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Preparing for the worst: ED liability in the face of bioterrorism

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Editor's note: *As a result of the Sept. 11 terrorist attacks and subsequent events of bioterrorism in the months since, the United States has a heightened sense of insecurity and fear at the realization that we not free from acts of terror. There has been an enormous amount of information disseminated to emergency department (ED) medicine practitioners regarding bioterrorism. Hospitals, ED directors, and emergency medical service (EMS) medical directors have endured countless organizational meetings to make preparations for the next event. Special response teams have been developed to help care for patients when the next attack occurs. However, many questions remain: "What is the hospital's obligation regarding preparedness?" "What authority do ED physicians have to quarantine?" and "What duty is there to warn third parties?"*

This article will identify and attempt to answer some of the potential legal dilemmas that may arise as a result of domestic bioterrorism. The hospital's responsibilities regarding the newest legislative attempts at increasing preparedness will be addressed. The author does an outstanding job of describing the problems that any ED practitioner one day may encounter as a result of bioterrorism.

There was a time, not so long ago, when residents of the United States considered themselves immune from the horrors of terrorism. Incidents such as the 1993 bombing of New York City's World Trade Center were dismissed as tragic aberrations, unlikely to be repeated.[1] Even the 1995 attack on Oklahoma City's Murrah Federal Building, which left 168 dead, did little to dispel the nation's sense of domestic security.[2] In the minds of most Americans, terrorists operated only in faraway places such as northern Ireland and the Middle East.

The tragic events of Sept. 11 have changed this way of thinking forever. Suddenly, Americans feel vulnerable to attack. For the first time, they see themselves as potential targets of hijackings and weapons of mass destruction.

Recent anthrax incidents in Florida, New York, and Washington, DC, have reinforced this view.[3] The people of the United States have begun to demand increased protection, and the federal government has responded with sweeping changes in national security policy.[4]

Terrorism occurs in many forms. Explosives, nerve gas, bacterial pathogens, and a lethal plant toxin, ricin, already have been unleashed on the United States and other civilized nations.[5-8] Among these weapons, the dissemination of a biological agent, or "bioweapon," poses the greatest management challenge to the public health system. Unlike explosives and chemical agents, bioweapons produce delayed symptoms that often can be transmitted from person to person. Thus, a single victim of bioterrorism unwittingly can spread the resulting disease throughout the population.[9]

Managing such an attack likely could require a rapid, extensive, and prolonged public health response. Public health officials will need to recognize that a bioterrorist attack has occurred, identify the offending organism, ensure suitable treatment for victims, and control the spread of the disease. Much of this work will take place in hospital EDs. Due to the relative paucity of statutory and common law governing the actions of health care providers during intentionally created epidemics, the personnel of these facilities may find themselves confronted by legal dilemmas to which there are no clear answers. This article will identify and analyze some of the unique legal issues that may confront EDs, their administrators, and their personnel as a result of domestic bioterrorism.

Readiness

The first step in preparing for bioterrorism is to acknowledge its existence. Public health officials and ED personnel no longer can view the threat of bioterrorism as a theoretical problem of the future. It already has arrived.

On Oct. 2, 2001, a 63-year-old male entered a hospital in Palm Beach County, FL, with fever and altered mental status. A gram stain of the patient's cerebrospinal fluid (CSF) revealed gram-positive bacilli. Suspecting anthrax exposure, the hospital staff initiated antibiotic therapy and notified the Palm Beach County Health Department and the Florida Department of Health. Two days later, the state laboratory and Centers for Disease Control and Prevention (CDC) confirmed *Bacillus anthracis* from a culture of the patient's CSF fluid. The patient died three days after admission. While an autopsy confirmed the cause of death as inhalational anthrax, no method of exposure was identified.[10]

In the days that followed, additional anthrax cases surfaced in Florida, New York, and Washington, DC.[11] Environmental sampling subsequently revealed that some of these exposures arose from the intentional delivery of *B. anthracis* spores through mailed letters or packages. These events represent the first instances of deliberate anthrax exposure ever confirmed in the United States.[12]

Given this background, ED administrators cannot turn a blind eye to the threat of domestic bioterrorism. To the contrary, a hospital could incur negligence liability if it fails to adopt adequate bioterrorism response plans. Health care facilities caught off guard by acts of bioterrorism never again can justify

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a lack of proper planning by arguing that attacks were unforeseeable.

The CDC, through its Strategic Planning Workgroup, recently compiled a series of recommendations intended to strengthen the United States against the dangers of chemical and biological terrorism.[13] *Preparedness and Response to Biological and Chemical Terrorism: A Strategic Plan* represents the first collaborative effort between the CDC, the Department of Defense, law enforcement agencies, and the intelligence community to address a national security threat.[14] While most of the CDC's recommendations pertain to the public health infrastructure, some carry significant implications for health care providers. The plan encourages EDs and other "frontline medical personnel," for example, to maximize their ability to detect and report patterns of illness suggestive of biological attack, to participate in the CDC's Laboratory Response Network for Bioterrorism (LRNB), and to mitigate biological illness by providing medical treatment and distributing prophylactic medications obtained from a national pharmaceutical stockpile managed by the CDC.[15]

Working in conjunction with the CDC, the Association for Professionals in Infection Control and Epidemiology (APIC) has developed similar recommendations. In their *Bioterrorism Readiness Plan: A Template for Healthcare Facilities*, the APIC Bioterrorism Task Force and CDC Hospital Infections Program Bioterrorism Working Group recommend that health care facilities incorporate bioterrorism response plans into existing disaster preparedness and emergency management policies.[16] These response plans should include the identification of triage and isolation areas capable of handling large numbers of patients, mandatory universal infection-control precautions, and the development of a program to provide prophylaxis, post-exposure immunization, and bioterrorism education to employees.[17-19]

Presently, the CDC and APIC proposals consist only of recommendations. In the absence of comparable statutory law, hospitals need not comply with them. ED administrators should bear in mind, however, that such recommendations soon might define the standard of care for bioterrorism readiness planning, and that an ED's lack of compliance one day may contribute to a finding of negligence.[20] The adoption of a bioterrorism response plan, therefore, constitutes good risk-management practice, whether such plans are statutorily required or not.

ED administrators should remember, too, that the "recommendations" of today might become statutes tomorrow. In recent months, 36 state legislatures have introduced bills pertaining to the emergency management of bioterrorism.[21] Sixteen of these states have gone on to enact statutes based at least partially on the Model State Emergency Health Powers Act, and six other states are contemplating similar bills.[22,23] A number of states already impose statutory planning requirements on health care facilities.[24] In light of the nation's heightened bioterrorism concerns, others may soon follow.[25] The imposition of federal bioterrorism readiness requirements on hospitals and other health care facilities now seems possible, as well.[26] Hospital administrators must monitor legislative developments in this area to ensure that their facilities remain compliant with newly enacted state or federal planning requirements.

Detection

The effects of terrorism tend to become immediately obvious. A bomb explodes in an Oklahoma City office building, and the building collapses.[27] Nerve gas is released into a Tokyo subway station, and passengers fall ill.[28] Planes crash into the World Trade Center, and thousands of people are incinerated within minutes.[29]

When terrorists utilize biological weapons, however, the impact generally is not felt until days or even weeks after the attack.[30] Unlike most chemical agents, bioweapons do not inflict damage immediately upon absorption or inhalation. Rather, the biological agent first must incubate within the host.[31] Only at the completion of this incubation period does the individual exposed to the agent become ill.[32] Meanwhile, the asymptomatic victim is likely to spread the disease through person-to-person contact, thereby multiplying the number of victims and complicating the public health response. By the time the original victims manifest symptoms, a second wave of victims already may be infected.[33] In the case of variola virus — the causative agent of smallpox — a relatively modest infection of 50-100 people would expand by a factor of 10-20 times with each new generation of exposures.[34]

ED personnel, therefore, play a crucial role in the detection of biological attacks. Many Americans now utilize hospital EDs as their primary care facilities, and as a result, ED personnel will be among the first health care providers to treat the victims of bioterrorism.[35] Unfortunately, the majority of bioterrorism victims

TABLE 1: Biological Agents

CATEGORY A AGENTS

These agents pose a risk to national security because they are readily disseminated, cause high mortality, will likely cause public panic, and require special action for public health preparedness.

- *Variola major* (smallpox)
- *Bacillus anthracis* (anthrax)
- *Yersinia pestis* (plague)
- *Clostridium botulinum* (botulism)
- *Francisella tularensis* (tularemia)
- Filoviruses (Ebola hemorrhagic fever and Marburg hemorrhagic fever)
- Arenaviruses (Lassa fever and Argentine hemorrhagic fever)

CATEGORY B AGENTS

These agents are moderately easy to disseminate, cause moderate morbidity and low mortality, and require enhanced diagnostic capabilities and disease surveillance.

- *Coxiella burnetti* (Q fever)
- *Brucella* (brucellosis)
- *Burkholderia mallei* (glanders)
- Alphaviruses (Venezuelan and equine encephalomyelitis)
- Ricin toxin from *Ricinus communis* (castor beans)
- Epsilon toxin of *Clostridium perfringens*
- *Staphylococcus* enterotoxin B
- *Salmonella*
- *Shigella dysenteriae*
- *Escherichia coli*
- *Vibrio cholerae*
- *Cryptosporidium parvum*

CATEGORY C AGENTS

These agents include pathogens that could be engineered for future mass dissemination.

- Nipah virus
- Hantaviruses
- Tickborne hemorrhagic fever viruses
- Tickborne encephalitis viruses
- Yellow fever
- Multidrug-resistant tuberculosis

would complain, at least initially, of seemingly minor problems such as fever, headache, and nausea — all of which might be attributed to an ordinary viral infection.[36] Even after signs suggesting bioterrorism begin to appear — the vesicular rash associated with smallpox, for example, or the petechiae and ecchymoses that typically accompany Ebola-induced hemorrhagic fever — unfamiliarity with such rare diseases might preclude timely diagnosis.[37] Few American ED physicians have treated hemorrhagic fever, and fewer still have practiced medicine long enough to recall pre-vaccination smallpox outbreaks.

In an effort to detect biological attacks as rapidly as possible, the CDC and its partners are working with state and local health departments to establish a multilevel LRNB that eventually will include facilities in all 50 states.[38] Once this network becomes fully operational, initial testing of suspicious substances will occur at clinical laboratories in hospitals and at public health agencies, while additional confirmatory testing will be performed at regional CDC facilities and at a newly created Rapid Response and Advanced Technology Laboratory.[39] The target date for completion of the LRNB, along with other CDC anti-bioterrorism initiatives, is 2004.[40]

ED personnel must do their part by remaining alert to diagnostic clues and patterns of illness suggestive of intentional exposure to a biological agent. ED practitioners generally will not utilize sophisticated laboratory facilities in a hunt for exotic pathogens when the patient is thought to be suffering from an ordinary viral illness. Rather, health care providers must seek out victims of bioterrorism. Toward this end, the APIC Bioterrorism Task Force and CDC Hospital Infections Program Bioterrorism Working Group recommend that ED personnel and other health care providers monitor patients for select high-risk syndromes. Specifically, ED personnel should familiarize themselves with the signs and symptoms of exposure to three categories of agents, characterized by the CDC as "critical biological agents" and classified by ease of dissemination and threat of mortality.[41] **(See Table 1, at left .)**

ED practitioners must remain vigilant not only for particular types of unusual illnesses, but also for *patterns* of illness suggesting bioterrorism. EDs should perform this task in conjunction with local, state, and federal public health agencies.[42] According to the APIC Bioterrorism Task Force and CDC Hospital Infections Program Bioterrorism Working Group, the following events could signal the presence of a bioterrorism-related outbreak:[43]

- Clusters of patients arriving from a single locale;
- A rapid increase of disease incidence in a normally healthy population;
- A sudden, sharp, unexplained increase in the number of people seeking care;
- The emergence of an endemic disease at an uncharacteristic time or in an unusual pattern;
- Large numbers of rapidly fatal cases.

The CDC already has funded a number of infectious

disease sentinel networks that should aid ED personnel in the detection of bioterrorism, including the Infectious Disease Society of America Emerging Infections Network, EMERGency ID NET, and Geo Sentinel.[44] Another electronic network, the National Electronic Telecommunications System for Surveillance, permits the collection, transmission, and analysis of infectious disease reports from public health agencies throughout the United States.[45] The CDC has long utilized its own on-line system, CDC WONDER, to gather information from various CDC surveillance systems.[46]

These systems have improved the capability of the CDC to compile data about infectious disease outbreaks, but their outdated methods do not permit the immediate collection, analysis, and reporting of data necessary to identify bioterrorism in a timely fashion.[47] A more recent project of the CDC — the National Electronic Disease Surveillance System — has resolved some of these issues by providing for the electronic interchange of laboratory data among EDs and public health agencies. Unfortunately, the usefulness of this system has been hampered by the lack of a uniform method of data collection among EDs and other surveillance sources.[48] The newest proposal, a collaborative effort between the emergency medicine, public health, government, law enforcement, and informatics communities known as the Frontlines of Medicine Project, seeks to develop an "early warning" bioterrorism detection system by linking regional public health networks with a nonproprietary, vendor-neutral, standards-based infrastructure.[49] This project eventually will obtain standardized data sets from doctors' offices, medical clinics, pharmacies, schools, and other public health information sources, but the investigators initially will target hospital EDs.[50] ED administrators and personnel should lend their full cooperation to such programs. In so doing, they will protect their patients, employees, and the public to the greatest extent possible, thereby minimizing their own liability exposure.

Treatment

ED personnel are responsible not only for detecting diseases resulting from bioterrorism, but also for treating the victims of such acts. In some cases, the unusual nature of the disease will complicate diagnosis and the formulation of an appropriate treatment plan. Bioterrorists already have utilized pathogens rarely seen in the United States, and the CDC has warned that bioterrorists might use combinations of pathogens, or even genetically engineered pathogens, in an effort to render diagnosis and treatment as difficult as possible.[51,52]

A discussion of specific treatment modalities for the many types of potential bioweapons falls beyond the scope of this article. Accordingly, ED personnel must consult appropriate resources when confronted with diseases with which they are unfamiliar. Several broad treatment principles apply to virtually all bioterrorism-induced diseases, however. To minimize the liability that would accompany the unnecessary exposure of hospital employees and other patients to biological agents, ED personnel should familiarize themselves with these concepts. Hospitals also should incorporate these principles into their operational policies and bioterrorism readiness plans. Some states already require such action by statute.[53]

To reduce the likelihood of disease transmission, ED personnel should practice "universal precautions."

Each ED should designate a triage and isolation area, suitable for the grouping of patients with like symptoms.

In general, movement within the hospital of potentially infectious patients should be limited to that which is essential to care.[54]

Each hospital should adopt a policy that mandates regular and appropriate cleaning, disinfection, or sterilization of all surfaces with which patients and employees will likely come into contact. Measures should be taken to ensure that ED personnel follow these policies. Each facility should appoint an individual to be responsible for institutional compliance with federal, state, and local infection control laws, as well as Occupational Safety and Health Administration standards, where applicable.

Discharge Management. Patients with infectious diseases resulting from bioterrorism should remain hospitalized until the medical staff deem them non-infectious. An extensive outbreak may preclude admission of all infected patients, however. When this happens, ED staff must provide patients and their families with discharge instructions that highlight methods of post-discharge infection control.[55] In some states, the law requires this.[56]

Post-Exposure Management. As a general rule, patients exposed to biological agents require decontamination only when they have become grossly contaminated or when the risk of re-aerosolization is great.

The efficacy of prophylaxis varies significantly

with regard to the type of pathogen and nature of the exposure. ED personnel, therefore, should consult with the CDC and state and local health departments before deciding whether post-exposure vaccinations, medications, or other measures are indicated for patients or health care providers.[57]

ED administrators should not underestimate the likely effect of panic following a bioterrorist attack. Hospitals will find themselves inundated not only with infected patients, but also with the "worried well" — healthy individuals seeking medical attention and reassurance after hearing about the possibility of exposure.[58] Each health care facility should establish a network of mental health support personnel, including psychiatrists, psychologists, social workers, clergy, and volunteer organizations, as part of its bioterrorism response plan. These individuals can be specially trained to handle the emotional issues associated with terrorism, and their involvement will free ED personnel to perform other duties. Providing information to the public through local media outlets may prove useful in limiting misconceptions and the spread of panic.[59] ED spokespeople never should downplay the nature or extent of the threat; however, as one crisis intervention specialist has observed of bioterrorist incidents, "Any damage to the public trust at the beginning of the crisis ensures that distrust will continue throughout the crisis."[60]

Post-Mortem Management. Infectious diseases can spread even after the death of the patient. Hospitals, therefore, may be required to take special precautions when disposing of corpses after a bioterrorism incident.[61] Personnel engaged in the transfer of dead bodies or performance of autopsies must employ the same universal precautions as health care providers. Each facility should develop appropriate instructions for funeral directors, and should incorporate this information into its bioterrorism readiness plans.[62]

Reporting and Notification

Most states require health care providers to report cases of infectious disease to state or local public health departments.[63] A 1999 study of U.S. public health law revealed, however, that virtually all of the relevant statutes and regulations were enacted individually, many years apart, in response to specific health threats then in existence.[64] Not until the past few years have states passed legislation that specifically requires the reporting of diseases linked to a bioterrorist attack.[65]

TABLE 2: Notification Procedures

When ED personnel detect a bioterrorism incident:

- ED personnel notify local health officials
- Local health officials notify the FBI and local law enforcement agencies
- Local health officials notify the state health department and other response partners
- State health department notifies the CDC

When epidemiological information obtained from EDs and other health care facilities suggests bioterrorism:

- Local health officials notify the state health department
- State health department notifies the CDC
- CDC investigates
- If bioterrorism is confirmed or deemed probable, CDC notifies the FBI and other response partners
- If bioterrorism is deemed unlikely, the CDC will continue its investigation

The release of the Model State Emergency Powers Act in late 2001 prompted a flurry of bioterrorism-related statutes, most of which contain infectious disease-reporting provisions. In New Hampshire, for example, health care providers, hospital administrators, and others who become aware of communicable disease syndromes must report their findings to the Commissioner of Health and Human Services.[66] Similarly, in Vermont, health care providers must report the existence of "any illness, disease, injury, or death" likely to be caused by a weapon of mass destruction, including bioterrorism.[67] The majority of states still have not passed bioterrorism reporting statutes, however, because of lingering concerns over privacy invasion.[68]

The failure of state legislatures to adopt universal reporting requirements does not diminish the importance of this practice. To the contrary, experts in the fields of public health and public health law have recognized that the reporting of suspicious illnesses by health care providers is critical to bioterrorism detection.[69] Similarly, the establishment of notification procedures have been deemed essential to a prompt public health response.[70] EDs, therefore, should report suspicious cases to the appropriate authorities — within the limits of applicable law — even if such reporting is not statutorily mandated.

Recognizing that health care facilities occupy the best position from which to detect a bioterrorism incident, APIC and the CDC recommend that any ED personnel suspecting such an event promptly notify local

infection control personnel, state and local health departments, local police, the nearest Federal Bureau of Investigation field office, the CDC, and local EMS officials.[71] The CDC has established a separate recommended notification procedures that would take effect whenever ED personnel inform the local health officer of a bioterrorist threat or incident, including the observation of a suspicious illness.[72] These procedures are summarized in **Table 2 (see box, p. 90.)**

ED personnel who report potential acts of bioterrorism must take care not to incur liability by violating their patients' right to privacy. At least 40 states currently impose civil or criminal penalties for the unauthorized disclosure of medical information.[73] While some jurisdictions recognize exceptions for legitimate public health disclosures, and others confer statutory immunity for the reporting of narrowly defined bioterrorism information, health care providers who divulge protected diagnostic or treatment information about identified patients may invite a lawsuit or even a guilty verdict.[74,75] ED personnel can minimize exposure to such liability by familiarizing themselves with the disclosure laws of the states in which they practice and by exercising great discretion whenever they reveal private information that ultimately may be linked to a particular individual.

Forced Treatment and Deprivation of Rights

The right of an individual to accept or reject medical treatment is well established in the United States.[76] Equally well established is the obligation of the state to ensure the health of its citizens.[77] In the aftermath of a domestic bioterrorism incident, these interests undoubtedly will clash. States will attempt to control the spread of infection by imposing examination, treatment, quarantine, and isolation requirements on those who have been infected, yet some victims undoubtedly will refuse to comply. This will place ED personnel and other health care providers in a precarious legal position as they struggle to reconcile the needs of the public and demands of the government with the rights of their patients.

The responsibility for controlling the spread of infectious disease falls, for the most part, on the government of each state. The 10th Amendment confers upon the states a "police power" that permits the enactment of legislation reasonably related to the health, safety, or morals of the public.[78] While the Supreme Court has refrained from defining the limits of this power, it has recognized the authority of the states to pass regulations for the protection of public health, including quarantine laws.[79,80] The state may delegate this power to local bodies of government, such as municipal boards of health.[81]

Every state has enacted some form of legislation intended to control the spread of infectious disease.[82] Measures authorized under these laws include the examination, testing, immunization, treatment, counseling, detention, isolation, and quarantine of infected or potentially infected individuals.[83] Some of these laws create vague obligations that barely interfere with individual rights. A Massachusetts statute, for example, requires only that public health officials launch an investigation whenever an outbreak of infectious disease is suspected.[84] Others, such as a Nevada statute permitting the confinement of individuals whose behavior is likely to spread AIDS, amount to the total curtailment of individual liberty. Reviewing these laws in 1999, Georgetown University law professor Lawrence Gostin found them to vary "so significantly as to defy meaningful tabulation or categorization."[85,86]

A state may not abolish the rights of its citizens at will, however, even under the guise of protecting them. Nearly 100 years ago, the Supreme Court ruled that state public health interventions must bear a "real or substantial relationship" to a public health objective.[87] Public health policies that restrict an individual's freedom of movement, association, or privacy may implicate the due process clause of the 14th Amendment to the Constitution.[88] Similarly, the Fourth Amendment's prohibition against unreasonable searches and seizures can limit the state's ability to order examinations or treatment, or to obtain information.[89]

It is difficult to predict how much latitude states can expect from the courts as they enact legislation in response to bioterrorism. During much of the 20th century, the courts routinely upheld quarantines and other public health measures, despite seemingly excessive government tactics. The New York Court of Appeals, for example, once upheld the quarantine of a healthy woman simply because she had lived next door to a person infected with smallpox.[90] Seventy-five years later, the Supreme Court of Florida held that the involuntary confinement of tuberculosis patients represented a "legitimate exercise of the police power," which, when fairly administered, was not subject to constitutional limitation.[91] In fact, as recently as 1966, courts

have ruled that the involuntary confinement of an infected individual does not amount to deprivation of liberty without due process.[92]

In recent years, however, society's pleas for enhanced civil liberties have prompted the Supreme Court to impose increasingly severe due process restrictions on government action.[93] Noting little difference between mental health detentions and public health detentions, the Court repeatedly concluded between 1967 and 1980 that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due-process protection.[94,95] The nature and extent of this protection varies with the nature of the interests affected, the risk of an erroneous decision, the value of additional safeguards, and the administrative burden of additional procedures.[96] Due process in civil commitment proceedings, the court announced, requires an impartial hearing, in which the patient must be afforded the right to counsel, an opportunity to be heard, and the right to confront and cross-examine opposing witnesses.[97-100] The government must prove at this hearing, *at least* by clear and convincing evidence, that the individual poses a threat to himself or to others.[101] In addition, the government may be required to prove that less restrictive means of protecting the public health — such as directly observed therapy — would not be as effective.[102,103]

A number of states have incorporated these principles into the language of their public health laws. A newly enacted law in New Hampshire, for example, creates for infectious patients the statutory right to a pre-detention hearing at which the government must show, by clear and convincing evidence, that the isolation or quarantine is necessary to alleviate a threat to the public health.[104] Moreover, when detaining such patients, the government must employ the "least restrictive means necessary to protect the citizenry."[105]

Other states have enacted vague laws that vest broad discretionary powers in local health officials.[106] New Jersey, for example, authorizes the state health department or a local board of health to isolate or quarantine persons "whenever deemed necessary" and to remove "any person infected with a communicable disease to a suitable place, if in its judgment removal is necessary and can be accomplished without any undue risk to the person infected."[107] Similarly, in California, the department of health is empowered to "quarantine, isolate, inspect, and disinfect persons, animals, houses, rooms, and other property, places, cities, or localities, whenever in its judgment such action is necessary to protect or preserve the public health."[108] The problem with such laws is that, as Gostin has noted, "[w]ithout clear criteria, public health officials may restrict an individual's liberty without valid public health grounds, or may be so unsure of their authority to act that they do not use these measures to respond to actual threats."[109]

Where does this leave the ED practitioner who must react to bioterrorism? Unfortunately, like the public health officials to which Gostin alludes, most will lack an understanding of the obligations and restrictions imposed upon them by the law. Surrounded by chaos, they will scramble to determine the extent to which they may — or, indeed, *must* — treat infected patients.

In the worst-case scenario, exposed and infected patients will overwhelm the ED. The vast majority of these patients will seek treatment or prophylaxis. Some will resist, however. They will demand to be freed from isolation, and will refuse the administration of antibiotics or other therapeutic measures.

To control the spread of the disease, state and local public health officials will order some form of compulsory treatment, which could range from prophylaxis to quarantine. For ED practitioners and administrators, this creates a liability dilemma. If hospital personnel comply with the order by detaining or treating a reluctant patient, and the authority of the public health officer is successfully challenged afterward, the hospital and its personnel may face tort claims for assault, battery, or even wrongful imprisonment.[110] As the Supreme Court of New Jersey observed in 1940, even a minimally invasive procedure, such as phlebotomy or vaccination, can form the basis for such lawsuits.[111] This scenario is not as farfetched as it might sound. Some states permit isolation or quarantine only upon the issuance of a court order, and a public health official or emergency physician could inadvertently violate such a provision by ordering the detention of an infected ED patient without first obtaining judicial approval.

ED personnel who impose unwanted treatment or detention under such circumstances could incur civil rights liability as well. Under the federal civil rights statute, government officials such as state and local public health officials can be held personally liable for intentional violations of federally protected rights.[112] Private citizens who act under "color of state law" at the request of such officials incur the same liability.[113] Of course, health care providers accused of such violations can argue in defense that they were entitled to rely on the public health official's representations as to

the nature and extent of his authority, and that this reliance precludes the requisite finding of intent.[114] Alternatively, ED personnel might argue that the need to protect the public from the spread of infectious disease justified their actions — a defense that the law has recognized as valid in both criminal and civil actions.[115]

On the other hand, if the personnel in the ED refuse to comply with the order, and the authority of the health official is later deemed valid, the ED personnel may — at least in some states — face civil or criminal penalties. In Arizona, for example, the legislature has conferred upon local boards of health the power to investigate outbreaks of contagious disease and impose quarantines to prevent the spread of infection.[116] Violation of this statute or any other Arizona public health measure intended to control the spread of contagious diseases constitutes a Class 3 misdemeanor.[117] Other states have enacted similar laws.[118]

One might argue as well that negligence liability accrues when ED personnel allow an infected patient to leave the hospital knowing that he poses a public health threat. In *Rohde v. Lawrence General Hospital*, the Massachusetts Supreme Judicial Court ruled that the failure of ED personnel to detain a psychiatric patient who later committed suicide represented sufficient evidence of negligence to withstand a medical malpractice tribunal.[119] Similar liability might attach when a patient known to be infected is allowed to harm others by leaving the hospital and spreading his disease.

As a general rule, ED personnel should endeavor to overtreat, rather than undertreat, victims of bioterrorism. Hospital counsel will find it easier to defend the actions of a hospital that violates the rights of a patient through overzealous care than to defend an absence of treatment. ED personnel should proceed with caution when detaining or imposing unwanted care on reluctant patients, however. The risk of tort and civil-rights liability probably is small when compared to the good that can be achieved from such measures, but it is a risk that warrants consideration.

Conclusion

The novelty of bioterrorism creates substantial legal uncertainty. The paucity of case law and the wide variation between applicable statutes makes it impossible to define with any degree of accuracy the legal obligations of health care providers with respect to bioterrorism. In the event of a domestic bioterrorism strike, the emphasis — quite properly — initially will fall on the mitigation of disease. Once the spread of infection has been arrested, however, a certain amount of treatment-related litigation is inevitable. ED personnel can minimize the risk of liability now by preparing comprehensive bioterrorism response plans and familiarizing themselves with federal, state, and local infectious disease control requirements. ED administrators and hospital counsel also should meet with government agencies to delineate the powers of public health officials during such an event, and to define the responsibilities of health care providers under applicable statutory law.

Endnotes

1. See, *United States v. Salameh*, 152 F.3d 88, 107-08 [2d Cir. 1998].
2. See, *United States v. McVeigh*, 153 F.3d 1166, 1177 [10th Cir. 1998].
3. See, Centers for Disease Control and Prevention. Update: Investigation of Anthrax Associated with Intentional Exposure and Interim Public Health Guidelines. *MMWR* October 2001; 50:889.
4. See, e.g., *Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT) Act of 2001.* Pub. L. No. 107-56 (2001) (significantly expanding the United States Code's anti-terrorism provisions).
5. See, *Salameh*, 152 F.3d at 88, 108; *McVeigh*, 153 F.3d at 1177.
6. See, Okumura T, et al. Tokyo subway sarin attack. *Acad Emerg Med* 1998; 5:613.
7. See, Torok TJ, et al. Large community outbreak of salmonellosis caused by intentional contamination of restaurant salad bars. *JAMA* 1997; 278:389.
8. See, WuDunn S, et al. How Japan germ terror alerted world. *The New York Times;* May 26, 1998:A1, A10.
9. Centers for Disease Control and Prevention. Biological and chemical terrorism: Strategic plan for preparedness and response. *MMWR* 2000; 49(RR-4):1,3.
10. Centers for Disease Control and Prevention, *supra* note 3, at 890.
11. Id. at 889-91.
12. Id. at 891.
13. Centers for Disease Control and Prevention, *supra* note 9, at 1.
14. Id.
15. Id. See, Barthell EN, et al. The Frontlines of Medicine Project: A proposal for the standardized communication of emergency department data for public health uses including syndromic surveillance for biological and chemical terrorism. *Ann Emerg Med* 2002; 39:422, 426-27.
16. Association for Professionals in Infection Control and Epidemiology, Centers for Disease Control and Prevention Hospital Infections Program Bioterrorism Working Group.

Bioterrorism Readiness Plan: A Template for Healthcare Facilities. 1999; 3.
17. Id. at 6.
18. Id. at 5-6.
19. Id. at 8-9.
20. See *Decker v. St. Mary's Hosp.,* 619 N.E.2d 537, 541-42 [Ill. App. Ct. 1993]; (noting that courts must consider "a broad range of evidence" when establishing a standard of care for health care facilities, including "accreditation standards, customs, policies, regulations, standards, [s]tate licensing requirements, and bylaws."). See also Jost T. *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest,* 24 B.C. L. Rev. 835 [1983].
21. See, Emergency Health Powers Act Update, *Emergency Department Law* June 2002; at 63.
22. Id.
23. Id. at 63-64. North Carolina and New Mexico have passed study bills. Bioterrorism management bills have passed both legislative houses in Hawaii, Missouri, and South Carolina, and now await the signature of those states' governors. An interim legislative committee will examine the model act in Nevada.
24. See,e.g., 6 Colo. Code Regs. § 1009 (requiring each general hospital to prepare a comprehensive bioterrorism response plan to take effect whenever the governor declares an actual or imminent bioterrorism disaster).
25. See, Pub. L. No. 107-56 [2001].
26. The federal government could justify such action under the Constitution's Commerce Clause, which empowers Congress to regulate "all activities substantially related to interstate commerce," including public health. See U.S. Const. art. I, § 8, cl. 3.
27. See, e.g., *McVeigh*, 153 F.3d at 1177.
28. See, e.g., Okumura et al., *supra* note 6, at 613-17.
29. See, e.g., Stein J. Digging out. *Time*, Sept. 24, 2001; at 65.
30. Centers for Disease Control and Prevention, *supra* note 9, at 3.
31. Id.
32. Id.; Centers for Disease Control and Prevention. *Public Health Emergency Response: The CDC Role* (visited June 6, 2002). www.bt.cdc.gov/documentsapp/improvingbiodefense.asp.
33. Centers for Disease Control and Prevention, *supra* note 9, at 3.
34. Henderson DA, et al. Smallpox as a biological weapon: Medical and public health management. *JAMA* 1999; 281(22):2,127, 2,134.
35. See, Centers for Disease Control and Prevention, *supra* note 9, at 3.
36. Centers for Disease Control and Prevention. Recognition of illness associated with the intentional release of a biologic agent. 50 *MMWR* 2001; 50:893, 894; Henderson, *supra* note 36, at 2,129. Inglesby TV, et al. Plague as a biological weapon: Medical and public health management. *JAMA* 2000; 283:2,281, 2,284-85. Inglesby TV. Anthrax as a biological weapon: Medical and public health management. *JAMA* 1999; 281:1,735, 1,737-1,739. Centers for Disease Control and Prevention, *supra* note 9, at 3.
37. Centers for Disease Control and Prevention, *supra* note 9, at 3; Centers for Disease Control and Prevention, *supra* note 36, at 894-95. Henderson, *supra* note 36, at 2,129-31.
38. Centers for Disease Control and Prevention, *supra* note 9, at 9.
39. Id.
40. Id. at 13.
41. Association for Professionals in Infection Control and Epidemiology, Centers for Disease Control and Prevention Hospital Infections Program Bioterrorism Working Group, *supra* note 16, at 4-5.
42. Gostin LO, et al. The Law and the public's health: A study of infectious disease law in the United States. *Columbia L Rev* 1999; 99:59, 82.
43. Association for Professionals in Infection Control and Epidemiology, Centers for Disease Control and Prevention Hospital Infections Program Bioterrorism Working Group, *supra* note 16, at 5.
44. Barthell, *supra* note 15, at 424.
45. Centers for Disease Control and Prevention. National electronic telecommunications system for surveillance — United States, 1990-1991. *MMWR* 1991; 40:502-3.
46. Freide A, et al. CDC WONDER: A comprehensive on-line public health information system of the Centers for Disease Control and Prevention. *Am J Public Health* 1993; 83:1,289, 1,289-94.
47. Barthell, *supra* note 15, at 424.
48. Id. at 424.
49. Id. at 423.
50. Id.
51. Centers for Disease Control and Prevention, *supra* note 9, at 1.
52. Centers for Disease Control and Prevention, *supra* note 9, at 4; Centers for Disease Control and Prevention, *supra* note 31.
53. E.g., Colo. Code Regs. 6 § 1009, reg. 2 [2001].
54. Id. at 6-7; Centers for Disease Control and Prevention, *supra* note 32.
55. Centers for Disease Control and Prevention, *supra* note 16, at 7.
56. Nev. Rev. Stat. § 441A.270 [2001] (requiring physicians to instruct patients with sexually transmitted diseases in methods of prevention); Okla. Stat. tit. 63, § 1-403 [2002] (requiring local health officers to instruct tuberculosis patients as to precautions necessary to prevent the spread of the disease to others).
57. Centers for Disease Control and Prevention, *supra* note 16, at 8.
58. Centers for Disease Control and Prevention, *supra* note 9, at 4.
59. Centers for Disease Control and Prevention, *supra* note 16, at 9. *See* Holloway HC, et al. The threat of biological weapons. prophylaxis and mitigation of psychological and social consequences. *JAMA* 1997; 278:425, 427.
60. Holloway, *supra* note 65, at 427
61. See ,e.g., Colo. Rev. Stat. § 24-32-2104 [2001] (empowering a "governor's expert emergency epidemic response committee" to determine how safely to dispose of corpses and infectious waste following acts of bioterrorism).
62. Association for Professionals in Infection Control and Epidemiology, Centers for Disease Control and Prevention Hospital Infections Program Bioterrorism Working Group, *supra* note 16, at 7.
63. E.g., Fla. Stat. ch. 384.25 [201] (mandating a report to the Florida Department of Health by each person who diagnoses or treats a person with a sexually transmissible disease); Fla. Stat. ch. 392.53 [2001] (same, tuberculosis); Mass. Gen. Laws ch. 111, § 7 [2001] (empowering the Massachusetts Department of Public Health to mandate reports of "diseases dan-

gerous to the public health" by physicians, hospitals, and other classes of health professionals); Okla. Stat. tit. 63, § 1-527 [2002] (requiring physicians who diagnose or treat venereal disease to the state commissioner of health or the local health officer).

64. Gostin et al., *supra* note 42, at 102.
65. See, e.g., New Hampshire Public Health Emergency Preparation and Response Act, ch. 258 [July 1, 2002]; Vermont Public Safety Act of 2002, No. 137 [June 12, 2002].
66. New Hampshire Public Health Emergency Preparation and Response Act, ch. 258 [July 1, 2002].
67. Vermont Public Safety Act of 2002, No. 137 (June 12, 2002).
68. See, Emergency Health Powers Act Update. *Emergency Department Law* June 2002; at 64.
69. Model State Emergency Health Powers Act § 301 (2001).
70. Centers for Disease Control and Prevention. *Interim Recommended Notification Procedures for Local and State Public Health Department Leaders in the Event of a Bioterrorist Incident* (visited June 11, 2002). www.bt.cdc.gov/emcontact/protocols.asp.
71. Association for Professionals in infection Control and Epidemiology, Centers for Disease Control and Prevention Hospital Infections Program Bioterrorism Working Group, *supra* note 16, at 3.
72. Centers for Disease Control and Prevention, *supra* note 75.
73. See, e.g., Colo. Rev. Stat. § 25-1-122 [2001]; Neb. Rev. Stat. § 71-506 [2001]. See, Gostin LO, et al. The public health information infrastructure: A national review of the law on health information privacy. *JAMA* 1996; 275:1,921, 1,924.
74. See, e.g., 35 Pa. Cons. Stat. § 521.15 [2001] (permitting disclosure of information at the discretion of public health officials).
75. See, e.g., Vermont Public Safety Act of 2002, No. 137 [June 12, 2002].
76. See ,*Cruzan v. Director, Missouri Dep't of Health,* 497 U.S. 261 [1990]; *Washington v. Harper,* 494 U.S. 210 [1990]; *Schloendorff v. Soc'y of New York Hosp.,* 105 N.E. 9 [N.Y 1914]; *Union Pacific Railroad v. Botsford,* 141 U.S. 250 [1891].
77. See, *Varholy v. Sweat,* 15 So.2d 267, 269-70 [Fla. 1943]; *People v. Robertson,* 134 N.E. 815, 817 [Ill. 1922]; *Moore v. Lumpkin,* 630 N.E.2d 982, 993 [Ill. App. Ct. 1994]; *City of Newark v. J.S.,* 652 A.2d 265, 271 [N.J. Super. 1993].
78. U.S. Const. amend. X. See, *Dobbins v. Los Angeles,* 195 U.S. 223, 237 [1904].
79. *Jacobson v. Massachusetts,* 197 U.S. 11, 25 [1905].
80. Id.; *People v. Robertson,* 134 N.E. 815, 817 [1922].
81. *Jacobson*, 197 U.S. 11 at 25.
82. Gostin, *supra* note 41, at 102.
83. Id. "Quarantine" differs from "isolation" in that the former refers to the segregation of an individual for a period sufficient to determine whether the person has acquired the infection, while the latter refers to the segregation of an infected person to prevent transmission of the disease to others.
84. Mass. Gen. Laws ch. 111 § 7 [2001].
85. Nev. Rev. Stat. § 441A.300 [2001].
86. Gostin, *supra* note 42, at 101.
87. *Jacobson*, 197 U.S. 11 at 31.
88. U.S. Const. amend. XIV. See, Gostin, *supra* note 41, at 113.
89. U.S. Const. amend. IV.
90. *Crayton v. Larabee,* 116 N.E. 355 [N.Y. 1917]. But see, *Kirk v. Wyman,* 65 S.E. 387 [S.C. 1909] (imposing the additional requirement that "the means used and the extent of the interference were reasonably necessary for the accomplishment of the purpose to be obtained."
91. *Moore v. Draper,* 57 So.2d 648, 650 [Fla. 1952]. See *Moore v. Armstrong,* 149 So.2d 36, 37-38 [Fla. 1963].
92. See, e.g., In re *Halko,* 54 Cal. Rptr. 661 [Cal. Ct. App. 1966].
93. See,Reilly RG. Combating the tuberculosis epidemic. *Columbia J. Law & Social Problems* 1993; 27:101, 117-18.
94. See, *Greene v. Edwards,* 263 S.E.2d 661, 662-63 [W. Va. 1980]. See also *O'Connor v. Donaldson,* 422 U.S. 563, 580 [1975].
95. See, *Vitek v. Jones,* 445 U.S. 480 [1980]; *Addington v. Texas,* 441 U.S. 418 [1979]; *O'Connor*, 422 U.S. at 563; *Jackson v. Indiana,* 406 U.S. 715 [1972]; *Humphrey v. Cady,* 405 U.S. 504 [1972]; In re *Gault,* 387 U.S. 1 (1967); *Specht v. Patterson,* 386 U.S. 605 [1967].
96. *Mathews v. Eldridge,* 424 U.S. 319, 334-35 [1976].
97. *Greene*, 263 U.S. at 662-63; *Specht*, 386 U.S. at 610-11.
98. *Vitek*, 445 U.S. at 496-97.
99. *Specht*, 386 U.S. at 611.
100. Id.
101. *Addington v. Texas,* 441 U.S. 418, at 428-33.
102. See, *City of New York v. Antoinette R.,* 630 N.Y.S.2d 1008 [Sup. Ct. 1995]. See also *J.S.*, 652 A.2d, at 272.
103. *Shelton v. Tucker,* 364 U.S. 479, 488 [1960].
104. New Hampshire Public Health Emergency Preparation and Response Act, ch. 258 [July 1, 2002].
105. Id.
106. See, e.g., 110. Idaho Code § 39-420 [2001] (authorizing local health districts to "maintain all proper and necessary civil actions" whenever necessary to eliminate health threats; Neb. Rev. Stat. § 71-502 [2001] (authorizing local health officials to adopt regulations "as will best serve health"); Okla. Stat. tit. 63 § 1-504 to -505 (conferring on local authorities total discretion to promulgate rules and regulations for the protection of public health).
107. N.J. Stat. Ann. § 26:4-2 [West 2002]. See also Mont. Code Ann. § 50-2-116 [2001] (authorizing local boards of health to quarantine and isolate people infected with communicable diseases without providing any criteria or process).
108. Cal. Health & Safety Code § 120145 [West 2001].
109. Gostin, *supra* note 42, at 116. *See also* Bayer R, Fairchild-Carino A. AIDS and the limits of control: Public health orders, quarantine, and recalcitrant behavior. *Am J Public Health* 1993; 83:1,471.
110. See, e.g., *Pizzalotto v. Wislon,* 437 So.2d 859 [La. 1983] (nonnegligent, medically necessary hysterectomy held to constitute battery in the absence of consent).
111. *Bednarik v. Bednarik,* 16 A.2d 80, 90-91 [N.J. 1940].
112. 42 U.S.C. § 1983 [2001].
113. See, *Dennis v. Sparks,* 449 U.S. 24, 27-28 [1980] ("Private citizens, jointly engaged with state officials in the challenged action, are acting 'under color' of law for purposes of § 1983 actions"); *Adickes v. S.H. Kress & Co.,* 398 U.S. 144, 152 [1970]; *United States v. Prince,* 383 U.S. 787, 794 [1966]; *Wagenmann v. Adams,* 829 F.2d 196 [1st Cir. 1987] ("A § 1983 defendant need not be an officer of the state. It is enough if he is a willful participant in joint activity with the state or its agents.")
114. See, *Daniels v. Williams,* 474 U.S. 327 [1986]; *Butts v. Carey,*

706 F. Supp. 158 [D. Conn. 1988]; *McGhee v. Draper*, 564 F.2d 902 [10th Cir. 1977].

115. See, e.g., *Baender v. Barnett*, 255 U.S. 224, 226 [1921] (prisoners' need to flee burning prison justified crime of escape); *The William Gray*, 29 F. Cas. 1300, 1302 [C.C.D.N.Y. 1810](No. 17,694); (adverse weather conditions, necessitating sale of cargo in foreign port, justified embargo violation); *United States v. Ashton*, 24 F. Cas. 873, 874 (C.C.D. Mass. 1834)(No. 14-470) (apparent unseaworthiness of ship justified mutiny); *Surocco v. Geary*, 3 Cal. 69, 74 [1853] (control of fire justified destruction of property).
116. Ariz. Rev. Stat. § 36-624 [2001].
117. Ariz. Rev. Stat. § 36-630 [2001].
118. See, e.g., Ind. Code § 16-41-9-11 [2002] (empowering local health officers to take into custody and transport carriers of communicable diseases to an appropriate emergency care facility for "observation, examination, testing, diagnosis, care, and, if necessary, temporary detention," subject to court order and other restrictions); Ind. Code § 16-41-9-12 [2002] (imposing civil penalty of up to $1,000 per violation per day against anyone who interferes with or obstructs any designated state agent in the performance of such duties).
119. 614 N.E.2d 686 [Mass. 1993].

CE/CME Objectives

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The participants will be able to:

- identify high-risk patients and use tips from the program to minimize the risk of patient injury and medical malpractice exposure;
- identify a "standard of care" for treating particular conditions covered in the newsletter;
- identify cases in which informed consent is required;
- identify cases which include reporting requirements; and
- discuss ways in which to minimize risk in the ED setting.

CE/ CME Questions

5. In the wake of a bioterrorism incident, EDs must provide treatment:
A. to every patient who requests it.
B. as directed by the CDC.
C. in accordance with accepted medical and legal principles.
D. to every person exposed to the biological agent, regardless of the person's wishes.
E. Both A and C

6. When ED personnel observe a pattern of illness suggesting bioterrorism, they should first notify:
A. other hospitals in the area.
B. local law enforcement agencies, the FBI, local and state public health officials, and the CDC.
C. the news media, to alert the public to the threat.
D. independent clinical laboratories.

7. Bioterrorism most often is detected through:
A. the observance of certain high-risk syndromes.
B. the observance of unusual disease patterns.
C. the observance of suspicious activity in the area around the ED.
D. Both A and B

8. Which of the following statements is *false* regarding state public health laws?
A. Most states have enacted laws specifically designed to mitigate the effects of bioterrorism.
B. In the wake of a bioterrorism attack, states may rush to enact new bioterrorism-related laws.
C. All states have enacted some form of contagious-disease control law.
D. Local health officials derive their regulatory powers from the "police power" of the state.

In Future Issues: Missed Asthma