

## Public Health Law for the 21st Century

*Public health law was neglected and did not keep pace with societal change over time.*

**I**n the United States, 1952 was the worst year for polio.<sup>210</sup> More than 57,000 patients filled hospital wards; most were infants and children. Of the stricken, 3,000 died and 21,000 were left permanently paralyzed.<sup>210</sup> The imagery of polio—iron lungs, the airtight chambers that forced patients’ diaphragms to expand and contract so they could breathe, and March of Dimes posters featuring children in leg braces inspired widespread fear.<sup>211</sup> But all of that changed when a polio vaccine became available. Mass trials of vaccine began in the United States in 1954, and by 1965, fewer than one hundred cases were reported.<sup>212,213</sup> The last US epidemic, which occurred in 1979, was an anomaly:

LAWS JUST ATROPHIED  
BECAUSE THERE WAS NO  
NEED FOR THEM.

Dimes posters featuring children in leg braces inspired widespread fear.<sup>211</sup> But all of that changed when a polio vaccine became available. Mass trials of vaccine began in the United States in 1954, and by 1965, fewer than one hundred cases were

polio struck in an Amish community whose members refused the vaccine that was by then part of the routine childhood immunization schedule.<sup>213</sup>

Gaining control of polio entailed a massive public health effort, but once the threat was eliminated, public health visibility in the realm of infectious diseases decreased, and some laws that public health officials depended on atrophied.<sup>214</sup> Public health officials and workers still had to be able to isolate sick people to protect the healthy from contagious disease, and they still had to be able to order tuberculosis patients to take their medication or be jailed for noncompliance.<sup>215,216</sup> With polio gone, though, so were the once routine signs that declared swimming pools closed, prohibited public gatherings, or restricted travel “By Order of the Board of Health.”<sup>210,211</sup>

After the polio epidemic ended, public health law was neglected and did not keep pace with societal change over time. Decades after the polio era of the 1950s, some states still had laws on their books that granted public health officials tremendous powers to restrict travel, institute quarantine, and order compulsory medical treatment. However, there was no guarantee that those laws would be upheld in an emergency, especially given the Warren Court’s reforms of due process and civil liberties in the 1960s, which opened to challenge the existing broad public health powers.<sup>217</sup>

In a recent interview, Gene Matthews, who served as chief legal advisor to the CDC from 1979 to 2004,<sup>214</sup> suggested that political skill withered along with public health law after the 1950s. He pointed out that public health officials had to be well connected in local politics and politically astute to mount successful mass vaccination campaigns, cancel sporting events, close public facilities, or declare quarantines in the name of disease control. In comparing then and now, Matthews observed that “there was this rich linkage

between the law and public health and between public health and politics, and [then] we went into this era of what's called 'narrow public health.'"<sup>214,218</sup> Explaining further, Matthews added, "We wear white coats, and we do not get dirty with what goes on at the city council, at the county commissioner's office, at the state capital, and anything happening across the Potomac River, so all those laws just atrophied because there was no need for them."<sup>214</sup>

Thus, by 2001 only a handful of states had revised the outdated public health laws on their books,<sup>219</sup> leaving open the possibility that in the event of a health emergency such as a bioterrorism attack, officials would be left without the legal tools needed for response. They could, for instance, find themselves without the legal authority to act quickly and without hindrance to protect the uninfected, treat the infected, prevent the spread of disease, and manage the consequences.

A fortuitous turn of events in late 2000 helped correct this situation. Paula Olsiewski had joined the Sloan Foundation as director of the biosecurity program and began inquiring about the nation's biosecurity needs. After talking with Matthews, Larry Gostin from Georgetown University, and other leaders in the field, she made the foundation's first grants in this area to support projects aimed at updating public health law. As a result, the Sloan Foundation was instrumental in remedying the neglect of public health law that occurred after the end of the polio era and ensuring that laws were updated to meet twenty first century public health needs.



## Modernizing Public Health Powers

### *The Cantigny Conference on State Emergency Public Health Powers and the Bioterrorism Threat*

In January 2001, Olsiewski called Gene Matthews, then chief legal advisor at CDC (now director of the Southeastern Regional Center of the Network for Public Health Law), to ask what help the agency needed to prepare for a bioterrorist attack. At that time, Matthews had on his desk an internal report indicating that at least half of the fifty United States had not updated their emergency preparedness laws since 1930.<sup>214</sup> Matthews's reply to Olsiewski, therefore, was, "We've got a problem with these state laws. Nobody knows how to quarantine, and they don't know if they have the authority. How would they implement them in an emergency situation? We need to educate, and we need to get some people together and talk about it."<sup>214</sup>

Olsiewski agreed, and her first grant as director of the Sloan Foundation's biosecurity program was to underwrite the April 2001 *Cantigny Conference on State Emergency Public Health Powers and the Bioterrorism Threat*. The conference was sponsored by CDC, the American Bar Association Standing Committee on Law and National Security, and the National Strategy Forum. It brought together groups that had not traditionally worked with each other: public health attorneys, national security attorneys, public health officers,

members of the national defense community, academics, and experts from nonprofit organizations.<sup>220</sup>

The conference had four objectives: (1) identify public health powers that would be needed in a bioterrorism event, (2) assess the status of current emergency health powers, (3) determine the gaps in such powers, and (4) develop a framework for future action.<sup>220</sup> Over the two day meeting, participants agreed that many legal authorities for responding to an emergency existed, but many had to be re examined, especially those laws that had been passed fifty to eighty years earlier. They also observed that public health officers in many states could be unaware of the legal authorities they had and lack access to expert legal advice. The conference participants emphasized that, for all states and

jurisdictions, the procedures for rapid public health decision making had to be tested and rehearsed to be effective in an emergency.

IN AT LEAST HALF OF THE FIFTY  
UNITED STATES, EMERGENCY  
PREPAREDNESS LAWS WERE NOT  
UPDATED BETWEEN 1930 AND 2001.

At the close of the session, the Cantigny conference participants declared the actions they would personally take to promote the conference objectives, such as analyzing their state's emergency powers laws or drafting executive orders that political leaders could use in an emergency.<sup>220</sup>

The April 2001 Cantigny conference was followed not long after by 9/11 and the anthrax letters. The day after the first anthrax case was reported, Matthews read that many state legislators were planning to convene the following January (2002) to enact tough new legislation about bioterrorism. "But we had all been thinking about how we get public health statutes revised," he explained. "We needed to channel that energy in a direction

beneficial for public health.”<sup>220</sup> Matthews immediately called Larry Gostin at Georgetown University. Gostin was working on a Sloan funded project to address legal aspects of bioterrorism preparedness and response.

Gostin told Matthews that he had already started compiling a database of all state laws related to emergency powers.<sup>221</sup> Matthews replied that they would need to use that data to create model legislation before the end of the year before the state legislators convened in January 2002 if their work were going to have any impact on policy. Then, Matthews recollected, “Larry [Gostin] asked, ‘What should be the organizing structure?’ and I said, ‘Let’s follow that outline in Appendix A to the Cantigny Report.’”<sup>222</sup>

The Cantigny conference participants had already detailed a long list of public health powers that would be needed in a bioterrorism event. That list became “Appendix A” of the conference report.<sup>220</sup> Those necessary powers included: collection of records and data from hospitals, pharmacies, workplaces, and the like; control of property, to include the ability to close facilities or use them temporarily to provide medical care; management of people, to include instituting isolation or quarantine; and access to communications and public relations, to include the ability to establish a command center. The Cantigny list of public health powers needed in an emergency thus became the basis for the 2001 Model State Emergency Health Powers Act.<sup>223</sup>



## Fortifying Essential Public Health Powers

### *The Model State Emergency Health Powers Act*

In spring 2001, Larry Gostin, global health law professor at Georgetown University and director of the Centers for Law and the Public's Health at Georgetown and Johns Hopkins Universities, initiated what was to be a three year Sloan funded project to address legal aspects of bioterrorism. Gostin and his colleagues intended to use the year one Sloan funding to draft model legislation that would give state and local public health officials appropriate legal powers in a bioterrorism emergency. The tragedies of 9/11 and the subsequent anthrax attacks dramatically sped up the project's timeline: States were demanding it, and CDC needed model legislation quickly because of the great concern about biosecurity that followed the anthrax attacks.

Within weeks, the team charged with drafting the legislation at the Centers for Law and the Public's Health put forward its first version of the Model State Emergency Health Powers Act (MSEHPA). The draft act drew from three primary sources: proceedings from the Cantigny conference;<sup>220</sup> experience with an earlier effort to develop a broad model public health law, which produced the Turning Point Model State Public Health Act;<sup>221</sup> and data on existing state laws that already had been collected by the centers. Once

MSEHPA became public in October 2001, the centers received and addressed hundreds of comments before publishing it on December 21, 2001.<sup>223,224</sup>

MSEHPA gave policymakers a menu of options for granting states the power to conduct five basic public health functions in an emergency: preparedness, surveillance, management of property, protection of

WITHIN TEN YEARS OF MSEHPA,  
TWENTY SIX STATES AND THE  
DISTRICT OF COLUMBIA HAD  
CRAFTED “PUBLIC HEALTH  
EMERGENCIES” INTO THEIR LAWS.

people, and public information and communication.<sup>225</sup> The model act also used the term “public health emergency,” which was defined as an imminent threat that “poses a high probability of . . . a large number of deaths in the affected population;

a large number of serious or long term disabilities in the affected population; or 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.”<sup>223</sup> The drafters’ definition was formulated carefully to trigger public health authorities necessary for a rapid public health response to such threats as anthrax, smallpox, or flu, but to avoid triggering those authorities for other serious but not acute public health threats, such as HIV.<sup>224</sup>

MSEHPA authorizes timely disease reporting and data collection and exchange. During a public health emergency, state and local officials are authorized to use and appropriate property as necessary for the care, treatment, and housing of patients. They are also empowered to provide care, testing, treatment, and vaccination to people who are sick or have been exposed to a contagious disease and to separate infected people from the population at large to interrupt disease transmission. At the same time, the act



recognizes that a state's ability to respond to a public health emergency must respect people's dignity and rights.<sup>225</sup>

The model act was extraordinarily successful. Within five years, thirty nine states had passed bills related to MSEHPA.<sup>224</sup> Within ten years, by 2011, twenty six states and the District of Columbia had crafted “public health emergencies” into their laws.<sup>224</sup> The Turning Point Model State Public Health Act, a tool for state, local, and tribal governments to use in assessing their public health laws and identifying areas in need of update and improvement, had a section based on MSEHPA.<sup>221</sup> On the federal level, HHS was vested with similar “public health emergency” declaration authority through the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.<sup>226</sup> Other nations, including the United Kingdom, Canada, China, India, Australia, and New Zealand, introduced similar legislation. In 2007, the WHO's updated International Health Regulations integrated themes from MSEHPA in its definition of a “public health emergency of international concern.”<sup>224</sup> Most recently, the Institute of Medicine praised MSEHPA in its June 2011 report *For the Public's Health: Revitalizing Law and Policy to Meet New Challenges* and recommended that state and local governments continue to review existing public health laws and modernize them as necessary.<sup>227</sup>

Not everyone applauded the act, though. MSEHPA triggered public debate about the proper balance between personal rights and the common good.<sup>228</sup> Critics objected to compulsory powers to vaccinate, test, medically treat, isolate, and quarantine, even though, in fact, all are standard public health powers. As Gostin wrote in *Health Affairs* in 2002, “The MSEHPA was designed to defend personal as well as collective interests. But in a country so tied to rights rhetoric on both sides of the political spectrum, any proposal

that has the appearance of strengthening governmental authority was bound to travel in tumultuous political waters.”<sup>225</sup> Gostin, who had his American Civil Liberties Union (ACLU) membership card torn up, on television, by the head of that organization, observed that “there was a complete failure to understand the model act, because it actually had very strong safeguards of individual rights while still protecting public health.”<sup>229</sup> All told, though, critics were a tiny minority in the response to the many experts who have described these changes to public health law as ranking “among the most significant public health law reforms in history.”<sup>224</sup>

Gostin acknowledged that if the US experiences another public health emergency like the 2001 anthrax attacks, response would not be perfect, but it would be much better because of MSEHPA: “The model public health law requires preparedness training, which has been funded by the federal government. It gives states more power but also tells them that they must exercise that power within the rule of law. To me, all that suggests that we would have a more effective and more civilized way of dealing with an emergency.”<sup>229</sup>



# Protecting Good Samaritan Organizations

## *Liability Protections for Organizations that Assist in Disaster Response*

Most states have Good Samaritan laws to provide legal protections for *people* acting in good faith who provide assistance in an emergency, and in some states, these protections extend to licensed healthcare practitioners. However, most Good Samaritan laws do not protect *organizations*, including businesses and nonprofits, that assist the government in responding to a disaster. This leaves “significant gaps of liability exposure”<sup>230</sup> that could inhibit organizations from providing assistance in a public health emergency.

Why would an organization need Good Samaritan protection? Because, for instance, a church that offers its facilities for shelter could face liability exposure for disease transmission or other injuries that occur in that shelter, as could an organization that provides food to emergency workers if the workers get sick.<sup>230</sup> Even an organization like the Red Cross would need liability protection should volunteers deployed in a disease emergency get sick.<sup>231</sup> In 2006, with a grant to the North Carolina Institute for Public Health at the University of North Carolina Gillings School of Global Public Health, the Sloan Foundation helped fill this gap in preparedness by supporting establishment of the Good Samaritan Entity Liability Protection Initiative.<sup>232</sup>

With this funding, Gene Matthews and Edward Baker, director of the North Carolina Institute for Public Health, created templates that outlined key elements of Good Samaritan liability protection for businesses and nonprofits like the Red Cross that participate in emergency response.<sup>230</sup> These protections are triggered only when a state declares an emergency, they apply only to emergency activities conducted in coordination with a state agency, and they cover pre event planning and training activities that take place before an emergency is declared.<sup>230</sup>

The initiative's team worked with members of other public health organizations, including the American Public Health Association (APHA), the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and

THERE IS STILL NO FEDERAL  
POLICY FOR GOOD SAMARITAN  
LIABILITY PROTECTION.

the CDC,<sup>230</sup> but it was a series of reports from the organization Trust for America's Health (TFAH) that called the most attention to the issue.<sup>233</sup> Beginning in 2007, TFAH added liability protection to the list of preparedness indicators that the organization used in *Ready or Not? Protecting the Public's Health from Diseases, Disasters, and Bioterrorism*,<sup>233</sup> its annual assessment of states' public health preparedness. Once TFAH reported that many states did not have the appropriate level of Good Samaritan liability protections in place, change occurred. By 2009, thirty three states and the District of Columbia had either enacted the liability laws for entities or made a formal determination that their existing laws provided such protection.<sup>234</sup>

There remains a gap in protection from liability exposure, though, because there is still no federal policy that accords Good Samaritan liability

protections. This means that a nationwide business that was willing to assist the government in a disaster would have to establish different policies in every state instead of relying on a nationwide policy. What has been proposed is a way to ease concerns about liability but still allow claims to be settled. As was described in TFAH's 2009 report,<sup>234</sup> the federal government could apply the provisions of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) to create a national standard for liability protection. The Stafford Act allows the federal government to pay certain costs related to state emergency activities, which means that a lawsuit filed against an organization acting in good faith could be resolved through a state's administrative torts claim mechanism, and the federal government could then reimburse the state for any costs incurred.<sup>234</sup> A federal solution would allow nationwide businesses to have nationwide policies to help the government in a bioterrorism emergency. This important next step in legal preparedness could encourage companies to help the government in the immediate response to an event and could prompt large companies to participate in drills and training with government partners.



## Building Bioterrorism and Public Health Law into Law School Curricula

### *The Pacific McGeorge School of Law's Curriculum Updates*

In March 2003, the University of the Pacific McGeorge School of Law held the Sloan funded two day workshop Creating a Model Syllabus for Bioterrorism and Public Health Law. “Bioterrorism and national security were certainly on people’s mind,” observed law professor Leslie Gielow Jacobs, director of the Capital Center for Public Law and Policy, who organized the meeting with her colleagues J. Clark Kelso and law school dean Elizabeth Rindskopf Parker.<sup>235</sup> Since 2003, SARS, pandemic flu, and ongoing concern about smallpox and other pathogens have kept biosecurity issues salient in public health law and have confirmed the relevance of the conference. Explained Jacobs: “The importance of the subjects discussed in this conference has become more obvious because of the wars, claims of bioterrorism, concerns about dual use research and civil liberties, and the intersection between individual rights and the right of the state to protect national security.”<sup>235</sup>

Law professors, lawyers, and public health practitioners from around the country attended the workshop,<sup>236</sup> which aimed to encourage and

facilitate teaching and scholarship in the nation's law schools related to bioterrorism and public health.<sup>237</sup> Participants created four model syllabi and sets of teaching problems, all still posted on the McGeorge bioterrorism website.<sup>237</sup> The model syllabi are composed of discrete units so professors can incorporate public health law materials into other regular courses in the law school curriculum, including constitutional law, criminal law, and torts.

In June 2003, Jacobs compiled the four class teaching module "Bioterrorism, Infectious Diseases and Constitutional Rights," which is still available by request at the same McGeorge website. The module covers constitutional implications of quarantine and vaccination and free speech and national security limits on disseminating dangerous information. It was distributed to all American Bar Association law schools.

IT IS IMPORTANT TO THINK  
ABOUT LEGAL ISSUES AND LEGAL  
STRUCTURES BEFORE  
EMERGENCIES HAPPEN.

McGeorge encouraged law schools to use the workshop materials in their courses, and nineteen schools have requested information on the curriculum. In 2003, the McGeorge participants worked on creating the National Security Law Section that was inaugurated in January 2004 within the Association of American Law Schools.<sup>235</sup> In 2004, McGeorge also published the first issue of the *Journal of National Security Law and Policy*, which has published articles on laws pertaining to bioterrorism and infectious disease.<sup>238</sup>

Jacobs believes that graduates who work in policymaking positions will have an advantage if they understand biosecurity and public health issues. She believes that efforts to update law school curricula to include these issues "developed awareness that people took home that likely caused them

to infuse public health issues into their law school teaching. The message delivered and received was that it's important to think about legal issues and legal structures before emergencies happen."<sup>235</sup> This, too, is an important part of modernizing public health law for the twenty first century.

