Compulsory Personal Health Measure Legislation

NATHAN HERSHEY, LL.B.

THE VARIETY of legislative enactments requiring personal health measures for children as exercises of State power to provide for the public's health are explored limitedly in this paper. (As used here, the phrase "personal health measures" encompasses preventive, therapeutic, and diagnostic procedures and examinations to determine the presence or absence of disease or impairment performed by professional and other health workers.)

The paper includes (*a*) a review of a number of court decisions which have considered personal health measures in the light of principles of administrative and constitutional law, (*b*) a comparative analysis of the legislation of four States relating to testing of the newborn for phenylketonuria, examinations of school children, and immunization and vaccination procedures for school children, (*c*) an analysis of this legislation to determine the internal consistency, or lack thereof, in the legislation of each State, and (*d*) a discussion of several issues relating to the policies and objectives underlying compulsory personal health measures and the methods used to achieve them.

Review of Court Decisions

Judicial decisions involving legislated or mandated personal health measures for children are usually concerned with students who are required to have examinations or preventive measures performed in order to be admitted to or remain in school. While compliance by university students with personal health measures is voluntary, in the sense that no compulsory education law requires university attendance, elementary and most secondary school students do not have such a choice. The net effect of the presence of a compulsory education law and a mandated health requirement is to make the health measure compulsory.

Most compulsory health measures for children are established by State legislation; although some are established by local entities, such as county or district school boards, pursuant to authority granted by the State. The authority to enact and enforce legislation and regulations requiring personal health measures is derived from the State's police power.

Compulsory health measures are challenged in court from time to time by students or parents who claim to be adversely affected. They offer two basic arguments. The constitutional law argument propounded is that the State or governmental entity is illegally intruding upon the personal liberty of the individual, and the objectors allege that the statute or regulation violates due process of law, or is contrary to the guarantee of freedom of religion, or both. The administrative law argument is that the requirement is illegal because it exceeds the authority delegated to the governmental entity.

The pertinent section of the 14th amendment to the U.S. Constitution provides, ". . . nor shall any State deprive any person of life, liberty, or property without due process of the law . . . ." The first amendment provides in part, "Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof . . . ." Objections to State statutes and regulations, premised upon alleged

Mr. Hershey is a research professor of health law, Graduate School of Public Health, University of Pittsburgh. *The study described was supported in part by the National Institutes of Health 1966 general research support grant No. FR 5451-05 to the graduate school.*

violation of the individual's freedom of religion, rely upon the incorporation of the guarantees in the first amendment of the Federal Bill of Rights within the protective mantle of the 14th amendment, which limits State power. (For an illustrative case see *1*.)

One recent decision concerned vaccination as a prerequisite of school attendance. In *Mannis* v. *State ex rel. DeWitt School Dist. #1*, a county school supervisor instituted proceedings to declare the Mannis child neglected and to compel vaccination (*2*). The child's father asserted that such a forcible vaccination, approved of by a court guardian, violated his and his son's religious beliefs and practices. The Arkansas Supreme Court rejected the argument and decided that the child could be forcibly vaccinated and that the compulsory vaccination law was a valid exercise of the police power. Authority to require all students to receive vaccinations as a condition precedent to compulsory school attendance was based upon statutory provisions granting the State board of health general supervision and control of all matters pertaining to the health of its citizens and conferring authority upon the board to make all necessary and reasonable general rules and regulations for the protection of the public's health (*3*).

The facts of the *Mannis* case are similar to those in most cases concerning compulsory vaccination as a condition of school attendance; the concurrence of a compulsory attendance law with a requirement for vaccination before entering school. A dilemma results for the parents who object to the health regulation. Though the parents desire to have their child attend school, and by law they must send the child to school, if they fail to comply with the law requiring vaccination the child is not permitted by the educational authority to attend. The parents are then usually subject to a penalty for neglecting the child's education. With but few exceptions, it has been held that compulsory vaccination as a condition of school attendance does not conflict with statutory provisions concerning compulsory education laws. (For collected cases on the subject see *4*.)

In *Pierce* v. *Board of Education*, the father refused to have his minor son vaccinated because he did not believe in vaccinations and believed they would be detrimental to his child's health (*5*). When the boy was refused admission to school because he was not vaccinated, his father brought a suit against the local board of education. The suit was ultimately dismissed by the court. The board claimed authority to require proof of vaccination as a condition of entry into school from a provision of the New York Public Health Law (*6*), which states that local school authorities shall exclude children who have not been successfully vaccinated against smallpox whenever smallpox exists in the school district or vicinity.

In a 1948 decision, *Mosier* v. *Board of Health*, the Kentucky Supreme Court affirmed a decision in favor of the local board of health requiring Mosier's daughter to be vaccinated against smallpox as a condition of attendance at school, despite Mosier's religious objections (*7*). The school board claimed authority to require vaccinations for school children by referring to two statutes (*8*). One statute required parents to have children vaccinated within 12 months after birth, and the other stated that all students admitted to the common schools shall comply with the lawful regulations for the government of schools. The court considered the two provisions together and held that the school board had the right to promulgate the challenged regulation.

While the cases mentioned involved vaccination requirements as prerequisites for attending elementary school, in *State ex rel. Holcomb* v. *Armstrong* the court considered the validity of a chest X-ray requirement as a prerequisite for attendance at a State university (*9*). The Washington Supreme Court found that a regulation of the University of Washington requiring registering students to submit to a chest X-ray for the detection of tuberculosis was necessary to protect university students from a clear and present danger to their health, against objections to the required chest X-ray on religious grounds. The court reasoned that the welfare of the students on campus required the examination of the students, that this health requirement was indispensable to the continued operation of the university, and that authority for the questioned regulation could be implied from the legislature's grant to the board of regents of "full control of the University" (*10*).

In *Streich* v. *Board of Education*, the regulations of a local school board were upheld, although no specific legislative authority existed which permitted it to adopt health requirements as a school admission prerequisite (*11*). The child's mother refused to furnish a report, required by the school board, based upon an examination of the child by a physician provided by the board of education or by one selected and paid by her. The court, despite religious objections of the mother, upheld the regulation requiring the report. The board claimed inherent power, derived from the creation of local school districts by the South Dakota Legislature, to impose reasonable requirements to insure the proper discharge of the work for which the districts were created. The court reasoned that the educational objectives of the school board were integrally connected with the good health of the students. In the absence of express authority to establish and implement health regulations deemed essential to the accomplishment of the board's objectives, reliance upon inherent authority was necessary.

The foregoing decisions indicate that objections on religious grounds to compulsory personal health measures, in the absence of express legislative exemptions, are usually unsuccessful. Also, attacks upon requirements for such measures, on the basis that they are beyond the authority of local boards not granted specific authority to require them by legislation, have almost uniformly been rejected. Because of the relatively extensive power of the States and local governmental units to require health measures, it is worth considering how far some States have gone in exercising such power.

Legislation of Four States

Legislation requiring the performance of procedures on minors and examinations of minors as health measures varies from State to State. This section consists of an analysis of legislation of New Jersey, New York, Ohio, and Pennsylvania concerning three health measures that represent three different types of personal health measures that minors may be subject to by legislation.

The first type of measure pertains to the performance of medical tests upon all the individuals within a described group to determine whether a specific disorder exists. Legislation requiring testing of newborn infants for phenylketonuria (PKU) exemplifies this type of personal health measure. The benefits of this procedure inure primarily to the individuals, since phenylketonuria is not communicable to others in the community.

The second type of health measure consists of the general or partial examination of all individuals within a specified group and tests requiring the performance of a medical technique to determine the existence of a specific communicable disease that might endanger other students. Examinations of school children to detect disorders and defects that may hinder performance at school and tests for tuberculosis illustrate this type of measure. The specific tests differ from the general examination in that detection of the condition can be the basis for protecting the other students, as well as leading to treatment for the diseased individual; however, the following subsections discuss the tests with the examination procedures rather than as a subcategory.

The third type of measure is the medical procedure to produce immunity from a specific communicable disease, the purpose of which is to protect both the public and the individual. Vaccination against smallpox is an example of this type of personal health measure.

No legislation at present requires the entire population to submit to a particular health measure. Health legislation requirements fix upon events, definitions of certain segments of the population by other legislation, or natural processes to establish the classes or groups of individuals subject to them. Thus, phenylketonuria testing requirements fix on birth, requirements for the confinement of certain active tuberculosis cases fix on a finding of disease, vaccination requirements often fix on entry to school, and physical examination requirements for adults in some States fix on seeking a license to operate a motor vehicle. No State has legislation that requires everyone to submit to any procedure or examination at regular intervals.

Phenylketonuria

General. Mandatory testing programs designed to detect phenylketonuria have been the subject of legislation in three of the four States considered here. The purpose of the testing

programs is to mitigate the effect of one known cause of mental retardation. PKU is a rare, inherited condition in which a newborn infant suffers an enzyme deficiency which manifests itself in the infant's inability to metabolize the phenylalanine received with its nourishment. Prompt recognition of the existence of the enzyme deficiency and the adjustment of the infant's diet to exclude foods containing the phenylalanine will increase the likelihood that the child's mental development will not be retarded as the result of PKU.

Two kinds of procedures are used to determine whether a child is afflicted with PKU—examination of a specimen of blood for phenylalanine and examinaton of urine stain on the infant's diaper for the presence of phenylpyruvic acid. The effectiveness of urine analysis to detect PKU is limited because it does not indicate the presence of phenylalanine until its concentration in the infant's blood is beyond the threshold at which some permanent damage to the brain will result. However, it is used to monitor the child's ability to metabolize phenylalanine over the first few weeks of life, after the blood test has been completed. The initial blood examination performed prior to the infant's routine discharge from the hospital, usually about the third or fourth day of life, plus continued testing at home using the urine or "diaper" test, together constitute a reliable recognition process.

Duty to test. In three States the responsibility for obtaining the performance of the PKU test on a specimen of blood drawn from a newborn infant is directly imposed upon the person in attendance at the birth or upon the person or agency responsible for the care of the child. The Pennsylvania statute expressly requires the physician or hospital providing care for the newborn infant to perform the test or to secure its performance (*12*). The New York statute imposes the duty to secure the test upon the person in charge of the institution in which the birth occurred or the person required to register the birth (*13*). Ohio charges each person whose duty it shall be to file a certificate of birth to cause the infant to be tested (*14*); the local health district commissioner is responsible for tests if the birth does not occur in a hospital and is not attended by a physician (*15*).

In New Jersey the legislation does not require PKU testing, but merely expresses the view of the State that every newborn should be tested (*16*). The New Jersey State Department of Health has the duty to provide laboratory services and to educate hospital personnel, physicians, nurses, and the public concerning the need for the test and diet modification to prevent retardation (*17*).

Since the majority of births occur in hospitals, the statutory obligation to secure the performance of the PKU test falls upon the hospital as a practical matter; thus, the hospital conceivably could incur liability for failure to fulfill the statutory obligation to conduct the test.

Specific tests to be performed in each State. All four States provide that the PKU test procedure performed shall be approved by a State agency. In Pennsylvania three tests, all blood procedures, are accepted by the advisory health board (*18*). The New York commissioner of health has determined that the only acceptable test is the Guthrie inhibition test, a test requiring a blood sample (*19*). Ohio's director of health (*20*) and the New Jersey State Department of Health (in a letter from the State commissioner of health to physicians, July 7, 1965) also have approved the Guthrie test. Pennsylvania, New York, and Ohio do not provide that the urine testing procedure alone is acceptable as a method of detecting PKU.

Exemptions. The statutes of Ohio and Pennsylvania do not require infants to undergo the PKU test if their parents express religious objections. The exemption makes no distinction between the blood test that requires a medical technique and the urine test which does not. Presumably, the urine analysis would be less offensive than the blood test to persons who entertain certain religious beliefs, but no provision is made to substitute the urine procedure for the blood test when objection is raised by the parents under the religious beliefs exemption. Although a specific duty to test is not imposed in the New Jersey statute, an exemption based on parental objection on religious grounds is recognized. The New York legislation does not provide any exemption from PKU testing.

Duty to treat. The PKU statutes provide for the testing of newborn infants for the existence

of the disease. However, they uniformly fail to establish a duty to treat an infant in whom PKU is detected.

Treatment requires an adjustment of the child's diet. Apparently it is assumed the parents will be informed that the child is afflicted and will receive instructions regarding the child's diet. But the ultimate responsibility for the care of the child and his mental development, free from the effects of PKU, rests upon the parents. None of the statutes imposes a specific duty upon the parents to provide the proper diet or provides sanctions for failure to provide the necessary diet. However, the child neglect legislation of every State provides that parents or others legally responsible for minors who willfully fail to provide them with necessary care, which in the case of children afflicted with PKU would include a proper diet, can be convicted and penalized for child neglect. Resort to the procedures in child neglect legislation is possible in order to bring about provision of necessary attention to children in whom PKU is detected when the parents fail to provide care.

Cost of testing. The PKU legislation in New York, Ohio, and Pennsylvania is completely silent with respect to the cost of testing. The New Jersey statute adverts to the cost of the test to the extent of authorizing the State commissioner of health to fix fees for the PKU testing services performed on specimens of blood submitted to the State for analysis (*21*). By regulation in Ohio, the department of health laboratory shall provide PKU tests on specimens submitted without charge (*22*).

If the test is performed in a hospital before the newborn's discharge, the cost would either be included in the basic hospital charge or reflected as a separate laboratory item charge. Hospitalization insurance covering the mother and infant would probably cover the charge, which in any instance would be small.

Penalties for noncompliance. The duty to secure the performance of the PKU test is directly imposed by statute in three States, but there are no provisions in the PKU legislation which provide penalties for noncompliance. A provision in the New York statutes provides that violation of a statute that imposes no penalty is a misdemeanor (*23*). Neither New Jersey nor Pennsylvania have a statute comparable to this New York law, and the general sanction provision of chapter 3701 of the Ohio Revised Code does not apply to failure to meet the duties imposed by the PKU testing provision because such failure falls into neither grouping of violations for which penalties are imposed (*24*).

Examinations of School Children

Duty to examine. All four States have statutory provisions that require testing of school children to determine the existence of defects that may affect school performance or to detect diseases that may be transmitted to other school children. Legislation in New York, New Jersey, and Pennsylvania directly imposes the duty to secure the examinations upon school authorities (*25*). The Ohio legislation implicitly requires the local school boards to provide the examination; however, the legislation apparently also provides that if a school board fails to provide them, the local board of health must (*26*).

Examinations and tests to be performed. Required examinations and tests are described in New Jersey as those to determine the existence of "physical defects" (*27*). Apparently the school board may then determine which tests shall be required to meet the duty to detect physical defects. Another New Jersey provision, enacted prior to the legislation requiring examinations to determine the existence of physical defects, specifically requires an examination for tuberculosis (*28*). Examinations to determine the existence of diseases, as well as eye and ear examinations, are required in New York (*29*). Ohio legislation specifies that hearing, vision, and dental examinations, approved by the State department of health, are to be performed as part of the general examinations (*30*). The Pennsylvania legislation enumerates vision, hearing, dental, and tuberculosis examinations, and further provides that the advisory health board may add to the examinations required by the statute (*31*).

Exemptions on religious grounds. The New York legislation has no religious exemption provisions. In New Jersey a qualified exemption for religious reasons is provided with respect to the provisions requiring examinations to determine the existence of physical defects (*32*). The religious exemption does not apply to ex-

aminations deemed necessary by the school board to determine the existence of a communicable disease, or to determine the child's fitness to participate in physical education activities, or to required tuberculosis examinations. The Pennsylvania legislation provides that objections on religious grounds permit exemption from the examination procedures (*33*). The Ohio legislation permits exemption from a medical examination conducted by a local board of health upon objection of the parent or guardian (*34*) and does not provide that the objection need be on religious grounds.

Occasions for performing the examinations. In New York (*35*), New Jersey (*36*), and Ohio (*37*), the examinations, or health certificates in lieu of examinations, are required yearly, either expressly or impliedly. The Pennsylvania legislation requires an annual vision examination, dental examinations upon entry into school and in the third and seventh grades, and other examinations are to be performed in accordance with a schedule established by the advisory health board (*38*).

Vaccination and Immunization

Responsibility of school authorities. All four States have enacted legislation requiring or authorizing local school authorities to exclude children who are not vaccinated against the communicable diseases specified by each State. None of the States directly imposes the duty to perform vaccinations or immunizations upon school authorities. The approach is indirect, in that the State laws require that school officials exclude unvaccinated or unimmunized children from school, unles they fall within the scope of an exemption provision. Coupled with the State mandatory school attendance legislation, these provisions effectively impose the requirement of obtaining the vaccinations and immunizations upon the children's parents.

A provision in the New York public health legislation requires that school authorities deny admission to any child who has not been immunized against poliomyelitis (*39*). Other legislation in New York requires school authorities in communities of 50,000 or more persons to deny any child admission to school who has not been vaccinated for smallpox. Cities or school districts not in the class subject to these requirements may be required to exclude children from school if the commissioner of health certifies to them that smallpox exists in such areas or school districts (*40*). In Pennsylvania a provision in the education statutes (*41*), similar to the New York legislation, requires school authorities to exclude unvaccinated children. The Ohio legislation provides that the State board of education may formulate admission requirements for school children and that no child will be admitted to school unless he has complied with the requirements or can avail himself of an exemption, and it permits local school boards to establish additional or more stringent requirements (*42*).

The Ohio Court of Appeals considered the extent of a local school board's authority to establish such requirements in *State* v. *Board of Education* (*43*). The child's parents had objected to immunization requirements, based on the religious exemption provision in the State legislation. The court, adverting to a prior published opinion by the attorney general (*44*), held that the local school board did not exceed its authority in excluding the child, because the legislative provisions permitting exemptions from the State requirements did not preclude enactment of regulations by the local school board requiring vaccination or immunization procedures without exemption.

New Jersey has two similar statutory enactments, in the education legislation and in the health legislation, that permit but do not require local boards of education to exclude children who have not been vaccinated against smallpox (*45*). The education legislation also permits local school boards to require immunization against diphtheria and poliomyelitis (*46*).

Specification of diseases. The following discussion merely enumerates the procedures that have been the subject of this legislation. In some instances the immunization or vaccination against specified diseases is required; in others, authorities may establish a requirement concerning particular diseases as an exercise of discretion.

All four States have laws for vaccination against smallpox (*45*, *47*). New York, New Jersey, and Ohio have legislation providing for poliomyelitis immunization (*48*). Diphtheria immunization is the subject of legislation in

New Jersey and Ohio (*49*). School authorities in Ohio may require immunization from pertussis and tetanus (*50*).

Duty to secure the vaccination or immunization. The primary responsibility for securing the vaccination or immunization of school children is imposed by legislation upon their parents. Provisions requiring the exclusion of the children from school for whom proof of immunization or vaccination is lacking, coupled with compulsory attendance legislation, lead to this result. The New York provision requiring the performance of the poliomyelitis immunization procedure directly imposes the duty upon the parents (*51*).

Legislation usually provides for the vaccination or immunization of children of indigent parents at public expense. In Pennsylvania they are to be vaccinated by the school physician (*52*). In Ohio specified local authorities are required to immunize children at public expense upon application of school authorities (*53*). Any physician who vaccinates a child of indigent parents in New Jersey is entitled to payment from the school or public funds (*54*). New York provides that vaccination of children of indigent parents shall be performed by the local board of health at public expense and that the county physician shall immunize such children against poliomyelitis (*55*).

Exemptions. No exemptions from the legislation requiring school authorities to exclude children who have not been vaccinated against smallpox are recognized in New York and Pennsylvania. The Pennsylvania legislation expressly provides penalties for school authorities who fail to comply with the requirements of the statutes (*56*). However, although there is no exemption provision in the Pennsylvania legislation requiring exclusion of unvaccinated children if the vaccination is to be performed by the school physician because the parents are indigent, parental objection on religious grounds is recognized as a reason for exempting the child from the procedure (*57*).

An exemption is provided to the poliomyelitis immunization requirement of New York, if the parents express objection on religious grounds (*58*). In Ohio local school boards may adopt requirements for admission to school in addition to the requirements established by the State. However, an exemption on religious grounds from the State requirements only is expressly provided by the legislation; no legislation requires that exemption from local school board requirements be granted, and the State exemption provision is not applicable to the local school board requirements (*59*). There is no exemption on religious grounds from the requirements of the health statute relating to smallpox vaccination in New Jersey; however, the corresponding provisions in the education legislation provide that exemption on religious grounds is discretionary with the school board (*60*). Exemption on religious grounds from the New Jersey requirements for immunization of school children for diphtheria and poliomyelitis is also discretionary with the local school board (*61*).

Analysis of the Legislation

This section examines the legislation relating to the personal health measures discussed in the preceding section on a State-by-State basis. This analysis is intended to point out apparent inconsistent approaches taken in the statutes of a particular State, with special reference to the exemption provisions.

New Jersey. In New Jersey legislation requiring examination of school children and testing of school children for tuberculosis directly imposes a duty upon some person to secure the performance of the procedures required by the statute (*62*). The legislation for testing of newborn infants for PKU is not compulsory (*63*). Legislation imposing the vaccination or immunization requirements for school children is discretionary with the local school board (*64*).

An exemption for religious reasons is provided in the PKU legislation, although it is not a compulsory measure, and in provisions requiring examinations of school children. No exemption for religious reasons is provided from the tuberculosis testing procedure or vaccination of school children as established by the health legislation. However, exemption from the vaccination and immunization requirements established in the education legislation is discretionary with the school board (*65*) as is exemption from poliomyelitis immunization (*66*).

New York. Almost all of the legislation in New York requiring the performance of a medical procedure upon an individual for public health reasons is found in the public health laws. The provisions are written in such a manner that the duty to secure the performance of the procedure or the duty to perform the procedure is directly imposed upon some person, agency, or institution. Only in the legislation requiring the performance of the poliomyelitis immunization is an exemption on religious grounds provided (*67*).

Ohio. Legislative provisions requiring the performance of a medical procedure impose these requirements in a variety of ways. The person required to secure the performance of the PKU procedure is identified by reference to another statute (*68*). In the legislation dealing with medical examination of school children, the requirements are discretionary in that the school board is not required to conduct the examinations, but the local board of health apparently must if the school board does not provide them (*69*). The State's authority to prescribe minimum standards for admission to school, including immunization requirements, does not preclude local school boards from requiring additional procedures (*70*).

Religious exemptions are permitted by the legislation requiring PKU testing and the State requirements of vaccination and immunization. School children are exempted from required examinations if their parents express an objection for any reason. No exemption from any requirements the local school board might consider necessary for admission to school is provided by law.

Pennsylvania. All of the legislation in Pennsylvania relating to the performance of procedure or examination upon an individual directly imposes the duty to secure the performance of the procedure upon some person, agency, or institution.

Most of this legislation is specific, specifying in almost all instances the persons charged with the duty to perform or secure the performance of the procedure. Although this may be desirable for the sake of clarity, if all possible situations are not covered by the legislation, the purpose of the statute may be frustrated. The purpose of the PKU legislation is to assist in the elimination of one known cause of mental retardation (*71*). However, by specifying only that hospitals or other institutions caring for a newborn or a physician attending the birth are obliged to cause this test to be performed, the legislation does not apply to births occurring beyond the scope of the statute, such as a birth at home attended by a midwife, and the PKU test is not required in such circumstances.

Religious objections to the performance of the PKU test and the examination of school children are recognized as the basis for exemption from the Pennsylvania requirements. There is no religious exemption from the requirements of the legislation regarding the vaccination of school children, except if the parents are indigent and the procedure is to be performed by the school physician (*72*). Thus, a religious exemption might be recognized for indigent children, but not for nonindigent children.

Discussion

The preceding review of compulsory health measures affecting minors reveals that different purposes and concepts underlie the establishment of such measures and that there are reasons for the variance in techniques and programs; some reasons are obvious and others are obscure.

The justification for the most basic kinds of public health measures affecting individuals that interfere with personal freedom—isolation and confinement of individuals with communicable diseases such as tuberculosis—is protection of the public at large from the health hazard created by the individual carrier. The protection and treatment of the afflicted individual himself is secondary although, of course, desirable. A requirement that each child be vaccinated against smallpox as a condition for entry to school, although usually viewed as the means to protect other individuals from the risk created by an unvaccinated person in whom smallpox may develop, seems designed primarily to protect each child as an individual. Theoretically, if all but one child entering school were vaccinated, there would be no risk of smallpox to any child, except the one who was not vaccinated. The danger of a smallpox epidemic in the school population would not be present.

Of course, on a practical basis, there is some risk because immunity diminishes over the course of time and some individuals do not develop sufficient antibodies.

Nevertheless, on close analysis, the effect of compulsory vaccination appears to be to protect every member of the group from a danger to his personal health by performing the vaccination procedure on each individual. It can be thus viewed as an individual health measure in one sense; as a public health measure in a cumulative sense. One obvious basis for distinction between isolation of persons with active cases and compulsory vaccination is simply that once an active case is detected, immunization of the infected individual cannot be employed to minimize the risks to the community. Different kinds of measures are appropriate to different situations.

Fluoridation of the community water supply is not a compulsory health measure in a traditional sense, as is vaccination against a communicable disease. Its purpose is not to deal with communicable diseases, but it restricts the freedom of choice of individuals who object to it. To avoid use of the fluoridated water supply, the serious objector must suffer the bother and expense of obtaining water from unfluoridated sources.

Since PKU is not a communicable disease, the purpose of legislation requiring PKU testing of newborns can be viewed as individual health. The public health aspect of the PKU testing is in the cumulative sense, as it is with fluoridation of the public water supply to reduce tooth decay.

If PKU is detected, individual families can avoid the burden of rearing a retarded child by controlling the infant's diet. Advantages to the public accrue in that the financial burden of caring for the retarded youngster for almost his entire lifetime, which often falls upon the State ultimately at enormous cost to the taxpayer, may be avoided. Also, there is a recognized public interest in assisting individuals to live meaningful and productive lives, and compulsory detection programs can be justified when detection of a remediable defect will improve their prospects for such lives.

There is nothing novel in the acceptance of this broadened concept of public health—health in the cumulative sense. Society has as much interest in keeping A from infecting B, C, and D and thereby protecting their health, as it does in protecting A, B, C, and D from noncommunicable diseases. However, restricting A's freedom—to impinge on his personal rights—for the purpose of protecting B, C, and D, is different from infringing on the freedom of A, B, C, and D for their individual benefit.

Many compulsory personal health measure programs for children, specifically detection and examination programs, are linked to school attendance. Their objectives are to alert the parents to the services their children require and to stimulate efforts to obtain the services. Programs requiring periodic examination of school children proceed on the assumption that they will lead to the provision of service. The children whose parents secure the services will benefit; however, the child with the remediable defect for whom no service is provided usually does not create any risk to the health of his fellows. Thus, compulsory examination programs to determine defects are essentially aids to individuals, as individuals, and to the public in the cumulative sense only. The danger to others in the community from the failure of an individual parent to obtain service for his child is absent.

Detection programs created by law are different from compulsory vaccination, in that the remedial service is often not provided when a defect or condition is detected through examination, but in vaccination programs all children are vaccinated through one or another mechanism. Is the difference accounted for by the distinction between a preventive measure and a remedial or treatment measure? Is the difference based upon the relatively great expense to the public in implementing an extensive remedial or treatment program for individuals, as against a simple, specific preventive program? Is the difference explained by a view of therapeutic or remedial measures as strictly within parental prerogatives? Is the reason that many defects or conditions do not require attention because they are not acute problems, although remedying them is advisable? Is the reason simply that our society lacks sufficient resources to provide the services? The reason is probably a combination of all of these factors.

The underlying assumption of compulsory detection and examination programs is that necessary treatment will be provided, once the condition or defect has been recognized. Thus, while PKU legislation requires that practically all newborns be tested, although some parents may be unwilling to provide or are incapable of providing the necessary diet, the laws do not require the parents to provide it. With respect to conditions and defects ascertained through examinations, parents may be unwilling or unable to provide the remedial attention. No sanction is imposed in the school health legislation upon a parent for failure to secure desirable treatment for detected defects.

Neglected child legislation in every State permits the public authorities to take custody of a child denied necessary medical attention by a parent or guardian in order to have such attention provided. Perhaps, for certain serious conditions that might be identified by examination, the legislation establishing the program should contain specific provisions requiring treatment and, where the parents do not provide it, establish a mechanism for the treatment under public auspices. The absence of treatment requirements may be recognition of the fact that present programs—for fiscal, personnel, and facility reasons—cannot include methods for implementation, that the expense of the followup to determine when to impose sanctions for failure to remedy or treat conditions or defects is too great, and that even if the followup took place, the necessary service for nonacute conditions or diseases could not be provided.

However, establishment of a compulsory detection program without placing responsibility for its effectuation and imposing sanctions for failure to meet such responsibility may be the result of careless legislative drafting, not design.

Regulations issued by agencies and departments often establish methods for implementation of detection programs beyond those specifically provided by legislation. (For an example of such a regulation see *73*.) Thus, the State's laws alone do not provide the complete picture of how the compulsory health measure programs are implemented. However, limits imposed by legislation may not be ignored by the agencies and departments, and responsibilities or duties may not be placed on private individuals by regulation without specific legislative authority.

Much compulsory personal health measure legislation affords exemptions for reasons of religious belief. Religious exemptions need not be granted to otherwise valid compulsory health measure legislation by reason of the U.S. Constitution. Exemption of children from preventive health measure or detection and examination programs because of the religious beliefs of the parents appears to be ill-conceived, in that the health and proper development of the youngster may be jeopardized. Although a decision as to when society may substitute its judgment for that of the parents is difficult in many contexts, it is tragic to permit a child to be subjected to the risk that PKU will not be detected and treated, because his parents object to the removal of a sample of blood, and therefore the child becomes mentally retarded. Beyond the issue of support of the child at public expense, if he becomes retarded, is it even proper for the State to permit parents to affect the quality of the child's life because of their religious beliefs? Why are religious exemptions included in any compulsory public health legislation in view of the unwillingness of the U.S. Supreme Court and the State courts to hold public health measures that may conflict with individual religious beliefs beyond the scope of the police power?

A number of judicial decisions have permitted blood transfusions and other necessary therapeutic treatment for children over parental objections, as an exercise by the State of its power of *parens patriae*, in the interest of the health and safety of children, pursuant to neglected child legislation. (For illustrative cases see *74*.) Note that the risk to the public at large from failure to obtain the treatment for the particular child does not exist—the neglected child legislation applies to the personal medical needs of the individual children. If religious objections by parents cannot bar necessary treatment for children, because resort may be had to neglected child legislation, why engraft religious exemption provisions on compulsory health measure legislation designed to protect children?

An even more inconsistent situation is evi-

dent where a particular State by law provides a religious exemption from one compulsory health measure for children but not from another. The issue of religious exemption in legislation concerning compulsory personal health measures apparently has not been well thought out. The inclusion of exemptions is haphazard, probably depending upon the content of the legislation when proposed and views casually stated during committee or floor discussion. Thorough consideration of the implications of such exemptions probably does not take place.

Careful reexamination of the requirements or authority for compulsory personal health measures in State legislation, local legislation, and regulations of school boards and other agencies or entities seems necessary. The analysis should focus upon, at the minimum, the following points.

1. The breadth or comprehensiveness of the particular requirement. It is necessary to determine whether a particular requirement is likely to achieve its objective. Exemption on the basis of religious belief is one matter that should be given attention in this regard.

2. The establishment of the duty that a test or procedure be performed. Parents, the school boards, the hospitals, the public health agencies, family physicians, and others can be considered when deciding where the ultimate responsibility for the performance of a test belongs. Thoughtful consideration of the objectives and nature of the program in relation to those upon whom the duty might be placed would narrow the field sufficiently to lead to a logical choice.

3. The implementation mechanism must be assessed:

• Consideration should be given to whether a test or examination requirement should be accompanied by a corrective treatment requirement for detected remediable defects or conditions.

• If a remedial treatment is to be required, the financial resources available to pay for it must be considered. Where economic reasons are likely to foreclose the provision of remedial attention by some parents, programs for implementation at public expense will be necessary.

• If a treatment requirement is to be imposed, procedures must be established to implement the program effectively. Sanctions for failure to provide or obtain remedial attention and methods to ascertain when such failure has taken place are required.

• Separation of two matters, the point of contact with the individuals to identify those needing services from the provider of tests, examinations, and services, is essential. Thus, the school system can provide the contact for an examination or test program for children, without becoming the entity that provides the test or examination. Need there be a little health department in the education department, or should the State or local health department provide the service to the school system with its personnel? Assignment of functions which results in proliferation of specialized health departments in agencies and departments with primary responsibilities in other substantive fields is not necessary to achieve objectives.

Conclusions

The variation in legislation concerning compulsory personal health measures from State to State and the inconsistency with respect to specific matters in a single State's legislation appear to be more the result of chance than design. Legislation on a specific subject need not be identical in all States; in fact, there may be good reasons for differences. Also, all legislation within a single State need not be consistent on one issue, such as exemption for religious reasons. Yet, the rationale for some variation and inconsistency, if one actually existed at a time in the past, may no longer be valid. Furthermore, there may not have been any rational reason for the differences at the outset. Reexamination of existing legislation establishing these measures should be conducted with a view toward making changes by amendment of the legislation where changes appear necessary to make the programs more effective and comprehensive. Proposed legislation should also, of course, be given the same critical scrutiny.

REFERENCES

(1) *Cantwell* v. *Connecticut*, 310 U.S. 296 (1940).
(2) *Mannis* v. *State ex rel. DeWitt School Dist. #1*, 240 Ark. 42, 398 S.W. 2d 206 (1966).
(3) Ark. Stat. Ann. §§ 82-109, 82-110 (1960).

(4) Annot., 92 A.L.R. 1413, 1434–1441 (1934).
(5) *Pierce* v. *Board of Education*, 30 N.Y. Misc. 2d 1039, 219 N.Y.S. 2d 519 (1961).
(6) N.Y. Public Health Law § 2130(2) (McKinney 1954).
(7) *Mosier* v. *Board of Health*, 308 Ky. 829, 215 S.W. 2d 967 (1948).
(8) Ky. Rev. Stat. Ann. §§ 214.050, 158.150 (1963).
(9) *State ex rel. Holcomb* v. *Armstrong*, 39 Wash. 2d 860, 239 P. 2d 545 (1952).
(10) Wash. Rev. Code Ann, §§ 28.77.090 to 28.77.130 (1964)
(11) *Streich* v. *Board of Education*, 34 S.D. 169, 147 N.W. 779 (1914).
(12) Pa. Stat. Ann. tit. 35, § 621 (Supp. 1966).
(13) N.Y. Public Health Law § 2500-a (McKinney Supp. 1966).
(14) Ohio Rev. Code Ann. § 3701.501 (Supp. 1966).
(15) Ohio Reg. HE–45–01, par. (c) (3), Department of Health, effective July 1, 1966.
(16) N.J. Stat. Ann. § 26:2–84 (Supp. 1966).
(17) N.J. Stat. Ann. § 26:2–85 (Supp. 1966).
(18) Pa. Department of Health Rules and Regulations, ch. 3, art. 356, Oct. 29, 1965.
(19) N.Y. Administrative Rules and Regulations, ch. 2, § 69.1, Jan. 1, 1965.
(20) Ohio Reg. HE–45–01, par. (B)(1), Department of Health, effective July 1, 1966.
(21) N.J. Stat. Ann. § 26:2–85 (Supp. 1966).
(22) Ohio Reg. HE–45–01, par. (A), Department of Health, effective July 1, 1966.
(23) N.Y. Penal Law § 29 (McKinney 1965).
(24) Ohio Rev. Code Ann. §§ 3701.501, 3701.99 (Supp. 1966).
(25) N.Y. Education Law § 901 (McKinney Supp. 1966); N.J. Stat. Ann. § 18:14–57 (Cum. Supp. 1964); Pa. Stat. Ann. tit. 24, § 14–1402 (Supp. 1966).
(26) Ohio Rev. Code Ann. §§ 3313.69, 3313.71, 3313.73 (1964).
(27) N.J. Stat. Ann. § 18:14–57 (Cum. Supp. 1964).
(28) N.J. Stat. Ann. § 18:14–64.5 (1940).
(29) N.Y. Education Law § 901 (McKinney Supp. 1966).
(30) Ohio Rev. Code Ann. § 3313.69 (1964).
(31) Pa. Stat. Ann. tit. 24 §§ 14–1402, 14–1403 (Supp. 1966).
(32) N.J. Stat. Ann. § 18:14–57 (Cum. Supp. 1964).
(33) Pa. Stat. Ann. tit. 24, § 14–1419 (1962).
(34) Ohio Rev. Code Ann. § 3313.73 (1964).
(35) N.Y. Education Law § 903 (McKinney 1953).
(36) N.J. Stat. Ann. § 18:14–57 (Cum. Supp. 1964).
(37) Ohio Rev. Code Ann. § 3313.69 (1964).
(38) Pa. Stat. Ann. tit. 24, §§ 14–1402, 14–1403 (Supp. 1966).
(39) N.Y. Public Health Law § 2164 (McKinney Cum. Supp. 1966).
(40) N.Y. Public Health Law § 2130 (McKinney 1954).
(41) Pa. Stat. Ann. tit. 24, § 13–1303 (1962).
(42) Ohio Rev. Code Ann. §§ 3301.07(D), 3313.671 (1964).
(43) *State* v. *Board of Education*, 1 Ohio App. 2d 143, 204 N.E. 2d 86 (1963).
(44) Op. Atty. Gen. Ohio 890 (1959).
(45) N.J. Stat. Ann. § 26:4–6(b) (1964); § 18:14–52 (Cum. Supp. 1964).
(46) N.J. Stat. Ann. §§ 18:14–64.2, 18:14–64.10 (Cum. Supp. 1964).
(47) N.Y. Public Health Law § 2130 (McKinney 1954); Pa. Stat. Ann. tit. 24, § 13–1303 (1962); Ohio Rev. Code Ann. § 3313.671 (1964).
(48) N.Y. Public Health Law § 2164 (McKinney Supp. 1966); N.J. Stat. Ann. § 18:14–64.10 (Cum. Supp. 1964); Ohio Rev. Code Ann. § 3313.671 (1960).
(49) N.J. Stat. Ann. § 18:14–64.2 (Cum. Supp. 1964); Ohio Rev. Code Ann. § 3313.671 (1964).
(50) Ohio Rev. Code Ann. § 3313.671 (1964).
(51) N.Y. Public Health Law § 2164(2) (McKinney Supp. 1966).
(52) Pa. Stat. Ann. tit. 24, § 14–1413 (1962).
(53) Ohio Rev. Code Ann. § 3313.671(B) (1964).
(54) N.J. Stat. Ann. § 26:4–8 (1964), § 18:14–53 (1940).
(55) N.Y. Public Health Law § 2131 (McKinney 1954); § 2164 (McKinney Supp. 1966).
(56) Pa. Stat. Ann. tit. 24, § 13–1303 (1962).
(57) Pa. Stat. Ann. tit. 24, § 14–1419 (1962).
(58) N.Y. Public Health Law § 2164(8) (McKinney Supp. 1966).
(59) Ohio Rev. Code Ann. § 3313.671(A) (1964); *State* v. *Board of Education*, 1 Ohio App. 2d 143, 204 N.E. 2d 86 (1963).
(60) N.J. Stat. Ann. § 18:14–52 (Cum. Supp. 1964).
(61) N.J. Stat. Ann. §§ 18:14–64.2, 18:14–64.10 (Cum. Supp. 1964).
(62) N.J. Stat. Ann. § 18:14–57 (Cum. Supp. 1964); § 18:14–64.5 (1940); § 37:1–20 (Supp. 1966); § 26:4–49.1 (1964).
(63) N.J. Stat. Ann. §§ 26:2–84, 26:2–85 (Supp. 1966).
(64) N.J. Stat. Ann. § 26:4–6(b) (1964); §§ 18:14–52, 18:14–64.10 (Cum. Supp. 1964).
(65) N.J. Stat. Ann. § 18:14–52 (Cum. Supp. 1964).
(66) N.J. Stat. Ann. § 18:14–64.10 (Cum. Supp. 1964).
(67) N.Y. Public Health Law § 2164 (McKinney Supp. 1966).
(68) Ohio Rev. Code Ann. § 3701.501 (1964).
(69) Ohio Rev. Code Ann. §§ 3313.68, 3313.69, 3313.73 (1964).
(70) Ohio Rev. Code Ann. §§ 3301.07(D), 3313.67 (1964).
(71) Pa. Stat. Ann. tit. 35, § 621 (Supp. 1966).
(72) Pa. Stat. Ann. tit. 24, § 14–1419 (1962).
(73) Ohio Reg. HE–45–01, Department of Health, effective July 1, 1966.
(74) *State* v. *Perricone*, 67 N.J. 517, 171 A. 2d 140 (1961); *People ex rel Wallace* v. *Labrenz*, 411 Ill. 618, 104 N.E. 2d 769 (1952).