointed by the Attorney General to a newly formed position, the Director of Homeland Security and Special Projects, where he is responsible for coordinating emergency legal response training for all states' attorneys general. In 2005, he was named the state public administrator. In addition to serving on numerous boards and commissions, and teaching and writing on various legal topics, he was also responsible for coordinating a conference on state attorneys general that took place in Michigan in the spring. His talk will share some of the lessons learned from that conference.

Cynthia Honssinger
This talk is organized by the powers that are vested in the health department and that the attorney general's office is charged with helping the state health departments carry out. These include: reporting; quarantine and isolation; and the Governor's Emergency Epidemic Response Committee.

The power to investigate is a common police power that almost every state has and that allows them to report and track diseases. How much should the state expand its statutory powers given the current potential for bioterrorism, emergency epidemics, radiological, and chemical incidents? It is a difficult question whether to open up basic public health powers via statute as we have significant and broad ability to investigate disease. At the time that these laws were passed, the context was that of tuberculosis. Many statutes have not changed, and are still quite adequate – probably better than what the legislature could do in the 2000's. When Colorado added powers, it was in the statute that applies to the Department of Local Affairs, which grants the power to declare a disaster emergency, not in the public health code. That strategic decision worked well in Colorado, and avoided hot debate regarding powers public health has always had.
The investigative power is not highly utilized by the attorney general’s office, except to explain or distinguish where public health can go with its investigations, and how broad those powers are. The power to investigate is partnered with the public health power to report and track disease. Reporting allows the attorney general the authority to access medical records. It is important to take a forensic epidemiology class, like the one offered by CDC, and work with law enforcement and find out how they would conduct investigations in the event of a bioterrorism incident. The course is also a good opportunity for those working in public health to try to mesh languages of public health and law enforcement when dealing with investigation. Forensic epidemiology classes are taught in many jurisdictions. In Colorado, a deputy attorney general created a teaching module as a “train the trainer” exercise, so that people could go out and teach law enforcement and local public health departments to work together. The more conversations and training that has been done in Colorado, the more the barriers to information sharing have broken down.

Information sharing is another vital area that follows the discussion about law enforcement. Colorado has bolstered a statute to allow the attorney general to receive confidential information on disease, make it easier to track old and new diseases, and look for patterns and clusters of exposure. The statute limits the release of personal medical information, to what is necessary to allow law enforcement to do its job. And while the Health Insurance Portability and Accountability Act (HIPAA) of 1996 prevents the disclosure of identifiable information it does allow disclosure to public health authorities, and permits disclosures that are required by state law. Once information is reported to public health agencies, HIPAA no longer limits disclosure and that allows sharing of necessary information with law enforcement.

Isolation and quarantine have led to some of the most interesting questions and research in the attorney general’s office, and an opportunity to interact with public health in a way that AGs have not historically had a chance to do. Prior to dealing with bioterrorism, the attorneys general learned about public health on a case-by-case basis and did not really understand how public health accomplished its goals. Severe Acute Respiratory Syndrome (SARS) gave the states a chance to look at their own laws and think about how to handle mass quarantine. Police powers generally allow for quarantine and isolation and in Colorado that power is vested in both the local and state-level public health authorities. Who gets to exercise authority? The local health department? The state health department? In reality, hopefully both levels would be working together.

Colorado has set up a quarantine enforcement sequence, and the attorney general’s office has created templates so that the state is prepared if a situation does occur. The sequence would begin with a verbal order requesting citizens to comply with a quarantine. If necessary, a written, administrative order could be given to specific people who have been identified as being exposed with a particular disease or agent. That written order would set parameters, detailing the state’s requests, including how long the person should stay in place, and whether they can be quarantined at home. If a person is recalcitrant, a written order is prepared describing how to seek a court order asking that the person stay at home. And finally, non-compliance with a health department order results in a misdemeanor.

Colorado is still working to create uniform orders to streamline the process. The attorney general’s office has met with the state court administrator to explain what a public health emergency would be, and what the AG would expect of the courts. Judges still need education, and the CDC’s bench book for judges detailing public health powers would be very useful for most states. Some states have continuing legal education about public health powers.

Participation by law enforcement is still an unknown in Colorado. Who will enforce a quarantine order? Law enforcement has had a mixed reaction – officers do not want to knock on the door of a citizen with a fatal exposure. Should they drive around neighborhoods? Follow ambulances making sure emergency response workers get where they are needed? That sort of decision may not be made until a critical situation unfolds, and priorities become clear.

Colorado has a unique group called the Governor’s Expert Emergency Epidemic Response Committee (GEEERC), which was created to build into the disaster emergency powers of the governor, specifically to respond to a bioterrorism incident, pandemic, or epidemic. The GEEERC comprises experts in public health, and would advise the governor in the event of a public health emergency. In the event of an emergency, the GEEERC will come together to evaluate the evidence, and decide whether to advise the Governor to declare a disaster emergency. Once the governor does that, his broad powers to draft executive orders and direct the movement of personnel would go into effect. The GEEERC would have a grave responsibility to not over-react to an emergency.

The attorney general’s office has written draft executive orders that follow the powers the governor
would have in response to an emergency. Some of the draft orders include the power to procure and take supplies from pharmacies, stockpile medicines and vaccines, and distribute medicines without following pharmacy regulations; the power to tell a hospital to cease other admissions and become a dedicated facility; issue quarantine and isolation orders; deal with the aftermath, including disposing of bodies and waste; provide mental health support for emergency responders; and provide and control information to the public.

Declaring a disaster makes other resources available and extends immunity from civil and criminal liability of health workers. The Colorado attorney general’s office is looking into the extension of immunity to volunteers, for example, the law now does not provide good immunity for people acting as “Good Samaritans.” Colorado law also makes government responsible for the aftermath of an emergency, although the state is beginning to recognize that it may have gone too far, and needs to at least limit caps of governmental immunity in tort.

Robert Ianni

This presentation is a summary of the National Association of Attorneys General (NAAG) conference, entitled “Legal Preparedness for Public Health Emergencies,” held in April 2005. The conference was intended to discuss legal issues surrounding emergency situations because most states do not have dedicated people working solely on emergency management or pre-prepared manuals. The conference was attended by 75 lawyers from 32 states, state, and local health agencies, plus emergency response departments. The purpose was to provide attorneys general the information needed to provide counsel before, during, and following an acute public health emergency.

Conference topics included the key roles of the attorney general, the basics of emergency management law, and the role of the judiciary. The conference also featured speakers such as Wilfredo Lopez from New York, who discussed legal issues stemming from September 11, 2001 and the anthrax attacks. One of the most important events at the conference was a tabletop exercise. Every participant received a legal manual, which was Michigan-specific, but designed to be converted to state-specific documents, and also a legal exercise manual to be used to conduct exercises in each state. The AGs were encouraged to return to their states and carry out the exercise, which included a scenario that involved a judge having to decide how to rule on a quarantine/isolation case in an emergency situation. The manual is a good tool to educate judges, and was created after Michigan judges were trained in public health and emergency law by the state Attorney General’s office.

The primary roles of the attorney general are to represent the state’s interests, provide legal advice on disaster response, assist local authorities on legal issues, and in its role as a law enforcement agency, the AG’s office helps with any state criminal investigations. Risk management is also a key function of the AG. The office also provides legal counsel to the governor, and works with other various state officials to back up policy decisions.

For the most part, the attorneys general will review state law for soundness, especially in public health. The office will draft executive orders in an emergency. The attorney general in many states is a recognizable public figure, and can often use that recognition to reassure the public, or explain government decisions via the media in the event of an emergency.

Minimizing liability is also an important area for attorneys general. Issue areas covered during the conference include liability for acting, failure to act, and using approved documents. Tort liability and constitutional considerations are areas of concern. It is important to look to history to learn lessons about the loss of tort immunity when state officers are taken to federal court for claims alleging constitutional violations. Issues of representation are also important.

Emergency management law includes a discussion of the use of the National Guard, including a warning that if they become federalized, issues involving the use of the military for civil problems can arise. Evacuation is a concern, as is the issue of commandeering or destroying property, since the state may be required to provide just compensation.

Mutual aid agreements are of particular concern for attorneys general offices. The Emergency Management Assistance Compact (EMAC) is worrisome, as the workers’ compensation language is wholly inadequate. The language provides no defense for the state if a worker from another state is injured. International mutual aid agreements are also problematic, since there are generally no dispute resolution procedures or forum indicated in the event of a problem with another country. Another problem arises if a worker from one state is sent to assist in another state, but is injured in a third state: who is responsible? The worker’s home state? The state to which she is going to work? Who will be his or her legal counsel?

It is vital that the attorney general’s office document all actions taken by the state. For example, in
Washington state, when Mount St. Helens erupted, the state forced evacuation from a wider geographic area than was necessary and businesses that subsequently were forced to close sued the state. The state prevailed because all decision-making was documented, and the court found that the decisions made in the governor's office were reasonable.

Another important aspect of the NAAG conference was a presentation on ethics. Common ethical concerns include conflicts of interest, confidentiality, misuse of government assets, misbehavior in public, discriminating practices, and misuse of the media.

Maintaining continuity of operations is of vital importance. Having alternate facilities and access to resources like computer files is important. Planning ahead is indispensable!
## Appendix A

### Conference Planning Committee

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<tr>
<th>Name</th>
<th>Title</th>
<th>Organization/Location</th>
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Appendix B

Conference Collaborating Organizations

Alfred P. Sloan Foundation, New York, NY
Alston & Bird, LLP, Atlanta, GA
American Public Health Association, Washington, DC
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Asian Institute for Bioethics and Health Law, Yonsei University, Seoul, Korea
Association of State and Territorial Health Officials, Washington, DC
Center for Law, Health & Society at Georgia State University College of Law, Atlanta, GA
Center for Law and the Public's Health, Washington, DC and Baltimore, MD
Center for Public Health Law Partnerships, Louisville, KY
Center for Strategic and International Studies, Washington, DC
Committee on Public Health, Environmental Law & Bioterrorism, American Bar Association, Chicago, IL
Council of State Governments, Lexington, KY
Department of Health Policy, School of Public Health & Health Services, George Washington University, Washington, DC
Health Law Section, American Bar Association, Chicago, IL
Healthcare Georgia Foundation, Atlanta, GA

Institute for Practical Ethics and Public Life, University of Virginia School of Law, Charlottesville, VA
Institute for Public Health Law, Atlanta, GA
McGeorge School of Law, University of the Pacific, Stockton, CA
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