

Crisis in the Making: What's Wrong with Pennsylvania Public Health Law

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Acknowledgement

The author would like to extend his gratitude to the Hon. John M. Cleland, President Judge of McKean County and a national advocate for a broader understanding of the role of the judiciary in matters of public health, for his critical and most insightful review of this manuscript.

There are few areas of government enterprise where the need to “get it right” is so critical as formulating and executing laws affecting the public health. When the government sets out to exercise its police power¹ to control the spread of disease, its goal is to accomplish an immensely important practical task and its success is to a great degree objectively determinable; the spread of disease is either curtailed or not. However, the manner in which the government’s goal is reached reflects not only its pragmatic concerns but also a society’s political, social and legal values.

Recent attention to matters of public health in the area of infectious disease has brought to the fore both the nature and effectiveness of the federal government’s response to incidents of contagious disease both actual and anticipated. In 2003, Severe Acute Respiratory Syndrome (SARS), a contagious viral disease, seemed to rapidly spread throughout a number of countries, including Canada and to a lesser degree the United States (Centers for Disease Control 2003; Mason 2003; Reich 2003). Beginning in 2003 with reports of outbreaks in various parts of the world, much attention has been focused on what is generally referred to as “bird flu” and commonly identified as avian influenza. There are a number of variants of avian flu virus but the H5N1 virus has caused the most concern among public health officials with regard to transmission

to humans (Centers for Disease Control and Prevention 2008; O'Leary 2006; Pennsylvania Department of Health 2008).² It was widely suggested that should an outbreak of the bird flu materialize, it could lead to a worldwide epidemic or as it was described, a "pandemic," and result in a great loss of human life (MSNBC 2005; Centers for Disease Control and Prevention May 28, 2008). This concern led to considerable activity among public health officials throughout the world and was the subject of intense attention in the federal government's public health community largely centered at the Centers for Disease Control. Gratefully, no worldwide outbreak, or for that matter, even a significant local outbreak, of bird flu in humans in the United States seems to have developed and anecdotally, there seems to have been a noticeable diminution of public attention to the pandemic issue (Centers for Disease Control and Prevention 2008).

Most recently the public's attention has been brought to bear on the activity of an American whose wedding celebration was interrupted by an international incident precipitated by his contraction of tuberculosis. Andrew Speaker's reported failure to adhere to a United States government request to refrain from international airline travel resulted in a great deal of attention to the potential risks associated with an individual's reluctance to refrain from public interaction in circumstances where he or she has a serious, perhaps life-threatening communicable disease (Schwartz 2007). While Mr. Speaker eventually complied with a federal government request for isolation and treatment, and it was ultimately determined that the government's belief that he had the most drug resistant form of tuberculosis was wrong, the episode brought to the public light the difficulties that the government may encounter when trying to curb a perceived public health threat.

While the public's attention to both episodes has diminished and government's concern for an imminent outbreak of a human bird flu pandemic has moved off the front page, each has served as a much-needed impetus for the examination of the sufficiency of public health law and policy. From both a practical and legal perspective, public health is one of those areas of human endeavor that tends to receive attention only when things are going badly. Indeed it is the absence of experience, and in particular recent experience, that makes preparation for a public health crisis so challenging and what, quite understandably, results in a largely untested legal framework replete with unanswered

questions and therefore the potential for considerable confusion (Batlan 2007).³

This article is intended to highlight significant legal issues associated with the current state of public health law in Pennsylvania that may have adverse practical consequences on the government's ability to effectively respond to a public health crisis. While the need to update state public health laws has long been recognized (see generally, Gostin, Burris and Lazzarini 1999), there has been almost no movement in that direction in Pennsylvania. Revisions to Pennsylvania law are necessary to assure that the response to a perceived public health emergency is not impaired by legal uncertainty and that citizens are protected from arbitrary government action. Perhaps it will be accomplished before the crisis begins.

Although Pennsylvania's public health law framework is the focus of discussion, it is likely that the issues that are addressed have some applicability in other state jurisdictions and the federal government. Indeed there is an ongoing concern about the interrelationship between federal and state authority in the public health law arena, especially as it applies to the spread of communicable disease. Although recent public health events have served as a reminder of the potential need for a coordinated national and ideally an international effort, to curb threats to the public health, the vital role of state and local governments in this area of the law and public policy has long been recognized (Gostin, Burris and Lazzarini 1999; Weeks 2007).⁴ And given the overlapping jurisdiction of state and federal governments in such important matters as ordering quarantines, the need for well-conceived state statutes will remain a compelling consideration for state legislatures (Batlan 2007, 59; Chen 2005).⁵ It must also be recognized that although there have been efforts to formulate model acts (Gostin et al. 2002; Turning Point Model State Public Health Act 2003), these initiatives have not been without significant criticism and may well have some of the same limitations as are addressed below (Chen 2005, 168-173).⁶

With that backdrop, it is this author's objective to critically review Pennsylvania's public health law using a conceptual methodology that focuses on the practical consequences of flaws in legislative enactments and administrative regulations that may limit the effectiveness of the government's response to a public health crisis or unduly complicate it.

In that regard it is suggested that any review of public health law requires, at a minimum, consideration of three key questions: 1) Which agencies or officials, collectively referred to as a Public Health Authority (PHA), are authorized or required to take action to prevent or control disease? 2) Under what circumstances can a PHA take action? 3) What steps may a PHA take to respond to such a public health concern? While these inquiries serve as the framework for this analysis, they by no means constitute a comprehensive scrutiny of public health law. In particular, the issue of how a PHA enforces its directives through the judicial process is not addressed and this is ultimately a matter of critical importance left for another day (Daubert 2007; Chen 2005, 165, 186-190).⁷

The Current State of Pennsylvania Public Health Law

There are three primary sources of public health law in Pennsylvania that deal with the control of communicable disease: 1) The Disease Prevention and Control Law of 1955 (DPCL; 35 P.S. §511 et seq.); 2) The Counterterrorism, Planning, Preparedness and Response Act ("Counterterrorism Act;" 35 P.S. §2140 et seq.); and 3) Pennsylvania Health Department regulations set forth in 28 Pa. Code §27.1 et seq. The DPCL includes a broad authorization for the State Advisory Health Board (Board) to issue rules and regulations concerning the prevention and control of both communicable and non-communicable diseases [35 Pa. Stat. Ann. §521.16(a) 1-12]. Very few have been promulgated and so there is much about the application of the DPCL that remains uncertain. And those rules that have been formulated are more on the order of broad mandates rather than narrow prescriptions for government action. Moreover, the DPCL also allows certain municipalities to enact ordinances and regulations concerning the control and prevention of disease so long as they are not "less strict" than the provisions of the DPCL or rules and regulations [35 Pa. Stat. Ann. 521.16(c)].⁸ This exercise in limited state preemption sets the stage for considerable conflict and disparity. Finally, case law interpreting or applying the key provisions of both the statutes and health department regulations is entirely absent.

Generally in Pennsylvania, local and state governments have been delegated the responsibility of controlling the spread of disease and have

been given broad discretionary authority to carry out their mandate. Specifically, the DPCL provides as follows:

Responsibility for disease prevention and control. --

(a) Local boards and departments of health shall be primarily responsible for the prevention and control of communicable and non-communicable disease, including disease control in public and private schools, in accordance with the regulations of the board and subject to the supervision and guidance of the department.

(b) The department shall be responsible for the prevention and control of communicable and non-communicable disease in any municipality which is not served by a local board or department of health, including disease control in public and private schools (35 Pa. Stat. Ann. §521.3).⁹

The Counterterrorism Act takes a markedly different approach from the DPCL. While its public health provisions are also intended to limit the transmission of a contagious or potentially contagious disease, it largely relies on the authority of the governor rather than local officials to take action (35 Pa. Stat. Ann. §2140.301). In addition, it is based on the Model State Emergency Health Powers Act (MSEHPA) and its focus is multifaceted with limited attention devoted to contagious disease or epidemic. Furthermore, because government action is limited to circumstances involving a bioterrorist or biohazardous event, and neither term is defined, there is considerably less certainty in the 35 Pa. Stat. Ann. as to both the conditions that may give rise to government action and the character of the government's response.

The health department regulations add little to the clarification of the issues noted above with regard to the locus of responsibility for the public health decisions required by either the DPCL or the Counterterrorism Act.

Who Can Take Action?

Government attempts to prevent the spread of communicable disease may very well necessitate action that significantly interferes with individual liberty and must always be based on sound judgment predicated on a high degree of scientific acumen. In turn, the

government's action has to be sufficiently accepted by the public to assure meaningful compliance and thus limit the scope of a public health threat. In such circumstances, clearly identifying the agencies or officials that are empowered to act to protect the public health is of critical importance. At a time of heightened public concern, not knowing who precisely is authorized to make potentially life-altering decisions, such as directing isolation or quarantine, or mandating diagnosis and treatment, could result in delayed or faulty action, potentially contradictory positions on the nature of the danger posed, or what must be done to respond to it, and a reluctance on the part of the community to follow directives or to accept the government's position. In this regard, Pennsylvania law presents significant issues.

The DPCL

In general, the DPCL specifies that certain local governmental entities have the responsibility to act "for the prevention and control of communicable and non-communicable disease" (35 Pa. Stat. Ann. §521.3). These PHA's are identified as "local boards and the departments of health" (35 Pa. Stat. Ann. §521.3). They are in turn defined as "(t)he board of health or the department of health of a city, borough, incorporated town or township of the first class, or a county department of health, or joint county department of health" (35 Pa. Stat. Ann. §521.2). In circumstances where a municipality is not served by one of these entities, the state Department of Health (the "department") is responsible for this mission (35 Pa. Stat. Ann. §521.3b).

There is, however, an important caveat to the exercise of public health responsibilities by a local PHA. The DPCL requires that a local PHA is "subject to the supervision and guidance" of the state Department of Health suggesting that it is the state Department of Health that is the true decision-maker [35 Pa. Stat. Ann. §521.3(b)]. This begs the question as to whether the Department can either compel a local authority to act or forbid it from doing so or alternately simply shape the character of a local PHA's response to a public health issue. This role ambiguity has the potential for leading to divergent positions or strategies and diminishing the public's confidence in decision-makers.

In addition, the DPCL provides that in certain instances, designated individuals are authorized to take action. Specifically the DPCL refers to "local health officer," "a local qualified medical health officer," "the

local medical health officer,” and the Secretary of Health as persons who can carry out activities set forth in the act. For example, §521.7 directs that “a local qualified medical health officer” require an infected person “to undergo a medical examination and any other approved diagnostic procedure” (35 Pa. Stat. Ann. §521.7). This person also has the authority to cause an individual who refuses examination or diagnosis to be quarantined (35 Pa. Stat. Ann. §521.7). However, it is left entirely to speculation as to who qualifies as “a local qualified medical health officer.” There is similar uncertainty regarding the identity of “the local medical health officer” who is authorized to isolate an infected person who refuses treatment (35 Pa. Stat. Ann. §521.11).¹⁰ A “local health officer” is defined as the head of a local department of health (35 Pa. Stat. Ann. §521.2). No definition of the other designations is provided (35 Pa. Stat. Ann. §521.2). Although not defined, the reference to the Secretary of Health is apparent.

The Counterterrorism Act

Under the Counterterrorism Act this issue is far less complicated. In circumstances involving a public health emergency, the governor is designated as the primary decision-maker and is authorized to temporarily isolate or quarantine an individual or group under specified circumstances [35 Pa. Stat. Ann. §2140.301(a)]. Moreover, the “department or local health department” is authorized to petition the court for continuing isolation or quarantine [35 Pa. Stat. Ann. §2140.301(b)]. Both terms are defined. The “department” is defined as the Commonwealth Department of Health, and “local health department” as a county department of health under the Local Health Administration Act or certain municipal health departments (35 Pa. Stat. Ann. §2140.102).

Health Department Regulations

Under the regulations promulgated pursuant to the DPCL, action to protect the public health may be taken by either the Department of Health or by a “local health authority” which in turn is defined as “a county or municipal department of health, or board of health of a municipality that does not have a department of health. The term includes a “sanitary board” (28 Admin. Code, §27.1). In that respect the regulations are similar to the provisions of the DPCL. It is noteworthy, however, that the regulations require that if a local health authority

(LHA) is not a local morbidity reporting office (LMRO), the LHA must consult with the department before acting in certain instances.¹¹ This provides some clarification about the circumstances when the Department must become directly involved in decision-making under the DPCL although there is no indication as to whether the duty to consult also requires a LHA to follow the Department's advice.

Under What Circumstances May a PHA Act?

The government's ability to take steps to protect the public health must be triggered by an event or circumstance implicating the prospect of a health risk. Both the DPCL and the Counterterrorism Act set forth criteria by which a public health authority (PHA) or the governor must determine the need for action. Unfortunately, both statutes suffer from a lack of precision in this area and a tendency, particularly with the DPCL, to afford a PHA broad discretion in defining the circumstances under which action must be taken.

The DPCL

Under the DPCL, a PHA may be required to take action when it receives "a report of a disease which is subject to isolation, quarantine, or any other control measure" (35 Pa. Stat. Ann. §521.5). Although the Act does not specify which diseases are subject to "control measures" a fair reading of the statute leads to the conclusion it must be a "... a venereal disease, tuberculosis or any other communicable disease" (35 Pa. Stat. Ann. §521.2).¹² Communicable disease is broadly defined as:

An illness due to an infectious agent or its toxic products which is transmitted, directly or indirectly, to a well person from an infected person, animal or arthropod, or through the agency of an intermediate host, vector of the inanimate environment [35 Pa. Stat. Ann. §521.2(c)].

Venereal disease is not defined.¹³ There is no further delineation of the characteristics of an "illness" that allow or require action. Specifically there is no requirement that the illness be serious or life threatening or rise to some level of contagion except that with regard to the isolation of an "infected" person, the disease must be in a "communicable stage" [35 Pa. Stat. Ann. §521.11(a)].¹⁴ (For the

purposes of this discussion, communicable disease includes tuberculosis but not venereal diseases. Both the DPCL and the regulations have a number of separate provisions applicable only to sexually transmitted diseases.)

The threshold issue is whether a PHA is compelled to act in a particular manner or whether its actions are discretionary and therefore more subject to disparity and perhaps, arbitrariness. In this regard, the DPCL has divergent and perhaps conflicting provisions. Directive language is utilized with regard to a PHA's general responsibility under the Act. Section 521.5 provides:

Upon the receipt by a local board or department of health or by the department ... a report of a disease which is subject to isolation, quarantine, or any other control measure, the local board, department of health or the department shall carry out the appropriate control measures in such a manner and in such a place as is provided by rule or regulation.

While the need to act as prescribed by rule is unequivocal, there is obviously room for the exercise of discretion in selecting a control measure.¹⁵ This flexibility may be intended to accommodate the demographic and resource diversity of counties and municipalities.

Further indication of the directive orientation of the DPCL is found in §521.7, relating to examination and diagnosis, which provides that whenever a PHA has "reasonable grounds to suspect any person being infected ... or being a carrier..." the PHA shall require the person "to undergo a medical examination or other approved diagnostic procedure." In this circumstance it is apparent that a PHA has no choice but to test persons it reasonably suspects as having a communicable disease.

The discretionary nature of a PHA's responsibility is exemplified by §521.11(a.1), which provides that a PHA "may cause" a person who is infected with a communicable disease including a venereal disease to be isolated in an appropriate institution. While directed to take "control measures" under §521.5, the applicable PHA is not obligated to select any one in particular and is not required to either isolate or quarantine a person infected with a disease in a communicable stage. Moreover, if it chooses to isolate an individual, the PHA has the discretion to select an "appropriate institution" [35 Pa. Stat. Ann. §521.11(a.1)].

Finally, it is not clear under the DPCL whether a PHA is required to compel treatment for one diagnosed with a communicable disease. There is no provision in the Act that specifically sets forth such a requirement. However, if it does require treatment, the character of the treatment is within its discretion as the Act only refers to “treatment approved by the department or by a local board or department of health” (35 Pa. Stat. Ann. §521.2). Additionally, as will be discussed below and as would be expected, there is no discrete time limitation on how long a person may be subject to isolation by a PHA as the DPCL provides that isolation may last until a disease is rendered non-communicable (35 Pa. Stat. Ann. §521.2).

The Counterterrorism Act

As noted above, it is the governor who is the prime actor under the 35 Pa. Stat. Ann. and who is authorized to act only in a case of “an actual or suspected outbreak of a contagious disease or epidemic due to an actual or suspected bioterrorist or biohazardous event” [35 Pa. Stat. Ann. §2140.301(a)]. The governor’s actions are broadly discretionary, as the Act does not define any of these terms while providing that he or she “may” isolate or quarantine an individual or group [35 Pa. Stat. Ann. §2140.301(a)]. The failure to define the terms “biohazardous” and “bioterrorist” opens the door to a considerable range of scenarios that could give rise to action by the governor. On the other hand, the statute limits the governor’s ability to act to circumstances where waiting for a PHA to pursue authorization for quarantine or isolation through judicial proceedings currently available, would jeopardize the Department’s ability to prevent or limit the transmission of a contagious or potentially contagious disease [35 Pa. Stat. Ann. §2140.301(a)].

Perhaps most notable, the governor’s written order for isolation or quarantine can only last until a court reviews the matter and determines whether such an order shall continue. The government must file a petition for court review within 24 hours or the next business day following the governor’s order and a hearing must be conducted within 72 hours of the filing of the petition. The court is authorized to extend the governor’s order up to 30 days.

Health Department Regulations

Under the regulations, a PHA is authorized to engage in control measures when a person has a communicable disease or infection and it is "... necessary to protect the public from the spread of infectious agents" [28 Pa. Admin. Code §27.60(a)]. The definition of communicable disease is different from that provided in the DPCL:

An illness which is capable of being spread to a susceptible host through the direct or indirect transmission of an infectious agent or its toxic product by an infected person, animal or arthropod, or through the inanimate environment (28 Pa. Admin. Code §27.1).

Here the illness has to be one that "is capable of being spread to a susceptible host" while under the DPCL the language is arguably more limiting, requiring that the illness from an infectious agent be "transmitted, directly or indirectly, to a well person from an infected person..." [35 Pa. Stat. Ann. §521.2(c)]. While it is not clear what the term "susceptible host" encompasses, ostensibly it would include more than humans and thus the range of diseases subject to control measures under the regulations would likely extend to illnesses that are either confined to animals or transmitted from humans to animals. This interpretation is reinforced by §27.60 that provides that a PHA shall direct the isolation of "a person or *an animal*" with a communicable disease or infection (28 Pa. Admin. Code, §27.60(a); emphasis added).

The rules also potentially broaden a PHA's authority to act by requiring the government to take control measures when a person or animal has a communicable "infection," as opposed to a communicable disease. The legal distinction between disease and infection is not evident and needs to be clarified. While it is possible to speculate that "infection" relates to a situation where one is carrying an "infectious agent" without overt symptomology, it is by no means apparent that this is the distinction intended by the Board. It is important to recognize that under the rules, a PHA is required to take specified actions when necessary to protect the public from the spread of both communicable diseases or infections. The discretionary nature of a PHA's authority under the regulations focuses on a determination of what is needed to protect the public and then directing isolation, surveillance, segregation, quarantine or modified quarantine or any other control measure it deems appropriate [28 Pa. Admin. Code §27.60(a)].

What May a PHA Do to Respond to a Public Health Concern?

Ultimately what really matters in a public health crisis or potential crisis is the government's ability to require individuals or entities to do things that reduce the likelihood of the spread of disease. When a potential public health problem emerges, the government's response is obviously intended to have a practical benefit. Therefore the measure of effectiveness of a public health statute resides in its ability to provide a PHA with the tools necessary to respond to an outbreak of a communicable disease while at the same time limiting the likelihood of arbitrary actions. In that regard, Pennsylvania public health statutes have significant limitations. In general there is broad authority vested in public health officials, particularly with regard to isolation and quarantine directives. There is no requirement in either the DPCL or the Counterterrorism Law that the government adopts the control measure least restrictive of individual liberty, to effectuate public health objectives.

The DPCL

In general the DPCL provides that a PHA may use "appropriate control measures in such a manner and in such a place as provided by rule or regulation" (35 Pa. Stat. Ann. §521.5). Although the term "control measures" is not defined, §521.5 makes reference to taking steps to respond to "a disease which is subject to isolation, quarantine, or any other control measure" (35 Pa. Stat. Ann. §521.5). Implicitly, isolation and quarantine are authorized control measures. Moreover, a subsequent section of the DPCL provides that a PHA must require a person to submit to a medical examination (35 Pa. Stat. Ann. §521.7). It is also apparent that a PHA has the authority to at least request an infected person undergo treatment (35 Pa. Stat. Ann. §521.11).¹⁶ No other control strategies are described or even referred to in the Act.

While the DPCL does provide some limited guidance, the manner in which and place where control measures may be carried out are issues explicitly left to rule making (35 Pa. Stat. Ann. §521.5). Unfortunately, the regulations promulgated by the State Advisory Health Board do not materially clarify either of these questions and, with the exception of authorizing "placarding," do not expand the list of acceptable control measures.

1. Isolation. Under the DPCL, isolation is defined as:

The separation for the period of communicability of infected persons or animals from other persons or animals in such places and under such conditions as will prevent the direct or indirect transmission of the infectious agent from infected persons or animals to other persons or animals who are susceptible or who may spread the disease to others. [35 Pa. Stat. Ann. §521.2(e)]

It is directly authorized in only one instance where a person is infected with a communicable disease in a communicable state and refuses to submit to treatment. In that circumstance, either the secretary of the department or the local health officer “may cause the person to be isolated in an appropriate institution” (35 Pa. Stat. Ann. §521.11). In no other instance is isolation, as defined in the DPCL, explicitly authorized.

It is apparent the PHA has broad discretion with regard to isolation in two respects. First, it is entirely up to the PHA to determine what is an appropriate institution and second, the PHA must determine when the infected person has been rendered non-communicable. In circumstances where the disease in question is a venereal disease, the DPCL specifically provides that the person may be “received” by a county jail [35 Pa. Stat. Ann. §521.11(b)]. Otherwise there is no designation as to an appropriate place, nor are there criteria for determining what may be an appropriate location. Further, there is no time limitation.

There is also no provision for the isolation of someone who is infected but who has agreed to treatment. In this circumstance, a PHA may be able to proceed under the quarantine provision as described below or under the “any other control measure” provision of §521.5.

2. Quarantine. The DPCL provides that the Secretary of the Department of Health or the local “qualified medical health officer” may require that a person who refuses to be examined be placed in quarantine. Quarantine is defined under the Act as:

The limitation of freedom of movement of persons or animals who have been exposed to a communicable disease for a period of time equal to the longest usual incubation period of the disease in such manner as to prevent effective contact with those not so exposed. Quarantine may be complete, or, as defined below, it may

be modified, or it may consist merely of surveillance or segregation.¹⁷ [35 Pa. Stat. Ann. §521.2(i)]

The period of the quarantine may last until it is determined that the person is not infected or a carrier of the disease. There is no other time limitation. A person who refuses to be examined may be “committed by the court to an institution determined by the Secretary of Health to be suitable for the care of such cases” (35 Pa. Stat. Ann. §521.7). This suggests that a PHA is without authority to require institutional commitment on its own.

There are no specific guidelines for the use of quarantine, nor does the DPCL list the type of quarantine measures that may be taken. However, given the very broad definition of the term in the Act, it is apparent that the range of possibilities is considerable. The notion that a quarantine may be carried out “in such a manner as to prevent effective contact with those not so exposed” [35 Pa. Stat. Ann. §521.2(i)] suggests that the only criteria for selecting the form of the measure is its effectiveness in preventing contact. Contrary to the implication of the right of the PHA to seek a court ordered commitment discussed above, this would seem to connote isolation as an option. Importantly, the DPCL does not require that a PHA or the court limit its selection to the alternative that is the least restrictive of the individual’s liberty.

3. Involuntary examination. The DPCL provides that a PHA may require a person who it reasonably suspects is infected or a carrier of a communicable disease “to undergo a medical examination and any other approved diagnostic procedure” (35 Pa. Stat. Ann. §521.7). If the person refuses, then a PHA, limited to either the secretary of the department or the “local qualified medical officer,” may cause the person to be quarantined (35 Pa. Stat. Ann. §521.7). The quarantine may last until it is determined that the person is not infected or a carrier. Alternatively, either person may petition the Court of Common Pleas seeking an order to compel the examination. Unlike the PHA who compels quarantine, the Court must find that the person refused to be examined for no valid reason before ordering an examination or subsequently committing the person to an institution “determined by the Secretary of Health to be suitable for the care of such cases.”¹⁸

4. Involuntary treatment. There is no provision of the DPCL that authorizes a PHA to require treatment. However, there is certainly an

implication in §521.11 that a PHA may request it. It is not clear just how far it may go in ultimately coercing it. The stated remedy provided in §521.11 for refusing treatment is isolation “in an appropriate institution ... until the disease has been rendered non-communicable.” This may be accomplished through court action. If a person refuses treatment, a PHA is authorized to petition the Court of Common Pleas and the Court, after a hearing, may commit the person to an appropriate institution (35 Pa. Stat. Ann. §511(a.2)).

Of potential practical significance is the Act’s provision that certain forms of spiritual healing constitute acceptable treatment. Section 521.11(a.3) expressly approves of such treatment:

...it is understood that treatment approved by the department or by the local board or department of health shall include treatment by a duly authorized practitioner of any well recognized church or religious denomination which relies on prayer or spiritual means alone for healing: Provided, however, that all requirements relating to sanitation, isolation or quarantine are complied with. [3 Pa. Stat. Ann. §521.11(a.3)]

This section seems to suggest that where spiritual treatment has been chosen by an infected person, a PHA is authorized to use other control measures including isolation. This appears to be contrary to the language set forth in §521.11(a) that the PHA may cause a person to be isolated when treatment is refused.

The Counterterrorism Act

1. Isolation. The term is not defined in the Act but the governor is authorized to temporarily isolate a group or individual suspected of having or actually having a contagious disease due to an actual or suspected bioterrorist or biohazardous event. The governor may only order isolation if going through judicial proceedings “currently available” would cause a delay that would prevent or limit the PHA’s ability to prevent or limit transmission of a contagious or potentially contagious disease to others [35 Pa. Stat. Ann. §2140.301(a)]. If the governor proceeds without judicial authorization, he or she must petition the court within 24 hours and after a hearing, the court may order continued isolation for 30 days with additional isolation authorized, if warranted, upon further review.

2. Quarantine. The term is not defined in the Act. The Act makes no distinction between isolation and quarantine and it would appear that the government's authority with regard to quarantine is the same as isolation. As with isolation, a governor's order is subject to judicial review [35 Pa. Stat. Ann. §2140.301(a)].
3. Involuntary examination. There are no provisions related to this issue in the Act.
4. Involuntary treatment. There are no provisions related to this issue in the Act.

Health Department Regulations

The DPCL's "control measure" approach to the spread of communicable disease is further developed in the regulations. Section 27.60(a) provides that a PHA:

... shall direct ... any other control measure the Department or the local health authority considers to be appropriate for the surveillance of the disease, when the disease control measure is necessary to protect the public from the spread of infectious agents.

Section 27.60(b) further provides:

The Department and local health authority will determine the appropriate disease control measure based upon the disease or infection, the patient's circumstances, the type of facility available and any other available information relating to the patient and the disease or infection.

1. Isolation. The definition is, in all material respects, identical to that set forth in the DPCL. Contrary to the DPCL, the regulations seem to require that a PHA isolate a person who has a communicable disease. Section 27.60 provides that the PHA "shall direct the isolation of a person or an animal with a communicable disease or infection" (27 Pa. Admin. Code §27.60). The regulations provide little guidance as to the proper place for isolation but §27.61 suggests that forms of isolation other than institutionalization may be appropriate by requiring that instructions be given to specified persons "defining the area within which the case is to be isolated and identifying the measures to be taken to prevent the spread of the disease" [35 Pa. Stat. Ann. §27.61(3)].¹⁹

Section 27.87 provides that a PHA shall isolate a person infected with a communicable disease who refuses treatment in an appropriate institution, “if it determines the action advances public health interests” [35 Pa. Stat. Ann. §27.87(a)]. Although the character of the institution is not precisely defined, it must be an institution designated by the PHA and the isolation is to continue until the person is rendered non-communicable. The rules also provide that the PHA may release an individual from isolation when it determines the person no longer presents a threat to the public health (35 Pa. Stat. Ann. §27.68).

There are special isolation rules for persons infected with tuberculosis. A person who is suspected of having tuberculosis is to be kept in his or her residence if facilities for isolation are available there and the person accepts the isolation (35 Pa. Stat. Ann. §27.161).²⁰ If isolation in the person’s residence cannot be accomplished, then isolation is to occur in a manner as contemplated for other communicable diseases [35 Pa. Stat. Ann. §27.161(2)].

2. Quarantine. Under the rules, the definition of quarantine is similar but not identical to that found in the DPCL. As with isolation, the regulations require that a PHA shall direct the “... surveillance, segregation, quarantine or modified quarantine of contacts of a person or an animal with a communicable disease or infection” [35 Pa. Stat. Ann. §27.60(a)]. However, the rules also ascribe to a PHA broad discretionary authority by providing that a PHA “shall determine which contacts shall be quarantined, specify the place to which they shall be quarantined, and issue appropriate instructions” (35 Pa. Stat. Ann. §27.65). The regulations also provide that a person under quarantine may be moved from one place to another as otherwise provided under §27.67, ostensibly to avoid contacts with others (35 Pa. Stat. Ann. §27.1ii).²¹

There is one material difference in the definition that could significantly affect the duration of quarantine. The definition in the regulations states that a quarantine may last for “a period of time equal to the longest usual incubation period of the disease, or *until judged non-infectious by a physician*” (35 Pa. Stat. Ann. §27.1ii; emphasis added). The highlighted language does not appear in the DPCL and is not further explained in the regulations. By simply referring to “a physician” it raises the prospect that the opinion of any physician, not withstanding the expression of a contrary view or for that matter an incorrect conclusion,

may control the decision of the PHA. Moreover, the failure to adopt a more exacting standard sets the stage for potential conflict between a patient's physician and the government's physician. It also denotes that moving beyond the incubation period and being "non-infectious" are not necessarily synonymous. Apparently the regulations contemplate that one can be non-infectious prior to the conclusion of the period or perhaps continue to be infectious following the incubation period. This is obviously a matter of scientific determination and thus the opinion of an appropriate expert regarding this matter would to be essential.

3. Involuntary examination. The authority of a PHA to require testing under the regulations is similar to the DPCL. Whenever a PHA has reasonable grounds to suspect that a person has been infected with an organism causing a communicable disease, it may require the individual to submit to a medical examination and "any other approved diagnostic procedure" (35 Pa. Stat. Ann. §27.81). If the person refuses, the PHA may cause the person to be quarantined until "it is determined that the person does not pose a threat to the public health ..." [35 Pa. Stat. Ann. §27.82(a)]. As with the DPCL, the rules authorize a PHA to petition the court in circumstances where the person refuses a quarantine directive, and the court, following a hearing, may commit an individual who continues to refuse, to an institution determined by the state Department of Health to be suitable to care for such individuals [35 Pa. Stat. Ann. §27.82(b)(2)(c)]. Also consistent with the DPCL, a person ordered by the court to be examined may be examined by a physician of his or her own choosing (35 Pa. Stat. Ann. §27.83).

4. Involuntary treatment. Section 27.88 allows the PHA to order certain individuals to undergo preventative therapy, that is, therapy designed to prevent a disease from reverting to a communicable stage:

If the disease is one which may be significantly reduced in its communicability following short-term therapy, but is likely to significantly increase in its communicability if that therapy is not continued, such as tuberculosis, the Department or local health authority may order the person to complete therapy which is designed to prevent the disease from reverting to a communicable stage, including completion of an inpatient treatment regimen [35 Pa. Stat. Ann. §27.87(a)(1)].

The form of treatment for a communicable disease is not otherwise specified. Like the DPCL, the regulations allow the PHA to petition the court in the event that an individual refuses treatment and, although the court after a hearing shall upon finding that the person has refused treatment “issue an appropriate order,” nothing in the regulations state that the court can compel treatment.

Issues of Compelling Concern: A Summary

Delineating Clear Lines of Authority and Responsibility

In a time of a real or potential crisis, knowing which governmental authority or individual is authorized to act and, perhaps more significantly, who has the responsibility to act, is of paramount importance. The DPCL and related regulations need to be clarified to assure that decision-making will not be stymied by uncertainty about who has the authority to do what. The DPCL does not sufficiently differentiate the authority of local public health authorities from that of the Department. As noted above, the Act does not indicate whether the Department has veto power over decisions of local public health authorities. Although the Department is designated as a supervisor who provides guidance to a local PHA, neither the DPCL nor the regulations give precise parameters to that role. Consider that the DPCL unequivocally states that primary responsibility for prevention and control of communicable disease resides with “(l)ocal boards and departments of health.” This ambiguity gives rise to the prospect of perhaps contradictory decisions with potentially disastrous results. There is some safeguard provided by the DPCL’s provision that if the secretary of the state Department of Health determines that the local PHA’s “disease control program” is so inadequate that it constitutes a “menace to the health of the people,” he or she may appoint agents to carry out a disease control program [35 Pa. Stat. Ann. §521.3(c)]. Unfortunately, “disease control program” is not defined and it is not clear that this authority applies to a local decision in an individual case or circumstance.

While it is conceivable that this situation could be clarified by administrative rulemaking, to date, it has not been. With regard to issues involving examination, treatment, quarantine and isolation of persons

who have or are suspected of having a communicable disease, the regulations simply state that either the Department or local health authority is authorized to take the appropriate action (see 27 Pa. Admin. Code §§27.60, 27.82, 27.87, 27.88). The regulations do not address the relationship between state and local public health officials in any manner that clarifies the lines of authority or responsibility in this area of vital public concern.

Moreover, the terms “local qualified medical health officer” and “local medical health officers” are not defined in the statute and, although the regulations do not use these designations, they do not alter the authority of such individuals to take certain actions specified in the DPCL.²² In each instance, the terms connote a plethora of possible actors including virtually any physician and perhaps a variety of other health care workers who may be authorized to take action. Neither term explicitly incorporates the designation of “local health officer,” a term that is defined in the DPCL as the head of the local department of health [35 Pa. Stat. Ann. §521.2(g)].²³ The use of these terms does seem to connote someone who has some form of medical training.

Even if it were to be assumed that the legislature intended some relationship among these designations or for that matter that they all referred to the same individual, the question remains as to what separates a “qualified” medical health officer from one who is not, or a “medical health officer” from one who is simply a health officer? The DPCL says that a “qualified” one may order a person suspected of being infected to undergo an examination and diagnostic testing and to quarantine the person for refusing to go along with it. If the court is ultimately requested to enforce an order from such an individual, it may well be necessary to first determine what it means to be “qualified.” Given that one who is a “local qualified medical health officer” has designated public health responsibilities and the authority, under certain circumstances, to quarantine someone, this is not simply a matter of semantic nitpicking. It would seem reasonable to know if this includes the family doctor, a podiatrist, a dermatologist, a nurse or any other health care provider. While the rules provide for a position designated “health officer” in certain municipalities, *only in certain counties does the person have to have to be a physician* (28 Pa. Admin. Code §§11.1, 13.11).

The Turning Point Model State Public Health Act (“Model Act”), the product of a collaborative initiative involving five states and a number of national organizations and experts in the in field of public health, provides no guidance with regard to the relationship between state and local PHA’s (Turning Point Model State Public Health Act 2003). Indeed it seems to leave this issue to the drafters of state statutes by referring to either a “state or local public health agency” as the actor responsible for undertakings such as mandatory treatment [Turning Point Model State Public Health Act 2003, §5-107(b)] or quarantine and isolation [Turning Point Model State Public Health Act 2003, §5-108(a)], without delineating particular lines of authority. It does, however, distinguish between those who are authorized to carry out the provisions of the Act, ostensibly anyone so designated in a statute or regulatory scheme, from those who have the authority to “manage and supervise” an agency’s activities [Turning Point Model State Public Health Act 2003, §1-102 (44, 47)].²⁴ The Model Act avoids the problem of designating a public health role for individuals whose titles are left undefined.

While under the 35 Pa. Stat. Ann., it is specifically provided that the governor is authorized to act, the question remains as to who actually determines that there is a cognizable threat in the first place. While the governor is empowered to act, upon whom he or she must depend for a determination of what are likely to be largely scientific questions is not addressed in the statute. This is particularly significant because, as noted above, the governor can only act in limited circumstances where *inter alia* there is an outbreak, actual or suspected, of a contagious disease due to a bioterrorist or biohazardous event and where the failure to do so will jeopardize the Department’s ability to curtail the transmission of a contagious disease [35 Pa. Stat. Ann. §2140.301(a)]. None of the critical terms are defined in the Act and there is no framework, other than consultation with the “Secretary of Health,” for interpreting whether the conditions precedent to the exercise of the governor’s authority have been met [35 Pa. Stat. Ann. §2140.301(a)].²⁵

So if it were reported to the police in Scranton, or Kane, or Harrisburg that there was what appeared to be an outbreak of an unknown disease of uncertain origin in the area of a waste-water treatment plant or perhaps another “white powder” incident at a courthouse, who within the Commonwealth would be enlisted to determine whether it was a contagious disease resulting from a

biohazardous event that required immediate action and advise the governor or a PHA accordingly? Moreover, who will be responsible for coordinating the overall government response and in particular assuring that the perhaps divergent priorities of criminal justice and public health authorities are properly accommodated? Assuming that these issues would eventually get sorted out, any initial delay caused by either role ambiguity or a failure of necessary expertise could be very costly. In a similar vein, the consequences of precipitous action predicated on bad information or poor advice could be far reaching for individuals unnecessarily subjected to quarantine or isolation orders. And while these issues could well be addressed through administrative rulemaking, the Board has adopted none.

The provisions of the Model State Emergency Health Powers Act (MSEHPA) are applicable to circumstances where a governor of a state declares a “public health emergency” (Model State Emergency Health Powers Act 2001, Article IV). Such an emergency arises only when there is a high probability of a large number of deaths, serious or long-term disabilities, or widespread exposure to agents that pose a significant risk of substantial future harm [Model State Emergency Health Powers Act 2001, §104(m)]. In such a circumstance the governor is authorized to take certain steps to respond to the threat of a public health crisis while the coordination of matters pertaining to a public health response is left to the PHA. Unfortunately, MSEHPA defines PHA in such a way as to include both state and local officials without delineating their respective scope of authority [Model State Emergency Health Powers Act 2001, §403(b)]. It therefore offers little guidance in formulating a practical approach to adjusting Pennsylvania’s public health law in a way that avoids confusion in the face of a public health event.

Controlling the Government’s Discretion

While there can be no doubt that the government’s mission of responding to a public health concern is an essential component of a state’s police power, determining when and how that power should be exercised is the *sine qua non* of public health policy. In part this is because the state of science and more specifically, medicine, is inherently dynamic and as such, both the way we view the severity and significance of a health condition may very well change over time. Yesterday’s epidemic may be rendered nothing more than an interesting

historical event by the development of an effective vaccine or treatment or improvement in environmental conditions or simply because of a change in the way in which a culture views it. The DPCL, for example, singles out both tuberculosis and venereal diseases for particular attention.²⁶ While there are very important reasons to be concerned about both of these disease classifications, with the development of modern antibiotics, there is nowhere near the level of concern that existed when the DPCL was originally adopted. And yet even that has changed recently because the bacterium that causes tuberculosis has developed a strain that is resistant – sometimes very much so – to current modes of otherwise effective treatment (Lewis 1995; see Centers for Disease Control and Prevention January 2008).

When, then, is the threat to the public's health sufficient to justify the government's intervention? The law must serve as a vehicle for answering this question and provide a protocol for governmental decision-making. The challenge is do this in a way that accommodates the compelling need to take effective action while minimizing the risk of unnecessary restrictions on individual liberty. While the conditions that give rise to government action need to be delineated with a degree of precision, this must be accomplished without being so restrictive that the government's ability to respond to serious threats to the public's health is impaired. And while discretionary authority to act in such matters is essential, the need for competent scientific and medical expertise in support of decision-makers is of critical importance. Protecting the public's health demands science-driven decision-making.²⁷ The definitions of both the DPCL and the Counterterrorism Act need to be revisited to provide for more precise standards related to a PHA's decision to act in the face of a public health concern. In its present form, the definition of "communicable disease" is so broad as to be unworkable. The Board through its rule-making power has not provided any guidance. As a consequence, a PHA has almost unlimited discretion in selecting control measures necessary to respond to a public health event involving communicable disease whether it be an outbreak of bird flu or the common cold.

This issue is addressed in the Model Act in more than one way. For example, with regard to mandatory treatment, the Act provides that a state may require a person to undergo medication therapy only when infected with "... a contagious disease that poses a significant risk to

others or the public's health" (Turning Point Model State Public Health Act 2003). By imposing a "significant risk" condition, the Model Act specifically limits the circumstances under which the government may act to require treatment for an infectious disease.

Perhaps most significantly however, the Model Act requires that when a public health agency acts "to accomplish essential public health services and functions, it shall, to the extent possible, employ the policy or practice that least infringes on the rights or interests of individuals" [Turning Point Model State Public Health Act 2003, §5-101(b)(4)]. The drafters of the Model Act reinforced the importance of this conceptual scheme by specifically requiring that the use of isolation and quarantine must be effectuated by the "least restrictive means" required to prevent the spread of a contagious disease [Turning Point Model State Public Health Act 2003, §5-108(a)(b)(1)]. By adopting a least restrictive alternative approach to the overall application of the Act, it reduces the prospect that the government's response to a public health concern will be disproportionate to the actual threat posed to the public. This concept is not included in either the DPCL or the Counterterrorism Act, nor is it a part of the Board's regulations.²⁸ However, it is a concept that is firmly imbedded in Pennsylvania jurisprudence. The Mental Health Procedures Act has embraced the notion that the government's response to persons suffering from a serious mental illness and who require involuntary treatment must be measured and proportionate such that it "... shall impose the least restrictive alternative consistent with affording the person adequate treatment for his condition" (50 Pa. Stat. Ann. §7107).

Moreover, the Pennsylvania Supreme Court has long recognized the constitutional mandate to limit the exercise of government power in restricting personal liberty to means that are narrowly rather than broadly tailored to achieve the government's legitimate purposes (*Appeal of Albert L. Niccoli* 1977). In large part this orientation towards a minimalist approach to public health policy results from a belief that many, if not most, people afflicted with a communicable disease will voluntarily seek treatment or comply with the government's request to obtain it or embrace other restrictions and that for those who do not, it is likely the result of some psychological condition that interferes with their rational decision-making ability. For this group, lesser rather than greater efforts on the part of the government may well be adequate to meet the government's concern (Gostin, Burris and Lazzarini 1999, 123-124). On

the other hand this assumption may be entirely too optimistic. In the face of what is portrayed or perceived as an imminent health threat, compliance with even relatively innocuous preventive measures may be seriously problematic because of distrust of government or the medical community or because of the inherently uncertain nature of a public health threat presented. Therefore any least restrictive alternative requirement must be adopted in a context that explicitly contemplates its practical limitations and provides accordingly.

MSEHPA by definition limits action to circumstances that meet a certain threshold of seriousness. This is encompassed in the definition of public health emergency. Most notably, however, the MSEHPA also embraces the least restrictive alternative approach to isolation and quarantine that is so critical to the conceptual scheme of the Model Act:

Isolation and quarantine must be by the least restrictive means necessary to prevent the spread of a contagious disease or possibly contagious disease to others and may include, but are not limited to, confinement to private homes or other private or public premises [Model State Emergency Health Powers Act 2001, §604(b)(1)].

Harmonizing Statutory and Regulatory Provisions

At a time of crisis the law should be a source for direction that points the way for government action in a clear and concise manner. The existence of separate statutes dealing with what are essentially identical public health concerns poses a barrier to effective and proper governmental action. Whether a contagious disease is the result of a bioterrorist or biohazardous event, however defined, or of some natural phenomenon, may be of immense practical consequence in terms of the steps needed to ultimately stop its spread. However, from the perspective of the kind of legislative guidance needed to deal with a public health crisis, divergent statutes that incorporate contradictory or differing terminology and differing mechanisms for decision-making only serve to obfuscate the matter and serve as a barrier to sound and expedient decision-making. There is no public policy or other reason that Pennsylvania could not adopt a single statutory scheme that incorporates the provisions of both the DPCL and the public health sections of the Counterterrorism Act. This would allow for conceptual clarity, common terminology, uniform procedures, and a single source for administrative

rule making, while at the same time assuring the flexibility critical for an effective localized response.

Conclusion

We learned from the disaster that followed hurricane Katrina that preparedness is much more than a state of mind and that there can be little comfort in the mere existence of laws or the development of plans. In the final analysis, in times of crisis, it is performance that counts. Pennsylvania has a body of public health law that provides for the implementation of various measures to control the spread of contagious diseases in varying circumstances. It has provided for the development of plans to respond to health and other emergencies (35 Pa. Stat. Ann. §2140.201). But the cornerstone of Pennsylvania public health law, the Disease Control and Prevention Act, has not been comprehensively overhauled since its adoption in 1955. More importantly, its efficacy has never been seriously tested in the context of a significant public health crisis and as a consequence it has received almost no judicial attention. A similar situation exists with the Counterterrorism Planning, Preparedness and Response Act although it is of far more recent vintage. And although the Board is authorized to formulate rules to facilitate the implementation of the DPCL, it has not done so in any kind of comprehensive manner.

How, then, will Pennsylvania perform in the face of a threatened public health crisis, including the outbreak of deadly flu epidemic or antibiotic-resistant tuberculosis or some other ominous but yet to be identified infectious agent? It is suggested that unless key aspects of Pennsylvania law are clarified and/or modified, we risk far from adequate performance from public officials responsible for the public's health. Responding to a public health crisis should not be an experiment. That we will surely learn from our ultimate mistakes and the shortcomings of our laws should give us no comfort. Now is the time to act to address the limitations of our statutory and regulatory scheme.

Notes

1. The government's authority to require people to act in a certain manner to further the public's health has long been recognized as emanating from its "police power" (see *Nat'l Wood Preservers v. Commonwealth Dep't of Envtl. Res.* 1980; *O'Connor v. Donaldson* 1975).
2. Influenza A (H5N1) virus is one subtype that is highly contagious in birds and has been transmitted to humans in a limited number of cases. The Centers for Disease Control provides a more complete description of the history and current status of avian influenza (Centers for Disease Control and Prevention 7 May 2007). The Pennsylvania Department of Health has an excellent explanation of avian flu on its website (2005).
3. In discussing the nature and history of quarantines, Batlan notes that, "... (T)here has not been a widespread medical quarantine in the United States for at least eighty years" (Batlan, 2007, 59).
4. The authors describe the significance of jurisdiction in the public health law arena and note the need to articulate clearly the scope of authority and responsibility of public health departments (Gostin, Burris and Lazzarini, 1999). Weeks generally discusses the need for a coordinated response between federal and state authorities when faced with a public health crisis and points out the interplay of state and federal authority (Weeks, 2007).
5. Batlan notes the potential for confusion resulting from divergent responses to public health events from government bureaucracies (Batlan, 2007, 59). Chen comments on the important role of state governments while recognizing the necessity of federal action in certain circumstances (Chen, 2005, 175-176).
6. Chen observed that the Model State Emergency Health Powers Act (MSEHPA), which was formulated at the request of the Center for Disease Control and that has been the used as basis for Pennsylvania's Counterterrorism Act, has "engendered a storm of controversy" (Chen, 2005, 168-173).
7. Similarly, the significant due process issues that often arise any time the government seeks to invade liberty interests are not addressed but are of nonetheless compelling concern (Daubert, 2007). Chen describes the due process issues associated with the provisions of Pennsylvania's Counterterrorism Act (Chen, 2005).
8. This section [35 Pa. Stat. Ann. §521.16(c)] provides that, "Municipalities which have boards or departments of health or county departments of health may enact ordinances or issue rules and regulations relating to disease control, which are not less strict than the provisions of this act or the rules and regulations issued there under by the board." By adoption of the Local Health Administration law, Pennsylvania provides for the creation of county departments of health authorized to act in particular circumstances (16 Pa. Stat. Ann. §12005). It has been observed that there are 237 local boards or departments of health that operate outside the Local Health Administration law (Pennsylvania Public Health Law Bench Book 2006, note 2).
9. "Department" is defined in the DPCL as the State Department of Health [35 Pa. Stat. Ann. §521.2(d)].

10. Moreover, some municipalities and counties with health departments may adopt rules that authorize other individuals or entities to act [see, DPCL 1955, §521.16(c)]. Under such arrangements there is a way to anticipate the role that may be played by the State Department of Health or any local public health authority.

11. See 28 Pa. Admin. Code, §27.65, requiring an LHA not a LMRO to consult with the state Department before requiring isolation of a person harboring an infectious agent.

12. See 35 Pa. Stat. Ann. §521.7, relating to examination and diagnosis; and 35 Pa. Stat. Ann. §521.11, relating to treatment. However, it must be noted that the DPCL does specify that certain PHA's are "responsible for the prevention and control of communicable and non-communicable disease," so it is apparent that a PHA may act to prevent non-communicable disease as well. For purposes of this analysis non-communicable diseases are not addressed.

13. However, the DPCL was amended in 1994 to deal separately with mandatory testing for Human Immunodeficiency Virus (HIV) [35 Pa. Stat. Ann. §521.11(a)]. The amendments were ostensibly necessitated by requirements of the federal Omnibus Crime Control and Safe Streets Act.

14. There is no similar requirement for isolating persons who are suspected of being infected but who have refused testing (35 Pa. Stat. Ann. §521.7).

15. However, a more realistic view of the scope of a PHA's authority comes into focus when the practical impact of the Pennsylvania Department of Health's sparse regulations is considered.

16. The DPCL only explicitly addresses treatment for venereal disease and then only by providing for "free treatment" when necessary for preservation of the public health.

17. The terms modified quarantine, surveillance and segregation are also defined in §521.2(i)(1,2,3).

18. This section of the DPCL also sets forth certain procedures to follow in court cases and more fully describes the parameters of the examination.

19. There is, however, specific authorization to isolate or quarantine a person suspected of having a sexually transmitted disease in an institution where the person's movement is physically restricted [35 Pa. Stat. Ann. §27.88(a)].

20. This procedure is akin to the least restricted alternative approach discussed hereafter as it requires the government to first try to accomplish its objective by having the person confined to her home with instructions on how to prevent the spread of the disease. If that doesn't work, then other less favorable means may be invoked.

21. The term does not exclude the movement of a person "... from one location to another when approved by the Department or local health authority..."

22. It is entirely possible that municipal codes have the same, different or additional designations for individuals authorized to act.

23. However, the rules identify the "health director" as the administrator of the county health department (16 Pa. Stat. Ann. §12012). Although the health director is not required to be a physician, a local health department must employ one (28 Pa. Admin. Code §§15.22, 15.25).

24. Public health agents would include a broad class of individuals who are designated to carry out the specific public health functions, while public health officials are those more narrowly concerned with the day-to-day operation of a public health agency. Nonetheless, the Model Act leaves it to individual states to more precisely define who is to be included in each category as well as their scope of authority. There is an exception to this approach with regard to reporting requirements where the Model Act imposes a duty on a “health care provider,” broadly defined to report a condition of public health importance [see §5-103f(1)].
25. Similarly, when the PHA proceeds to petition the court to authorize isolation or quarantine, the Act is silent as to how a decision is to be made with regard to the nature of a biohazardous event, its potential public health consequences and the appropriate response.
26. HIV is not included in the venereal disease category and is treated separately in the DPCL. This focus on specific diseases in state codes is not uncommon and over time this focus has shifted to different disease processes and other health concerns (Gostin, et al. 1999).
27. HIV is not included in the venereal disease category and is treated separately in the DPCL. This focus on specific diseases in state codes is not uncommon and over time this focus has shifted to different disease processes and other health concerns (Gostin, et al. 1999).
28. But, see 28 Pa. Admin. Code §27.161(1), requiring that if adequate facilities are available, a person infected with tuberculosis must be isolated in his or her own residence.

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