

N.C. Communicable Disease Law: Some Frequently Asked Questions

Jill Moore, MPH, JD
UNC School of Government
Revised November 2004

Sources of Law

1. Where do you find North Carolina's communicable disease (CD) laws?

The laws that are most important to day-to-day practice are of two types: statutes and rules.

Statutes are found in the North Carolina General Statutes (abbreviated GS). Most of the relevant statutes are in Chapter 130A, the public health code, but sometimes important statutes can be found elsewhere. For example, the statute addressing the testing of sexual offenders for certain CDs is found in Chapter 15A, the criminal procedure code. A citation to the GS looks like this:

GS 130A-135

130A is the chapter number. 135 is the section number. If you look up this statute, you will find the law that requires physicians to report communicable diseases and conditions to the local health department.

Rules are contained in the North Carolina Administrative Code (abbreviated NCAC). Most of the relevant rules are in Title 10A, chapter 41A. A citation to the NCAC looks like this:

10A NCAC 41A.0202

10A is the title number. 41A is the chapter number. .0202 is the section number. If you look up this rule, you will find the HIV control measures.

2. Are these laws in the burgundy book ("Public Health and Related Laws of North Carolina," formerly known as the green book)?

All of the statutes in GS Chapter 130A are in both the hard copy and on the compact disc. The relevant provisions of the NCAC are on the disc.

3. Are these laws available on the Internet?

Yes. The General Statutes are available through the NC General Assembly's website: www.ncleg.net/Statutes/Statutes.asp. The NC Administrative Code is on-line at <http://ncrules.state.nc.us> (click on the link to NC Administrative Code).

Enforcement

4. How are CD laws enforced?

There are two ways a local health director can enforce public health laws, including the CD laws.

- Civil enforcement: The health director can ask a superior court judge for a court order directing a person to comply with the law. GS 130A-18. A person who refuses to comply with a court order could be held in contempt of court.
- Criminal enforcement: A person who violates a public health law can be charged with a misdemeanor. GS 130A-25.

Reporting Communicable Diseases and Conditions

5. Which communicable diseases and conditions are reportable in North Carolina?

The NC Commission for Health Services establishes the list of reportable CD/CCs, and it changes as needed. Several diseases have been added to the list in recent years, including listeriosis, smallpox, and SARS. At present, there are 68 diseases and conditions on the list. 10A NCAC 41A.0101.

6. Who is required to report communicable diseases and conditions?

NC law requires the following people to make reports to the local health director:

- Physicians (GS 130A-135)
- School principals and child care operators (GS 130A-136)
- Operators of restaurants/other food or drink establishments (GS 130A-138)
- Persons in charge of laboratories (GS 130A-139)

Medial facilities are allowed, but not required, to make reports (GS 130A-137).

Local health directors are required to make reports to the state, and to other local health directors when the reported person resides in another health department's jurisdiction. (GS 130A-140).

7. Does every required reporter have to report every CD/CC on the list?

No. For example, a restaurant owner must only report foodborne illnesses. Laboratory reports are also limited to specific findings. Others, such as physicians, must report everything on the list.

8. Must a physician wait for lab reports confirming the CD/CC before making the report?

No. GS 130A-135 requires physicians to report when they have *reason to suspect* that a person has a CD/CC. Not only are they not required to wait for lab confirmation, in some cases they should not wait for lab confirmation. For example, if a physician has reason to suspect SARS, waiting for lab results could significantly delay public health response and the disease could spread.

9. Suppose there is an outbreak of an emerging illness that is not yet on the reportable CD/CC list. Can physicians be required to report it?

Yes. Two new NC laws authorize the State Health Director to issue a temporary order requiring health care providers to report symptoms, diseases, conditions, trends in use of health care services, or other health-related information, in either of two circumstances:

- When the information is needed for the investigation or surveillance of an illness, condition, or symptoms that may indicate a communicable disease (GS 130A-141.1), or
- When the information is needed for the investigation or surveillance of an illness, condition, or symptoms that may indicate an illness or condition caused by bioterrorism (GS 130A-476(b)).

A temporary order is valid for 90 days. The State Health Director could use this authority to require reporting of new illnesses that have not yet been added to the reportable list. Likewise, she could use it to require reporting of certain symptoms that could indicate a bioterrorist attack. For example, if the State Health Director had had this authority during the anthrax letter attacks, she could have used it to require reports of severe respiratory illnesses.

10. Does HIPAA prohibit physicians from making CD/CC reports?

No. To the contrary, HIPAA specifically allows physicians to make these reports. There are at least two sections of the HIPAA privacy rule that allow health care providers to make CD/CC reports:

- Section 164.512(a) allows health care providers to disclose protected health information when the disclosure of information is required by another law, such as a state law. North Carolina state laws regarding CD/CC reports are perfect examples of state laws requiring disclosure of protected health information.
- Section 164.512(b) specifically allows health care providers to disclose protected health information to a public health authority that is authorized by law to receive the information for public health purposes, including the investigation or control of diseases. HIPAA specifically mentions CD reporting laws as examples of laws that would fit into this category.

11. Could a physician who reports CD/CCs be held liable for violating state confidentiality laws?

No. GS 130A-142 provides immunity from liability for persons who make reports in good faith. This immunity applies not only to physicians, but to all the other reporters as well (school principals, restaurant operators, etc.).

12. What if a physician refuses to make reports, citing HIPAA or another objection?

Theoretically, a local health director could enforce the reporting laws the same way other public health law violations are enforced: by asking a court to order the physician to comply with the law, or by charging the physician with a misdemeanor. In practice, such extreme measures

should be a last resort. As a first step, the director should try to resolve the matter through discussions with the physician. The director should explain the reporting requirements and be prepared to address questions about HIPAA and state confidentiality laws. Many health care providers are confused and worried about their obligations under HIPAA and are erring on the side of refusing to disclose information as a result. It may be that a physician would be willing to cooperate if he or she were simply shown the relevant sections of the privacy rule (cited above in question 10).

Investigation

13. What do NC's statutes and rules say about the health department's duty to investigate CD/CCs?

Not much. GS 130A-144(a) requires an investigation of all CD/CC reports. The rules elaborate on this requirement a little, requiring the local health director (or designee) to immediately investigate the circumstances of each report to determine the authenticity of the report and the identity of all persons for whom control measures are required, and to collect and submit any lab specimens that are necessary. 10A NCAC 41A.0103(a). The local health director also is required to determine which control measures have been given—this is presumably done as part of the investigation as well. 10A NCAC 41A.0103(b). There is nothing else in the *law* specifying how investigations are to be conducted. However, the NC Division of Public Health has published practical guidance in conducting an investigation.¹

14. Can local health department staff obtain access to medical records, if they are necessary for an investigation of a disease report or an outbreak?

Yes. Physicians, persons in charge of medical facilities, and persons in charge of laboratories must make confidential medical records available to health department staff investigating:

- a CD/CC report, or a known or suspected outbreak of a CD/CC (GS 130A-144(b)), or
- a report, case, or outbreak of an illness, condition, or health hazard that may have been caused by bioterrorism (GS 130A-476(c)).

A person who provides access to records or information pursuant to these laws is immune from civil or criminal liability that might otherwise be imposed under state law. GS 130A-144(c) and 130A-476(d).

15. What about HIPAA? Does it prohibit a physician or person in charge of a medical facility or laboratory from providing access to records pursuant to these laws?

No. As noted under question 10, above, HIPAA specifically allows disclosures of information that are required by state law. GS 130A-144(b) and 130A-476(c) are both state laws that require the disclosure of health information.

¹ The N.C. General Communicable Disease Branch describes the steps of an outbreak investigation in its "NC Communicable Disease Control Manual." The outbreak investigation portion of the manual is available on the Internet at <http://www.epi.state.nc.us/epi/gcdc/manual/outbreakinvest.pdf>.

Control Measures in General

16. Are CD/CC control measures established in law?

Yes. Control measures are established by rule in NC and can be found in the NC Administrative Code (10A NCAC 41A.0201 through .0213).

The NCAC establishes specific control measures for the following diseases:

- HIV (10A NCAC 41A.0202)
- Hepatitis B (10A NCAC 41A.0203)
- Sexually transmitted diseases, defined as syphilis, gonorrhea, chlamydia, nongonococcal urethritis, mucopurulent cervicitis, chancroid, lymphogranuloma venereum, and granuloma inguinale (10A NCAC 41A.0204)
- Tuberculosis (10A NCAC 41A.0205)
- Smallpox and vaccinia disease (10A NCAC 41A.0208)
- SARS (10A NCAC 41A.0213)

For all other CD/CCs, the control measures are obtained from one of two other sources:

- Guidelines and recommended actions published by the CDC (usually available at www.cdc.gov), or, if no CDC guidelines are available,
- The APHA's Control of Communicable Diseases Manual.²

17. Can a local health department impose additional control measures, on top of those in the NCAC, CDC guidelines, or Manual?

The answer depends on the CD/CC.

- Isolation or quarantine orders for persons with HIV, Hepatitis B, STDs, and TB are prohibited from being more restrictive than the control measures established in the NCAC. 10A NCAC 41A.0201(d). Since more restrictive control measures cannot be enforced through the isolation/quarantine authority, it is reasonable to conclude they can't be imposed at all for those diseases/conditions.
- The rules are not entirely clear when it comes to all other CD/CCs, but it appears that a local health director could devise additional control measures for those CD/CCs, so long as the director followed several general principles that are set out in 10A NCAC 41A.0201(b). Those principles are:
 - Control measures must be reasonably expected to decrease the risk of transmission and be consistent with recent scientific and public health information.
 - Control measures for diseases/conditions transmitted by the airborne route must require physical isolation for the duration of infectivity.
 - Control measures for diseases/conditions transmitted by the fecal-oral route must require exclusion from situations in which transmission can reasonably be expected to occur, such as food-handling work, for the duration of infectivity.

² David L. Heymann (Editor), *Control of Communicable Diseases Manual, 18th Ed.* (American Public Health Association, 2002). The book can be ordered through the APHA's website, www.apha.org.

- Control measures for diseases/conditions transmitted by sexual or bloodborne routes must include prohibitions on donating blood or tissue, needle-sharing, and sexual contact in a manner likely to result in transmission for the duration of infectivity.

18. Can a local health director impose control measures for CD/CCs that are not reportable?

Yes. The local health director has a duty to ensure that control measures are given for both reportable CD/CCs and “any other communicable disease or communicable condition that represents a significant threat to the public health.” GS 130A-144(e).

19. Are individuals legally required to comply with CD/CC control measures?

Yes. GS 130A-144(f) states: “All persons shall comply with control measures, including submission to examinations and tests, prescribed by the Commission ...” Failure to comply is a misdemeanor and is punishable by a sentence of up to two years (GS 130A-25).

Bloodborne Pathogens

20. What is a bloodborne pathogen exposure incident?

Under NC’s CD rules, a bloodborne pathogen exposure incident occurs when a person has:

- A needlestick, or
- A nonsexual contact that:
 - Exposes the person’s nonintact skin or mucous membrane to the blood or body fluids of another person, *and*
 - The contact is of a nature that it would pose a significant risk of transmission of HIV or Hepatitis B, if the other person were infected with those viruses.

10A NCAC 41A.0202(4) and .0203(b)(3).

21. Who is a source person? Who is an exposed person?

The source person is the person who contributes the blood or body fluids to the exposure incident. The exposed person is the one who suffers the needlestick or the nonintact skin or mucous membrane exposure to the blood or body fluids.

22. Do you have to know or suspect that the source person has HIV or Hepatitis B for the bloodborne pathogen rules to apply?

No. To the contrary, you essentially need to assume or imagine that the source person does have one of those diseases, and then ask: was this contact of a type or nature that creates a significant risk of them giving it to another person? In other words, what is important is the nature of the contact, not any knowledge or suspicions anyone may have about the source person’s HIV or Hepatitis B status.

23. What constitutes a significant risk of transmission?

Needlesticks are assumed to always pose a significant risk of transmission and therefore are always treated as exposure incidents. All other nonsexual contacts must be treated on a case-by-case basis. In making the determination, the CD rules state that the following factors must be considered (if they are known):

- The type of body fluid or tissue involved in the incident
- The volume of body fluid or tissue
- The concentration and virulence of pathogen (note that this factor will only apply if the source person's infection status is known), and
- The type of exposure, ranging from intact skin to non-intact skin, or mucous membrane (this factor is unclearly worded but seems redundant, since the rules only apply if non-intact skin or mucous membranes are involved).

10A NCAC 41A.0201(f).

24. What happens after an exposure incident occurs?

The procedures to be followed vary depending on whether the source person is known or unknown. In general, the procedures require known source persons to be tested for HIV and Hepatitis B. The results of the test are provided to the exposed person. Testing and counseling must also be offered to exposed persons, and the exposed person may be offered the Hepatitis B vaccine as well, depending upon the circumstances. If the source person is unknown, the exposed person must be offered testing and counseling and possibly vaccination against Hepatitis B. The detailed procedures are contained in 10A NCAC 41A.0202(4) (HIV) and .0203(b)(4) (Hepatitis B).

25. The rules seem to rely a lot on the “attending physicians” of the source and exposed persons. For example, they say that the attending physician of the exposed person initiates the process by notifying the source person’s attending physician of the incident. What if you don’t know who a person’s attending physician is, or if they don’t have one?

The rules allow (but do not require) health care facilities to release the name of a source person's attending physician upon the request of the exposed person's attending physician. 10A NCAC 41A.0202(4)(c).

If either person (source or exposed) does not have an attending physician, or if the identity of the attending physician cannot be determined, the health director (or designee) should assume that role for the purpose of carrying out the bloodborne pathogen rules.

26. In a biting incident that breaks the skin, who must be tested—biter, or bite victim?

It depends on who was exposed to whose body fluids in a manner that creates a significant risk of transmission. In a typical incident, we would probably assume that the bite victim was exposed to the biter's saliva, but the biter was exposed to the bite victim's blood. This means that, in most cases, the conclusion will be that the victim is the source person who must be tested, since exposure to blood is much more likely to constitute a significant risk of transmission

than exposure to saliva. Of course, it is possible a different conclusion could be reached, depending upon the facts of a particular case. It is always important to consider each case separately, based upon all available information.

27. Are there special rules for testing criminal defendants?

Yes. If there is probable cause to believe that a person under arrest may have exposed someone to bloodborne pathogens, the magistrate who conducts the initial appearance hearing can order the arrestee detained for up to 24 hours so that public health officials can investigate and decide whether the arrestee should be tested for HIV and/or Hepatitis B. GS 15A-534.3. Note that the magistrate is not authorized to order the tests; he or she simply may order the person detained so that public health officials can decide whether testing is indicated. In making this determination, public health officials would evaluate the incident according to the usual bloodborne pathogen rules. That is, they would determine first whether there was a needlestick or a nonsexual contact in which nonintact skin or mucous membranes were exposed to body fluids, and if so, whether the incident created a significant risk of transmission.

Another law, GS 15A-615, allows courts to order an alleged sexual offender to be tested for HIV, Hepatitis B, and several STDs (chlamydia, gonorrhea, herpes, and syphilis). A victim of rape or certain other sexual offenses may ask the district attorney to have the defendant tested. Upon receiving the victim's request, the district attorney must petition the court for an order requiring the tests. If the judge finds that there is probable cause to believe that the alleged sexual conduct would pose a significant risk of transmission of one of the diseases named above, the judge must order the tests. In this case, it is the judge who makes the determination of significant risk of transmission rather than public health officials. If the judge orders the tests, they must be performed by either the local health department (if the defendant is in the custody of the local jail) or the Department of Correction (if it has custody of the defendant). In either case, the local health director must be notified of the test results, and the local health director is responsible for notifying the victim of the results and counseling the victim appropriately. The defendant must also be notified of the results and counseled by the agency that conducted the tests (either the local health department or DOC).

Isolation and Quarantine

28. What is the key difference between isolation and quarantine?

Isolation limits the freedom of movement or action of a person or animal who *is infected with* (or is reasonably suspected of being infected with) a communicable disease or condition. GS 130A-2(3a). Quarantine limits the freedom of movement or action of a person or animal who *has been exposed* (or is reasonably suspected of having been exposed) to a communicable disease or condition. Under North Carolina law, quarantine also can be used in two additional circumstances: (1) to limit access by a person or animal to an area or facility that may be contaminated with an infectious agent; or (2) to limit the freedom of movement or action of unimmunized persons in an outbreak. GS 130A-2(7a).

29. What is the difference between an order limiting freedom of movement and an order limiting freedom of action?

An order limiting freedom of movement essentially prohibits an individual from going somewhere. It may confine the person to a particular place, such as his home or a health care facility. Or it may prohibit the person from entering a particular place—for example, it may prevent a person from returning to school or work during the period of communicability. In contrast, an order limiting freedom of action limits specific behaviors, but not the ability to move freely in society. For example, a person who is required to refrain from sexual activity during the course of treatment for gonorrhea has had his or her freedom of action restricted.

30. In North Carolina, who has the authority to order isolation or quarantine?

Either the state health director or a local health director may order isolation or quarantine. GS 130A-145.

31. Are there any limitations on what can be included in an isolation or quarantine order?

Yes. The Commission for Health Services has imposed restrictions on isolation and quarantine orders “for communicable diseases and conditions for which control measures have been established.” 10A NCAC 41A.0201(d). The diseases and conditions with specific control measures in the NCAC are HIV, Hepatitis B, sexually transmitted diseases, and tuberculosis. For those diseases and conditions, isolation and quarantine orders may be no more restrictive than the control measures in the NCAC. They may not embrace control measures that appear in other sources, such as the APHA Manual.

For all other communicable diseases and conditions, isolation or quarantine orders should be consistent with the control measures for those diseases that are established in CDC guidelines or the APHA’s Manual and with the principles described under question 17, above.

32. Can isolation or quarantine be ordered if the communicable disease or condition is not reportable in North Carolina?

Yes. Isolation and quarantine are control measures. As question 18 states, health directors can impose control measures for diseases or conditions that are not reportable.

33. How is isolation or quarantine ordered? What should be in the order?

There is no North Carolina statute or rule that sets forth specific steps to follow in ordering isolation or quarantine, but considering all the various laws together, we can reach a few conclusions:

- Although the law does not specifically state that an isolation or quarantine order must be in writing, it should be. An individual who is isolated or quarantined has a right to have notice that he or she is being isolated or quarantined, and the clearest and most direct way to do this is to put it in writing. The written order will also be an important piece of evidence if you must go to court to enforce, defend, or extend the order.

- The order should include:
 - The name of the person who is subject to the order,
 - The identity of the health department and the health director issuing the order,
 - A statement of the control measures the person is subject to,
 - A statement that the control measures have been explained to the person,
 - A statement of the penalties that may be imposed if the person fails to comply with the order,³
 - The health director's signature, and
 - The date and time the order was issued.
- If the order limits the person's freedom of movement, a new law requires the health director to give reasonable notice to the person that he or she has a right to have a court review the order. GS 130A-145(d) (as amended by SL 2004-80 (S 582)). A local health director could satisfy this requirement by putting a statement in the order.

34. How long can a person be isolated or quarantined?

The basic limitation on the duration of an isolation or quarantine order is contained in GS 130A-145(a), which states that isolation and quarantine may be ordered only *and for so long* as the public health is endangered. The period of time is therefore likely to vary depending upon the communicable disease or condition and possibly other circumstances. For example, an order directing a person with HIV to refrain from donating blood could endure for years, but an order directing a person with gonorrhea to refrain from sexual intercourse would apply only until treatment was completed and any lesions healed. Note that both of those examples involve orders limiting freedom of action.

Orders limiting freedom of movement or access to persons or animals whose movement has been limited are treated somewhat differently. Health directors still must comply with the basic rule of GS 130A-145(a) and only issue such orders when and for so long as the public health is endangered, but only up to a maximum of 30 days. A new law imposes the 30-day maximum on all orders limiting freedom of movement or access, and the maximum applies even if the threat to the public health still exists after 30 days. GS 130A-145(d) (as amended by SL 2004-80 (S 582)).

So, for example, suppose a person has a CD that requires a 21-day period of isolation. The order should not exceed 21 days, because the order must be limited to the period of time during which the public health is endangered. On the other hand, suppose a CD requires a period of isolation that exceeds 30 days. The health director's order cannot exceed 30 days, even though the danger to the public health will still persist after 30 days.

35. What if you need to restrict a person's freedom of movement for more than 30 days in order to protect the public health? Can that be done?

³ An order issued to a person with HIV, hepatitis B, an STD, or tuberculosis *must* state the penalties for failure to comply with the order. 10A N.C.A.C. 41A.0201(d). Although there is no statute or rule imposing this requirement on isolation or quarantine orders issued to persons with other illnesses, the best practice would be to do so.

Yes, but you have to go to court. If the 30-day period is inadequate to protect the public health, the local health director or state health director must seek an order extending the time period from the superior court. If the court determines by a preponderance of the evidence that the limitation of freedom of movement is reasonably necessary to prevent or limit the conveyance of any communicable disease or condition except tuberculosis, the court shall continue the limitation for a period of up to 30 days. (If the person whose freedom of movement has been limited has tuberculosis, the court shall continue the limitation for up to one year.) Note that the burden of producing sufficient evidence to support the order will be on the health director. When necessary, the state health director or local health director may return to court and ask the court to continue the limitation for additional periods of up to 30 days each (up to one year for persons with tuberculosis). G.S. 130A-145(d) (as amended by SL 2004-80 (S 582)).

Ordinarily, this action is instituted in the superior court in the county in which the limitation on freedom of movement was imposed. However, if the individual who is the subject of the order has sought review of the order in Wake County Superior Court (see the next question), then you have to go to court in Wake County.

36. Can a person object to being isolated or quarantined?

Yes, by asking a court to review the order. A person who is substantially affected by an order limiting freedom of movement may institute an action in superior court seeking review of the limitation, and the court must respond by conducting a hearing within 72 hours (excluding Saturdays and Sundays). The person is entitled to an attorney and will receive appointed representation if he or she is indigent. The court must reduce the limitation if it determines by the preponderance of the evidence that the limitation is not reasonably necessary to prevent or limit the conveyance of the communicable disease or condition to others. In this case, the burden of producing sufficient evidence to show that the limitation is not reasonably necessary is on the substantially affected person. The person has a choice of where to institute this action: either in the superior court of the county where the limitation is imposed, or in the Wake County Superior Court. GS 130A-145(d).

What about a person who is subject to a limitation on freedom of action? Such an individual has a right to due process, which includes the opportunity for his or her objections to the order to be heard. However, our law does not spell out how a person subject to this kind of limitation can exercise this right. Most likely, the person would file an action in superior court seeking a declaratory judgment about the validity of the order, or an injunction barring enforcement of the order.

37. How is isolation or quarantine enforced?

Any violation of the state's public health laws or rules is a misdemeanor. G.S. 130A-25(a). Thus, a person can be criminally prosecuted for violating quarantine or isolation orders. Because the arrest and detention of such a person creates public health concerns, North Carolina's criminal procedure laws allow for arrests and detentions that minimize the exposure of others to the arrested person.

A law enforcement officer who arrests an individual for violating an order limiting freedom of movement or access may detain the person in an area designated by the state health director or a local health director, until the individual's first appearance before a judicial official. GS 15A-401(b)(4). In other words, the person need not be taken to the magistrate's office or jail if the state health director or local health director orders the person detained in a different place. At the first appearance, the judicial official must consider whether the person poses a threat to the health and safety of others. GS 15A-534.5. If the judicial official determines by clear and convincing evidence that the person does pose a threat, the official must deny pretrial release and order the person to be confined in an area the official designates after receiving recommendations from the state health director or local health director. The burden to produce sufficient evidence to support the determination that the person poses a threat is on the health director.

Isolation and quarantine orders may also be enforced through a civil action. GS 130A-18 provides that, if a person violates any of the public health laws and rules, a local health director can request an injunction from the superior court in the county in which the violation occurred.

38. Is an isolation or quarantine order issued by a local health director “portable”? That is, can it follow a person from one local health department’s jurisdiction to another?

GS 130A-145 authorizes local health directors to issue isolation or quarantine orders. Although it does not specifically state that local health directors may issue these orders only in their own jurisdictions, that is undoubtedly the case. Since a local health director could not issue an isolation order outside of his or her own jurisdiction, then the order is probably not valid outside the local health director's jurisdiction. *This does not mean that a person who is subject to an order is relieved of the obligation to comply with the terms of the order—the control measures—when he or she crosses the county line.* GS 130A-144(f) requires all persons to comply with communicable disease control measures adopted by the Commission for Health Services. This law applies throughout the state. So, if a person is diagnosed with HIV in Orange county and told of the control measures while there, he is still obligated to comply with those control measures when he moves to Chatham county. Furthermore, if he violates control measures while in Chatham county, an Orange county isolation order could be used as evidence that he knew he had HIV and was subject to control measures. Thus, for practical purposes, whether the order is valid outside the jurisdiction in which it is issued may not matter much.

39. Suppose the local health director is out of town. A case of probable SARS is identified in the county. The person resists being confined to home, so communicable disease staff decide an isolation order should be issued. Can anyone issue the order in the local health director’s absence?

Yes. The local health director may delegate the authority to issue the order to a staff member. GS 130A-6 provides that any public official granted authority under GS Chapter 130A may delegate that authority to another person.