

Promoting healthy people and healthy communities through dialogue, partnerships, education and research in public health law.

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Protecting Pregnant Women Against Violence: The Case Against the Unborn Victims of Violence Act

Sarah Gareau & Kathryn J. Luchok

Violence during pregnancy is a significant public health issue. Each year, approximately 324,000 pregnant women are raped or physically assaulted by an intimate partner.¹ Pregnant women who are victims of intimate partner violence are more likely to suffer from depression and suicide, as well as to engage in tobacco, alcohol and drug use during pregnancy.² They are also more likely to delay entry into prenatal care³ and have a significantly higher likelihood of pregnancy complications, including low weight gain, anemia, infections, and first and second trimester bleeding.⁴ Murder is the second most common cause of injury-related death for pregnant women (31%) after car accidents.⁵ Yet, the legal response to violence during pregnancy, which focuses on the unborn, has not been adequate.

On April 1, 2004, the federal Unborn Victims of Violence Act (UVVA) was signed into law by President Bush. This legislation created a separate criminal offense for causing "the death of, or bodily injury to, a child, who is in utero."⁶ Thirty-four states now recognize the unborn as separate victims.⁷ Sadly, there is no indication that these laws have done anything to protect pregnant women or their children. The UVVA does not make the death or harm of a pregnant woman a separate offense nor does it create harsher penalties for those who assault or murder a woman while pregnant.

Rather, pregnant women in states with feticide laws are more likely to be punished if something they did or did not do is believed to have risked harm to a fetus. Since 1984, when the first feticide case was decided in South Carolina (*State v. Horne*),⁹ only one man in that state has been prosecuted and convicted of murder based on the recognition of fetal personhood. However, prosecutors have relied on South Carolina's current case law to arrest more than 80 pregnant women and new mothers for child abuse or related crimes for prenatal drug use and other behaviors.¹⁰ In Utah, prosecutors publicly declared that their state's version of the UVVA provided the basis for arresting a woman who decided to wait to have a cesarean section.¹¹ They argued that she could be prosecuted for murder because, by exercising her right of informed medical decision-making, they claimed she caused one of her twins to be stillborn. In states whose homicide/feticide laws create explicit exceptions for the pregnant woman, such as California and Missouri, the laws have nevertheless been cited as a basis for arresting women who prosecutors claimed risked harm to their future children (e.g., *Reyes v. California* and *Missouri v. Smith*).¹²⁻¹³ A 2005 opinion of the American College of Obstetricians and Gynecologist's Committee on Ethics states that laws which seek to protect the fetus as an entity separate from the woman are not justified because they erode women's basic rights to privacy and bodily integrity.⁸

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President's Column

Lori H. Spencer



This is my last President's column. I started writing it figuring it was supposed to be about my accomplishments during my tenure as PHLA President. Recently, I have been reading—or actually looking at the pictures—in a book called “The Hidden Messages in Water,” by Masaru Emoto. Dr. Emoto photographed water crystals under many different circumstances and found that the shape of the crystals changed depending on what the water was exposed to. He found that exposure to the

word gratitude evoked some of the most astonishingly beautiful crystals. So, absorbed in the metaphysical, I realized what this column is really supposed to be about—gratitude. While this was my presidency, the accomplishments are not mine, they are the accomplishments of many others, all of whom gave generously of their time and talent. Despite our funding disappointments, we have still had a banner year and one that will culminate at the annual public health law conference, where PHLA will have a major presence once again.

Our achievements this year include the continued production of high quality newsletters and teleconferences, all thanks to the work of volunteers, like Board member, Marty Wasserman, who organized our recently fully subscribed teleconference on the “Wal-Mart” bill, and Jill Moore, who edited the newsletters after Susan Steeg's departure in January. We will soon sponsor another high-quality student poster session at the conference, thanks to the efforts of Board member Jean O'Connor, who organized the session, and to the efforts of the students who contributed their work. This year, PHLA will debut a new signature event at the conference, the “Year in Review” plenary session, to which Board members Wendy Parmet and Gene Matthews have contributed countless hours, joined by association member, Rick Hogan, who is profiled in this issue. Martha Brocato stepped in as dedicated Interim Executive Director and she has helped us tremendously.

To the list of achievements, I can add many things, including the work of the Awards Committee, the Nominating Committee, and the Executive Committee, which included the other PHLA officers, Jane Speakman, Cynthia Honssinger Coffman, and Dan O'Brien. Cynthia also spearheaded the awards efforts, and Board member Anne Murphy undertook the time-consuming task of heading the Nominating Committee (and thus of Board development). Jane, as Treasurer, wrestled with our finances, and Dan, as President-Elect, spent hours and hours working with me on everything (and I fully plan to return the favor). The other Board members, Linda Chezem, Larry Gostin, and Angela Monson, have been PHLA's advocates and supporters on many fronts we could not have reached without them.

Upon reflection, then, there have been many achievements during my Presidency. I hope seeing the word gratitude from me will inspire the same reaction from all of you as it does from water crystals ... more astonishing things. Thanks everybody, for all you have done. You have my deepest gratitude.

Gareau & Luchok article continued from page 1...

Besides diminishing the issue of violence against women, UVVA and other feticide laws also undermine the foundation for *Roe v. Wade* by creating a separate status for the unborn. These laws give rights to fertilized eggs, embryos and fetuses, which ultimately sets the stage to legally reverse a woman's right to choose some family planning options.¹⁴ The laws put the “assumed” rights of the unborn (since they can not speak for themselves) over the rights of born persons. Such “rights” could conflict with born persons' inheritance rights, pregnant women's rights to determine acceptable treatment and delivery methods, use of some contraceptives, and any other arena where someone could represent the rights of those in utero.¹⁵

If states truly do want to reduce attacks on pregnant women, alternative legislation does exist. Statutes in other states such as New Mexico (N.M. Stat. § 30-3-7) and North Carolina (N.C. Gen. Stat. § 14-18.2) increase the penalty for a person who, in the commission of a felony or act of domestic violence, inflicts an injury on a pregnant woman that results in miscarriage or stillbirth.¹⁶⁻¹⁷ These statutes value both maternal and fetal life without making pregnant women vulnerable to arrest by separating fetal and maternal rights. We can best support healthy children by protecting the health and well-being of mothers and mothers-to-be. Let us concentrate our efforts on crafting bills that can truly value women, protect them from violence, and appropriately punish those who perpetrate violence against them.

Kathryn J. Luchok, Ph.D., is a maternal and child specialist on the faculty of the University of South Carolina Arnold School of Public Health. Sarah Gareau, M.Ed., Dr.P.H. (candidate), CHES is a doctoral student at the same institution, focusing on women's health policy. Both are members of the S.C. Women's Health Coalition, which seeks to improve the health of all South Carolina women and increase access to health care services for all South Carolina citizens.

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Contact PHLA

Web: <http://www.phla.info>

Email: msbrocato@phla.info

Phone: 770-401-9403

Fax: 770-491-9359

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⁷ National Right to Life Committee. (2006). State homicide laws that recognize unborn victims (fetal homicide). Retrieved online April 30, 2006 at http://www.nrlc.org/Unborn_Victims/Statehomicidelaws092302.html.

⁸ ACOG Committee on Ethics. (2005, Nov.). Maternal decision making, ethics, and the Law. *Obstetrics & Gynecology*, 106(5): 1127-37.

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¹² *Reyes v. Superior Court In and For San Bernardino County*, 75 Cal.App.3d 214 (1977).

¹³ *Missouri v. Smith*, Jackson County Circuit Court, Case No. CR2000-00964, State's Response to Motion to Dismiss the Indictment (Aug 10, 2002) at 2.

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¹⁶ N.M. Stat. § 30-3-7 (2005).

¹⁷ N.C. Gen. Stat. § 14-18.2 (2005).

New Members

Denise Ashby, University of Nevada School of Public Health, Las Vegas, NV

Chinyere O. Ekechi, US Department of Health and Human Services, Atlanta, GA

Rick Hogan, Arkansas Department of Health and Human Services, Little Rock, AR

Joyce Roper, Washington State Attorney General's Office, Olympia, WA

Renewing Members



Marice Ashe, Public Health Institute, Oakland, CA

Georges C. Benjamin, American Public Health Association, Gaithersburg, MD

Kelley M. Clancy, Alexian Brothers Hospital Network, Arlington Heights, IL

Cynthia Honssinger Coffman, Office of the Colorado Attorney General, Denver, CO

Robert "Bob" Eadie, Florida Department of Health, Tallahassee, FL

Sarah Gareau, Arnold School of Public Health, Columbia, SC

Anada I. Gunn-Sanders, House & Sanders, Fort Worth, TX

Gail A. Horlick, Centers for Disease Control and Prevention, Atlanta, GA

Patricia C. Kuszler, University of Washington School of Law, Seattle, WA

Joan Miles, Montana Department of Public Health & Human Services, Helena, MT

Anthony D. Moulton, Centers for Disease Control and Prevention, Atlanta, GA

Judith W. Munson, Double Team, Inc., Chicago, IL

Mona T. Peterson Rosow, Halleland, Lewis, Nilan and Johnson, Minneapolis, MN

Ross D. Silverman, SIU School of Medicine, Springfield, IL

Stefanie L. Steines, University of Iowa College of Law, Iowa City, IA

Martin P. Wasserman, Ellicott City, MD

Donna M. Weinstein, Region V, US Department of Health and Human Services, Chicago, IL

Howard A. Zucker, World Health Organization, Cliffside Park, NJ

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Membership Spotlight: Rick Hogan

Interview by Kyle Kingsley



Mr. Rick Hogan is the General Counsel for the Division of Health of the Arkansas Department of Health and Human Services. As part of his duties, Mr. Hogan regularly represents over 2,000 public health employees and officials in state and federal courts. Mr. Hogan spent fifteen years in the Arkansas Attorney General's Office, serving with five different Attorneys General. During that time, he represented several state agencies and officials, including former Governor Bill Clinton, the State Police, the Department of Corrections, the Department of Pollution Control and Ecology, the Department of Health, and the Board of Nursing. Mr. Hogan is experienced in Title VII employment litigation including the Americans with Disabilities Act, the Fair Labor Standards Act and the Family Medical Leave Act. He has participated in more than fifty federal trials and defended the State of Arkansas in two of the largest class action litigation cases ever brought in federal court in Arkansas. Mr. Hogan received his law degree from the University of Arkansas at Little Rock in 1980 and a Master of Public Health degree from Tulane University in 2002.

There has been substantial litigation surrounding childhood immunizations in Arkansas. What have you learned from your experiences with this litigation?

In the last several years, Arkansas experienced a lot of activity regarding immunizations. Before I discuss my impressions, I would like to start by noting that vaccination laws embrace several constitutional ideas: freedom of speech and religion, and the police power that allows state governments to require immunizations. Vaccination harkens back to the very root of public health law and *Jacobson v. Massachusetts*,¹ which goes to heart of what public health is all about. When you look at public health's history, vaccination and immunization is public health's greatest success story.

My litigation experiences have taught me that philosophical and religious exemption approaches are closely aligned. My impression is that, nationally, states are moving away from utilizing the religious exemption from vaccination toward the philosophical exemption. That goes for Arkansas too. I think that most people prefer the philosophical exemption because that exemption is easier to get than a medical exemption. Further, the philosophical exemption avoids many of the constitutional issues

surrounding using a religious exemption. Right now, Arkansas public health officials are monitoring recent changes in Arkansas law to determine if there is a correlation between increasing philosophical exemptions from vaccinations and communicable disease outbreaks. I have noticed—and based on some research—that in states moving toward the philosophical exemption the result is that the medical exemption is often rendered meaningless. This in turn undercuts our surveillance and monitoring of the population.

I have seen first-hand the emotional stake that parents have in their children's health and how immunization provokes an emotional response. I have had an Eighth Circuit Court of Appeals judge ask during oral arguments whether I would be comfortable recommending childhood vaccinations for HIV if a vaccine was available. I replied that I would. I believe that we must do whatever we can in order to prevent disease; vaccinations represent an efficient way for achieving that goal. However, we need to ask what the effect is for any new vaccine. Additionally, vaccine production methods that raise religious objections must be examined and, if possible, adjusted. Right now in Arkansas, we are examining how to address these issues in the long-term and whether we are legally ready. Anyone interested in reading more about this issue can check out the following cases: *Boone v. Boozman*, 217 F.Supp.2d 938 (E.D.Ark. 2002); *Brock v. Boozman*, 2002 WL 1972086 (E.D.Ark. 2002); *McCarthy v. Boozman*, 212 F.Supp.2d 945, (W.D.Ark. 2002); *McCarthy v. Ozark School District*, 359 F.3d 1029 (8th Cir. 2004).

Many states are focusing on preparing for pandemic influenza. Arkansas was obviously substantially affected by the Hurricane Katrina disaster. What are the most important public health law lessons you learned from your recent experiences?

I would say the thing that became the most apparent in responding to the Katrina and Rita disasters and preparing for the thousands of evacuees was finding the necessary surge capacity for the basic public health and medical care needs. It is estimated that 50,000 people entered Arkansas—equivalent to Arkansas's fifth largest city. I believe that there are separate medical and legal aspects to disaster preparedness. A state should envision the absolute worst-case scenario and then devise laws and regulations flexible enough to allow either the governor or the state public health director to make effective decisions.

Returning to our earlier immunization topic, after Katrina about 20,000 children moved into Arkansas. Many of those children needed to enroll in public schools. However, the children were unable to prove that they met Arkansas's immunization requirements for attending school. Therefore, we needed to create some leniency



allowing the children to attend school. We also worked with the children's families to ensure that the children received any vaccinations that they lacked.

Another issue was trying to get sufficient numbers of the appropriate health care professionals (e.g., emergency medical technicians, doctors, and nurses) into the affected area; in order to work out the licensure and volunteer issues we needed a very flexible process. An additional lesson we learned was that you need direct communication available on a 24-hour basis for responding immediately to any disaster situation. We found that you must incorporate the legal response into the medical response in order to quickly give the medical personnel the necessary resources. We also had a cadre of county health officers in each of our 75 counties. These doctors are appointed by the Arkansas Board of Health and serve as volunteers. We had a great resource locally that we had not organized effectively until after the disasters. We are currently updating the legal infrastructure to incorporate this important public health resource. One very important lesson learned was that a state must have the appropriate health regulations in place long before any disaster strikes. In Arkansas, the legislature meets every two years and the health board infrequently meets so a quick legislative or regulatory response is not always possible.

Maybe the most important lesson I learned is to be prepared to respond immediately and have a process for allowing public health officials to implement very fluid responses. One thing I must mention—the CDC's public health law program was a tremendous help. I was trained in public health emergency law in April 2005 and I never thought that my training would be needed so soon. However, I could consult my training resources for answering many legal questions. I would especially mention that the assistance and guidance Drs. Rick Goodman and Tony Moulton have given to the states are indispensable. I feel very fortunate to be practicing public health law now because four or five years ago public health lawyers did not have this wonderful resource. As a result of our experiences with the CDC's program, we are putting together a similar training program in Arkansas.

What is your involvement in the public health law community?

One of the most enlightening things I have seen the last year is public health's remarkable breadth. We have so many different partners—public and private—with a stake in public health. They have a need for us and we need them; we all have that in common. Outside the private sector, we now know we need law enforcement and surge capacity and we need planning. As far as the legal community is concerned, we work directly with the Arkansas Bar

Association and local law enforcement ensuring that all facets of public health law response are in place. However, public health's scope is so much broader since the 2001 terrorist attacks. I can see another aspect to public health's spread by looking back to 1999 and the West Nile virus, followed by SARS and monkeypox, and now the coastline disasters. In a way, these terrible events were a wake-up call because public health finally grabbed the spotlight and people could immediately see how necessary a public health response is.

With a background in finance and accounting and many years with the Arkansas Attorney General, how did your public health law interest develop? What intrigues you regarding public health law? What public health law challenges does Arkansas face?

You know, I've always been interested in community health issues. One of the first things I learned to read was the warning label on cigarette packs. My parents were both smokers so I'll never forget reading those labels and thinking that either no one reads these labels or no one cares what the labels say. People's continued smoking always mystified me. I'm encouraged that in the last couple of decades public health was successful getting people to think that their individual behavior could affect others. The practical message is that failed public health policy costs everybody.

I am intrigued by how topical public health is. I am also amazed at how quickly public health changes. You always have to be on your toes; there is never a dull moment in public health law. As far as challenges go, limited money for public health initiatives presents the biggest obstacle. We pay professional athletes and entertainers a lot of money and what do we get back? In contrast, a dollar invested in public health returns decreased mortality and morbidity. I get frustrated at times because it seems that public health is always battling against other priorities du jour. We are now the priority du jour and we have to create permanent and lasting solutions and prove to policy makers that we are worth substantial tax dollars. We should be about raising yourself up—which I believe is exemplified by public health—but the reality is that sometimes we are more about tearing others down. There is an axiom in property law that states "you cannot prove your good title to property by disproving others"—you have to rely on the strength of your title. Now we have to rely on our strength and prove we are worthy of this recognition.

Kyle Kingsley is a student member of the PHLA. He recently finished his Master of Laws studies in Health Law, focusing on public health law, at the Beazley Institute for Health Law and Policy, Loyola University-Chicago School of Law. Kyle can be contacted at kakamack@hotmail.com.

¹ 197 U.S. 11 (1905).

Fact & Fiction in Pandemic Flu: A Panel of Experts Discusses ABC's "Fatal Contact"

On May 9, ABC aired the movie "Fatal Contact: Bird Flu in America." One week later, the PHLA Reporter convened a group of experts in North Carolina to discuss the movie's portrayal of the science underlying flu pandemics, the use of quarantine as a response to the pandemic, and any effect the movie may have had on efforts to educate the public about public health threats and response to public health emergencies. The participants in the conversation were Dr. Jeff Engel, North Carolina State Epidemiologist; Chris Hoke, Chief of the Office of Legal and Regulatory Affairs in the North Carolina Division of Public Health; Dr. Steve Cline, Chief of the Epidemiology Section in the North Carolina Division of Public Health; and Debbie Crane, Public Affairs Director, North Carolina Department of Health and Human Services. Jill Moore, the PHLA Reporter's Interim Editor, conducted the interview.

The first point I want to explore with Dr. Cline and Dr. Engel is whether the movie's portrayal of the science respecting avian flu and its transmission to humans was realistic. Was there anything about the movie that jumped out at you as a particularly good portrayal of a realistic scenario? Did anything strike you as particularly unrealistic?

Engel: We knew this would be about entertainment, and not education, so we were obviously expecting a spectacle—that was trying to compete with American Idol. Some things were realistic and some were not. The origin of the pandemic in Southeast Asia was fairly accurately portrayed. The sudden onset of the disease with high fever was also pretty accurate. What wasn't accurate was the hemorrhagic complication. Bloody noses occurred in the 1918 flu, but they weren't a big part of it. There was pulmonary hemorrhage in 1918 as well, but that was only seen at autopsy. The movie portrayed the disease more like an Ebola virus than the flu.

Cline: I had the same impression about the hemorrhagic issue and wished I had Jeff with me when I was watching so I could ask, "What's that?" But I thought they had done some homework with somebody, because a lot of things that happened—there was some scientific basis for it. Some of the sequencing and rapidity was not realistic, but some of the scenarios were things we've talked about. I was pleasantly surprised it wasn't science fiction, it was just fiction.

At the very beginning of the show, one of the fictional scientists said that containment wouldn't be possible if more than 20 people got sick. Shortly thereafter they had 25 patients, and the lead character—the doctor/epidemiologist who worked with the EIS—said, "We've lost any chance of containment." To a non-scientist like me, the implication was that 20 to 25 is some sort of magic number. What's that all about?

Engel: We didn't understand that either. Certainly respiratory viruses spread rapidly through communities, but I'm not aware of a threshold number of 20 people. That could easily be contained. For example, with SARS, we had eight cases in the United States and that was contained.

The original projection of flu deaths in the movie was something like 350 million – is that realistic?

Engel: That was worldwide? There are 6 billion people on the planet so that would have been about a ... let me do the math ...

Hoke: A lot of zebras.

Engel: (Laughs) A lot of zebras, yes. That's five percent of the world's population. One in twenty people would die—but not everyone would get sick, so that's a case-fatality rate of 10 to 20 percent. That's totally unrealistic. The 1918 flu had a case-fatality rate of about 1 percent.

Hoke: So why do you think they did that?

Engel: I think they wanted to do the mass burial scene with a dumptruck.

Cline: Which they could have done with a 1 percent death rate. But the exaggerated version was not scientific.

Crane: I think they are doing some unfortunate mathematical equations and that is largely related to the way the material is being conveyed in the popular media, sometimes even by medical experts. They look at the WHO web site, which today shows 217 cases and 123 deaths, and they extrapolate a 56.6 percent mortality rate. That 50 percent-plus number gets bandied around without any real clarification. Dr. Anthony Fauci¹ really makes a point when he is talking to explain that the rate is no doubt artificially high—in part because authorities are seeing the nearly dying in the first place. We saw the same thing when West Nile virus first hit. The figures on fatalities were much higher until more people were aware of the disease and went to the doctor with less serious cases.

Let's talk some now about the movie as a media event. Here's a quote from a New York Times review of the movie: "Fatal Contact' is a May sweeps movie, not a public service message, so it is hardly surprising that it errs on the side of Armageddon, but that does not mean it is irresponsible. It is a soberly and compellingly told tall tale, and quite alarming."² Do you agree or disagree with that assessment?

Cline: That is kind of what I was saying. It wasn't so far-fetched that it wasn't believable. We were shocked that we got so few calls about it after the fact. After that night, we didn't get questions on the Careline [N.C. Department of Health and Human Services public service hotline] or the website. I'm thinking the public did understand it as good TV rather than as good science.

Crane: The bottom line is that the movie was up against American Idol, followed by House, which has also become enormously popular. It was the lowest rated show in its time slot. Not many people were watching the movie and from my perspective that is a good thing. I also have to say that I was really impressed with the ABC news side of coverage of this issue, both at the national and local level. While the movie was produced by the entertainment side of the network, the news side is a separate operation and I think they handled things beautifully. Good Morning America dissected the movie and even mentioned that a consultant for the movie thought it was over the top. At the local level WTVD, the Durham (N.C.) ABC affiliate, offered state health director Dr. Leah Devlin the opportunity to be on a webcast answering viewer's questions. The webcast had so many queries, that they had to start limiting the queries to those that affected the most people.

Law didn't get a lot of direct attention in this movie. The only public health legal authority that was explicitly portrayed was quarantine – and it was unleashed in its most powerful form early in the epidemic when the Governor of Virginia ordered whole neighborhoods quarantined. What was your reaction to that?

Hoke: I thought it was pretty unrealistic in terms of what we've been talking about—using quarantine very early, recognizing that we're not going to stop anything, but that we will slow the spread down and hopefully curtail some of the damage that's done. But this idea that neighborhoods and places will be locked down for long periods of time wasn't consistent with our plan. Of course the way the epidemic evolved in nanoseconds on TV, we missed out the first phase of trying to lock it down in the country of origin and catch it in the airport when it came to the US. All we saw was the community quarantine. I think that's sending the wrong message in about how we intend to use isolation or quarantine in pandemic flu.

So how do you plan to use it?

Hoke: To keep it localized and slow its spread if it arises out of the country, then try to address it at the airport. Then very early on to try to slow down community spread. But once the spread is generalized, you wouldn't use quarantine, you would use things like the canceling of public events, encouraging people to telecommute to work, doing other things to try to avoid people congregating in large groups in public places—social distancing strategies.

Engel: The cordon sanitaire that was used in the movie was completely ridiculous. First of all, it wasn't working, but the Governor still maintained it, which was pretty funny. Our mantra is practice the least restrictive measures necessary, so when we're restricting movement of people, we're talking about a very early response—at the airport like Chris described. So if we have someone sick on an airplane originating in the country of concern, we're going to quarantine that plane when it lands in North Carolina. I don't think cordon sanitaire is anywhere in our plan. No fences with razor wire or anything like that.

The public health law community has done a lot of work in preparation for a flu pandemic. Here in North Carolina, the legal infrastructure has been studied and made more robust. You've made novel influenza viruses reportable. You've drafted model isolation and quarantine orders. All of this has been important prep work—but where are the lawyers when the event is actually going on? What do you anticipate they'll be doing?

Cline: Lawyers are part of the state emergency response plan. There's a structure for us for getting legal advice for these kinds of emergencies.

Hoke: Certainly that is what occurred during our SARS event a couple of years ago. [One of the eight confirmed U.S. SARS cases occurred in North Carolina.] I was at our public health command center advising on the use of isolation and quarantine to control that outbreak. I would anticipate, particularly as we're planning on using those public health authorities early on in the epidemic, that the public health lawyers will be right in the middle of all that helping make good decisions that will stand up.

Cline: We also worked a lot with hospital lawyers around SARS. I think risk managers will be in the discussion.

In the movie, the grocery stores ran out of food. The hospitals were overwhelmed almost immediately. Health care providers walked off the job. The Governor's son died because he couldn't get insulin. We've talked about all of these things in preparation exercises, so we can't say we think they're unrealistic. But do you really think it will get to that point? What are the most important things to do to contain it early so it doesn't get to that point?

Engel: My thoughts are in alignment with the WHO early response plan.³ It focuses on rapid identification of cases, quarantine, and Tamiflu deployment. I think we can realistically nip this in the bud. We know from other pandemics that the disease comes in on travelers. If we have a robust plan that focuses on ports we can actually limit entry into North Carolina.

Crane: I am afraid of at least an initial run on grocery stores. People in this part of North Carolina just have to hear the word "snow" and they run to the grocery store and buy all of the bread and milk. I do think there is going to be some of that. The same thing happens with a potential hurricane. That's why I think one of the most valuable lessons we can push right now is personal preparation—having food and water in your pantry and medicines on hand. I actually thought the most effective part of the movie was the subplot with the Governor's son dying because he couldn't get his medication.

Any last thoughts before we end?

Cline: One point that stuck with me was that sort of mob mentality of people trying to get limited resources, vaccine or whatever—that's the scariest thing to me. How people can behave so extremely and out of character when they think they're protecting their families. That part may have been realistic. I think we have to expect that people will go to extreme measures.

Engel: The other thing that I thought was realistic was the death count meter that was always running on the screen. I think death counts are going to be important. Media are going to demand exact numbers by day, and I think mortality is going to be our major measure of severity and success, and that's kind of scary too. If we can't provide accurate numbers for media, they're going to find them themselves, so it's actually part of the plan in North Carolina. We have a proposal, it's not actually in action—but it's to turn our current vital records system which is very non-real time to near-real time using sentinel registrars. It currently takes several weeks to report deaths.

Crane: I totally agree with Jeff. But, I have to go back to the 2003-04 flu season. Once the state of Colorado started reporting child deaths, then we had to report ours. I certainly thought that was what we should do and fought to make it happen, but a lot of the medical community was really angry about that decision. They said that we shouldn't be issuing a "body count" and tried to stop us. Yet, when I did a media comparison between states that reported numbers and states that did not, the scariest stories were in the states that did not. If reporters didn't have anything from the authorities than they were forced to report on rumor and innuendo, and I can't blame them. I used to work in a television newsroom, and I can tell you that whatever is going on in the world—someone is always calling the newsroom to give them the scoop. We need to give them the information first and frame it in a fashion that puts it in context and provides actions that people can take to alleviate the situation. We need to provide the public, through the media conduit, with everything that we have that is factual.

¹ Dr. Anthony S. Fauci is Director of the National Institute of Allergy and Infectious Diseases in the United States.

² Alessandra Stanley, Bird Flu Comes to America, at Least in a TV Movie (New York Times, May 9, 2006).

³ WHO Pandemic Influenza Draft Protocol for Rapid Response and Containment (updated draft, March 17, 2006). Available on the Internet at http://www.who.int/csr/disease/avian_influenza/guidelines/fluprotocol_17.03.pdf.

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Guide to PHLA Events at the 5th Annual Partnership Conference



The Public Health Law Association is sponsoring or co-sponsoring several conference sessions and other special events. Please see your conference program for locations and other information.

Monday, June 12

12:00-5:00 p.m.

4:00-5:30 p.m.

Student Posters on Display

Concurrent Session: The Courts-Guardians of
Health and Liberty

Tuesday, June 13

7:30 a.m.-8:30 a.m.

7:30 a.m.-5:00 p.m.

8:30-10:00 a.m.

PHLA Annual Membership Meeting

Student Posters on Display

Plenary Session: Public Health Law Year in
Review, with PHLA members Rick Hogan, Gene
Matthews, and Wendy Parmet

10:30 a.m.-12:00 noon

1:30-2:00 p.m.

4:00-5:30 p.m.

Concurrent Session: Connecting Pain Management

Student Poster Session-Authors Present

Concurrent Session: Law at Intersection of
Civilian/Military PH Practice

6:00-7:00 p.m.

PHLA Annual Reception and Announcement of
Student Poster Awards

7:00-9:00 p.m.

Special Screening: "A Closer Walk," HIV/AIDS
Documentary

Wednesday, June 14

7:30 a.m.-5:00 p.m.

8:45-10:15 a.m.

Student Posters on Display

Concurrent Session: Private Bar-Partner for
Healthy Communities

10:30 a.m.-12:00 noon

12:00-1:15 p.m.

1:30-2:30 p.m.

Concurrent Session: Best Practices in Faith/Health
Partnerships

PHLA Luncheon and Presentation of Annual
Awards for Excellence in Public Health Law

Final Plenary Session, to be introduced by
incoming PHLA President Dan O'Brien

Newsletter Contributions Wanted

Would you like to write for the PHLA Reporter? We are seeking articles on public health law issues and news items on events that are of interest. For further information, contact editor@phla.info.



P.O. Box 133122
Atlanta, GA 30333
USA

www.phla.info