LEARNING OBJECTIVES
At the completion of this case study, participants should be able to

- Describe the public health rationale for enforced compliance with medical treatment
- Explain the legal bases of isolation and detention of patients with communicable disease
- Evaluate the appropriateness of individual cases of enforced compliance with treatment

ASPH HEALTH POLICY AND MANAGEMENT ADDRESSED

- D.2. Describe the legal and ethical bases for public health and health services
- D.3. Explain methods of ensuring community health safety and preparedness
THE LEGAL AND ETHICAL BASES OF ENSURING PUBLIC HEALTH MEASURES: 
AN EXAMPLE OF TUBERCULOSIS TREATMENT COMPLETION

Required reading: Parmet, Wendy. Legal power and legal rights – isolation and quarantine in 
http://content.nejm.org/cgi/content/full/357/5/433

Part I: Overview of Public Health Powers in the United States

Introduction
In the United States, governmental power to act in the interest of public health is derived from 
police powers, which fall largely within the authority of state and tribal governments. They and 
designated local authorities use their police power to promote health and prevent or reduce 
risks to health, including the control of disease. The specific ways in which public health laws 
and regulations evolve and are implemented differ across the states.

Federal Role
The federal role in public health law is restricted in comparison with state authority. The 
federal government is authorized through the Public Health Service Act to take measures to 
prevent the entry and spread of communicable diseases from foreign countries into the 
United States and between states. These include “Do Not Board” and “Border Look Out” 
provisions, according to which the Bureau of Customs and Border Patrol limit movement of 
identified patients, defined by the U.S. Department of Homeland Security.1 While their local 
power to mandate is limited, federal public health agencies exercise considerable influence 
over state and local entities through funding public health activities and by setting guidelines, 
standards, and requirements to be met as a condition for federal funding.

State Role
State governments exercise broad authority to enact laws and promote regulations to 
safeguard the health, safety, and welfare of their citizens, and to conduct their activities in 
accordance with state statutes. As a result of this authority, the individual states are 
responsible for isolation and quarantine practices within their borders. Isolation refers to the 
detention of people with a transmissible disease to avoid exposing others to the disease. 
Quarantine is the practice of detaining people who have been exposed to a transmissible 
disease and who may or may not become ill until the risk of them becoming ill and exposing 
others to the disease has passed.2,3

As the required reading (Parmet 2007) points out, one of the oldest human responses to the 
spread of disease is the practice of detention, whether by isolation or quarantine. Individual
states have long exercised this authority to impose quarantine. Following late-19th century scientific developments that established the role of microbes and human transmission vectors in disease, the isolation of sick and contagious individuals was codified in several cities. State and local laws and regulations regarding the issues of mandatory isolation and quarantine vary widely. While some states have codified extensive procedural provisions related to the enforcement of these public health measures, other states rely on older statutory provisions that can be very broad. In some jurisdictions, local health departments are governed by the provisions of state law, while in other settings, local health authorities may be responsible for enforcing state or more stringent local measures. In many states, violation of a quarantine order constitutes a criminal misdemeanor.

Rationale for Mandatory Treatment
The principle of removing a source of contagion from public spaces in which disease can be transmitted was extended to mandatory treatment of communicable disease when effective antibiotic treatments for many diseases became available in the mid-20th century. Successfully eradicating communicable disease in individual patients not only promotes their health but also removes the risk that they will infect others. Therefore, effective treatment for some diseases can be seen as serving the public good. Detention as a means of compelling patient adherence to treatment for communicable disease has been applied mainly to patients with tuberculosis (TB).

Inherent in the constitutional use of public authority is the balance between the state’s obligation to protect its citizens’ well-being, on the one hand, and individual autonomy and right to privacy of people with a communicable disease such as TB, on the other. The medical ethics of public health actions under consideration have to be evaluated in terms of how they affect this balance. The exercise of powers granted to control the actions of people diagnosed with infectious or potentially infectious TB always involves the questions, “Is it ethical?” and “Is it legal?”

Ethical considerations involved in the detention of patients to facilitate completion of TB treatment include:

- Individual autonomy
- Right to medical privacy
- Right to liberty and self-determination
- States’ obligation to protect citizens’ health and well-being
- Risk to public health (eg, transmission of TB)

Enforced Completion of TB
Before the epidemiology of TB was understood, officials often described TB patients who resisted isolation as vicious and a public health menace, reinforcing public perceptions that detention of such patients was legitimate. Most US states adopted legislation requiring
treatment of TB in the years after antibiotic treatments for the disease were made available. \(^9\) However, statutory guidelines and procedures concerning treatment completion were generally lacking, although some institutions did adopt detention methods to promote completion of treatment in patients who did not voluntarily adhere to recommended treatment. \(^{10}\)

Despite widespread noncompletion of treatment, rates of TB in the US steadily decreased from the 1950s to the early 1980s. Many in the general public and even some public health professionals saw TB as a disease of the past, and funding for programs declined. \(^{11}\)

However, perceptions of TB as a vanquished threat were overly optimistic. The de-funding of public TB control programs coincided with long-term upward trends in urban poverty, increased immigration from countries in which TB is endemic, and in some cities, housing shortages. Outbreaks of TB in shelters, hospitals, and prisons revealed that infection control systems for congregate facilities were inadequate. The 1980s also saw a rise in substance use in major US cities, with injection drug and crack cocaine users disproportionately affected by the new surge in TB. Most importantly, the emergent epidemic of HIV/AIDS created a national pool of immunocompromised individuals uniquely vulnerable to TB disease. During the 1980s, TB case rates doubled in some metropolitan areas. New York City was particularly hard hit with cases tripling from 1979 to 1992. \(^{12}\)

In the midst of the resurgence of TB was a frightening subepidemic of multidrug resistant TB (MDR-TB), stemming in large part from widespread noncompletion of treatment (physicians’ inadequate prescribing practices also played a role). MDR TB required a more complex, longer course of treatment and, especially in immunocompromised patients, led to high fatality rates if not adequately treated. \(^{13}\) Many of the causative factors associated with MDR-TB intersected; thus the population within urban shelter systems might include high numbers of substance users who tended to be malnourished and spent time together, often engaging in behaviors that put them at high risk for HIV infection, and who had no regular access to health care or were reluctant to access services for fear that their drug use would be investigated. Such a group would be at high risk for TB transmission and for succumbing to the disease in the absence of treatment, especially when HIV was involved. The same group would be a source of ongoing transmission in the wider community. \(^{14}\)

In response, federal, state, county, and local public health authorities invested in rebuilding TB surveillance and treatment programs, and in strategies to encourage patients to adhere to TB treatment and to remove barriers to treatment completion. The most important of these strategies has been directly observed therapy (DOT) for outpatients, in which patients receive daily or intermittent (twice-weekly) doses of TB medications from a health care worker who witnesses that each dose is ingested. DOT may be done in a clinical setting, patient residences, schools, workplaces, or other settings convenient to patients. TB programs have adopted a patient-centered approach, which addresses the cultural and social conditions that may impede patients’ completion of treatment, such as language barriers, unfamiliarity with
the US medical system, chronic unemployment, homelessness, and alcohol and drug abuse. The programs are often combined with other outpatient services, including substance use treatment programs.15

Services that TB programs regularly provide to all patients include:
- 'Enablers' that facilitate treatment completion, such as the direct provision of transportation or reimbursement for travel costs to TB-related appointments
- Incentives, or small rewards to recognize adherence
- Interpreter services
- Appropriate health education15

The public health rationale for DOT services enhanced in these ways is 2-fold. First, effective treatment reduces the time in which a person with pulmonary TB can transmit the disease to others. Second, completion of treatment reduces the risk that a patient who has completed only part of a course of treatment will experience a recurrence of TB, and possibly develop drug-resistant TB.

Detention
Along with substantial increases in program funding, staffing, and services that actively engage patients in DOT, programs also made use of existing state laws to institute procedures for isolating and detaining patients for whom less restrictive approaches to treatment completion were contraindicated or had failed. While none of these approaches allows for forcible administration of medication, they represent progressively substantial restrictions on patients' liberties during the prescribed period of treatment. In 1993, the Centers for Disease Control and Prevention's Advisory Council for the Elimination of TB (ACET) recommended that detention be included in the range of strategies that programs employ to promote completion of TB treatment. While legal interventions are mandated in all US states, the types of interventions and the mechanisms used to deploy them vary widely from state to state.16

As they have evolved since the resurgence of TB in the United States, state and local laws, statutes, and regulations and TB program procedures recognize several standards that must be met before patients are detained.

Accepted procedural standards include:
- Maintenance of patient confidentiality
- Documentation of all measures taken to ensure prompt diagnosis of TB disease, treatment adherence, and completion of therapy
- Individualized assessment of the noncompletion risk posed by each patient considered for detention
- Use of the least restrictive possible alternative to detention of patients to ensure completion of treatment7
Challenges to state procedures for detaining patients who are or who are likely to be nonadherent to TB treatment have emphasized that public health powers, like other state police powers, must provide adequate procedural protections for the patients' right to due process of law, as guaranteed by the 14th amendment to the US Constitution.

Due process rights include:

- Adequate written notice of the reasons for the request for detention
- Legal counsel, including appointed counsel for people unable to pay for legal counsel
- The right to hear charges, cross examine witnesses, and bring witnesses in defense of the patient’s position
- The application of a “clear and convincing” standard of proof that, while not as high as the standard for criminal proceedings, is higher than that used in civil court decisions
- The right to a full transcript of the proceedings that can be used in the preparation of an appeal\textsuperscript{17}
Part II: Case Studies

New York City Case Study

Nowhere was the rise of TB in the United States as dramatic as in New York City in the late 1980s. The city responded with rapid increases in funding, services, and personnel for its TB control program, and with changes to the municipal health code that defined how city officials could compel the diagnosis and treatment of TB. As the required reading (Parmet 2007) points out, patients detained in New York during this period were mainly homeless and overwhelmingly people of color, raising concerns that detention would be applied disproportionately to vulnerable or marginalized groups in the city. This highlighted the need to clearly delineate the scope and limitations of detention. The following table describes the regulatory actions permitted in New York City, the evidence required before such actions may be undertaken, and conditions under which regulatory measures may be rescinded.
### TABLE 1. TYPES OF REGULATORY ACTION*18

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>EVIDENCE REQUIRED</th>
<th>BASIS FOR RESCINDING ORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Order for examination for suspected TB</td>
<td>Clinical symptoms or history of TB and patient refusal to come to clinic or submit to examination in hospital</td>
<td>After minimal time required, TB can be either diagnosed or ruled out. No forcible examination allowed</td>
</tr>
<tr>
<td>as outpatient or in detention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Order to complete treatment</td>
<td>History of leaving hospital against medical advice or noncompliance early in course of treatment</td>
<td>Patient completes treatment or is given another order</td>
</tr>
<tr>
<td>Order for DOT</td>
<td>Noncompliance with voluntary DOT, history of leaving hospital against medical advice, or previous order for detention while infectious</td>
<td>Patient completes treatment, self-administration of medication is allowed, or patient is detained</td>
</tr>
<tr>
<td>Written warning of possible detention</td>
<td>Failure to adhere to order for DOT without plausible excuse or less than 80% compliance for more than 2 weeks</td>
<td>Patient completes treatment or is detained</td>
</tr>
<tr>
<td>Order for detention while infectious</td>
<td>Proof of suspected infectiousness, either by [test results] or clinical symptoms, plus failure to abide by infection-control guidelines or inability to be separated from others as outpatient</td>
<td>Patient has 3 negative [tests] or clinical evidence of noninfectiousness</td>
</tr>
<tr>
<td>Order for detention while noninfectious</td>
<td>Proof of substantial likelihood that patient cannot complete treatment as outpatient (eg, documented noncompliance with DOT, denial of diagnosis of TB, history of inability to be located)</td>
<td>Patient is discharged early to court-ordered DOT or patient completes therapy. Order must be periodically reviewed by court</td>
</tr>
<tr>
<td>Discharge from detention before cure</td>
<td>Change in circumstances so that compliance with outpatient DOT is likely (eg, new insight, substance-abuse treatment, new home environment, or family support)</td>
<td>Patient completes treatment or is detained again if patient fails to comply with outpatient treatment</td>
</tr>
</tbody>
</table>

*None of the orders permits forcible administration of medications

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The following describes the case of a detained patient that was appealed to the New York State Supreme Court in 1995.

**Case of Antoinette R**

This is the case of the patient Antoinette R, a 33-year-old New Yorker who used the aliases Marie C and Chastity C during multiple admissions to local hospitals over a period of 2 years.

November 1993

On November 30, 1993, a 33-year-old female resident of New York calling herself Marie C was admitted to a local hospital with a diagnosis of infectious TB in 1 lung. While she was hospitalized she began treatment for TB. During the hospitalization, she was interviewed by a department of health (DOH) employee, who explained the importance of completing at least 6 months of treatment for TB to avoid a recurrence of the disease, transmission to others, and the development of drug-resistant strains of TB. The health care worker also told Marie that, after she was discharged from the hospital, she would be scheduled to receive DOT in which a DOH worker would come to her residence and observe her taking her medication. Marie said that she had no fixed address and often stayed with friends. She explained that her children lived with her mother and that she sometimes stayed at her mother’s house too. She provided her mother’s address but no phone number. Soon after, while she still had infectious TB, Marie left the hospital against medical advice (AMA). DOH employees made several attempts to reach Marie at the only address they had obtained, her mother’s. When they contacted her mother, she said that she did not know where her daughter was or when she might see her again. She did, however, share with the DOH employees her daughter’s actual name, Antoinette R.

**Discussion Question 1: What regulatory action could the DOH appropriately take in Antoinette’s case at this point?**

May 1994

Six months after she left the hospital AMA, Antoinette reappeared in the emergency department of the same hospital complaining of difficulty breathing, but left without being discharged. A week later, she was admitted under her real name to that hospital with high fever. A chest X-ray showed signs of TB disease in 1 lung. Although she was reluctant to speak to DOH employees, they eventually realized that she was the “Marie C” they had lost track of months ago. They obtained an order from the New York City Commissioner of Health requiring her to remain in the hospital.

Antoinette was hospitalized for 5 weeks. In preparation for her impending discharge, DOH employees took steps to encourage her adherence with outpatient care and DOT. They also requested and obtained an order from the Commissioner of Health ordering her to be adherent while on DOT. The order was served to her before she left the hospital.

As an outpatient, Antoinette met with her DOT worker on 5 of 8 scheduled visits in the first 2 weeks following her discharge but was reluctant to take the medication that was brought to
Discussion Question 2: What regulatory action could the DOH appropriately take in Antoinette’s case at this point?

January 1995
Six months later, Antoinette was admitted to a local hospital with chest X-rays showing severe, worsening TB disease in both lungs. She registered under the name Chastity C. DOH workers visited her and began to educate her about infectious TB, the need to avoid transmitting the disease to others, and the importance of treatment to ensure her recovery and avoid the possibility of developing drug-resistant TB. They also discussed DOT. Eventually they discovered she was the same person as Marie C and Antoinette R. Given her history, the DOH applied for an order of detention requiring Antoinette R to remain in the hospital until she completed treatment and was determined to have been cured of TB. New York City regulations require that the order of detention be reviewed every 90 days. Thus, the DOH would have to make a request to renew the order within 90 days.

For 2 months Antoinette was hospitalized and cooperated with all medical instructions, even searching out the nursing staff to request her TB medications. She participated in programs and activities offered to hospital patients and received regular visits and phone calls from her mother. Under treatment, her TB disease was rendered noninfectious. She requested that her order of detention be reviewed and asked that it be rescinded, allowing her to complete outpatient care under the supervision of a local clinic and allowing her to receive DOT at her mother’s residence. She explained that her behavior had changed because she had undergone a religious conversion while hospitalized.

Her mother was willing to have Antoinette’s DOT done in her home and confirmed that Antoinette’s attitude and demeanor had changed dramatically, so that she was much more cooperative, pleasant, and receptive to medical care. The hospital nursing staff also gave evidence for the review of Antoinette’s order of detention indicating that she was now a cooperative patient actively engaged in her treatment.

April 1995
The Appellate Court reviewed the order of detention to determine if Antoinette should be allowed to complete her TB treatment as an outpatient, given that Antoinette no longer had infectious TB and had undergone a change in her demeanor and attitude regarding TB treatment.

The Court determined that:

The DOH has demonstrated through clear and convincing evidence the respondent’s [Antoinette’s] inability to comply with a prescribed course of medication in a less restrictive
environment. The respondent has repeatedly sought medical treatment for the infectious stages of the disease and has consistently withdrawn from medical treatment once symptoms abate. She has also exhibited a pattern of behavior that is consistent with one who does not understand the full import of her condition nor the risks she poses to others, both the public and her family. On the contrary, she has repeatedly tried to hide the history of her condition from medical personnel. Although the court is sympathetic to the fact that she has recently undergone an epiphany of sorts, there is nothing in the record that would indicate that once she leaves the controlled setting of the hospital she would have the self-discipline to continue her cooperation. Moreover, her past behavior and lack of compliance with out-patient treatment when her listed residence was her mother's house makes it all the more difficult to have confidence that her mother's good intentions will prevail over the respondent's inclinations to avoid treatments. In any event, the court will reevaluate the progress of the respondent's ability to cooperate in a less restrictive setting during its next review of the order in 90 days.

Accordingly, the respondent shall continue to be detained in a hospital setting until the petitioner [the DOH] or the court determines that the respondent has completed an appropriate course of medication for tuberculosis, or a change in circumstances indicates that the respondent can be relied upon to complete the prescribed course of medication without being in detention. The petitioner is further directed, pursuant to New York City Health Code § 11.47 to apply to the court within 90 days for authorization to continue respondent's detention.20

Discussion Question 3: How did Antoinette's behavior represent an actual or potential threat to public health?

Discussion Question 4: To what degree did the New York City DOH fulfill the procedural principle to provide treatment to Antoinette under the least restrictive conditions possible?

Discussion Question 5: Do you agree with the court's decision to detain Antoinette in the hospital for the duration of treatment? Please offer a rationale for your response.

Discussion Question 6: Could DOH employees have handled this case differently? If so, how?
California Case Study

The following describes the case of a detained patient that was appealed to the California Supreme Court in 2002.

In California, county and local governments undertake TB control activities according to state regulations. In 1995, the California state legislature enacted several provisions of the California Health and Safety Code related to TB control. The provisions authorize county and local health officials to order individuals to comply with proper isolation procedures, undergo a course of treatment, or adhere to DOT and related clinic appointments.21

The California Health and Safety Code further authorizes health officials to detain an individual with TB disease if there is "a substantial likelihood, based on the person’s past or present behavior, that he or she cannot be relied upon to participate in or complete an appropriate prescribed course of medication for tuberculosis disease and, if necessary, follow required infection control precautions for tuberculosis disease." Behavior that would support detention under California regulations includes refusing or failing to take medication, to keep appointments, to complete treatment, or to follow measures to avoid transmitting TB to others (California health and safety code).22

The state Code also provides specific measures to safeguard patients' due process rights in the case of detention for noncompliance with prescribed treatment or infection control measures.

“Because civil detention entails an extreme deprivation of liberty, the civil detention process in the TB control statute involves extra procedural due process measures. The state statute says that a local health officer may detain without prior court authorization, but gives detainees the following rights:

- Upon a detainee’s request, the local health officer must apply for a court order authorizing continued detention within 72 hours of the request.
- Whether or not a detainee makes a request, a court order is required for detentions of more than 60 days.
- The health officer must seek further court review of a detention within 90 days of the initial court order and within 90 days of each subsequent court review.
- The health officer must prove the necessity of the detention by clear and convincing evidence.
- A person subject to detention has the right to counsel and to have counsel provided.
- Each health order must advise the detainee of his or her rights regarding release requests, court orders, court review, and legal representation.
- Each health order must be accompanied by a separate notice that explains the detainee’s right to request release; that lists the phone number the detainee may call to request release; that explains the detainee’s right to counsel; and
that informs the detainee that, at the detainee’s request, the health officer will notify two individuals of the detention.

- A detainee may only be detained for the amount of time necessary to fulfill the purpose of the detention.  

Interpreters
The California Health and Safety Code also calls for language interpreters to communicate with patients for the purposes of executing TB related investigations and orders. “As such, TB control workers who interact with the public ought to try to make sure that they are understood. In addition, it would prudent to translate health orders (either verbally or in writing) for non-English speakers.”

Site of Detention by TB-Related Health Order
The California Health and Safety Code also specifies that correctional facilities shall not be used to house individuals detained through a health order, and that funds available under that program should not be paid to, or used by, correctional facilities.

Case of Patient Hongkham Souvannarath

Hongkham Souvannarath was among the thousands who fled economic and political upheaval in Laos after the Vietnam War. She made her way to a refugee camp in Thailand and eventually gained entry to the United States in 1984 settling in Fresno County, California.

In February 1998, Souvannarath, then 51 years old and living with her teenaged daughters, was diagnosed with MDR TB. Once her TB disease was rendered non infectious and she was released from the hospital, she received outpatient medical care from the county health department at the local chest clinic. Souvannarath’s treatment included the use of intravenous drugs in combination with oral medication. She had adverse reactions to the treatment, which compounded the symptoms of TB disease that she experienced. She was not able to communicate fully with the clinic staff as they did not provide an interpreter fluent in Laotian, but they did use a Hmong interpreter who spoke rudimentary Laotian. Thus Souvannarath lacked a full comprehension of her medical condition. She did, however, cooperate with the prescribed treatment for several months.

After several months in which she continued to suffer side effects from her medications, Souvannarath made plans to move to Ohio to live with one of her sons. She hoped that the son would be more able than she was to oversee her medical care and that her condition might improve under his care. Souvannarath informed the chest clinic of her intentions and gave the clinic her son’s address. On her last clinic visit, she was given a 1-month supply of oral medications to self-administer while she was in the process of moving. Following protocol, the chest clinic notified the TB Program in Ohio of Souvannarath’s new address and of her impending arrival.
However, there was an unexpected delay in Souvannarath leaving and as a result she completed her month’s supply of medications while remaining in California. As soon as she stopped taking the medications, Souvannarath also stopped feeling adverse effects and actually felt much better. She thus decided to avoid the chest clinic until she moved. Souvannarath instructed her daughters not to disclose her whereabouts to any local authority.

In early July, 1998, the chest clinic received word from the Ohio TB program that Souvannarath had never arrived at her son’s address. The clinic staff in California was worried that Souvannarath might be lost to follow-up and that she was not receiving appropriate TB treatment. If this were the case, the situation could potentially result in her becoming infectious and posing a continued risk to her family and community. In an attempt to locate Souvannarath, clinic staff visited her last known address and her older daughters informed them that their mother’s whereabouts were unknown. However, her daughters suggested that the clinic call Souvannarath’s sons, who had more influence over their mother. The chest clinic did not contact the sons.

**Discussion Question 1:** What regulatory action could the Fresno County TB Control Program appropriately take in Souvannarath’s case at this point?

On July 23, 1998, during a routine field visit to another patient in the same neighborhood, a nurse from the TB clinic located Souvannarath. The next day, a communicable disease specialist from the state health department visited her with an interpreter. The specialist served Souvannarath with an English-language order for examination instructing her to appear at the chest clinic on July 28. Although the interpreter explained the meaning of the order and that Souvannarath could be detained if she did not appear, she and her daughters had trouble understanding the interpreter. She did not keep her appointment at the chest clinic.

**Discussion Question 2:** What regulatory actions were available to the county at this point?

When Souvannarath failed to appear at the clinic, TB control staff immediately requested an order of detention from the county health officer. The order was granted directing Souvannarath to be detained in the county jail until she completed the prescribed course of treatment. The order did not provide reasons for the detention, and it contained no reference to Souvannarath’s rights under the state TB control statute, which included the right to petition for her release, the right to a hearing, and the right to a court appointed counsel.

On July 30, 1998, a state communicable disease specialist and 2 police officers served Souvannarath with the order of detention and arrested her. They took her at gunpoint to the county jail after asserting that she was only going to the hospital. When she reluctantly agreed to proceed into the jail, she was strip-searched. She was crying during this process and had access only to a Hmong interpreter. He incorrectly interpreted some of her
statements as suicide threats, and, therefore, she was confined in a cold, dark safety cell for 3 days.

After being released from the safety cell, Souvannarath was sent to the jail’s infirmary for the 6 months that it took to complete the intravenous portion of her therapy. She was allowed 30-minute visits with her daughters twice a week through a glass security barrier. To attend her TB appointments at the county chest clinic, she was escorted down a major thoroughfare in town shackled at her wrists, ankles, and waist. When she was hospitalized in the course of her treatment, she was chained to her hospital bed. Souvannarath was ultimately placed in the general population of the county jail, where she was treated as the other inmates were. She was often too weak to climb to her assigned top bunk, and she had trouble obtaining her nausea medications. One guard was able to provide occasional interpretation services, but most of the time Souvannarath could not communicate with the prison staff.

During her incarceration, Souvannarath’s sons sought legal advice about their mother’s case. Their lawyers’ inquiries led local authorities to review the case as well. In May, 1999, the Fresno County Counsel’s office informed the county health officer that the order of detention issued for Souvannarath in July of the previous year did not fully meet state requirements. Therefore, 10 months after her arrest, Souvannarath was served with a revised detention order and was given an attorney and a hearing date. At a May 27, 1999, hearing, Souvannarath was released from jail to home and placed on electronic monitoring. At a July 19, 1999 review hearing in the Superior Court of Fresno County, Souvannarath was unconditionally released from detention. The county TB control program contested this decision; however, the California State Supreme Court upheld it in 2002.22

Discussion Question 3: How did Souvannarath’s behavior represent an actual or potential threat to public health?

Discussion Question 4: To what degree did the county and state officials fulfill the procedural principle to provide treatment to Souvannarath under the least restrictive conditions possible?

Discussion Question 5: Do you agree with the TB controller’s request for an Order of Detention for the duration of treatment? Please offer a rationale for your response.

Discussion Question 6: Could the clinic personnel assigned to this case have handled it differently? If so, how?
Suggested Reading:


References


20. In the Matter of City of New York et al, Petitioners, v Antoinette R., Also Known as Marie C., Also Known as Chastity C., Respondent. Index No. 005518/95 SUPREME COURT OF NEW YORK, QUEENS COUNTY 165 Misc. 2d 1014; 630 N.Y.S.2d 1008; 1995 N.Y. Misc. LEXIS 392.


