

PUBLIC HEALTH LAW: A JUDICIAL REFERENCE GUIDE FOR ARIZONA COURTS

CENTER FOR PUBLIC HEALTH LAW PARTNERSHIPS

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CENTERS FOR **D**ISEASE **C**ONTROL & **P**REVENTION

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Disclaimers

This Reference Guide has been reviewed by the Arizona Judicial Council, but the author alone is responsible for its contents. It has been prepared primarily to assist judges in the conduct of their work (although the author hopes it may also be of value to public and private attorneys working in public health law and to public health administrators).

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Introduction

In 1905 the United States Supreme Court decided the landmark case *Jacobson v. Massachusetts*, 197 U.S. 11, upholding Massachusetts' law requiring citizens to be vaccinated against pending smallpox epidemics over a citizen's constitutional challenge based on the "liberty" clause of the 14th Amendment. *Jacobson* firmly established the judiciary as both an enforcer of government public health policies and an arbiter of the conflicts between individual liberties and public interests that often arise when government acts to protect public health. The principles set forth in that case still constitute the bedrock of American public health law.

One hundred years later, and notwithstanding the continuing centrality of *Jacobson*, scholars and policymakers are drawing attention to the need for a "renaissance" in public health law. The latter third of the 20th Century saw a decline in support for and attention to the infrastructure of the American public health system. At the same time, however, the emergence of new infectious diseases, concerns about bioterrorism, and other factors have prompted a sense of renewed urgency about the adequacy of the public health system to meet contemporary challenges. Far from escaping such scrutiny, the legal underpinnings of that system have rightly received especially close attention. Events of fall 2001 starkly illustrated that renewed focus on both the administrative and legal dimensions of public health was needed in order to deal adequately with emerging public health threats, both man-made and natural. Such concerns were only heightened by the subsequent global epidemic of Severe Acute Respiratory Syndrome (SARS), and then by the emerging threat of avian influenza. In recent years policymakers and scholars have turned a critical eye on public health "legal preparedness" – assessing current public health laws, updating those laws as needed, and educating those who enforce and apply public health laws to ensure adequate responses both to the novel threats noted above and to more traditional ones that are likewise the subject of renewed concern, such as immunization and tuberculosis.

Public health law is primarily state law. Several considerations make judicial interpretation of public health law especially challenging. First, like *Jacobson*, the majority of public health cases addressing infectious diseases or other conditions requiring the intervention of county or local health departments date to at least the early 20th Century. In Arizona, the statutory framework itself arose at precisely that time: the first comprehensive public health code was enacted in 1903 as Territorial Law. Much of that statutory law was re-adopted upon Arizona's transition to statehood, and much of it remains codified today -- in many instances literally unchanged. While such statutory and case law doctrine clearly remains "good law" in a formal sense, its suitability to drastically changed state, national and global conditions can be questioned.

Second, the application of many public health laws is complicated by the fact that the authorizing statutes often predate current rules of evidence, procedure, and constitutional doctrine. That is -- in addition to the kinds of changes *outside* the law just noted -- there have been important changes in “surrounding” law. In constitutional law, for example, there has been a major transformation in the judicial recognition and protection of individual rights, beginning with the Warren Court at mid-century (initially in the criminal context and expanding subsequently into civil realms). Yet public health law itself, which is largely civil in nature, has not kept pace. To choose but one example: statutes providing for the management of tuberculosis generally predate the mid-20th Century. When TB re-emerged in the late 1980s and early 1990s, some patients, objecting to their treatment and confinement by government authorities, brought legal claims asserting that their rights to both procedural and substantive due process were being violated under application of the “old” laws (which, in many cases, were indeed blunt instruments by contemporary standards). With little else to go on, such courts frequently looked for guidance to their state laws on civil commitment of the mentally ill, where law reform to accommodate the new constitutional doctrines had already occurred. (In Arizona, we have a newly drawn law specifically for TB, which is covered in chapter 4.

Third, public health experts in court proceedings often use complex scientific terminology in describing public health science methodology (*e.g.*, epidemiology, biostatistics, contact tracing; see Appendix H for Public Health Glossary). In some situations, judges will need to adapt legal parlance to the public health context. For example, at law the term “quarantine” means (a) the right of a widow to remain in her deceased husband’s principal home for a period of forty days following his death; (b) the holding of potentially contaminated ships and other vessels of transportation away from the general public for a specified period (originally, forty days); (c) the segregation of plants and animals to prevent the spread of agricultural diseases; or (d) the placement of a prisoner into solitary confinement. Although several of these definitions are clearly health-related, none specifically captures the most common public-health usage of the term “quarantine”: the limitation of a healthy individual’s activities and movement after exposure (known or suspected) to a communicable disease, in order to prevent the disease’s spread during its period of transmissibility.

Finally, in the event of a public health emergency, the deliberative nature of the judicial process may be strained to keep pace with the rapid response and containment measures sought by members of the public health community and, perhaps, by the sheer scale of the emergency.

This Judicial Reference Guide was created as a significant part of the current public health emergency legal preparedness initiative under way at the Public Health Law Program of the Centers for Disease Control and Prevention (CDC). This work, initiated in early 2001, has generated draft model state public health legislation; training materials and programs for public health personnel,

law enforcement agents, emergency management, and state attorneys general, addressing issues such as the legal bases for coordinated responses to public health emergencies; checklists and other tools for assessing county- and state-level public health legal preparedness; and the CDC Public Health Emergency Legal Preparedness Clearinghouse, among other products and services. The Center for Public Health Law Partnerships was founded in October 2003, with funding from the Public Health Law Program, to improve legal preparedness by developing partnerships with public health agencies, judicial education organizations, and law enforcement training organizations. Several other states, notably Indiana and Kentucky, have already developed their own state judicial reference guides to public health law under this CDC program. This Arizona Judicial Reference Guide benefits greatly from the existence of those other guides, which in many particulars have served as models for the contents and organization of this book.

The Judicial Reference Guide is intended to help protect the health and safety of communities by improving legal preparedness for both public health emergencies and more routine public health cases. In addition, the Guide may help increase communication between the judiciary and public health agencies (and their attorneys) at the community, state, and national levels and across a broad spectrum of public health issues. Although courts have historically been vital protectors of the public's health (e.g., authorizing sanitary inspections through the issuance of warrants, enjoining nuisances, enforcing immunization requirements), relationships between public health agencies and the judiciary remain rare. In this new era of bioterrorism, emerging infectious diseases, and potential pandemics, courts play an even more critical role in protecting the public's health. This Guide is intended to be a tool that judges may use as they confront the range of public health issues that come into their courtrooms, and that public health policymakers and their attorneys may consult, as well.

It would be impractical to address every aspect of the legal system potentially affected by public health concerns. Reference guides, or "bench books," are not exhaustive analytical works; rather, they are readily accessible legal references for judges to consult, providing, for example, procedural frameworks, statutory texts, summaries of relevant case law, and model orders. This Guide to Arizona public health law focuses on eight discrete topics (each of which constitutes a chapter), grouped into four major areas, or "Parts." Part I, jurisdiction and government structure, focuses on the legal nature and authority of each of the institutions whose activities intersect around the contents of this document – the Arizona judiciary and the Arizona public health system. Chapter 1 explores jurisdictional matters, both in terms of federalism and within the state. Chapter 2 sets forth the structure, powers, and duties of Arizona's government public health agencies – the "governmental public health infrastructure" -- at the state and local levels.

Part II explores many of the important areas where classic, recurring tensions arise between public health and individual liberties. Chapter 3 reviews public health “surveillance” – the collection of information about the population’s health status that includes the reporting of communicable diseases and, therefore, raises issues about intrusions upon privacy and can lead to restrictions on behavior. Chapter 4 explores those restrictions, under the heading of “control” measures for communicable disease that may include isolation, quarantine, and less draconian interventions (such as temporary re-assignment of work responsibilities), as well as school immunization law and tuberculosis control. Chapter 5 explores applicable state and federal law on “health information privacy.” The topics in this Part are, in a sense, the “meat and potatoes” of much of traditional public health law.

In Part III, the Guide turns to the other major area where government policy to advance health and safety trenches upon cherished freedoms: the ownership, use and control of property. Chapter 6 explores constitutional dimensions of these issues and then turns to a review of traditional regulatory tools: nuisance control, sanitary laws, and “takings.”

Finally, Part IV focuses solely on “emergency” powers of government. Chapter 7 sets forth the general provisions of state law under which emergencies are to be managed, while Chapter 8 specifically explores emergency public health powers and their limits.

There are a number of other health-related regulatory functions undertaken by government, which, as the above review suggests, are not included in this book. These include hospital licensure; licensure and certification of health care professionals; administration of the Arizona Health Care Cost Containment System (AHCCCS); environmental and land use planning; and a range of others. There is a lively debate over what, precisely, the subject of “public health law” should be understood as including and what it properly omits; some believe topics such as the foregoing fall within the term’s ambit. All agree, however, that the matters chosen for inclusion in this book are *bona fide* “public health law” topics, which lie beyond that dispute. For this reason, as well as for considerations of space and scope, the eight chapter topics just described constitute the Guide’s contents.

The Guide concludes with a series of Appendices. These are Legislative Milestones in Arizona Public Health Law (Appendix A); An Essay on Arizona Public Health Case Law (Appendix B); A Public Health Primer (Appendix C); A Public Health Glossary (Appendix D); Arizona Influenza Pandemic Response Plan -- Legal and Other Materials (Appendix E).

A Note on Citation Format and the Content of Cited Material

In this book, references to the ARIZONA REVISED STATUTES are identified as "A.R.S ." References to the ARIZONA ADMINISTRATIVE CODE are identified as "A.A.C." Each citation to a statute or administrative code provision references all codified material subsequent to the previous citation. Thus, citations may appear as frequently as every sentence, or as infrequently as every few paragraphs, depending on the amount of codified material that is contained in the cited provision.

In the interests of clarity, both statutory and administrative code provisions are generally summarized or paraphrased rather than quoted exactly. Thus, in analyzing legal problems, readers should consult the statutes and rules themselves.

1.00 AUTHORITY AND JURISDICTION IN PUBLIC HEALTH LAW

1.10 FEDERAL AND STATE AUTHORITY OVER PUBLIC HEALTH

1.11 Federal Authority; the United States Constitution The federal government is one of enumerated rather than inherent powers. Federal powers are limited to those conferred expressly, or by necessary implication, by the Constitution. The closest the Constitution comes to saying anything directly about public health is the language in the Preamble that speaks of promoting the “general welfare.”¹

This constitutional silence, in conjunction with the Tenth Amendment's reservation of undelegated powers to the states, indicates that federal authority in matters of public health must arise as ancillary to the enumerated powers. In these realms, however, it is often viewed as being quite broad. *See, e.g., Carolene Products Co. v. Evaporated Milk Assn.*, 93 F.2d 202, 204 (7th Cir. 1937) (“While the police power [discussed §1.12, *infra*] is ordinarily said to be reserved by the states, it is obvious that it extends fully likewise to the federal government in so far as that government acts within its constitutional jurisdiction... ..” (internal citations omitted)). The powers that have proved most productive of federal public health lawmaking are the commerce, taxing and spending, and defense powers. In addition, the federal government is responsible for protecting the public health in discrete geographic areas directly under its control (e.g., military bases).

Pursuant to such itemized powers, the federal government asserts authority to protect and promote Americans' health across an extremely broad range of activities. It can and does address interstate and international dimensions of public health, and assume responsibility for public health emergencies precipitated by acts of war or terrorism. As a practical matter, the federal presence in public health has grown to be very large, notwithstanding the constitution's doctrinal limitations. *See generally* LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 34-46 (2000); (discussing scope and examples of federal public health power); KENNETH R. WING, WENDY K. MARINER, GEORGE A. ANNAS, DANIEL S. STROUSE, PUBLIC HEALTH LAW: A LAW SCHOOL TEXTBOOK 38, 41-50 (2007) (describing structure of federal Department of Health and Human Services and functions of Centers for Disease Control and Prevention).

¹ *We the people of the United States, in Order to form a more Perfect Union, establish Justice, insure domestic Tranquility, provide for the common defence, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America.* U.S. CONST., Preamble

1.12 The Primacy of State Authority In areas other than the foregoing (and sometimes overlapping with federal authority), it is the *states* that bear the primary responsibility for preventing and responding to threats to the public's health. See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 38 (1905) ("The safety and health of the people of Massachusetts are, in the first instance, for that commonwealth to guard and protect. They are matters that do not ordinarily concern the national government.") Unlike the federal government, which possesses only those powers that are enumerated or necessarily implied, states are political sovereigns with inherent, plenary powers, limited only by applicable provisions of their own and the U.S. Constitutions. See, e.g., *Compagnie Francaise de Navigation a Vapeur v. State Board of Health*, 186 U.S. 380, 387 (1902) ("That from an early day the power of the states to enact and enforce quarantine laws for the safety and the protection of the health of their inhabitants has been recognized by Congress is beyond question. That until Congress has exercised its power on the subject, such state quarantine laws and state laws for the purpose of preventing, eradicating, or controlling the spread of contagious or infectious diseases, are not repugnant to the Constitution of the United States, although their operation affects interstate or foreign commerce, is not an open question.").

A. Sources of States' Public Health Authority The power of a state to protect the health of its people is derived from two inherent artifacts of the political sovereignty just noted: the police power, and the *parens patriae* power.

1. **The police power** The "police power" is the power to promote the public safety, health, and morals by restraining and regulating the use of liberty and property. See *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996) ("Throughout our history the several States have exercised their police powers to protect the health and safety of their citizens. Because these are primarily, and historically, matters of local concern, the States traditionally have had great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons." (internal citations omitted)); BLACK'S LAW DICTIONARY 1196 (8th ED. 2004); ERNST FREUND, THE POLICE POWER: PUBLIC POLICY AND CONSTITUTIONAL RIGHTS iii, 3 (1904). The police power supports the authority of a state to enact and enforce "health laws of every description." *Jacobson, supra*, 197 U.S. at 25.
2. **The *parens patriae* power** The *parens patriae* power is the power of the state to serve as guardian of persons under legal disability, such as juveniles or the insane. See *Heller v. Doe*, 509 U.S. 312, 332 (1993) (" [T]he state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable to care for themselves....") (internal citations omitted; BLACK'S LAW DICTIONARY 1144 (8th ed. 2004).

- B. The Arizona Constitution** The Arizona Constitution does not explicitly address the authority of the state to protect public health or safety. This, of course, does not undermine its inherent police and *parens patriae* powers.

1.20 ARIZONA COURTS: JURISDICTION AND VENUE IN PUBLIC HEALTH LITIGATION

1.21 Jurisdiction

A. Original jurisdiction

- 1. Superior court.** The superior court has original jurisdiction of, *inter alia*, “cases and proceedings in which exclusive jurisdiction is not vested by law in another court.” ARIZ. CONST. Art. 6, § 14; A.R.S. § 12-123.A. It may issue “writs of mandamus, quo warranto, review, certiorari, prohibition, and writs of habeas corpus.” ARIZ. CONST. Art. 6, § 18; A.R.S. § 12-124 B, C. In addition to the powers conferred by constitution, rule, or statute, the court “may proceed according to the common law.” A.R.S. § 12-122.
- 2. Supreme court.** The supreme court has original jurisdiction of habeas corpus, and of quo warranto, mandamus, injunction and other extraordinary writs to state officers. ARIZ. CONST. Art. 6, sec. 5.1

B. Appellate jurisdiction: superior court: judicial review of administrative agency decisions

- 1. Jurisdiction; basic rule** The superior court has “appellate jurisdiction in all actions appealed from...boards and officers from which appeals may, by law, be taken.” A.R.S. § 12-124.A. The court may issue “writs of certiorari to...boards or officers to compel a return of their proceedings, examine or try such proceedings and give any judgment or make any order necessary in furtherance of justice.” A.R.S. § 12-124.C.
- 2. Administrative finality** The court’s jurisdiction is to review “administrative decisions” (defined A.R.S. § 12-901.2) which are “final.” A.R.S. § 12-905.A.
- 3. Venue** If venue of the action is prescribed by the statute under authority of which the decision was made, such venue shall control. If not, the action may be commenced in superior court in

any county in which specified conditions obtain (details omitted).
A.R.S. § 12-905.B.

4. Scope of review

a. Evidentiary hearing An evidentiary hearing shall be held if requested by a party, to the extent necessary to enable the court to affirm, reverse, modify or vacate and remand the agency action. A.R.S. § 12-910.A.

b. New evidence New evidence shall be admitted under specified circumstances. A.R.S. § 12-910.B.

c. Demand for trial de novo; whether granted; circumstances; jury Details omitted. A.R.S. § 12-910.C.

d. Record The record in superior court shall consist of the record of the administrative proceeding, and the record of any evidentiary hearing in the superior court, or the record of the trial de novo. A.R.S. § 12-910.D.

e. Decision; standard of review The court may affirm, reverse, modify or vacate and remand the agency action. The court shall affirm unless after reviewing the administrative record and supplementing evidence from the evidentiary hearing, the court concludes that the action is not supported by “substantial evidence, is contrary to law, is arbitrary and capricious or is an abuse of discretion.” A.R.S. § 12-910.E.

f. Additional powers of superior court See A.R.S. § 12-911.

g. Rules of civil procedure Where applicable, the rules of civil procedure in superior courts, including rules relating to appeals to the supreme court, shall apply to all proceedings except as otherwise provided. A.R.S. § 12-914.

4. Further appeal See A.R.S. § 12-913; see also § 1.21.C., D., *infra*.

C. Appellate jurisdiction: Court of Appeals

The court of appeals has appellate jurisdiction “in all actions and proceedings originating in or permitted by law to be appealed from the superior court....” A.R.S. § 12-120.21.A.1. It also has “jurisdiction to issue injunctions and other writs and orders

necessary and proper to the complete exercise of its appellate jurisdiction.” A.R.S. § 12-120.21.A.3.

D. *Appellate jurisdiction: Supreme Court*

The supreme court has appellate jurisdiction “in all actions and proceedings....” ARIZ. CONST. Art. 6., § 5, as well as “such other jurisdiction as may be provided by law.” *Id.*, § 6.

1.22 Courts of Record The supreme court, court of appeals and the superior court are all courts of record. ARIZ. CONST. Art. 6, § 30.A.

1.23 Venue

A. *Rule*

No person shall be sued out of the county in which such person resides.... A.R.S. § 12-401

B. *Exceptions*

1. *Action against counties* Actions against counties shall be brought in the county sued unless several counties are defendants, when it may be brought in any one of the counties. A.R.S. § 12-401.15. However, in a civil action where the county is a party, the opposite party is entitled to a change of venue to some other county without making an affidavit therefore. A.R.S. § 12-408.A.

2. *Actions against public officers* Actions against public officers shall be brought in the county in which the officer, or one of several officers, holds office. A.R.S. § 12-401.16

3. *Actions on behalf of the state* Actions on behalf of the state shall be brought in the county in which the seat of government is located. A.R.S. § 12-401.16

C. *Change of venue by consent.*

Change of venue by consent of parties and their attorneys is permitted. A.R.S. § 12-405.

2.00 HEALTH AGENCIES AND BOARDS

This chapter identifies the state and local government authorities responsible for implementing Arizona's public health laws. It sets forth their powers and duties and, where applicable, how the institutions are to be constituted and managed.

2.10 ARIZONA DEPARTMENT OF HEALTH SERVICES

2.11 Creation There is established a department of health services, referred to throughout A.R.S. Tit. 36, Ch. 1 as "the department." A.R.S. §§ 36-102.A, 36-101.3.

Note: For the names of predecessor agencies and their powers and duties, to which the department succeeded in 1973, see A.R.S. § 36-103.01

2.12 Organization

A. Director. In Tit. 36, Ch. 1, "director" means the director of the department of health services. A.R.S. § 36-101.4

1. Appointment and Qualifications The director is appointed by and serves at the pleasure of the governor. The criteria for appointment are:

- a. Administrative experience in the private sector, with progressively increasing responsibilities;
- b. An educational background that prepares the director for the administrative responsibilities assigned to the position; and
- c. Health related experience that insures familiarity with the peculiarities of health problems. A.R.S. § 36-102.C.

2. General Administrative Responsibilities The director shall:

- a. Be the executive officer of the department of health services, as well as the state registrar of vital statistics;
- b. Perform all duties necessary to carry out the functions and responsibilities of the department;
- c. Prescribe the organization of the department, including appointment and removal of personnel and abolition of unnecessary positions (A.R.S. § 36-136.A.1-3, 36-102.B.). The director may establish, abolish or reorganize positions or

organizational units, subject to legislative appropriation A.R.S. § 36-103.A.

Note: For a complete listing of the director's powers and duties, see § 2.15, *infra*.

B. Deputy director A deputy director is appointed by the director with the approval of the governor, serves at the director's pleasure, and assists the director in administering the department and its services. A.R.S. § 36-103.B.

C. Assistant directors The director may appoint an assistant director, serving at the director's pleasure, to each organizational unit that he may establish. A.R.S. § 36-103.C.

2.13 Functions of the department.

A. Specific Responsibilities The department is charged with the following responsibilities, in addition to any other powers and duties vested in it by law:

1. **Health of the public** Protect the health of the people in the state.
2. **Effective local health departments** Promote the development, maintenance, efficiency and effectiveness of local health departments.
3. **Vital statistics** Collect, preserve, tabulate and interpret all information required by law in reference to births, deaths and all vital facts, and obtain, collect and preserve information relating to the health of the people of the state and the prevention of diseases as may be useful in the discharge of the department's functions.
4. **Facilities operation** Operate facilities (sanitariums, hospitals, others) assigned to it by law or by the governor.
5. **Health education** Conduct a statewide program of health education; prepare educational materials on health of individuals and communities; prepare technical information for professionals, officials, and hospitals; prepare materials and technical assistance relating to education of children in hygiene, sanitation, and personal and public health; provide consultation and assistance to counties, communities, and groups of people.

6. **Public health nursing** Administer or supervise a program of public health nursing; provide minimum qualifications therefore; encourage and coordinate local public health nursing services.
7. **State/local disease prevention** Encourage and aid in coordinating local programs concerning control of preventable diseases in accordance with statewide plans formulated by the department.
8. **Maternal and child health** Encourage and help coordinate local programs on maternal and child health, including midwifery, antepartum and postpartum care, and health of infants, preschoolers, and school children (including special needs such as blindness prevention and sight- and hearing-conservation).
9. **Nutrition programs** Encourage and help coordinate local nutrition programs
10. **Dental health** Encourage, administer, provide dental services; help coordinate local programs on dental public health; deposit payments received for providing dental services in oral health fund.
11. **State laboratories** Establish, maintain and staff laboratories (serological, bacteriological, parasitological, entomological, chemical) adequate for examinations, analyses, investigations, and research in matters affecting public health.
12. **Public bathing** Supervise, inspect, & enforce rules adopted under A.R.S. § 36-136.H.10. regarding public bathing places, public/semi-public swimming pools.
13. **Bottled water and food-handling water** Ensure safety of bottled water sold to the public, and water used to process, store, handle, serve and transport food and drink.
14. **State and federal food and drug law** Enforce state food, caustic alkali and acid laws (as specified); collaborate in enforcement of federal Food, Drug and Cosmetic Act.
15. **Public health personnel** Recruit and train personnel for state, local and district health departments.
16. **Program evaluation and planning** Conduct continuing evaluations of state, local and district public health programs; study, appraise, and develop plans to solve state health problems.

17. **Licensure of health care institutions** License and regulate health care institutions.
18. **Required licenses and permits** Issue or direct issuance of licenses and permits required by law.
19. **State civil defense.** Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.
20. **Perinatal health** Subject to available funds, develop and administer perinatal health care programs, including: early pregnancy screening for high risk conditions; comprehensive prenatal health care; maternity, delivery, and post-partum care; perinatal consultation (and transportation of pregnant women when medically indicated); perinatal education for professionals and consumers.
21. **Licensure of group homes for developmentally disabled** License and regulate group homes for the developmentally disabled (details omitted). A.R.S. § 36-132.A.

Note: Fees authorized by the foregoing provisions are regulated under A.R.S. § 36-132.C.

- D. **Grants and Donations.** The department is authorized to accept grants or donations from, and to contract with, state, federal, and private sources to advance any program, project, research or facility authorized by Tit. 36. A.R.S. § 36-132.B.
- E. **Authority to Contract Regarding Organ Transplants and Renal Disease.** The department is authorized to contract with organizations that perform non-renal organ transplants, and organizations that manage end-stage renal disease, to provide, as payers of last resort, necessary prescription medications, transportation to and from treatment facilities, and contractually specified administrative costs. A.R.S. § 36-132.D
- F. **Sharing information with federal health services agencies.** Subject to the laws and department rules on confidentiality of information, the department shall furnish information to any agency of the United States that is charged with the administration of health services upon request. A.R.S. § 36-105.

2.14 Enforcement of state statutes and rules; violations; penalties

A. Administrative penalty for violation

- 1. Civil penalty; notice of violation; appeal; hearing** A person who violates Tit. 36, Ch. 1, Art. 1 or a rule adopted thereunder is subject to a civil penalty of not to exceed three hundred dollars for each violation. Each day that a violation continues constitutes a separate violation. The director shall issue a notice of the violation and the penalty pursuant to tit. 41, Ch. 6, Art. 10 (Administrative Procedure Act). A person may appeal the penalty by filing a written request for a hearing within thirty days after receiving the notice. The department shall conduct this hearing pursuant to Tit. 41, Ch. 6, Art. 10. The director shall not enforce the penalty until the hearing is concluded.
- 2. Enforcement** The attorney general shall enforce penalties imposed under this section in the justice court or the superior court in the county in which the violation occurred.
- 3. Cumulative penalties** Penalties imposed under this section are in addition to other penalties imposed under Ch. 1. Penalties collected pursuant to this section shall be deposited in the state general fund. A.R.S. § 36-126.

B. Procedures for hearings and appeals Appeals heard by the department shall be conducted in accordance with Tit. 41, Ch. 6, Art. 10 (Administrative Procedure Act). A.R.S. § 36-111.

C. Criminal penalty for violation A person who violates a provision of Tit. 36, Ch. 1, Art. 2, or a regulation adopted pursuant thereto, is guilty of a class 3 misdemeanor for each violation. In the instance of continuing violation, each day constitutes a separate offense. A.R.S. § 36-140.

2.15 Powers and duties of the director

A. General Powers and Duties The director shall:

- 1. Manage department** Be responsible for the direction, operation and control of the department. A.R.S. § 36-102.B.
- 2. Executive/registrar of vital statistics** Be the executive officer of the department, and also the state registrar of vital statistics.

3. **All necessary duties** Perform all duties necessary to carry out the functions and responsibilities of the department.
4. **Health and sanitation laws** Administer and enforce health and sanitation laws, and rules of the department. A.R.S. § 36-136.A.1., 2, 4.
5. **Departmental organization** Prescribe the organization of the department, including appointment and removal of personnel and abolition of unnecessary positions (A.R.S. § 36-136.A.3), and may establish, abolish or reorganize positions or organizational units subject to legislative appropriation (A.R.S. § 36-103.A.)
6. **Supervision of health and sanitation** Exercise general supervision over all matters of health and sanitation in the state. In his/her discretion, the director may conduct sanitary surveys, and may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage systems, and many other listed facilities and institutions (details omitted), and any premises in which there is reason to believe there is a violation of any state health law or rule.
7. **Preparation of sanitary and public health rules** Prepare sanitary and public health rules.
8. **Other duties prescribed by law** Perform other duties prescribed by law. A.R.S. § 36-136.A.6.-8.
9. **Deputization** The director may deputize, in writing, any qualified departmental employee to perform any act the director is empowered or required by law to perform. A.R.S. § 36-136.C.

B. *Specific Powers and Duties.* The director shall:

1. **Administer certain services.**
 - a. ***Administrative services***, including without limitation accounting, personnel, standards certification, data processing, vital statistics, departmental buildings and grounds.
 - b. ***Public health support services***, including without limitation:
 - (i) Consumer health protection programs (e.g., the functions of community water supplies, general sanitation, vector control, food, and drugs).

- (ii) Epidemiology and disease control programs (e.g., the functions of chronic disease, accident and injury control, communicable diseases, tuberculosis, venereal disease and others).
- (iii) Laboratory services programs.
- (iv) Health education and training programs.
- (v) Disposition of human bodies programs.

c. Community health services, including but not limited to:

- (i) Medical services programs (e.g., maternal and child health, preschool health screening, family planning, public health nursing, premature and newborn program, immunizations, nutrition, dental care prevention, and migrant health).
- (ii) Dependency health care services programs (e.g., need determination, availability of health resources to medically dependent, quality control, utilization control, and industry monitoring).
- (iii) Crippled children's services programs.
- (iv) Programs for the prevention and early detection of mental retardation.

d. Program planning, including without limitation an organizational unit for comprehensive health planning programs; program coordination, evaluation and development; need determination programs; health information programs.
A.R.S. § 36-104.1

- 2. Administer staff services** Include and administer staff services, including without limitation budget preparation, public information, appeals, hearings, legislative and federal government liaison, grant development and management and departmental and interagency coordination.
- 3. Rules for departmental organization** Make rules and regulations for the proper and efficient operation of the department.

4. **Health emergencies** Determine when a health care emergency or medical emergency situation exists or occurs within the state that cannot be satisfactorily controlled, corrected or treated by available health care delivery systems and facilities. Upon that determination, the director shall immediately report such situation to the legislature and the governor, including information on the scope of the emergency, recommendations for its solution, and estimates of costs involved.
5. **Coordinated state/county health services and programs** Provide a system of unified and coordinated health services and programs between state and county governmental health units at all levels of government.
6. **Policy and planning** Formulate policies, plans and programs to effectuate the missions and purposes of the department.
7. **Contracting authority** Make contracts and incur obligations within the general scope of its [*sic*] activities and operations subject to the availability of funds.
8. **Designated state agency** Be designated as the single state agency [*sic*] for the purposes of administering and in furtherance of each federally supported state plan.
9. **Information and advice to government, citizens** Provide information and advice on request to agencies at all levels of government, citizens, businesses, and community organizations on matters within the scope of its duties, subject to departmental rules and regulations on confidentiality of information.
10. **Account separation** Establish and maintain separate financial accounts as required by federal law or regulations.
11. **Legislative and gubernatorial advice** Advise and make recommendations to the governor and the legislature on all matters concerning its [*sic*] objectives.
12. **Health care cost containment** Take appropriate steps to reduce or contain costs in the field of health services.
13. **Planning assistance** Encourage and assist in improving systems of comprehensive planning, program planning, priority setting and allocating resources.

14. **Effective use of federal resources** Encourage effective use of available federal resources in this state.
15. **Health facilities development** Research, recommend, advise and assist in the establishment of public and private community or area health facilities, and encourage the integration of planning, services and programs for the development of the state's health delivery capability.
16. **Utilization of health manpower and health facilities** Promote the effective use of health manpower and facilities which provide health care for the citizens of Arizona.
17. **Health care services for medically dependent** Take appropriate steps to provide health care services to the medically dependent citizens of Arizona.
18. **SIDS – Training (fire fighters and EMTs)** Certify training on the nature of sudden infant death syndrome for use by professional fire fighters and certified emergency medical technicians as part of their basic and continuing training requirements.
19. **SIDS – Training (law enforcement)** Certify training on the nature of sudden infant death syndrome, including information on the investigation and handling of cases for use by law enforcement officers as part of their basic training requirement.
20. **SIDS – autopsies** Adopt protocols for the conduct of an autopsy in cases of sudden infant death syndrome.
21. **Cooperation with Arizona-Mexico commission** Cooperate with the Arizona-Mexico commission in the governor's office and with researchers at Arizona universities to collect data and conduct projects in the United States and Mexico on issues within the scope of the department's duties relating to quality of life, trade, and economic development.
22. **Administer federal family violence act grants** Administer the federal family violence prevention and services act grants; the department is designated as Arizona's recipient of such grants.
23. **Methamphetamine prevention programs – private funds** Accept and spend private grants of monies, gifts and devises for the purposes of methamphetamine education.

24. Methamphetamine prevention programs – other states as models Identify successful methamphetamine prevention programs in other states that may be implemented in this state. A.R.S. § 36-104.2-.24

C. Examination and Inspection of Properties The director shall provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of the state. A.R.S. § 36-136.A.5. If the director has reasonable cause to believe that there exists a violation of any health law or rule of the state, the director may inspect any person or property in transportation through the state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health. A.R.S. § 36-136.B.

D. Delegation to local government authority The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the latter, provided the latter is willing to accept the delegation and agrees to perform in accordance with the director's standards, and provided that money can be allocated to assure accomplishment of the delegated functions. A.R.S. § 36-136.D.

Note: See Appendix B for discussion.

E. Administrative Rulemaking.

1. General authority The director “may” make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health. A.R.S. § 36-136.F.

2. Specific subject areas The director “shall” make rules on the following specific subjects (A.R.S. § 36-136.H., except where otherwise indicated):

a. Communicable and Preventable diseases: Define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases. The rules shall declare certain diseases reportable; prescribe measures, including isolation or quarantine, reasonably required to prevent the occurrence of, or to seek early detection and alleviation of, disability, insofar as possible, from communicable or preventable diseases; include reasonably necessary measures to control animal diseases transmittable to humans.

Note: See Appendix B for discussion.

- b. *Handling of dead bodies.*** (Details omitted).
- c. *Vital records.*** Define and prescribe reasonably necessary procedures not inconsistent with law in regard to the use and accessibility of vital records, delayed birth registration, and the completion, change, and amendment of vital records.
- d. *Wholesome food and drink.*** (Details omitted). The rules shall provide for inspection and licensing of regulated premises and vehicles, and non-complying premises or vehicles shall be abated as public nuisances.
- e. *Meat and meat products sold at retail.*** (Details omitted).
- f. *Bottled drinking water.*** (Details omitted). The rules shall provide for inspection and certification of bottled drinking water sources, plants, processes and transportation, and for abatement as a public nuisance of any non-complying water supply, premises, equipment, process or vehicle.
- g. *Ice production, handling, storage and distribution.*** (Details omitted). The rules shall provide for inspection and licensing of premises and vehicles, and for abatement as public nuisances any non-complying ice, premises, equipment, processes or vehicles.
- h. *Sewage and excreta disposal – camps, hotels, motels, trailer parks.*** Define and prescribe reasonably necessary measures concerning sewage and excreta disposal, garbage and trash collection, storage and disposal, and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels. (Details omitted). The rules shall provide for inspection of such premises and for abatement as public nuisances of non-complying premises or facilities.
- i. *Sewage and excreta disposal – public schools.*** Define and prescribe reasonably necessary measures concerning sewage and excreta disposal, garbage and trash collection, storage and disposal, water supply and food preparation of all public schools. The rules shall provide for inspections of covered premises and facilities and for abatement as public nuisances any non-complying premises.

- j. *Water pollution and deleterious health conditions at public or semi-public swimming pools and bathing places.*** (Details omitted). The rules, to be developed in cooperation with the director of the department of environmental quality, shall provide for inspections and for abatement as public nuisances of non-complying premises and facilities.
 - k. *Confidential information about patients and contacts.*** Prescribe reasonably necessary measures to keep confidential information relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients; prohibit making confidential information available for political or commercial purposes.
 - l. *HIV testing.*** Prescribe reasonably necessary measures regarding HIV testing as a means to control transmission of the virus, including designation of anonymous test sites as dictated by current epidemiologic and scientific knowledge.
 - m. *Asbestosis and mesothelioma.*** The department shall develop and implement by rule standards and procedures to make asbestosis and mesothelioma diseases reportable to the department. A.R.S. § 36-134.
 - n. *Rules protecting confidential information*** The director shall promulgate such rules and regulations as are required by state or federal law to protect confidential information. No names or other information of any applicant, claimant, recipient or employer shall be made available for any political, commercial or other unofficial purpose. A.R.S. §36-107.
- 3. *Statewide application of rules; enforcement of rules by local boards of health and public health services districts; non-pre-emption of more restrictive local rules*** The rules in the areas described in § 2.15.E.1 & 2.a.-I., *supra* (rules adopted by the director under A.R.S. § 36-136) are of statewide application, and shall be enforced by each local board of health or public health services district. However, this does not limit the authority of any local board of health or county board of supervisors to adopt ordinances and rules authorized by law within their jurisdiction, as long as they do not conflict with state law and are equal to or more restrictive than the director's rules. A.R.S. § 36-136.I.

Note: See Appendix B for discussion.

4. Rulemaking Procedures. The requirements of A.R.S. §§ 41-1001 *et seq.* (the Administrative Procedure Act) apply to all rules promulgated under Tit. 36 and to the actions of the director and the department (A.R.S. § 36-115.A.), except as otherwise indicated (A.R.S. § 36-115.B., C).

F. Emergency Measures. Notwithstanding the normally-applicable rules regarding communicable and preventable diseases developed under § 2.15.E.2.a., *supra* (A.R.S. § 36-136.H.1.), the director may define and prescribe emergency measures for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for no longer than eighteen months. A.R.S. § 36-136.G.

Note: See also chapters 7 and 8.

G. Sanitarians' Council. The director shall establish a 5-member sanitarians' council to classify, set standards concerning, examine, and register sanitarians (details omitted). A.R.S. § 36-136.01. A "sanitarian" is one who by education or experience in the physical, biological and sanitary sciences is qualified to carry out educational, investigational and technical duties in the field of environmental health. A.R.S. § 36-136.01.J.

H. Non-overlap of powers. The powers and duties of the director under A.R.S. § 36-136 do not apply where the legislature has vested them in some other entity, except that the department and the department of agriculture each have distinct jurisdiction over the regulation of meat and meat products. A.R.S. § 36-136.J.

I. Annual Report The director shall submit annually to the governor, the president of the senate and the speaker of the house of representatives a copy of the annual report setting forth the condition of the public health in the state, the activities of the department during the preceding fiscal year, the work done in each county, the character and extent of all diseases reported, the expenditures of the department and of each county or district health department, recommendations he deems advisable for protection of the public health, the financial statement of the affairs of the Arizona state hospital, and the operations and administration of the program of service for crippled children. A.R.S. § 36-137.

2.16 Advisory Health Council

A. Purpose. In order to form a council advisory to the governor and the department and representative of the needs of the people of Arizona,

and with respect to providing health services, there is established the advisory health council. A.R.S. § 36-109.A.

B. *Membership of the Advisory Health Council.*

1. **Appointment.** Members of the advisory health council are appointed by the governor, in compliance with applicable federal regulations. A.R.S. § 36-109.B.
2. **Number.** The council consists of fifteen (15) members representing the public and relevant professional, health, hospital, labor, industry and educational organizations, who shall serve at the pleasure of the governor. A.R.S. § 36-109.C, D.
3. **Council Chairman.** The governor shall annually select the council chairman from the membership of the council. A.R.S. § 36-109.B.

C. *Special Purpose Councils.* The director may also establish special purpose councils (details omitted). A.R.S. § 36-109.E., F., G.

2.17 County or district liaison officers

A. *Appointment.*

1. The department shall assign a county liaison officer for each county of the state.
2. A county liaison officer may serve more than one county. A.R.S. § 36-110.A.
3. If the director determines that regional health planning has been established for the state, he shall establish, in lieu of the county liaison officers, district liaison offices in each of the regions that are established. Such district liaison offices shall carry out the same functions as the county liaisons. A.R.S. § 36-110.C.

B. *Duties*

1. Each county liaison officer shall function as a liaison between the department and county health officials, local health planning groups, health consumer groups, private health care agencies and programs and any other health-related concerns within the county. A.R.S. § 36-110.A.
2. County liaison officers may:

- a. Evaluate the success of state programs, coordination and integration in local health planning.
- b. Relay deficiencies of local health programs and services to the department.
- c. Act as a means of input for local concerns of health to the department.
- d. Work to provide successful delivery of health services at the community level.
- e. Provide information on client needs and services effectiveness to the department. A.R.S. § 36-110.B.

2.20 LOCAL HEALTH DEPARTMENTS

Note: The phrase “local health departments” is used periodically throughout Tit. 36, Ch. 1, Art. 4, both in titles and headings and occasionally in statutory text. However, the term is not defined. In the context of its use, the phrase seems generally to signify county departments of health, although sometimes it might be read as including, as well, the other organizational option under state law: public health services districts. See § 2.21, *infra*.

2.21 Establishment of local health departments

A. *Establishment by county board of supervisors* For the purpose of providing local full-time public health service, the board of supervisors of a county shall establish a county department of health or a public health services district. A.R.S. § 36-182. A. “Full-time public health service” means a funded, staffed service under the direction and supervision of a director appointed by the county board of supervisors and conducted in conformity with the rules, regulations and policies of the state department of health services. A.R.S. § 36-181.

Note: A public health services district, if established, assumes all the powers and duties of the county board of health for that county. A.R.S. § 48-5804.C. The board of supervisors serves as the district’s board of directors. A.R.S. § 48-5803. Most importantly, a public health services district is empowered to levy a transaction privilege tax (sales tax) or a property tax, and to utilize the revenues therefore to provide public health services. A.R.S. §§ 48-5805, 48-5804.A.5.

B. *Authority upon establishment* Upon establishment of a county health department in conformity with Tit. 36, Ch. 1, Art. 4, or a public health services district under A.R.S. § 48-5802, the department or district succeeds to the authority of any existing city or local board of

health in that county, and any references to a city or local board of health apply instead to that department or district. A.R.S. § 36-188.

C. *Organizational planning by state department of health services*

The state department of health services shall prepare a plan for recommendation to the counties, which shall outline a practical grouping of cities and counties of sufficient population and of such area as may be sustained with reasonable economy and efficient administration in order to provide efficient and effective local health services. A.R.S. § 36-182.D.

2.22 Composition of boards of health of local health departments.

A. *Counties having three supervisorial districts*

1. Presumptive five-member model. The board of supervisors shall appoint a five-member board for the county department of health, consisting of:

- a. One member of the board of supervisors,
- b. One licensed allopathic or osteopathic physician, and
- c. Three citizens selected for their interest in public health, each citizen member to be a resident of a different supervisorial district, so that each district in the county has a representative on the board. A.R.S. § 36-183.A. Citizen members cannot be county health department employees. A.R.S. § 36-183.F.

2. Alternate nine-member model. The board of supervisors may determine by majority vote to appoint a nine-member board for the county department of health. In that event, the board shall consist of:

- a. One member of the board of supervisors,
- b. One licensed allopathic or osteopathic physician,
- c. One member of a city governing body selected by the board, and
- d. Six citizens selected for their interest in public health. The citizen members shall be residents of different supervisorial districts, so that each district in the county has two representatives on the board. A.R.S. § 36-183.B. Citizen

members cannot be county health department employees. A.R.S. § 36-183.F.

3. **Term.** Under either model, the member selected from the board of supervisors shall serve during that member's term of office, and the term of office of the physician member and of the "first three" citizen members shall be four years. A.R.S. § 36-183.A.,B. In the event four additional members are appointed pursuant to the "alternate nine-member model," the city governing body member shall be appointed for a term of four years, to be served during his term of office [*sic*]; of the three additional citizen members, one shall be appointed for a term of one year, one for a term of two years, and one for a term of three years. A.R.S. § 36-183.B. Appointments to fill unexpired terms are for the balance of that term. A.R.S. § 36-183.D.
4. **Ex officio:** The county health department's director is a non-voting *ex officio* member of the board. A.R.S. § 36-183.E.

B. Counties having five supervisorial districts.

1. **Composition.** In a county having five supervisorial districts, the board of supervisors shall appoint a board of eleven members consisting of:
 - a. One member of the board of supervisors,
 - b. One licensed allopathic or osteopathic physician,
 - c. Five citizen members selected for their interest in public health, each citizen member to be a resident of a different supervisorial district so that all five supervisorial districts are represented on the board, and
 - d. Four citizen members appointed from the county at large. A.R.S. § 36-183.C. Citizen members cannot be county health department employees. A.R.S. § 36-183.F.
2. **Term.** The term of office of each member shall be four years. A.R.S. § 36-183.C. Appointments to fill unexpired terms are for the balance of that term. A.R.S. § 36-183.D.
3. **Ex officio:** The county health department's director is a non-voting *ex officio* member of the board. A.R.S. § 36-183.E.

2.23 Powers of local health departments. A department of health may:

- A. Health services.** Develop health services with the use of any combination of federal, state or local funds. A.R.S. § 36-182.C.1. (Regarding financial assistance from the state department of health services, see also A.R.S. § 36-189 (details omitted)).
- B. Expenditure of money.** Expend monies budgeted for use of the department with the advice of the local board of health. A.R.S. § 36-182.C.2.

2.24 Powers and duties of directors of county health departments. The director of a county health department shall:

- 1. Executive officer of department.** Be the executive officer of the department.
- 2. Secretary.** Be the secretary of the board of health.
- 3. Record of proceedings; monthly report.** Keep a record of the proceedings of the board of health and of the director's official acts and submit a monthly written report to the department on these proceedings and acts.
- 4. Report health dangers and contagious diseases.** Report to the department when the health of persons is in danger or when any contagious or infectious disease occurs. A.R.S. §36-186. 4.
- 5. Enforce state and local rules.** Enforce and observe the rules of the director of the department of health services, the director of the department of environmental quality and the local board of health, county rules and regulations concerning health, and laws of the state pertaining to the preservation of public health and protection of the environment. A.R.S. § 36-186.5

Note: See Appendix B.

- 6. Appoint personnel** Appoint necessary personnel in accordance with regulations of the county board of supervisors
- 7. Annual report** Submit an annual report to the local board of health, the county board of supervisors, each city in the county and the director of the department. The report shall set forth:
 - a. The condition of public health in the county.**
 - b. Activities of the department during the preceding year.**
 - c. The character and extent of all diseases reported.**

d. Expenditures of the department

e. Such recommendations as the director deems advisable for protection of the public health.

8. Enforce public health laws, ordinances. Enforce any law or ordinance enacted or adopted by the respective jurisdiction relating to public health, including laws and ordinances that relate to public businesses, rental properties and vacant properties. A.R.S. § 36-186.8.

9. Ex officio Serve, without vote, as an *ex officio* member of the board of health. A.R.S. § 36-183.E.

2.25 Powers and duties of boards of health of local health departments.

A. Internal organization and administrative operation (details omitted). A.R.S. §§ 36-184.A., B.1,2,4.

B. Budgeting for local health department (details omitted). A.R.S. § 36-185.A.,B

C. Substantive responsibilities The board of health shall:

1. Enact rules Make rules and regulations, not inconsistent with the rules and regulations of the department of health services, for the protection and preservation of public health. A.R.S. § 36-184.B.3.

Note: See Appendix B.

2. Enforce state laws and rules Each local board of health or public services district shall enforce rules of the director of the state department of health services. A.R.S. § 36-184.B.3

Note: See Appendix B.

3. Recommend rules to boards of supervisors Recommend rules and regulations to the respective county boards of supervisors for adoption and enforcement in their respective counties. A.R.S. § 36-184.B.3,5.

2.26 County rules and regulations; violations; enforcement by administrative civil sanctions; enforcement by judicial civil and criminal sanctions

See § 6.40 *et. seq., infra.*

2.27 Relationship of county health services to cities and towns.

A. *Provision of county public health services to cities and towns.*

The director of a county health department shall provide equal public health services to all residents of the county including residents of incorporated cities and towns and as consistent with any grant requirements. A.R.S. § 36-190. Whether or not a county forms a public health services district, it must provide public health services to the entire county, including cities and towns. A.R.S. § 48-5802.B., C., D. The county may spend monies for public health services to address a specific public health need that is unique to a particular area or condition. Any city or town may provide services to its residents beyond the county's basic level of service and may use any combination of internal municipal departments or any other provider, including an intergovernmental agreement with a county for the provision of those services. A.R.S. § 36-190.

B. *Charges to cities or towns.*

1. A board of supervisors shall not impose any charges on any city or town for public health services unless a valid intergovernmental agreement was in effect during the period being charged. A.R.S. § 36-182.B.
2. A board of supervisors shall not require a city or town to contribute to the county's public health budget if the board did not require the city or town to contribute monies to the county for a portion of the county's public health budget before Jan. 1, 1999. A.R.S. § 36-185.C.

3.00 INFORMATION COLLECTION: PUBLIC HEALTH SURVEILLANCE AND REPORTING

The collection of information about the health of a population is both a core responsibility and a key function of public health agencies. Information about cases of contagious disease is critical to controlling the spread of epidemics; information about the incidence and prevalence of non-contagious diseases can help illuminate both the causes of, and possible remedies for, such conditions. Accordingly, the law imposes reporting requirements on various persons and institutions to facilitate the acquisition of this information. This chapter sets forth the law governing Arizona's performance of these "surveillance" functions in public health.

Of course, the acquisition of information about the health status of an individual can generate serious issues in at least two realms. First, such information may lead government to seek to control the individual's behavior in liberty-restricting ways, in the interest of protecting the health of others. These issues are addressed in Chapter 4. Second, government acquisition of health information can pose threats to the maintenance of personal privacy. A number of the surveillance programs contain program-specific provisions to protect health information privacy; these are described in this chapter. See, e.g., §§ 3.12.B.3-5; 3.12.C.3.-5; 3.12.D.1.E; 3.33.C; 3.34.A.,C. The general laws governing the protection of health information are set forth in Chapter 5.

3.10 SURVEILLANCE

3.11 General authority of DHS to engage in public health surveillance

The department shall collect, preserve, tabulate and interpret all information required by law in reference to births, deaths and all vital facts and obtain, collect and preserve information relating to the health of the people of the state and the prevention of diseases as may be useful in the discharge of functions of the department (§ 2.13, *supra*), not in conflict with several other statutory provisions (details omitted). A.R.S. § 36-132. A. 3.

3.12 Specific Categories of Public Health Surveillance Activities

A. *Vital Records and Public Health Statistics*

1. **Vital records** The director of the department of health services is the state registrar of, and is responsible for a statewide system of, "vital records." A.R.S. §§ 36-302.A; 36-302.B; 36-301.32. Since "vital record" is defined as "a registered birth certificate or a

registered death certificate” (A.R.S. § 36-301.33), those subjects describe the basic scope of the director/registrar’s activities under this chapter.

2. **System of public health statistics** The DHS is also charged with administering a “system of public health statistics” (A.R.S. § 36-303A.2), defined as the “processes and procedures” for “tabulating, analyzing and publishing public health information derived from vital records data and [other statutorily authorized] sources” and performing “other activities related to public health information.” ARIZ. REV. STAT § 36-301.31.

Note: For further details, see A.R.S. Tit. 36, Ch. 3, Arts. 1-5; A.A.C. Tit. 9, Ch. 19, Art’s 1-4

B. Chronic disease surveillance system A central statewide chronic disease surveillance system is established in the DHS. (For *communicable* disease surveillance, see § 3.20, *infra*).

1. **Covered diseases** Diseases shall include cancer, birth defects, and “other chronic diseases” required by the director of DHS to be reported to the department. A.R.S. § 36-133.A. The DHS has established the two disease programs named in the statute: a pesticide illness program mandated by another statute (A.R.S. § 36-606); and a blood-lead level monitoring program.

a. Cancer registry Case reports “shall be submitted” by cancer clinics, doctors, and hospitals to the Arizona Cancer Registry (ACS), the cancer-surveillance unit located within DHS, on forms provided by ACS. Pathology laboratories “shall permit” the DHS to review pathology reports once every 90 days to collect necessary information; affirmative reporting by pathology laboratories does not appear to be required. For details and additional information, see A.A.C. Tit. 9, Ch. 4, Art’s 4 and 1.

b. Birth defects monitoring program A hospital, genetic testing facility, prenatal diagnostic facility, or the Children’s Rehabilitative Services (a program within DHS) that is treating an individual from the time of fertilization to one year of age who has been diagnosed with a birth defect (a defined term of art), “shall permit” the birth defects monitoring program within DHS to review and record specified information. Affirmative reporting does not appear to be required. For definitions, details and additional information, see A.A.C. Tit. 9, Ch. 4, Art’s 5 and 1.

c. Pesticide illness A health care professional or medical director of a certified poison control center, who participates in the

diagnosis of or identifies an individual with pesticide illness, “shall file” a report of such illness with the Department. For definitions, details and additional information, see A.A.C. Tit. 9, Ch. 4, Art’s 2 and 1. This program has an express statutory source, as well, directing the establishment of a system for “reporting and preventing” pesticide-provoked illness. A.R.S. § 36-606 (details omitted).

d. Blood lead levels Physicians who receive laboratory results showing certain levels of lead in the blood of their patients, and clinical laboratory directors whose test results show certain levels, “shall report” the results to the DHS. For definitions, details, and additional information, see A.A.C. Tit. 9, Ch. 4, Art’s 3 and 1.

2. Characteristics of the system In establishing the surveillance system, the department shall:

a. Provide a chronic disease information system

b. Provide a mechanism for patient follow-up

c. Promote and assist hospital cancer registries

d. Improve the quality of information gathered relating to the detection, diagnosis and treatment of patients with cancer, birth defects and other diseases included in the surveillance system

e. Monitor the incidence patterns of diseases included in the surveillance system

f. Pursuant to rules adopted by the director, establish procedures for reporting diseases included in the surveillance system

g. Identify population subgroups at high risk for cancer, birth defects and other diseases included in the surveillance system

h. Identify regions of the state that need intervention programs or epidemiological research, detection and prevention

i. Establish a data management system to perform various studies, including epidemiological studies, and to provide biostatistics and epidemiologic information to the medical community relating to diseases in the surveillance system. A.R.S. § 36-133.B.

3. **Use of data by others** DHS may authorize other persons and organizations to use chronic disease surveillance data:
 - a. To study the sources and causes of cancer, birth defects and other chronic diseases
 - b. To evaluate the cost, quality, efficacy and appropriateness of diagnostic, therapeutic, rehabilitative and preventive services and programs related to cancer, birth defects and other chronic diseases. A.R.S. § 36-133.D.
4. **Liability protection for reporters and authorized users.** A person who provides a case report to the surveillance system or who uses case information from the system authorized pursuant to this section (A.R.S. § 36-133) is not subject to civil liability with respect to providing the case report or accessing information in the system. A.R.S. § 36-133.C.
5. **Confidentiality of information; penalty.** Information collected by the surveillance system that can identify an individual is confidential and may be used only for the designated purposes. A person who discloses confidential information in violation of this section (A.R.S. § 36-133) is guilty of a class 3 misdemeanor. A.R.S. 36-133.E.

C. Child immunization reporting system

1. **System.** The child immunization reporting system is established in the department of health services, to collect, store, analyze, release and report immunization data. A.R.S. § 36-135.A. It is known as the "Arizona State Immunization Information System." A.A.C. § R9-6-701.3
2. **Reporting obligation of health care professionals.** Health care professionals licensed under A.R.S. § 32-101 *et seq.* shall report to the DHS the type and date of administration of vaccine administered to a child; the child's name, address, telephone number, and social security number (if known and not confidential), gender, date of birth, and the mother's maiden name; and the health care professional's name, address, and telephone number. The information may be submitted to the DHS weekly or monthly, by telephone, facsimile, mail, computer, or any other method prescribed by the department. A.R.S. § 36-135.B, C. *See also* A.A.C. § R9-6-707.H for details regarding required reporting.

3. Use and protection of information.

a. Release of information. The department shall release identifying information only to the child's health care professional, parent, guardian, certain health care institutions (details omitted), or a school official authorized by law to receive and record immunization records. The department may, by rule, release immunization information to persons for a specified purpose. A.R.S. § 36-135.D.

Note: The Department has in fact exercised the mentioned rulemaking authority, for several classes of persons and specified purposes. See A.A.C. § R9-6-709 (details omitted).

b. Confidential status of information. Identifying information in the system is confidential. A person authorized to receive confidential information shall not disclose it to any other person. A.R.S. § 36-135.D., E.

c. Penalty. Any agency or person receiving confidential information from the system who subsequently discloses it to any other person is guilty of a class 3 misdemeanor. A.R.S. § 36-135.H.

4. Parental “opt out.” At the request of the child's parent or guardian, DHS shall provide a form for signature that allows confidential information to be withheld from all persons, including those otherwise authorized to receive it (§ 3.12 C.3., *supra*). If delivered to the health care professional prior to immunization, the professional shall not report the information to the department as otherwise required (§ 3.12. C.2., *supra*). A.R.S. § 36-135.I.

5. Non-identifying information. The department may release non-identifying summary statistics. A.R.S. § 36-135.D

6. Protections and sanctions of health care professionals. A health care professional who provides information in good faith pursuant to this section (A.R.S. § 36-135) is not subject to civil or criminal liability. A health care professional who does not comply with the requirements of this section violates a law or task applicable to the practice of medicine and an act of unprofessional conduct [*sic*]. A.R.S. § 36-135.F., G

D. Newborn Screening Program

1. Screening for congenital disorders

- a. Program; database.** The director of DHS shall establish a screening program for newborns within the department (A.R.S. § 36-694.D), maintaining a central database of newborns (those not more than 28 days old) and infants (children between 29 days and two years old) who are tested for congenital disorders. A.R.S. §§ 36-694.E, 36-694.K. The program shall include an education program for the general public, the medical community, parents and professional groups. A.R.S. § 36-694.D.
- b. Required reporters.** The attending physician or person required to make a report on a birth “shall order or cause to be ordered” tests for congenital disorders. The results “must be” reported to the DHS. A.R.S. § 36.694.B. For requirements on who must report, see A.A.C, Tit. 9, Ch. 13, Art. 2.

Note: Is screening mandatory? Some parents may oppose newborn genetic screening on the basis of personal beliefs, religion, concern about the confidentiality of test results (addressed in A.R.S. § 12-2802 and A.A.C. § R9-13-206.D), or concern about future access to a child’s genetic information that can be derived from a retained blood sample. Can parents effectively withhold consent to screening? Arizona Revised Statutes § 12-2803.A. provides that “a genetic test shall not be conducted on an unemancipated minor without the consent of the parent or legal guardian *except for* testing under the newborn screening program pursuant to A.R.S. § 36-694.” (emph. added). This language could be read as authorizing -- and might provide immunity from liability for -- genetic screening either without parental consultation, or over parental objection, or both. (*Compare, e.g.,* A.R.S. § 36-792.42.C (*informed consent required* for test of adult or minor for sickle cell anemia). In practice, however, DHS appears to accommodate parental refusals. The DHS’s description of the program expressly states that “Parents/guardians may refuse consent for the newborn screening test for their infant after they have received information about the screening program and acknowledged that they understand the potential risks of refusal.” See ARIZONA NEWBORN SCREENING PROGRAM GUIDELINES, ARIZONA DEPARTMENT OF HEALTH SERVICES, August 2003, sec. 3.9, p. 3-4, available online at http://www.azdhs.gov/phs/owch/pdf/az_nbs_scrn_guide_2003.pdf (last visited October 5, 2006). Other states vary in treating newborn screening tests as mandatory or optional.

- c. Disorders for which screening to be done; collecting and submitting specimens.** DHS shall specify by rule the disorders to be screened for. A.R.S. § 36.694.B. The DHS director shall establish a committee (membership to be determined per A.R.S. § 36.694.H) to provide recommendations and advice, at least annually, regarding tests the committee believes should be included; recommendations for inclusion are to be accompanied by cost-benefit analyses. A.R.S. § 36.694.G. DHS shall also specify by rule the process for

collecting and submitting specimens, and reporting requirements for test results. A.R.S. § 36.694.B.

Note: The aforementioned rules are found at A.A.C. Tit. 9, Ch. 13, Art. 2.

(i) *Disorders to be screened for.* The list of twenty-eight disorders for which screening is currently required is found at A.A.C. §§ R9-13-202; R9-13-201.

(ii) *Process for collecting and submitting specimens to DHS.* See A.A.C. Tit. 9, Ch. 13, Art. 2.

d. Follow-up services If tests conducted pursuant to this program indicate that a newborn or infant may have a congenital disorder, the screening program shall provide follow-up services to encourage the child's family to access evaluation services, specialty care and early intervention services. A.R.S. § 36.694.F.

e. Confidentiality Under A.A.C. § R9-13-206. D., test results are confidential subject to the disclosure provisions of A.A.C. Tit. 9, Ch. 1, Art. 3 (discussed at § 5.21.c.2, *infra*) and A.R.S. § 2801, 2802.

2. Hearing tests Hearing tests are a part of the newborn screening program, and test results are part of the DHS database. A.R.S. § 36.694.E. When tests are performed, their reporting is mandatory (A.R.S. § 36.694.C., D.); but it does not appear that the tests *themselves* are mandatory. Follow-up on evidence of hearing loss is required. A.R.S. § 36.694.F. See also A.A. C. Tit. 9, Ch. 13, Art. 1.

E. Maternal syphilis tests Upon first examining a woman who is pregnant, a physician is required to draw blood and send it to a laboratory for a syphilis test; if a woman has not been tested prior to delivery; a physician is required to submit a sample of umbilical blood at delivery. A.R.S. § 36.693A. Non-physicians permitted by law to attend births but not to draw blood have the same obligation, which is to be discharged through physician involvement. A.R.S. § 36.693.A. An attending physician or other person required to report a birth shall, when reporting the birth or a stillbirth, state on the certificate whether a blood test for syphilis was made. A.R.S. § 36.693.A.

Note: See also A.A.C. § R-6-202 and Table 1 thereto, regarding required reporting of syphilis by health care providers and laboratories.

3.20 REPORTING OF COMMUNICABLE AND PREVENTABLE DISEASES

A.R.S. § 36-136H.1. is an *omnibus* statute that delegates to the DHS director the duty and power to “prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases.” Sections **3.21-3.23**, *infra* address reporting. Control measures are taken up in chapter 4.

It is necessary to begin with an explanation of the somewhat confusing use of terminology in applicable Arizona law

3.21 Definitions

A. *Statutes*

1. **“Communicable disease”**: a “contagious, epidemic or infectious” disease (terms not defined) that is required to be reported to a local board of health or to the DHS pursuant to Tit. 36, Ch’s. 1 and 6 (i.e., any disease made reportable under the provisions discussed in **§§ 3.22-3.23**, *infra*). A.R.S. § 36-661.4
2. **“Communicable disease related information”**: information regarding a communicable disease in the possession of a person who provides “health services” (defined *infra*) or who obtains the information pursuant to the release of communicable disease related information. A.R.S. § 36-661.5
3. **“Contact”**: one exposed to a “protected person” (defined *infra*) with a communicable disease, including HIV, in a manner posing an epidemiologically significant risk of transmission. A.R.S. § 36-661.6.
4. **“Protected person”**: a person diagnosed as having a communicable disease, including HIV. A.R.S. § 36-661.19
5. **“Health service”**: a wide range of enumerated services, including “the detection, reporting, prevention and control of communicable or preventable diseases.” A.R.S. § 36-661.13

B. Administrative rule The DHS defines “communicable disease” as an illness caused by an agent or its toxic products that arises through the transmission of that agent or its product to a susceptible host, either directly or indirectly. A.A.C. § R9-6-101.2.

Note: Among public health professionals, *infectious* diseases are generally considered to be those diseases that can be transmitted to a human being by

means of a virus, bacterium or parasite which infects a person. *Contagious* diseases – for which *communicable* is often a synonym -- constitute a subset of infectious diseases: those that can be transmitted *from* one person *to* another. Thus, many diseases are infectious, but not all of these are contagious/communicable.

Neither Arizona's statutory nor administrative definition is in line with these conventions. The statute expressly embraces both infectious *and* contagious diseases in its definition of "communicable." And the administrative rule defines the term in a way that usually describes the more-inclusive category of *infectiousness*. While somewhat odd in scientific terms, this approach may have a pragmatic rationale: since the authorizing statute (A.R.S. § 36-136H.1) applies to both "communicable" *and* "preventable" diseases, a broad definition of "communicable" allows treating both categories under a single "heading" for regulatory purposes – even though, of course, the strategies for control of contagious disease differ from those for non-contagious disease, given the different modes of transmission. In any event, reporting obligations for both categories of disease are treated in a unified codification in A.A.C. Tit. 9, Ch. 6, Art. 2, the provisions of which are described in the materials that follow.

3.22 Statutory reporting of "contagious, epidemic, or infectious" diseases.

Contemporary reporting requirements are largely handled through administrative rules under a general statutory delegation, as described in detail in § 3.23, *infra*. There are, however, several vague, very old statutes (enacted as Territorial law¹) which require particular classes of individuals to report "contagious, epidemic, or infectious diseases" (terms which are not defined, but which seem to fall within the inclusive definition of "communicable" explained at § 3.21, *supra*). These statutes remain in effect. Moreover, their very generality makes it plausible that they might be invoked as authority to support a "catch-all" or "back-up" duty to report such diseases, beyond the specific requirements described in § 3.23, *infra*. Accordingly, they are summarized here.

A. Reporting by "persons" and attending physicians. "A person" shall immediately report such disease in writing to "the appropriate" board of health or health department, including names and residences of those afflicted. If the reporter is "the attending physician," s/he shall report in writing on the condition of the person afflicted and the status of the disease at least twice each week. A.R.S. § 36-621

B. Reporting by innkeepers. A "keeper" of a private house, boarding house, lodging house, inn or hotel shall report in writing to "the local board of health or health department" of that jurisdiction each case of such disease "in his establishment" within twenty-four hours after its existence is known, including the name of persons afflicted and the nature of the disease. A.R.S. § 36-622.

¹ Laws 1903, Ch. 65, §§ 24-26.

C. Reporting of deaths by physicians. “Physicians” shall report in writing to “the local board of health or health department” the death of patients from such disease, within twenty-four hours after death, including the specific name and character of the disease. A.R.S. § 36-623.

3.23 Detailed administrative rules for reporting “communicable and preventable” diseases.

Under authority of A.R.S. § 36-136H.1., the director of DHS has set forth in administrative rules (Tit. 9, Ch. 6, Art. 2 of the Arizona Administrative Code) reporting obligations for particular classes of individuals; reportable diseases; information that must be reported; and agency responsibilities in connection with reporting. These provisions constitute the primary framework for disease reporting.

A. Duties of individuals and institutions to report communicable diseases to health agency.

- 1. Health care providers² and administrators³ of health care institutions⁴ or correctional facilities.⁵** A health care provider who diagnoses, treats, or detects a case⁶ or suspect case⁷ of a communicable disease listed in Table 1 of A.A.C. § R9-6-202 (of which there are 87), or who detects an occurrence listed in Table 1; and an administrator of a health care institution or correctional facility in which a case or suspect case of such a disease is diagnosed, treated, or detected, or an occurrence listed in Table 1 is detected, shall, personally or through a representative, submit a report to the local health agency⁸ within the time limitation in Table 1. The report shall include specified information about the case or suspect case;⁹ specified information about the disease;¹⁰ for certain kinds of sexually transmitted infections, specified information about treatment undertaken;¹¹ and the name, address and telephone number of the individual making the report.¹²

² “Health care provider” means a physician (defined A.A.C. § R9-6-101.39), physician assistant (defined A.A.C. § R9-6-101.40), registered nurse practitioner (defined A.A.C. § R9-6-101.42), or dentist (A.A.C. § R9-6-101.27)

³ “Administrator” means the institution’s senior leader. A.A.C. § R9-6-101.1

⁴ “Health care institution” is defined at A.A.C. § R9-6-101.26

⁵ “Correctional facility” is defined at A.A.C. § R9-6-101.15.

⁶ “Case” is defined at A.A.C. § R9-6-101.8

⁷ “Suspect case” is defined at A.A.C. § R9-6-101.48

⁸ “Local health agency” is defined as county health department, public health services district, tribal health unit, or US Public Health Service Indian Health Service Unit. A.A.C. § R9-6-101.34

⁹ See A.A.C. § R9-6-202.C.1 (details omitted).

¹⁰ See A.A.C. § R9-6-202.C.2 (details omitted).

¹¹ See A.A.C. § R9-6-202.C.3 (details omitted).

¹² See A.A.C. § R9-6-202.C.4.

Different information is called for in reports that must be submitted for each unexplained death with a history of fever.¹³ For each outbreak¹⁴ for which a report is required by the above, the provider or administrator shall submit a report describing the outbreak.¹⁵ Other provisions apply to reports regarding providers' performance of HIV-tests on infants exposed perinatally to HIV.¹⁶ Except as specified in Table 1, the provider or administrator shall submit the report by telephone; in a document sent by fax, delivery service, or mail; or through an electronic reporting system authorized by the DHS.¹⁷ A.A.C. § R9-6-202.

2. **Administrators of schools,¹⁸ child care establishments,¹⁹ or shelters.²⁰** Analogous, though simpler, reporting requirements for 17 diseases apply to these reporters. A.A.C. § R9-6-203 and Table 2.
3. **Clinical laboratory²¹ directors.** Analogous, though simpler, requirements for 53 diseases apply to these reporters. A.A.C. § R9-6-204 and Table 3.
4. **Pharmacists²² and pharmacy²³ administrators.** These reporters are required to make specified reports when two or more of the following drugs are initially prescribed for an individual: isoniazid, streptomycin, any rifamycin, pyrazinamide, or ethambutol. A.A.C. § R9-6-205 (details omitted). These are anti-tuberculosis medications.

B. Responsibilities of local health agencies in connection with communicable disease reporting.

1. **Reporting forms.** Local health agencies (defined A.A.C. § R9-6-101.34) shall distribute the proper form, provided by the DHS, to reporters (§ 3.23.A., *supra*) for use in reporting. A.A.C. § R.9-6-206.A.
2. **Report to DHS of unexplained death with history of fever.** For each reported case or suspect case of unexplained death with a

¹³ See A.A.C. § R9-6-202.D (details omitted).

¹⁴ "Outbreak" is defined as an "unexpected increase in incidence." See A.A.C. § R9-6-101.36.

¹⁵ See A.A.C. § R9-6-202.E. (details omitted).

¹⁶ See A.A.C. § R9-6-202.F (details omitted)

¹⁷ See A.A.C. § R9-6-202.G.

¹⁸ "School" is defined at A.A.C. § R9-6-101.44 (details omitted).

¹⁹ "Child care establishment" is defined at A.A.C. § R9-6-101.10 (details omitted).

²⁰ "Shelter" is defined at A.A.C. § R9-6-101.45 (details omitted).

²¹ "Clinical laboratory" is defined at A.A.C. § R9-6-210.1

²² "Pharmacist" is defined at A.A.C. § R9-6-201.5

²³ "Pharmacy" is defined at A.A.C. § R9-6-101.38

history of fever (defined A.A.C. § R9-6-101.48, .50) the local health agency for the jurisdiction in which the death occurred shall provide the DHS with prescribed information about the deceased individual and submit a written report of its required epidemiologic investigation (defined A.A.C. § R9-6-101.19). A.A.C. § R9-6-206.B (details omitted)).

3. **Report to DHS of epidemiologic investigation of a case.** After the local health authority completes a required epidemiologic investigation of a case, it shall submit a report thereon to the DHS. A.A.C. § R9-6-206.C (details omitted).
4. **Report to DHS of original report.** A local health agency shall forward to the DHS each original report it receives. A.A.C. § R9-6-206.D (details omitted).
5. **Report to DHS of epidemiologic investigation of outbreak.** A local health agency shall submit to DHS a written summary of a required epidemiologic investigation of an outbreak (defined A.A.C. § R9-6-101.36). A.A.C. § R9-6-206.E. (details omitted).
6. **Report to DHS of receipt of report of outbreak or suspect outbreak.** A local health agency shall immediately notify the DHS when the agency receives a report or reports indicating an outbreak of suspect outbreak. A.A.C. § R9-6-101.F

C. Federal or Tribal entity reporting. To the extent permitted by law, a federal or tribal entity (defined A.A.C. § R9-6-207.B.) shall comply with certain specified reporting requirements of A.A.C. Tit. 9, Ch. 6, Art. 2 (§ 3.23.A., B., *supra*). A.A.C. § R. 9-6-207.A (details omitted).

3.24 Confidentiality of Communicable Disease Information.

Note: For applicable definitions, see § 3.21, *supra*.

- A. **Access to records.** In investigating a reportable communicable disease, the DHS and local health departments may inspect and copy medical or laboratory records in possession of or maintained by a health care provider (defined A.R.S. § 36-661.11) or health care facility (defined A.R.S. § 36-661.12) which are related to the diagnosis, treatment and control of the specific communicable disease case reported. Requests for records shall be in writing and shall specify the disease case and the patient. A.R.S. § 36-662.
- B. **Basic rule: confidentiality.** A person who obtains communicable disease related information in the course of providing a health service or obtains that information from a health care provider pursuant to an

authorization shall not disclose or be compelled to disclose that information. A.R.S. § 36-664.A.

C. *Exceptions: disclosure permitted.*

1. In the situation described in § 3.24.B., supra, disclosure to the following is permitted:

- a. The protected person or, if lacking capacity to consent (defined A.R.S. § 36.661.2), his health care decision maker (defined A.R.S. § 36.661.10)
- b. The department or a local health department, for purposes of notifying a “good Samaritan” (defined A.R.S. § 36-661.9) who may have sustained a “significant exposure risk” (defined A.R.S. § 36-661.20) while rendering assistance. The procedures for providing information to a “good Samaritan” are set forth in A.R.S. § 36-664.E., including requirements for departmental rulemaking on “significant exposure risk” and for continued protection of confidentiality.
- c. An agent or employee of a health facility under specified circumstances.
- d. A health facility or health care provider under circumstances relating to cadavers and organ donation.
- e. A health facility or health care provider engaged in peer review activities.
- f. A private health care accrediting entity bound to by agreement to protect patient confidentiality.
- g. A health officer (federal, state, or local) to whom disclosure is legally mandated.
- h. A federal, state or local government agency legally authorized to receive the information; re-disclosure is allowed only as permitted by this article or other provisions of law.
- i. An authorized federal, state or local government employee working for an agency that supervises or monitors the health care provider or health facility or administers the program under which the health service is provided.

- j. A person, health care provider or health facility to which disclosure is judicially or administratively ordered pursuant to A.R.S. § 36-665.
- k. The industrial commission under specified conditions.
- l. Insurance entities under specified conditions.
- m. A person or entity authorized by the patient or his health care decision maker,
- n. A person or entity as required by federal law.
- o. The lawyer for the entity holding the information, in order to secure legal advice.
- p. A person or entity for research conducted pursuant to applicable federal or state laws and regulations governing research A.R.S. § § 36-664.1.-16.

2. Other permitted disclosures

- a. **a state, county or local health department** may disclose communicable disease related information if the disclosure is any of the following: specifically authorized or required by federal or state law; made pursuant to an authorization signed by the protected person or his health care decision maker; made, without identifying the protected person, to a contact of the protected person; for the purposes of research as authorized by state and federal law. A.R.S. § 36-664.C.
- b. **the DHS director** may authorize the release of information that identifies the protected person to the national center for health statistics of the United States Public Health Service in order to conduct a search of the national death index. A.R.S. § 36-664.D.

D. Exception: disclosure required. At the request of the department of economic security in conjunction with the placement of children in foster care or for adoption or court-ordered placement, a health care provider shall disclose communicable disease information to the department of economic security. A.R.S. § 36-664.B.

E. Prohibition on re-disclosure. A person (other than the protected person or his health care decision maker) to whom communicable disease related information is disclosed shall not disclose the

information to another person except as authorized by this section. A.R.S. § 36-664.G.

F. *Form of authorization to disclose; notice of prohibition of further disclosure.* An authorization shall be signed by the protected person (or if lacking capacity, his health care decision maker); shall be dated; shall specify to whom disclosure is authorized, the purpose for the disclosure, and the time during which the release is effective. A.R.S. § 36-664.F. The disclosure shall be accompanied by a written statement warning that the information is from confidential records protected by state law and prohibiting further disclosure of the information without the specific written authorization of the person to whom it pertains or as otherwise permitted by law. A.R.S. § 36-664.H.

G. *Non-prohibition of listing information in death certificate.* This section does not prohibit listing communicable disease related information, in a certificate of death, autopsy report or other related document prepared pursuant to law to document cause of death or to prepared to release a body to a funeral director. A.R.S. § 36-664.I.

H. *Judicially- or administratively-ordered disclosures.*

1. *Prohibition on orders of disclosure; exceptions.* Notwithstanding any other law, no court or administrative body (including an administrative law judge or hearing officer) may issue an order for disclosure of, or a search warrant for, communicable disease related information, except as follows, upon application showing:

a. *A compelling need for adjudication* of criminal, civil or administrative proceeding;

b. *A clear and imminent danger to a person* whose life or health may unknowingly be at significant risk as a result of contact with the person to whom the information pertains;

c. *A clear and imminent danger to the public health* (if the application is filed by a state, county or local health officer);

d. *That the applicant is lawfully entitled to the disclosure* and the disclosure is consistent with the provisions of A.R.S. Tit. 36, Ch. 6 , Art. 4

e. *A clear an imminent danger to a person or to public health, or a compelling need* requiring disclosure of the communicable disease related information. A.R.S. § 36-665.A.,B

2. Conduct of proceeding; orders for disclosure

- a. Sealed file; in camera proceedings.** Upon application for an order of disclosure, the judicial or administrative body shall seal the file and make it unavailable to any person, except to the extent necessary to conduct a proceeding to determine whether to grant the application, including an appeal. All subsequent proceedings shall be in camera and, if appropriate, shall not state the name of the person about whom the information is sought.
- b. Notice.** The person about whom information is sought, and the person holding the records, shall be given adequate notice (not requiring a subpoena) of the application in a manner that does not disclose the identity of the person, and may file a written response to the application or appear in person for the limited purpose of providing evidence on the criteria for issuance of an order.
- c. Order for disclosure without notice or hearing.** The court or administrative body may grant an order without notice or opportunity to be heard, and without subpoena, if an *ex parte* application by a public health officer shows that a clear and imminent danger to a person whose life or health may unknowingly be at risk requires an immediate order and that notice to the person about whom the information is sought is not reasonable.
- d. Requirements for findings; balancing.** In assessing “compelling need” and “clear and imminent danger,” the court or administrative body shall provide written findings of fact (medical, scientific, and other) citing and supported by specific evidence in the record, and shall weigh the need for disclosure against the privacy interest of the protected person and the public interest which may be disserved by disclosure which deters future testing or treatment or may lead to discrimination.
- e. Content of order for disclosure or for search warrant.** An order authorizing disclosure of, or a search warrant for, communicable disease related information shall limit disclosure to information necessary to fulfill the purpose of the order; limit disclosure to persons whose need for the information is the basis for the order, and prohibit re-disclosure to any other person; conform to the provisions of this article to the extent

possible; include other measures deemed necessary to limit disclosures not authorized by the order. A.R.S. § 36-665.C.-H.

I. *Violations and remedies.*

1. ***Criminal violation.*** A person who knowingly discloses, compels another person to disclose, or procures the disclosure of communicable disease related information in violation of this article is guilty of a class 3 misdemeanor. A.R.S. § 36-666.A.2.
2. ***Civil penalty.*** The department may impose a civil penalty of not more than \$5,000 if a person discloses, compels another person to disclose, or procures the disclosure of communicable disease related information in violation of this article. A.R.S. § 36-667.A.2
3. ***Private right of action.*** A protected person may bring an action in superior court for legal and equitable relief on his own behalf against a person who violates this article. A.R.S. § 36-668

J. *Immunities*

1. ***For disclosure of information.*** A person, health facility or health care provider disclosing communicable disease related information pursuant to or required by this article is immune from civil or criminal liability if acting in good faith and without malice.
2. ***For nondisclosure of information.*** A health facility or health care provider, including a physician, the physician's employer or the health care facility or health care provider with which the physician is associated is immune from civil or criminal liability for failing to disclose communicable disease related information to a contact or a person authorized pursuant to law to consent to health care for a protected person if the health facility or health care provider acted in good faith and without malice.
3. ***Presumption of "good faith" and "absence of malice."*** Good faith and the absence of malice are presumed; the presumption may be overcome by a demonstration of clear and convincing evidence to the contrary. A.R.S. § 36-666.B.-D.

- K. *Protection of HIV-related information.*** For provisions specifically addressing the confidentiality and treatment of HIV-related information (defined A.R.S. § 36-664.17.,.19), see A.R.S. §§ 36-663, 36-664.B.,F.,I,J.,K., 36-665.I., 36-666.A.1. 36-667.A.1., 36-669; A.A.C. Tit. 9, Art's. 4,8,9.

- L. ***Inapplicability of certain provisions.*** A.R.S. §§ 36-663, 36-664, 36-666, 36-667 and 36-668 do not apply to persons or entities subject to regulation under Tit. 20. A.R.S. § 36-664.L.

3.30 ENHANCED SURVEILLANCE ADVISORIES

Note: The provisions discussed in this section were enacted in 2002 (Ch. 303, Ariz. Laws 2002), as part of a legislative effort to address public health emergencies in the wake of 9/11 and other developments creating heightened awareness of new risks to public health. For discussion of enhanced governmental public health powers during gubernatorially-declared *emergencies*, see **chapter 8**.

- 3.31** Enhanced surveillance advisory; when appropriate. The governor, in consultation with the director of the DHS, may issue an enhanced surveillance advisory if the governor has reasonable cause to believe that an illness, health condition or clinical syndrome caused by bioterrorism (defined at A.R.S. § 36-781.1), epidemic or pandemic disease or a highly fatal and highly infectious agent or biological toxin has occurred or may occur or that there is a public event that could reasonably be the object of a bioterrorism event. A.R.S. § 36-782.A.

Note: The illness or health condition may not include acquired immune deficiency syndrome or any other infection caused by the human immunodeficiency virus. A.R.S. § 36-782(A).

- 3.32** Measures taken during an enhanced surveillance advisory. As determined by the governor after considering the least restrictive measures necessary that are consistent with public health and safety, the enhanced surveillance advisory shall direct the following in accordance with this article (A.R.S. Tit. 36, Ch. 6, Art. 9):

Those persons and entities required to report; the clinical syndromes, any illness or health condition that may be associated with bioterrorism or a specific illness or health condition to be reported; patient tracking; information sharing; and specimen testing coordination. A.R.S. 36-782.B.

- 3.33** Increased reporting during enhanced surveillance advisory.

A. Persons required to report.

- 1. Health care providers.** A health care provider (defined at A.R.S. § 36-781.3 by cross-reference to A.R.S. § 12-2291) or medical examiner shall report to the local health authority (defined at A.R.S. § 36-781.4) all cases of any illness, health condition or clinical syndrome specified in the enhanced surveillance advisory. The report shall provide additional information designated in the enhanced surveillance advisory. A.R.S. § 36-783.A.

2. **Veterinarians.** The state veterinarian, a veterinarian, a veterinarian laboratory professional or a wildlife professional shall report any case of animal illness or death due to the disease or other health condition designated in the enhanced surveillance advisory to the department or local health authority. A.R.S. § 36-783.B. (details of report omitted).
3. **Pharmacists.** A pharmacist who identifies any unusual increase in prescriptions for antibiotics or any unusual increase in prescriptions or sales of over-the-counter pharmaceuticals to treat the illness, health condition or clinical syndrome identified in the enhanced surveillance advisory shall report this information to the local health authority. A.R.S. § 36-783.C. (details of report omitted).

B. Reporting requirements. The reports must be in writing or by any method directed by the department or local public health authority and must be submitted within twenty-four hours after identifying the reportable circumstance. All persons required to report under this section (A.R.S. § 36-783) must cooperate with the department and local health authority in effecting the enhanced surveillance advisory. Failure to report is an act of unprofessional conduct.

C. Confidentiality of information reported pursuant to an enhanced surveillance advisory. The department and local public health authority shall maintain as confidential any information or particular part of information provided pursuant to the enhanced surveillance advisory that, if made public, would divulge the trade secrets of a person or business, or other information likely to cause substantial harm to the person's or business' competitive position. A.R.S. § 36-783.E.

3.34 Patient tracking during enhanced surveillance advisory.

A. Power to access confidential patient information. During an enhanced surveillance advisory, in order to identify, diagnose, treat and track persons who may have been exposed to an illness, health condition or clinical syndrome identified in an advisory, the department and local health authority may access confidential patient information, including medical records, wherever held and by whomever held and whether or not patient identity is known. A.R.S. §36-784.A.

B. Investigative authority. Authority in connection with identification of exposed persons and development of information relating to the source and spread of the illness or health condition. A.R.S. § 36-784.B. (details omitted).

C. Confidentiality. Any medical information or other information from which a person might be identified that is received by the department or local health authority in the course of an enhanced surveillance advisory is confidential and is not available to the public. A.R.S. § 36-784.C.

3.35 Laboratory testing during enhanced surveillance advisory.

A. State laboratory to coordinate testing. The state laboratory shall coordinate specimen testing. If necessary at state expense, the department may designate other laboratories to assist it.

B. Laboratory criteria. The department shall determine the criteria necessary for private or public laboratories to conduct clinical or environmental testing under the enhanced surveillance advisory.

C. Transportation of samples. A public safety authority, if requested by the department or local health authority shall coordinate and provide transportation of clinical or environmental samples to the designated testing laboratory. A.R.S. § 36-786

3.36 Notification

A. Notification of local health authorities. The director shall notify local health authorities before the governor issues an enhanced surveillance advisory.

B. Notification of required reporters. The department and local health authorities shall provide the enhanced surveillance advisory to those persons and entities required by the advisory to report by using any available means of communication. A.R.S. § 36-782.C.

C. Notification of DHS of receipt of reports. The local health authority shall immediately notify the DHS of any reports received during the period of an enhanced surveillance advisory. A.R.S. § 36-783.F.

3.37 Coordination among public health authorities.

A. Required meeting. Before the governor issues an enhanced surveillance advisory, the department and local health authorities must meet with representatives of persons or institutions who will be affected by the enhanced surveillance advisory pursuant to A.R.S. § 36-783.A-C (reporting obligations; see § 3.33.A.1-3, *supra*). If, because of an immediate threat to the public health, the department and local health authorities are not able to hold this meeting before the

governor issues the advisory, the meeting must take place within seventy-two hours after the governor issues the advisory. A.R.S. § 36-782.D.

B. *Resource sharing.* To the extent possible, the department and local health authorities shall share department and local health authority personnel, equipment, materials, supplies and other resources to assist persons and institutions affected to implement the terms of the advisory. A.R.S. § 36-782.E.

C. *Information sharing.*

1. Notification of health authorities by public safety authority. During an advisory, when a public safety authority learns of a suspicious disease event, or it learns of a threatened bioterrorism act at any time, it shall immediately notify the department or the local health authority, and the agency that receives this information must immediately notify the other agency.

2. Notification of public safety and tribal authorities by health authorities. When the department or the local health authority identifies a reportable illness or health condition, unusual disease cluster or suspicious disease event that it reasonably believes may be caused by bioterrorism, the department or local health authority must immediately notify at any time the appropriate public safety authority (defined at A.R.S. § 36-781.5.) and, if appropriate, tribal health authorities.

3. Limitation on information sharing; confidentiality. Sharing of information on reportable illnesses, health conditions, unusual disease clusters or suspicious disease events between public safety and local health authorities is limited to the information necessary to affect the enhanced surveillance advisory and does not include the release of medical records to public safety authorities. Information from which a person might be identified that is received by the department, local health authority or public safety authority in the course of an advisory is confidential and not available to the public. A.R.S. § 36-785.

3.38 Discretionary assistance with reimbursement. At the governor's direction, the department may use reasonable efforts to assist the persons and institutions to receive reimbursement of costs incurred because of the implementation of the advisory. A.R.S. § 36-782.F.

3.39 Termination of enhanced surveillance advisory. An enhanced surveillance advisory may be revised or terminated at any time by the director and

automatically terminates after sixty days, unless renewed by the governor.
A.R.S. § 36-782.G.

3.40 Effect of enhanced surveillance advisory on health agencies' "routine" legal powers of surveillance and control. The foregoing statutory provisions on enhanced surveillance advisories (Tit. 36, Ch. 6, Art. 9, §§ **3.30-3.39**) do not alter the ability of the DHS or a local health authority to monitor community health status (§§ **3.10-3.23**, *supra*) or implement control measures (discussed in **chapter 4**, *infra*) for the early detection of communicable and preventable diseases otherwise allowed by law.
A.R.S. § 36-782.C.

4.00 LIMITATIONS ON PERSONAL LIBERTY AND INTRUSIONS ON BODILY INTEGRITY: MEASURES FOR THE PREVENTION AND CONTROL OF COMMUNICABLE DISEASES

This chapter explores the control measures that public health authorities undertake in meeting one of their primary responsibilities: controlling the spread of communicable disease. Some of these measures are not particularly controversial, such as requirements for disinfection of property or discarding of contaminated food. Rather quickly, however, more coercive interventions can come into play. These include such measures as restrictions on individuals' employment, or exclusion from particular places (e.g., prohibiting the attendance of unimmunized children from schools during epidemics). Even when they are temporary, such measures can generate controversy and dissatisfaction, as well as challenges to the wisdom or necessity of the state's conduct.

Draconian interventions such as involuntary isolation of persons known to be contagious, or quarantine of persons suspected of exposure (and thus potentially infectious to others) may become deeply controversial. Moreover, they vividly implicate constitutional issues, inasmuch as they constitute *bona fide* "deprivations of liberty" within the meaning of the 14th Amendment, thereby triggering scrutiny both of the fairness of the process by which the infringement was imposed (procedural due process), and the adequacy of the state's justification for imposing the particular limitation (substantive due process). Further, where a liberty-restricting measure is imposed in an improperly discriminatory fashion, equal protection concerns can likewise arise.

By statute, Arizona rather strongly disfavors the imposition of truly compulsory, unconsented medical treatment, provided that the hazards of a person's infectiousness can be adequately controlled by other measures, such as behavioral compliance. See § 4.37 (tuberculosis); § 4.50 (general limitations on compulsory treatment); §§ 8.13, 8.14 (emergency powers and compulsory treatment). Thus, the substantive constitutional sufficiency of a state interest in actually imposing compulsory treatment may rarely, if ever, need to be tested. However, the constitutional issues arising from all other restrictions on liberty are surely present, and indeed may be all the more important since extended confinement of dangerous contagious persons is one alternative to proposed treatment that the patient refuses.

For these and related reasons, Arizona, like a number of other states, recently revised its statutes on the control of tuberculosis (a paradigm disease for public health because of its dangerousness and its communicability) and on isolation and quarantine. The book gives lengthy attention to these important new and highly detailed laws.

4.10 GENERAL PROVISIONS FOR CONTROL OF COMMUNICABLE DISEASES

4.11 Definitions See § 3.21.A. B, *supra*.

4.12 Statutory Provisions on Control of “Infectious or Contagious” Diseases

Most of the contemporary control measures for communicable diseases are set forth in administrative rules under a single general statutory delegation (§ 4.13, *infra*). There are, however, several individual statutes, originally enacted as Territorial law¹ (and in several cases never amended), which authorize or require local health agencies to employ particular measures for the control of “infectious or contagious” disease. (These terms are not defined, but they appear to be included within the broad current category of “communicable” diseases addressed in § 4.13, *infra*; see applicable definitions at § 3.21.A.,B, *supra*, and **Note** thereto). Because these statutes remain in effect, they are summarized here.

A. Quarantine and sanitary measures. A.R.S. § 36-624. See § 4.40, *infra*, discussing quarantine separately; for sanitary measures, see chapter 6.

B. Disposition of contaminated articles; transportation of articles or persons. A local board or health department may have beds, bedding, clothing, carpets or other articles exposed to contamination from infectious or contagious disease destroyed, and allow reasonable compensation. It may provide for disinfection of contaminated articles, and may provide transportation for the conveyance of articles or persons afflicted with contagious or infectious disease. A.R.S. § 36-626.

C. Temporary hospitals. A local board of health or health department is authorized to provide a temporary hospital or “place of reception” for persons with infectious or contagious diseases. A hospital or other place in which infectious disease exists shall be under the board’s or department’s control, and subject to its regulations, while the disease exists. During such period of hospital control, “inmates” shall obey the board’s or department’s regulations and instructions. A.R.S. § 36-627.

Note: This statute seems to confer on local government the power to take over temporary management and control of private health care facilities housing persons with “infectious or contagious” disease.

¹ Laws 1903, Ch. 65, §§ 31-35; 1901 Pen. Code, § 359.

D. Care of and payment for afflicted persons.

1. **Personnel** Local boards of health or health departments may employ physicians and others and provide “such necessities of life” as they “deem necessary” for care of those with contagious or infectious diseases.
2. **Government expenses** Expenses incurred under Tit. 36, Ch. 6, art. 2 (contagious diseases) shall be a charge against the city or county.
3. **Patient expenses** Expenses for the care, medical attendance or support of a sick person shall also be a charge against that person and those liable for his support, and may be collected by the city or county. Physician care directed by the local board or health department is a city or county charge. A.R.S. § 36-628.

E. Violation; class 3 misdemeanor. The following acts constitute class 3 misdemeanors, unless another classification is specifically prescribed in this article (Tit. 36, Ch. 6, article 2):

1. **Secreting patients** Knowingly secreting oneself or others known to have a contagious or infectious disease;
2. **Non-performance of duty** A health officer failing or refusing, with criminal negligence, to perform a duty;
3. **Other violations** A person violating a provision of this article (Tit. 36, ch. 6, art. 2) or a rule, regulation, order, instruction or measure adopted and given the required publicity by a board of health. A.R.S. § 36-630.

F. Violation; class 2 misdemeanor: knowing exposure. A person who knowingly exposes himself or another afflicted with a contagious or infectious disease in a public place or thoroughfare, except in the necessary removal of such a person in a manner least dangerous to the public health, is guilty of a class 2 misdemeanor. A.R.S. § 36-631.

4.13 Control of “communicable and preventable” diseases: unified system of administrative rules.

A. Introduction A.R.S. § 36-136H.1, the *omnibus* statute that authorizes the basic system of disease reporting (§ 3.20, *supra*), likewise give the director of DHS authority to provide for the “prevention and control” of communicable and preventable diseases. And like the reporting provisions, the control measures are largely embodied in DHS administrative rules (Tit. 9, Chapter 6, Art. 2 of the Arizona

Administrative Code). Under those rules, the “front line” responsibility for implementing control measures rests with local health agencies, as the following sections make clear.

B. Control measures

1. local health agency control measures: A local health agency shall:

- a.* Review each report submitted to it (see § 3.23, *supra*) for completeness and accuracy
- b.* Confirm each diagnosis
- c.* Conduct epidemiologic and other investigations required under Tit. 9, Ch. 6
- d.* Facilitate notification
- e.* Conduct surveillance
- f.* Determine trends
- g.* Implement control measures
- h.* Disseminate surveillance information to health care providers. A.A.C. § R9-6-302

2. Particular control measures for particular diseases. Tit. 9, Ch. 6, Art. 3 of the Arizona Administrative Code sets forth control measures to be undertaken by local health agencies for 84 different diseases. A.A.C. § R9-6-304 to A.A.C. § R9-6-387.

a. Examples of diseases. The diseases run from “Amebiasis” to “Yersiniosis,” and include such more-familiar diseases as anthrax, coccidioidomycosis (valley fever), gonorrhoea, the various forms of hepatitis, Lyme disease, malaria, measles, mumps, pertussis, polio, rubella, smallpox, syphilis, tetanus, and tuberculosis.

b. Examples of “control measures.” Depending on the particular disease, examples of control measures include:

- (1) Appropriate restrictions on individuals’ employment
- (2) Sterilization of contaminated objects

- (3) Boiling and discarding of contaminated food
- (4) Recommendations for appropriate medical treatment including administration of antibiotics
- (5) Contact tracing
- (6) Exclusions from school
- (7) Sanitary inspection
- (8) Epidemiologic investigation
- (9) Isolation or quarantine and
- (10) Other measures (details omitted)

C. *Persons subject to control measures.* For most of the diseases, the rules prescribe measures for management of “cases” (generally, persons with documented illness; see definition at A.A.C. § R9-6-101.8); where applicable, they also set forth measures for the control of “contacts” (generally, persons exposed; see definition at A.A.C. § R9-6-101.14). For some diseases, measures for “environmental control” (undefined) and “outbreak control” are also specified (“outbreak” is defined at A.A.C. § R9-6-101.36).

4.20 CONTROL OF VACCINE-PREVENTABLE DISEASES

Other than in gubernatorially-declared emergencies (**chapter 8**), Arizona law on vaccine-preventable diseases, like the law of many states, focuses solely on immunization of children attending schools and child-care facilities

4.21 Basic rule: proof of immunization or immunity as a condition of attendance at school or child-care facility.

A. *Schools.* A “pupil” (defined A.R.S. § 15-871.10) shall not be allowed to attend “school” (public, private, or parochial, grades K-12; A.R.S. § 15-871.11) without providing “documentary proof” (written evidence of immunization or laboratory evidence of immunity; A.R.S. 15-87.1). A.R.S. § 15-872.B. *See also* A.R.S. 15-872.B (documentary proof required for attendance unless student exempted, as described in § **4.22.A. *infra***).

Note: “Immunization,” “immunized,” and “laboratory evidence of immunity” defined at A.R.S. 15-871.5.-7.

B. *Child-care facilities.* The director of the DHS shall prescribe reasonable rules, which may include rules on immunization, regarding the health, safety and well-being of “children” (aged 0-14, or 0-18 if developmentally disabled; A.R.S. 36-881) cared for in a “child care facility” (defined A.R.S. 36-881.2., 3). A.R.S. 36-883.A., C. The director has in fact, promulgated administrative rules requiring immunizations for attendance at child-care facilities. A.A.C. § R9-6-702

4.22 Exemptions from immunization requirements.

A. *Schools*

- 1. Medical exemption; duration.** “Documentary proof” is not required when a school administrator receives written certification, signed by the parent or guardian and the physician, that one or more required immunizations “may be detrimental to the pupil’s health,” and which indicates the “specific nature and probable duration” of the medical condition or circumstance which precludes immunization. Such an exemption is valid only for the duration of the circumstance or condition. A.R.S. §§ 15-73.A.2., B; A.A.C. § R9-6-706.E.
- 2. “Personal beliefs” exemption.** “Documentary proof” is not required when a parent or guardian submits a signed statement to the school administrator stating that the parent or guardian:
 - a.** has received information about immunizations provided by the DHS; and
 - b.** understands the risks and benefits of immunizations and the potential risks of non-immunization; and that
 - c.** due to “personal beliefs,” does not consent to immunization of the pupil. A.R.S. 15-873.A.1.

Note: Exemptions of this kind based on “personal beliefs” (or “philosophy”) are in place in about 20 states. Narrower “religious” exemptions are found in all but two of the remaining states (and indeed in the law governing Arizona child-care facilities; see **4.22.B.2., infra**).

The broad K-12 Arizona exemption essentially makes immunization voluntary, and therefore a proper subject of parental “informed consent,” as recognized by another statute (“A minor child shall not be immunized without the informed consent of the parent.” A.R.S. 36-673.D; A.A.C. § R9-6-703.

B. *Child care facilities*

- 1. Medical exemption; duration.** See A.A.C. § R9-6-706.F.5.

- 2. Religious exemption.** DHS regulations governing child-care facilities must exempt from immunization children whose parents adhere to “tenets and practices of a recognized church or religious denomination” that rejects immunization. A.R.S. § 36-883.C.

Note: This narrow statutory religious exemption for childcare facilities predates the broader “personal beliefs” exemption in the K-12 statute (see **4.22.A.2. supra**); it is not otherwise clear why there should be two different standards. However, DHS seems to minimize the difference in practice. Unlike the rule for K-12 exemptions (A.A.C. § R9-6-706.E), the rule for child-care exemptions does not expressly name *any* belief-based category of exemption (A.A.C. § R9-6-706). More important, while the form that DHS uses correctly advises parents that a “religious” exemption is available, it omits the critical statutory language about “*tenets and practices of a recognized church or religious denomination*,” asking instead only for a parental signature to the effect that immunizations are “against your religious beliefs.” See http://www.azdhs.gov/phs/immun/idr_forms.htm (last visited Oct. 28, 2006). This seems to be an effort to make this “religious” exemption operationally as similar as possible to the easily invoked, broader “personal beliefs” exemption available in K-12 schools.

- C. Consequences of exemption: exclusion from school or child-care facility during outbreak.** Pupils who lack documentary proof of immunization “shall not attend school during outbreak periods” of communicable, immunization-preventable diseases as determined by the DHS or local health department, which shall notify school administrators of such determination. A.R.S. § 15-873.C. The DHS rules apply the same policy to childcare facilities. A.A.C. § R9-6-705.H.

Note: See Appendix B, discussing *Maricopa County Health Dept. v. Harmon*, 156 Ariz. 161, 750 P.2d 1364 (Ariz. Ct. App. 1987).

Note: the statute bars attendance, during outbreaks, by students who lack “documentary proof of immunization.” Because “documentary proof” is defined as written evidence of either “immunization” or of “*laboratory evidence of immunity*” (see A.R.S. § 15-871.1.), the phrase “documentary proof of immunization” might be read to suggest that only actual past immunization -- not laboratory evidence of immunity -- suffices to allow a student to attend school during an outbreak. Probably this language was a drafting error rather than a policy choice, since its logic is not apparent. Moreover, DHS’s administrative rules on attendance during an outbreak make no such distinction. A.A.C. § R9-6-705.H.

4.23 Required immunizations; other matters.

The following subjects are addressed primarily by administrative rule, in accordance with statutory delegations of authority to the director of DHS:

A. Required immunizations; dosages; schedules for administration

1. Diphtheria
2. Tetanus
3. Hepatitis A (for a child age 2-5 in Maricopa County)
4. Hepatitis B
5. Pertussis
6. Poliomyelitis
7. Measles (rubeola)
8. Mumps
9. Rubella (German measles)
10. *Haemophilus influenzae* type B
11. Varicella

For dosages, administration schedules, and related matters, see A.R.S. §§ 36-672.A; 15-872.; A.A.C. § R9-6-702; A.A.C. Tit. 9, Ch.6, Art. 7, Tables 1, 2.

- B. *Documentary proof of immunization status*** A.R.S. §§ 15-872.A., D; 36-672 .B.; 36-674; A.A.C. § R9-6-704
- C. *Records; reporting requirements*** A.R.S. § 15-874; A.A.C. § R9-6-707.
- D. *Duties of local health agencies*** A.R.S. § 36-673 (including providing and administering free immunizations, A.R.S. 36-673.B., C); A.A.C. § R9-6-703.

4.24 Responsibilities of schools and child care facilities.

- A. *Duty of public schools to publicize immunization requirements and exemptions.*** Each public school shall make full disclosure of the requirements exemptions as prescribed in A.R.S. § 15-872 and § 15-873. A.R.S. 1§ 5-872.C.
- B. *Other Responsibilities of schools and child care facilities.*** A.A.C. § R9-6-705; A.A.C. § R9-6-706.G.

4.25 School liability protection.

A school and its employees are immune from civil liability for decisions concerning the admission, readmission and suspension of a pupil which are based on a good faith implementation of the requirements of Chapter 15, Tit. 8 (school immunization). A.R.S. § 15-872.I.

4.30 CONTROL OF TUBERCULOSIS

Tuberculosis (TB), under control for several decades in the United States, became resurgent in some locales in the 1980s and 1990s. Although completing the full, lengthy course of drug therapy generally cures patients and renders them non-contagious to others, some patients lack the means, knowledge, or inclination to complete treatment. This can result in multi-drug-resistant (MDR) forms of TB, which present greater danger both to the patient and to others. Some public health authorities responded by implementing “directly observed therapy” (DOT), in which public health workers maintain daily contact with certain patients (such as some homeless persons) to supervise their taking of medications. Persons truly unable, or even unwilling, to take their medications on their own are sometimes civilly confined for public protection. More recently, extensively drug-resistant (XDR) strains have emerged, even more difficult to treat.

The original state laws providing for treatment or involuntary confinement of TB patients preceded, often by decades, the “revolution” in civil rights of the mid-to-late-20th Century. (See Appendix A, “1955”). Accordingly, in the 1980s courts began to be faced with cases in which tuberculosis patients claimed that health departments and trial courts had deprived them of constitutionally protected liberty by treating and/or confining them without due process of law in violation of the 14th Amendment. See, e.g., *Greene v. Edwards*, 164 W. Va. 326, 263 S.E.2d 661 (1980); *City of Newark v. J.S.*, 279 N.J. Super. 178, 652 A.2d 265 (1993). Recognizing the need for modernization, some states revised their TB control statutes to provide greater procedural and substantive protections for TB patients, while still safeguarding the public’s health. Arizona was one. The current statutes, found at A.R.S. §§ 36-711 to 36-738, contain lengthy and highly detailed provisions aimed at both objectives.

4.31 General provisions: definitions; personnel, administration, payment; confidentiality; investigation of cases; voluntary treatment.

A. Definitions. See A.R.S. § 36-711.

B. Tuberculosis control officer. The tuberculosis control officer (defined A.R.S. § 36.711.21), a licensed physician appointed by the

director of DHS, is responsible for all matters pertaining to the investigation, control and treatment of tuberculosis. A.R.S. § 36.714.A.

- C. Confidentiality.** Records, reports, and other data pertaining to the condition of afflicted persons (defined A.R.S. § 36.711.2) is confidential and privileged and shall not be divulged so as to disclose the identity of the person to whom it relates, although the tuberculosis control officer may examine such information, and that officer or a local health officer (defined A.R.S. §36.711.14) may disclose such information to health care facilities, health care providers, county and state agencies and courts as necessary to enforce this article and related rules. A.R.S. § 36.714.B.
- D. Financial assistance for treatment.** Financial assistance for treatment is available to afflicted persons through the department of economic security. A.R.S. § 36-716.A., B.
- E. County responsibility to provide or arrange for medical care or treatment.** The local board of health, through the county board of supervisors, is responsible for providing or arranging for the provision of medical care and treatment for persons in the county with tuberculosis. A.R.S. § 36-717.
- F. Contract for care by DHS director.** The director of the DHS may contract for the care of any afflicted person, provided that appropriated monies may not be used until an individual's health insurance is exhausted or shown to be insufficient. A.R.S. § 36-718
- G. Rules.** The DHS director shall adopt rules regarding reporting and statistics, standards of medical care, and enforcement of the provisions of this article. A.R.S. § 36-721 Rules have been adopted, and are codified at A.A.C. Tit. 9, Art 6, §§ A.A.C. § R9-6-601 to A.A.C. § R9-6-604. Their key provisions are as follows:
- 1. Reporting:** Within 30 days after receiving information, a local health department shall report on a specified form to the department regarding each individual in its jurisdiction who (1) has been diagnosed with active TB, (2) is suspected of having active TB, and (3) is believed to have been exposed to an individual with infectious active TB. A.A.C. § R9-6-602.
 - 2. Tuberculosis Control in Correctional Facilities** (details omitted). A.A.C. § R9-6-603.
 - 3. Standards of Medical Care.** A health care provider caring for an afflicted person shall comply with the recommendations for

treatment of TB in [citations to medical authorities omitted] unless the provider believes, based on the provider's professional judgment, that deviation from the recommendations is medically necessary. If a provider deviates from the recommendations for treatment, the provider shall, upon request, explain to the Department or a local health agency the rationale for the deviation. If the TB control officer determines that deviations from the recommendations in is inappropriate and that the public health and welfare require intervention, the TB control officer may take charge of the afflicted person's treatment as authorized under A.R.S. § 36-723.C. See A.A.C. § R9-6-604. There do not appear to be separate rules on the other subjects mentioned in the statute (statistics and enforcement).

H. Investigation of TB cases.

- 1. Investigation and search of premises by health officers.** Upon learning that an afflicted person (defined A.R.S. § 36-711.2) is within his jurisdiction, a local health officer shall immediately investigate. A local health officer or the TB control officer may enter and inspect public places (defined A.R.S. § 36-723.A.1), commercial means of transportation, and private property and premises. The officer shall seek consent to enter; if withheld, the officer shall obtain a search warrant, appropriately limited and in compliance with A.R.S. § 13-3912. A.R.S. § 36-723.A.
- 2. Role of TB control officer.** A local health officer who conducts an investigation shall immediately notify the TB control officer and keep that officer informed. The TB control officer may take charge of the investigation and suppression of a suspected case, outbreak, or epidemic if s/he reasonably believes this is necessary for public health and welfare; in that event, the TB officer has exclusive authority over the case, outbreak, or epidemic. A.R.S. § 36-723.B., C
- 3. Reporting responsibilities of health care providers and others.**
 - a. Notification of knowledge of afflicted person.** A treating, screening or attending health care provider (defined A.R.S. § 36-661), clinical laboratory (defined A.R.S. § 36-651), or operator of a homeless shelter who knows of an afflicted person shall notify the TB control officer or local health officer of specified information, and cooperate in any investigation. A.R.S. § 36-723.D.

b. Notification of non-compliance by afflicted person. An institution or health care provider shall notify the TB control officer or local health officer (information as specified) if an afflicted person ceases or refuses to accept treatment or fails or refuses to comply with medical recommendations for voluntary examination, isolation, monitoring, quarantine or treatment for active tuberculosis (definitions A.R.S. §§ 36-711.8, 13, .18, .19, .20, .1). A.R.S. § 36-723.E.

I. Voluntary treatment. If, as a result of an investigation or report, the TB control officer or local health officer believes someone is an afflicted person, the officer shall encourage that person (or that person's parent or guardian, if the person is a minor or incapacitated) to accept or consent to voluntary control measures and voluntary treatment to meet the minimum requirements prescribed by the department. A.R.S. § 724.

4.32 Administrative orders to cooperate; emergency custody.

A. Written administrative order to cooperate.

- 1. When issuable.** If the TB control officer or the local health officer reasonably believes that someone is (a) an afflicted person who (b) endangers another or the community and (c) fails or refuses to comply with voluntary examination, monitoring, treatment, isolation or quarantine, the officer shall issue a written order to cooperate to the person (or parent or guardian if a minor or incapacitated). A.R.S. § 36-725.A.
- 2. Oral delivery.** An order to cooperate may be an oral statement in urgent circumstances, but is to be followed by a written order by the end of the next business day. "Urgent circumstances" means reasonably impractical due to circumstances beyond the officer's control, including inaccessibility, dangerous conditions, or the threat of violence. A.R.S. § 36.725.B.
- 3. Service.** An order to cooperate shall be individual and specific and shall not be issued to a class of persons. It shall be served on the afflicted person or, if a minor or incapacitated, the parent or guardian thereof. If personal service cannot be performed despite due diligence, the order may be served by certified mail, return receipt requested. An affidavit of service detailing the procedures used shall be prepared and maintained by the TB officer or the local health officer. A.R.S. § 36-725.C

4. **Contents of order.** The written order shall require compliance with all intervention efforts to prevent and control the transmission of TB. It may require participation in education, counseling, examination, medical treatment and supervision programs, and medical tests for monitoring and to verify the afflicted person's status. A.R.S. § 36-725.A. It shall include a statement that, unless the afflicted person complies with its required terms, the TB officer or local health officer may order the afflicted person into emergency custody and shall seek a court order for compulsory examination, monitoring, treatment, isolation or quarantine. The order shall also state that if a court order is sought, the afflicted person has the right to notice and a hearing and other rights as provided by law. A.R.S. § 36-725.D.

B. Noncompliance with written order to cooperate; dangerousness; administrative emergency custody order.

1. **When administrative emergency custody order may be issued.** If an afflicted person (a) refuses to comply with the order to cooperate, *or* (b) the TB control officer or health officer (i) knows that the person has previously failed or refused to comply with an appropriate prescribed course of medication, treatment, or monitoring, *and* (ii) has reasonable grounds to believe the afflicted person poses a substantial danger to another person or the community and that emergency custody is necessary to prevent such danger, the officer may issue an emergency custody order. A.R.S. § 725.E
2. **Contents of administrative emergency custody order.** The order directs a sheriff or law enforcement officer, or a health care provider or emergency medical services personnel, to take the afflicted person into custody, to take precautions reasonable and necessary under the circumstances to protect their own health, and to transport the afflicted person to an institution or facility specified in the order. The order may be oral, followed by a written order by the end of the next business day. A.R.S. § 36-725.E.

C. Action by receiving institution.

1. **Housing and care.** The receiving institution shall provide suitable housing and care of the afflicted person. A.R.S. § 36-725.E.
2. **Admission.** The admitting officer shall admit the person as an emergency patient and shall perform an examination to determine whether the afflicted person must be isolated (physically separated; see definition at A.R.S. § 36-711.13). A.R.S. § 36-725.F.

3. **Release.** An afflicted person admitted pursuant to an emergency custody order shall be released from custody if the institution's medical director, with advice and consent of the TB control officer or a local health officer, determines that the afflicted person is either:

a. **Not afflicted with active TB;** or

b. **Not a danger to another person or the community and release is appropriate;** or

c. **Qualified for release as a voluntary patient.** A.R.S. § 36-725.G.

D. Petition for judicial order of public health protection; when filed

1. **Within three days of emergency detention.** A petition for public health protection, in compliance with A.R.S. § 36-726 (§ 4.33, *infra*), shall be filed in superior court within three business days after the afflicted person's emergency detention authorized pursuant to an order of the TB control officer or local health officer. If a petition is not filed within three days after the detention, the afflicted person shall immediately be released from custody, and shall not be returned to emergency custody by a subsequent order unless the TB control officer or health officer first obtains an order from superior court permitting detention pursuant to this article. A.R.S. § 36-725.L.

2. **Within three days of [admission].** If an afflicted person is admitted pursuant to an emergency custody order, the TB control officer or health officer or designated legal representative shall file a petition for public protection within three business days after the detention, in compliance with A.R.S. § 36-726 (§ 4.33, *infra*), unless the afflicted person has been accepted as a voluntary patient. A.R.S. § 36-725.H.

Note: It is not entirely clear whether A.R.S. § 36-725.L and A.R.S. § 36.725.H (§§ 4.32.D.1.,2., immediately *supra*) are meant to address different circumstances. Perhaps in § 36-725.H. the phrase "within three business days after the *detention*" was meant to read "within three business days after the *admission*," which would help illuminate a distinction between the two sections. In any case, because of the presumption against interpreting statutes to create redundancy, they are presented separately here.

E. Information to be provided to persons by TB control officer or health officer, including rights under this article and right to legal representation. When an afflicted person is taken into emergency

custody, the TB control officer or local health officer shall, within the limits of due diligence, promptly notify the person's physician, parent or guardian, or an adult member of the afflicted person's family, identifying the location of the detention, terms and conditions of custody, and the authority that ordered the detention. The officer shall inform the afflicted person, or his parent or guardian if a minor, of the person's rights under this article, including the right to consult an attorney and to have a court-appointed attorney if financially necessary, both of which also apply during proceedings pursuant to a petition for public health protection, if filed. A.R.S. § 36-725.I.

F. *Special provisions regarding minors and incapacitated persons; limitation on unconsented treatment.* If an afflicted person is a minor or is incapacitated, the TB control officer or local health officer shall use reasonable efforts to find and confer with a parent or guardian prior to initiating an intervention under this article. If a parent or guardian cannot be found or is unwilling to consent to such a recommended intervention, the officer may initiate any intervention that does not prescribe medical treatment unless it is otherwise authorized by A.R.S. §§ 44-132, 44-133, 14-5209, or 14-5312. A.R.S. § 36-725.J.

G. *No involuntary treatment without judicial approval.* This section (A.R.S. § 36-725; §§ 4.32, 4.33) does not allow a private or public facility to forcibly or involuntarily administer medications to an afflicted person unless authorized by the written order of the superior court pursuant to this article or as otherwise permitted by law. A.R.S. § 36-725.M.

4.33 Petition for judicially-ordered examination, monitoring, treatment, isolation, or quarantine (“petition for public health protection”)

Note: A.R.S. § 36-726 (discussed in this § 4.33) does not identify itself as the statutory locus of the requirements for “petitions for public health protection,” a phrase used elsewhere in the TB control statutes. However, that inference seems inescapable.

A. *Circumstances for bringing petition; where filed.* The tuberculosis control officer, local health officer, or designated legal representative may petition the superior court, in the county where the afflicted person resides or is located, and in the form and manner approved the director of DHS, for court-ordered examination, monitoring, treatment, isolation or quarantine of an afflicted person who (1) presents a substantial danger to another person or to the community *and* (2) has failed to comply with a voluntary treatment plan or a written order to cooperate. A.R.S. § 36-726.A.

B. *Petition and affidavits.*

- 1. Contents of petition.** The petition shall include the afflicted person's name and address; a statement of the grounds and facts demonstrating that the person is an afflicted person; a statement that the afflicted person has failed to comply with a voluntary treatment plan or an order to cooperate or has a history of noncompliance with an appropriate prescribed course of medication or other interventions; a statement containing the grounds and facts demonstrating the person's dangerousness to another person or the community; the least restrictive alternatives to court-ordered examination, monitoring, treatment, isolation or quarantine that are appropriate or available; a statement identifying the afflicted person as a minor or incapacitated person, if applicable, and any facts that could help the court determine whether a guardian is needed pursuant to A.R.S. § 36-730. A.R.S. § 36-726.B.
 - 2. Accompanying affidavits.** The petition shall be accompanied by affidavit(s) of person(s) who conducted the investigation, and of the petitioner or intervener. The affidavits shall detail the evidence that indicate that the person is an afflicted person, that s/he is a substantial danger to another person or the community, and a summary of the facts that support the petition's allegations. A.R.S. § 36-726.E.
- C. Request for authorization to treat prior to hearing.** If the petitioner determines that the afflicted person's health is likely to deteriorate before a court hearing can begin, the petition shall describe the person's current medical condition and request an immediate order from the court authorizing medically necessary treatment before hearing. A.R.S. § 36-726.C.
- D. Adjustment of conditions.** The petitioner shall inform the court when the afflicted person's medical condition may require the court to adjust the conditions and circumstances to accommodate the afflicted person's condition pursuant to A.R.S. § 36-725. A.R.S. § 36-726.D.
- E. Permissible time between filing of petition and holding of hearing.** A detention hearing shall be held within fifteen days after the petition is filed with the clerk of the superior court unless (1) the court determines for good cause shown that a continuance is necessary in the interests of public health ("good cause" to include the unavailability of necessary witnesses or incomplete laboratory results), or (2) the afflicted person or, if a minor or incapacitated person, the afflicted person's parent or guardian, on consultation with an attorney, determines that the request for a continuance would be in the best interests of the afflicted person. A.R.S. § 36-726.L., F. The grant of a continuance shall not exceed

thirty days unless pursuant to the parties' agreement. A.R.S. § 36-726.M.

F. Proceedings after filing of petition.

- 1. Request for immediate detention prior to hearing.** The petition shall request an immediate order authorizing compulsory and continued detention, in a designated facility for supervised monitoring, treatment, isolation or quarantine, pending a detention hearing on the petition for public health protection. A.R.S. § 36-726.F.
- 2. Order for immediate detention; right to attorney.** Before it has an opportunity to rule on the petition's merits, the superior court may order immediate or continued detention in an approved institution, if the court determines there is reasonable cause to believe the afflicted person is likely to be a substantial danger to another person or to the community. A.R.S. § 36-726.G. If the court orders immediate detention, it shall issue orders for the apprehension, transportation and detention of the afflicted person pending the outcome of the detention hearing, and shall provide notice of detention to the afflicted person's physician (or, if a minor or incapacitated person, a parent or guardian or, if none, next of kin). The court shall appoint an attorney for the afflicted person if one has not been appointed. A.R.S. § 36-726.H.
- 3. Release upon finding of non-affliction or non-dangerousness.** If after reviewing the petition and evidence the court determines that the evidence does not support a finding that the person is an afflicted person or is a substantial danger to another person or the community, the court shall issue a written order to release the person as soon as reasonably possible. A.R.S. § 36-726.I.
- 4. Voluntary withdrawal or abeyance of petition prior to hearing.** If, after filing of the petition and before the hearing, the petitioner or the medical director of the receiving institution, with advice and consent of the TB control officer or local health officer, determines that:
 - a. The person is not an afflicted person,** the petitioner shall withdraw the petition and the person shall be discharged as soon as reasonably possible. A.R.S. § 36-726.J
 - b. The afflicted person will voluntarily comply with the orders of the tuberculosis control officer or the local health officer,** the petitioner may request the court to hold the petition in

abeyance pending satisfactory compliance by the afflicted person with the terms of the voluntary treatment plan. The court shall not hold the petition in abeyance for longer than six months. Prior to the end of six months, the petitioner may request the court to continue holding the petition in abeyance for a period of time specified by the court. A.R.S. § 36-726.K.

G. *Procedural duties of petitioner to afflicted person subsequent to filing of petition and prior to hearing.*

- 1. *After filing petition.*** Within five days after filing a petition for public health protection, the petitioner shall serve on the afflicted person (or, if a minor or incapacitated, the person's parent or guardian) a copy of the petition and affidavits and the notice of the hearing. The notice shall inform the afflicted person of the purpose of the hearing and the right to an attorney. If the afflicted person does not have an attorney, the court shall appoint one at least seven days before the hearing. The notice shall fix the date, time and place for the hearing. The notice requirements of this section cannot be waived. A.R.S. § 36-726.P.
- 2. *Before hearing.*** At least five days before the hearing or within a reasonable time after the appointment of a court appointed attorney, copies of the petition, affidavits in support of it, the notice of the hearing, the investigation reports, the afflicted person's medical records and copies of other exhibits shall be made available by the petitioner to the afflicted person or, if a minor or incapacitated person, the afflicted person's parent or guardian or that person's attorney for examination and reproduction. A.R.S. § 36-276.Q.

H. *Purpose of detention hearing; burden of proof.* "The purpose of a detention hearing is to determine if the afflicted person has tuberculosis. The burden of proof is on the petitioner to prove by clear and convincing evidence that detention is necessary because the person is an afflicted person and is a substantial danger to another person or the community." A.R.S. § 36-726.N.

Note: The first sentence of this provision is potentially misleading in two important ways. First, finding out whether someone "has tuberculosis", standing alone, cannot logically constitute the "purpose" of the hearing, since such knowledge has limited value: many people have an *inactive* form of tuberculosis that is of little immediate public health concern. (Indeed, under the law, an "afflicted person" is one who has, or is suspected of having, *active* tuberculosis. A.R.S. § 36-711.2). The first sentence should therefore be understood as applying to *active* tuberculosis. Second, as both the balance of this section and many other sections in the law make clear, "the purpose" of the hearing is not limited to the medical determination of the

presence or absence of even active TB, but includes also the essential inquiry into “substantial dangerousness to another person or the community” – an element which is measured in significant part by the person’s expected *behavior* (taking medication, self-imposed voluntary temporary isolation, etc.). Indeed, the other Arizona TB statutes consistently contemplate *non*-confinement of persons who can be expected to voluntarily comply. If it were otherwise, the law would authorize forcible confinement of persons not expected to present a hazard to others, a result not only irrational but unconstitutional. Accordingly, the first sentence should be read as addressing at least *two* “purposes” – the presence or absence of active tuberculosis, and (if active TB is present), the person’s “dangerousness.” Ironically, if the first sentence had simply been left out of the statute, the foregoing confusion would have been avoided.

- I. ***Right to independent medical evaluation.*** A person has the right to an independent medical evaluation, including physical examination and laboratory analysis, to be appointed by the court if the person is unable to pay. The person may require the independent physician who performed the evaluation to appear as a witness at the hearing. A.R.S. § 36-726.R
- J. ***Department as intervener.*** At any time before the hearing the department may intervene as a party to any proceedings pursuant to this section by filing written notice with the court. The intervener cross-examine witnesses, subpoena and present witnesses, and present evidence. Upon stipulation among the parties or by order of the court, the intervener may have physicians conduct physical examinations of the afflicted person and offer testimony as to whether the person has active tuberculosis or is a substantial danger to another person or the community, and offer testimony as to the least restrictive examination, treatment, monitoring, isolation or quarantine alternatives available to the court. A.R.S. § 36-726.O.

4.34 Judicial hearings

A. *Right to attend; conduct of hearing; confidentiality.*

1. **Right to attend.** The afflicted person or, if a minor or incapacitated person, the person’s parent or guardian and attorney have the right (which may be waived) to be present at all hearings, subject to judicially-imposed conditions or procedures to protect the health and safety of all participants. A.R.S. § 36-727.A
2. **Inability/unwillingness to attend.** If the afflicted person is unable or unwilling to attend, or the hearing cannot be reasonably conducted where the person is being treated or confined or in the person’s presence, the court shall enter a finding and may proceed with the hearing. A.R.S. § 36-727.B.

3. **Protection of participants.** The court may impose conditions it deems necessary to protect the health and safety of all participants and to ensure humane treatment with due regard to the comfort and safety of the afflicted person and others, including the use of video or telephonic conference appearances, and interpreters and others to aid in communication. A.R.S. § 36-727.C.
4. **Hearing closed; confidentiality.** The court hearing shall not be open to the public and all records, notices, exhibits and other evidence are confidential and shall not be released to the public. The court may order portions released, or a public hearing to be held, upon request of the afflicted person or the parent or guardian or attorney thereof. Judicial records and exhibits are available to the petitioner, afflicted person, department, TB control officer, health officer, or a legal representative of these persons or agencies. A.R.S. § 36-727.H.

B. Evidence and Testimony

1. **In general.** Parties may present evidence and subpoena and cross-examine witnesses. Evidence may include testimony of experts on infectious diseases or public health matters, or a physician who performed an examination or evaluation of the afflicted person. The petitioner may prove its case on the affidavits filed in support of the initial petition. The clinical record of the afflicted person for the current admission shall be available and may be presented in full or in part as evidence at the request of the court, the afflicted person or his attorney, or any party in interest. A.R.S. § 36-727.D
2. **Information regarding drugs affecting afflicted person's judgment or behavior.** At the hearing, the court shall be advised of any drugs known to have been administered to the afflicted person before the hearing that would affect his judgment or behavior. A.R.S. § 36-727.E.
3. **Reports of appointed witness; recommendation as to least restrictive alternative.** Persons appointed to conduct an examination and evaluation of the afflicted person shall make their reports in writing to the court. The reports shall include a recommendation as to the least restrictive alternative measures available to the court. A.R.S. § 36-727.F.

C. Record; transcript

1. **Record.** A verbatim record of all proceedings shall be made by stenographic or electronic means, to be retained as provided by statute. A.R.S. § 36-727.G
2. **Transcript to be made available.** An afflicted person ordered by the court to undergo examination, monitoring, treatment, isolation or quarantine or, if a minor or incapacitated person, the person's parent or guardian, may request and obtain a certified transcript of the hearing. The cost shall be charged to the afflicted person if s/he is able to pay, and to the county if s/he is not. A.R.S. § 36-727.I.

4.35 Judicial action

A. Findings necessary to support judicial order; standard of proof. If the court finds by clear and convincing evidence that a person

1. **Is an afflicted person, and**
2. **Poses a substantial danger to another person or to the community,** the court shall order one or more of the steps identified in the next **§ 4.45.B.** A.R.S. § 36-728.A.

B. Judicial actions. Upon making the findings specified in **§ 4.45.A,** the court shall order the afflicted person to do any of one or more of the following, pursuant to a written treatment plan developed or submitted by the TB control officer or the local health officer and approved by the court:

1. **Participate in** a designated education program
2. **Participate in** a designated counseling program
3. **Participate in** a designated treatment program
4. **Undergo** medically accepted tests to verify the status of the afflicted person
5. **Undergo** a program of directly observed therapy
6. **Participate in** a program to notify or appear before designated health officials for verification of status, testing or other purposes consistent with monitoring
7. **Comply with** an order that the afflicted person refrain from conduct that is a health threat to others or to the community

8. **Comply with** an order that the afflicted person undergo isolation or quarantine at an approved facility, location or setting for the period and under the conditions set by the court and as approved by the department, the TB control officer or the local health officer.
9. **Comply with** an order that the afflicted person be committed to an appropriate facility for the period and under the conditions set by the court and as approved by the department, the TB control officer or the local health officer.
10. **Comply with** any other order the court determines is necessary and appropriate. A.R.S. § 36-728.A.

C. *Voluntary treatment; judicial approval.* The court may approve and order the afflicted person's participation in a voluntary program, under the terms prescribed by the court pursuant to this section. A person who accepts a voluntary treatment plan remains under the jurisdiction of the court for the purposes of court ordered examination, treatment, monitoring, isolation or quarantine. The terms prescribed by the court may incorporate the terms of a voluntary treatment plan that shall include provision for the medically successful complete course of anti-tuberculosis treatment. A.R.S. § 36-728.B.

D. *Requirement to impose least restrictive measure.* The court shall order the least restrictive measures necessary for examination, treatment, monitoring, isolation or quarantine of the afflicted person that will effectively protect the public health and provide appropriate care for the afflicted person. In doing so the court shall also consider input from the parent or guardian of an afflicted person, if the person is a minor or incapacitated. A.R.S. § 36-728.C.

E. *Facilities or programs to which afflicted person is assigned; responsibilities*

1. **Court's designation of facility or program.** If the court enters an order pursuant to this section it shall designate a facility or program to supervise the afflicted person and administer the court's order. A.R.S. § 36-728.D.
2. **Use of consenting, competent service providers.** The director of a facility or program shall only use the services of any person, institution or program that has agreed to provide these services in the afflicted person's case and only if the local health agency or department determines that the person, institution or program is competent do so. A.R.S. § 36-728.E.

3. **Notice of referral.** The person, facility or program assigned to supervise the afflicted person pursuant to the court's order shall be notified at least three days before a referral. Relevant information shall be shared about the afflicted person to promote the health and safety of the public and to provide effective intervention and continuity of treatment. A.R.S. § 36-728.F.

F. *Matters arising after issuance of judicial order.*

1. **Modification of order on motion.** On a motion by the director of the afflicted person's assigned institution or program, or by the petitioner, the TB control officer or the local health officer, the court after hearing may amend or alter its original order if it determines that any of the following is true:
 - a. ***The afflicted person is not complying with the terms of the original order.***
 - b. ***The designated treatment plan is no longer appropriate.***
 - c. ***Further observation, examination, treatment, isolation or quarantine is required. A.R.S. § 36-728.G.***
2. **Non-compliance.** If an afflicted person refuses to comply with any order or amended order issued pursuant to this section, the court may issue additional orders necessary to address and correct the afflicted person's noncompliance and may direct a sheriff or law enforcement officer, on the request of the TB control officer or local health officer, to take the afflicted person into custody and to transport the person to a designated institution or program. A.R.S. § 36-728.H.
3. **Absence.** If any afflicted person who is under court ordered examination, monitoring, treatment, isolation or quarantine issued pursuant to this article is absent without proper authorization from a designated facility or program or if a court order is amended, rescinded or modified, a sheriff or law enforcement officer may be directed by the TB control officer or the local health officer to take the person to a designated and approved institution or program. A.R.S. § 36-728.K.
4. **Confinement pursuant to amended court order.** If the TB control officer or local health officer determines that an afflicted person who is not currently detained is in need of immediate and acute intervention or care because his behavior is dangerous to

another person or the community, the officer may issue a written or oral order to a sheriff or law enforcement officer to take the person to a location designated by the officer. The afflicted person may be confined for not more than three days after taken to the institution, pending consideration by the court of an amended order sought under A.R.S. § 36-728.G (§ 4.35.F.1., *supra*), which the officer or designated legal representative shall file not later than three business days after confinement. A.R.S. § 36-729. A., B.,C

5. Early release. An afflicted person under court-ordered examination, treatment, monitoring, isolation or quarantine may be released before the expiration of the period ordered by the court, if the petitioner or the medical director of the institution, upon advice and consent from the TB control officer, determines through examination and evaluation that the person no longer has active TB or no longer poses a substantial danger to another or the community and that release is appropriate. Notice of discharge shall promptly be given to the judge. The person may be released or discharged without further court order, in accordance with the terms of the treatment plan or court order. On finding of good cause, the court may order a further hearing on a motion for early discharge or to amend or modify an existing court order pursuant to an affidavit of the petitioner or intervener or afflicted person or the latter's attorney, stating the need for further evidentiary hearing and reasons the hearing is necessary before the time set for release of the afflicted person. A.R.S. § 36-732.A.,B.,C

G. Appointment of guardian or conservator. If the court determines that the afflicted person may need a guardian or conservator or both, it shall order an investigation concerning that need and shall appoint a suitable person or agency to conduct it. If the court finds the afflicted person needs an immediate guardian or conservator to protect the person or to carry out alternatives to court-ordered examination, treatment, monitoring, isolation or quarantine, and there is no one qualified and willing to act in that capacity, the court may appoint a person or the public fiduciary to serve as a temporary guardian or conservator. A.R.S. § 36-730.

H. Calculation of time. The period of court ordered examination, monitoring, treatment, isolation or quarantine does not run during any unauthorized absence from the jurisdiction or from any required monitoring or supervision. The period resumes only on the afflicted person's return to the designated facility or program. A.R.S. § 36-728.K.

- I. **Maximum time.** Except as provided in this section, court ordered examination, treatment, monitoring, isolation or quarantine shall not exceed three hundred sixty-five days. A.R.S. § 36-728.L.
- J. **Right to appeal.** On issuance of an order or an amended order issued pursuant to this section, the afflicted person shall be informed of the right to appeal and the right to consult with an attorney. A.R.S. § 36-728.I.
- K. **Appeal to court of appeals; permissive scheduling preference.** An order of the superior court that imposes, denies, modified, amends or rescinds court ordered examination, treatment, monitoring, isolation or quarantine pursuant to this article may be reviewed at the request of any party in interest by appeal to the court of appeals as prescribed in the Arizona rules of civil procedure or by special action. The court may give scheduling preference to this appeal or special action. A.R.S. § 36-736.B.

4.36 Suitable custodial facilities.

- A. **Comfortable, safe confinement; transportation.** The TB control officer or local health officer is responsible for selecting a facility or quarters suitable for the comfortable, safe and humane confinement of an afflicted person who has been taken into custody pursuant to this article, if the person is not otherwise admitted or confined in a health care institution. The officer may authorize transportation of an afflicted person to a designated institution or location (details omitted), if the officer determines that the means of transportation are reliable and would not be detrimental to any person's health, welfare or safety. A.R.S. § 36-731.F.A.
- B. **Confinement not in prison or jail.** An afflicted person subject to an order or petition under this article who is not incarcerated on a criminal charge shall not be confined in any prison or jail where those charged with crimes are incarcerated, unless the person represents an immediate and serious danger to the staff or physical facilities of a hospital or any institution to which committed, or unless s/he has failed to obey a court order or a lawful order of the TB control officer or local health officer issued pursuant to this article and the medical director of the receiving facility has determined that no less restrictive confinement measures are appropriate. The court shall subsequently determine the appropriate level of confinement necessary during this initial consideration of the petition and the request for compulsory detention pursuant to § 36-726.F (**§ 4.33.E., F.1**). A.R.S. § 36-731.B.

4.37 Limitations on involuntary treatment

A. *Religious exemption from compulsory treatment.* An afflicted person is not required to undergo treatment under this article if that person depends exclusively on prayer or spiritual means for healing in accordance with the tenets and practices of a recognized church or religious denomination and claims an exemption on that ground. [However,] [t]he requirements of this article regarding compulsory reporting of TB disease, exclusion from employment or school, monitoring, examination, isolation and quarantine apply if there is clear and convincing evidence that the person is an afflicted person and is a substantial danger to another person or the community. A.R.S. § 36-734.A

Note: With respect to exemptions provided (as here) on a religious basis, see § 4.22 (immunization).

B. *Exemption from medical treatment or institutional confinement in presence of satisfactory alternatives.* An afflicted person is not required to submit to any medical treatment or go to, or be confined in, any hospital or other medical institution, if s/he can be safely examined, monitored, isolated or quarantined in his/her home or another place that is suitable to his/her health, provides appropriate protection to other persons and the community, and is approved by the department, the TB control officer, or a local health officer. A.R.S. § 36-734.B

C. *Non-exemption from sanitation laws.* This section does not exempt a person from complying with applicable laws regarding sanitation. A.R.S. § 36-734.C

4.38 Notice of rights; additional duties of institutional care providers.

A. *Written notification of rights.* An afflicted person ordered to receive court-ordered examination, treatment, monitoring, isolation or quarantine pursuant to this article (or if a minor or incapacitated, such person's parent or guardian) shall be informed in writing of the following rights, in the person's primary language (if reasonably possible) and, if applicable, through means calculated to overcome a visual or hearing impairment:

1. The right to appropriate care and treatment in accordance with accepted standards of medical practice and in an appropriate setting consistent with protection of the afflicted person, the community and the public health;

2. The right not to receive unnecessary or excessive medication;

3. **The right to refuse to participate in a research program;**
4. **A humane treatment environment** that provides reasonable protection from harm and appropriate privacy for personal needs. A.R.S. § 36-735.A.,B.

B. Responsibilities of institution or program providing care. The director of an institution or program that provides care pursuant to this article is responsible for the following:

1. **Safety/security.** Reasonable efforts to provide for the care, safety and detention of the afflicted person and adequate security to prevent his/her leaving the institution or program without permission or from transmitting the communicable disease to others in the community.
2. **Medical examination.** The examination and evaluation by a licensed physician at least once every thirty days and as medically necessary.
3. **Reports.** Reports advising the TB control officer or local health officer of the statutes of the afflicted person's disease and the person's compliance with any orders or treatment plan.
4. **Notification of discharge.** Adequate prior notification under the circumstances to the TB control officer or local health officer of the pending discharge of the afflicted person. A.R.S. § 36-735.C.

4.39 Miscellaneous provisions.

A. Procedure; exemption of administrative orders from generally applicable procedures Orders of the TB control officer or local health officer issued pursuant to this article, and to procedures prescribed by this article, are exempt from Tit. 41, Ch. 6 (A.R.S. § 41-1001 *et seq.*) and Tit. 12, Ch. 7, Art. 7 (A.R.S. § 12-901 *et seq.*)

B. Criminal liability.

1. **Class 3 misdemeanors.** The following conduct constitutes a class 3 misdemeanor:
 - a. **Health care providers and others; failure to perform a legal duty.** A treating, screening or attending health care provider as defined in A.R.S. § 36-661, a clinical laboratory as defined in A.R.S. § 36-451, or an operator of a homeless shelter who

knowingly fails or refuses to perform a duty or legal responsibility imposed pursuant to this article. A.R.S. § 36-737.A.

b. Interference with investigation. Any person who knowingly obstructs, impairs or hinders an investigation conducted pursuant to this article A.R.S. § 36-737.D.

c. False report. Any person who knowingly makes a false report of tuberculosis to the TB control officer or the local health officer. A.R.S. § 36-737.E.

d. Assisting noncompliance. Any person who, without proper authorization, knowingly assists another to be noncompliant with an order issued pursuant to this article. A.R.S. § 36-737.F.

2. Class 2 misdemeanors. The following conduct constitutes a class 2 misdemeanor:

a. Intentional exposure of others. An afflicted person who intentionally or knowingly exposes others to infection. A.R.S. § 36-737.B,

b. Violation of isolation, quarantine, custody. An afflicted person who leaves or attempts to leave the custody, isolation, quarantine or detention imposed by the superior court or the order of the TB control officer or local health officer pursuant to this article. A.R.S. § 36-737.C.

C. Qualified civil Immunity. Any person or entity that acts pursuant to this article is not subject to civil liability for good faith conduct in following or attempting to follow the requirements of this article. Good faith means “reasonable under the circumstances.” This immunity does not extend to gross negligence or intentional misconduct. A.R.S. § 36-738.

4.40 ISOLATION AND QUARANTINE – “NON-EMERGENCY”

4.41 Introduction.

Voluntary isolation is not particularly controversial: people in hospitals with contagious diseases are commonly isolated during treatment, with their consent, until they are non-contagious. However, *involuntary* isolation and quarantine are

among the most liberty-restricting, and therefore most controversial, measures that can be imposed for disease control. Accordingly, the law (and this book) address involuntary isolation and quarantine separately from, and in greater detail than, other control measures (which are described in **§4.10-4.20**, *supra*).

In the absence of a gubernatorially declared emergency (see **Chapters 7-9**, *infra*) A.R.S. §36-624 (**§4.42**, *infra*) requires local health authorities to implement isolation and quarantine “consistent with” two different legal authorities: generally-applicable (non-emergency) DHS rules on isolation and quarantine; and two statutes on isolation and quarantine that are otherwise applicable only *during* emergencies, A.R.S. §§ 36-788 and 36-789 (see **§§ 8.32-8.33**). To minimize confusion that arises from some differences among these authorities, this book addresses governmental authority for “non-emergency” quarantine and isolation here (**§§ 4.40-4.45**, *infra*) *separately* from isolation and quarantine in an “emergency” (discussed in **chapter 8**, at **§§ 8.30-8.33**). The following materials identify areas of ambiguity and, where needed, propose and explain resolutions.

4.42 Local health departments: duty to investigate infectious or contagious disease; authority to impose isolation and quarantine.

When a county health department or public health services district is apprised that infectious or contagious disease exists within its jurisdiction, it shall immediately make an investigation; if the investigation establishes that the disease does exist, the county department or district may adopt quarantine and sanitary measures to prevent the spread of the disease, consistent with DHS rules and with A.R.S. §§ 36-788 and 36-789. The county department or district shall immediately notify the DHS of the existence and nature of the disease and measures taken concerning it. A.R.S. § 36-624.

4.43 Definitions.

A. “Isolation”: separation, during the communicable period,² of an infected individual or animal from others to limit the transmission of infectious agents. A.A.C. § R9-6-101.33. (“Isolate”: to separate an infected individual or animal from others to limit the transmission of infectious agents. A.A.C. § R9-6-101.32).³

B. “Quarantine”: the restriction of activities of an individual or animal that has been exposed to a case⁴ or carrier⁵ of a communicable

² Defined at A.A.C. § R9-6-101.13

³ *Accord*, R. DETELS, J. MCEWEN, R. BEAGLEHOLE, & H. TANAKA, OXFORD TEXTBOOK OF PUBLIC HEALTH 1850 (4th ed. 2002) (isolation is “the separation, for the period of communicability, of infected persons or animals from others in such places and under such conditions as to prevent or limit the direct or indirect transmission of the infectious agent from those infected to those who are susceptible to infection or who may spread the agent to others.”)

⁴ Defined at A.A.C. § R9-6-101.8

⁵ Defined at A.A.C. § R9-6-101.7

disease during the communicable period, to prevent transmission of the disease if infection occurs. A.A.C. § R9-6-101.41.⁶

4.44 Diseases. A local health agency shall isolate or quarantine an individual or group when required to do so by the control measures prescribed for particular diseases in Tit. 9, Ch. 6, Art. 2 of the director's rules, as follows. A.A.C. § R9-6-388.

A. Diseases for which isolation of "cases" and quarantine of "contacts" are both specified:

1. **Diphtheria** (A.A.C. § R9-6-323)
2. **Emerging or exotic diseases** (A.A.C. § R9-6-325, defined A.A.C. § R9-6-101.18)
3. **SARS** (A.A.C. § R9-6-364)
4. **Smallpox** (A.A.C. § R9-6-366)
5. **Viral hemorrhagic fever** (A.A.C. § R9-6-384).

B. Diseases for which isolation of "cases" alone is called for, without quarantine of "contacts":

1. **Hemophilus influenzae: invasive disease** (A.A.C. § R9-6-331)
2. **Measles** (A.A.C. § R9-6-347)
3. **Meningococcal invasive disease** (A.A.C. § R9-6-348)
4. **Pneumonic plague** (A.A.C. § R9-6-352)
5. **Rubella** (A.A.C. § R9-6-360)
6. **Congenital rubella syndrome** (A.A.C. § R9-6-361)
7. **Tuberculosis** (A.A.C. § R9-6-373)
8. **Tularemia** (A.A.C. § R9-6-374)

⁶ Accord, R. DETELS, J. McEWEN, R. BEAGLEHOLE, & H. TANAKA, OXFORD TEXTBOOK OF PUBLIC HEALTH 1851 (4th ed. 2002) (quarantine is "the restriction of the activities of well persons or animals who have been exposed to a case of communicable disease during its period of communicability (i.e., contacts) to prevent disease transmission during the incubation period if infection should occur.")

9. **Vancomycin-resistant *enterococcus* spp.** (A.A.C. § R9-6-379)
10. **Vancomycin resistant or vancomycin intermediate *staphylococcus aureus*** (A.A.C. § R9-6-380)
11. **Vancomycin-resistant *staphylococcus epidermidis*** (A.A.C. § R9-6-381)
12. **Varicella (chicken pox)** (A.A.C. § R9-6-382).

4.45 Implementation of isolation or quarantine.

- A. Investigation by local health authority.** See A.R.S. § 36-624 (§4.42, *supra*); A.R.S. 36-788.A (§8.32.A. *infra*).
- B. Requirement for use of least restrictive means.** See A.R.S. § 36.788.A. (§ 8.32.B. *infra*).

Note: A.R.S. § 36.788.A, applicable in *declared emergencies*, authorizes isolation or quarantine when, *inter alia*, such steps are the “least restrictive means” consistent with public protection. See § 8.30 *et seq.* Does this requirement apply to *non-emergency* isolation or quarantine? Formally, perhaps not: in non-emergencies the requirements for employing isolation or quarantine are disease-specific and non-discretionary. See § 4.44, *supra*; § 4.45C.2., *infra*.. On the other hand, for the relatively small number of listed diseases to which non-emergency quarantine or isolation apply (§ 4.44, *supra*, § 4.45C.2. *infra*), such measures are arguably *ipso facto* the “least restrictive means” consistent with public protection. Finally, constitutional principles also suggest that it is necessary to employ the “least restrictive means” when effecting a liberty deprivation such as involuntary isolation or quarantine. See, *e.g.*, cases cited in § 4.30, *supra*.

C. Imposition of isolation or quarantine without court order; circumstances; limitations.

- 1. Requirement of immediate and serious threat to the public health.** The local health authority may isolate or quarantine a person or group of persons through a written directive without first obtaining a written order from the court *if any delay in the isolation or quarantine of the person would pose an immediate and serious threat to the public health.* A.R.S. § 36-789.A.

Note: This statute requires that, *in a gubernatorially declared emergency*, an “immediate and serious threat to public health” must exist to warrant issuance of an order for isolation or quarantine without prior judicial approval. Should this “threat” requirement be read as applicable to *non-emergency* orders, as well? Formally, such a reading would add an additional element – “serious public health threat” – to rules whose text currently makes the issuance of a (judicially unapproved) quarantine order *non-discretionary*, depending only on a

determination that the disease is one that triggers isolation or quarantine (see § 4.44, *supra*; § 4.45.C.2, *infra*). Such an interpretive result seems strained. In practice, however, it may not matter much: isolation or quarantine in non-emergencies are undertaken only for specified diseases (see §4.44, *supra*; § 4.45.C.2, *infra*) -- diseases which presumably inherently carry with them the "threat" specified in A.R.S. § 36-789.A. Thus, in practice it is likely that the threat to public health is established, either way, in the case of an order issued prior to judicial consideration.

2. Duty of local health agency to issue written order for isolation or quarantine of persons; circumstances. When a local health agency is required by Tit. 9, Ch. 6, Art. 2 of the Arizona Administrative Code to isolate or quarantine an individual or group of individuals (§ 4.44, *supra*), it shall issue a written order for isolation or quarantine and other control measures.

a. Notice to affected persons: The order shall be issued to each individual or group of individuals to be isolated or quarantined and, for each individual who is a minor or incapacitated adult, the individual's parent or guardian. A.A.C. § R9-6-388.A.; A.R.S. § 36-789.A.2.

b. Notice to affected persons; exception. If an order applies to a group of individuals, and it would be impractical to provide a copy to each individual, the local health agency may post the order in a conspicuous place at the premises at which the individuals areas to be isolated or quarantined. A.A.C. § R9-6-388.A.3; A.R.S. 36-789.A.2. .

3. Required contents of administrative order for quarantine or isolation. The order shall specify:

a. Control measures being imposed. The isolation or quarantine and other control measure requirements being imposed, which may include requirements for physical examinations and medical testing to ascertain and monitor each individual's health status. A.A.C. § R9-6-388.A.1.a.

b. Identity of persons. The identity of each individual or group subject to the order. A.A.C. § R9-6-388.A.1.b; A.R.S. § 36-789.A.1.

c. Premises. The premises at which each individual or group is to be isolated or quarantined. A.A.C. § R9-6-388A.1.c.; A.R.S. § 36-789.A.1.

d. Date and time commenced. The date and time at which isolation or quarantine and other control measure requirements begin. A.A.C. § R9-6-388.A.1.d; A.R.S. § 36-789.A.1.

e. Justification. The justification for isolation or quarantine and other control measure requirements, including, if known, the disease for which the individual or individuals are believed to be cases, suspect cases, or contacts. A.A.C. §§ R9-6-388.A.1., R9-6-388.A.1.d; A.R.S. § 36-789.A.1.

4. Discretionary content of administrative order for quarantine or isolation. The written order may provide information about existing medical treatment, if available and necessary to render an individual less infectious, and the consequences of an individual's failure to obtain the medical treatment. A.A.C. § R9-6-388.2.

5. Noncompliance; assistance of law enforcement. In the event of noncompliance with a written order for quarantine or isolation, a local health agency may contact law enforcement to request assistance in enforcing the order. A.A.C. § R9-60388.D.

D. Conduct of isolation or quarantine.

1. Where conducted. For provisions authorizing local health agencies to establish, operate, and regulate a temporary hospital or "place of reception" for persons with "contagious or infectious" disease, see § 4.12.C., *supra*, discussing A.R.S. § 36-627. See also § 8.32.D.1. *infra*, discussing A.R.S. § 36-788.B.1.

2. How conducted. See § 832.D.2., *infra*.

E. Restrictions on persons during period of quarantine or isolation. See § 8.32.E., *infra*.

F. Termination of isolation or quarantine. See § 8.32.F., *infra*.

G. Exception for HIV/AIDS. See §8.32.G, *infra*.

4.46 Judicial review of isolation or quarantine.

This section sets forth the provisions for *judicial review* of administratively ordered isolation or quarantine.

A. Courts having jurisdiction. See § 8.33.A., *infra*.

B. *Petition for judicial review.* After issuing a written order for isolation or quarantine (§ 4.45.C., *supra*), if the local health agency determines that isolation or quarantine and other control measure requirements need to continue *for more than 10 days after the date of the order*, the agency shall file a petition for a court order authorizing the continuation of isolation or quarantine and other control measure requirements. A.A.C. § R9-6-388.B; *see also* § 8.33.B. *infra*, discussing A.R.S. § 36-789.B.

1. When petition must be filed. The petition must be filed *within ten days after issuance of the written order*. A.A.C. § R9-6-388.B; *see also* § 9.33.B.1. *Infra*, discussing A.R.S. § 36-789.B.

2. Required contents of petition.

a. *Basic Information.* The petition shall include the information listed in § 4.45.C.3.a.-e., *supra*. *See also* § 8.33.B.2.a, *infra*, discussing A.R.S. § 36-789.B.1-6.

b. *Sworn Affidavit; other information.* The petition must be accompanied by a sworn affidavit of a representative of the local health agency or the DHS attesting to the facts asserted in the petition, together with any further information that may be relevant and material to the court's consideration. A.A.C. § R906-388.B.2; *see also* § 8.33.B.2.b. *infra*, explaining A.R.S. § 36-789.C.

C. *Notice, to affected individual, of petition to isolate or quarantine for more than 10 days.* A local health agency filing a petition for a court order to extend isolation or quarantine and other control measures beyond 10 days shall provide notice to each individual or group identified in the petition according to the Arizona Rules of Civil Procedure, except that notice shall be provided within 24 hours after the petition is filed. A.A.C. § R9-6-388.C. *See also* § 8.32.C., D., *infra*, discussing A.R.S. § 36-789.D.,E.

D. *Timing of judicial hearing.* *See* § 8.32.D. *infra*.

E. *Consolidation of claims.* *See* § 8.32.E., *infra*.

F. *Burden of proof.* *See* § 8.32.F. *infra*.

G. *Required elements of judicial order authorizing isolation or quarantine.* *See* § 8.32.G., *infra*.

H. *Duration of judicial order for isolation or quarantine* *See* § 8.32.H., *infra*.

- I. **Claims challenging isolation or quarantine; judicial hearings.** See § 8.32.I., *infra*.
- J. **Record of proceedings.** See § 8.32.J. *infra*.
- K. **Party unable personally to appear.** See § 8.32.K. *infra*.
- L. **Provision of counsel.** See § 8.32.L., *infra*.

4.50 NO COMPULSORY TREATMENT BY COUNTY OR STATE

4.51 Limitation upon county health departments to impose treatment.

Nothing in A.R.S. Tit., Ch. 1, Art. 4 authorizes a county department of health, its officers or representatives to impose on any person any mode of treatment against his will, or any examination inconsistent with the creed or tenets of a religious denomination to which the person is an adherent, provided that the person complies with sanitary and quarantine laws, rules and regulations. A.R.S. § 36-184.C.

Note: This provision operates to preclude compulsory treatment by county health departments, under the stated circumstances, where less intrusive alternatives will meet public health objectives.

4.52 Limitation upon authority of state department of health services to impose treatment.

Nothing in title 36 authorizes the department of health services, its officers or representatives to impose on any person against his will, or contrary to his religious concepts, any mode of treatment, provided that the person complies with sanitary or preventive measures and quarantine laws. A.R.S. § 36-114.

Note: This provision operates to preclude compulsory treatment by the department of health services, under the stated circumstances, where less intrusive alternatives will meet public health objectives.

5.00 HEALTH INFORMATION PRIVACY

The surveillance activities described in chapter 3 and the disease-control activities described in chapter 4 frequently generate sensitive health-related information about individuals. This chapter addresses federal and state law applicable to the difficult issues of privacy and confidentiality that arise from the

acquisition of such information. The discussion of federal law focuses on the provisions of the federal Health Insurance Portability and Accountability Act of 1996 -- “HIPAA” -- that are applicable to public health matters. The areas of Arizona law that are explored are two: general health law, and public records law.

Much of the state law designed to protect privacy and confidentiality of public health information applies to specific public health programs and activities. Accordingly, those provisions -- such as the legal protection of communicable disease information (§ 3.24, *supra*) -- are discussed in chapters 3 and 4, in the context of their particular programs. The state-law provisions discussed in this chapter of those of general applicability.

5.10 PRIVACY OF HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (“HIPAA”)

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), contains provisions intended to protect the privacy of certain individually identifiable health information, referred to as “protected health information” (“PHI”). See 42 U.S.C. § 1320d-2 (2005). Generally speaking, the administrative rules adopted under HIPAA limit the ability of certain entities to use and disclose an individual’s PHI without notifying, and/or obtaining authorization from, that person. It is important to note that HIPAA contains numerous exceptions to this general rule. One of the most significant exceptions involves uses and disclosures of PHI for public health activities, as set forth in this section.

5.11 Applicability of HIPAA.

A. Covered entities. The following are covered by HIPAA’s privacy regulations:

1. **Health Plan:** An individual or group plan that provides or pays the cost of medical care
2. **Health care clearinghouse:** A public or private entity that processes or facilitates the processing of health information.
3. **Health care provider:** A provider of medical or health services or any person or organization that furnishes, bills, or is paid for health care in the normal course of business. 45 C.F.R. §§ 160.02, 160.103.

B. Public health departments as covered entities subject to HIPAA; “hybrid entity” limitation. Many public health departments and

agencies, including Arizona's, provide health care services. On this basis (see § 5.11.A.3. *supra*) they are covered entities.

However, a public health department may designate itself as a "hybrid entity" and designate those health care-providing components of its organization to which HIPAA applies. Then, the *non*-designated components need *not* comply with HIPAA's privacy requirements. See 45 C.F.R. § 164.504.

5.12 Permitted uses and disclosures of PHI for public health activities. A covered entity may disclose PHI for public health purposes without an individual's authorization provided such disclosure is made to:

A. Authorized public health authority: A public health authority authorized by law to collect such information to prevent or control disease, injury, or disability.

A "public health authority" is an agency or authority of the United States, a state, a territory, a political subdivision of State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency that is responsible for public health matters as part of its official mandate. 45 C.F.R. § 164.501

B. International collaboration: An official of a foreign government agency that is acting in collaboration with a public health authority.

C. Authorized abuse/neglect authority: A public health authority or other government authority authorized to receive reports of child abuse or neglect.

D. FDA jurisdiction: A person subject to the jurisdiction of the Food and Drug Administration (FDA) for the purpose of activities related to the quality, safety, or effectiveness of an FDA-regulated product or activity.

E. Person exposed to disease: A person who may have been exposed to a communicable disease or is at risk of contracting or spreading a disease if the covered entity is otherwise authorized by law to notify such a person as necessary in the conduct of a public health intervention or investigation; or

F. Employer: An employer if such information is related to an employee's workplace injury or workplace medical surveillance. 45 C.F.R. § 164.512(b)

5.13 Other permitted uses and disclosures of PHI. A covered entity may also disclose PHI without an individual's authorization in a number of other circumstances, which include:

- A. *Health oversight activities:*** Uses and disclosures for health oversight activities, such as audits, criminal investigations, or licensing actions.
- B. *Legal process:*** Disclosures for judicial and administrative proceedings in response to a court or tribunal order, subpoena, discovery request, or other lawful process.
- C. *Law enforcement:*** Disclosures for law enforcement purposes, such as identification of a suspect, apprehension of a criminal suspect, or ascertainment of a potential victim's cause of death or injury.
- D. *Deaths:*** Uses and disclosures about decedents for purposes such as identifying a deceased person or determining a cause of death.
- E. *Organ donation:*** Uses and disclosures for cadaveric organ, eye, or tissue donation purposes to organ procurement, banking, or transplantation organizations.
- F. *Public health research:*** Uses and disclosures for public health research purposes regardless of the source of research funding.
- G. *Threats to health and safety:*** Uses and disclosures to avert a serious threat to health or safety.
- H. *Workers' compensation:*** Disclosures for workers' compensation
- I. *Otherwise authorized:*** Uses and disclosures otherwise authorized by law. 45 C.F.R. § 164.512 (details concerning permissibility of above disclosures omitted).

5.14 Preemption of state privacy law contrary to HIPAA; exceptions.

HIPAA provisions preempt contrary provisions of state privacy law unless:

- A. *Compelling need:*** The state law serves a compelling need related to public health, safety, or welfare;
- B. *Controlled substances:*** The principal purpose of the state law relates to the control of any controlled substance;

- C. **State law more stringent:** The state law provides more stringent privacy protections for health information than the applicable HIPAA provisions;
- D. **Surveillance:** The state law provides for the reporting of disease, injury, child abuse, birth, death, or other public health surveillance or investigation; or
- E. **Monitoring:** The state law requires health plans to report or provide access to health information for purposes of financial audits or other programmatic monitoring. 45 C.F.R. § 160.203

5.20 PRIVACY OF HEALTH INFORMATION UNDER ARIZONA LAW

5.21 General Health Law.

A. **Omnibus statute on confidentiality of medical records**

1. Definitions

- a. **Medical records:** communications, recorded in any medium, that relate to a patient's condition and are kept for purposes of diagnosis and treatment. A.R.S. § 12-2291.5
- b. **Payment records:** communications related to payment for a patient's care that contain individually identifiable information. A.R.S. § 12-2291.6
- c. **Health care provider:** licensed professionals, health care institutions (including hospitals), and other institutions. A.R.S. 12-2291.4

2. **Basic rule; confidentiality.** Unless otherwise provided by law, all medical records and payment records, and the information contained therein, are privileged and confidential. A health care provider may only disclose that part or all of a patient's medical records and payment records as authorized by state or federal law or written authorization signed by the patient or the patient's health care decision maker. A.R.S. § 12-2292.A. This rule does not limit the effect of other state or federal law regarding confidentiality of records. A.R.S. § 12-2292.B.

3. **Exception: disclosure required pursuant to law or judicial order.** A health care provider shall disclose medical records or

payment records, or the information contained in medical records or payment records, without the patient's written authorization as otherwise required by law or when ordered by a court or tribunal of competent jurisdiction. A.R.S. § 12-2294.A.

4. **Exception: patient-authorized disclosure.** A health care provider may disclose medical records or payments or the information therein pursuant to the patient's written authorization. A.R.S. § 12-2294.B.
5. **Exceptions: disclosure without patient authorization; HIPAA; others.** A health care provider may disclose medical records or payment records or the information therein without the patient's written authorization:
 - a. as otherwise authorized by state or federal law, including HIPAA (see § 5.10, *supra*), or
 - b. to a variety of named persons and institutions (including other health care providers, accrediting agencies, professional licensing boards, third party payers, and others) under specified circumstances. A.R.S. § 12-2294.C.
6. **Release pursuant to subpoena.** See A.R.S. § 12-2294.01
7. **Immunity of providers and others:** See A.R.S. § 12-2296.

B. Medical licensure law: breach of professional confidence. "Intentionally disclosing a professional secret or intentionally disclosing a privileged communication except as either act may otherwise be required by law" constitutes "unprofessional conduct" by an allopathic physician, which can lead to disciplinary sanction by the state licensing board. A.R.S. § 32-1401.27(b).

Similar provisions are found in the licensing laws for other health professionals.

C. Statutes requiring DHS rulemaking on confidentiality; rules.

1. **Statutes.**

a. Protection of confidential information required by state or federal law. The DHS director "shall" promulgate such rules as are required by state law or federal law or regulation to protect confidential information; no names or other information of any applicant, claimant, recipient or employer shall be made

available for any political, commercial or other unofficial purpose. A.R.S. § 36-107.

b. Protection of diagnostic and treatment-related confidential information and communicable disease information. The director also “shall” prescribe, by rule, reasonably necessary measures to keep confidential information relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients. In no event shall confidential information be made available for political or commercial purposes. A.R.S. § 36-136.H.11

2. Rules. The only administrative rules on such subjects appear to be the following:

a. Nondisclosure by DHS employees. DHS employees are prohibited from disclosing “medical records” (defined A.A.C. § R9-1-311.2.), to which the person has employment-related access, that allow an individual to be identified (with specified exceptions). A.A.C. § R9-1-312

b. Disclosure of disease control-related health information protected by HIPAA to state or local health agency. A person in possession of protected health information, as defined in 45 C.F.R. § 160.103, shall release the protected health information to the department of health services or a local health agency upon request if the protected health information is requested for the purpose of detecting, preventing, or controlling disease, injury, or disability. A.A.C. § R9-6-102.

D. DHS to share requested information with federal government, subject to state-law confidentiality restrictions. Subject to the laws and departmental rules and regulations on the confidentiality of information promulgated pursuant thereto, and upon request, the DHS shall furnish information to any agency of the United States charged with the administration of health services. A.R.S. § 36-105

5.22 Public Records Law.

Public records requests are made of governmental entities. In the context of public health, such a request might be made of a state or local health department in possession of personally identifiable information about one or more individuals. The issue would be whether the agency could lawfully refuse to disclose such information.

Under Arizona public records law, the general rule is that all persons are entitled to inspect all public records and other matters in the custody of any officer at all times during office hours. A.R.S. § 39-121. There are statutory exemptions (e.g., adoption records, records of home addresses and telephone numbers of peace officers). Further, “confidentiality, privacy, or the best interests of the state,” where demonstrable, will lead courts to apply a balancing test to determine whether such interests outweigh the public’s right of inspection. *Carlson v. Pima County*, 141 Ariz. 487, 687 P. 2d 1242P.2d (1984). The public entity resisting the request for disclosure has the burden of overcoming “the legal presumption favoring disclosure.” *Scottsdale Unified School Dist. No. 48 v. KPNX Broadcasting Co.*, 191 Ariz. 297, 300, 955 P.2d 534, 537 (1998).

Accordingly, the first question is whether, in this context, demonstrable interests in confidentiality and privacy exist. The answer is surely yes: individuals clearly have legitimate privacy and confidentiality interests in their medical information.¹ The very existence of the laws described in §§ 5.10 and 5.20, *supra*, which in turn are undergirded by professional ethical norms of confidentiality, establish that point. Moreover, the *state’s* interest in the protection of medical privacy is comparably strong. This is because the main policy justification for maintaining the privacy of health information is that persons are likely to receive optimal treatment only if they are confident that frank and open communication with their health care providers will go no further. Thus, underlying a robust protection of health-information privacy is the state’s interest in *public health*.

Finally, in a public health emergency, such as an outbreak of infectious disease, the interest in privacy and confidentiality may be dramatically heightened: disclosing the identity of infected individuals who are subject to (for example) isolation and quarantine orders might well subject them to discrimination or retaliatory activities.

¹ The Arizona Supreme Court has held that information disclosing the birth date of school teachers was clothed with an expectation of privacy, even though it was likely available from other sources; one’s interest in controlling the dissemination of information regarding personal matters does not dissolve simply because that information may already be available to the public in some form. *Scottsdale Unified School Dist. No. 48 v. KPNX Broad. Co.*, *supra*, 191 Ariz. 297, 300-01, 955 P. 2d at 538. Surely the interest in one’s health-related information is of higher stature than the interest in one’s date of birth. Indeed, the court defended protection of the birth-date information partly on the basis that, if disclosed, it could lead persons to “obtain information...concerning [*inter alia*] an individual’s *complete medical ... history*.” *Id.*, 191 Ariz. At 302, 955 P. 2d at 539 (emph. added). This reasoning clearly reveals the court’s view that medical information is a higher-order interest than the birth-date information – itself protectible – at issue in the case.

Having established the existence of powerful individual and state interests in maintaining the confidentiality and privacy of health information, the analysis under the public records law would proceed to the second step: balancing, or weighing, these interests against the public interest in disclosure. *Id.*, 191 Ariz. at 302-03, 955 P. 2d at 539. Without concrete scenarios, and notwithstanding the presumption in favor of disclosure, perhaps all that can be said is that it would seem to require an extremely strong public interest in disclosure to overbalance the described interests in non-disclosure.

6.00 LIMITATIONS ON ECONOMIC INTERESTS: CONTROLS ON THE USES OF PROPERTY IN THE INTEREST OF PUBLIC HEALTH AND SAFETY

Public health regulation can infringe on personal liberty, bodily integrity, and privacy; these topics were the subjects of chapters 4 and 5. This chapter focuses on public health regulation as it affects economic interests, the other primary “object” of public health-related government action. It begins with an overview of constitutional constraints on states’ exercise of economic regulation. From there it turns to the state-law subjects of search warrants, and finally reviews provisions on the scope of substantive authority for public health inspections and orders, such as the law of nuisance and so-called “sanitary” inspections.

6.10 SEARCHES AND INSPECTIONS: CONSTITUTIONAL DIMENSIONS

The following materials explore the application of both federal and Arizona constitutional provisions to inspections – often called “administrative searches” – that are undertaken by public health authorities under regulatory programs aimed at protecting public health and safety.

6.11 United States Constitution.

The Fourth Amendment to the United States Constitution provides:

The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

Public health authorities regularly conduct administrative searches, or inspections, as a part of the enforcement of health and safety standards in a wide variety of industries. Since 1967, it has been clear that the Fourth Amendment governs such inspections, not just criminal searches. Accordingly, “unreasonable” searches and seizures are prohibited, and a pre-inspection warrant must presumptively be obtained, based on a showing of “probable cause.” *Camara v. Municipal Court*, 387 U.S. 523 (1967); *See v. City of Seattle*, 337 U.S. 541 (1967). *See also Donovan v. Dewey*, 452 U.S. 594, 598 (1981) (Fourth Amendment’s prohibition against unreasonable searches applies to administrative inspections of private commercial property).

The following materials set forth (A) the nature of the “probable cause” that presumptively must be shown prior to issuance of a warrant (since that standard differs from “probable cause” in the criminal context); (B) the judicially-recognized *exceptions* to the requirement for a pre-inspection warrant; (C) limitations on warrantless searches; and (D) “mixed” administrative/criminal searches. For additional information on these matters, see FRANK P. GRAD, *THE PUBLIC HEALTH LAW MANUAL* 158-79 (3D ED. 2005); LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 256-58 (2000)

A. Nature of “probable cause” where warrant required. As noted, a warrant is presumptively required for an administrative search or inspection. However, the showing required to establish “probable cause” to support its issuance is different from the showing required to authorize a criminal search warrant. The two bases for “administrative search” probable cause are:

- 1. Specific evidence of an existing violation of a standard in the premises to be inspected.** Based upon evidence known to it, a regulatory agency may well have reason to believe in the present existence of a violation of a health or safety rule at particular premises. Such evidence will generally meet the requirement for issuance of a warrant. *Camara v. Municipal Court, supra*, 387 U.S. at 535-39. (In its requirement for an evidentiary basis, the determination of “probable cause” under this standard is not unlike the criminal standard, although with different “stakes.”)
- 2. Alternative basis: generalized legislative or administrative standard for conducting the inspection, supported by a valid public interest.** This standard, which has no criminal analog, requires “a showing that ‘reasonable legislative or administrative standards for conducting an inspection are satisfied with respect to a particular... [premises].’” *Marshall v. Barlow’s, Inc., supra*, 436 U.S. at 320 (quoting *Camara v. Municipal Court of San Francisco, supra*, 387 U.S. at 538). Such standards might be the passage of time, the nature of the particular building, or the condition of an entire area, but “will not necessarily depend upon specific knowledge of the particular...[premises].” *Camara, supra*, 387 U.S. at 538. For example, an agency can merely state that the entity has been selected for inspection on the basis of a general administrative plan for the enforcement of a legislative act derived from neutral sources. *Marshall v. Barlow’s, Inc., supra*, 436 U.S. at 321.

B. Circumstances where warrant generally not required. In a number of circumstances, courts have dispensed with the presumptive requirement for a pre-inspection warrant.

1. **Consent.** Many inspections are conducted with the consent of the responsible person. A legally valid consent dissolves the need for a warrant. *J.L. Foti Construction Co. v. Donovan*, 786 F.2d 714 (6th Cir. 1986).
2. **Emergency.** Immediate threats to public health or safety (e.g., fire; imminent risk of explosion) can justify a warrantless search, as can the need for prompt action to inspect quarantined fruit or vegetables that may be infected with pests. *See State v. Bailey*, 586 P.2d 648 (Ariz. 1978).
3. **Public places.** Areas open to the general public (such as the area of a restaurant in which customers eat), where the proprietor does not have a reasonable expectation of privacy, may be administratively searched without a warrant. *Donovan v. Lone Steer, Inc.*, 464 U.S. 498 (1984).
4. **“Pervasively regulated businesses.”** In *New York v. Burger*, 482 U.S. 691 (1987) the Supreme Court created a three-part test which, if satisfied, dispenses with the need for a warrant for inspection of “pervasively regulated businesses.” The rationale for the exception seems to be a combination of the importance of prompt, routine inspections for health and safety purposes (without the delay and opportunity for concealment that a warrant requirement might provide), and the diminished expectation of privacy that characterizes heavily regulated enterprises. *Id.* at 691, 704-07.
 - a. **What constitutes “pervasively regulated business.”**
Examples of “pervasively regulated businesses,” taken from Supreme Court and 9th Circuit jurisprudence, include the vehicle dismantling industry, firearms dealers, the liquor industry, veterinary drug manufacturers, and liquefied propane gas dealers. *Tucson Woman’s Clinic v. Eden*, 379 F.3d 531, 550 (9th Cir. 2004) (holding that abortion clinics do not qualify and that warrant is therefore necessary).
 - b. **The three elements that must be satisfied for warrantless search of pervasively regulated business.**
 - (i) **“Substantial” state interest.** First, there must be a “substantial” government interest that informs the regulatory scheme pursuant to which the inspection is made. *See, e.g., Donovan v. Dewey*, 452 U.S. 594, 602 (1981) (“substantial federal interest in improving the health and safety conditions in the Nation’s underground

and surface mines”). This interest can be demonstrated by a business that has a “long tradition of government supervision, of which any person who chooses to enter such a business must already be aware.” *Marshall v. Barlow’s, Inc. supra*, 436 U.S. 307, 313.

(ii) *Necessity of warrantless search.* The warrantless inspection must be “necessary to further the regulatory scheme.” *See, e.g., Donovan v. Dewey, supra*, 452 U.S. at 600 (forcing mine inspectors to obtain a warrant before every inspection might alert mine owners or operators to the impending inspection, thereby frustrating the purposes of the Mine Safety and Health Act--to detect and thus to deter safety and health violations).

(iii) *Regulatory statute provides notice to affected parties and limits discretion of inspectors.* The regulatory statute must:

(1) advise the owner of the commercial premises that the search is being made pursuant to the law and has a properly defined scope (statute must be “sufficiently comprehensive and defined that the owner of commercial property cannot help but be aware that his property will be subject to periodic inspections undertaken for specific purposes.”)

Note: On a related point, see *Mendez v. Arizona State Bd. of Pharmacy*, 129 Ariz. 89, 91-92, 628 P.2d 972, 974-75 (Ariz. Ct. App. 1981) (no Fourth Amendment violation where statutes provide expressly for warrant less access to pharmacy records).

(2) limit the discretion of the inspecting officers (discretion of inspectors must be “carefully limited in time, place, and scope” by the statute. *New York v. Burger*, 482 U.S. 691, 702-03 (1987); *see also State v. Hone*, 177 Ariz. 213, 866 P.2d 881, (Ariz. Ct. App. 1993) (statute permitting livestock officers to stop any vehicle that may be transporting livestock, in order to determine whether driver has necessary permit to do so, does not sufficiently limit livestock officers’ discretion).

In contrast to the foregoing, “Warrantless inspections of commercial property may be constitutionally objectionable if their occurrence is so random, infrequent,

or unpredictable that the owner, for all practical purposes, has no real expectation that his property will from time to time be inspected by government officials.” *Donovan v. Dewey, supra*, 452 U.S. at 599. Moreover, if a statute providing for administrative inspections “does not provide any standards to guide inspectors either in their selection of establishments to be searched or in the exercise of their authority to search,” then a warrant will be required. *Id.*

C. Limitations on warrantless inspections.

- 1. Limitations on time, place, scope.** The circumstances (time, place, scope) leading to inspection generally define the permissible boundaries of a warrantless search. *See, e.g., United States v. Biswell*, 406 U.S. 311 (1972).
- 2. Subsequent use of evidence wrongfully obtained without warrant.** In reviewing administrative proceedings, courts may, but generally do not, apply the “exclusionary rule” to evidence obtained during an administrative inspection where the consequences of the proceeding are not criminal. *United States v. Article of Food Consisting of Twelve Barrels*, 477 F. Supp. 1185 (S.D.N.Y. 1979) (not applying exclusionary rule); *but see Finn’s Liquor Shop Inc. v. State Liquor Authority*, 294 N.Y.S.2d 592 (App. Div. 1st Dep’t. 1968) (applying rule).

D. “Mixed” public health/criminal inspections. Where a public-health purpose predominates in an otherwise lawful inspection, neither the fact that the investigation also has a criminal objective, nor the discovery of criminal evidence, will render the inspection unlawful. *New York v. Burger, supra*, 482 U.S. at 716; *Michigan v. Clifford*, 464 U.S. 287, 294 (1984).

6.12 Arizona Constitution.

ARIZ. CONST. Art. 11, § 8 provides: “No person shall be disturbed in his private affairs, or his home invaded, without authority of law.”

There is some Arizona case law suggesting that the scope of this protection may not be limited to that of the 4th Amendment to the U.S. Constitution. *State v. Bolt*, 689 P.2d 519 (Ariz. 1984); *Turley v. State*, 59 P.2d 31, 316-17 (Ariz. 1936). However, no authority to that effect has been found applicable to the administrative searches under discussion here.

6.20 SEARCH WARRANTS

6.21 Definition.

A search warrant is an order in writing issued in the name of the state of Arizona, signed by a magistrate, directed to a peace officer, commanding him to search for “personal property, persons or items described in § 13-3912.” A.R.S. § 13-3911. One of the specified grounds for issuing a warrant in A.R.S. § 13-3912 is “When the property is to be searched and inspected by an appropriate official *in the interest of the public health, safety or welfare as part of an inspection program authorized by law.*” A.R.S. §13-3912.5 (emph. added)

6.22 Requirements for issuance of warrant

A. Probable cause required. No search warrant shall be issued except on probable cause, supported by affidavit, naming or describing the person and particularly describing the property to be seized and the place to be searched. A.R.S. § 13-3913.

B. Affidavit.

1. Before issuing a warrant, the magistrate may examine on oath the person or persons seeking the warrant, and any witnesses produced, and must take his affidavit to be subscribed by the party or parties making the affidavit. Before issuing the warrant, the magistrate may also examine any other sworn affidavit submitted to him, which sets forth facts tending to establish probable cause for the issuance of the warrant. A.R.S. § 13-3914.A.
2. The affidavit(s) must set forth the facts tending to establish the grounds of the application, or probable cause for believing the grounds exist. A.R.S. § 13-3914.B.
3. An oral statement may be taken in addition to or in place of the written affidavit, and shall be deemed to be an affidavit (details omitted). A.R.S. § 13-3914.C.

Other provisions regarding procedural and substantive aspects of the issuance and use of search warrants may be found at A.R.S. §§ 13-3915 to 13-3925.

See § 6.34, *infra*, regarding right to enter and inspect for nuisance or filth with consent, and right to enter with warrant if consent refused.

6.30 PUBLIC NUISANCES

Public nuisances are difficult to define. At common law, a public nuisance was an act or omission “which obstructs or causes inconvenience or damage to the public in the exercise of rights common to all.” Today, public nuisances are usually defined by the legislature. Alternatively, the legislature delegates to state and local public health agencies the power and duty to define, prevent, and abate nuisances. The legislative or administrative definition is often broad and virtually coterminous with the police power. Legislatures or agencies also may specify particular conditions as public nuisances.

Legislative or administrative definitions of nuisances are presumed constitutional, but courts reserve the right to determine the presence of a nuisance. LAWRENCE O. GOSTIN, *PUBLIC HEALTH: POWER, DUTY, RESTRAINT* 259-60 (2000) (internal citations omitted)

In the context of public health, public nuisances are those actions or uses of property that significantly interfere with the public’s health or safety. See *generally* RESTATEMENT (SECOND) OF TORTS § 821(B)(2)(a) (1979)

6.31 Public nuisance and private nuisance defined and distinguished.

A. *Private nuisance:* A “private nuisance” is one that affects a single individual or a definite number of persons in the enjoyment of some private right, which is not common to the public. *City of Phoenix v. Johnson*, 75 P.2d 30, 34 (Ariz. 1938). The action for private nuisance is strictly limited to an interference with a person’s interest in the enjoyment of real property (*Armory Park Neighborhood Ass’n v. Episcopal Community Services in Arizona*, 712 P.2d 914, 917 (1985)); a private nuisance constitutes “a nontrespassory invasion” of that interest. *Id.* Summary abatement of a private nuisance, by self-help, may be permitted if it can be achieved without a breach of the peace. *State ex rel. Herman v. Cardon*, 544 P.2d 657, 660 (1976).

B. *Public nuisance:* A “public nuisance” encompasses “any unreasonable interference with a right common to the general public,” affecting the “rights of ‘citizens as a part of the public...’” *Armory Park v. Episcopal Community Services*, 712 P.2d 914, 917 (Ariz. 1985) (quoting *City of Phoenix v. Johnson*, 75 P.2d 30, 34 (Ariz. 1938)). It must affect a “considerable number of persons or an entire community or neighborhood.” *City of Phoenix v. Johnson*, 75 P.2d 30, 34 (1938); *Armory Park v. Episcopal Community Services*, *supra*, 712 P.2d at 917. See also *Spur Industries, Inc. v. Del E. Webb Development Co.*, 494 P.2d 700 (Ariz. 1972).

Unlike a private nuisance, a public nuisance claim is *not* limited to an interference with the use and enjoyment of the plaintiff's land. *Armory Park v. Episcopal Community Services, supra*, 712 P.2d at 917 (emph. added)

C. Public and private nuisance claims not necessarily mutually exclusive. Although public and private nuisance claims implicate different interests, "the same facts may support claims of both." *Armory Park v. Episcopal Community Services, supra*, 712 P.2d 914 at 917. Thus, a nuisance "may be simultaneously public and private." *Id.* Such a "mixed nuisance" affects the general public and at the same time inflicts some special injury upon a private individual, who accordingly may have a right of action under either theory. *City of Phoenix v. Johnson, supra*, 75 P.2d 30, 34.

6.32 Public nuisance actions by citizens.

A. Tort claim. Public nuisance is a tort claim, although it originated in criminal law. *Armory Park v. Episcopal Community Services, supra*, 712 p. 2dat 917.

B. Relationship to criminal law. The tort-based claim of public nuisance exists independent of criminal statute; it can be brought even though the underlying conduct is not prohibited by the criminal law. *Armory Park v. Episcopal Community Services, supra*, 712 P.2d at 922-23.

C. Standing. Although at common law only a public official could bring a public nuisance claim, in Arizona a private person can have standing to bring such a claim, provided that s/he alleges harm to an interest in use and enjoyment of real property that is "special in nature and different in kind" from that experienced by citizens generally. *Armory Park v. Episcopal Community Services, supra*, 712 P.2d at 918.

D. Applicability of nuisance doctrine to both individuals and municipalities. Both individuals and municipalities are subject to liability for maintaining a nuisance. *See, e.g., City of Phoenix v. Johnson, supra*, 75 P.2d at 37 (holding that a city's sewage plant constituted a public nuisance); A.R.S. § 36-601.A.4 (any government place, condition, or building not maintained in a sanitary conditions constitutes a public nuisance).

E. Equity; balancing test; reasonableness.

1. Equitable concept. A suit to enjoin a nuisance sounds in equity and the courts have long recognized a special responsibility to the

public when acting as a court of equity. *Spur Industries, Inc. v. Del E. Webb Development Co.*, 494 P.2d 700, 706 (Ariz. 1972).

2. **Overall reasonableness standard; balancing test.** “Since the rules of a civilized society require us to tolerate our neighbors, the law requires our neighbors to keep their activities within the limits of what is tolerable by a reasonable person. However, what is reasonably tolerable must be tolerated; not all interferences with public rights are public nuisances; to constitute a nuisance, the complained-of interference must be substantial, intentional and unreasonable under the circumstances.” *Armory Park, supra*, 712 P.2d at 920. A balancing test is performed to determine the utility and reasonableness of the “interference” (*id.*; see also *McQuade v. Tucson Tiller Apartments, Ltd.*, 543 P.2d 150, 152 (Ariz. Ct. App. 1975), measured against the extent of harm inflicted and the nature of the affected [surroundings]. *Armory Park, supra*, 712 P.2d at 920-21.

Note: As an example of the foregoing, a defendant’s compliance with zoning regulations is a factor in the determination of reasonableness, but not conclusive thereof; it does not by itself preclude enjoining activity as a public nuisance, since “the equitable power of the judiciary exists independent of statute.” *Armory Park, supra*, 712 P.2d at 921-22.

Note: Nuisances of the foregoing kind are sometimes called “nuisances *per accidens*” (nuisances in fact). Nuisances *per accidens* are a “class of acts, exercise of occupations or trades, and use of property which become nuisances by reason of their location or surroundings”; as to this category, “it is necessary not only to prove the act, but also to prove the circumstances which make it a nuisance.” *Engle v. Scott*, 114 P.2d 236, 238 (Ariz. 1941). Compare “nuisances *per se*” (nuisances at law); see, e.g., § 6.33.B., *infra*.

6.33 Public nuisance actions by government.

- A. **Governmental regulation of public nuisance arises under police power.** The regulation and abatement of nuisances is one of the ordinary functions of the police power, and demolition or abatement of a nuisance is not a “taking” under the power of eminent domain. *Moton v. City of Phoenix*, 410 P.2d 93, 94-95 (Ariz. 1966).
- B. **Specific conditions statutorily determined to be “public nuisances dangerous to the public health,” to be abated by public health authorities.** Notwithstanding the flexible nature of the concept of nuisance, certain specific conditions have been declared by statute to be “public nuisances dangerous to the public health.” These are to be abated by order of the director of the DHS. See A.R.S. § 36-601.A., B.

Note: Twenty such situations are listed. Examples include: in populous areas, breeding conditions for rodents, flies, mosquitoes and other disease-transmitting insect vectors; contaminated or spoiled food intended for human consumption; unsanitary food establishments; any unsanitary government building; exposed sewage; defective and leaking containers used in transport of garbage, human excreta and organic material; the presence of bedbugs, lice, mites, etc. in public sleeping accommodations; and a wide variety of other hazards.

Such conditions are sometimes placed in a category referred to as “nuisances *per se*” or nuisances at law -- “[a]n act, occupation, or structure which is a nuisance at all times and under any circumstances, regardless of location or surroundings.” BLACK’S LAW DICTIONARY 962 (5TH ED.1979). The court must abate a nuisance *per se* by injunction. *Cactus Corp v. State*, 480 P.2d 375, 378 (Ariz. Ct. App. 1971). Compensation is not required for a nuisance *per se*. *Mutschler v. City of Phoenix*, 129 P.3d 71, 78 (Ariz. Ct. App. 2006). “When anything is a nuisance *per se*, all that is necessary to establish the right of the public authorities to demand the proper remedy is to prove the act which, as a matter of law, constitutes the nuisance.” *Engle v. Scott*, 114 P.2d 236, 238 (Ariz. 1941).

C. Prosecution of public nuisance by public attorneys; crime.

1. A.R.S. § 13-2917.

a. Definition of “public nuisance” for purposes of action by public attorneys: The Arizona criminal code defines “public nuisance” as any activity that, *inter alia*, is “injurious to health, indecent, offensive to the senses or an obstruction to the free use of property that interferes with the comfortable enjoyment of life or property by an entire community or neighborhood or by a considerable number of persons.” A.R.S. § 13-2917.A.1. (Note similarity of definition to that for a civil claim, remarked upon by court in *Armory Park, supra*, 712 P.2d at 917.

b. Equitable remedies. A county attorney, the attorney general, or a city attorney may bring an action in superior court to abate, enjoin, and prevent a “public nuisance” as defined in A.R.S. §§ 13-2917.A.1, 13-2917.C.

c. Public nuisance as a crime. Any person who knowingly maintains or commits such a “public nuisance” or who knowingly fails or refuses to perform any legal duty relating to its removal is guilty of a class 2 misdemeanor. A.R.S. § 13-2917.D.

2. A.R.S. § 13-2908

a. A person commits criminal nuisance:

(i) If, by conduct, either unlawful in itself or unreasonable under the circumstances, such person recklessly creates

or maintains a condition which endangers the safety or health of others.

- (ii) By knowingly conducting or maintaining any premises, place or resort where persons gather for purposes of engaging in unlawful conduct.

b. Criminal nuisance is a class 3 misdemeanor.

D. Unavailability of eminent domain power for nuisance abatement.

Municipalities may not abate a nuisance through the power of eminent domain, but may assess fines or assess the cost of removing the nuisance. *City of Tempe v. Fleming*, 815 P.2d 1, 5 (Ariz. Ct. App. 1991).

6.34 County inspections of premises for nuisance and other violations; warrant-less entry with consent; right to enter with warrant if consent withheld; removal of nuisance.

When a county board of health or health department deems it necessary to enter a building or structure within its jurisdiction for the purposes of examining, destroying, removing or preventing a nuisance, source of filth or cause of sickness and is refused entrance, any member of the board or officer of the department may make a complaint under oath to a justice of the peace. The justice of the peace shall issue a warrant directing the sheriff or other peace officer accompanied by and under the direction of at least one member of the board or department to destroy, remove or prevent, between the hours of sunrise and sunset, such nuisance, source of filth or cause of sickness. A.R.S. § 36-603. *See also § 6.22, supra.*

6.35 Administrative remedies for abatement of nuisances; enforcement.

A. Local health authorities: removal or abatement of nuisance

- 1. Duty of local health authority to order removal, at owner's expense.** When a nuisance, source of filth or cause of sickness exists on private property, the county board of health, the local health department, the county environmental department or the public health service district shall order the owner or occupant to remove it within twenty-four hours at the expense of the owner or occupant.
- 2. Notice; service of process.** The order may be delivered to the owner or occupant personally, or left at the owner or occupant's usual place of abode or served on the owner or occupant in the same manner as provided for service of process under the Arizona rules of civil procedure.

- 3. Penalty for failure to comply.** If the order is not complied with, the board or department may impose a civil penalty pursuant to A.R.S. § 36-183.04 and shall cause the nuisance, source of filth or cause of sickness to be removed, and expenses of removal shall be paid by the owner, occupant or other person who caused the nuisance, source of filth or cause of sickness. A.R.S. § 36-602.A.
- 4. City or county law authorizing assessment of abatement costs on offending land.** A city or county may prescribe by sanitary ordinance or regulation a procedure for making the actual cost of this removal or abatement, including the actual costs of any additional inspection and other incidental costs in connection with the removal or abatement, an assessment on the lots and tracts of land on which the nuisance, source of filth or cause of sickness was abated or removed, subject to the following:
 - a.** Any such ordinance or regulation shall include a provision for appeal of the assessment to the governing body or the board of supervisors or its designee.
 - b.** The assessment, from the date of its recording in the office of the county recorder in the county where the lot or tract of land is located, is a lien on the lot or tract of land until paid.
 - c.** Any assessment recorded is prior and superior to all other liens, obligations or other encumbrances, except liens for general taxes and prior recorded mortgages.
 - d.** The city or county may bring an action to enforce the lien in the superior court in the county in which the property is located at any time after the recording of the assessment, but failure to enforce the lien by this action does not affect its validity. The recorded assessment is *prima facie* evidence of the truth of all matters recited in the assessment and of the regularity of all proceedings before the recording of the assessment.
 - e.** A prior assessment for the purposes provided in this section is not a bar to a subsequent assessment or assessments for these purposes, and any number of liens on the same lot or tract of land may be enforced in the same action.
 - f.** An assessment or lien recorded pursuant to this section does not limit, restrict or otherwise affect the authority of a city or county to undertake any additional enforcement action that is

authorized by law, including applicable ordinances or regulations.

- g.* The ordinance or regulation shall provide notice to all lien holders. A.R.S. § 36-602.B.

B. Authority of director of DHS to issue and enforce cease and desist order for nuisance; injunction.

- 1. Reasonable cause; duty to issue cease and desist order.** When the director of the DHS has reasonable cause to believe from information furnished him or from investigation made by him that any person is maintaining a nuisance or engaging in any practice contrary to the health laws or rules of the state, he shall forthwith serve upon such person by certified mail a cease and desist order requiring the person, upon receipt of the order, forthwith to cease and desist from such act. A.R.S. § 36-601.B.
- 2. Hearing.** Within fifteen days after receipt of the order, the person to whom it is directed may request the director to hold a hearing. The director, as soon as practicable, shall hold a hearing, and if he determines the order is reasonable and just and that the practice engaged in is contrary to the health laws or rules of the state, the director shall order such person to comply with the cease and desist order. A.R.S. § 36-601.B.
- 3. Failure to comply with order; injunction.** Upon the failure or refusal of a person to comply with the order of the director, or if a person to whom the order is directed does not request a hearing and fails or refuses to comply with the cease and desist order served by mail under the provisions of A.R.S. § 36-601.B the director may file an action in the superior court in the county in which a violation has occurred, restraining and enjoining the person from engaging in further acts. The court shall proceed as in other actions for injunctions. A.R.S. § 36-601.C.

- C. Destruction v. abatement.** Destruction of property causing or constituting a public nuisance is permissible if “there is no reasonable way of destroying the nuisance without also destroying the property.” *MacDonald v. Perry*, 255 P. 494, 499 (Ariz. 1927).

- D. Property owner not entitled to financial compensation for nuisance abatement; distinction between nuisance abatement and “taking.”** The abatement or destruction of property deemed a nuisance is an exercise of the government’s police powers to enforce a use restriction inherent in the owner’s property title, and not a taking.

As such, the owner of property abated or destroyed as a nuisance is not entitled to financial compensation from the government.

Note: See *Lucas v. South Carolina Coastal Council*, 505 U.S. 1003, 1029 (1992) (“Any limitation [that prohibits all economically beneficial use of land] cannot be newly legislated or decreed (without compensation), but must inhere in the title itself, in the restrictions that background principles of the State’s law of property and nuisance already place upon land ownership. A law or decree with such an effect must, in other words, do no more than duplicate the result that could have been achieved in the courts – by adjacent landowners (or other uniquely affected persons) under the State’s law of private nuisance, or by the State under its complementary power to abate nuisances that affect the public generally . . .”).

However, “[a]n arbitrary, conceived exaction, purportedly under the police power, will be nullified as a disguised attempt to take private property for public use without resort to eminent domain. *Transamerica Title Ins. Co. v. City of Tucson*, 533 P.2d 693, 696 (Ariz. Ct. App. 1975). See also § 6.50, *intra*.

6.40 SANITARY RULES AND REGULATIONS OF LOCAL HEALTH AUTHORITIES; VIOLATIONS; ENFORCEMENT

6.41 Investigation of nuisances; duty to make regulations necessary for public health and safety; public notice of regulations. Each county shall:

- A. *Investigation; Regulations.*** Investigate all nuisances, sources of filth and causes of sickness and make regulations necessary for public health and safety. A.R.S. § 36-183.02.A.
- B. *Notice of Regulations.*** Give notice of all general orders and regulations by publishing them in a local newspaper; if there is none, by posting in five public places. A.R.S. 36-183.02.B

6.42 Administrative Enforcement Proceedings.

- A. *Notice of violation and demand for compliance.*** If the director of a local health department or public health services district has reason to believe that a person has violated Tit. 36, Ch. 1, Art. 4 (dealing with powers of local health departments), or a sanitary ordinance or regulation, the director may issue a notice of violation and demand for compliance (by certified or registered mail or by hand delivery), stating with reasonable specificity the nature of the violation and the deadline for compliance. The notice of violation shall also state that the respondent may request a hearing.

- B. *Timely compliance, request for hearing, or issuance of compliance order.*** Unless the respondent either complies with the notice of violation by the stated deadline, or requests a hearing within 15 days after service, the director of the local health department or public health services district may issue a compliance order consistent with the terms of the notice of violation.
- C. *Hearing.*** The director of a local health department, county environmental department or public health services district may appoint a hearing officer to conduct a hearing in accordance with Tit. 41, Ch. 6, Art. 6 (part of the Administrative Procedure Act). The hearing officer shall either issue or deny a compliance order and shall make a finding regarding a civil penalty.
- D. *Appeal to director.*** A compliance order is final and enforceable in superior court unless the respondent appeals to the director of the local health department, county environmental department or public health services district within 15 days after receiving the compliance order.
- E. *Enforcement or appeal of director's decision.*** On appeal, the director may affirm, modify or vacate the hearing officer's decision. The director shall consider the factors prescribed in § 6.42.F., *infra*. The director's decision is enforceable as a judgment in superior court, and is subject to appeal pursuant to Tit. 12, Ch. 7, Art. 6.
- F. *Civil penalty.*** A compliance order may provide for a maximum civil penalty of \$750. per violation by an individual and \$5,000. per violation by an enterprise. A compliance order shall not impose a civil penalty for the same acts for which a court has previously imposed a civil or criminal penalty. In determining the amount of a civil penalty, the hearing officer and director shall consider the following factors:
- 1. The seriousness of the violation,**
 - 2. As an aggravating factor only, any economic benefit** that results from the violation;
 - 3. The history of that violation,**
 - 4. The economic impact of the penalty on the violator,**
 - 5. Any good faith efforts to comply with the applicable requirements,**

6. **The duration of the violation** as established by any credible evidence,
7. **Payment by the violator of penalties previously assessed** for the same violation, and
8. **Other factors** affecting the public health and safety that the director [and, presumably, the hearing officer] deems relevant.

Collected civil penalties shall be deposited in the county general fund.
A.R.S. § 36-183.04

6.43 Judicial Enforcement Proceedings.

A. Civil Proceedings.

1. **Remedies.** If the director of a local health department, county environmental department or a public health services district has reasonable cause to believe that a person is violating Tit. 36, Art. 4, any sanitary ordinance or regulation adopted pursuant to Tit. 36, Art. 4, *or a nuisance-abatement order under A.R.S. § 36-602* the director through the county attorney may file an action in the superior court:
 - a. **For injunctive relief** in the form of a temporary restraining order, a preliminary or permanent injunction or any other appropriate relief necessary to enjoin the person from further violations and to protect public health or the environment.
 - b. **To compel compliance** with a nuisance abatement order or a compliance order, including the collection of civil penalties assessed under that order.
 - c. **To impose civil penalties** of not to exceed one thousand dollars a day but not more than ten thousand dollars for each violation. A.R.S. § 36-183.05.A.
2. **Amount and disposition of civil penalties.** In determining the amount of a civil penalty, the court shall consider the same factors set forth in § 6.42.F. *supra*. A.R.S. § 36-183.05.B. Civil penalties shall be deposited into the county general fund. A.R.S. § 36-183.05.C
3. **Settlement permitted by consent decree** A.R.S. § 36-183.05.D

6.44 Criminal Sanctions and Proceedings.

A. Classification of violations as misdemeanor.

- 1. Violation of regulation; noncompliance with order.** A person who violates a published order or regulation of a county, or maintains in an unsanitary condition premises located within the county and refuses or fails to place the premises in a sanitary condition within three days after being ordered to do so by the director of a local health department, county environmental department or public health services district, the county sanitary officer or any county peace officer acting under the direction and authority of the director or who thereafter refuses or fails to maintain the premises in a sanitary condition, is guilty of a class 3 misdemeanor if the person holds a valid permit under Tit. 36, Ch. 4, or a class 2 misdemeanor if the person does not hold such a permit. A.R.S. § 36-183.03
- 2. Violation of statute, ordinance, order, or nuisance abatement order.** A person who violates Tit. 36, Ch. 1, Art. 4; a sanitary ordinance or regulation adopted or order issued pursuant thereto; or an order issued pursuant to A.R.S. § 36-602 (nuisance abatement) is guilty of a class 3 misdemeanor if the person holds a valid permit issued under this Tit. 36, Art. 4, or a class 2 misdemeanor if the person does not hold such a permit. A penalty under this section [A.R.S. § 36-183] shall not be imposed for the same acts for which a civil penalty has been imposed under Tit. 36, Ch. 1, Art. 4. In determining the penalty, the court shall consider the same factors set forth in § 6.42.F. *supra*. Lack of criminal intent does not constitute a defense to violations alleged under this section [A.R.S. § 36-183]. A.R.S. § 36-183.A.-D.
- 3. Violation of statute or rules.** A person violating any provision of Tit. 36, Art. 4 or the rules and regulations adopted thereunder is guilty of a class 3 misdemeanor. A.R.S. § 36-191.

B. Health inspector's notice of violation; notice to appear, notice of criminal sanctions. If a health inspector reasonably believes a person is violating Tit. 36, Art. 4; a sanitary ordinance or regulation adopted or order issued pursuant thereto; or an order issued pursuant to A.R.S. § 36-602 (nuisance abatement), the inspector may serve a notice of violation. The notice of violation:

- 1. Specify the violation:** shall specify the statute, ordinance, regulation or order violated;

2. **Notice of appearance:** shall contain a specific time and place for the alleged violator to appear;
3. **Time for response:** must state the time prescribed for a response;
4. **Service:** may be served in the manner provided in A.R.S. § 13-3903. If a health inspector is unable to personally serve the notice, the notice may be served in the same manner prescribed for alternative methods of service by the Arizona rules of criminal procedure, and a response is required within the time prescribed by the rule under which it is served
5. **Notice of Penalty:** shall specify the penalty sought pursuant to A.R.S. A.R.S. § 36-183.07. A.R.S. § 36-183.06

6.50 GOVERNMENT TAKINGS UNDER ARIZONA LAW

See also §6.42, supra.

Private property shall not be taken for private use, except for private ways of necessity, and for drains, flumes, or ditches, on or across the lands of others for mining, agricultural, domestic, or sanitary purposes. No private property shall be taken or damaged for public or private use without just compensation having first been made, paid into court for the owner, secured by bond as may be fixed by the court, or paid into the State treasury for the owner on such terms and conditions as the Legislature may provide, and no right of way shall be appropriated to the use of any corporation other than municipal, until full compensation therefor be first made in money, or ascertained and paid into court for the owner, irrespective of any benefit from any improvement proposed by such corporation, which compensation shall be ascertained by a jury, unless a jury be waived as in other civil cases in courts of record, in the manner prescribed by law. Whenever an attempt is made to take private property for a use alleged to be public, the question whether the contemplated use be really public shall be a judicial question, and determined as such without regard to any legislative assertion that the use is public. ARIZ. CONST., art. II, § 17.

6.51 Eminent Domain

For the basic statutory provisions on eminent domain, see A.R.S. §§ 12-1111 to 12-1129.

6.52 Property Rights Protection Act (enacted by Initiative, Prop. 207, November 7, 2006). This initiative expanded protection of property under eminent domain.

A. Definitions

1. “Public use” means any of the following:

a. possession, occupation, enjoyment of land by general public or by public agencies;

b. use of land for creation or functioning of utilities;

c. acquisition of property to eliminate a direct threat to public health or safety caused by the property in its current condition, including the removal of a structure that is beyond repair or unfit for human habitation or use;

d. acquisition of abandoned property

2. “Public use” does not include the public benefits of economic development, including an increase in tax base, tax revenues, employment or general economic health. A.R.S. §12-1136.5.

B. Limitation on use of eminent domain. Eminent domain may be exercised only if authorized by this state, by statute or otherwise, and for a public use. A.R.S. § 12-1131.

C. Determination of “public use” a judicial, not legislative, question. A.R.S. §12-1132.A

D. Slum clearance and redevelopment. In any use of eminent domain for slum clearance and redevelopment:

1. **Burden of proof.** Government has burden of proof that each parcel is necessary to eliminate a “direct threat to public health or safety caused by the property in its current condition...and that no reasonable alternative to condemnation exists.” A.R.S. § 12-1132.B.

2. **Just compensation.** If an individual’s principal residence is taken, the occupants shall be provided a comparable replacement dwelling that is decent, safe, and sanitary (defined by reference to other law). Owner may elect compensation instead, in which case the amount shall be not less than

necessary to purchase a comparable replacement dwelling that is decent, safe, and sanitary.

E. Diminution in value due to enactment of any land use law

- 1. Rule.** If existing rights are reduced by enactment or applicability of any land use law (defined A.R.S. §12-1136.3), which reduces fair market value (defined A.R.S. §12-1136.1), owner is entitled to just compensation. A.R.S. §12-1134.A.
- 2. “Public health” exceptions.** The foregoing rule does not apply to land use laws that, *inter alia*, limit land use “for the protection of the public’s health and safety....” (A.R.S. §12-1134.1) of use that is “commonly and historically recognized as a public nuisance under common law.” (A.R.S. §12-1134.2). The burden of demonstrating the existence of such exceptions falls on the government. A.R.S. § 12-1134.C.

7.00 EMERGENCIES: GENERAL GOVERNMENTAL POWERS AND DUTIES

The events of 9/11, the subsequent “anthrax attacks,” and rising concerns about fast-moving epidemics -- either naturally occurring, such as avian influenza, or introduced by bioterrorism -- have all combined to generate increased attention to the emergency-response capabilities of the public health system. State, federal and local governments have undertaken a variety of planning activities and “preparedness” exercises, many of which are designed to test the administrative and law-enforcement capabilities of government as well as its disease-control mechanisms.

One part of “preparedness” is *legal* preparedness: the effort to evaluate and, where indicated, modify legal authority thought to be important to an increased likelihood of effective disaster response. This chapter reviews the general emergency-response mechanisms that exist in Arizona. Chapter 8 turns to public health emergencies in particular.

7.10 STATE OF EMERGENCY

7.11 Definition.

“**State of emergency**” means the duly proclaimed existence of conditions of disaster or of extreme peril to the safety or persons or property within the state caused by air pollution, fire, floor or floodwater, storm, epidemic, riot, earthquake or other causes, except those resulting in a state of war emergency, which are or are likely to be beyond the control of the services, personnel, equipment and facilities of any single county, city or town, and which require the combined efforts of the state and political subdivision. A.R.S. § 26-301.15.

Note: “Epidemic” is expressly included as a triggering cause for a proclamation of emergency.

7.12 Proclamation of state of emergency; gubernatorial powers; termination.

A. *Proclamation.*

1. **Proclamation by governor; effective date; circumstances.** The governor may proclaim a state of emergency, which shall take effect immediately in an area affected or likely to be affected if the governor finds that circumstances described in A.R.S. § 26-301.15 (§ 7.11, *supra*) exist. A.R.S. § 26-303.D.

2. **Alternative proclamation by state emergency council.** If the governor is inaccessible, the state emergency council (see A.R.S. § 26-304 for membership and duties) may issue a state of emergency proclamation under the same conditions by which the governor could issue such a proclamation, if the action is taken at a meeting of the council called by the director and if not less than three council members, one of whom is an elected official, approve the action. A.R.S. § 26-304.B.3.

B. Governor's powers during state of emergency. During a state of emergency:

1. **General authority:** The governor shall have complete authority over all agencies of the state government and the right to exercise, within the area designated, all police power vested in the state by the constitution and laws of Arizona in order to effectuate the purposes of A.R.S. Tit. 36, ch. 2.

2. **Directives to state agencies.** The governor may direct all agencies of the state government to utilize and employ state personnel, equipment and facilities for the performance of any and all activities designed to prevent or alleviate actual and threatened damage due to the emergency. The governor may direct such agencies to provide supplemental services and equipment to political subdivisions to restore any services in order to provide for the health and safety of the citizens of the affected area. A.R.S. § 26-303.E.

C. Delegation. The governor may delegate any of the powers vested in the office of the governor under Tit. 26, Ch. 2 to the adjutant general, who may further delegate the powers to the director of emergency management with stated exceptions (details omitted). A.R.S. § 26-302.

D. Termination of emergency and of governor's emergency powers.

1. **By governor or legislature.** The powers granted to the governor with respect to a state of emergency shall terminate when the state of emergency has been terminated by proclamation of the governor or by concurrent resolution of the legislature declaring it at an end. A.R.S. § 26-303.F.

2. **Advice of the state emergency council.** The state emergency council shall monitor each emergency declared by the governor and the activities and response of the division of emergency management (A.R.S. §§ 26-301.4, 26-305) to the emergency. The

council shall recommend to the governor or the legislature based on the reports submitted to it by the auditor that the emergency conditions have stabilized and that the emergency is substantially contained. A.R.S. § 26-304.C.

E. *Short-term authority of adjutant general pursuant to authorization by governor.* If in the judgment of the adjutant general the circumstances described in A.R.S. § 26-301.15 (§ 7.11, *supra*) exist, the adjutant general may, upon authorization of the governor:

1. **Powers.** Exercise those powers pursuant to statute and gubernatorial authorization following a gubernatorial proclamation of a state of emergency.
2. **Financial obligations.** Incur obligations of twenty thousand dollars or less for each emergency or contingency payable pursuant to A.R.S. § 35-192 as though a state of emergency had been gubernatorially proclaimed. A.R.S. § 26-303.H.
3. **Expiration.** The powers exercised by the adjutant general pursuant to A.R.S. § 26-303.H (§ 7.12.E.1., 2, *supra*) expire 72 hours after the adjutant general makes the determination that a state of emergency exists. A.R.S. § 26-303.I

7.20 STATE OF WAR EMERGENCY

7.21 Definition.

“**State of war emergency**” means the condition which exists immediately whenever this nation is attacked or upon receipt by this state of a warning from the federal government indicating that such an attack is imminent. A.R.S. § 26-301.16.

Note: In contrast to the “state of emergency,” § 7.11, *supra*, there is no express requirement for a gubernatorial proclamation to trigger a “state of war” emergency.”

7.22 Governor’s powers during state of war emergency; termination.

A. *Suspension of statutes governing conduct of state business; suspension of rules, orders.* The governor may suspend the provisions of any statute prescribing the procedure for conduct of state business, or the orders or rules of any state agency, if the governor determines and declares that strict compliance with the provisions of any such statute, order or rule would in any way prevent, hinder or delay mitigation of the effects of the emergency.

- B. Taking and use of property and personnel.** The governor may commandeer and utilize any property or personnel deemed necessary in carrying out the responsibilities vested in the office of the governor by this chapter as chief executive of the state and thereafter the state shall pay reasonable compensation therefore as follows:
- 1. Temporary use.** If property is taken for temporary use, the governor, within ten days after the taking, shall determine the amount of compensation to be paid therefor. If the property is returned in a damaged condition, the governor shall, within ten days after its return, determine the amount of compensation to be paid for such damage.
 - 2. Taking title.** If the governor deems it necessary for the state to take title to property under this section, the governor shall then cause the owner of the property to be notified thereof in writing by registered mail, postage prepaid, and then cause a copy of the notice to be filed with the secretary of state.
 - 3. Owner refusal of amount of compensation offered.** If the owner refuses to accept the amount of compensation fixed by the governor, the amount shall be determined by appropriate proceedings in the superior court in the county where the property was originally taken. A.R.S. § 26-303.A.1. 2.
- C. Plenary authority over state government; police power.** During a state of war emergency, the governor shall have complete authority over all agencies of the state government and shall exercise all police power vested in this state by the constitution and laws of this state in order to effectuate the purposes of this chapter. A.R.S. § 26-303.B.
- D. Delegation of governor's powers.** See § 7.12.C., *supra*.
- E. Termination.** The powers granted the governor with respect to a state of war emergency shall terminate if the legislature is not in session and the governor has not, within twenty-four hours after the beginning of such state of war emergency, issued a call for an immediate special session of the legislature for the purpose of legislating on subjects relating to such state of war emergency. A.R.S. § 26-303.C.

7.30 POWERS AND DUTIES OF LOCAL GOVERNMENTS AND STATE AGENCIES

7.31 Authority of state agencies and local governments to issue orders, make rules

- A. Authority; procedure.** State agencies when designated by the governor, and counties, cities and towns may make, amend and rescind orders, rules and regulations necessary for emergency functions, not inconsistent with orders, rules and regulations promulgated by the governor. Any order, rule or regulation issued by the governing body of a county or other political subdivision of the state is effective when a copy is filed in the office of the clerk of the political subdivision. Existing laws, ordinances, orders, rules and regulations in conflict with A.R.S. Tit. 26, Ch. 2 or orders, rules or regulations are suspended during the time and to the extent that they conflict. A.R.S. § 26-307.A., B.
- B. Waiver of procedures by local governments during state of war emergency.** In a state of war emergency, counties, cities and towns may waive procedures and formalities otherwise required by law pertaining to the performance of public work, entering into contracts, incurring obligations, employing permanent and temporary workers, utilizing volunteer workers, renting equipment, purchasing and distributing supplies, materials and facilities and appropriating and expending public funds when such governmental entity determines and declares that strict compliance with such procedures and formalities may prevent, hinder or delay mitigation of the effects of the state of war emergency. A.R.S. § 26-307.C.
- C. Power in absence of specific authority; necessity.** In the absence of specific authority in state emergency plans and programs, the governing body of each county, city and town of the state shall take emergency measures as deemed necessary to carry out the provisions of this chapter. A.R.S. § 26-307.D.

Note: Regarding “necessity” as a standard, see Appendix B discussing *Globe School Dist. No. 1 v. Bd. Of Health of City of Globe*, 20 Ariz. 208, 179 P. 155 (1919).

7.32 Local government emergency management.

- A. Authority to spend money and distribute supplies.** Each county and incorporated city and town of the state may appropriate and expend funds, make contracts and obtain and distribute equipment, materials and supplies for emergency management purposes.

- B. *Establishment of local emergency management.*** Each county and incorporated city and town of the state shall establish and provide for emergency management within its jurisdiction in accordance with state emergency plans and programs. Each unincorporated community may establish such emergency management programs.
- C. *Local director of emergency management.*** The chief executive officer or governing body of each county, incorporated city or incorporated town may appoint a director who shall be responsible for the organization, administration and operation of local emergency management programs, subject to the direction and control of such executive officer or governing body.
- D. *Requirement for local emergency plans.*** State emergency plans shall be in effect in each such political subdivision of the state. The governing body of each such political subdivision shall take such action as is necessary to carry out the provisions thereof, including the development of additional emergency plans for the political subdivision in support of the state emergency plans.
- E. *Contents of county management plans.*** Each county's emergency management organization shall:
- 1. *List of organizations:*** Maintain a list of public and private organizations within the county, which have personnel trained and available for assisting in meeting emergency needs.
 - 2. *Inventory of resources:*** Maintain an inventory of facilities, equipment, supplies and other resources within the county available for use in meeting emergency needs.
 - 3. *Information:*** Provide a summary of the information required in § 7.32.E.1., 2., *supra*, to the state director of emergency management. A.R.S. § 26-308.

7.33 Locally-declared emergencies; powers.

- A. *Declaration of local emergency.*** In addition to the powers granted by other provisions of the law or charter, whenever the mayor of an incorporated city or town or the chairman of the board of supervisors for the unincorporated portion of the county, shall deem that an emergency exists due to fire, conflagration, flood, earthquake, explosion, war, bombing, acts of the enemy or any other natural or man-made calamity or disaster or by reason of threats or occurrences of riots, routs, affrays or other acts of civil disobedience which endanger life or property within the city, or the unincorporated areas of

the county, or portion thereof, the mayor or chairman of the board of supervisors, if authorized by ordinance or resolution, may by proclamation declare an emergency or a local emergency to exist. A.R.S. § 26-311.A.

B. Additional powers during locally-declared emergency. If a local emergency is declared, the mayor or the chairman of the board of supervisors shall, during such emergency, govern by proclamation and shall have the authority to impose all necessary regulations to preserve the peace and order of the city, town, or unincorporated areas of the county, including but not limited to:

1. **Curfew.** Imposition of curfews in all or portions of the political subdivision.
2. **Business closure.** Ordering the closing of any business.
3. **Barring public access.** Closing to public access any public building, street, or other public place.
4. **Assistance of law enforcement.** Calling upon regular or auxiliary law enforcement agencies and organizations within or without the political subdivision for assistance.
5. **Notification.** Notifying the constitutional officers that the county office for which they are responsible may remain open or may close for the emergency. A.R.S. § 26-311.B.

C. Mutual aid

1. **Powers of government to provide mutual aid.** In periods of local emergency, including an emergency declared pursuant to subsection A.R.S. § 26-311.A. (§ 7.33.A, *supra*), political subdivisions have full power to provide mutual aid to any affected area in accordance with local ordinances, resolutions, emergency plans or agreements therefore. State agencies may provide mutual aid, including personnel, equipment and other available resources to assist political subdivisions during a local emergency in accordance with emergency plans or at the direction of the governor. A.R.S. § 26-311.C., D.
2. **Mutual aid agreements and emergency plans, undertaken in advance of emergencies.** During emergencies, outside aid may be provided to any county, city or town in accordance with emergency plans. The governor may, on behalf of the state, enter into reciprocal aid agreements or compacts, mutual aid plans, or

other interstate arrangements for the protection of life and property with other states and the federal government, for such things as supplies, equipment, facilities, personnel and services. A.R.S. § 26-309.

7.34 Authority of state and local governments to accept materials or funds

The governor on behalf of the state, or the governing body of a political subdivision of the state, may accept for purposes of emergency services an offer of the federal government or an agency or officer thereof, or an offer of any person, firm or corporation of services, equipment, supplies, material or funds, whether by gift, grant or loan and may designate an officer of the state or subdivision thereof to receive them on behalf of the state or subdivisions subject to terms, if any, of the offeror. A.R.S. § 26-312.

7.35 Acceptance of professionals' out-of-state licenses.

During a state of emergency or state of war emergency, any person holding any license, certificate, or other permit issued by any state evidencing the meeting of qualifications of such state for professional, mechanical or other skills may render aid involving such skill to meet the emergency as fully as if such license, certificate or other permit had been issued in this state, if any substantially similar license, certificate or other permit is issued in this state to applicants possessing the same professional, mechanical or other skills. A.R.S. § 26-310.

7.36 Immunity from liability for conduct during emergency.

A. *Immunity of state and political subdivisions for discretionary acts of emergency workers.* This state and its departments, agencies, boards, commissions and all other political subdivisions are not liable for any claim based upon the exercise or performance, or the failure to exercise or perform, a discretionary function or duty by any emergency worker, excepting willful misconduct, gross negligence or bad faith of any such emergency worker, in engaging in emergency management activities or performing emergency functions pursuant to this chapter (Tit. 26, Ch. 1) or Tit. 36, Ch. 6, Art. 9. A.R.S. § 26-314.A.

B. *Extraterritorial activities of individuals.* The immunities from liability, exemptions from laws, ordinances and rules, all pensions, relief, disability workers' compensation and other benefits that apply to the activity of officers, agents, employees or emergency workers of this state or of any political subdivision when performing their respective functions within this state or the territorial limits of their respective political subdivisions apply to them to the same degree and extent

while engaged in the performance of any of their functions and duties extraterritorially under this chapter (Tit. 26, Ch. 1) or Tit. 36, Ch. 6, Art. 9, excepting willful misconduct, gross negligence or bad faith. A.R.S. § 26-314.B.

C. *Liability of emergency workers; liability insurance.* Emergency workers engaging in emergency management activities or emergency functions under this chapter (Tit. 26, Ch. 1) or Tit. 36, Ch. 6, Art. 9, in carrying out, complying with or attempting to comply with any order or rule issued under this chapter (Tit. 26, Ch. 1) or Tit. 36, Ch. 6, Art. 9 or any local ordinance, or performing any of their authorized functions or duties or training for the performance of their authorized functions or duties, shall have the same degree of responsibility for their actions, and enjoy the same immunities and disability workers' compensation benefits as officers, agents and employees of the state and its political subdivisions performing similar work. This state and its departments, agencies, boards and commissions and all other political subdivisions that supervise or control emergency workers engaging in emergency management activities or emergency functions under this chapter (Tit. 26, Ch. 1) or Tit. 36, Ch. 6, Art. 9 are responsible for providing for liability coverage, including legal defense, of an emergency worker if necessary. Coverage is provided if the emergency worker is acting within the course and scope of assigned duties and is engaged in an authorized activity, except for actions of willful misconduct, gross negligence or bad faith. A.R.S. § 26-314.C.

D. *Limitation.* No other state or its officers, agents, emergency workers or employees rendering aid in this state pursuant to any interstate mutual aid arrangement, agreement or compact are liable on account of any act or omission in good faith on the part of such state or its officers, agents, emergency workers or employees while so engaged, or on account of the maintenance or use of any equipment or supplies in connection with an emergency. A.R.S. § 26-314.D.

E. *Rules.* The division of emergency management shall adopt rules prescribing the procedures for registration of emergency workers. A.R.S. § 26-314.E.

7.40 ENFORCEMENT

7.41 Law enforcement

The law enforcing authorities of the state and political subdivisions shall enforce orders, rules and regulations issued pursuant to A.R.S. Tit. 26, Ch. 2. A.R.S. § 26-316

7.42 Violation

Any person who violates any provision of this chapter or who knowingly fails or refuses to obey any lawful order or regulation issued as provided in this chapter shall be guilty of a class 1 misdemeanor. This provision does not apply to the refusal of any private organization or member thereof to participate in a local emergency or state of emergency as defined by this chapter. A.R.S. § 26-317

7.50 OPERATION OF THE COURTS IN PUBLIC HEALTH EMERGENCIES

The conduct of judicial proceedings involving a person infected or suspected of being infected with a dangerous communicable disease may require courts to alter standard procedures in order to ensure the health of court personnel and parties participating in the proceedings. For example, courts must consider whether such an individual should be permitted to appear physically in the courtroom and, if not, how the proceedings will be conducted to ensure that the individual can participate adequately. Additional issues, including the individual's access to and consultation with counsel, also challenge courts in such situations. In planning for such matters, reference to management of diseases already known to courts, such as tuberculosis (see § 4.30, *infra*), may be useful. In the event of a public health emergency, such as the widespread outbreak of a communicable disease, the challenges facing the courts will be greater. Court personnel, including judges and sheriffs, may themselves become ill by contact (either in court or in their lives outside of court) with contagious persons. Courts may be forced to relocate to safer and more sanitary premises. Hundreds (if not thousands) of hearings may be required to consider and/or review the imposition of isolation or quarantine orders. Such scenarios will strain the resources of the courts and require innovative solutions that ensure the continued operation of the judicial system and the provision of fair and constitutional process.

Neither Arizona law nor court rules currently address such challenges in the context of public health emergencies. Nonetheless, some guidance can be offered.

7.51 Appearance of persons posing a potential threat to public health

While federal and state constitutional provisions entitle persons to attend hearings implicating them, persons subject to isolation may be physically unable to appear in court due to illness. Further, a court may be unwilling to allow persons subject to isolation or quarantine to appear in court due to the hazard posed to others. In these circumstances, courts should

consider what alternatives may exist. As the brief review of existing provisions provided below suggests, there may well be a need for new legislation and/or judicial rules, to develop novel mechanisms for reconciling the interests of the persons proceeded against with the interests of and public health and safety. Expanded use of video and audio telecommunications constitute one possibility.

Some of the existing judicial rules of possible relevance follow:

A. Audio, video, and telephonic depositions. Under specified circumstances, depositions may be taken by audio or video (ARIZ. R. CIV. PRO. 30(b)(1), (4)) or by telephone (ARIZ. R. CIV. PRO. 30(b)(7)).

B. Telephonic settlement conferences. Attorneys and parties may, with leave of court, participate in judicially-ordered settlement conferences by telephone. ARIZ. R. CIV. PRO. 16.1(a). *See also* ARIZ. R. CIV. PRO 16(d), which seems to allow participation in settlement conference, other than “in person,” by stipulation of the parties.

C. Trial judge discretion to exclude electronic and still photographic coverage. Under ARIZ. SUPR. CT. RULE 122(b), trial judges have discretion to allow or permit electronic and still photographic coverage of proceedings.

7.52 Supreme Court emergency rulemaking authority.

ARIZ. SUPR. CT. RULE 28(G) provides for emergency or expedited adoption of rules by the Arizona Supreme Court, when a petition for rulemaking “presents an urgent matter for which compelling circumstances render the annual rule processing cycle inadequate.” Presumably this authority could be invoked, pursuant to petition, in the event of a threatened epidemic or other disaster, resulting in the creation of new authority, or the following of specified procedures, by local trial courts and appellate courts.

For example, even under current rules the Superior Court in Maricopa County prioritizes trials by a list of factors; the first of these is “Any case granted a preference by statute or other rule of court.” LOCAL RULES OF PRACT. – SUP. CT. – MARICOPA COUNTY, RULE 2.2.a. This suggests that the Supreme Court might create such priorities by emergency rulemaking. There might well be a broad range of other emergency measures that could be adopted under ARIZ. SUPR. CT. RULE 28(G)

7.53 Planning for court operations in emergencies: selected resources

In recent years, a number of studies and plans have been developed that are designed to provide guidance to state courts for the maintenance of

continued operations and safety in epidemics and other emergencies. This section provides references to several such reports.

NATIONAL CENTER FOR STATE COURTS, A COMPREHENSIVE EMERGENCY MANAGEMENT PROGRAM FOR STATE & TERRITORIAL COURTS (2007), *available online* at <http://www.ncsconline.org/emp/>

UNIFIED SUPREME COURT BRANCH COURT EMERGENCY MANAGEMENT GROUP, FLORIDA STATE COURT: STRATEGY FOR PANDEMIC INFLUENZA: KEEPING THE COURTS OPEN IN A PANDEMIC (March 2006), *available online* at http://www.flcourts.org/gen_public/emergency/bin/panflu_strategy.pdf

FLORIDA STRATEGY FOR PANDEMIC INFLUENZA – KEEPING THE COURTS OPEN IN A PANDEMIC – TEMPLATE FOR PLANNING TASKS ASSOCIATED WITH PREPARING FOR A PANDEMIC, *available online* at http://www.flcourts.org/gen_public/emergency/bin/Pan%20Flu%20Template%20updated%2011_1_06.pdf

FLORIDA EMERGENCY COURT OPERATIONS WEBSITE, *available online* at <http://www.floridasupremecourt.org/emergency/html> (includes discussion of “tolling orders” that extend legal time deadlines)

FLORIDA STATE COURTS: EMERGENCY PREPAREDNESS HOME PAGE, *online* at http://www.flcourts.org/gen_public/emergency/reports.shtml

8.00 EMERGENCIES: PUBLIC HEALTH POWERS

In recent years, many states have reviewed and amended their statutory mechanisms for dealing with public health emergencies, for the reasons suggested in the introductory paragraph to chapter 7 (see § 7.00, *supra*). Arizona enacted the provisions discussed in this chapter in 2002 (see Appendix A, “2002”).

8.10 PUBLIC HEALTH AUTHORITY DURING STATE OF EMERGENCY OR STATE OF WAR EMERGENCY: GENERAL POWERS AND LIMITATIONS

8.11 Powers of department of health services during declared emergency or state of war emergency involving bioterrorism, epidemic, infectious agent or biological toxin.

During a state of emergency or state of war emergency declared by the governor in which there is an occurrence or imminent threat of an illness or health condition caused by bioterrorism, an epidemic or pandemic disease or a highly fatal infectious agent or biological toxin and that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability, the department of health services shall coordinate all matters pertaining to the public health emergency response of the state. The department has primary jurisdiction, responsibility and authority for:

- A. **Planning and executing** public health emergency assessment, mitigation, preparedness response and recovery for the state.
- B. **Coordinating public health emergency response** among state, local and tribal authorities.
- C. **Collaborating with** relevant federal government authorities, elected officials of other states, private organizations and private sector companies.
- D. **Coordinating recovery operations** and mitigation incentives subsequent to public health emergencies.
- E. **Organizing public information activities** regarding state public health emergency response operations.
- F. **Establishing, in conjunction with applicable professional licensing boards**, a process for temporary waiver of the professional licensure requirements necessary for the implementation of any

measures required to adequately address the state of emergency or state of war emergency.

G. *Granting temporary waivers of health care institution licensure requirements* necessary for implementation of any measures required to adequately address the state of emergency or state of war emergency. A.R.S. § 36-787.A.

8.12 Powers of governor to issue orders during state of emergency or state of war emergency.

In addition to the authority provided in A.R.S. § 36-787.A. (§ 8.11, *supra*), the governor, in consultation with the director of the department of health services, may issue orders that:

A. *Mandate medical examinations for exposed persons*

B. *Ration medicine and vaccines*

C. *Provide for transportation of medical support personnel and ill and exposed persons*

D. *Provide for procurement of medicines and vaccines*
A.R.S. § 36-787.B.

8.13 Powers of governor to issue orders during state of emergency or state of war emergency involving smallpox, plague, viral hemorrhagic fevers or other diseases.

In addition to the authority provided in A.R.S. §§ 36-787.A., B. (§§ 8.11-8.12, *supra*), during a state of emergency or state of war emergency in which there is an occurrence or the imminent threat of smallpox, plague, viral hemorrhagic fevers or a highly contagious and highly fatal disease with transmission characteristics similar to smallpox, the governor, in consultation with the director of the department of health services, may issue orders that:

A. *Mandate treatment or vaccination of persons* who are diagnosed with illness resulting from exposure or who are reasonably believed to have been exposed or who may reasonably be expected to be exposed.

B. *Isolate and quarantine persons*
A.R.S. § 36-787.C. (see § 8.30, *infra*)

8.14 Limitation on compulsory treatment if individual cooperates with less intrusive measures

If during a state of emergency or state of war emergency the public health is not endangered nothing in A.R.S. Tit. 36 shall authorize the department of health services or any of its officers or representatives to impose on any person against the person's will any mode of treatment, provided that sanitary or preventive measures and quarantine laws are complied with by the person. Nothing in Tit. 36 shall authorize the department or any of its officers or representatives to impose on any person contrary to his religious concepts any mode of treatment, provided that sanitary or preventive measures and quarantine laws are complied with by the person. A.R.S. § 36-787.F

Note: This section appears to prohibit compulsory treatment on two grounds: (1) in circumstances where public health "is not endangered," that treatment would be "against the...will" of a person; (2) that treatment would be "contrary to [a person's] religious concepts."

Arguably, the broad first exemption encompasses the narrower second one. See discussion of immunization exemptions, §4.22.A., B., *supra*, in which Arizona authorizes a "personal beliefs" exemption that is broad enough to include religion. One might argue, contrarily, that the "religious" exemption is meant to command greater state deference than the "against personal will" exemption: taken as a whole, the statutory text might be read to suggest that the "religious" exemption, unlike the "personal will" exemption, is available even when the public health *is* "endangered." However, this view is met by the fact that *both* exemptions are expressly contingent upon the person's compliance with "sanitary or preventive measures and quarantine laws." These are steps (short of treatment) to prevent transmission; as such they are tantamount to a requirement -- applicable to *both* exemptions -- to avoid "endangerment" of public health.

Finally, although the second exemption is not expressly limited to emergencies, it probably should be read that way by virtue of its context (location in the "emergency" statutes), as well as the fact that *other* statutes limit compulsory treatment in *non-emergencies*. See §§ 4.37, 4.50.

8.15 Exception for HIV disease. Diseases subject to this section (A.R.S. § 36-787) do not include acquired immune deficiency syndrome or other infection caused by the human immunodeficiency virus. A.R.S. § 36-787.E.

8.16 Enforcement. Law enforcement officials of this state and the National Guard shall enforce orders issued by the governor under this section (A.R.S. § 36-787). A.R.S. § 36-787.D.

8.20 ENHANCED SURVEILLANCE ADVISORIES

See §§ 3.30-3.40, *supra*, discussing A.R.S. §§ 36-781 to 36-786.

Note: the cited sections of the book demonstrate that – unlike the other powers discussed in this chapter 8 -- a state of emergency or state of war emergency is *not* necessary to trigger the authority for enhanced surveillance.

8.30 ISOLATION AND QUARANTINE PURSUANT TO A GUBERNATORIALLY-DECLARED STATE OF EMERGENCY

8.31 Conditions precedent to exercise of emergency isolation and quarantine powers; powers vested in governor.

The governor, in consultation with the director of the department of health services, may issue orders that quarantine and isolate persons if:

- A. *The governor has declared a state of emergency or state of war emergency that is still in effect; and***
- B. *There is an occurrence or the imminent threat of smallpox, plague, viral hemorrhagic fevers or a highly contagious and fatal disease with transmission characteristics similar to smallpox.***
A.R.S. § 36-787.A., C.2.

8.32 Implementation of isolation or quarantine.

- A. *Investigation by DHS or by local health authority.*** During a state of emergency or state of war emergency as declared by the governor pursuant to A.R.S. § 36-787, the department or local health authority must initiate an investigation if that agency has reasonable cause to believe that a highly contagious and fatal disease exists within its jurisdiction. A.R.S. § 36-788.A.
- B. *Requirement for use of least restrictive means.*** Persons who have contracted the disease or who have been exposed to the disease may be subject to isolation and quarantine if the director determines that quarantine is the least restrictive means by which the public can be protected from disease, due to:
 - 1. *The nature of the disease and available preventive measures, or***
 - 2. *Refusal by an individual to accept less restrictive measures to prevent disease transmission.*** A.R.S. § 36-788.A.
- C. *Administrative imposition of isolation or quarantine without court order; circumstances; limitations.***

1. **Requirement of immediate and serious threat to the public health.** The department or local health authority may isolate or quarantine a person or group of persons through a written directive without first obtaining a written order from the court if any delay in the isolation or quarantine of the person would pose an immediate and serious threat to the public health. A.R.S. § 36-789.A.
2. **Required contents of administrative directive.** The directive shall specify:
 - a. **Identity of persons.** The identity of the person(s) subject to isolation or quarantine. A.R.S. § 36-789 A.1.;
 - b. **Premises.** The premises subject to isolation or quarantine. A.R.S. § 36-789 A.1.;
 - c. **Date and time commenced.** The date and time at which isolation or quarantine commences. A.R.S. § 36-789 A.1.;
 - d. **Disease.** The suspected highly contagious and fatal disease, if known. A.R.S. § 36-789 A.1.;
 - e. **Declared emergency.** That a state of emergency has been declared by the governor. A.R.S. § 36-789 A.1.;
 - f. **Notice to affected persons.** The directive shall be given to the person(s) to be isolated or quarantined. If the directive applies to groups of persons and it is impractical to provide individual copies, it may be posted in a conspicuous place in the isolation or quarantine premises. A.R.S. § 36-789.A.2.

D. Conduct of isolation or quarantine.

1. **Where conducted.** The department or local health authority may, during the declared state of emergency or state of war emergency, establish and maintain places of isolation and quarantine, which may include the residence of the person quarantined. A.R.S. § 36-788.B.1.

Note: For provisions authorizing local health agencies to establish, operate, and regulate a temporary hospital or “place of reception” for persons with “contagious or infectious” disease, see § 4.12.C., *supra*, discussing A.R.S. § 36-627.

2. **How conducted.**

- a. Least restrictive means.** The department of public health and safety or local health authority may require isolation or quarantine of any person by the least restrictive means necessary to protect the public health. A.R.S. § 36-788.B.2.
- b. Preventing transmission to others in isolation or quarantine.** The department or local health authority shall use all reasonable means to prevent the transmission of disease among the isolated or quarantined persons. A.R.S. § 36-788.B.2.
- c. Safety, hygiene, and comfort.** The department, a county health department or a public health services district shall ensure, to the extent possible, that the premises in which a person is isolated or quarantined is maintained in a safe and hygienic manner and is designed to minimize the likelihood of further transmission of disease or other harm to a person subject to isolation or quarantine. Adequate food, clothing, medication and other necessities, competent medical care and means of communicating with those in and outside these settings shall be made available. A.R.S. § 36-788.C.

E. Restrictions on persons during period of quarantine or isolation.

- 1. Persons quarantined or isolated.** A person subject to isolation or quarantine shall comply with the department's or local health authority's rules and orders, shall not go beyond the isolation or quarantine premises and shall not come in contact with any person not subject to isolation or quarantine other than a physician or other health care provider, department or local health authority or person authorized to enter an isolation or quarantine premises by the department or local health authority. A.R.S. § 36-788.D
- 2. Other persons.** Other than a person authorized by the department or local health authority, a person shall not enter an isolation or quarantine premises. If, by reason of an unauthorized entry into an isolation or quarantine premises, the person poses a danger to public health, the department, or local health authority may place the person in isolation or quarantine pursuant to A.R.S. § 36-788 or § 36-789. A.R.S. § 36-788.E.

F. Termination of isolation or quarantine. The department or local health authority must terminate isolation or quarantine of a person if it determines that the isolation or quarantine is no longer necessary to protect the public health. A.R.S. § 36-788.F.

G. Exception for HIV/AIDS: Isolation and quarantine may *not* be ordered for acquired immune deficiency syndrome (AIDS) or other infection caused by the human immunodeficiency virus (HIV). A.R.S. § 36-788.A.

8.33 Judicial review of isolation or quarantine.

This section sets forth the provisions for judicial review of administratively-ordered isolation or quarantine (§ 8.32.C.-F., *supra*).

A. Courts having jurisdiction. Tit. 36, Art. 9 of the Arizona Statutes does not specify the courts of jurisdiction for proceedings brought regarding disease control. Thus, jurisdiction is vested in state courts of general jurisdiction; see **Chapter 1**, *supra*.

B. Petition for judicial review. The department or local health authority that implemented isolation or quarantine shall file a petition for a court order authorizing the initial or continued isolation or quarantine. A.R.S. § 36-789.B.

1. When petition must be filed: The petition must be filed within ten days after issuing the written directive (§ 8.32.C. *supra*), or when any delay in the isolation or quarantine of a person or group of persons will not pose an immediate and serious threat to the public health. A.R.S. § 36-789.B.

2. Required contents of petition.

a. Basic information. The petition shall include the information listed in § 8.32.C.2.a-d, *supra*, as well as a statement of compliance with the conditions and principles for isolation and quarantine, and a statement of the basis on which isolation or quarantine is justified pursuant to Tit. 36, Ch. 6, Art. 9 (public health emergencies). A.R.S. § 36-789.B.1-6.

b. Sworn affidavit; other information. The petition must be accompanied by a sworn affidavit of the department or local health authority attesting to the facts asserted in the petition, together with any further information that may be relevant and material to the court's consideration. A.R.S. § 36-789.C.

C. Notice to persons identified in a petition. Notice to a person or group of persons identified in a petition filed must be completed within twenty-four hours after filing the petition and in accordance with the rules of civil procedure. A.R.S. § 36-789.D.

D. *Timing of judicial hearing.*

- 1. Within 5 days of filing.** A hearing must be held on a petition filed within five days after filing the petition. A.R.S. § 36-789.E.
- 2. Continuance.** In extraordinary circumstances and for good cause shown, the department or local health authority may apply to continue the hearing date on a petition for not more than ten days. If the court grants a continuance it must give due regard to the rights of the affected persons, the protection of the public's health, the severity of the emergency and the availability of necessary witnesses and evidence. A.R.S. § 36-789.E.

E. *Consolidation of claims.* To promote the fair and efficient operation of justice and having given due regard to the rights of the affected persons, the protection of the public's health, the severity of the emergency and the availability of necessary witnesses and evidence, the court may order the consolidation of individual claims into groups of claims if:

- 1. The number of persons involved or to be affected is so large as to render individual participation impractical;**
- 2. There are questions of law or fact common to the individual claims or rights to be determined;**
- 3. The group claims or rights to be determined are typical of the affected person's claims or rights;**
- 4. The entire group will be adequately represented in the consolidation.** A.R.S. § 36-789.N.1-4.

F. *Burden of proof.* The court shall grant the petition filed by the department or local health authority if, by a preponderance of the evidence, isolation or quarantine is shown to be reasonably necessary to protect the public health. A.R.S. § 36-789.F.

G. *Required elements of judicial order authorizing isolation or quarantine.*

- 1. Identify person or group.** The court order must identify the isolated or quarantined person or group of persons by name or shared or similar characteristics or circumstances. A.R.S. § 36-789.G.1.

2. **Justification.** The court order must specify factual findings warranting isolation or quarantine, including any conditions necessary to ensure that isolation or quarantine is carried out within the stated purposes and restrictions required. A.R.S. § 36-789.G.2.
3. **Service.** The court order must be served on an affected person or group of persons in accordance with the rules of civil procedure. A.R.S. § 36-789.G.3.

H. *Duration of judicial order for isolation or quarantine*

1. **Not more than 30 days.** A court order authorizing isolation or quarantine may do so for a period not to exceed thirty days. A.R.S. § 36-789.G. However:
 2. **Continuation for an additional 30 days.** Before an isolation or quarantine order expires, the department or local health authority may move to continue the isolation or quarantine for an additional period not to exceed thirty days. The court shall grant the motion if, by a preponderance of the evidence, isolation or quarantine is shown to be reasonably necessary to protect the public health. A.R.S. § 36-789.H.

I. *Claims challenging isolation or quarantine; judicial hearings*

1. **Application for order to show cause for release.** A person or group of persons isolated or quarantined pursuant to A.R.S. § 36-789 may apply to the court for an order to show cause why the person or group of persons should not be released. A.R.S. §36-789.I.
 - a. **Timing of ruling on application to show cause.** The court must rule on the application within 48 hours after it is filed. A.R.S. §36-789.I.
 - b. **Hearing; timing.** If the court grants the application, the court must schedule a hearing on the order to show cause within twenty-four hours after issuing it. A.R.S. §36-789.I.
 - c. **Effect of order to show cause on isolation or quarantine.** The issuance of an order to show cause does not stay or enjoin an isolation or quarantine order. A.R.S. §36-789.I.
2. **Request for hearing on treatment and conditions of isolation or quarantine.** A person isolated or quarantined may request a

court hearing regarding the person's treatment and the conditions of the quarantine or isolation. A.R.S. § 36-789.J.

a. Timing of hearing. The court must hold a hearing within ten days of receiving the request. A.R.S. § 36-789.K.

b. Finding of noncompliance. If the court finds that the isolation or quarantine of the person or groups of persons does not comply with the requirements of A.R.S. § 36-788 or § 36-789, the court may provide remedies appropriate to the circumstances of the state of emergency, the rights of the individual and in keeping with the provisions of Tit. 36, Ch. 6, Art. 9. A.R.S. § 36-789.K.

J. Record of proceedings. A record of the proceedings pursuant to A.R.S. § 36-789 shall be made and retained. A.R.S. 36-789.L.

K. Party unable personally to appear. If, because of a declared state of emergency or state of war emergency, parties cannot personally appear before the court, the proceedings may be conducted by the authorized representative of the parties and held by any means that allows all parties to fully participate. A.R.S. § 36-789.L.

L. Provision of counsel.

1. Court appointed counsel provided at state expense. The court shall appoint counsel at state expense to represent a person or group of persons subject to isolation or quarantine under a state of emergency or state of war emergency and who is not otherwise represented by counsel.

2. Duration of representation. Representation by appointed counsel continues throughout the duration of the isolation or quarantine of the person or group of persons.

3. Adequate means of communication. The department or local health authority must provide adequate means of communication between the isolated or quarantined persons and their counsel. A.R.S. § 36-789.M.

8.40 ADDITIONAL POWER OF DIRECTOR OF DEPARTMENT OF HEALTH SERVICES: EMERGENCY MEASURES FOR CONTROL OF COMMUNICABLE OR PREVENTABLE DISEASES IN THE FACE OF A THREAT TO PUBLIC HEALTH

Notwithstanding A.R.S. § 36.136.H.1. (which requires the director of DHS to promulgate rules for the routine detection, reporting, prevention, and control of communicable and preventable diseases, including measures such as isolation and quarantine; see § 2.15E.2.a. and §§ 3.23, 4.13., *supra*), the director may define and prescribe *emergency measures* for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for no longer than eighteen months. A.R.S. §36-136.G.

Note: Observe the generality and flexibility of this statute (see Appendix A, “1986”), as well as the relatively long duration (18 months) of the emergency measures that it authorizes, in contrast with the detailed, generally more-stringent, and shorter-duration recent enactments discussed in §§ 8.30-8.33, *supra*). The latter, more specific provisions should probably apply in the event of doubt. However, there may be circumstances in which the authority created by the above statute could still properly be invoked.

Appendix A

Legislative Milestones in Arizona Public Health Law

The following timeline is a history of major Arizona legislative enactments concerning public health. Its purpose is to identify the origins, and the statutory context, of laws with special significance in the evolution of the state's public health policy. Notwithstanding a few 19th Century predecessors, the timeline begins in 1903, when the Territorial legislature enacted the first major comprehensive, structural approach to public health, which the new State legislature re-enacted ten years later. It continues to the present.

Some of these provisions have played an important role in public health litigation, as discussed in Appendix B (exploring Arizona public health case law). Where applicable, that fact is noted below.

Citations are generally to session laws; references to particular statutory codifications are provided where some reason for their inclusion was apparent. Interested readers can find the complete codifications of all these enactments by consulting the 1913, 1928, 1939, and current (1956-present) compilations and their supplements, as follows: REV. STAT. ARIZ, CIV. CODE §§ 4367-4403 (1913); REV. CODE ARIZ. §§ 2678-2700 (1928); ARIZ. CODE §§ 68-101 to 68-314 (1939); A.R.S. Tit. 36 (1956-present).

1903 Foundational Public Health Law for Arizona Ch. 65, 1903 Ariz. Terr. Laws 106

This Act, enacted by the Territorial Legislature in 1903 and re-enacted shortly after statehood (see "1913", *infra*), was modeled closely on North Dakota's public health law. *Globe School Dist. No. 1 of Globe v. Board of Health of City of Globe*, 20 Ariz. 208, 179 P. 55, 57-58 (1919). A number of its provisions remain on the statute books today, *verbatim*, while others have been modified only slightly. Accordingly, despite the passage of more than a century, many of these provisions have continuing applicability to Arizona public health law.

Establishment of territorial board of health. Establishes territorial board of health; superintendent of board to be a physician, appointed by governor. *Id.*, § 1, at 106.

Powers of territorial board. The board has power to:

“make and enforce all needful rules and regulations for the prevention and cure, and to prevent the spread of any contagious,

infectious or malarial diseases among persons and domestic animals.” *Id.*, § 4.3, at 107.

“establish quarantine, and isolate any person affected with an contagious or infectious or epidemic and endemic disease.” *Id.*, § 4.4, at 107

“condemn or cause to be destroyed any impure or diseased article of food that may be offered for sale.” *Id.*, § 4.7, at 107

“superintend...boards of health in the cities, villages and towns, and the County Boards of Health....” *Id.*, § 4.8, at 107.

Establishment of county boards of health. Establishes county boards of health; superintendent of public health for county to be a physician. *Id.*, § 6, at 108.

Powers of county board: Within their counties, and outside of corporate limits of cities having boards of health, and subject to the “supervisory control” of the state superintendent of public health, county boards have power to do “all things mentioned in subdivisions 3,4,5,6,7,8 of Section 4” – that is, under the prescribed circumstances, the county boards possess the territorial (later, state) superintendent’s powers of: rulemaking and enforcement for contagious disease control (subd. 3); quarantine (subd. 4), isolation or killing of any animal with infectious disease (subd. 5); removal of dead, decaying, or putrid body or other substance dangerous to humans or animals (subd. 6); and condemnation/destruction of impure food (subd. 7). See “1928,” *infra*, for language modification, and “2000,” *infra*, for repeal. See **Appendix B** for discussion of local public health power.

Establishment and powers of city boards of health. City boards created, with powers “conferred upon such board by law and by the ordinances of such city” (*id.*, § 15, at 111); these powers apply within the city limits (*id.*, § 16, at 111. See “1928,” *infra*, for language modification, and “2000,” *infra*, for repeal. See **Appendix B** for discussion of local public Health power.

County and city boards to be known as the “Local Board of Health” *Id.*, § 17, at 111.

Isolation and quarantine power of county superintendent. County superintendent has power over quarantine and isolation – and “in case of immediate danger to the health of persons by reason of any contagious or infectious disease, he may act as in his judgment he deems

best, without consultation with the other members of the Board, for the prevention of such danger....” *Id.*, § 10, at 109-110.

City health officer to be a practicing physician. *Id.*, §16, at 111

Local boards’ authority to regulate nuisances. Each local board of health, within its jurisdiction, “may examine into all nuisances, sources of filth and causes of sickness and make such regulations regarding the same as it may judge necessary for the public health and safety of the inhabitants....” *Id.*, § 18, at 112.

Violations. Violation of a published order or regulation made “by any Board of Health” is a misdemeanor subject to fine, imprisonment. *Id.*, § 18, at 112.

Notice of local board rules and orders. Each local board of health shall give notice of “all general orders and regulations made by them,” (e.g., by publishing them in newspapers). *Id.*, § 19, at 112

Nuisance/filth removal; owner’s expense. “Whenever any nuisance, source of filth or cause of sickness is found on private property, any member of the Local Board of Health may order the owner or occupant thereof, at his own expense, to remove the same within twenty-four hours....” *Id.*, § 20, at 112. Owner’s failure to comply allows board to cause the removal and charge costs to the owner. *Id.*

Inspections. When a local board deems it “necessary for the preservation of the health of the inhabitants,” it may “enter any building or other structure...for the purpose of examining into and destroying, removing or preventing any nuisance, source of filth or cause of sickness” and if refused by owner, may go to a justice of the peace and seek a warrant, which the justice of the peace shall issue, directed to sheriff or peace officer, commanding him to go, with at least one member of the board, during daylight, and “have such nuisance, source of filth and cause of sickness destroyed, removed, or preventing....” *Id.*, § 23, at 113

Disease reporting. “Whenever it shall come to the knowledge of any physician or other person that a contagious epidemic or infectious disease exists with the jurisdiction of any local Board he shall immediately report to such Board in writing the name and place of residence, if known, of every person afflicted....and if he is the attending physician of such person he shall report not less than twice in each week the condition of such person....” *Id.*, § 24, at 113.

Reporting of death. Duty of physician to report “to the local Board of Health the death of each of his patients who shall have died...of any

contagious, infectious or epidemic disease” within 24 hours of death. *Id.*, § 25, at 113.

Reporting by innkeepers. “Each keeper of any private house, boarding house, lodging house, inn or hotel shall report, in writing, to the local Board of Health...each case of contagious, infectious or epidemic disease which may occur in his house, inn, or hotel” within 24 hours of learning of it. *Id.*, § 26, at 113

Quarantine and isolation. Local boards of health given following powers over cases of “smallpox, scarlet fever, diphtheria, or other infectious or contagious disease”: board “shall adopt such quarantine and sanitary measures as in its judgment tend to prevent the spread of such disease,” and “may immediately cause any person infected with such disease to be removed to a separate house” if, in opinion of health officer or superintendent of public health, person can be removed without danger to his health; and if not, then local board “shall make such quarantine regulations as is deemed proper with reference to the house within which such infected person is, and in such cases may cause the persons in the neighborhood to be removed,” and to take “such other measures as it deems necessary”.... *Id.*, § 31, at 115.

Temporary hospital. Each local board may provide “such temporary hospital or place of reception for persons afflicted with infectious or contagious diseases as it judges best for the accommodation and safety of the inhabitant,” and all such hospitals to be under the control and regulations of the local board, and all the “inmates” must conform to those regulations and obey board’s instructions. *Id.*, § 32, at 115.

Bedding. Local boards may destroy “any bed or bedding, clothing, carpets or other articles which have been exposed to infection from such infectious or contagious disease” and allow reasonable compensation for same, or may provide a place for its disinfection, and cause such disinfection, and provide a carriage for conveyance of such articles or of persons suffering from such contagious or infectious disease. *Id.*, § 33, at 115-16.

Provision of necessaries. Local boards may “provide such necessaries of life as in their judgment shall be needed for the maintenance, welfare and comfort of persons afflicted with contagious or infectious diseases.” Expenses therefor shall be paid out of the general fund (city or county as appropriate), and also shall be a charge upon the person (except if unable to pay, in which case chargeable to the county). Exception: charges for physicians called to attend a person at request of local board of health. *Id.*, § 34, at 116.

Transporting contagious persons. Without a permit from local board of health, no one may transport another into the Arizona Territory, or within the Territory, who is “afflicted with any contagious, infectious or epidemic disease,” or the body of such a person. *Id.*, § 27, at 113.

Mandatory vaccination against smallpox. All parents or guardians in custody or control of a minor or other person “shall cause such minor or other person to be vaccinated.” *Id.*, § 28, at 114.

Exclusion of children with contagious disease from school. Principals, parents and others are prohibited from allowing public or private school attendance by “any child having scarlet fever, diphtheria, smallpox, whooping cough, measles or any other dangerous, infectious or contagious disease,” or attendance by any child residing in a house where such exists or has recently existed, until the Local Board of Health gives permission. *Id.*, § 29, at 114.

Noncompliance; secretion of or by contagious persons. “Any person who willfully secretes himself or others known to have a contagious or infectious disease, or any [health official]...who shall neglect or refuse to perform any of the duties required...under this Act...and any person who fails to comply with or violates any of the provisions of this Act or neglects or refuses to conform to any rule, regulations or measures adopted by the local board of health...shall be guilty of a misdemeanor...[punishable] by a fine...or imprisonment...or by both.” *Id.*, § 35, at 116-17.

Vital statistics. “A book of record shall be kept by each county Superintendent of Health, recording all cases of contagious or infectious diseases, by who reported, location, measures adopted, termination and other facts necessary to record.” *Id.*, §§ 36-37, at 117.

1909 Unified Vital Statistics Law
Ch. 76, 1909 Ariz. Terr. Laws 187

Establishes a unified Territorial system of registration of vital statistics – births, deaths. Makes the Secretary of the Territorial Board of Health the Territorial Registrar of vital statistics. *Id.*, § 3, at 188.

1913 New State Legislature Re-Enacts 1903 Territorial Public Health Law
Ch. 32, Ariz. Laws 1913 (3rd Spec. Sess.)

With limited changes, the new state legislature re-enacts the foundational 1903 Territorial public health law (described at “1903,” *supra*), which is then codified at REV. STAT. ARIZ, CIV. CODE §§ 4367-4403 (1913).

1919 Repeal of Mandatory Child-Vaccination for Smallpox
Init. & Ref. Meas., 1919 Ariz. Laws 21

Initiative repeals the existing statutory mandate that all parents have their children vaccinated against smallpox (enacted by Ch. 65, § 28, 1903 Ariz. Terr. Laws 106, 114 see “1903,” *supra*). It substitutes new language *prohibiting* compulsory vaccination of child without parental consent, and instead barring unvaccinated children’s attendance at “at any public school in any district in the State...during the period in which a smallpox epidemic may be prevalent...” (Note: Passed by a popular vote of 13,941 to 13,411).

1928 Powers of County and City Boards of Health

In REV. CODE ARIZ. (1928), the powers of local boards of health, originally created in 1903 (see “1903”, *supra*) are described in modified language as follows:

“§ 2683. Powers and duties of boards. *County boards of health...shall have such...powers, within their respective counties, outside of the corporate limits of cities having a city board of health, subject to the supervisory control of the state board of health, as have been hereinbefore granted the state board.”* [Emph. added]

“§ 2685. City boards of health. *...[T]he city board of health...shall have and exercise the powers within the limits of the city, as hereinbefore conferred on the county boards of health, and such further powers as may be conferred by ordinance of such city....”* [Emph. added]

This language seems expressly to grant both county and city boards of health all the powers given by law to the *state* public health board, subject to the latter’s superintendence and to appropriate jurisdictional limits.

In this regard it is somewhat simpler, and perhaps more expansive, than the language originally enacted in 1903 and then re-enacted and codified in 1913 (see “1903” and “1913,” *supra*). It has not been possible to identify a session law in which these changes were made; instead, it seems likely that the changes arose from the 1928 recodification and revision, which included a mandate, *inter alia*, that the Code Commissioner “reduce [the code] in language,” which the Commissioner sought to do in the interest of “clearness and certainty.” REV. CODE ARIZ.

(1928), Preface, at v,vi. Most important, these provisions remained in the law, substantially unchanged from the above language, until their repeal in 2000 (see “2000,” *infra*), playing an important role in case-law addressing the powers of local health authorities (see Appendix B., *infra.*); it is for that reason that portions are italicized *supra*.

1941 Restructuring of State Public Health Authority: Creation of “State Department of Health” with Expanded Powers

Ch. 105, 1941 Laws 212

This law makes organizational, administrative, and substantive changes at the state level (although not to local boards of health; on that subject, see “1947”, *infra*). It repeals the existing statutory provisions regarding the state superintendent of health and the state board of health and their powers, replacing them with a state department of health and a superintendent of health with expanded powers, and a board of health with modified powers. The changes it makes include:

Composition of state department of health. State department of health to consist of state board of health, superintendent of public health, and the several divisions of the department. Department succeeds to and is vested with duties, powers, purposes, responsibilities and jurisdiction heretofore by law vested in and imposed upon the state board of health, the superintendent of public health, the state registrar of vital statistics, the supervisor of public health nursing, the state laboratory, the board of regents of the University of Arizona in relation to the state laboratory, and the director thereof. *Id.*, § 2, at 212.

Divisions of department. The department has the following divisions: local health administration; maternal and child health; vital statistics; sanitary engineering; state laboratory; public health nursing; and such others as the superintendent with the approval of the board may establish. *Id.*, § 3, at 212.

Duties of superintendent of public health. The superintendent is to be the executive officer of the department and the registrar of vital statistics; to perform all executive duties now required by law of the state board of health, and such others as are incident to his position as chief executive officer; to administer laws relating to health and sanitation and the regulations of the department; to prepare sanitary and public health regulations for the board’s consideration; to recommend to the board new legislation; and to perform other duties as prescribed by law or by the board. *Id.*, § 4, at 123.

Qualifications of superintendent. The superintendent is to be appointed by the board, for a 5-year term; s/he is removable only for cause. The superintendent is to be a “reputable physician” with specified experience, public health educational degree, and an Arizona license. *Id.*, § 9, at 214.

Duties of board of health. The board shall advise the superintendent and formulate general policies regarding public health. The board has no administrative or executive functions other than as set forth in this Act. *Id.*, § 5, at 213

Board’s rulemaking authority. The board has the power to adopt, promulgate, repeal and amend rules and regulations consistent with law to: define and control communicable diseases; prevent and control public health nuisances; regulate sanitation and sanitary practices; cooperate with local boards of health and health officers; protect and promote public health and prevent disability and mortality; isolate any person affected with and prevent the spread of any contagious or infectious disease; govern the transportation of dead bodies; establish quarantine; carry out the purposes of this Act. Rules and regulations are to be published in newspaper when adopted, and issued in pamphlet form for health officers and interested citizens. *Id.*, § 6, at 213.

Membership of state board of health. The board has 5 members, appointed by the governor. Two are to be doctors, licensed and having practiced in the state; three are to be chosen for their “interest in public health.” *Id.*, § 11, at 215.

State laboratory. The director of the state laboratory is to be appointed by the superintendent of public health, and is to be a skilled pharmaceutical chemist or bacteriologist and analyst of foods, water supplies, and drugs. The state laboratory is to analyze such foods, water supplies, drugs, and other specimens as the superintendent may direct. *Id.*, § 10, at 214-15.

Violations. Violations of this Act, or rules and reg’s adopted pursuant to this Act, are misdemeanors punishable by fine, prison, or both. *Id.*, § 14, at 216.

1947 Restructuring of Local Health Departments
Ch. 55, 1947 Ariz. Laws 87

This Act restructures *local* health departments.

Formation of county department of health or district of health.

In order to provide “local full time public health service” (defined *id.*, § 1, at 87) (and including a requirement that it be “conducted in conformity with the rules, regulations and policies of the state department of health”), a county board of supervisors may:

- * establish a county department of health;
- * enter into a cooperative agreement with a city for the establishment of a city-county department of health; or
- * enter into a cooperative agreement with one or more counties to establish a district department of health. *Id.*, § 2, at 87.

Membership of each of these three models. Specified *id.*, § 3, at 87-88

Powers and duties of the boards. In each of the three different models, the board shall:

- * appoint the director;
- * *make rules and regulations “not inconsistent with the rules and regulations of the state department of health, for the protection and preservation of public health.”* *Id.*, § 4(b), at 89.

The italicized portion of the foregoing has been important in case-law addressing the powers of local health departments; see Appendix B., *infra*. It is currently found, as insignificantly amended, at A.R.S. § 36-184.B.3.

Duties and powers of director. In each of the three models, the director shall:

- * be executive officer of the dept;
- * perform all duties now required by law of the county superintendent of health;
- * *“Enforce and observe the rules and regulations of the state department of health, the local board of health, and all laws of Arizona pertaining to the preservation of public health.”* *Id.*, § 5(a)3, at 89. Note: “*county rules and regulations concerning health*” were added to the foregoing list by Ch. 156, § 4, 1954 Ariz. Laws 324, 327.

The italicized portion of the foregoing has been important in case-law addressing the powers of local health departments; see Appendix B., *infra*. It is currently found, as insignificantly amended, at A.R.S. § 36-186.5

Services to cities and towns. County or district health departments not to provide health services or have jurisdiction over the health services of any incorporated city or town within the county or district except by request of the city or town and subject to its financial participation. *Id.*, § 8, at 90.

Conditional abolition of former departments. When a county, city-county, or district health department is established under this Act, all boards, positions and regulations of participating cities and counties existing under prior law are abolished. [cite] (Note: this law does not appear to formally repeal those earlier sections, which therefore presumably remained in effect as to any local department that did not reorganize under the new provisions).

1948 Changes in Governance of State Department of Public Health

Ch. 43, 1948 Ariz. Laws 563 (5th Spec. Sess.)

This law abolishes the office of superintendent of public health (created in 1941; see “1941,” *supra*) and replaces it with the office of “director of state department of public health.” The director is appointed by the board of health, to 5 year term; is removable only for cause; must hold the M.D. degree; must be a reputable physician and licensed to practice in Arizona. The law prescribes relevant experience and a degree from a school of public health. The director shall have all powers and duties heretofore vested in and imposed upon the superintendent of public health. *Id.*, §§ 1, 2, at 563.

1951 Brief Creation and Dissolution of State “Super-agency” for Public Health, Welfare, and Corrections.

Ch. 13, 1951 Ariz. Laws 24 created a new “super-agency” – the department of of public health, welfare, and correction -- of which public health would be one of four “divisions” (*id.*, § 8, at 28). The department would be led by a “director” with designated responsibilities (*id.*, § 12, at 29-30). A petition for a referendum on this law was filed five months after it was signed. *Id.* at 38. The reorganization law was repealed the next year by Ch. 18, 1951 Ariz. Laws 23 (1st Spec. Sess.). Shortly thereafter, the legislature enacted a resolution to create a referendum on the creation of a modified “super-agency” for public health and welfare alone. Sen. Concurr. Res. 11, 1951 Ariz. Laws 386 (1st Spec. Sess.)

1954 Expansion of State Public Health Powers and Rulemaking Authority; Enforcement by Local Health Authorities, and Non-Preemption; Administrative Re-Organization; Limitation on Compulsory Treatment

Ch. 140, 1954 Ariz. Laws 279

“Commissioner” replaces “director” of public health. Replaces the “director” of the state department of public health with a “commissioner” thereof; deletes the requirement that his license to practice medicine must

be in Arizona; and deletes the requirement for 5 years' administrative experience in public health or (alternatively) master's level training in public health. *Id.*, § 10, at 295.

Composition of state board of health. Changes the professional component of the five-member board from three physicians to two physicians and a nurse. The criterion for the remaining two members (an "interest in public health") is unchanged. *Id.*, §11, at 295-96.

New "functions of the department" added to existing statutory powers. Adds 18 new powers to the department. *Id.*, § 3, at 280-83.

New "powers and duties of the commissioner" added to existing powers. Gives the state commissioner of public health a series of new powers -- notably organizational and personnel powers within the department, and powers of inspection of premises to determine compliance with sanitary laws and regulations. *Id.*, § 5, at 283-84

Expanded rulemaking responsibilities of the state board of health. Doubles (from 9 to 19) the range of subjects which the board is required to address by administrative rules. Key features include rulemaking responsibilities for "preventable and communicable" diseases, the reporting of such diseases, isolation and quarantine, and other matters. *Id.*, § 7(a), at 285-92. See, today, A.R.S. § 36-136.H.

Rulemaking procedures. Requires that these regulations be promulgated in accordance with then-existing statutory procedures. *Id.*, §7(b), at 291.

Enforcement of state rules by local boards of health; non-pre-emption of more-restrictive local rules. Provides that the regulations adopted by the board "*shall be observed throughout the state and shall be enforced by each local board of health.*" Moreover, "*[n]othing herein contained...shall be deemed to limit the right of any board of health...or...supervisors, to adopt such ordinances, rules and regulations, as authorized by law within its jurisdiction, provided that such ordinances, rules and regulations are not in conflict with the state law and are equal to or more restrictive than the provisions of the regulations of the state board of health.*" *Id.*, § 7(d), at 292.

The italicized portion of the foregoing has been important in case-law addressing the powers of local health departments; see Appendix B., *infra*. It is currently found, as insignificantly amended, at A.R.S. § 36-136.I.

New provision on public nuisances and their abatement. New provision lists 17 statutorily-determined types of public nuisance and provides for their administrative and, if necessary, judicial abatement by the commissioner. *Id.*, § 8, 1 at 292. (For the current version, see A.R.S. § 36-601.)

Limitation on compulsory treatment by state. Disclaims any authority in the state board of health to “impose on any person” either “against his will” or “contrary to his religious concepts” any “mode of treatment, provided that sanitary or preventive measures and quarantine laws are complied with by any such person.” *Id.*, § 14, at 296-97. (found today at A.R.S. § 36-114.).

Limitation on compulsory treatment or examination by local health department . Disclaims any authority in a local health department to “impose on any person any mode of treatment against his will, or any examination inconsistent with the creed or tenets of any religious denomination of which he is an adherent,” provided that “sanitary and quarantine laws, rules and regulations are complied with by such person.” Ch. 156, §3(c), 1954 Ariz. Laws 324, at 327 (found today at A.R.S. § 36-184.C.).

1955 Polio Vaccine Funding
Ch. 27, 1955 Ariz. Laws 44

Appropriates \$20,000 for free polio vaccinations of first and second grade children

1955 Tuberculosis Control
Ch. 126, 1955 Ariz. Laws 226 (“The Tuberculosis Control Act of 1955”)

Isolation of contagious tuberculosis patients. Declares it to be state policy that patients with contagious tuberculosis should be “isolated in an approved hospital, institution or nursing home, or at home...to the fullest extent regardless of such person’s ability to pay”; and that such patients “shall be given full opportunity to enter isolation voluntarily.” *Id.*, § 4, at 228.

When quarantine prohibited. Prohibits “quarantine for tuberculosis...if [a patient’s] physician...shall certify to the health officer that...[the patient] is observing adequate sanitary and precautionary measures to prevent communication...to others.” *Id.*, § 3(c), at 228.

Treatment; costs. Counties are responsible for securing care or treatment, though the state will reimburse them. *Id.*, §§ 8-11, at 230-32.

Limitation on compulsory treatment. Disclaims any authority in the state board of health or any county to “impose on any person” either “against his will” or “contrary to his religious concepts” any “mode of treatment, provided that sanitary or preventive measures and quarantine laws are complied with by any such person.” *Id.*, §13, at 232. (Related current provision regarding treatment for tuberculosis is found at A.R.S. § 36-734.)

1956 New Statutory Codification of All Arizona General Law

Ch. 3, 1956 Ariz. 501 (3rd Spec. Sess.)

Repeals all existing general, public, permanent statutes and re-codifies them as the Arizona Revised Statutes. Most of the existing public health laws are renumbered as parts of Tit. 36 of the new code -- the title in which they are found to this day.

1966 Confidentiality of Patient Information

Ch. 50, § 1, 1966 Ariz. Laws 63, 68.

Adds to existing rulemaking powers of state board of health the authority to establish regulations “necessary to keep confidential information relating to diagnostic findings and treatment of patients, as well as information related to contacts, suspects and associates of communicable disease patients,” and flatly prohibiting making such confidential information available “for political or commercial purposes.”

1970 Quarantine and Isolation Orders by Tuberculosis Control Officer

Ch.105, § 4, 1970 Ariz. Laws 315, 318

Gives the state TB control officer the administrative power, “[w]hen he reasonably believes it is necessary for the protection of public health and safety,” to “issue and sign an isolation and quarantine order to confine persons reasonably suspected of having communicable and contagious tuberculosis” and to deputize others to do the same.

1971 Authority of DHS to Delegate Any of Its Powers to Local Health Departments of County Boards of Health

Ch. 158, 1971 Ariz. Laws 495, 512

Gives the state health commissioner the authority, with the approval of the board of health and under specified conditions, to delegate to a local health department or to a county board of health “any functions, powers, or duties which he believes can be competently, efficiently, and properly performed by the health department or board...” *Id.*, § 4, at 512

1972 First Comprehensive School Immunization Law

Ch. 80, 1972 Ariz. Laws 309

Each school district, in cooperation with the county health department, shall “provide for” the vaccination or immunization of children attending a “kindergarten or common school,” and “shall provide such vaccinations and immunizations at no cost to the parent or guardian”, both of the foregoing in accordance with regulations to be prescribed by the state board of health. The longstanding prohibition against smallpox vaccination without parental consent (see “1919,” *supra*) is retained, and expanded to all other immunizations. The prohibition against unvaccinated children attending school during an epidemic (see “1919,” *supra*) is also retained, but, as in the original, remains applicable only to smallpox. The rules to be adopted by the state board of health shall prescribe a list of those diseases “detrimental to the public health” for which immunizing agents approved by the National Institute of Health are available, and recommend to districts appropriate doses and related information. The state department of health is authorized to create a uniform statewide system of reporting and follow-up. *Id.*, §§ 1,22 at 309-11.

1973 State-Level Administrative Reorganization: Abolition of State “Department of Health,” State “Board of Health,” and State “Commissioner of Health;” Creation of State “Department of Health Services” And “Director” Thereof; Integration and Transfer of Powers From Other State Health Agencies to New Department of Health Services

Ch.158, 1973 Ariz. Laws 1306

Purpose. The declared purpose of this law is to “provide an integration of health services” to “reduce duplication of administrative efforts, services and expenditures through planning and coordination. The department of health services [created by this bill] will promote a means by which people with health problems might find a solution...in a single department’s coordinated service.” Specific goals include health-care quality, cost-control, control of quantity and quality of facilities, essential health care

services, comprehensive health planning, and compliance with licensing standards. *Id.* § 1, at 1308-09.

New governance structure. The law repeals the existing provisions regarding the state department of health, state commissioner of health, and state board of health, and creates in their place a new “department of health services” (DHS) led by a “director,” with specified qualifications, who is appointed by the governor. There is no longer a state board. *Id.* §§ 2, 3, at 1309-10. This remains the basic administrative structure of the agency today.

Succession of power. The new DHS succeeds to the authority, powers, duties and responsibilities of the pre-existing state department of health, Arizona health planning authority, crippled children’s services, Arizona state hospital, Arizona pioneers’ home, state hospital for disabled miners, and anatomy board. *Id.* at § 3, 1311-12. The director of the DHS succeeds to the powers of the former state board of health, notably including rulemaking power. *Id.* § 3, at 1311, 1312-16.

New rulemaking provision on confidentiality. Requires DHS director to promulgate such rules and regulations as are required by state law or federal law or regulation to protect confidential information; no names or other information of any applicant, claimant, recipient or employer shall be made available for any political, commercial or other unofficial purposes. *Id.* § 3, 1317, creating A.R.S. § 36-107.

1980 Establishment of Central Statewide Cancer Registry in Department of Health Services

Ch. 130, 1980 Ariz. Laws 307

Purposes: to provide a cancer information system, provide a mechanisms for patient follow-up, promote and assist hospital-based cancer registries, and improve the quality of information documents relative to detection, diagnosis and treatment of cancer patients.... *Id.* § 1, at 307. Various mandates follow aimed at implementation of these purposes. This law was later repealed and replaced by a broader law; see “1988,” *infra*.

1980 Establishment of Arizona Poison Control System in Department of Health Services

Ch. 131, 1980 Ariz. Laws 308

The DHS, in cooperation with the University of Arizona, shall “provide for the establishment of an Arizona poison control system to provide

comprehensive poison and drug information and management of the poisoned person.” *Id.*, § 1, at 308.

1984 Establishment of Disease Control Research Commission

Ch. 353, 1984 Ariz. Laws 1397.

Purpose: “...to improve the health of the people...by providing a means of funding research into the causes, treatments and cures of diseases.” *Id.*, § 1, at 1397.

1986 Emergency Measures for Control of Communicable or Infectious Diseases

Ch. 8, 1986 Ariz. Laws 37

Adding to the DHS director’s existing powers to detect, report, prevent and control communicable and preventable disease under routine circumstances, this law gives the director of the department of health services new emergency power to take “measures for detecting, reporting, preventing and controlling new communicable or infectious diseases or conditions if he has reasonable cause to believe that a serious threat to public health and welfare exists *and that the communicable disease advisory council* [established by this same law] *has reviewed and approved the emergency measure.*” (Emph. added). Emergency measures are effective for up to eighteen months. *Id.*, § 3, at 39-40.

In 2001, the discretion-limiting italicized provisions noted above were deleted. Ch. 19, § 1, 2001 Ariz. Laws at 69; Ch. 21, § 2, 2001 Ariz. Laws at 76. That left the director with unilateral authority to impose rather sweeping and long-lasting emergency measures -- authority that still remains under current law (see A.R.S. § 36-136.G.).

1988 Chronic Disease Surveillance System

Ch. 215, 1988 Ariz. Laws 742.

This law repeals the cancer-registry (see “1980,” *supra*) and enacts a broader law, creating a “central statewide chronic disease surveillance system in the department.” Diseases in the system are to include “cancer, birth defects and other chronic diseases required by the director to be reported to the department.” *Id.*, §§ 1,2, at 742. It provides that information that can identify an individual is “confidential and may be used only pursuant to this section.” A violation is a class 3 misdemeanor. *Id.*, § 2, at 743.

1990 Omnibus HIV/AIDS Law
Ch. 335, 1990 Ariz. Laws 1437

This law creates new provisions regarding the treatment and management of AIDS and other matters.

Testing of defendants and convicted persons for benefit of crime victims. Based on “significant exposure” of crime victims, provides procedures aimed at HIV-testing of defendants or convicted persons, and disclosure to victim of test results. *Id.*, § 1, at 1438.

Insurance protections. Provides for protection of HIV-related information in connection with insurance. *Id.*, § 2, at 1439-41. Also provides for accelerated payment of certain benefits of life insurance. *Id.*, § 3, at 1441

Employees. Provides for employee claims of condition, infection, disease or disability relating to HIV or AIDS. *Id.*, § 3, at 1441-42.

Physician licensing boards: education regarding autologous blood transfusions. Requires health-care provider licensing boards to establish educational programs for their licensees regarding the “uses and advantages” of autologous blood transfusions. *Id.*, § 5, at 1442-43 (allopathic physicians); § 7, at 1443-44 (osteopathic physicians)

Physician immunity for disclosure or nondisclosure of HIV-positive status of patient. Declares that it does not constitute unprofessional conduct under licensing law for a physician (1) to report to the DHS the name of a person with whom the physician’s HIV-positive patient shares needles or sex without disclosing own HIV-positive status; or (2) to disclose to a health care or public safety employee a “significant exposure” to physician’s HIV-positive patient. Makes clear that this imposes no affirmative duty to disclose such information, and that a physician enjoys both civil and criminal immunity for either disclosure or non-disclosure, as well as the foregoing disciplinary immunity. These provisions all apply to allopathic physicians (*id.*, § 6, at 1443) and osteopathic physicians (*id.*, § 8, at 1444-45).

Procedures for Isolation and Quarantine. Adds to existing law on DHS rulemaking for isolation or quarantine new requirements for “procedures and measures...including the right to a hearing,” but allowing the director to institute isolation or quarantine before completion of a hearing if “clear and convincing evidence” demonstrates that a person “poses a substantial danger to another person or the community.” *Id.*, § 9, at 1446. For changes to the quarantine authority of local health

departments and local boards of health, see *id.*, § 10, at 1449. Note that these provisions are general, not mentioning HIV/AIDS or any other specific disease. Note also the later impact on these laws of subsequent public health emergency legislation (see “2002,” *infra*).

HIV testing as a disease control measure; anonymous testing. Provides that DHS director shall prescribe measures regarding HIV testing as a tool of disease control, including anonymous testing sites. *Id.*, § 9, at 1448.

Management and protection of confidential communicable disease-related information and confidential HIV-related information. The law enacts detailed provisions regarding the protection of confidential communicable disease related information and confidential HIV-related information, including requirements for individual informed consent to testing. *Id.*, § 11, at 1449-56.

1990 School Immunization Law Reform

Ch. 208, 1990 Ariz. Laws 692.

This law replaces the one enacted in 1972, *supra*. It requires the DHS director to promulgate rules prescribing those immunizations that will be required for school attendance; means of immunization; doses; optimum ages; and other matters. *Id.*, § 4, at 694. It prohibits students from attending school (K-12, public, private, or parochial) unless they provide evidence that they have either received the required immunizations (or have laboratory evidence of immunity), or that they are exempt from compliance. *Id.*, § 2, at 693. Exemptions can be claimed on the basis of physician-certified hazard to the student’s health, or parents’ “personal beliefs.” *Id.* at 694. Minors cannot be immunized with parents’ informed consent. *Id.* at 696. Any child who has neither been immunized nor provides laboratory evidence of immunity is prohibited from attending school during “outbreak periods” of disease, as determined by the DHS or local health department. *Id.* at 694.

1994 Disease Control [now “Biomedical”] Research Commission

Ch. 82, 1994 Ariz. Laws 211

Creates the “disease control” research commission, whose purpose is to “protect the public health and safety.” *Id.*, § 6, at 212. It was later renamed the “biomedical” research commission. Ch. 170, § 1, 2005 Ariz. Laws 565.

1997 Tuberculosis Control

Ch. 184, 1997 Ariz. Laws 1464.

This law modernizes tuberculosis control, substantially amending both substantive and procedural provisions of existing law and adding a variety of new provisions. It is fully discussed in the book.

2000 Repeal of Provisions Relating to “Local Boards of Health”; Abolition of City Public Health Authorities, and Consolidation of Local Public Health Power in Counties; New Option of County-Based “Public Health Services Districts”

Ch. 11, 2000 Ariz. Laws 47.

From 1903 to 2000, Arizona law provided for state, county, and city public health authorities (see “1903,” *supra*; “1928,” *supra*). The net effect of the changes made by this law appears to be the abolition of city boards of health and city health departments. County health departments and county boards of health remain, and are supplemented by new authority for the creation of county-based “public health services districts.” The following material explains the foregoing conclusions.

Beginning with their creation in 1903 (see “1903,” *supra*), city and county boards of health were called “Local Boards of Health,” and were governed by their own statutory provisions; as of 2000, these were found in Art. 3 of Tit. 36, Ch. 1. (Art. 4 addressed, and still addresses, “Local Health Departments.”) The powers and duties of these “local boards of health” under Art. 3 in 2000 expressly included all the powers given by law to the *state* public health authority, subject to the latter’s superintendence and to appropriate jurisdictional limits, as follows:

County boards of health. Under A.R.S. § 36-162.B., county boards of health enjoyed “such powers within their respective counties and outside the corporate limits of cities having a city board of health as are granted the department of health services, subject to supervisory control by the director [of that department].” This provision had existed, substantially unchanged, since at least 1928. (See “1928,” *supra*).

City boards of health. Under A.R.S. § 36-165.B., city boards of health had permissive authority, within city limits, to “exercise the same powers as are granted county boards of health by § 36-162 [immediately *supra*], and such further powers as conferred by ordinance.” This provision has existed, substantially unchanged, since at least 1928. (See “1928,” *supra*).

Nuisance regulation by city and county boards. Both boards were charged with the duty, within their jurisdictions, to “investigate nuisances, sources of filth and causes of sickness and make regulations necessary for the public health and safety of the inhabitants.” A.R.S. § 36-167.A

Chapter 11 repeals all of then-existing Article 3, including the foregoing provisions. Ch. 11, § 4, 2000 Ariz. Laws 47, 52. Next, Chapter 11 deletes all references throughout Article 4 (“Local Health Departments”) to “city” health authorities. *Id.*, § 5, at 52; § 6, at 53; § 8, at 54, 55; § 9, at 55; § 12, at 56; § 14, at 57; § 16, at 57; § 17, at 58; § 18, at 59; § 20, at 61; § 21, at 61; § 22, at 61. Third, Chapter 11 reinstates the repealed authority of city and county boards to regulate nuisances (*supra*) -- but under the sole authority of *county* health departments in Article 4. *Id.*, § 7, at 53. Fourth, Chapter 11 creates new authority in counties to create “public health services districts.” *Id.*, § 19, at 59-61. Finally, upon its establishment, a county health department or public health services district succeeds to the authority of “any existing city or local board of health in that county” and “any references to a city or local board of health apply instead to that county health department or public health services district.” *Id.*, § 12, at 56-57.

Taken as a whole, city boards of health and city health departments appear to have been abolished. County (and, of course, state) authorities remain.

Whether the authority of counties in matters of public health has also been diminished by the repeal of the expansive language of former ARIZ. REV. STAT. § 36-162.B (*supra*) is explored in Appendix B, *infra*.

2002 Public Health Emergencies; Enhanced Surveillance Advisories; Bioterrorism or Infectious Disease

Ch. 303, 2002 Ariz. Law 1376

This law creates new government powers for public health emergencies; authorizes “enhanced surveillance advisories” under specified conditions; and includes provisions modifying the imposition of isolation or quarantine.

Isolation and Quarantine. The law revises existing law on these measures. With regard to DHS rulemaking authority, it deletes both the requirement that a hearing precede the imposition of quarantine, and the qualification on that right (which was that isolation or quarantine could be imposed without a hearing if the director determined by clear and convincing evidence that a person posed a substantial danger to another person or to the community). *Id.*, § 1, at 1377. In their stead, it creates substantially more detailed provisions -- although the latter are, by their

terms, applicable only in emergencies. *Id.*, § 2, at 1384-86. At the local level, the law modifies the authority of a county to impose quarantine, by requiring compliance with not only with DHS rules but also with these same new, more detailed, “emergency” statutory provisions. *Id.*, § 2, at 1379.

New Governmental Powers During a Public Health Emergency. New provisions create new governmental powers during a gubernatorially-declared emergency. *Id.*, § 3, at 1383-84.

Enhanced surveillance advisories. The law creates new governmental surveillance authority, as well, although a declared emergency is not necessary for their invocation; bioterrorism or infectious disease may suffice. *Id.*, § 3, at 1380-83.

Appendix B

An Essay on Arizona Public Health Case Law

INTRODUCTION

The dominant issue in Arizona public health cases has been the nature, scope and extent of the regulatory powers of local departments and boards of health. The legal challenges to local public health regulation, brought by aggrieved persons or entities, have generally been of two kinds. One asserts that the legislature has given these bodies unduly broad discretionary power, with insufficient standards or guidance, thereby unconstitutionally delegating “legislative” power to an administrative agency. Especially in recent decades, as will be shown, Arizona courts have generally rejected such claims.¹ This, of course, is consistent with the general demise of constitutionally-based “non-delegation” claims, in both federal and state law, that has accompanied the full flowering of the modern administrative state.

The second kind of claim is the still-vital assertion, quite common in administrative law generally, that a particular action taken by an agency exceeds the authority conferred upon it by statute. In this realm, Arizona courts have generally been deferential to health agencies’ own views of the extent of their statutorily-conferred powers.

In addressing both types of claims, state courts over the decades have interpreted the Arizona statutes as conferring upon local boards of health, within their jurisdiction, the same powers that the legislature has granted to the state health agency (now the Department of Health Services). Accordingly, judicial analysis in the reported cases begins by asking whether the legislature has given the controverted authority to the *state* health agency, by statute. When the answer is “yes” – and, in the reported cases, it virtually always is -- the courts have consistently concluded that the same authority has devolved to the local health agency by operation of law.

¹ One older counter-example is *Loftus v. Russell*, 69 Ariz. 245, 212 P.2d 91 (1949), ruling that a county’s effort to regulate milk products constituted an impermissible exercise of “legislative” power. However, two similar cases, one preceding and one following *Loftus*, eschewed the “delegation” analysis and instead applied pre-emption analysis. See *Associated Dairy Products Co. v. Page*, 68 Ariz. 393, 206 P.2d 1041 (1949); *City of Flagstaff v. Associated Dairy Products Co.*, 75 Ariz. 254, 255 P.2d 191 (1953). Pre-emption analysis seems to better fit the facts of these cases. Moreover, the fact that in *City of Flagstaff* the court largely ignored its own *Loftus* precedent – even though it was decided just four years earlier – may suggest the court’s awareness of the weakness of *Loftus*’s reasoning.

GLOBE SCHOOL DIST. NO. 1 V. BOARD OF HEALTH OF CITY OF GLOBE

The leading Arizona decision calling upon the court to determine the extent of local public health authority is *Globe School Dist. No. 1 v. Board of Health of City of Globe*, 20 Ariz. 208, 179 P. 55 (1919). In this fascinating case concerning governmental management of the “Spanish influenza” epidemic of 1919, the Arizona Supreme Court upheld the power of a city board of health to order closure of schools as an emergency measure -- notwithstanding the absence of any express, specific statutory power to take such a step.

In the face of the epidemic, a statewide conference of the state and local boards of health was convened. Consensus emerged that a range of locally-enacted steps, particularly the closure of various gathering places, constituted the best preventive strategy. Accordingly, the Board of Health of the City of Globe – the city having now experienced several thousand cases of the disease, and many deaths -- enacted a regulation making it a misdemeanor for “two or more persons” to congregate in the post office, banks, stores, theaters, motion picture shows, and many other places – including schools. *Id.*, 179 P. at 56. Effectively, this regulation closed the schools “until further order of the city board of health.” *Id.* at 58.

The Globe school board resisted, apparently based on the fact that 80% of students were currently well and that the schools were staffed with nurses. It sought an injunction declaring the board of health without legal power to enact and enforce the regulation. When the superior court upheld the board of health’s authority to close the schools, the school board appealed to the supreme court.

The supreme court began its inquiry into the scope and limits of local public health power by thoroughly reviewing the state’s foundational public health statutes, codified at that time as REV. STAT. ARIZ, CIV. CODE §§ 4367-4403 (1913). (See Appendix A, “1903” and “1913.”). The starting point was the extent of the *state* health board’s relevant statutory power. That power was “... to make and enforce all needful rules and regulations for the prevention and cure, and to prevent the spread of any contagious...[or] infectious disease among persons” and to “establish quarantine, and isolate any person....”² The court suggests that this language would provide the state board sufficient authority to close schools if necessary. *Id.*, at 59. Next, the *county* board of health possessed the same authority, by operation of law, under the statute giving it virtually identical enumerated powers.³ So the only question was whether the statutory language granting *city* boards of health the powers “herein provided” should be read as referencing the same disease-control powers specified for the state and county boards, or (as the school board argued) only a series of less-controversial sanitary and nuisance-control powers identified in later sections. Notwithstanding the obvious difference in statutory language applicable to the

² Note that this provision is the predecessor of current A.R.S. § 36-136.H, excerpted *infra*.

³ This provision eventually became A.R.S. § 36-162.B, (repealed 2000), excerpted *infra*.

city health boards, the court concluded that the former interpretation was the sounder one, for reasons of policy and of presumed legislative purpose: county boards and city boards alike should enjoy “power equal within their territorial jurisdiction, and as such...[will be] effective agencies for the administration of the health laws of the state...It is clear that the local boards were intended by the Legislature to have and exercise within their respective jurisdictions identical duties and powers....” *Id.*, at 59-60. In short, both county *and* city health agencies were to serve as co-equal administrators of the state’s health laws, under the state board’s superintendency. (Indeed, the court appears to have attached some practical weight to the fact that the city board’s institutional-closure policy was enacted “on the approval of the state superintendent of public health.” *Id.*, at 60. Whatever counter-argument might be made based on the conceded textual differences between the city and county board statutes, the court’s interpretation was expressly codified in the next (1928) edition of the state statutes. See Appendix A, “1928.”

Thus, the court concluded that the city board possessed whatever powers the state and county boards held. But the court then offered a critical second basis for the outcome: In an “emergency” – which, as the court recognized, is surely characterized by epidemic disease -- public health powers will be viewed especially expansively.⁴ Toward the end of the opinion, the court actually conceded the absence of any textual authority to close the schools. Yet it brushed that problem aside on the basis of “necessity”:

[In normal times], school trustees and educational administrative officers... are... no wise subject to the direction or control of the state or county or city boards of health, yet when the necessity arises to close the schools for the protection of the public health such emergency, while it exists, is a superior power to that given the school...officers, and the law of necessity controls the situation during the existence of the emergency giving rise to the power.

Id. This is almost tantamount to saying that, during an emergency, anything goes. The court quoted with approval the strong language of other courts: “Undoubtedly, every possible presumption should be indulged in favor of the validity” of actions of boards of health; “Especially in the presence of a great calamity and in times of great public danger, courts will go to the greatest extent, and give the widest discretion, in reviewing regulations adopted by boards of health...”; the state’s police power “is coextensive with self-protection and is not inaptly termed ‘the law of overruling necessity.’” *Id.* (citations omitted).

There are, of course, constitutional limits to the exercise of such power -- notably 14th Amendment protections of due process (both procedural and substantive) and equal protection -- which will not be addressed here; the

⁴ The court expressly states that two considerations dictate the result it reaches: “the statute...and the public exigency.” *Id.*

excerpts quoted above reference some of the early cases exploring those limits. But for present purposes, note the court’s articulation of an extraordinarily deferential stance toward the executive branch’s exercise of public health powers in emergencies – language that is quite characteristic of other courts at the time.

The primary limit that the court recognized upon the scope of such “emergency” power is its temporary nature. The opinion closed with a recognition that the extraordinary public health powers that arise with “emergencies,” from “necessity,” likewise fall with the termination of the emergency and the disappearance of the necessity: “The authority to adopt the order closing the schools arose from the prevalence of Spanish influence in Globe in epidemic form at that time, and...’The order made has no effect beyond the existence of the emergency.’...” *Id.*⁵

MODERN CASES: CONTINUING JUDICIAL DEFERENCE TO STATE AND LOCAL PUBLIC HEALTH AUTHORITY

To simplify the case discussion that follows, the key statutes that the courts have invoked in exploring the relationship between state and local public health regulatory power are set forth at the outset of this section. These versions of the statutes are taken from current law. However, except as noted, all of the provisions were in effect, in materially the same form, at the time all of the cited cases were decided.

§ 36-136. Powers and duties of director [of state DHS]...

D. The director may delegate to a local health department...any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department...[followed by criteria for delegation and rescission of delegation].

F. The director may make and amend rules necessary for the proper administration and enforcement of the law relating to the public health.

⁵ For other early Arizona decisions upholding the power of local governments to enact local health laws (albeit on municipal law rather than public health law grounds), and describing some of the policy reasons why courts have always interpreted public health powers generously, see *Gardenhire v. State*, 26 Ariz. 14, 221 P. 228 (1923) (charter city may criminalize the adulteration of milk); *City of Phoenix et al. v. Breuninger*, 72 P.2d 580 (1937) (charter city may limit sale of milk to pasteurized products, notwithstanding that this was more stringent than state law on the subject).

H. The director shall, by rule:

1. Define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases...including isolation or quarantine...[and] animal diseases transmittable to humans.

I. The rules [of the director]...shall be observed throughout the state and shall be enforced by each local board of health...but this section does not limit the right of any local board of health or county board of supervisors to adopt ordinances and rules as authorized by law within its jurisdiction, provided that...[they] do not conflict with state law and are equal to or more restrictive than the rules of the director.

§ 36-162 County boards of health.

B... [County boards of health have] such powers within their respective counties and outside the corporate limits of cities having a city board of health as are granted the [state] department of health services, subject to supervisory control by the director [of that department].” [Repealed by Ch. 11, § 4, 2000 Ariz. Laws 47, 52].

§ 36-165 City boards of health.

B... [City boards of health have permissive authority, within city limits, to] “exercise the same powers as are granted county boards of health by § 36-162 [immediately *supra*], and such further powers as conferred by ordinance.” [Repealed by Ch. 11, § 4, 2000 Ariz. Laws 47, 52].

§ 36-184. Boards of health of local health departments...powers and duties

B. The board shall:

3. Make rules and regulations, not inconsistent with the rules and regulations of the [state] department of health services, for the protection and preservation of public health.

§ 36.186 Director of county health department; powers and duties

The director of a county health department shall:

5. Enforce and observe the rules of the director of the department of health services, the director of the department of environmental quality and the local board of health, county rules and regulations concerning health, and laws of the state pertaining to the preservation of public health and protection of the environment.

Four court of appeals cases from the 1970s and 1980s follow the pattern and principles first established in the *Globe* case, discussed *supra*. First, in *State v. Phelps*, 12 Ariz. App. 83, 467 P.2d 923 (Ariz. Ct. App. 1970), a grocer claimed that his misdemeanor convictions for (1) operating a grocery store without a permit from the county health department, and (2) refusing to admit a county inspector to the premises, both in alleged violation of the county health code, were invalid because based on an unconstitutional delegation of legislative power to the county health department. The court rejected these claims.

The court first noted the *state* health department's statutory duty to provide, by rule, for the "inspection and licensing" of retail food premises (currently A.R.S. § 36.136.H.4); identified the power of *county* boards to make their own rules to protect public health (currently A.R.S. § 36.184.B.3, *supra*), as well as the statutory requirement that local health boards observe and enforce all state regulations (currently A.R.S. § 36-136.I, *supra*); and observed that violation of applicable public health statutes or "rules and regulations adopted thereunder" constitutes a misdemeanor (A.R.S. 36-191, currently the same section)

Reviewing these provisions, the court observed: "[I]f the State legislature has properly and legally given the *State* Department of Public Health the power [contested by the defendant]...then the *county* boards of health *also* have this power and authority." *Id.* at 925 [emph. added]. It concluded that the requirement for a grocery-store permit, and the imposition of a criminal sanction for failure to obtain one, were clearly within the state's -- and, therefore, the county's -- authority, under the statute authorizing state inspection and licensing of food premises. Accordingly it upheld the conviction for this violation.⁶ It also upheld the grocer's conviction for failure to allow inspection of his premises, reasoning that the statute clearly gave the state the power to inspect, that such inspection is a "proper and necessary" function of health authorities in protecting the public and enforcing state and county regulations, that it is "reasonably to be expected" by both the public and regulated entities, and that the statutes provide ample notice of the criminal consequences of noncompliance.

⁶ However, the court reversed the second conviction -- for the proprietor's failure to pay a fee for a permit -- concluding that imposition of a fee (unlike the underlying permit requirement) was *not* permissible, since not expressly authorized by the statute. The court's analysis quite clearly suggests this was because non-payment was *criminal*, and criminal sanctions are not to be imposed without express authority. *Id.* at 926-27.

Similar concepts were applied in *State v. Kelsall*, 22 Ariz. App. 97, 523 P.2d 1334 (Ariz. Ct. App. 1974). In *Kelsall*, a pig farmer was convicted of a misdemeanor violation of a county health regulation that prohibited maintaining a pigsty within 300 feet of housing. The court of appeals upheld his conviction, rejecting his claim that the county regulation was the invalid product of an unconstitutionally standardless delegation of legislative power to state and local health authorities.

The court first described the “multi-level” statutory allocation of public health power in Arizona: the *state* board of health enjoys statutory authority to enact “reasonably necessary” rules for disease control, including animal diseases transmittable to man (currently A.R.S. § 36-136.H.1, *supra*); *county* boards of health possessed, within their jurisdiction, the powers held by the state board (former A.R.S. § 36-162.B, repealed 2000; note that the *Phelps* court had *not* cited or referred to this statute as a source of county power); the county boards’ power, then as now, includes the authority to enact regulations not in conflict with state statutes and at least as restrictive as the state’s rules (currently A.R.S. § 36-136.I); city boards of health enjoyed the same authority as the county and state boards, including the power to enact regulations (former A.R.S. § 36-165.B, repealed 2000) (*dictum*); and finally, “local health departments” (then as now) possess rulemaking power (currently A.R.S. § 36-184.B.4).⁷ As in *Phelps, supra*, the court accordingly concluded that “any authority the legislature has given to the state board of health to regulate specific activity or to attain specific objectives is likewise possessed by local departments of health....” *Id.* at 1337.

The court readily rejected the farmer’s claim that the state board of health’s statutory power, shared by operation of law with the county, to prescribe “reasonably necessary” measures for controlling communicable diseases and animal diseases transmittable to man was so vague as to constitute an impermissible delegation of legislative power to the health agencies. Based on state supreme court precedents, it concluded that the statutory standard -- “necessity,” to be determined by the administrative agency -- was sufficiently specific to withstand a non-delegation challenge. *Id.* at 1338-39. Indeed, the state supreme court cases cited by the court, and others, establish that not much legislative guidance to administrative agencies is necessary to defeat a non-delegation challenge under Arizona law.

Another hallmark of public health litigation appears in this case: judicial deference to the discretionary policy judgments of public health agencies. The court of appeals refused to re-evaluate whether the required distance between housing and pigsties (300’) chosen by the county health authorities was unreasonably great (and therefore, presumably, unconstitutional for irrationality):

⁷ This last statute was the source of power for the rules enacted by the county board of health Maricopa County in this case. *Id.* at 1337.

In the absence of evidence to the contrary, we hold that where the regulation on its face bears a rational relationship to the alleviation of the conditions which it seeks to regulate and the regulation is within statutory bounds, the regulation may be deemed valid....Whether the permitted proximity should be 300 feet or 1,000 feet, in absence of evidence either way, we leave to the determination of the body which is empowered to make that decision.

Id. at 1338.

In *Black Cloud Building Corporation v. Maricopa County*, 149 Ariz. 55, 716 P.2d 424 (Ct. App. 1985), the court of appeals ruled that a county health department had sufficient authority to define, in its county health code, the state statutory phrase “public and semipublic pools and bathing places,” thereby giving it the regulatory authority to require permits and charge fees for construction of a spa in a new condominium complex. (The claim in this case was not that the health agencies were purporting to exercise unconstitutionally-delegated “legislative” power, but rather that the statute simply did not authorize the particular regulatory action).

While in many respects similar to *Phelps* and *Kelsall*, *supra*, *Black Cloud* is different in one important respect: the court’s understanding of the legal mechanism by which the county acquired its power. *Phelps* found that local power, derivative of a particular statutory power given to the state health agency, arose by virtue of the statutes empowering county authorities to make their own rules (currently A.R.S. § 36.184.B.3.) and to enforce those of the department (currently A.R.S. § 36-136.I.). *Kelsall* embraced that reasoning, but relied additionally on the statute expressly conferring on local boards, by operation of law, all the powers of the state health agency (then A.R.S. § 36-162, repealed 2000). *Black Cloud*, like *Phelps* before it, makes no mention of the latter provision. It relies instead on the existence of local boards’ rulemaking authority (*Black Cloud*, *supra*, 716 P.2d at 426) and on a *delegation agreement* between the state and the county, specifically *transferring* to the county the state regulatory power over public and semi-public pools, pursuant to a general enabling statute authorizing the state to do so (now, as then, A.R.S. § 36-136.D, *supra*, enacted in 1971). It is not clear why the court took this approach. Nor is it clear how much reliance the court placed on the delegation agreement in relation to the other legal mechanisms by which counties enjoy public health power.⁸ From a county’s standpoint, delegation would seem less desirable than “automatic” power by operation of law, since it requires the state to execute a delegation agreement which, for many reasons, might not occur.

⁸ The court stated that the “statutory scheme...governing public health and safety, *combined with* the delegation agreement between the State and county Health Departments...provide sufficient authority for the County Health Department to define public and semipublic pools and bathing places, and to issue license and assess fees.” *Id.* at 430. Which (if either) factor was more important to the court is unclear.

The final case in this series, which serves as a kind of “bookend” to the *Globe* case on the topic of contemporary disease control, is *Maricopa County Health Dept. v. Harmon*, 156 Ariz. 161, 750 P.2d 1364 (Ariz. Ct. App. 1987).

In the face of a developing measles epidemic, the Maricopa County Health Department issued an emergency order that all children within a school *district* not immunized against measles be excluded from school for a period of two weeks from the last-reported case in that district. Before this order took effect, the department received a report of a “probable” but unconfirmed case at a particular school, and that same day notified parents of all unimmunized children at that *school* that they were excluded effective the next school day. A number of those children, however, continued to attend. The department sought and obtained a trial court order that the named children were prohibited from attending for two weeks after the latest outbreak in the district, unless they were immunized in the interim. The parents appealed.

A statewide DHS administrative rule at the time provided that an “outbreak” at a particular “school” called for the exclusion of unimmunized students from that “school.”⁹ The court of appeals first considered the parents’ claim that this rule precluded the county from enforcing the non-attendance of unimmunized students on a *district-wide*, rather than a school-specific, basis.

The court began with the observation that under the Arizona statutory scheme for public health powers as elaborated in *Black Cloud* and *Kelsall*, a regulatory power held by the state DHS is also held, and to the same extent, by local health departments. *Id.* at 430. Given the authority of the state DHS to promulgate communicable-disease rules (currently A.R.S. § 36-184.H.1, *supra*), as well as the explicit general statutory power of local health departments to make rules of their own (currently A.R.S. § 36-184.B.3, *supra*), the court found it clear that local health departments have “independent authority coextensive with that of the DHS to adopt reasonably necessary measures to prevent and control communicable diseases.” *Id.*¹⁰ The court concluded that the temporary district-wide exclusion order was “well within” the county health department’s authority,

⁹ The DHS administrative rule, ACRR R9-6-116.G., provided that a child who was unimmunized or did not have serologic confirmation of past infection “shall not be permitted to attend school during an *outbreak* of such disease *in that school* for the duration of the period of risk, as determined by the county health officer.” The rule is no longer in effect. However, under current law, statutes erase any distinction between “district” and “school” and simply vest the DHS or local health department with authority to prevent attendance of students during “outbreak periods,” which are not defined. A.R.S. § 15-873.C.; see book at § 4.22.B.

¹⁰ The court cited, in addition, a then-existing administrative rule, R9-6-113(5), which provided local health officials with authority to institute any reasonable communicable disease control measures “in addition to those in the regulations of the DHS....” This has been repealed, and does not appear to have been replaced. Its existence, however, was not essential to the court’s analysis; it was introduced by “*See also....*” *Id.*

constituting a specific measure “reasonably necessary” to achieve a specific legitimate result (citing *Black Cloud, Kelsall*). (Note that, like the *Black Cloud* court, the court did not rely on or cite to the statute that, at the time, “automatically” gave local health boards all the powers of the state health agency, A.R.S. § 36-162.B. (repealed 2000)).

But the parents urged that the county department could not legitimately order district-wide exclusion in the face of an outbreak, because the state administrative rule provided only for *school-specific* exclusion, which meant the local rule was “inconsistent” with the state rule and thus exceeded the express limits of the rulemaking power provided by A.R.S. § 36-184.B.3. (*supra*). The court readily rejected this claim. It invoked another statute that *explicitly authorizes* local health departments to enact rules “more restrictive” than the state’s rules (currently A.R.S. § 36-136.I), concluding that this provision made it “obvious” that a local health department rule that is “more restrictive” than a state rule “cannot be viewed under A.R.S. § 36-184.B.3. [*supra*] as ‘inconsistent’ with the DHS rule.” *Id.* at 1368.

In effect, the *Harmon* court correctly read A.R.S. § 36-184.B.4 (*supra*) together with A.R.S. § 36-136.I (*supra*). Taken alone, the former statute can be viewed (as the parents in this case argued) as prohibiting any “conflict” at all between state and local rules. But the existence of the latter statute means that the proper analysis is, instead, a form of pre-emption inquiry: pre-emption of local rules by DHS’s statewide rules arises *only* if the local rules are *weaker than* the state rules. In that event the obligation of the county is to enforce the DHS rules (A.R.S. § 36-136.I). Otherwise, the stronger local rules may be implemented (provided, of course, they do not exceed the statutory grant of power to the state agency. *Id.*; see also *Phelps, supra*, 467 P.2d at 925.

The parents pressed an additional claim: that since there was no “confirmed” case of measles at the school in question, there was no “outbreak” -- and thus exclusion of unimmunized children was not allowable. The court readily rejected this claim, as well. Observing that the administrative rule did not speak to whether the declaration of “outbreak” required the presence of “confirmed” v. “probable” cases, the court concluded that it was entirely permissible for the health department to treat the existence of a “probable” case of measles at a school as an “outbreak,” and to promptly exclude unimmunized students from that school on that basis. (Thus, even if the county were bound to make school-specific exclusion decisions -- contrary to the court’s first conclusion, *supra* -- it had complied with that requirement here). The court noted that public health authorities are charged by statute with controlling the spread of communicable diseases. Given measles’ substantial incubation period and contagiousness, for the department to wait until laboratory tests came back before acting would be “to disable them from taking timely and effective steps against the spread of measles in school populations. We do not wonder at the absence of authority for [this] argument.” *Id.* at 1369.

The court's opinion reveals a consistent theme in judicial attitudes when asked to review the decisions of public health authorities seeking to control epidemic disease: a position of strong deference, and a willingness to construe the claimed authority generously. Indeed, in the context of two final claims attacking the county's authority to exclude students (insufficient state interest, and interference with free exercise of religion), the court suggests, quite consistently with judicial conclusions in other cases around the country, that the state's interest in taking the steps the county took here, "to combat a reasonably perceived risk of the spread of measles absent a serologically confirmed case," was "compelling." *Id.*

SUMMARY -- AND A FINAL QUESTION

Based on a statutory framework that has existed since Territorial days, Arizona courts have consistently evaluated the powers of local health agencies by looking first to whether a contested power was held by the state health agency; finding local public health powers to be coextensive with those of the state; interpreting both generously; and according the public health authorities wide policymaking discretion. All of the statutes relied on in the foregoing cases remain in effect, materially unchanged, except for two: the statutes expressly giving county and city boards of health all the powers enjoyed by the state health agency (former A.R.S. §§ 36-162.B., 36-165.B., *supra*, both repealed in 2000 as indicated *supra*.) Because city health departments themselves were abolished by the same legislation, the repeal of the statute applicable to city boards' powers is of no consequence. But as to county boards of health, which do remain, the question arises: did the 2000 repeal of this statute diminish the authority of those agencies, compared to the authority recognized in the decided cases -- all of which preceded the repeal?

The answer is uncertain. *Kelsall* appears to have placed some indeterminate amount of reliance on the now-repealed statute. If that reliance was great, then the reasoning of *Kelsall* is undermined somewhat by the repeal. On the other hand, only one post-*Kelsall* case (*Harmon*) even mentions *Kelsall*; all of the others reach the same general result, without invoking *Kelsall* or mentioning the repealed statute. Accordingly, it seems reasonable to conclude that, under the applicable case law, the remaining statutes suffice to retain the level of county health agency power that existed prior to the statutes' repeal of A.R.S. § 36-162.B. in 2000.

Appendix C

PUBLIC HEALTH PRIMER

WHAT IS PUBLIC HEALTH?

Public health is frequently defined as "what we, as a society, do collectively to assure the conditions in which people can be healthy."¹ In first proposing this definition nearly twenty years ago, the Institute of Medicine stressed three key components of public health. First, the mission of public health is to fulfill society's interest in assuring the conditions in which people can be healthy. Second, the substance of public health is organized community efforts aimed at the prevention of disease and the promotion of health. Third, the organizational framework of public health encompasses both activities undertaken within the formal structures of government and the associated efforts of private organizations and individuals.²

Although public health draws upon numerous scientific disciplines, its core science is epidemiology, the study of disease within populations and the factors that determine disease spread. In contrast to the practice of medicine, which is concerned with the health and treatment of individuals, public health is dedicated to promoting the health of the population as a whole. For example, while medical explanations for death focus on pathological causes, such as cancer or heart disease, public health seeks to understand why these pathologies exist in society and the societal measures capable of reducing or eliminating them. To attain this understanding, public health agents examine the environmental, social, and behavioral factors that contribute to disease, such as pollutant levels, diet patterns, and tobacco use.³ These data are then used to craft public health interventions, such as regulation of industrial emissions, school cafeteria nutrition requirements, and targeted smoking cessation programs. Scientific knowledge is, therefore, the foundation of public health decision-making.

In practice, public health encompasses an extremely broad range of activities, varying across the country with geography, community demographics, and resource availability. The public health priorities of New York City, for example, differ in many respects from those of rural Arizona towns. Still, it is possible to identify several essential public health activities and services:

¹ INSTITUTE OF MEDICINE, THE FUTURE OF THE PUBLIC'S HEALTH IN THE 21ST CENTURY 2 (National Academies Press 2003) [*hereinafter* INST. OF MED. 2003].

² INSTITUTE OF MEDICINE, THE FUTURE OF PUBLIC HEALTH 38-42 (National Academies Press 1988) [*hereinafter* INST. OF MED. 1988].

³ See LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 14 (University of California Press 2000) [*hereinafter* GOSTIN].

- Monitoring community health status (data collection, vital statistics, health interview surveys, health trends analyses);
- Diagnosing and investigating health problems (disease screening, laboratory analyses, epidemiology);
- Informing and educating people about health (health promotion, disease prevention, tobacco cessation campaigns);
- Mobilizing community partnerships to improve health (joint drafting of legislation by legislative and public health officials, utilization of physician associations for public education, needle distribution programs of AIDS clinics);
- Developing and enforcing health and safety protections (food and milk control, product safety requirements, premises inspections, sewage disposal, water quality monitoring, hazardous waste management);
- Linking people to needed personal health services (maternal and child health interventions, immunizations, substance abuse and mental illness treatment, home health programs);
- Assuring a competent health workforce (licensing, development of competency sets, public health school curriculum recommendations);
- Fostering health-enhancing public policies (seat-belt and motorcycle helmet laws, public smoking bans, health care for the indigent);
- Evaluating the quality and effectiveness of services (monitoring of health indicators such as immunization rates, prevalence of sexually transmitted diseases, and number of teenage pregnancies, assessment of pulmonary disease following institution of public smoking bans); and
- Researching new insights and innovations (publicly- and privately funded commissions on disease factors and treatments; intervention comparisons).⁴

A BRIEF HISTORY OF PUBLIC HEALTH

Organized community efforts have long been utilized to protect the public's health. Quarantine- and isolation-type measures were used as early as 532 B.C., when the Emperor Justinian of the Eastern Roman Empire commanded that persons arriving at the Empire's capital city from contaminated localities be

⁴ See INST. OF MED. 2003, *supra* note 1, at 31-33; INST. OF MED. 1988, *supra* note 2, at 87-98; GOSTIN, *supra* note 3, at 17; INSTITUTE OF MEDICINE, WHO WILL KEEP THE PUBLIC HEALTHY: EDUCATING PUBLIC HEALTH PROFESSIONALS FOR THE 21ST CENTURY (National Academies Press 2003).

housed in special cleansing facilities.⁵ During the fourteenth and fifteenth centuries, ships entering the port of Venice from certain localities were forced to remain offshore, in isolation, for a period of forty days (*quaranta giorni*) before persons and goods were permitted to disembark.⁶ Other ports and cities throughout Europe and Asia developed similar isolation procedures in subsequent centuries.⁷

In eighteenth-century America, isolation and quarantine were also widely used to contain disease, and these measures were enforced by appointed councils.⁸ At the same time, municipalities and local governments began to undertake programs to address the welfare of their most vulnerable citizens. Public hospitals were established to care for the physically ill, and the first public hospital for the mentally ill was founded in Williamsburg, Virginia in 1773.⁹

The nineteenth century marked the onset of the sanitary movement, often referred to as the "Great Sanitary Awakening." State and local governments began to focus on the environment as a source of disease, a particular challenge in the face of increasing urbanization and industrialization. The public health community also began to utilize health records and vital statistics to influence public policy. Sanitary surveys were performed in both London and Massachusetts during the mid-1800s, and their accompanying reports publicized the poor living conditions in urbanized areas and the disparate health status among socioeconomic classes.¹⁰ These reports emphasized the need for proper drainage systems and waste disposal mechanisms and recommended the establishment of state and local boards of health to enforce sanitary regulations. Consequently, the first public agency for health, the New York City Health Department, was established in 1866, followed by the Massachusetts State Board of Health in 1869.¹¹ By the end of the nineteenth century, more than 40 states and localities had established health departments.¹²

In 1877, Louis Pasteur discovered that anthrax was caused by a bacterium, ushering in the era of bacteriology and, simultaneously, revolutionizing disease control. Public health laboratories were created in state and local health departments to identify biological causes of disease. Science became the basis of public health, and individuals, in addition to the environment,

⁵ See INSTITUTE FOR BIOETHICS, HEALTH POLICY AND LAW, UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE, QUARANTINE & ISOLATION: LESSONS LEARNED FROM SARS – A REPORT TO THE CENTERS FOR DISEASE CONTROL & PREVENTION 17 (2003)

⁶ *Id.*

⁷ *Id.*

⁸ See INST. OF MED., *supra* note 2, at 57.

⁹ *Id.* at 57-58

¹⁰ *Id.* at 59-61 (*discussing* EDWIN CHADWICK, GENERAL REPORT ON THE SANITARY CONDITIONS OF THE LABOURING POPULATION OF GREAT BRITAIN (1842); JOHN GRISCOM, THE SANITARY CONDITION OF THE LABOURING POPULATION OF NEW YORK (1848); LEMUEL SHATTUCK, REPORT OF THE MASSACHUSETTS SANITARY COMMISSION (1850).

¹¹ See INST. OF MED. 1988, *supra* note 2, at 61.

¹² *Id.*

came to be viewed as agents of disease. Accordingly, the early twentieth century saw a renewed focus on individual treatment and the rise of mandatory disease reporting laws, sexual contact tracing, therapeutic clinics, and educational programs.¹³

Consistent with the overarching political philosophy of the times, the federal government's role in public health increased dramatically during the middle of the twentieth century. In 1930, the national laboratory was relocated to Washington, D.C. and renamed the National Institutes of Health (NIH). The Centers for Disease Control and Prevention (CDC) and the National Center for Health Statistics were founded during World War II. The federal government asserted jurisdiction over adulterated food, established national standards for drinking water, and provided states financial support for public health training.¹⁴

At the end of the twentieth century, federal involvement in public health dwindled as the rhetoric of cost containment and small government gained popularity. The federal government sought to encourage increased state activity (and diminished its own role) in the form of block grants, leading to the varied public health systems seen across America today.¹⁵ As early as 1988, the Institute of Medicine reported that the American public health system was in "disarray," unable to respond effectively to current and emerging public health threats and unnecessarily threatening the public's health and safety.¹⁶ Although the events of September 2001, the subsequent anthrax mailings, and the 2003 global outbreak of Severe Acute Respiratory Syndrome (SARS) reinvigorated federal involvement in the public health arena, the vast majority of public health decision-making remains at the state and local levels.¹⁷

THE ROLE OF GOVERNMENT IN PUBLIC HEALTH

Although the Institute of Medicine has acknowledged the role of private organizations and individuals in public health, it has repeatedly reaffirmed the central role of government public health agencies as providers of vital services and guardians of the public health mission.¹⁸ Democratically elected governments are alone legitimately capable of undertaking community activity on behalf of the public.¹⁹ Based upon this reality, several commentators have proposed a narrower conception of public health, one of which limits "public health" to "public officials taking appropriate measures pursuant to specific legal

¹³ *Id.* at 63-66; GOSTIN, *supra* note 3, at 10.

¹⁴ See INST. OF MED. 1988, *supra* note 2 at 67-68; GOSTIN, *supra* note 3, at 10-11.

¹⁵ See INST. OF MED. 1988, *supra* note 2, at 70-71.

¹⁶ *Id.* at 1-2.

¹⁷ See INST. OF MED. 2003, *supra* note 1, at 26-28.

¹⁸ *Id.* at 101-04; INST. OF MED. 1988, *supra* note 2, at 7.

¹⁹ See GOSTIN, *supra* note 3, at 8.

authority, after balancing private rights and public interests, to protect the health of the public."²⁰

Regardless of the exclusivity accorded them, government public health agencies serve three core public health functions. First, government agencies are responsible for assessment of the health of the communities they serve. To this end, government agencies collect data, conduct epidemiological investigations, and monitor and publish health statistics. Research endeavors are also critical components of assessment. Second, government agencies must actively engage in policy development using the scientific knowledge they gain through assessment. Given the constant political struggle for resources, these policy development efforts are most successful when strategic in nature and appropriately prioritized. Finally, government agencies have a duty to provide assurance to their communities in the form of services, legislative action, and partnership development. These assurances should include the guaranteed provision of essential health services for the indigent and socially-dependent.²¹

As indicated above, states are the "central force" in public health,²² exercising their constitutionally-reserved police powers and *parens patriae* powers to protect the public's health, safety, and welfare.²³ Currently, each state has a designated agency for public health. However, states delegate many of their public health responsibilities to localities, whose public health departments vary extensively in organizational structure and may serve municipalities, single counties, or combinations of counties.²⁴ Federal entities, such as the Public Health Service of the Department of Health and Human Services and the CDC, exist primarily to provide resources and knowledge support to state and local public health agencies.

PUBLIC HEALTH AND INDIVIDUAL RIGHTS

While science forms the basis of public health decision-making in theory, public values and popular opinions determine the feasibility of many public health activities in practice.²⁵ The power of governmental agencies to coerce individual behavior in the name of community welfare is inherent within public health.²⁶ Disease reporting requirements impinge upon privacy; mandatory testing and screening curtails autonomy; environmental and industrial regulations impact property and economic interests; and isolation and quarantine restrict liberty.²⁷ In

²⁰ Mark A. Rothstein, *Rethinking the Meaning of Public Health*, 30 J. L. MED. & ETH. 144 (2002); see also Lawrence O. Gostin, *Public Health, Ethics, and Human Rights: A Tribute to the Late Jonathan Mann*, 29 J.L. MED. & ETH. 121 (2001).

²¹ See INST. OF MED. 1988, *supra* note 2, at 7-12, 44-47.

²² *Id.* at 8.

²³ See Chapter 1 of this book, *supra*; U.S. CONST., Amend. X; GOSTIN, *supra* note 3, at 25-59.

²⁴ See INST. OF MED. 2003, *supra* note 1, at 108-110; INST. OF MED. 1988, *supra* note 2, at 78.

²⁵ See INST. OF MED. 2003, *supra* note 1, at 23-26; INST. OF MED. 1988, *supra* note 2, at 3.

²⁶ See GOSTIN, *supra* note 3, at 18-21; ROTHSTEIN, *supra* note 19, at 146.

²⁷ See GOSTIN, *supra* note 3, at 20.

this sense, public health and the notions of individualism central to American society coexist in a state of constant tension. This tension suggests that public health activities are most likely to gain popular support when they reflect an appropriate balancing of community and individual interests. For example, quarantine of individuals exposed to tuberculosis, a highly contagious disease, may be appropriate in certain circumstances, while quarantine of individuals exposed to anthrax, a disease that cannot be transmitted from person-to-person, is not. In the latter case, it would be improper for the government to restrain an individual's liberty when his freedom of movement poses no danger to society. Of course, there are many cases in which the appropriate balance between community and individual interests is more difficult to discern. Is an individual who is properly subjected to quarantine for an extended period of time entitled to government compensation and job protection? What is the appropriate penalty for an individual who violates an appropriate quarantine order? May an individual be forced to undergo mandatory testing and treatment during a public health emergency? What type of procedural due process protections are individuals entitled to in the context of mass quarantine and isolation orders?

Public health law is concerned with the ongoing struggle to reconcile these competing individual and community interests in the context of public health activities. As recently suggested:

Public health law [encompasses] legal powers and duties of the state to assure the conditions for people to be healthy (e.g., to identify, prevent, and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the protection or promotion of community health.²⁸

Though not always identified as such, public health issues have long been present on court dockets.²⁹ Legal issues such as nuisance abatement, civil commitment, and sentencing of mentally ill or substance-addicted individuals all reflect public health concerns. However, as recently noted by one commentator, "there appear to be few, if any, published manuals on public health emergency law for government and hospital attorneys, 'bench books' for judges to brief themselves on evidentiary standards for public health search warrants and quarantine orders, or databases of extant state and municipal public health emergency statutes and regulations."³⁰ The renewed focus on public health law prompted by concerns about bioterrorism and emerging infectious diseases presents an opportunity for judges and lawyers to familiarize themselves with the

²⁸ *Id.* at 4.

²⁹ INST. OF MED., *supra* note 2.

³⁰ Anthony D. Moulton *et al.*, *What is Public Health Legal Preparedness?*, 31 J. L. MED. & ETH. 672 (2003)

body of public health law and develop new legal approaches to current public health problems.

Appendix D

PUBLIC HEALTH GLOSSARY

A

- Acute** Of rapid onset; brief. An acute condition may, but need not necessarily, be severe. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).
- Adenopathy** Swelling or diseased enlargement of the lymph nodes. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).
- Aerosolize** To disperse a substance as particles in air. OXFORD ENGLISH DICTIONARY (2d. ed. 1989).
- Analytic validity** An index of how well a test measures the property or characteristic it is intended to measure. Analytic validity of a test is affected by the technical accuracy and reliability of the testing procedure, and also by the quality of the laboratory processes (including specimen handling). STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); NAT'L CANCER INSTS., U.S. NAT'L INSTS. OF HEALTH, CANCER GENETICS OVERVIEW, at http://www.cancer.gov/cancertopics/pdq/genetics/overview#Section_10 (last modified June 15, 2004).
- Anthrax** A disease caused by the bacterium *Bacillus anthracis*. Anthrax cannot be transmitted from person-to-person. There are three distinct types of anthrax:
cutaneous: An infection of the skin by *B. anthracis*, producing a characteristic lesion that begins as a papule and soon becomes a vesicle and breaks, discharging a bloody liquid. Approximately 36 hours after infection, the vesicle becomes a bluish-black dead mass. Cutaneous anthrax infection is usually accompanied by high fever, vomiting, profuse sweating, and extreme prostration, but is rarely fatal.
(gastro)intestinal: An infection of the digestive track caused by eating foods contaminated with *B. anthracis*. Gastrointestinal anthrax is usually accompanied by chill, high fever, pain in the head, back, and extremities, vomiting, bloody diarrhea, cardiovascular collapse, and, frequently,

hemorrhages from the mucous membranes and the skin; gastrointestinal anthrax is often fatal.

inhalation (pulmonary): An infection of the lungs caused by the inhalation of particles containing *B. anthracis*. Inhalation anthrax is usually accompanied by an initial chill followed by pain in the back and legs, rapid respiration, shortness of breath, cough, fever, rapid pulse, and extreme cardiovascular collapse; inhalation anthrax is frequently fatal. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Anthrax: What You Need to Know*, at <http://www.bt.cdc.gov/agent/anthrax/needtoknow.asp> (last modified July 31, 2003).

Antibody (Ab)

A molecule located in the blood or other body fluids that is produced in response to an antigen. An antibody reacts specifically with its corresponding antigen. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Antigen (Ag)

A foreign organism or substance or aberrant native cell that induces the production of its corresponding antibody when introduced into an organism. Production of the corresponding antibodies occurs following an antigen-specific latent period, which typically lasts days or weeks. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Antitoxin

An antibody formed in response to an antigen that is a poisonous biological substance. An antitoxin can neutralize the effect of the poison. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Asymptomatic

Without symptoms. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Ataxia

An inability to coordinate voluntary muscle movement. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Avian influenza

A contagious disease of animals, also called "bird flu," caused by influenza viruses that normally infect only birds and, less commonly, pigs. Avian influenza viruses tend to be species specific, but have on rare occasions passed the species barrier, allowing humans to be infected by animals. STEDMAN'S

MEDICAL DICTIONARY (28th ed. 2006). WORLD HEALTH ORGANIZATION, *Epidemic and Pandemic Alert Response, Avian influenza frequently asked questions*, at http://www.who.int/csr/disease/avian_influenza/avian_fags/en/index.html#whatis (last modified December 5, 2005). See **Influenza**.

B

- Bacterium** A single-celled microorganism that reproduces by cell division. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Anthrax: What You Need to Know*, at <http://www.bt.cdc.gov/agent/anthrax/needtoknow.asp> (last modified July 31, 2003).
- Botulism** An illness caused by the toxin produced by the bacterium *Clostridium botulinum*. Botulism is typically caused by ingestion of the pre-formed *C. botulinum* toxin; wound botulism may occur when wounds are infected with toxin-secreting *C. botulinum* bacteria. Botulism is characterized by severe paralysis and is often fatal. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Facts About Botulism*, at <http://www.bt.cdc.gov/agent/botulism/factsheet.asp> (last reviewed Dec. 5, 2005).
- Brachycardia** Slowness of the heartbeat; typically less than 50 beats per minute. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).
- Bradycardia** See **brachycardia**.
- Brucellosis** An infectious disease caused by the bacterium *Brucella*, of which the most common species are *B. melitensis*, *B. abortus*, *B. canis*, and *B. suis*. The *Brucella* bacterium is primarily transmitted among animals and is transmitted to humans upon contact with infected animals or ingestion of infected meats, milk, or cheese. Brucellosis is characterized by fever, sweating, weakness, aches, and pains; in rare cases, severe infections of the central nervous systems or

lining of the heart may occur, leading to death. Brucellosis is transmitted through breast-feeding, sexual intercourse, and, rarely, direct person-to-person contact. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); DIV. OF BACTERIAL & MYCOTIC DISEASES, CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Brucellosis*, at http://www.cdc.gov/ncidod/dbmd/diseaseinfo/brucellosis_g.htm (last modified Oct. 6, 2005).

C

Capillary A small blood vessel. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Case An instance of disease; a patient. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Chickenpox (varicella) An acute contagious disease, usually occurring in children, caused by the Varicellovirus, a member of the family *Herpesviridae*. Chickenpox is marked by a sparse eruption of papules, usually on the face, scalp, and/or trunk. The papules become vesicles and then pustules, like that of smallpox although less severe and varying in stages. Chickenpox has an incubation period of approximately 14 to 17 days and is usually accompanied by mild constitutional symptoms. In severe cases, most frequently in adults, chickenpox may lead to bacterial infection of the skin, swelling of the brain, and/or pneumonia. Chickenpox is highly contagious and is spread by coughing or sneezing. The varicella vaccine is available to prevent chickenpox. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); NAT'L IMMUNIZATION PROGRAM, CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Varicella – In Short*, at <http://www.cdc.gov/nip/diseases/varicella/vac-chart.htm> (last modified Feb. 15, 2001).

Cholera An acute epidemic infectious disease caused by infection of the intestine with the bacterium *Vibrio cholerae*. Cholera is characterized by profuse watery diarrhea, extreme loss of fluid and electrolytes, dehydration, and collapse. If untreated, cholera may lead to shock and death. Cholera is transmitted by

drinking water or consuming foods contaminated with *V. cholerae* bacteria. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); DIV. OF BACTERIAL & MYCOTIC DISEASES, CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Cholera*, at http://www.cdc.gov/ncidod/dbmd/diseaseinfo/cholera_g.htm (last modified Oct. 6, 2005).

Clinical utility

The likelihood that a test will, by prompting an intervention, result in an improved health outcome. The clinical utility of a test is based on the health benefits of the interventions offered to persons with positive test results. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); NAT'L CANCER INST., U.S. NAT'L INSTS. OF HEALTH, *Cancer Genetics Overview*, at http://www.cancer.gov/cancertopics/pdq/genetics/overview#Section_10 (last modified June 15, 2004).

Clinical validity

The predictive value of a test for a given clinical outcome (e.g., the likelihood that cancer will develop in someone with a positive test). Clinical validity is, in large measure, determined by the ability of a test to accurately identify people with a defined clinical condition. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); NAT'L CANCER INST., U.S. NAT'L INSTS. OF HEALTH, *Cancer Genetics Overview*, at http://www.cancer.gov/cancertopics/pdq/genetics/overview#Section_10 (last modified June 15, 2004).

Communicable

Capable of being transmitted from one organism or person to another. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Communicable Disease

An illness that is transmissible by direct or indirect contact with the sick, their bodily excretions or cell secretions, or a disease vector. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Constitutional Symptoms

General indications of disease pertaining to the body as a whole. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Contact	A person who has been exposed to a contagious disease. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Contact tracing	Identification and location of persons who may have been exposed to an infectious disease, which may result in surveillance of those persons. Contact tracing has been used to control contagious diseases for decades. A disease investigation begins when an individual is identified as having a communicable disease. An investigator interviews the patient, family members, physicians, nurses, and anyone else who may have knowledge of the primary patient's contacts, anyone who might have been exposed, and anyone who might have been the source of the disease. Then the contacts are screened to see if they have or have ever had the disease; in certain cases, the process of contact tracing will be repeated for identified contacts as well. The type of contact screened depends on the nature of the disease. A sexually transmitted disease will require interviewing only infected patients and screening only their sex partners. A disease that is spread by respiratory contact, such as tuberculosis, may require screening tens to hundreds of persons. CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., <i>Severe Acute Respiratory Syndrome (SARS): Appendix 2 – Glossary</i> , at http://www.cdc.gov/ncidod/sars/guidance/core/app2.htm (last modified May 3, 2005); THE MEDICAL & PUBLIC HEALTH LAW SITE, LOUISIANA STATE UNIV. LAW CTR., <i>Contact Tracing</i> , at http://biotech.law.lsu.edu/books/lbb/x578.htm (last visited January 1, 2006).
Contagious	See communicable disease .
Cutaneous	Relating to the skin. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Cyanosis	A dark bluish and purplish discoloration of the skin and mucous membrane due to deficient oxygen content in the blood. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).

D

Decontamination	The elimination of poisonous or otherwise harmful agents, such as chemicals or radioactive materials, from a person, area, thing, etc. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006); OXFORD ENGLISH DICTIONARY (2d. ed. 1989).
Directly observed Therapy	Visual monitoring of an individual's ingestion of medications by a health care worker to ensure compliance in difficult or long-term regimens, such as in oral treatment for tuberculosis. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Disease	An interruption, cessation, or disorder of a body function, system, or organ; a departure from a state of health. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006); OXFORD ENGLISH DICTIONARY (2d. ed. 1989).
Disease agent	A microorganism whose presence or absence results in disease. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Disease vector	See vector .
Distal	Situated away from the center of the body, often used in reference to the extremity or distant part of a limb or organ. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006); OXFORD ENGLISH DICTIONARY (2d. ed. 1989).
Dysphagia	Difficulty swallowing. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Dyspnea	Shortness of breath, usually associated with disease of the heart or lungs. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).

E

Edema	1. An accumulation of an excess amount of water fluid in cells, tissues, or body cavities. 2. A fluid-filled tumor or swelling. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
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Effectiveness	The extent to which a treatment achieves its intended purpose in an average clinical environment. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Efficacy	The extent to which a treatment achieves its intended purpose under ideal circumstances. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Encephalitis	Inflammation of the brain. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Endemic	Denoting a temporal pattern of disease occurrence in a population. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Epidemic	The occurrence in a community of cases of illness or health-related events clearly in excess of normal expectancy. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Epidemiology	The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to control of health problems. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Epistaxis	Bleeding from the nose. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Erythema	Redness due to dilation of the capillaries that can signal an infection. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
<i>Escherichia coli</i> (<i>E. coli</i>)	A type of bacteria. <i>E. coli</i> O157:H7 causes foodborne illness and is characterized by bloody diarrhea and, in severe cases, kidney failure and/or death. <i>E. coli</i> O157:H7 is transmitted through the ingestion of undercooked, contaminated ground beef, unpasteurized milk, or contaminated water. Non-Shiga toxin-producing <i>E. coli</i> (diarrheagenic <i>E. coli</i>) causes chronic diarrhea (watery or bloody) associated with abdominal cramps and fever. Non-Shiga toxin-producing <i>E. coli</i> is transmitted through ingestion of contaminated food and water, most commonly by

international travelers or children in the developing world. In rare cases, non-Shiga toxin-producing *E. coli* may be transmitted through person-to-person contact. DIV. OF BACTERIAL & MYCOTIC DISEASES, CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Diarrheagenic Escherechia coli*, at <http://www.cdc.gov/ncidod/diseases/hanta/hps/noframes/generalinfoindex.htm> (last reviewed Apr. 28, 2005); DIV. OF BACTERIAL & MYCOTIC DISEASES, CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Escherichia coli* O157:H7, at http://www.cdc.gov/ncidod/dbmd/diseaseinfo/escherichiacoli_g.htm (last modified Oct. 6, 2005).

Ex vivo

Referring to the use of human cells or tissues after their removal from an organism and while they remain viable. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Exanthema

A skin eruption occurring as a symptom of a viral or bacterial disease, such as measles. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

F

Fomite

An object (e.g., clothing, towel, utensil) that possibly harbors a disease agent and may be capable of transmitting it. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

G

Gastrointestinal (GI)

Relating to the stomach and intestines. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Genus

A group of species alike in the broad features of their organization but different in detail; species within a genus are incapable of fertile mating. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

H

Hantavirus	<p>A genus of <i>Bunyaviridae</i> viruses that cause pneumonia and hemorrhagic fevers. At least 7 species within the genus are recognized at the current time (Hantaan, Puumala, Seoul, Prospect Hill, Thailand, Thottapalayan, and Sin Nombre virus), while a number of other species have not yet been classified. Rodents are the asymptomatic carriers of Hantaviruses and shed the viruses in their saliva, urine, and feces. Hantavirus is transmitted from rodents to humans through bites, ingestion of contaminated foods, or inhalation of droplets containing the aerosolized virus; person-to-person spread of Hantavirus is rare. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); SPECIAL PATHOGENS BRANCH, NAT'L CTR. FOR INFECTIOUS DISEASES, CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., <i>All About Hantaviruses</i>, at http://www.cdc.gov/ncidod/diseases/hanta/hps/noframes/generalinfoindex.htm (last modified Apr. 28, 2005).</p>
Hematemesis	<p>Vomiting of blood. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).</p>
Hemoptysis	<p>The presence of blood in the urine. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).</p>
Hemorrhage	<p>To bleed. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).</p>
Hemorrhagic Fever	<p>See viral hemorrhagic fever.</p>
Hepatitis	<p>Inflammation of the liver, due usually to viral infection but sometimes to toxic agents. Previously considered a problem only of the developing world, viral hepatitis now ranks as a major public health problem in industrialized nations. The 3 most common types of viral hepatitis (A, B, and C) afflict millions worldwide. Acute viral hepatitis is characterized by varying degrees of fever, malaise, weakness, anorexia, nausea, and abdominal distress. Hepatitis A is caused by an enterovirus and is most often spread through ingestion of contaminated food or water. The case fatality rate is less than 1%, and</p>

recovery is complete. The presence of antibody to hepatitis A virus indicates prior infection, noninfectivity, and immunity to future attacks. An effective vaccine is available for immunization against hepatitis A.

Hepatitis B is caused by a small DNA virus and is transmitted through sexual contact, sharing of needles by IV drug abusers, needlestick injuries among health care workers, and from mother to fetus. The incubation period is 6-24 weeks. Some patients become carriers, and in some an immune response to the virus induces a chronic phase leading to liver failure and/or liver cancer. Hepatitis B is more likely to cause death than hepatitis A. Hepatitis B surface antigen (HBsAg) is detectable early in serum; its persistence correlates with chronic infection and infectivity. An effective vaccine is available for immunization against hepatitis B.

Hepatitis C is the principal form of transfusion-induced hepatitis, which may develop into a chronic active form of hepatitis. Hepatitis C is more likely to cause death than hepatitis A.

Hepatitis D is caused by an RNA virus capable of causing disease only in persons previously infected with hepatitis B.

Hepatitis E occurs chiefly in the tropics and resembles hepatitis A in that it is transmitted by the fecal-oral route and does not become chronic or lead to a carrier state. However, hepatitis E has a much higher mortality rate than hepatitis A. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

**Horizontal
Transmission**

Transmission of a disease agent from an infected organism or individual to another, susceptible organism or individual. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Host

The organism in or on which a parasite lives. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Hypertension

High blood pressure. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Hyperthermia Extremely high fever, often occurring as a side effect of therapeutic regimens. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Hypotension Low blood pressure. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Hypothermia A body temperature significantly below normal body temperature (98.6 °F/37 °C for humans). STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

I

Identifiable health Information

Information in any form (e.g., oral, written, electronic, visual, pictorial, physical) that relates to an individual's past, present, or future physical or mental health status, condition, treatment, service, products purchased, or provision of care and
(a) reveals the identity of the individual; or
(b) there is a reasonable basis to believe the information could be used, alone or with other information, to reveal the identity of the individual.
PUBLIC HEALTH STATUTE MODERNIZATION NAT'L EXCELLENCE COLLABORATIVE, TURNING POINT, MODEL STATE PUBLIC HEALTH ACT: A TOOL FOR ASSESSING PUBLIC HEALTH LAWS 13 (Sept. 2003).

Immune response Any response of the immune system to an antigen, including antibody production. The immune response to the initial antigenic exposure (primary immune response) is generally detectable only after a lag period of several days to 2 weeks; the immune response to a subsequent stimulus by the same antigen (secondary immune response) is more rapid. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Immune system An intricate complex of interrelated cellular, molecular, and genetic components that provides a defense (immune response) against foreign organisms or substances and aberrant native cells. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Immunogen See **antigen**.

<i>In vitro</i>	In an artificial environment, such as a test tube or culture media. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
<i>In vivo</i>	In the living body. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Incidence	The number of specified new events (e.g., new cases of a disease) during a specified period of time in a specified population. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Incubation Period	The period of time between a disease agent's entry into an organism and the organism's initial display of disease symptoms. During the incubation period, the disease is developing. Incubation periods are disease-specific and may range from hours to weeks. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Index case	The patient that brings a family, group, or community under study. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006); OXFORD ENGLISH DICTIONARY (2d. ed. 1989).
Infectious agent	A microorganism that causes infectious disease through transmission. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Infectious disease	A disease resulting from the presence and activity of a microorganism. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Influenza	An acute respiratory disease caused by influenza viruses. The virus is typically inhaled and then attacks the respiratory system, causing chills, fever, headache, loss of strength, muscle aches and a cough. Commonly occurs in epidemics, sometimes pandemics, usually with a low mortality rate. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Isolation	The separation, for the period of communicability, of known infected persons in such places and under such conditions as to prevent or limit the transmission of the infectious agent. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006); LAWRENCE O. GOSTIN,

J

K

L

Latent period

See **incubation period**.

Lymph node

One of numerous round, oval, or bean-shaped bodies that form part of the immune system. Lymph nodes produce a fluid (lymph) that is circulated throughout the body to remove impurities. *STEDMAN'S MEDICAL DICTIONARY* (28th ed. 2006).

M

Measles

An acute respiratory disease caused by a virus of the *Paramyxoviridae* family; one of the most infectious diseases in the world. Measles is usually marked by fever, inflammation of the respiratory mucous membranes, red watery eyes, and a generalized eruption of dusky red papules. The papules first appear on the cheeks in the form of spots (often referred to as "Koplik spots"), a manifestation utilized in early diagnosis. Measles has an average incubation period of 10 to 12 days; the rash begins approximately 14 days after exposure and lasts 5 to 6 days, progressing downward from the face. Recovery is usually rapid but respiratory complications caused by secondary bacterial infections are common. Severe cases may be accompanied by swelling of the brain. The measles vaccine is available to prevent measles. *STEDMAN'S MEDICAL DICTIONARY* (28th ed. 2006); NAT'L IMMUNIZATION PGM., CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Measles*, at <http://www.cdc.gov/nip/diseases/measles/> (last modified Apr. 15, 2004).

Monkeypox

A disease found in monkeys and rodents and caused by the monkeypox virus, a member of the family

Poxviridae. In humans, monkeypox is initially characterized by fever, headache, muscle aches, swelling of the lymph nodes, and fatigue. Approximately 3 days after the onset of these initial symptoms, a rash develops, typically beginning on the face, and progresses into raised pustules. Monkeypox has an incubation period of approximately 12 days. The disease is rarely found in humans, but may be transmitted through contact with the blood, bodily fluid, or rash of an infected animal. Monkeypox may also be transmitted among humans through exposure to large respiratory droplets during long periods of face-to-face contact or by touching the bodily fluids or contaminated objects of an infected individual. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *What You Should Know About Monkeypox*, at <http://www.cdc.gov/ncidod/monkeypox/factsheet2.htm> (last modified June 12, 2003).

Mucous Membrane

A tissue lining found in various bodily structures, including the nose, eyes, and mouth. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Myalgia

Muscular pain. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Mydriasis

Dilation of the pupil. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

N

Necrosis

Death of one or more cells or a portion of a tissue or organ due to irreversible damage. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Notifiable Disease

A disease that, by statutory requirements, must be reported to the public health or veterinary authorities when the diagnosis is made because of its importance to human or animal health. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

O

Outbreak A sudden rise in the number of new cases of a disease, usually during a specified period and in a specified population. MERRIAM-WEBSTER ONLINE, at <http://www.merriamwebster.com> (last visited Jan. 1, 2006).

P

Pandemic An occurrence of a disease affecting the population of an extensive geographic area. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Papule A circumscribed, solid elevation up to 100 cm in diameter on the skin. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Parasite An organism that lives on or in another and draws its nourishment therefrom. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Plague An acute infectious disease caused by the bacterium *Yersinia pestis*. Plague is characterized by high fever, prostration, a hemorrhagic eruption, lymph node enlargement, pneumonia, and hemorrhage from the mucous membranes. Plague is primarily a disease of rodents that is transmitted to humans by fleas that have bitten infected animals. In humans, plague takes one of three main forms:

Bubonic: The most common form of plague, caused when an infected flea bites a human or materials contaminated with *Y. pestis* bacteria contact broken skin. Bubonic plague cannot be transmitted person-to-person.

Pneumonic: A form of plague that occurs when *Y. pestis* infects the lungs. Pneumonic plague may be transmitted person-to-person through the air by inhalation of respiratory droplets containing *Y. pestis* or aerosolized *Y. pestis*. Pneumonic plague may also develop when an individual with bubonic or septicemic plague goes untreated and *Y. pestis* bacteria spread to the lungs.

Septicemic: A form of plague resulting from the presence of *Y. pestis* bacteria in the blood. Septicemic plague may develop from bubonic or pneumonic plague or occur alone. When septicemic plague occurs alone, lymph node enlargement is typically absent. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Facts About Pneumonic Plague*, at <http://www.bt.cdc.gov/agent/plague/factsheet.pdf> (last modified Oct. 14, 2001).

**Polymerase
Chain reaction
(PCR)**

A method for the repeated copying of a gene sequence. PCR is widely used to amplify minute quantities of DNA in order to provide adequate specimens for laboratory study. BRUCE ALBERTS ET AL., MOLECULAR BIOLOGY OF THE CELL 316-17 (3d. ed. 1994); STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Predictive value

The likelihood that a given test result correlates with the absence (R_f) or presence of disease. A positive predictive value is the ratio of patients with the disease who test positive to the entire population of individuals with a positive test result; a negative predictive value is the ratio of patients without the disease who test negative to the entire population of individuals with a negative test. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Prevalence

The number of cases of a disease existing in a given population at a specific period of time (period prevalence) or at a particular moment in time (point prevalence). STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Prostration

Extreme physical weakness or exhaustion. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); OXFORD ENGLISH DICTIONARY (2d. ed. 1989).

Proximal

Situated nearest to the center or trunk of the body; often used in reference to a portion of a limb, bone, organ, or nerve. STEDMAN'S MEDICAL DICTIONARY (28th

ed. 2006); OXFORD ENGLISH DICTIONARY (2d. ed. 1989).

Pruritis

Itching. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Public health

A societal effort to assure the conditions in which the population can be healthy. INST. OF MEDICINE, THE FUTURE OF THE PUBLIC'S HEALTH IN THE 21ST CENTURY 2 (National Academies Press 2003); PUBLIC HEALTH STATUTE MODERNIZATION NAT'L EXCELLENCE COLLABORATIVE, TURNING POINT, MODEL STATE PUBLIC HEALTH ACT: A TOOL FOR ASSESSING PUBLIC HEALTH LAWS 15 (Sept. 2003).

Public health Agency

Any organization operated by federal, tribal, state, or local government that principally acts to protect or preserve the public's health. PUBLIC HEALTH STATUTE MODERNIZATION NAT'L EXCELLENCE COLLABORATIVE, TURNING POINT, MODEL STATE PUBLIC HEALTH ACT: A TOOL FOR ASSESSING PUBLIC HEALTH LAWS 15 (Sept. 2003).

Public health Emergency

An occurrence or imminent threat of an illness or health condition that: (a) is believed to be caused by (i) bioterrorism, (ii) the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin, or (iii) a natural disaster, chemical attack or accidental release, or nuclear attack or accidental release; or (b) poses a high probability of (i) a large number of deaths in the affected population, (ii) a large number of serious or long-term illnesses in the affected population, or (iii) widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population. PUBLIC HEALTH STATUTE MODERNIZATION NAT'L EXCELLENCE COLLABORATIVE, TURNING POINT, MODEL STATE PUBLIC HEALTH ACT: A TOOL FOR ASSESSING PUBLIC HEALTH LAWS 15 (Sept. 2003).

Public health Law

The study of the legal powers and duties of the state to assure the conditions for people to be healthy (e.g.,

to identify, prevent, and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the protection or promotion of community health.

LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 4 (University of California Press 2000).

**Public health
Official**

The head officer or official of a state or local public health agency who is responsible for the operation of the agency and has the authority to manage and supervise the agency's activities.

PUBLIC HEALTH STATUTE MODERNIZATION NAT'L EXCELLENCE COLLABORATIVE, TURNING POINT, MODEL STATE PUBLIC HEALTH ACT: A TOOL FOR ASSESSING PUBLIC HEALTH LAWS 15 (Sept. 2003).

Pulmonary

Relating to the lungs. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Pus

A fluid product of inflammation. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Pustule

A circumscribed, superficial elevation of the skin, up to 1.0 cm in diameter, containing pus. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Pyrogenic

Causing fever. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Q

Quarantine

The restriction of the activities of healthy persons who have been exposed to a communicable disease, during its period of communicability, to prevent disease transmission during the incubation period if infection should occur. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 210 (University of California Press 2000).

R

Reportable Disease

See **notifiable disease**.

Reservoir

The living or non-living material an infectious agent depends on for its survival. The infectious agent multiplies and/or develops in or on the reservoir. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Rhinorrhea

A discharge from the nose. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Ricin

A poison that may be made from the waste materials generated during the processing castor beans. Ricin may be produced as a powder, a mist, a pellet, or dissolved in water and may be delivered through ingestion, inhalation, or injection. Ricin poisoning cannot be transmitted person-to-person. Treatment for ricin poisoning consists of supportive care only, as there is currently no effective antibiotic or antitoxin treatment available. Death from ricin poisoning may occur within 36 to 72 hours of exposure, depending upon the route of exposure. If death has not occurred within 3 to 5 days, the victim usually recovers. The symptoms of ricin poisoning vary according to the route of exposure:

Ingestion: Ingestion of a significant amount of ricin produces vomiting and diarrhea (that may become bloody) within 6 hours. Severe dehydration may result, followed by low blood pressure. Other symptoms may include hallucinations, seizures, and blood in the urine. In severe cases, the liver, spleen, and kidneys may cease to function, producing death.

Inhalation: The inhalation of significant amounts of ricin usually produces respiratory distress, fever, cough, nausea, and tightness in the chest within 8 hours. Heavy sweating and fluid build-up in the lungs may follow, and the skin may turn blue. In severe cases, low blood pressure and respiratory failure may occur, leading to death. CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Facts About Ricin*, at <http://www.bt.cdc.gov/agent/ricin/facts.asp> (last modified Feb. 5, 2004).

Rickettsia

A genus of small bacteria often found in lice, fleas, ticks, and mites. Pathogenic species of *Rickettsia* infect humans and other animals, causing epidemic typhus, endemic (murine) typhus, Rocky Mountain spotted fever, tsutsugamushi disease, rickettsialpox, and other diseases. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

S**Salmonella**

A genus of bacteria found in humans and animals, especially rodents. *Salmonella enterica* is a common species that causes gastroenteritis, enteric fever, and food poisoning in humans. Salmonellosis is characterized by the onset of diarrhea, fever, and abdominal cramps within 12 to 72 hours after infection and usually lasts 4 to 7 days. *Salmonella typhi* causes typhoid fever in humans. *Salmonella* bacteria are transmitted through the ingestion of contaminated food or water. Infection with *Salmonella* is treatable with antibiotics. Most persons recover with treatment, but, in severe cases, the infection may spread to the bloodstream, resulting in death. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); DIV. BACTERIAL & MYCOTIC DISEASE, CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Salmonellosis*, at http://www.cdc.gov/ncidod/dbmd/diseaseinfo/salmonellosis_g.htm (last modified October 13, 2005).

Sample

1. A relatively small quantity of material, or an individual object, from which the quality of the mass, group, species, etc. which it represents may be inferred. 2. A selected subset of a population. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); OXFORD ENGLISH DICTIONARY (2d. ed. 1989).

Screen

To systematically apply a test or exam to a defined population. PUBLIC HEALTH STATUTE MODERNIZATION NAT'L EXCELLENCE COLLABORATIVE, TURNING POINT, MODEL STATE PUBLIC HEALTH ACT: A TOOL FOR ASSESSING PUBLIC HEALTH LAWS 16 (Sept. 2003).

Sensitivity

The ability of a test to correctly identify those with a given characteristic or disease. LEON GORDIS, EPIDEMIOLOGY 59 (W. B. Saunders Co. 1996).

**Severe acute
Respiratory
Syndrome
(SARS)**

A viral respiratory illness first identified during a global outbreak in 2003 that originated in China. SARS is usually characterized by a high fever (temperature greater than 100.4°F/38.0°C), headache, an overall feeling of discomfort, and body aches. Some infected individuals also display mild respiratory symptoms, and about 10 to 20 percent of patients have diarrhea. Approximately 2 to 7 days following onset of the illness, infected individuals often develop a dry cough, and many infected individuals will go on to develop pneumonia. SARS is transmitted through close person-to-person contact. The SARS virus appears to be most easily transmitted by respiratory droplets produced when an infected person coughs or sneezes. These expelled droplets may be deposited directly on the mucous of the mouth, nose, or eyes of persons who are nearby or transferred thereto by persons who touch a contaminated surface or object. It remains uncertain whether the SARS virus is able to spread more broadly through the air or in other ways. CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Basic Information About SARS*, at <http://www.cdc.gov/ncidod/sars/factsheet.htm> (last modified May 3, 2005).

**Smallpox
(variola)**

An acute eruptive contagious disease caused by a virus of the family Poxviridae. Smallpox is characterized by initial chills, high fever, backache, and headache; within 2 to 5 days the constitutional symptoms subside and a skin eruption appears as papules, which become pit-like vesicles, develop into pustules, dry, and form scabs that, on falling off, leave a permanent marking of the skin (pock marks). Fatality rates for smallpox may exceed 20 percent. The average incubation period of smallpox is 8 to 14 days. Generally, direct and fairly prolonged face-to-

face contact is required to transmit smallpox from one person to another, although smallpox may also be transmitted through direct contact with infected bodily fluids or contaminated objects. Humans are the only natural hosts of smallpox; it is not known to be transmitted by insects or animals. There is no treatment for smallpox, although a vaccine is available to prevent infection. As a result of increasingly aggressive vaccination programs carried out over a period of about 200 years, smallpox has been eradicated; the last naturally occurring case of smallpox was reported in Somalia in 1977. Routine vaccination, discontinued in the 1970s, has been reinstated for military and health personnel and others who will be at high risk if the smallpox virus is ever used as a weapon of biological warfare or bioterrorism. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Smallpox Disease Overview*, at <http://www.bt.cdc.gov/agent/smallpox/overview/diseases-facts.asp> (last modified Dec. 30, 2004).

Species

A group of organisms that generally bear a close resemblance to one another in the more essential features of their organization; members of the same species may breed effectively to produce fertile offspring. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Specificity

The ability of a test to correctly identify those without a given characteristic or disease. LEON GORDIS, EPIDEMIOLOGY 59 (W. B. Saunders Co. 1996).

Sputum

Saliva, mucus, blood, or other fluid spit from the mouth. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Staphylococcus

A genus of bacteria found on the skin, in skin glands, on the nasal and other mucous membranes of warm-blooded animals, and in various food products. *Staphylococcus aureus* is a common species found especially on nasal mucous membrane and skin. *S. aureus* produces toxins including those that cause toxic shock syndrome and food poisoning. *Staphylococcus* infections are usually treatable with

antibiotics, although antibiotic resistant strains have been identified. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); DIV. OF HEALTHCARE QUALITY PROMOTION, CTRS. FOR DISEASE CONTROL & PREVENTION, *Healthcare-Associated Methicillin Resistant Staphylococcus aureus (HA-MRSA)*, at http://www.cdc.gov/ncidod/dhqp/ar_mrsa.html (last modified Jun. 1, 2005).

Surveillance

A type of observational study that involves continuous monitoring of disease occurrence within a population. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

T

Tachycardia

Rapid beating of the heart, typically more than 90 beats per minute. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Toxin

A harmful or poisonous substance that is formed during the metabolism and growth of certain microorganisms and some plant and animal species. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Transmissible Agent

A biological substance that causes disease or infection through conveyance from one organism to another. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); PUBLIC HEALTH STATUTE MODERNIZATION NAT'L EXCELLENCE COLLABORATIVE, TURNING POINT, MODEL STATE PUBLIC HEALTH ACT: A TOOL FOR ASSESSING PUBLIC HEALTH LAWS 16 (Sept. 2003).

Transmission

The conveyance of disease from one organism to another. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Tuberculosis (TB)

A disease caused by infection with the bacterium *Mycobacterium tuberculosis*, which can affect almost any tissue or organ of the body, but most commonly affects the lungs. Primary tuberculosis is typically a mild or asymptomatic local lung infection that in otherwise healthy people does not lead to generalized disease because an immune response arrests the

spread of the bacteria and walls off the zone of infection. The tuberculosis skin test will, however, become positive within a few weeks of infection and remain positive throughout life. Bacteria involved in primary tuberculosis remain viable and can become reactivated months or years later to initiate secondary tuberculosis. Progression to the secondary state eventually occurs in 10-15% of people who have had primary tuberculosis. The risk of reactivation and progression is increased by, *inter alia*, diabetes mellitus and HIV infection and in alcoholics, IV drug abusers, nursing home residents, and those receiving steroid or immunosuppressive therapy. Secondary or reactivation tuberculosis usually results in a chronic, spreading lung infection, most often involving the upper lobes. Rarely, secondary or reactivation tuberculosis results in widespread dissemination of infection throughout the body (miliary tuberculosis). The symptoms of active pulmonary tuberculosis are fatigue, anorexia, weight-loss, low-grade fever, night sweats, chronic cough, and hemoptysis. Local symptoms depend on the parts affected. Active pulmonary tuberculosis is relentlessly chronic and, if untreated, leads to progressive destruction of lung tissue. Tuberculosis ranks first among infectious diseases as a cause of death. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

Tularemia

A disease caused by the bacterium *Francisella tularensis*. Tularemia is characterized by symptoms including sudden fever, chills, headaches, diarrhea, muscle aches, joint pain, dry cough, progressive weakness, and swelling of the lymph nodes. In severe cases, infected persons may develop pneumonia, chest pain, bloody sputum, and respiratory distress. Tularemia is not transmissible through person-to-person contact and is most commonly transmitted to humans from rodents, through the bite of a vector, such as a deer fly, tick, or other bloodsucking insect. Tularemia may also be acquired through the bite of an infected animal, handling of an infected animal carcass, ingestion of contaminated food or water, or inhalation of the bacterium. Tularemia is treatable with antibiotics. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Key Facts About*

Tularemia, at <http://www.bt.cdc.gov/agent/tularemia/facts.asp> (last modified Oct. 7, 2003).

Typhoid fever

An acute infectious disease caused by the bacterium *Salmonella typhi*. Typhoid fever is characterized by a continued fever rising in a step-like curve during the first week of infection, severe physical and mental depression, an eruption of rose-colored spots on the chest and abdomen, swelling of the abdomen, early constipation, and subsequent diarrhea. In severe cases, typhoid fever may produce intestinal hemorrhage or perforation of the bowel. The average duration of typhoid fever is approximately 4 weeks, although aborted forms and relapses are not uncommon. *S. typhi* bacteria live only in humans, and typhoid fever is transmitted through the ingestion of contaminated food and water, most frequently in the developing world. Typhoid fever can be treated and prevented with antibiotics. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); DIV. OF BACTERIAL & MYCOTIC DISEASES, CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., *Typhoid Fever*, at http://www.cdc.gov/ncidod/dbmd/diseaseinfo/typhoidfever_g.htm (last modified Oct. 24, 2005).

Typhus

A group of acute infectious and contagious diseases caused by bacteria belonging to genus *Rickettsia*. Typhus occurs in two principal forms: epidemic typhus and endemic (murine) typhus. Typhus is characterized by severe headaches, shivering and chills, high fever, malaise, and a rash and ranges in duration from short-lived to chronic. Typhus is transmitted to humans by arthropods (e.g., ticks, mites, lice, fleas); transmission rarely occurs from person to person. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); NAT'L CTR. FOR INFECTIOUS DISEASES, CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., HEALTH INFORMATION FOR INTERNATIONAL TRAVEL, 2005-2006, THE YELLOW BOOK, *Rickettsial Infections*, available at <http://www2.ncid.cdc.gov/travel/yb/utills/ybGet.asp?section=dis&obj=rickettsial.htm&cssNav=browseyb> .

U

V

Vector	An invertebrate animal (e.g., tick, mite, mosquito, bloodsucking fly) capable of transmitting an infectious agent among vertebrates. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).
Vertical Transmission	Transmission of a disease agent from an infected individual to its offspring. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006);
Vesicle	A small, circumscribed elevation of the skin, less than 1.0 cm in diameter, containing fluid. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006);
Viral Hemorrhagic Fever	An infectious, epidemic disease caused by a number of different viruses in families including <i>Arenoviridae</i> , <i>Bunyviridae</i> , <i>Flaviviridae</i> , and <i>Filoviridae</i> . Viral hemorrhagic fever simultaneously affects multiple organs within the body and is characterized by high fever, malaise, muscular pain, vomiting, diarrhea, a body rash, organ bleeding, shock, and tremors. In severe cases, viral hemorrhagic fever results in vomiting of blood, hemorrhaging of blood from the eyes and nose, and kidney damage. At least some viral hemorrhagic fevers are transmitted through person-to-person contact, including Ebola, Marburg disease, and Crimean-Congo fever. Many viral hemorrhagic fevers are life-threatening. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006); SPECIAL PATHOGENS BRANCH, NAT'L CTR. FOR INFECTIOUS DISEASES, CTRS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., <i>Viral Hemorrhagic Fevers</i> , at http://www.cdc.gov/ncidod/dvrd/spb/mnpages/dispage/s/vhf.htm (last modified Aug. 23, 2004).
Viremia	The presence of a virus in the bloodstream. STEDMAN'S MEDICAL DICTIONARY (28 th ed. 2006).

Virus

A term for a group of infectious agents that are incapable of growth or reproduction apart from living cells. A complete virus usually includes either DNA or RNA and is covered by a protein shell. Viruses range in size from 15 nanometers to several hundred nanometers. Classification of a virus depends upon its physiochemical characteristics, mode of transmission, host range, symptomatology, and other factors. Many viruses cause disease. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); OXFORD ENGLISH DICTIONARY (2d. ed. 1989).

Vital statistics

Statistics relating to birth, death, marriages, health, and disease. MERRIAM-WEBSTER ONLINE, at <http://www.merriamwebster.com> (last visited Jan. 1, 2006).

W**X****Y****Z****Zoonosis**

A disease transmitted from one kind of animal to another or from animals to humans. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006); OXFORD ENGLISH DICTIONARY (2d. ed. 1989).

Appendix E

Arizona Influenza Pandemic Response Plan – Legal and Other Materials

The Arizona Department of Health Services has developed an Arizona Influenza Pandemic Response Plan, available on the agency’s website at <http://www.azdhs.gov/pandemicflu/index.htm>. This is a useful document, containing many recommendations regarding planning for a major “flu” epidemic.

Among the planning materials are some legal forms and model orders regarding isolation, quarantine, and other matters, based on Arizona law, that were designed for use in connection with influenza. They may be of interest to users of this Judicial Reference Guide. Of course, care should be taken in the use of such forms, given ongoing changes in the law, variations among particular diseases (or other threats), and other circumstances. Nonetheless, a number of items may be of particular relevance. These can be found in Appendix 4 (“Legal Preparedness: Isolation and Quarantine Templates”) to the Plan’s Supplement 8 (“Community Disease Control and Prevention”), beginning on page S8-37 of the document:

- Appendix 4.1: Administrative Quarantine Directive for Public Health Emergencies
- Appendix 4.2: Administrative Isolation Directive for Public Health Emergencies
- Appendix 4.3: Petition for Judicial Order of Compulsory Isolation or Quarantine
- Appendix 4.4: Affidavit in Support of Petition for Compulsory Isolation or Quarantine
- Appendix 4.5: Judicial Order for Isolation or Quarantine
- Appendix 4.6: Verification of Petition for Compulsory Isolation or Quarantine