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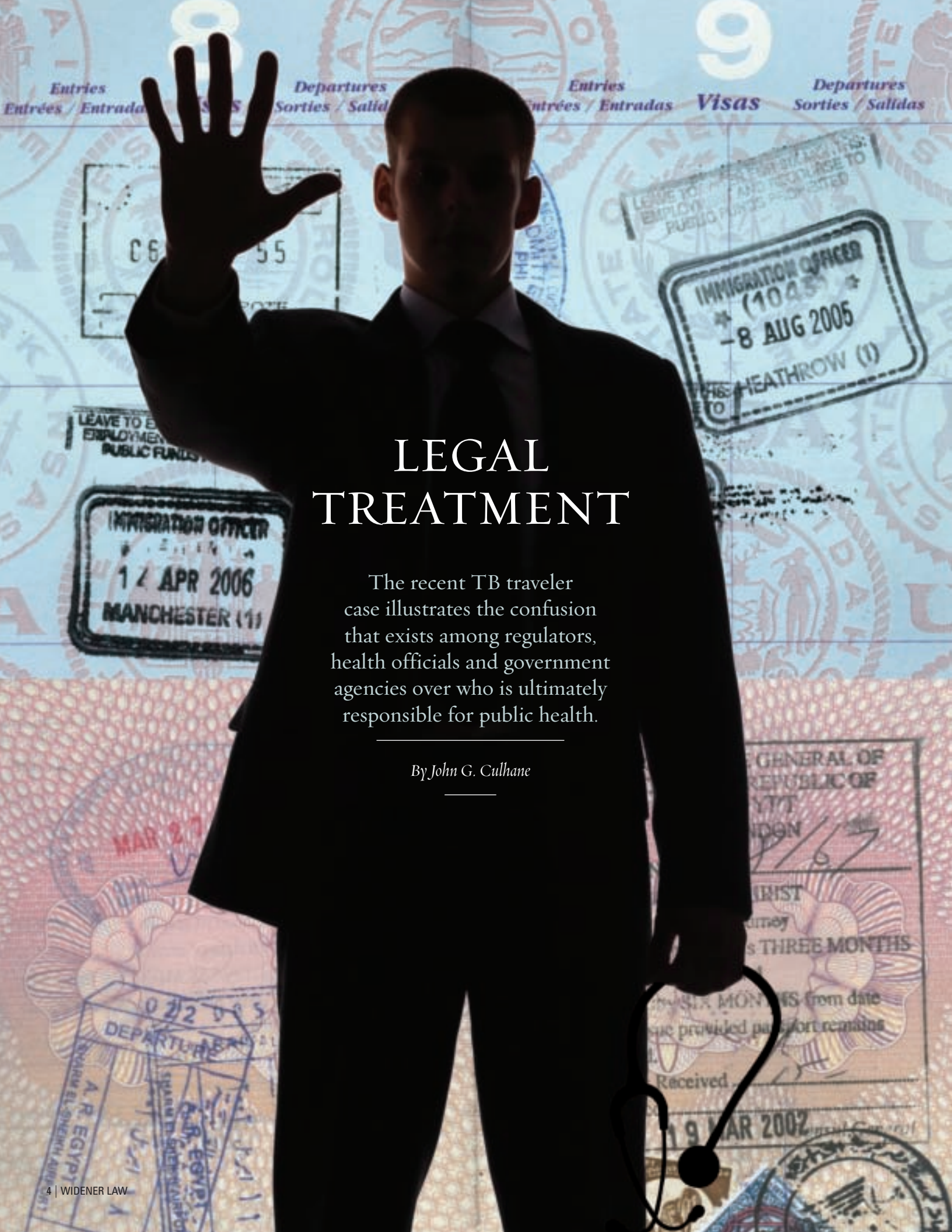

LEGAL TREATMENT

The recent TB traveler case illustrates the confusion that exists among regulators, health officials and government agencies over who is ultimately responsible for public health.

By John G. Culhane

A young man is diagnosed with a highly drug-resistant strain of an infectious disease. Disregarding a pointed request (if not an order) not to travel, he boards a plane in Atlanta and flies through Paris to Greece to prepare for his wedding. He is soon joined by his fiancée, and after the wedding, the couple flies to Rome for their honeymoon. Federal authorities track him down there and reiterate that air travel is too risky to other passengers. Undaunted, he flies to Montreal, rents a car, and drives across the border back into the U.S. Although an electronic "flag" keyed to his passport tells the patrol officer that the man poses a public health risk, he is waved through.

Finally, authorities track the man down, order him into quarantine, and "ship" him to Denver for treatment. After the regimen is successfully completed, Congressional hearings predictably follow. Reduced to basics, the question raised at the hearings is: "What the heck just happened?"

The man's name was Andrew Speaker, an Atlanta attorney. The disease was tuberculosis—and not of the garden variety, but the most drug-resistant strain, referred to as XDR-TB. In simplest terms, the "extensively drug-resistant" label means that almost all antibiotic treatments are ineffective, and that even with the most aggressive course of treatment, recovery rates are low and death rates high. On a worldwide level, such resistance is a major concern given that TB claims more than 1.5 million lives each year.

Fortunately, despite a positive sputum test indicating an active (and therefore potentially infectious) case of TB, Mr. Speaker was largely free of symptoms and therefore not at all likely to have infected anyone, even in the close quarters of a commercial airplane. On one level, then, the case can be seen as the proverbial tempest-in-a-teapot.

Taking such a sanguine view would be a mistake, though. The case raises several issues that are of broader concern: What is the proper legal and diplomatic relationship between the United States and other nations, and between the U.S. and the individual states in these cases, given that infection doesn't respect borders? Why did the system fail to stop Mr. Speaker from crossing borders, seemingly at will? Perhaps most seriously but most difficult to address, why do public health officials command so little respect, given the importance of their mission? Fully answering any one of these questions would require a full law review-style article, but more succinct answers can convey the essential points.

First, the communication and coordination needed for successful interdiction are fairly well in place, but are effective only if understood and used in a timely way. Here, a combination of delay and misinformation stymied efforts to prevent Mr. Speaker's travel. A more detailed chronological account of the events makes this point effectively.

An initial meeting between Mr. Speaker and the Fulton County (Georgia) Department of Public Health could have prevented him from traveling overseas. Depending on whose account of that meeting one credits, Andrew Speaker was either told or asked during that meeting not to make the trip. But given the severity of drug-resistant TB, the officials should have insisted that the trip not take place, and backed up that insistence with the threat of involuntary quarantine. To the extent that these officials believed that they lacked the authority to seek an order of quarantine, they insufficiently understood their own police power—the right of the state to take whatever means are necessary to protect the public's

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health. A hearing on the issue of quarantine could have determined whether Mr. Speaker's condition was sufficiently contagious to pose a serious public health threat, and, if so, what might have been done to mitigate the threat. Had this simple step been taken, the narrative that follows would have been cut off at the start.

After Fulton County officials communicated their concern to the Centers for Disease Control and Prevention (CDC)—conveniently, also located in Atlanta—authorities tried delivering a medical directive to Mr. Speaker ordering him not to travel, but were unable to locate him. The next day, his six-nation tour began: from the United States through France to Greece; from Greece to Italy; from Italy through the Czech Republic to Canada, where he rented a car and crossed back into the U.S.

In was not until he arrived in Rome that CDC became sufficiently concerned to attempt further intervention. The concern was justified, because by this time tests had shown that Mr. Speaker's strain of TB was not "merely"

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drug-resistant, but highly drug-resistant (XDR). Earlier and more insistent intervention by Fulton County might have caused the test for XDR-TB to have taken place sooner, but now CDC was faced with a problem of international magnitude.

At this point, CDC needed to contact several players in order to stop Mr. Speaker from boarding a commercial airplane. But which ones? Domestically, the candidates were the Department of Homeland Security (DHS) and several of its divisions: U.S. Customs and Border Protection (CBP), the Transportation Security Administration (TSA) and the Office of Health Affairs. The extraterritorial parties with an interest by that point would have included the Italian government and the World Health Organization (WHO).

Neither CDC nor CBP contacted TSA, which could have issued a "no-fly" order. But the Department of Homeland Security was itself unsure about its authority to issue such an order, given that Mr. Speaker was not a "terrorist." (Such an order was finally issued, but only after he had already re-entered the U.S.) Further, the timeline issued by the Congressional committee overseeing DHS suggests that CDC did not officially contact the Italian government (which itself might have prevented Mr. Speaker from flying), instead relying on a personal visit to Mr. Speaker by a former CDC employee who happened to be working for the Italian health ministry. The visit never took place, because Mr. Speaker had left his hotel by the time the official arrived. CDC did at least notify WHO in accordance with the requirements of the revised International Health Regulations, but by this time Mr. Speaker was on his way back to the U.S. (And WHO did not notify potentially affected nations until four days after they'd received CDC's message.) As mentioned earlier, the final error took place when an electronic message linked to Mr. Speaker's passport warning CBP personnel that he was contagious was ignored.

This course of events is obviously of grave concern. Clearer protocols and delineations of authority need to be in place. Only then can the cooperation needed for successful public health policy be realized. Officials at all levels need to be clear both on the etiology of disease and their legal authority, and every actor must be educated on the proper chain of communication in cases so clearly threatening the public. And then swift action needs to occur. WHO's four-day delay, although unimportant in this event, might have been disastrous.

Of course, had such protocols been in place, Mr. Speaker might never have been permitted to leave the United States in the first place. But this statement invites a hard question: Why did Mr. Speaker choose to ignore the public health threat that his condition might have posed to others? In an important sense, his actions and those of the customs official who ignored the e-warning are similar: Neither took the public health threat seriously enough to do anything about it.

More than any of the snafus detailed above, such indifferent responses to the requests, or even directives, of public health officials pose risks to the community. Consider these cases: An HIV-infected woman who has engaged in high-risk conduct remains ignorant of her status because she is apparently healthy and foregoes testing. A healthy young man never wears seatbelts because they're a nuisance and, anyway, he's not going to be involved in an accident. Millions regularly overeat because the dreadful health consequences aren't immediately suffered.

In short, the powerful and ever-present combination of ignorance, denial and selfishness makes the work of public health challenging and at times frustrating. These problems are well known, and those in the field have devised many creative and agile strategies for dealing with them. Indeed, the examples above can be countered by focusing on population-based, rather than individual, outcomes. So, community-specific HIV prevention and awareness messages have proven somewhat successful. The relentless seatbelt campaign has greatly increased the rate of regular use, so that the gentleman in the last paragraph is now the exception; a generation ago, he was the rule. We are belatedly and haltingly addressing the obesity problem, with recent hopeful successes such as the agreement former President Bill Clinton negotiated with soft drink companies to limit access to their products within the school system.

Success is usually incremental (exceptions such as childhood vaccinations aside) and always hard-earned. Public health and its officials do themselves no favors by making their own tasks more difficult, as was surely true in the Andrew Speaker case. ■