



Extensively Drug-Resistant Tuberculosis (XDR-TB): Emerging Public Health Threats and Quarantine and Isolation

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Summary

The international saga of Andrew Speaker, a traveler thought to have XDR-TB, a drug-resistant form of tuberculosis, placed a spotlight on existing mechanisms to contain contagious disease threats and raised numerous legal and public health issues. This report presents the factual situation presented by Andrew Speaker. It also discusses the application of various public health measures available to contain an emerging public health threat posed by an individual who ignores medical advice and attempts to board an airplane or take other forms of public transportation. These measures include quarantine and isolation authorities, the “Do Not Board” List, and application of certain provisions of the International Health Regulations. This report also examines constitutional issues relating to due process and equal protection. Legal issues which may be raised by application of federal nondiscrimination laws when emergency public health measures are used to contain emerging public health threats are also discussed.

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*“Infectious diseases are not a thing of the past.... We need to continually adapt our prevention and response capabilities in an era of increasing threat and globalization.”*¹

Introduction

The international saga of Andrew Speaker, a traveler thought to have XDR-TB, an extensively drug-resistant form of tuberculosis, placed a spotlight on existing mechanisms to contain contagious disease threats and raised numerous legal and public health issues. This report presents the factual situation presented by Andrew Speaker, an analysis of various public health emergency measures available to contain emergent public health threats when individuals with serious communicable diseases attempt to use public transportation such as commercial aviation, and legal issues related to the use of such public health measures.²

Background

Tuberculosis (TB) is a bacterial infection which usually attacks the lungs but can also damage other parts of the body. It is spread when an infected person coughs, sneezes, sings, or talks and another person breathes in the bacteria.³ The risk of becoming infected depends on various factors including the extent of the disease in the person with TB, the duration of the exposure, and ventilation. For example, when an infected individual travels on an airplane, the risk to other passengers is increased by proximity to the infected person, and the time spent on board.⁴ While the overall risk of TB or any communicable disease being transmitted on board aircraft is low,⁵ the increasing availability and duration of air travel increase the possibility of exposure to people with TB.⁶

The World Health Organization (WHO) has stated that one in three people in the world is infected with dormant TB bacteria.⁷ Generally, these individuals become ill only when the bacteria become active, often as a result of lowered immunity, such as when an individual has HIV/AIDS.⁸ TB is usually treatable with antibiotics, but antibiotic resistance has been increasing,

¹ *Impact of One Tuberculosis Patient on International Public Health Before the Subcomm. on Labor, Health and Human Services, Education, and Related Agencies of the S. Comm. on Appropriations*, 110th Cong., 1st Sess. (June 6, 2007) (statement of Julie L. Gerberding, MD, MPH, Director, Centers for Disease Control and Prevention).

² The H1N1 influenza pandemic raises similar, but factually different, issues. For a discussion of quarantine and isolation, transportation, and civil rights issues regarding this pandemic see CRS Report R40560, *The 2009 Influenza Pandemic: Selected Legal Issues*, coordinated by Kathleen S. Swendiman and Nancy Lee Jones.

³ <http://www.nlm.nih.gov/medlineplus/tuberculosis.html>.

⁴ Centers for Disease Control and Prevention (CDC), “Tuberculosis Information for International Travelers,” <http://www.cdc.gov/tb/publications/factsheets/general/tbtravelinfo.htm>.

⁵ WHO, *Tuberculosis and Air Travel: Guidelines for Prevention and Control* (3rd ed. 2008), available at http://www.who.int/tb/publications/2008/WHO_HTM_TB_2008.399_eng.pdf (hereinafter, *2008 WHO Guidelines*).

⁶ *WHO 2008 Guidelines* point out that “(w)hile screening for TB is often mandatory for immigrants and refugees, it is not required by countries for the overwhelming majority of passengers flying in commercial aircraft,” at 1.

⁷ In 2009, 11,545 tuberculosis (TB) cases were reported in the United States, a decline in the rate of infection from 2008. <http://www.cdc.gov/tb/publications/factsheets/statistics/TBTrends.htm>.

⁸ “Nearly nine million people in the world each year develop TB, and since adequate care is lacking for many people in resource-poor countries, about 1.6 million die.” *Drug Resistant TB: CDC’s Public Health Response Before the Subcommittee on Africa and HIV/Global Health, Committee on Foreign Affairs*, 110th Cong. 2d Sess. (Feb. 27, 2008) (continued...)

partly as a result of the misuse or mismanagement of the medication.⁹ Multi-drug resistant TB (MDR-TB) is resistant to two of the most effective antibiotics.¹⁰ Extensively drug resistant TB (XDR-TB) is a type of MDR-TB which is resistant not only to the first-line antibiotics, but also to other second-line drugs. XDR-TB is a serious condition because the treatment options are limited and successful treatment is not always possible.¹¹ In 2006 WHO issued a global alert about XDR-TB¹² which has been described as underscoring “the harsh reality that XDR-TB has the potential to transform a once treatable infection into an infectious disease as deadly, if not more so, than TB at the beginning of the 20th century.”¹³

On May 12, 2007, Andrew Speaker, a man with tuberculosis, flew from Atlanta, GA, to Europe, where he was married in Greece, and then traveled to Italy.¹⁴ While Mr. Speaker was in Europe, the Centers for Disease Control and Prevention (CDC) completed testing showing that he was infected with XDR-TB. At that point, CDC attempted to reach the patient in Europe, and to prevent his use of public transportation, such as passenger aviation, for his return to the United States.¹⁵ Fearing he would not be able to return to the United States for treatment, Mr. Speaker, without CDC’s knowledge, flew to Canada and entered the United States by car on May 24.¹⁶

Although CDC had alerted U.S. Customs and Border Protection (CBP) in the Department of Homeland Security to the possibility that Mr. Speaker was en route to the United States, Mr. Speaker was not stopped at the border.¹⁷ Once in the United States, Mr. Speaker contacted CDC,

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(statement of Julie L. Gerberding, MD, MPH, Director, CDC).

⁹ World Health Organization, “XDR-TB: Extensively Drug-Resistant Tuberculosis,” <http://www.who.int/tb/challenges/xdr/en/>.

¹⁰ For 2009, a total of 94 MDR-TB cases were reported in the United States. <http://www.cdc.gov/tb/publications/factsheets/statistics/TBTrends.htm>.

¹¹ Centers for Disease Control and Prevention (CDC), “Extensively Drug-Resistant Tuberculosis (XDR-TB),” <http://www.cdc.gov/tb/pubs/tbfactsheets/xdrtb.htm>. The CDC noted that “[s]ome TB control programs have shown that cure is possible for an estimated 30% of affected people [with XDR-TB].”

¹² World Health Organization, “Emergence of XDR-TB: WHO concern over extensive drug resistant TB strains that are virtually untreatable,” <http://www.who.int/mediacentre/news/notes/2006/np23/en/index.html>. WHO’s Global MDR-TB and XDR-TB Response Plan 2007-2008, launched on June 22, 2007, allocates \$2.15 billion to contain drug-resistant tuberculosis, with an emphasis on providing access to drugs in underserved countries. http://www.who.int/tb/xdr/global_response_plan/en/index.html. The WHO Task Force on XDR-TB met with TB experts and representatives of Member States to assess the progress of the 2007-2008 Response Plan in April, 2008. See http://whqlibdoc.who.int/hq/2008/WHO_HTM_TB_2008.403_eng.pdf.

¹³ Howard Markel, Lawrence O. Gostin, David P. Fidler, “Extensively Drug-Resistant Tuberculosis: An Isolation Order, Public Health Powers, and a Global Crisis,” 298 *JAMA* 83 (July 4, 2007). See also, CDC, “Plan To Combat Extensively Drug-Resistant Tuberculosis,” 58 *MMWR* 1 (February 13, 2009).

¹⁴ For a discussion of the incident see Committee on Homeland Security, *The 2007 XDR-TB Incident: A Breakdown at the Intersection of Homeland Security and Public Health*, <http://homeland.house.gov/SiteDocuments/tbreport.pdf>.

¹⁵ CDC has published a timeline of its actions at <http://www.cdc.gov/tb/XDRTB/timeline.htm>. Certain matters have been the subject of disagreement between Mr. Speaker and public health authorities at the local and federal levels, particularly those matters relating to information, recommendations, or advisories provided to Mr. Speaker at various times. It is not the intent of this report to resolve those matters of disagreement.

¹⁶ Testimony of Andrew Speaker before the Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, hearing regarding the tuberculosis travel incident, June 6, 2007, 110th Cong., 1st Sess., Washington, DC.

¹⁷ Testimony of CBP Commissioner Ralph Basham before the House Committee on Homeland Security, hearing regarding the XDR tuberculosis incident, June 6, 2007, 110th Cong., 1st Sess., Washington, DC. Issues relating to ports of entry, including issues relating to quarantine stations, are beyond the scope of this report. For a discussion of these (continued...)

and voluntarily went to a hospital in New York City. On May 25, CDC issued a federal order of provisional quarantine and medical examination pursuant to Section 361 of the Public Health Service Act.¹⁸ (This was the first such order since 1963.¹⁹) Mr. Speaker was then flown in a CDC aircraft to an Atlanta hospital, and later to the National Jewish Medical and Research Center in Denver, for treatment. On June 2, the federal order was rescinded when Denver health officials assumed public health responsibility for Mr. Speaker's case.

On July 3, 2007, physicians determined that Mr. Speaker had multi-drug resistant tuberculosis (MDR-TB) rather than XDR-TB.²⁰ On July 17, he had surgery to remove diseased and damaged tissue in his lung.²¹ Mr. Speaker was released from the National Jewish Medical and Research Center in Denver on July 26 after doctors determined that he was no longer contagious and had no further detectable evidence of infection. He was to continue antibiotic treatment for two years and was required to check in with local health authorities five days a week and have his treatment directly observed by health care workers.²²

On April 28, 2009, Mr. Speaker filed suit claiming that the CDC violated the Privacy Act²³ by disclosing protected information concerning his identity and medical history and seeking damages. The district court granted the CDC's motion to dismiss the case for failure to state a claim.²⁴ However, on appeal, the Eleventh Circuit reversed the district court decision finding that

(...continued)

issues see Institute of Medicine, *Quarantine Stations at Ports of Entry: Protecting the Public's Health* (National Academies Press 2006).

¹⁸ CDC has released the text of the three orders issued for the detention of the XDR-TB patient between May 25 and May 30, 2007, and the final order, issued June 2, 2007, rescinding the earlier orders. The Order for Provisional Quarantine is at <http://www2a.cdc.gov/phlp/docs/quarantine1.pdf>; the Order Pursuant to Public Health Service Act Section 361 is at <http://www2a.cdc.gov/phlp/docs/quarantine2.pdf>; the Revised Order Pursuant to Section 361 is at <http://www2a.cdc.gov/phlp/docs/quarantine3.pdf>; and the Order Rescinding Movement Restrictions is at <http://www2a.cdc.gov/phlp/docs/quarantine4.pdf>.

¹⁹ See *United States v. Shinnick*, 219 F. Supp. 789 (1963), where the court upheld the Public Health Service's quarantine of an arriving passenger because she had been in Stockholm, Sweden, a city declared by the World Health Organization to be a smallpox-infected area, and she could not show proof of vaccination. CDC routinely uses its authority under the Public Health Service Act to monitor passengers arriving in the United States for communicable diseases, sometimes delaying incoming planes and interviewing passengers for health reasons. <http://www.cdc.gov/ncidod/sars/quarantineqa.htm>.

²⁰ Lawrence K. Altman, "Traveler's TB not as Severe as Officials Thought," <http://www.nytimes.com/2007/07/04/health/04tb.html?ex=1184990400&en=39a65f739d333727&ei=5070>. Dr. Charles Daley, head of the infectious disease division at National Jewish Medical Center, was quoted stating: "[t]his discrepancy among results happens all the time in labs that do drug-resistance testing, including reference labs." *Id.* Despite the change in diagnosis, the CDC response has generally been supported by infectious-disease experts. See Lawrence K. Altman, "Experts Mostly Back Way U.S. Reacted in TB Case," <http://www.nytimes.com/2007/07/05/us/05tb.html?ex=1185076800&en=0c68daff1c1b4fc5&ei=5070>. For a discussion of MDR-TB see <http://www.cdc.gov/tb/pubs/tbfactsheets/mdrtb.htm>.

²¹ Lawrence K. Altman, "TB Patient Has Surgery to Remove Part of Lung," http://www.nytimes.com/2007/07/18/health/18tb.html?_r=1&n=Top%2fReference%2fTimes%20Topics%2fPeople%2fS%2fSpeaker%2c%20Andrew&oref=slogin.

²² Dan Forsch, "Traveler with TB is Released After Treatment in Denver," <http://www.nytimes.com/2007/07/27/health/27tb.html?ex=1187409600&en=bddfee426efef352&ei=5070>.

²³ 5 U.S.C. §552a.

²⁴ *Speaker v. U.S. Department of Health and Human Services Centers for Disease Control and Prevention*, 680 F. Supp.2d 1359 (N.D. Ga. 2009).

Mr. Speaker had provided enough factual specificity and raised a reasonable inference. The case was remanded for consideration on the merits.²⁵

Public Health Emergency Response Measures

Incidents involving persons with serious communicable diseases who disregard medical advice and either board commercial aircraft or express the intention to fly, cross borders, or take other forms of public transportation, have prompted the expansion of public health measures which may be used in emergency situations involving a public health threat. Some available measures, such as quarantine and isolation authorities, date back many hundreds of years, while others, such as the public health “Do Not Board” list, are recent measures, largely implemented in response to the Andrew Speaker incident in 2007.

Quarantine and Isolation Authority

Although the terms are often used interchangeably, quarantine and isolation are two distinct concepts.²⁶ Quarantine typically refers to the “(s)eparation of individuals who have been exposed to an infection but are not yet ill from others who have not been exposed to the transmissible infection.”²⁷ Isolation refers to the “(s)eparation of infected individuals from those who are not infected.”²⁸ Primary quarantine authority typically resides with state health departments and health officials; however, the federal government has jurisdiction over interstate and border quarantine.

Federal quarantine and isolation authority may be found in Section 361 of the Public Health Service Act, 42 U.S.C. § 264, wherein Congress has given the Secretary of Health and Human Services (HHS) the authority to make and enforce regulations necessary “to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession.”²⁹ While also providing the Secretary with broad authority to apprehend, detain, or conditionally release a person, the law limits the Secretary’s authority to the communicable diseases published in an executive order of the President.³⁰ Executive Order 13295 lists the communicable diseases for which this quarantine authority may be exercised, and specifically includes infectious tuberculosis.³¹ In 2000, the Secretary of HHS transferred certain authorities, including interstate

²⁵ 2010 U.S. App. LEXIS 22422 (11th Cir. Oct. 22, 2010).

²⁶ For a detailed discussion of quarantine and isolation, see CRS Report RL33201, *Federal and State Quarantine and Isolation Authority*, by Kathleen S. Swendiman and Jennifer K. Elsea.

²⁷ Homeland Security Council, National Strategy for Pandemic Influenza: Implementation Plan 209 (GPO May 2006). For a discussion of the history of quarantines in the United States see Felice Batlan, “Law in the Time of Cholera: Disease, State Power, and Quarantines Past and Future,” 80 TEMP. L. REV. 53 (2007).

²⁸ Homeland Security Council, National Strategy for Pandemic Influenza: Implementation Plan 207 (GPO May 2006).

²⁹ 42 U.S.C. § 264(a). Violation of federal quarantine and isolation regulations is a criminal misdemeanor, punishable by fine and/or imprisonment, 42 U.S.C. § 271.

³⁰ 42 U.S.C. § 264(b).

³¹ See also E.O. 13375, April, 2005, which amended E.O. 13295. The diseases listed are cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers, severe acute respiratory syndrome (SARS), and influenza viruses which have the potential to cause a pandemic. Other new threats would have to be added to E.O. 13295 in order to be “quarantinable diseases.”

quarantine authority, to the director of the CDC.³² Both interstate and foreign quarantine measures are now carried out by CDC's Division of Global Migration and Quarantine.³³

HHS also works closely with the Department of Homeland Security (DHS) and its agencies. HHS and DHS signed a memorandum of understanding in 2005 that sets forth specific cooperation mechanisms to implement their respective statutory responsibilities for quarantine and other public health measures.³⁴ DHS has three agencies that may aid CDC in its enforcement of quarantine rules and regulations pursuant to 42 U.S.C. § 268(b). They are U.S. Customs and Border Protection, U.S. Immigration and Customs Enforcement, and the United States Coast Guard. In addition to DHS, CDC may also rely on other federal law enforcement agencies and state and local law enforcement agencies.

While the federal government has authority to authorize quarantine and isolation under certain circumstances, it should be noted that the primary authority for quarantine and isolation exists at the state level as an exercise of the state's police power. States conduct these activities in accordance with their particular laws and policies. CDC acknowledges this deference to state authority as follows:

In general, CDC defers to the state and local health authorities in their primary use of their own separate quarantine powers. Based upon long experience and collaborative working relationships with our state and local partners, CDC continues to anticipate the need to use this federal authority to quarantine an exposed person only in rare situations, such as events at ports of entry or in similar time-sensitive settings.³⁵

The situation involving Andrew Speaker highlights a possible limitation of the federal quarantine and isolation power in that the federal statute authorizing quarantine authority does not directly address persons leaving the country. The law is clear in its application to persons coming into the United States from a foreign country or U.S. possession, and for persons moving from state to state. But the law does not address preventing the movement of persons with communicable diseases out of the country. Historically, quarantine has been used to keep people out of an area and/or to contain them if they may be contagious, but as the case of Mr. Speaker illustrates, in this age of global travel, public health authorities may have to deal with the possibility of detaining a person to prevent the exportation of an infectious disease.³⁶

³² 42 C.F.R. Part 70. Regulations regarding quarantine upon entry into the United States from foreign countries are also administered by the CDC, see 42 C.F.R. Part 71.

³³ See CDC Division of Global Migration and Quarantine home page at <http://www.cdc.gov/ncpcid/dgmq/index.html>.

³⁴ http://www.dhs.gov/xnews/testimony/testimony_1181229544211.shtm. The MOU may be viewed at http://www.aclu.org/pdfs/privacy/hhs_dhs_mou.pdf.

³⁵ Q&A on Executive Order 13295, available at <http://www.cdc.gov/quarantine/qa-executive-order-pandemic-list-quarantinable-diseases.html>. The complexities of this shared power have been noted. One analysis observed that "When it comes to the exercise of isolation and quarantine powers, reality tends to be messier than the conceptual realm. Public health officials need clear lines of authority in emergency situations, often the moments when isolation and quarantine might be required. Unfortunately, confusion about which level of government should take the lead often occurs, thus revealing the ability of quarantine powers to spotlight difficulties federalism poses for public health." David P. Fidler, Lawrence O. Gostin, and Howard Markel, "Through the Quarantine Looking Glass: Drug-Resistant Tuberculosis and Public Health Governance, Law and Ethics," 35 J. OF LAW, MEDICINE & ETHICS 616 (2007). Another commentator has noted that "Given the variation in due process rights in connection with quarantine, which may be afforded under federal and state law, one can foresee the possibility of considerable conflict." Felice Batlan, "Law in the Time of Cholera: Disease, State Power, and Quarantines Past and Future," 80 TEMP. L. REV. 53, 119 (2007).

³⁶ CDC Director Julie Gerberding, in her opening statement in a hearing on *Threat Posed by Patient with Drug* (continued...)

The CDC, on November 22, 2005, announced proposed changes to its quarantine regulations.³⁷ While these proposed regulations were not finalized, they would have constituted the first significant revision of the regulations in Parts 70 and 71 in 25 years. The proposed changes were an outgrowth of the CDC's experience during the spread of Severe Acute Respiratory Syndrome (SARS) in 2003, when the agency experienced difficulties locating and contacting airline passengers who might have been exposed to SARS during their travels.

The proposed regulations would have expanded reporting requirements for ill passengers³⁸ on board flights and ships arriving from foreign countries. They would also have required airlines and ocean liners to maintain passenger and crew lists with detailed contact information and to submit these lists electronically to CDC upon request.³⁹ The proposed regulations also addressed the due process rights of passengers who might be subjected to quarantine after suspected exposure to disease.⁴⁰

In her congressional testimony regarding XDR-TB and the situation involving Andrew Speaker, CDC Director Dr. Julie Gerberding summarized CDC efforts to control the spread of tuberculosis, particularly emerging drug-resistant TB threats:

To control TB, HHS/CDC and its partners must continue to apply fundamental principles including: (1) State and local TB programs must be adequately prepared to identify and treat TB patients so that further drug resistant cases can be prevented; (2) TB training and consultation must be widely available so that private health care providers recognize and promptly report tuberculosis to the public health system; (3) State and local public health laboratories must be able to efficiently perform and interpret drug susceptibility and genotyping results in TB specimens; and (4) CDC and local health authorities must work collaboratively to ensure that isolation and quarantine authorities are properly and timely exercised in appropriate cases.⁴¹

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Resistant Tuberculosis, before the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies, 110th Cong., 1st Sess. (June 6, 2007), raised this issue: "We also think we need clarification in the quarantine statute. It does not explicitly address exportation, meaning movement of patients out of the country.... So we may be able to use [the] existing statute with a clarification of intent, but we do need to identify what our responsibilities and authorities are under the statute and make a decision about whether a change is needed."

³⁷ See 70 *Fed. Reg.* 71892 (November 30, 2005). In announcing the proposed regulations, CDC Director Julie Gerberding said, "[t]hese updated regulations are necessary to expedite and improve CDC operations by facilitating contact tracing and prompting immediate medical follow up of potentially infected passengers and their contacts." See "CDC Proposes Modernizing Control of Communicable Disease Regulation, USA," *Medical News Today*, November 23, 2005, at <http://www.medicalnewstoday.com/medicalnews.php?newsid=34042>. Since the SARS outbreak, the CDC has increased its quarantine stations nationwide from 8 to 20. See <http://www.cdc.gov/quarantine/QuarantineStations.html>. However, the proposed regulations were withdrawn on April 26, 2010, 75 *Fed. Reg.* 21,789 (April 26, 2010), by the Obama Administration; see article at http://www.usatoday.com/news/washington/2010-04-01-quarantine_N.htm

³⁸ The definition of ill person would have been expanded to include anyone with a fever of at least 100.4 degrees plus one of the following: severe bleeding; jaundice; severe, persistent cough accompanied by bloody sputum; or respiratory distress. (Section 70.1 of proposed regulations.) It should be noted that Mr. Speaker apparently did not have any symptoms.

³⁹ *Id.* The lists, in electronic format, would have had to be kept for 60 days after arrival, and be able to be submitted within 12 hours of a CDC request. The lists would have included names, contact information, and seat assignments.

⁴⁰ See, *infra*, footnote 68, for articles discussing constitutional issues relating to the proposed regulations.

⁴¹ *Recent Case of Extensively Drug Resistant TB: CDC's Public Health Response: Statement to the US House of Representatives Committee on Homeland Security, 110th Cong., 1st Sess. (June 6, 2007) (testimony of Julie Gerberding, MD, MPH, director of the CDC), <http://www.hhs.gov/asl/testify/2007/06/t20070606a.html>.*

The Public Health “Do Not Board” List

In response to the Andrew Speaker incident, federal agencies have developed a new travel restriction tool to prevent the spread of communicable diseases of public health significance.⁴² The public health Do Not Board (DNB) list was developed by the Department of Homeland Security (DHS) and the CDC, and made operational in June 2007.⁴³ The DNB list enables domestic and international health officials to request that persons with communicable diseases who meet specific criteria and pose a serious threat to the public be restricted from boarding commercial aircraft departing from or arriving in the United States.⁴⁴ The list provides a new tool for management of emerging public health threats when local public health efforts are not sufficient to keep certain contagious people from boarding commercial flights.⁴⁵

In order to place a person on the DNB list, state and local health officials contact their local CDC quarantine station. The CDC determines if the person is (1) likely contagious with a communicable disease that presents a serious public health threat, (2) unaware of or likely to not comply with public health recommendations and medical treatment, and (3) likely to try boarding a commercial aircraft.⁴⁶ Once a person is placed on the DNB list,⁴⁷ airlines are instructed not to issue a boarding pass to the person for any commercial domestic flight or for a commercial international flight arriving in or departing from the United States. Other forms of transportation, such as buses and trains, are not covered by the DNB list. Once a patient is determined to be noncontagious, the CDC and DHS remove the person from the list, usually within 24 hours.⁴⁸ The list is not limited to the communicable diseases that are covered under quarantine and isolation laws.

The CDC released a report in September 2008,⁴⁹ in which it analyzed the first year’s experience with the DNB list. According to the report, the CDC received 42 requests to add persons to the

⁴² For a summary of recent actions taken by DHS and the CDC to improve procedures to restrict persons with serious communicable diseases who intend to travel despite medical advice, see *Public Health and Border Security: HHS and DHS Should Further Strengthen Their Ability to Respond to TB Incidents*. GAO-09-58. Washington, D.C: October, 2008. (Hereinafter, *GAO Public Health and Border Security Report*).

⁴³ CDC. *Federal Air Travel Restrictions for Public Health Purposes—United States, June 2007-May 2008*, MMWR 2008 Sep. 19; 57 (37): 1009-12, available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5737a1.htm>. (Hereinafter, *MMWR Report*). The State of California’s Department of Public Health issued guidance in 2007 for coordinating with the requirements of the “Do not Board” list at http://www.ctca.org/conferences/2008/Spring%202008/Look_Out_List_Interim_Guidance.pdf.

⁴⁴ Airlines also have general authority to refuse to board passengers with communicable diseases under certain circumstances pursuant to Air Carrier Access Act of 1986 (ACAA) regulations. See 49 U.S.C. § 41705, 14 C.F.R. § 382.51. Decisions to deny passengers scheduled to fly must be based on “reasonable judgment that relies on current medical knowledge or on the best available objective evidence,” that the individual poses a direct threat to the health and safety of others. See, discussion, *infra* at 12, regarding the application of federal nondiscrimination laws, including the nondiscrimination provisions of the ACAA.

⁴⁵ The list, which applies to all citizens and foreign nationals, appears to have been developed under the general authority of the Aviation and Transportation Security Act of 2001, at 49 U.S.C. § 114(f) and (h).

⁴⁶ *MMWR Report*, at 1009.

⁴⁷ The Transportation Security Administration maintains the DNB list, which is separate from the No Fly List used to prevent known terrorists from boarding airplanes, but it serves a similar purpose. *GAO Public Health and Border Security Report*, page 29.

⁴⁸ *MMWR Report*, at 1010.

⁴⁹ *MMWR Report*.

DNB list, all of whom had suspected or confirmed pulmonary TB.⁵⁰ The agency approved 33 of the requests, of which 28 were placed by public health departments in the United States, and 14 were placed on the list while they were outside of the country.⁵¹ Two of the 33 persons placed on the DNB list attempted to evade the air travel restriction, and both were detained by border officials and were taken to local hospitals for evaluation and treatment.⁵² In the editorial portion of the report, the CDC indicated that “(j)udicious use of the public health DNB list can obviate the human and economic costs associated with conducting contact investigations when people with communicable diseases travel on commercial aircraft.”⁵³

International Health Regulations

In May 2005 the World Health Assembly adopted a revision of its 1969 International Health Regulations (IHR), giving a new mandate to WHO and member states to increase their respective roles and responsibilities for the protection of international public health.⁵⁴ The IHR(1969) had focused on just three diseases (cholera, plague, and yellow fever). In addition, compliance of State Parties⁵⁵ with the IHR(1969) was uneven, a result of, among other things, resource limitations in poorer countries, and political factors, such as the reluctance to announce the presence of a contagious disease within one’s borders and face economic and other consequences.⁵⁶

The IHR(2005), which entered into force in June 2007, have broadened the scope of the 1969 regulations by addressing existing, new, and re-emergent diseases, as well as emergencies caused by non-infectious disease agents.⁵⁷ The IHR(2005) require State Parties to notify WHO of all events that may constitute a “public health emergency of international concern,” and to provide information regarding such events.⁵⁸ The IHR(2005) also include provisions regarding designated national points of contact, definitions of core public health capacities, disease control measures such as quarantine and border controls, and others. The IHR(2005) require WHO to recommend, and State Parties to use, control measures that are no more restrictive than necessary to achieve the desired level of health protection.

The IHR were agreed upon by a consensus process among the member states, and represent a balance between sovereign rights and a commitment to work together to prevent the international spread of disease. The IHR(2005) are binding on all WHO member states as of June 15, 2007,

⁵⁰ *Id.* at 1010.

⁵¹ *Id.*

⁵² *Id.* at 1011.

⁵³ *Id.*

⁵⁴ Fifty-eighth World Health Assembly, agenda item 13.1, Revision of the International Health Regulations, May 23, 2005, at <http://www.who.int/csr/ihr/en/>. For a discussion of these regulations, state sovereignty, and federalism issues see Eric Mack, “The World Health Organization’s New International Health Regulations: Incursion on State Sovereignty and Ill-Fated Response to Global Health Issues,” 7 *CHI. J. INT’L L.* 365 (2006).

⁵⁵ “State Party” is the name for WHO member states that have agreed to be bound by the IHR.

⁵⁶ M.G. Baker and D.P. Fidler, “Global Public Health Surveillance under New International Health Regulations,” *Emerging Infectious Diseases*, vol. 12, no. 7, July 2006, at <http://www.cdc.gov/ncidod/EID/vol12no07/05-1497.htm>.

⁵⁷ The full text of the IHR 2005 may be found at <http://www.who.int/ihr/9789241596664/en/index.html>.

⁵⁸ A “public health emergency of international concern” is defined as “an extraordinary event which is determined, as provided in these Regulations: (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response.” IHR(2005), Article 1.

except for those that have rejected the regulations or submitted reservations.⁵⁹ The United States accepted the IHR(2005) with three reservations, including the reservation that it will implement the IHR(2005) in line with U.S. principles of federalism.⁶⁰ State Parties now have a two-year period in which to assess the ability of existing national structures and resources for meeting the core surveillance and response capacities requirements set out in the regulations and to develop plans of action to ensure that these capacities are in place. Within five years of the entry into force date, State Parties must complete development of public health infrastructure that ensures full compliance with the regulations.

According to the IHR (2005), State Parties are not to bar the entry of a conveyance for public health reasons, but are rather to manage the public health threat through isolation, quarantine, disinfection, or other such applicable methods.⁶¹ Article 43 of the IHR allows nations to implement additional health measures in accordance with their relevant national law and obligations under international law in response to specific health concerns. If a State Party implements additional health measures significantly interfering with international traffic, the public health rationale and relevant scientific information for the measures must be provided to WHO. The WHO shall share the information with State Parties and institute procedures to find a mutually acceptable solution.⁶²

In June, 2008 WHO updated its aviation guidelines for tuberculosis prevention.⁶³ WHO notes in the guidelines that TB and other airborne infectious diseases can fall within the scope of the IHR(2005) in cases where public health risks present a serious and direct danger to human health that may spread internationally. While TB is not listed in the IHR(2005) as a disease that would always be considered as a potential public health emergency of international concern requiring notification to WHO, it may be the subject of a potential international emergency under the IHR(2005). The guidelines state that airline companies are expected to comply with the IHR and the laws of the countries in which they operate. IHR requirements as implemented by State Parties which may affect airlines include those relating to detection and control of public health risks, such as information-sharing requirements, notification of cases of illness, and medical examination or other health measures for ill or possibly ill travelers. WHO guidelines also note that confidentiality issues may arise when health authorities request the release of passenger and crew lists, as well as when health authorities need to release the name of a passenger with TB to an airline in order to confirm that the passenger was on a particular flight or flights.⁶⁴

⁵⁹ IHR(2005), Article 59.2.

⁶⁰ HHS Secretary Michael Leavitt announced the acceptance of the IHR(2005) by the United States on December 13, 2006. See News Release at <http://archive.hhs.gov/news/press/2006pres/20061213.html>.

⁶¹ IHR, Article 28.1, "Ships and aircraft at points of entry."

⁶² IHR, Article 43, "Additional Health Measures." While the IHR(2005) do not include an enforcement mechanism for State Parties that fail to comply with their provisions, the WHO considers the potential consequences of non-compliance within the global community, especially in economic terms, to be a powerful compliance tool. The IHR(2005) (Article 56) contain a dispute settlement mechanism to resolve conflicts which may arise among State Parties when applying or interpreting the regulations, including options such as negotiation, mediation, conciliation, or arbitration, or referral to the Director-General of WHO, if agreed to by all the parties to the dispute.

⁶³ World Health Organization, "Tuberculosis and Air Travel: Guidelines for Prevention and Control" (3rd ed. 2008), (*WHO 2008 Guidelines*) available at http://www.who.int/tb/publications/2008/WHO_HTM_TB_2008.399_eng.pdf.

⁶⁴ According to the WHO 2008 Guidelines, at p. 37, "States Parties are obligated to collect and handle health information containing personal identifiers in a confidential manner. However, States Parties may disclose and process personal data when it is essential for the purposes of assessing and managing a public health risk, subject to particular requirements (Article 45.1-2)."

One of the difficulties raised by Mr. Speaker's situation was the interaction of the varying state, federal, and international laws, regulations, and authorities.⁶⁵ The director of CDC, Dr. Julie Gerberding, observed that there were difficulties determining how CDC was to use its assets and how the statements of principle in the international health regulations were to be applied in a specific situation to determine, for example, who should pay to move a patient, and who should care for a patient in isolation or quarantine.⁶⁶

Civil Rights

Introduction

The situation presented by Andrew Speaker raises a classic civil rights issue: to what extent can an individual's liberty be curtailed to advance the common good? The U.S. Constitution and federal civil rights laws provide for individual due process and equal protection rights as well as a right to privacy,⁶⁷ but these rights are balanced against the needs of the community. With the advance of medical treatments in recent years, especially the use of antibiotics, the civil rights of the individual with a contagious disease have been emphasized. However, classic public health measures such as quarantine, isolation, and contact tracing are, nevertheless, available in appropriate situations and, as new or resurgent diseases have become less treatable, some of these classic public health measures have been increasingly used. Therefore, the issue of how to balance these various interests in a modern culture which is sensitive to issues of individual rights has become critical.⁶⁸

Constitutional Rights to Due Process and Equal Protection

Constitutional rights to due process and equal protection may be implicated by the imposition of a quarantine or isolation order.⁶⁹ The Fifth and Fourteenth Amendments prohibit governments at all

⁶⁵ Jennifer Prah Ruger, "Control of Extensively Drug-Resistant Tuberculosis (XDR-TB): A Root Cause Analysis," *GLOBAL HEALTH GOVERNANCE*, VOLUME III, NO. 2 (Spring 2010), available at <http://ghgj.org>.

⁶⁶ CDC, "Update on CDC Investigation into People Potentially Exposed to Patient With Extensively Drug Resistant TB," (June 1, 2007) <http://www.cdc.gov/media/transcripts/2007/t070601.htm>.

⁶⁷ As noted previously, Andrew Speaker filed suit against the CDC alleging that it violated the Privacy Act, 5 U.S.C. §552a. Although the district court dismissed the case, the Eleventh Circuit reversed and remanded for consideration of the merits.

⁶⁸ For a detailed discussion of constitutional issues relating to quarantine see Michelle A. Daubert, "Pandemic Fears and Contemporary Quarantine: Protecting Liberty Through a Continuum of Due Process Rights," 54 *BUFFALO L. REV.* 1299 (January 2007). For an analysis of how to balance the sometimes competing interests of personal and economic liberties with the public's health and security see Lawrence O. Gostin, "When Terrorism Threatens Health: How Far are Limitations on Personal and Economic Liberties Justified?" 55 *Fla. Law Rev.* 1105 (December 2003). See also David P. Fidler, Lawrence O. Gostin, and Howard Markel, "Through the Quarantine Looking Glass: Drug-Resistant Tuberculosis and Public Health Governance, Law and Ethics," 35 *J. OF LAW, MEDICINE & ETHICS* 616 (2007), where the authors note that courts have set four limits on isolation and quarantine authority: the subject must actually be infectious or have been exposed to infectious disease, the subject must be placed in a safe and habitable environment, the authority must be exercised in a non-discriminatory manner, and there must be procedural due process.

⁶⁹ It has been argued that the federal quarantine authority may not pass constitutional muster since it does not specifically provide for a right to a fair hearing. See Howard Markel, Lawrence O. Gostin, and David P. Fidler, "Extensively Drug-Resistant Tuberculosis: An Isolation Order, Public Health Powers, and a Global Crisis," 298 *JAMA* 83-84 (July 4, 2007). It should be noted that the CDC had proposed quarantine regulations containing detailed due (continued...)

levels from depriving individuals of any constitutionally protected liberty interest without due process of law. What process may be due under certain circumstances is generally determined by balancing the individual's interest at stake against the governmental interest served by the restraints, determining whether the measures are reasonably calculated to achieve the government's aims,⁷⁰ and deciding whether the least restrictive means have been employed to further that interest.

In *O'Connor v. Donaldson*⁷¹ the Supreme Court examined the civil commitment of an individual to a mental hospital and held that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."⁷² Clearly, an individual who is highly contagious with a serious illness may be considered dangerous, and thus subject to involuntary confinement if there is no less restrictive alternative. The lesson of *Donaldson* is that such confinements must be carefully examined in order to comport with the constitutional right to due process. *Donaldson* also raises the issue of whether less restrictive programs are required prior to the imposition of the more restrictive application of isolation or quarantine. It could be argued that the least restrictive alternative must first be applied or more restrictive alternatives will run afoul of constitutional requirements.⁷³

The unequal treatment of certain socially disfavored groups with regard to quarantine also raises equal protection issues. For example, in *Wong Wai v. Williamson*⁷⁴ a board of health resolution mandated Chinese residents to be quarantined for bubonic plague unless they submitted to inoculation with a serum with "the only justification offered for this discrimination ... a

(...continued)

process procedures including a right to a hearing for full quarantine. 70 *Fed. Reg.* 71,892 (November 30, 2005), <http://www.cdc.gov/ncidod/dq/nprm/>. The proposed regulations were withdrawn on April 26, 2010. 75 *Fed. Reg.* 21,789 (April 26, 2010). These proposed regulations were strongly criticized for what commentators have described as constitutional failings, and the criticisms highlighted the lack of independent judicial review for individuals subject to quarantine, the broad discretion accorded to directors of federal quarantine stations, the lack of hearings during provisional quarantine, and privacy concerns. See e.g., Lawrence O. Gostin, Benjamin E. Berkman, and David P. Fidler, *Comments on Department of Health and Human Services, Control of Communicable Diseases (Proposed Rule)*, 42 *C.F.R. Parts 70 and 71* (November 30, 2005), <http://www.publichealthlaw.net/Resources/BTlaw.htm>; The New England Coalition for Law and Public Health, *Comments on the Interstate and Foreign Quarantine Regulations Proposed by the Centers for Disease Control and Prevention*, <http://64.233.169.104/u/UMBaltimore?q=cache:fsSm0xxCULQJ:www.umaryland.edu/healthsecurity/docs/New%2520England%2520Coalition%2520Comments%2520CDC%2520revisions.pdf+%22new+england+coalition+for+law+and+public+health%22&hl=en&ct=clnk&cd=1&gl=us&ie=UTF-8>; Felice Batlan, "Law in the Time of Cholera: Disease, State Power, and Quarantines Past and Future," 80 *TEMP. L. REV.* 53 (2007).

⁷⁰ See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 27 (1905) (enforcement of public health laws must have some "real or substantial relation to the protection of the public health and the public safety"); *Jew Ho v. Williamson*, 103 F. 10 (C.C.N.D. Cal. 1900) (quarantine of San Francisco district inhabited primarily by Chinese immigrants purportedly to control the spread of bubonic plague was invalidated).

⁷¹ 422 U.S. 563 (1975).

⁷² *Id.* at 576.

⁷³ See Wendy D. Parmet, "Legal Power and Legal Rights—Isolation and Quarantine in the Case of Drug-Resistant Tuberculosis," 357 *NEW ENG. J. OF MEDICINE* 433, 435 (August 2, 2007). Professor Parmet argues that compulsory measures are not the most effective and may prompt individuals who may be subject to them to evade authorities. "By ensuring that coercion is used only when less restrictive alternatives will not work and with due regard for the rights of those detained, the law can foster public trust, minimizing the need for compulsion and laying the groundwork for the comprehensive and costly control programs needed to prevent the spread of XDR tuberculosis and other contagious pathogens." *Id.*

⁷⁴ 103 F. 1 (N.D. Cal. 1900).

suggestion ... that this particular race is more liable to the plague than any other.”⁷⁵ The court struck the resolution as a violation of the equal protection clause.⁷⁶

Although the Constitution does not specifically grant a right to travel, the Supreme Court has held that there is a fundamental right to travel.⁷⁷ This right, and the applicable due process procedures, have been examined in the context of transportation security, particularly regarding alleged terrorists.⁷⁸ Generally, restrictions on travel, such as identification policies for boarding airplanes, have not been found to violate the Constitution.⁷⁹ If the public safety arguments have prevailed regarding restrictions due to transportation security, they would be likely to prevail against a serious public health threat. However, the seriousness of the threat and the due process procedures used would be key to any constitutional determination.

Federal Nondiscrimination Laws

In addition to constitutional issues, discrimination against an individual with an infectious disease may be covered by certain federal laws, notably Section 504 of the Rehabilitation Act,⁸⁰ the Americans with Disabilities Act (ADA),⁸¹ and the Air Carrier Access Act (ACAA).⁸² However, under these statutes, an individual with a contagious disease does not have to be given access to a place of public accommodation or employment if such access would place other individuals at a significant risk.⁸³

⁷⁵ *Id.* at 15.

⁷⁶ One commentator observed that it is unlikely that such blatantly discriminatory actions would occur today but noted that “studies of New York City’s use of isolation orders for tuberculosis in the 1990s show that more than 90% of the people detained were non-white and more than 60% were homeless.... Although these figures may reflect the democracy of non-compliant patients with tuberculosis in New York City at that time, the fact that the most potent public health tool was used primarily against marginalized, nonwhite persons underscores the need for legal oversight—if only so that affected communities can be assured of the absence of discrimination.” Wendy D. Parmet, “Legal Power and Legal Rights—Isolation and Quarantine in the Case of Drug-Resistant Tuberculosis,” 357 *NEW ENG. J. OF MEDICINE* 433, 434 (August 2, 2007).

⁷⁷ *United States v. Guest*, 383 U.S. 745 (1966); *Shapiro v. Thompson*, 394 U.S. 618 (1969).

⁷⁸ See CRS Report RL32664, *Interstate Travel: Constitutional Challenges to the Identification Requirement and Other Transportation Security Regulations*, by Todd B. Tatelman; Justin Florence, “Making the No Fly List Fly: A Due Process Model for Terrorist Watchlists,” 115 *Yale L.J.* 2148 (2006).

⁷⁹ See *Gilmore v. Gonzales*, 435 F.3d 1125 (9th Cir. 2006), cert. den. 549 U.S. 1110 (2007). “We reject *Gilmore*’s rights to travel argument because the Constitution does not guarantee the right to travel by any particular form of transportation.” 435 F.3d 1125, 1136(9th Cir. 2006).

⁸⁰ 29 U.S.C. §794. For a more detailed discussion of Section 504 generally see CRS Report RL34041, *Section 504 of the Rehabilitation Act of 1973: Prohibiting Discrimination Against Individuals with Disabilities in Programs or Activities Receiving Federal Assistance*, by Nancy Lee Jones.

⁸¹ 42 U.S.C. §§12101 *et seq.* For a more detailed discussion of the ADA generally see CRS Report 98-921, *The Americans with Disabilities Act (ADA): Statutory Language and Recent Issues*, by Nancy Lee Jones. The ADA was recently amended by the ADA Amendments Act, P.L. 110-325, which rejects certain Supreme Court interpretations of the definition of disability and generally increases the likelihood that an individual will fall within the coverage of the definition. For a more detailed discussion of these amendments see CRS Report RL34691, *The ADA Amendments Act: P.L. 110-325*, by Nancy Lee Jones.

⁸² 42 U.S.C. §1374(c). For a more detailed discussion of the ACAA generally see CRS Report RL34047, *Overview of the Air Carrier Access Act (ACAA)*, by Emily C. Barbour.

⁸³ For a more detailed discussion of this issue in the ADA context see CRS Report RS22219, *The Americans with Disabilities Act (ADA) Coverage of Contagious Diseases*, by Nancy Lee Jones. See also CRS Report R40866, *The Americans with Disabilities Act (ADA): Employment Issues and the 2009 Influenza Pandemic*, by Nancy Lee Jones.

Although the language of Section 504 does not specifically discuss contagious diseases, the Supreme Court dealt with discrimination issues in the context of tuberculosis and Section 504 in *School Board of Nassau County v. Arline*.⁸⁴ The Court found that in most cases an individualized inquiry is necessary in order to protect individuals with disabilities from “deprivation based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns of grantees as avoiding exposing others to significant health and safety risks.”⁸⁵ The Court adopted the test enunciated by the American Medical Association (AMA) amicus brief and held that the factors which must be considered include “findings of facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.” The Court also emphasized that courts “normally should defer to the reasonable medical judgments of public health officials.”⁸⁶

The ADA provides nondiscrimination protections to individuals with contagious diseases but balances this protection with requirements designed to protect the health of other individuals. Title I of the ADA, which prohibits employment discrimination against otherwise qualified individuals with disabilities, specifically states that “the term ‘qualifications standards’ may include a requirement that an individual shall not pose a direct threat to the health or safety of other individuals in the workplace.”⁸⁷ In addition, the Secretary of Health and Human Services (HHS) is required to publish, and update, a list of infectious and communicable diseases that may be transmitted through handling the food supply.⁸⁸

Similarly, Title III, which prohibits discrimination in public accommodations and services operated by private entities, states the following:

Nothing in this title shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term ‘direct threat’ means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.⁸⁹

Although Title II, which prohibits discrimination by state and local government services, does not contain such specific language, it does require an individual to be “qualified” and this is defined in part as meeting “the essential eligibility requirements of the receipt of services or the

⁸⁴ 480 U.S. 273 (1987).

⁸⁵ *Id.* at 287.

⁸⁶ *Id.* at 288. These standards are incorporated into the regulations for the Air Carrier Access Act at 14 C.F.R. §382.51.

⁸⁷ 42 U.S.C. §12113(b). For an analysis of the ADA’s application to the H1N1 influenza pandemic see CRS Report R40866, *The Americans with Disabilities Act (ADA): Employment Issues and the 2009 Influenza Pandemic*, by Nancy Lee Jones.

⁸⁸ 42 U.S.C. §12113(d). This provision was added in an amendment by Senator Hatch after a long debate over the Chapman Amendment, which was not enacted. The Chapman Amendment would have allowed employers in businesses involved in food handling to exclude individuals with specific contagious diseases such as HIV infection. See 136 Cong. Rec. 10911 (1990).

⁸⁹ 42 U.S.C. §12182(3).

participation in programs or activities.”⁹⁰ This language has been found by the Department of Justice to require the same interpretation of direct threat as in Title III.⁹¹

Contagious diseases were discussed in the ADA’s legislative history. The Senate report noted that the qualification standards permitted with regard to employment under Title I may include a requirement that an individual with a currently contagious disease or infection shall not pose a direct threat to the health or safety of other individuals in the workplace and cited to *School Board of Nassau County v. Arline*,⁹² the Section 504 case discussed previously.⁹³ Similarly, the House report of the Committee on Education and Labor reiterated the reference to *Arline* and added “[t]hus the term ‘direct threat’ is meant to connote the full standard set forth in the Arline decision.”⁹⁴

The Air Carrier Access Act (ACAA) prohibits discrimination by air carriers against “otherwise qualified individual[s]” on the basis of disability.⁹⁵ Enacted in 1986,⁹⁶ prior to the ADA, the ACAA contains no statutory reference to communicable diseases. However, the regulations, like the ADA and its regulations, generally treat individuals with communicable diseases as falling within the definition of “individual with a disability.”⁹⁷ The regulations prohibit various actions by carriers against individuals with communicable diseases. A carrier may not “(1) refuse to provide transportation to the person, (2) require the person to provide a medical certificate, or (3) impose on the person any condition, restriction, or requirement not imposed on other passengers.”⁹⁸ However, an exception applies when an individual “poses a direct threat to the health or safety of others.”⁹⁹ “Direct threat” is defined as “a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures, or by the provision of auxiliary aids or services.”¹⁰⁰

⁹⁰ 42 U.S.C. §12131(2).

⁹¹ 28 C.F.R. Part 35, Appx A.

⁹² 480 U.S. 273, 287, note 16 (1987).

⁹³ S.Rept. 101-116, 101st Cong., 1st Sess. reprinted in Vol. I, Committee Print Serial No. 102-A Legislative History of P.L. 101-336 The Americans with Disabilities Act, prepared for the House Committee on Education and Labor at 139 (December 1990).

⁹⁴ H.Rept. 101-485, 101st Cong., 2nd Sess., reprinted in Vol. I, Committee Print Serial No. 102-A Legislative History of P.L. 101-336 The Americans with Disabilities Act, prepared for the House Committee on Education and Labor at 349 (December 1990). See also 136 Cong. Rec. 10858 (1990).

⁹⁵ 49 U.S.C. §41705. For a more detailed discussion of the ACAA see CRS Report RL34047, *Overview of the Air Carrier Access Act (ACAA)*, by Emily C. Barbour.

⁹⁶ Air Carrier Access Act of 1986, 100 Stat. 1080 (1986) (current version at 49 U.S.C. §41705).

⁹⁷ See, e.g., 14 CFR §382.51(c) (referring to “qualified individual with a disability with a communicable disease”).

⁹⁸ 14 CFR §382.51(a).

⁹⁹ 14 CFR §382.51(b)(1).

¹⁰⁰ 14 CFR §382.51(b)(2).

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