VOLUME IV, ISSUE 2 SPRING 2011

Seton Hall University School of Law
Health Law Forum

Health Law Outlook

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Smoke Free NYC

News Trend in Public and Private Smoking Restrictions

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Introduction

On February 2, 2011, the New York City Council (the "City" or "NYC") passed a law that bans smoking in public parks, on beaches, and in pedestrian plazas.[1] Mayor Michael Bloomberg commended the City's efforts, issuing the following statement:

> This summer, New Yorkers who go to our parks and beaches for some fresh air and fun will be able to breathe even cleaner air and sit on a beach not littered with cigarette butts. By voting to prohibit smoking in all 1,700 City parks and 14 miles of beaches, the City Council will help us protect more New Yorkers from the harmful effects of second-hand smoke – particularly children who suffer from asthma. Our efforts over the last 9 years have resulted in more than 350,000 fewer smokers, and contributed to New Yorkers living 19 months longer than they did in 2002.[2]

Not everyone, however, was quite so enthusiastic. Opponents argued that the City's latest effort creates a "slippery slope"[3] towards a "totalitarian society"[4] or "nanny state."[5] Those in support of the law countered, noting that "[t]he message that this action sends is that smoking is aberrant behavior" and that "we have to do everything we can to demoralize this activity."[6] As the debate among lawmakers continues, the private sector has joined the controversy, adopting policies more prohibitive than the City's restrictions that turn away applicants and terminate employees because they use tobacco products.[7] Whether the concern is public health or the bottom line, the next major trend in smoke-free restrictions may come from the private sector, not local regulations.

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Bullying as a Public Health Concern

A Look at New Jersey's Anti-Bullying Bill of Rights

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Violence and bullying have recently received lots of news coverage. There have been well-reported cases across the country, including disturbing events here in New Jersey.[1] While bullying and taunting have led to well-publicized suicides and deadly school shootings, it is a concern that is not limited to schools. Bullying is increasingly being described as a public health concern with many emotional and mental health consequences.[2] In addition, "cyber-bullying," through which bullying has found its way onto the pages of common social networking sites, has emerged as a new trend.[3] While this new phenomenon may not seem as harmful, it is having the same unfortunate impacts. A recent article in a major New Jersey newspaper detailed how, in some cases, cyber-bullying results in physical altercations as the bullying spreads from online sites to classroom hallways.[4] Recognizing bullying and violence as a public health and safety concern and in light of recent events, the New Jersey legislature, passed one of the toughest anti-bullying laws in the country, the Anti-Bullying Bill of Rights Act (the "Act") in November 2010.[5]

Evolution of the Anti-Bullying Law in New Jersey

The Act is not without precedence; there has been an anti-bullying statute in New Jersey that applies to all public schools since 2002.[6] The original statute has been amended twice -- once in 2007 and again in 2010. The 2007 amendments include additional provisions that recognize bullying through electronic devices.[7] The 2010 amendments, passed in November and signed into law in January 2011, refine the definition of bullying, require school districts to post their anti-bullying policies on their website and require school districts to distribute their policies to parents or guardians.[8]

One main change that has evolved over time is the definition of bullying. The initial 2002 New Jersey bullying statute defined "harassment, intimidation or bullying" as:

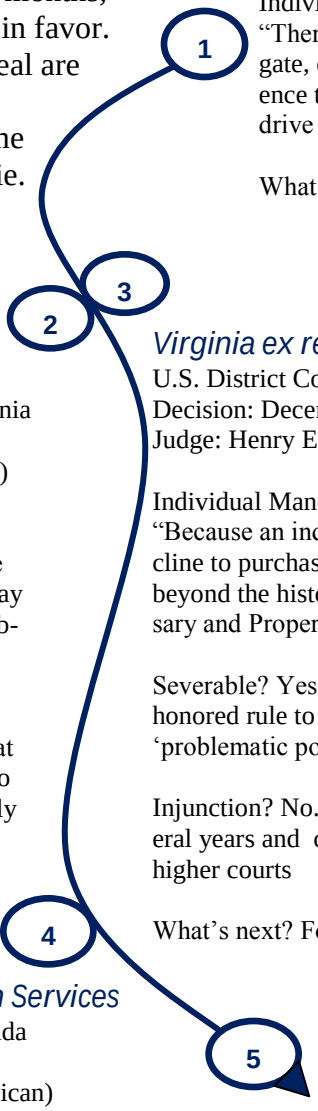
> [A]ny gesture or written, verbal or physical act that is reasonably perceived as being motivated either by any actual or perceived characteristic, such as race, color, religion, ancestry, national origin, gender, sexual orientation, gender identity and expression, or a mental, physical or sensory handicap, or by any other dis-

('Bullying as a Public Health Concern,' Continued on page 7)

PPACA's Road to the Supreme Court

As challenges to the constitutionality of the Patient Protection and Affordable Care Act (PPACA) make their way toward the Supreme Court, we have taken this opportunity to review the federal decisions up until this point. With five decisions over five months, the current tally on constitutionality is 3-2, in favor. As four of the thirteen circuit courts of appeal are slated to decide on the constitutionality of PPACA, it is without doubt that the Supreme Court will have to weigh in and break the tie.

Also, note the distribution of rulings along party (appointment) lines.



Thomas More Law Center, et al. v. Obama

U.S. District Court for the Eastern District of Michigan
Decision: October 7, 2010
Judge: George Carah Steeh (*appointed by a* Democrat)

Individual Mandate (§ 1501): Upheld
"There is a rational basis to conclude that, in the aggregate, decisions to forego insurance coverage in preference to attempting to pay for health care out of pocket drive up the cost of insurance."

What's next? Sixth Circuit Court of Appeals

Liberty University v. Geithner

U.S. District Court for the Western District of Virginia
Decision: November 30, 2010
Judge: Norman K. Moon (*appointed by a* Democrat)

Individual Mandate (§ 1501): Upheld
"[T]here is a rational basis for Congress to conclude that individuals' decisions about how and when to pay for health care are activities that in the aggregate substantially affect the interstate health care market."

Employer Coverage Requirement (§ 1513): Upheld
"A rational basis exists for Congress to conclude that the terms of health coverage offered by employers to their employees have substantial effects cumulatively on interstate commerce."

What's next? Fourth Circuit Court of Appeals

Virginia ex rel Cuccinelli v. Sebelius

U.S. District Court for the Eastern District of Virginia
Decision: December 13, 2010
Judge: Henry E. Hudson (*appointed by a* Republican)

Individual Mandate (§ 1501): Struck down
"Because an individual's personal decision to purchase – or decline to purchase – health insurance from a private provider is beyond the historical reach of the Commerce Clause, the Necessary and Proper Clause does not provide a safe sanctuary."

Severable? Yes. "[T]his court will hew closely to the time-honored rule to sever with circumspection, severing any 'problematic portions while leaving the remainder intact.'"

Injunction? No. The provisions at issue do not take effect for several years and constitutionality will ultimately be decided by higher courts

What's next? Fourth Circuit Court of Appeals

Florida et al v. Dept. of Health and Human Services

U.S. District Court for the Northern District of Florida
Decision: January 31, 2010
Judge: Clyde Roger Vinson (*appointed by a* Republican)

Individual Mandate (§ 1501): Struck down
"[T]he individual mandate seeks to regulate economic inactivity, which is the very opposite of economic activity. And because activity is required under the Commerce Clause, the individual mandate exceeds Congress' commerce power…"

Severable? No. "Because the individual mandate is unconstitutional and not severable, the entire act must be declared void."

Injunction? No, because "declaratory judgment is the functional equivalent of an injunction."

What's next? Eleventh Circuit Court of Appeals

Margaret Lee Mead, et al, vs. Holder

U.S. District Court for the District of Columbia
Decision: February 23, 2011
Judge: Gladys Kessler (*appointed by a* Democrat)

Individual Mandate (§ 1501): Upheld
"[T]he individual mandate provision is an appropriate means which is rationally related to the achievement of
Congress's larger goal of reforming the national health insurance system."

What's Next? United States Court of Appeals for the District of Columbia Circuit

Prescription Drug Monitoring Programs

A Discussion of Potential Practitioner Liability

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The nation has been facing an increasing rise in prescription drug abuse. In an effort to combat this growing trend, many states have implemented Prescription Drug Monitoring Programs (PMPs). A PMP is a statewide electronic database that collects data on controlled drug substances dispensed within the state.[1] PMPs help detect and prevent the diversion and abuse of controlled drug substances, particularly at the retail level where no other automated information collection system exists.[2] According to the National Alliance for Model State Drug Laws (NAMSDL), an organization that assists states with legislative and policy issues related to PMPs, these programs serve several goals, including:

> (1) to support access to legitimate medical use of controlled substances, (2) to help identify and deter or prevent drug abuse and diversion, (3) to facilitate and encourage the identification, intervention with and treatment of persons addicted to prescription drugs, (4) to help inform public health initiatives through outlining of use and abuse trends and (5) to educate individuals about PMPs and the use, abuse, and diversion of and addiction to prescription drugs.[3]

Pharmacists will generally submit information about the dispensing of controlled drug substances to the PMP on a periodic basis; this information includes, but is not limited to, dispenser identification, prescription number, quantity of drug dispensed, patient identification, prescriber identification and source of payment.[4] Authorized requesters and users of PMP data include practitioners, prescribers and pharmacists; designated federal, state, and local law enforcement; licensing, certification or regulatory boards, commissions and agencies; and individuals whose receipt of prescriptions has been included in the PMP database.[5] Only authorized requesters can access the information. States sometimes also allow officials working on Medicaid and fraud issues to use PMP data.[6] These organizations and agencies then track trends and patterns in usage to detect and prevent abuse.

As of October 2010, thirty-four states are "currently collecting prescription data and can respond to requests for reports by those authorized to make these requests."[7] Seven states (including New Jersey as of January 2007)[8] have passed enabling legislation, but have yet to begin monitoring.[9] Laws in most states, including New Jersey, allow monitoring of Schedule II through V substances, while a few states can only monitor Schedule II or Schedule II and III substances.[10]

Although implemented and operated wholly at the state level, PMPs receive funding from two federal sources. The first is the Harold Rogers Prescription Drug Monitoring Program (HRPDMP), administered by the Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. HRPDMP provides grants for planning, implementation, and enhancement of PMPs. A state must have a statute or regulation permitting PMP implementation in order to receive funding.[11] The second source is the National All Schedules Prescription Electronic Reporting Act (NASPER), which is administered by the U.S. Department of Health and Human Services and enables states to create a PMP database or enhance an existing one.[12] Again, these "state level programs must be in place before the state can apply for federal funding."[13]

> **" PMP**S HELP DETECT AND PREVENT THE DIVERSION AND ABUSE OF CONTROLLED DRUG SUBSTANCES, PARTICULARLY AT THE RETAIL LEVEL WHERE NO OTHER AUTOMATED INFORMATION COLLECTION SYSTEM EXISTS**."**

Issues of Liability

Liability issues surrounding PMPs are inevitable, given the immediate availability of information provided to pharmacists and other practitioners as well as the corresponding duty to check such information prior to prescribing and dispensing. Patients may object to electronic submission of their personal information and tracking of their prescription medication usage. Physicians may fear liability and disciplinary action by licensing authorities for being too lax in their prescribing practices. Pharmacists may be held liable for not recognizing and preventing a patient's pattern of drug abuse. Consequently, most states have included in their PMP enactment legislation safeguards against crushing liability.

One of the most obvious areas of liability stems from patient confidentiality and privacy. In the era of the Health Insurance Portability and Accountability Act (HIPAA), which imposes civil penalties for violations of patient privacy,[14] protecting patient confidentiality is a top concern.[15] HIPAA, however, "allows disclosure of [Protected Health Information (PHI)] without permission [from the patient] for 12 national priority purposes,"[16] several of which, including Health Oversight Activities,[17] apply to PMPs.[18] Thus, practitioners' lawful data input and access should not create liability issues surrounding confidentiality and privacy. Although these provisions of HIPAA seem to promote practitioner protection, patients should not fear mis-

('PMPs,' Continued on page 7)

'Smoke-Free NYC,' Continued

Background – Smoke-Free NYC

In 1995, the City banned smoking in most workplaces.[8] The law contained several loopholes, and in 2002, the City passed the Smoke-Free Air Act to extend the smoking ban to practically all businesses, including restaurants and bars.[9] That same year, the New York State Legislature and the City increased cigarette taxes, making the price of cigarettes in NYC the highest in the nation.[10]

In response to these initiatives, business owners expressed concern that the laws would decrease patronage, limit revenue, and deter future tourists.[11] Another common complaint was that the law infringed upon basic personal liberties of NYC's smokers.[12] The NYC Department of Health and Mental Hygiene ("DHMH") responded, noting that "smokers are free to continue to smoke — as long as they don't expose others involuntarily to cancer-causing chemicals . . . . When one person's right to engage in certain behaviors conflicts with another person's right not to be harmed, limits have generally been placed on the harmful behavior."[13]

Countering objections from the business community, a collaboration of NYC agencies issued a report which showed that since the City was officially smoke-free:

- Business tax receipts from restaurants and bars were up 8.7%;
- The number of restaurant and bar closings remained unchanged; and
- A majority (73%) of New Yorkers expected to go out to eat just as often as before.[14]

Contrary to arguments against the laws, the more restrictive smoke-free atmosphere did not hurt businesses. In fact, the laws may have actually helped employers by increasing profit margins as costs attributed to absenteeism and health insurance premiums declined.[15]

Parks, Beaches, and Pedestrian Plazas

The City's new smoking ban simply amends the Smoke-Free Air Act, prohibiting smoking in "park[s] or other property under the jurisdiction of the [D]epartment of [P]arks and

('Smoke-Free NYC,' Continued on page 9)

Mandating the HPV Vaccine for School-Age Children

Considering the Debate Five Years Later

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Discussion regarding the possibility of a public health mandate for the vaccine for human papillomavirus (HPV) began even before Merck & Co.'s vaccine, Gardasil, received its June 2006 approval from the Food and Drug Administration (FDA).[1] Supporters and critics of a mandated vaccination program engaged in polarizing debate regarding the legal, ethical and social implications of requiring the vaccine.[2] Five years later, only Virginia and the District of Columbia have mandated the vaccine; Virginia introduced legislation to eliminate the mandate in January of this year.[3] There are several possible reasons why states have turned away from mandating the vaccine, all of which have been at issue since the beginning of the debate over Gardasil.

> **"FIVE YEARS LATER, ONLY VIRGINIA AND THE DISTRICT OF COLUMBIA HAVE MANDATED THE VACCINE; VIRGINIA INTRODUCED LEGISLATION TO ELIMINATE THE MANDATE IN JANUARY OF THIS YEAR."**

The Gardasil Vaccine

The FDA approved the use of Gardasil in females ages nine through twenty-six for prevention of cervical cancer and genital warts caused by four strains of HPV, including the two types which are responsible for seventy percent of cervical cancers.[4] The vaccine is administered through three injections over a period of six months.[5] Both the scientific and medical fields embraced the vaccine's development, given that HPV is the most common sexually transmitted infection (STI) in the United States.[6]

Merck began an aggressive marketing campaign after Gardasil's approval, and twenty-four states and the District of Columbia introduced legislation mandating the vaccine for girls ages nine through fourteen.[7] Despite the flurry of legislation attempting to make the HPV vaccine compulsory, states decisively turned away from mandating the vaccine and only the District of Columbia and Virginia actually approved HPV vaccine mandates.[8] The marked change in state opinion may be attributed to the controversy over Gardasil's safety and efficacy, the concern of mandating a childhood vaccine for an STI, and the

('Mandating the HPV Vaccine,' Continued on page 10)

'Bullying as a Public Health Concern,' Continued

tinguishing characteristic, that takes place on school property, at any school-sponsored function or on a school bus and that:

a. a reasonable person should know, under the circumstances, will have the effect of harming a student or damaging the student's property, or placing a student in reasonable fear of harm to his person or damage to his property; or
b. has the effect of insulting or demeaning any student or group of students in such a way as to cause substantial disruption in, or substantial interference with, the orderly operation of the school.[9]

This law was amended in 2007 to include provisions for bullying through electronic devices. The amended law defined electronic communications and expanded the definition of bullying to include bullying through electronic communications:

"Electronic communication" means a communication transmitted by means of an electronic device, including, but not limited to, a telephone, cellular phone, computer, or pager;
"Harassment, intimidation or bullying" means any gesture, any written, verbal or physical act, *or any electronic communication* that is reasonably perceived as being motivated either by any actual or perceived characteristic, such as race, color, religion, ancestry, national origin, gender, sexual orientation, gender identity and expres-

('Bullying as a Public Health Concern,' Continued on page 8)

'PMPs,' Continued

appropriation of their PHI; safeguards are in place to protect patients from misuse of their PHI. In fact, several states have explicitly incorporated specific language designed to protect confidentiality and privacy rights into their PMP laws.[19] Common statutory safeguards include "[c]arefully specifying who is allowed to access the PMP, under what circumstances the information may be accessed or what criteria must be met for access, and for what purposes the lawfully accessed data may be used."[20] Such statutes often impose criminal penalties for the unlawful access or disclosure of PMP information.[21]

A second area of potential concern for practitioners involves the failure to comply with PMP submission requirements. Under several states' PMP enactment statutes, the failure to submit information to the database is grounds for the state's pharmacy licensing board to take disciplinary action against the responsible pharmacist or practitioner.[22] Additionally, some states, such as New Jersey, impose civil penalties up to $1,000 for repeated failure to comply with the PMP submission requirements.[23]

Although pharmacists and other practitioners have reason to fear penalties from licensing boards and administrative agencies for failing to submit information, liability claims from individuals are more difficult to raise, and thus less common. Many states' PMP statutes contain immunity provisions for failing to access PMPs to verify that patients are not abusers before prescribing and dispensing controlled substance prescriptions.[24] In particular, as of June 2010, nineteen states explicitly impose no burden on practitioners to access PMP information.[25]

Nevertheless, at least one case has been filed against a group of pharmacies for not using their state's PMP to recognize and stop abuse. In *Sanchez ex rel. Sanchez v. Wal-Mart Stores, Inc.*, the plaintiffs sued the pharmacies after Mr. Sanchez, husband and father, was killed in a car accident by a known drug abuser who was under the influence of prescription drugs at the time of the accident.[26] Through discovery, the plaintiffs learned that "each of the [sued] pharmacies had received a letter from the PMP administrator alerting them to the patient's drug use a year before the accident."[27] The letter informed the pharmacies that within one year, the patient "had obtained approximately 4,500 hydrocodone pills at 13 different pharmacies."[28] The lawsuit alleged that the pharmacies did not appropriately respond to the alerts and did not properly use the PMP. That failure, the plaintiffs claimed, led to the accident and subsequent death.

('PMPs,' Continued on Page 9)

'Bullying as a Public Health Concern,' Continued

> sion, or a mental, physical or sensory handicap, or by any other distinguishing characteristic, that takes place on school property, at any school-sponsored function or on a school bus and that:
>
> a. a reasonable person should know, under the circumstances, will have the effect of harming a student or damaging the student's property, or placing a student in reasonable fear of harm to his person or damage to his property; or
>
> b. has the effect of insulting or demeaning any student or group of students in such a way as to cause substantial disruption in, or substantial interference with, the orderly operation of the school.[10]

In 2010, the Act further refined the definition of bullying, intimidation or harassment to:

> any gesture, any written, verbal or physical act, or any electronic communication, *whether it be a single incident or a series of incidents*, that is reasonably perceived as being motivated either by any actual or perceived characteristic, such as race, color, religion, ancestry, national origin, gender, sexual orientation, gender identity and expression, or a mental, physical or sensory disability, or by any other distinguishing characteristic, that takes place on school property, at any school-sponsored function, on a school bus, *or off school grounds that substantially disrupts or interferes with the orderly operation of the school or the rights of other students* and that:
> a. a reasonable person should know, under the circumstances, will have the effect of *physically or emotionally* harming a student or damaging the student's property, or placing a student in reasonable fear of *physical or emotional* harm to his person or damage to his property;
>
> b. has the effect of insulting or demeaning any student or group of students; or
>
> c. *creates a hostile educational environment for the student by interfering with a student's education or by severely or pervasively causing physical or emotional harm to the student*.[11]

The 2010 changes try to clarify what constitutes bullying while also expanding the definition to include a broader range of circumstances. For example, the amendments specify that the law applies even if there was only one incident that harmed another student.[12] In addition, the law expands the definition of bullying to incidents that occur off school grounds if the incident has an effect on the school or the rights of a student.[13] Thus, the law is no longer limited to incidents occurring at the school or at school-sponsored events. Finally, the law expands the bullying definition to include an incident which causes either physical or emotional harm, or creates a hostile educational environment.[14] In addition to the changes to the definition of bullying, there were other important additions to the 2010 statute.

> **" IN THE WAKE OF RECENT HIGH-PROFILE SUICIDES RESULTING FROM BULLYING BOTH ACROSS THE COUNTRY AND IN NEW JERSEY, THE STATE QUICKLY ENACTED THIS NEW LEGISLATION."**

Other Changes in The Anti-Bullying Bill of Rights Act of 2010

In the wake of recent high-profile suicides resulting from bullying both across the country and in New Jersey,[15] the state quickly enacted this new legislation; it passed in November, was signed into law earlier this year and will go into effect September 1, 2011.[16] The intent of the new legislation is "to strengthen the standards and procedures for preventing, reporting, investigating and responding to incidents of harassment, intimidation, and bullying of students that occur in school and off school premises."[17] The Act outlines detailed procedures for reporting incidents of bullying and the steps that the principal must take in order to timely investigate the incident.[18] In regard to reporting, schools are required to report each bullying or harassment incident and the full details of each investigation twice every school year.[19] Schools then receive a grade based on these reports, which they are required to post on their website.[20] The Act notes that non-public schools are "encouraged" to comply with the provisions in the Act.[21]

In addition, the Act requires districts to take a more active role in providing bullying recognition and prevention training to educators.[22] Specifically, each public school teaching staff mem-

('Bullying as a Public Health Concern,' Continued on Page 11)

'PMPs,' Continued

The Supreme Court of Nevada ruled that "[p]harmacies do not have a duty to act to prevent a pharmacy customer from injuring an unidentified third party."[29] The majority explained that the PMP law was instead intended only to "enhance recordkeeping" for drug enforcement and regulation, and to provide information to physicians, pharmacies, and other practitioners.[30] Although *Sanchez* stands for the absence of a duty to third parties, in the author's opinion it is unlikely that courts will find pharmacists and pharmacies who fail to access PMPs liable for harm to their patients since many state laws explicitly prohibit this and legislative intent also indicates the same.

Conclusion

Prescription Monitoring Programs are quickly becoming a part of the healthcare landscape and their utility will only continue to grow. Physicians, pharmacists, and other practitioners can now look forward to a helpful tool to combat controlled drug substance misuse and abuse; and although PMPs present more responsibilities, practitioners need not fear crushing liability. As long as practitioners lawfully submit the required information to the PMPs, they can avoid disciplinary actions and liability related to confidentiality and privacy issues. Furthermore, states also safeguard practitioners from claims stemming from their failure to access and thereby prevent abuse.☼

'Smoke-Free NYC,' Continued

[R]ecreation" and "pedestrian plazas."[16] Parks or property under the jurisdiction of the Department of Parks and Recreation includes "public parks, beaches, waters and land under water, pools, boardwalks, marinas, playgrounds, recreation centers and all other property, equipment, buildings and facilities now or hereafter under the jurisdiction, charge or control of the [D]epartment of [P]arks and [R]ecreation."[17] Pedestrian plazas are defined as "area[s] designated by the [D]epartment of [T]ransportation for use as a plaza located within the bed of a roadway, which may contain benches, tables or other facilities for pedestrian use."[18]

The new restrictions ban smoking in many tourist destinations such as Central Park and large portions of Times Square. Smoking is not banned in a few select public areas such as (i) sidewalks adjoining parks and public places, (ii) pedestrian routes through medians or malls that are adjacent to vehicular traffic, (iii) parking lots, and (iv) theatrical productions.[19] The Department of Parks and Recreation is responsible for enforcing the new law and violators face a civil penalty of fifty dollars for each citation.[20] In contrast, a violation of the provisions which ban smoking in bars and restaurants carries a fine of $200 to $1000.[21]

Smoker-Free NYC?

The City's new smoking ban has spurred fervid debate among lawmakers and the public. Still, the law is nowhere near as restrictive as the policies adopted by employers throughout the country. For example, a growing number of hospitals have adopted policies that turn away job applicants if they smoke and in some cases call for the termination of employees testing positive for nicotine.[22] The American Lung Association, the American Cancer Society and the World Health Organization do not hire smokers;[23] neither does the Cleveland Clinic.[24] These policies extend well beyond the workplace and reach into the private lives of job applicants and employees by restricting tobacco use altogether.

> **"WHETHER THE CONCERN IS PUBLIC HEALTH OR THE BOTTOM LINE, THE NEXT MAJOR TREND IN SMOKE-FREE RESTRICTIONS MAY COME FROM THE PRIVATE SECTOR, NOT LOCAL REGULATIONS"**

The American Legacy Foundation, a non-profit anti-smoking organization, disagrees with this approach, arguing that the best thing to do is to help smokers quit rather than conditioning employment on quitting.[25] As Dr. Michael Siegel, from the Boston University School of Public Health, explains "[i]f enough of these companies adopt these policies and it really becomes difficult for smokers to find jobs, there are going to be consequences. Unemployment is also bad for health."[26] Others argue that the policies are too intrusive and may lead to restrictions regarding what employees eat and how often they exercise. As one opponent suggested, recent studies show that if you have an obese friend you are more likely to be overweight (so-called "second-hand obesity") and a health – and economic – risk to employers; if the employment restrictions continue, then what's next?[27]

Conclusion

Tobacco use causes one out of every six deaths in NYC, and second-hand smoke causes illness in more than 40,000 New Yorkers each year.[28] By all accounts, the City's public health initiatives have saved lives and prevented many of hazards of smoking.[29] The new law expands the City's efforts, making public parks and beaches safer for kids and families. New private sector restrictions, however, present new questions regarding just how far anti-smoking efforts should go.☼

'Mandating the HPV Vaccine,' Continued

risk of public backlash against a compulsory HPV vaccination.

Concerns with Mandating the Vaccine

Critics of the HPV vaccine mandate focus on the lack of data regarding Gardasil's efficacy.[9] The FDA completed a six-month priority review of Gardasil that included four studies with 21,000 women between the ages of sixteen and twenty-six.[10] Opponents consider this to be a small sample size with a limited period of follow-up.[11] Since the duration of the study was not long enough for cervical cancer to develop, researchers considered the prevention of cervical precancerous lesions to be equivalent to the prevention of cervical cancer.[12]

Clinicians argue that the duration of the vaccine-induced immunity remains unclear.[13] HPV antibodies are not detected in many women even in cases of naturally occurring HPV infection, suggesting that serologic (blood serum) measurement of HPV-induced antibody titers may not accurately represent HPV infection.[14] While current data may suggest that the vaccine is safe, the long-term protection of the vaccine is still unknown.[15]

Opponents also point out that mandating Gardasil, a vaccine for an STI, is a clear departure from traditional compulsory vaccinations.[16] In *Jacobson v. Massachusetts,* the United States Supreme Court first recognized the state power to mandate vaccinations.[17] The Court explained that a state's placement of limitations on individual rights due to public health concerns must be necessary, reasonable and proportionate.[18] Finding the smallpox vaccination to be a valid and necessary public health measure, the Court held that a mandated smallpox vaccination was a legitimate exercise of state police power.[19]

Critics of a mandated HPV vaccination argue that HPV does not present a public health necessity and is not reasonably related to school entry.[20] Unlike other diseases for which there are mandated vaccines, HPV is not highly contagious through casual contact and there is no significant morbidity or mortality that occurs shortly after exposure.[21] Current research has demonstrated transmission only through sexual contact and has shown that only some strains of HPV lead to cervical cancer, a disease which takes years to progress.[22] Further, because sexual contact is the only known route of transmission, children are not at risk of catching HPV from being in proximity to one another in a classroom setting. The Gardasil vaccine is therefore unreasonably related to school admission.[23]

Finally, opponents of a HPV vaccine mandate argue that it would unjustifiably restrict parental autonomy.[24] Not all children are equally at risk for exposure to HPV because transmission requires sexual behavior.[25] For that reason, parents should be able to discuss the issue with health care providers before weighing the need for the vaccine against any potential risks of the vaccination.[26] Research also suggests a general antipathy toward the sort of governmental coercion involved in mandating the HPV vaccine.[27] While many parents may prefer having their daughters vaccinated, fewer might agree that they should be told what to do regarding their child's risk of acquiring HPV.[28]

Alternative Responses

The overwhelming majority of states have not mandated the HPV vaccine because of the availability of alternative, less intimidating, measures. Instead of mandating Gardasil by linking it to school entrance, some states have mandated insurance coverage of the vaccine or provided state funding to cover costs for individuals who want the vaccine.[29] Other states have instead focused on educating their adult populations about HPV and Gardasil in an effort to promote educated decision-making regarding the health of their children.[30] Education includes explaining the link between HPV and cervical cancer and the etiology of the disease before allowing parents to weigh the risks and benefits for themselves.[31] Finally, some states have established recommendation committees that encourage parents to vaccinate their children for HPV, but do not require it.[32] These less coercive measures avoid much of the conflict surrounding the Gardasil vaccine while still raising HPV awareness.

Conclusion

Although many states considered mandating the HPV vaccine after Gardasil was approved, only two states actually did so and one state is in the process of revoking that mandate. Concerns about the safety and efficacy of the vaccine, about forcing children to receive a vaccine for an STI, and about infringing on parental autonomy have all played a role in changing the general opinion regarding a mandate. Further, states have other alternatives to increase awareness and use of the vaccine besides compulsory vaccination. As more vaccines are developed for STIs, the ethics around compulsory vaccinations will become increasingly relevant. States may be wise to consider this experience as a case study for future discussions regarding mandating vaccines for STIs. ☼

'Bullying as Public Health Concern,' Continued

ber must complete training in the relationship between bullying, harassment and suicide, as well as preventive measures to reduce bullying.[23] This requirement has raised concerns of increased costs among some school districts.[24] The Act states, however, that schools can apply for funding from the New Jersey Department of Education for these trainings.[25]

Does the Law Go Far Enough?

The Act also requires mandatory training for new school board members and school leaders on harassment, bullying and the school district's responsibilities.[26] Additionally, the Act requires each district to publish on its website the name of the district anti-bullying coordinator and the name of each school's anti-bullying specialist.[27]

The section devoted to bullying or harassment through "electronic communications" has been commonly referred to as cyber-bullying,[28] even though the term is not explicitly stated in the 2007 amendment to the statute.[29] Cyber-bullying has recently been recognized in academic journals and law review articles as a public health and safety concern,[30] but the law has not kept pace with our ever expanding technology and its associated negative impacts. For example, the 2010 law still does not "expressly instruct a district on how to thwart off-campus cyber-bullying, which is a problem considering that the majority of cyber-bullying does not occur on school grounds but rather in the comfort of students' homes."[31] Nevertheless, the 2010 law has taken steps in the right direction by expanding the definition of bullying, and even including a provision which makes the law apply for incidents off school grounds.[32]

Still, these improvements are not enough. More stringent legislation is needed to protect students from cyber-bullying and its mental and emotional health consequences. Specifically, the legislature should enact more protections for students on social networking pages, where they can be victims of cruel rumors which may potentially lead to the victim committing suicide[33] or result in physical altercations at school.[34] Since these cyber incidents can, and usually do, affect students at school, the law needs to clearly articulate how incidents of cyber-bullying on social networking sites will be addressed. For example, the law details how a student can be expelled for a physical assault on another student,[35] but does not address the consequences for a student who cyber-bullies a victim to the point that the victim commits suicide.

Similarly, the law does not address the consequences for a cyber-bully who hijacks a student's social networking profile and sends malicious messages to other students, which results in the innocent victim being attacked by students who received the malicious messages. This example, much like the case of a recent New Jersey student,[36] is a clear illustration of how cyber-bullying can spill over into the classrooms. Despite the fact that bullying on social networking sites affects the schools, however, this example is not covered under the existing statute. The law needs to go further in covering the educational consequences (e.g., expulsion) and criminal consequences for bullies who attack, impersonate or spread rumors on social networking sites and through other forms of electronic communications. Therefore, while the current law has certainly made progress in protecting victims of bullies and helped schools to take a proactive approach to schoolyard bullying, the law needs to catch up and realize the mental health and emotional consequences of cyber-bullying, where a student can be tar-

The Health Law Forum *& Health Law Outlook*
would like to thank the following:

Interim V. Provost Kathleen Boozang
Professor Carl Coleman
Helen Cummings
Denise Pinney
Sharon Carone
Gina Fondetta
Dorothea Harris
The SHU Law Copy Center
And the Members of
The Health Law Outlook
The Health Law Forum
The Student Bar Association

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