

Pandemic Influenza and the Law:

Isolation, Quarantine, and Other Legal Tools for Containing Outbreaks

Jill Moore, JD, MPH

Today, governments, health care providers, businesses, and others are developing plans to respond to an influenza pandemic. These plans may discuss isolation or quarantine, or use related terms such as social distancing. But what do they mean by those terms?

The words isolation and quarantine, in particular, are used different ways by different people. For a physician, the word isolation may suggest precautions that are taken against the spread of infection, or a particular place in a health care facility where people with infectious diseases are treated. For the general public, the words may conjure up images of what I call the “TV movie of the week” form of isolation or quarantine: a home with a red-lettered sign on the door, a subdivision surrounded by a chain-link fence, or roadblocks manned by armed law enforcement officers. But for the public health system, isolation and quarantine are simply two of the legal tools available to control the spread of communicable disease. In North Carolina, these tools are part of a comprehensive legal framework for communicable disease that includes:

- laws that allow the public health system to detect communicable disease within the population,
- laws requiring public health agencies to investigate cases and outbreaks of communicable disease, and
- laws that specify—and require individuals to comply with—communicable disease control measures, which may include isolation or quarantine.

The varying common-sense and professional understandings of terms such as isolation and quarantine are good for the purposes they serve, but they may conflict with how the terms are defined in law—and it is the legal definitions that both authorize and constrain how these strategies may actually be used in an outbreak. It is therefore important for anyone involved in pandemic preparedness to understand the legal meaning of isolation and quarantine, and also the broader legal framework in which they are used.

The Framework: Legal Authority to Control Communicable Disease

The individuals and agencies that make up North Carolina’s public health system—including the state health director and division of public health, local health directors and the health departments they administer, and the seven Public Health Regional Surveillance Teams (PHRSTs)—would likely be the first to identify and respond to a disease outbreak. North Carolina laws give the public health system specific duties during an outbreak, as well as specific powers to help it perform those duties.

“North Carolina laws give the public health system specific duties during an outbreak, as well as specific powers to help it perform those duties.”

The starting point for communicable disease control is to be aware that a disease exists in a population—thus, one of the duties of a public health system is to detect disease. One of the ways public health meets that duty is by requiring certain diseases to be reported. North Carolina law presently requires physicians and specified others to report known or suspected cases of communicable diseases or conditions that have been declared “reportable” by the state’s Commission for Health Services.¹ The list of reportable communicable diseases and

Jill Moore, JD, MPH, is an Associate Professor of Public Law and Government at the University of North Carolina at Chapel Hill School of Government. She can be reached at moore@sog.unc.edu or School of Government, CB# 3330 Knapp-Sanders Building, UNC Chapel Hill, Chapel Hill, NC 27599-3330.

conditions is dynamic and has grown rapidly in recent years, so that it now includes over 70 diseases and conditions. Novel influenza viruses are a recent addition to the list—known or suspected cases must be reported to the local health department immediately.²

In addition to this routine reporting, another state law authorizes the state health director to temporarily require health care providers to make reports of conditions that are not on the list.³ The idea behind this law was to allow the public health system to act rapidly to detect an emerging illness or syndrome. State law also supports disease detection by authorizing public health to obtain access to medical information so that it can carry out public health surveillance.⁴

When a communicable disease or condition is detected, whether through the receipt of a disease report or a surveillance system, the public health system's duty to investigate is triggered.⁵ Again, state law gives public health specific legal powers to help it meet this duty. Both state and local public health officials are authorized to obtain access to medical and other confidential records that may be relevant to a case or an outbreak. Health care providers are required by state law to make medical and other records available to public health officials in these circumstances.^{6,a} Investigations may also include interviewing ill or exposed people, collecting specimens for laboratory analysis, and identifying others who may be ill or exposed.

By carrying out its duties of detection and investigation, the public health system lays the foundation for its ultimate duty: controlling the spread of the communicable disease. Supporting this duty is a state law that requires all persons in North Carolina to comply with communicable disease control measures—that is, the steps individuals, their health care providers, or the public health system must take to control the spread of disease.⁷

Communicable disease control measures are disease-specific and cover a wide range of strategies. In the event of an influenza pandemic, how will public health officials decide which control measures are appropriate? They should look first to guidelines and recommended actions issued by the Centers for Disease Control and Prevention (CDC). North Carolina law specifies that CDC guidelines will be the source of control measures when they are available,⁸ and it is expected that CDC will issue guidelines during a pandemic. If for some reason it does not, the law also permits public health officials to devise their own control measures that are reasonable and meet certain guidelines depending on the disease's route of transmission (airborne, bloodborne, etc).

Because CDC guidelines are the primary source for control measures, and because those are likely to evolve in an emerging

illness event, public health officials cannot know for certain what the control measures for an outbreak of a novel influenza virus will be. However, it is expected that the control measures would include at least:

- Immunization, if an effective vaccine is available
- Use of antiviral medications, if effective and available
- Isolation of infected individuals
- Quarantine of exposed individuals

In addition, public health officials will likely urge individuals and communities to embrace social distancing strategies, such as avoiding unnecessary outings.^b

The Definitions: Isolation and Quarantine in the Law

The main distinction between isolation and quarantine is that isolation is a control measure applied to sick people, whereas quarantine is applied to people who might get sick—usually because they have been exposed to an infected person. North Carolina's legal definitions begin with this fundamental notion, but then they take it a bit further. State law defines “isolation authority” as the authority to limit the freedom of movement or the freedom of action of a person who is infected with, or is reasonably suspected of being infected with, a communicable disease or condition.⁹ “Quarantine authority” includes the authority to limit the freedom of movement or the freedom of action of a person who has been, or is reasonably suspected of having been, exposed to a communicable disease or condition.¹⁰ Either a local health director or the state health director may exercise isolation or quarantine authority.¹¹

The definitions of isolation and quarantine authority refer to limiting either a person's “freedom of movement” or “freedom of action,” and several North Carolina laws make important distinctions between orders based on which freedom they limit. For example, the law that authorizes health directors to order isolation or quarantine provides that orders limiting freedom of movement expire after 30 days unless they are extended by a court—even if the subject of the order is still a threat to the public health.¹² The same limit does not apply to orders limiting freedom of action. It is therefore critical for public health professionals to understand when they are limiting freedom of movement and when they are limiting freedom of action—but no law defines these terms. However, the definitions can be inferred from longstanding public health practice.

An order limiting freedom of movement essentially prohibits

a Health care providers sometimes worry that providing access to records with individually identifiable health information violates the federal HIPAA privacy rule, but the privacy rule explicitly states that providers may comply with state laws that require the disclosure of such information. (45 CFR. 164.512(a).)

b As this commentary was going to press, the Centers for Disease Control and Prevention released *Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States* (Feb. 2007), available on the Internet at http://www.pandemicflu.gov/plan/community/community_mitigation.pdf. The document states that it is “highly unlikely” an effective vaccine will be available in a pandemic and recommends control strategies that include isolation of the ill, quarantine of the exposed, and use of social distancing strategies such as school closures and cancellations of large public gatherings.

an individual from going somewhere. It may confine the person to a particular place, such as his home or a health care facility, or it may prohibit the person from entering a particular place. For example, a person with active infectious tuberculosis may be required to remain at home until laboratory tests reveal he or she is no longer infected, or an unimmunized child may be required to stay home from school for the duration of a measles outbreak. In contrast, an order limiting freedom of action restrains a person's behavior, but not her ability to move about freely in society. For example, a person taking medication for tuberculosis that is no longer in the active infectious stage may be ordered to participate in directly observed therapy. This is a limit on freedom of action.

Thus, in North Carolina, an order requiring a person to be physically separated from the public would be called an "isolation order" (for an infected person) or a "quarantine order" (for an exposed person). But an order simply directing a person to comply with control measures that do not include physical separation would also be called an isolation or quarantine order. This counterintuitive use of the terms isolation and quarantine can be tricky even for public health professionals, but it is important to understand. Health care providers and patients who receive isolation or quarantine orders need to know what is actually being required of them.

During the Pandemic: Isolation, Quarantine, and Other Forms of Social Distancing

During an outbreak of influenza, an isolation or quarantine order might limit either freedom of movement or freedom of action—but it seems most likely that the isolation and quarantine authority would be used primarily to separate ill or exposed people from the general public. It also seems likely that isolation and quarantine would be used early in an outbreak in an effort to contain it as quickly as possible, but these strategies may well be abandoned if widespread illness affects a community. There is some question about whether public health officials would have the legal authority to order a television movie-style isolation

or quarantine—but of greater importance, such measures are widely considered to be both impracticable and likely ineffective.

In contrast, isolation or quarantine orders that are directed to individuals, or groups of individuals with a common exposure (such as the passengers and crew of an airplane carrying an ill person), are clearly within public health's legal authority and may play an important role in preventing widespread community illness, depending on how the outbreak unfolds. Indeed, North Carolina used isolation and quarantine in this fashion during the severe acute respiratory syndrome (SARS) outbreak of 2003. Although only one person's infection was ultimately confirmed to be SARS, several people were isolated because they were suspected of being infected, and several dozen were quarantined because they were exposed to one of the isolated people.

There is, of course, no guarantee that an outbreak of novel influenza would be as limited as SARS was in North Carolina, and there are good reasons to believe that it would not. If an outbreak becomes widespread in the community, it is likely that isolation and quarantine would become less important than other forms of social distancing. Social distancing could happen spontaneously, if members of the worried well population elect to stay home. It could also occur voluntarily in response to the urging of public health officials to avoid unnecessary outings. There are also various governmental actors who have the legal authority to compel different types of social distancing. North Carolina local governments can adopt ordinances that permit them to take a number of actions in emergencies, including restricting the movement of people.¹³ The Governor has the authority to declare a state of disaster and may, with the consent of the Council of State, prevent people from congregating in public places.¹⁴ School boards can close schools and, to answer one of the questions I am most frequently asked: if the universities do not do it on their own, state or local officials could probably cancel the Carolina-Duke game, or at least prevent the public from attending. Although everyone hopes it does not come to that, the legal authority is there to be exercised if necessary. **NCMJ**

REFERENCES

- 1 NC Gen Stat. 130A-135 through 130A-141 (LexisNexis 2005).
- 2 NC Admin Code, Title 10A, sec. 41A.0101 (2006).
- 3 NC Gen Stat. 130A-141.1 (LexisNexis 2005).
- 4 See, eg, NC Gen Stat. 130A-480 (LexisNexis 2005 & 2006 Supp.) (establishing a syndromic surveillance program for hospital emergency departments and requiring hospitals to report data specified by the state health director).
- 5 See NC Gen Stat. 130A-41 (LexisNexis 2005); NC Admin Code, Title 10A, sec. 41A.0103 (2006).
- 6 NC Gen Stat. 130A-144(b) (LexisNexis 2005).
- 7 NC Gen Stat. 130A-144(f) (LexisNexis 2005).
- 8 NC Admin Code, title 10A, sec. 41A.0201(a) (2006).
- 9 NC Gen Stat. 130A-2(3a) (LexisNexis 2005).
- 10 NC Gen Stat. 130A-2(7a) (LexisNexis 2005). The definition also includes the authority to limit access to areas or facilities contaminated by infectious agents, or to limit the freedom of movement or action of unimmunized persons during an outbreak that can be controlled by mandatory immunizations.
- 11 NC Gen Stat. 130A-145(a) (LexisNexis 2005). The authority to order isolation or quarantine may be delegated to another appropriate person. NC Gen Stat. 130A-6 (LexisNexis 2005).
- 12 NC Gen Stat. 130A-145(d) (LexisNexis 2005).
- 13 NC Gen Stat. Ch. 14, Art. 36A (LexisNexis 2005 & 2006 Supp.).
- 14 NC Gen Stat. Ch. 166A, Art. 1 (LexisNexis 2005 & 2006 Supp.).