CD Summary

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DISEASE REPORTING—A NEW DAWN

"The thousand injuries of Fortunato I had borne as best I could, but when he ventured upon insult, I vowed revenge."

With these words, Edgar Allan Poe opened "The Cask of Amontillado," setting the stage for his classic tale of revenge and remorse. In much the same way, clinicians' reports set the stage for a public health response to many diseases. In this issue of the *CD Summary*, we review the eternal verities of disease reporting in the light of changed state reporting laws, bioterrorist assaults, and HIPAA. Regular readers may note that reporting is a favorite leitmotif of these pages, but we think that it is a message worth repeating. Many clinicians fail to appreciate their important role in the public health system. Moreover, some clinicians were never taught the simple mechanics of how to report, and now—perhaps after many years of practice—they are too embarrassed to admit that they don't know how. We can help.

A BRIEF HISTORY OF PUBLIC HEALTH

By at least the mid-19th century, there was a growing appreciation of the role of community-level interventions in human health. Clean drinking water as well as sanitary and solid waste disposal are only some of the most obvious examples where individual efforts can be inadequate without corresponding collective (e.g., government) programs. The adoption of the "germ theory" rapidly led to a better understanding of the way infectious diseases were transmitted, and the recognition that one's health was not independent of the health of others in the community. The development of public health has obviously been intertwined with that of clinical medicine. While the focus of public health is at the community or population level, the indicators that we usually rely on are based on individuals—most often individual case reports.

Much of public health practice is targeted at the detection and explanation of anomalies, e.g., disease outbreaks. The detection of abnormalities implies some appreciation of what is normal, which is why we maintain statistics.

Thus it was that an enlightened citizenry recognized that it was in their common best interest to empower their representatives to collect some health information that might otherwise be held in confidence by patients and their clinical service providers. Only by collecting, organizing, and analyzing these data at some community level can many general patterns be established. So public health agencies are granted legal access to many clinical records, and licensed medical professionals are obligated to provide them. It is for the collective good.

REPORTING OVERVIEW

Disease reporting is the province of state law. In Oregon, the legislature delegates the authority to make diseases reportable to the public health agency, a part of the Department of Human Services. The lists of what is reportable and the nitty-gritty of reporting requirements are spelled out in the Administrative Rules, notably OARs 333-018-0000 et seq. Reporting requirements are periodically reviewed and revised—typically every 3–5 years or so. The most recent changes were made in March 2002.

REPORTING FAQS

Q. *How do I know which diagnoses are reportable?*

A. The list is readily available in several formats: printed on a wall poster, available for download from our web page, listed in the Oregon Administrative Rules, etc.

Q. *How can I get a current poster?*

A. New posters were printed in November 2002. Local health departments may have a few copies, but we will be mailing them to all licensed MDs, DOs, and PAs shortly. If you can't wait, you can print a miniaturized, low-resolution version from a PDF file on our web page.

Q. *What's a PDF file?*

A. We'll be mailing you a poster soon.

Q. *OK, after 5 years in practice, I finally saw someone with a reportable condition—campylobacteriosis. I want to report but I'm not sure how to do it.*

A. Congratulations on your diagnosis. You make a good point, incidentally: most clinicians see only a tiny number of patients with reportable diseases in any given year. Overall, it's not really much of a time burden. The bigger problem is remembering what is reportable and how to do it. Let's get you up to speed on the mechanics of reporting.

First, determine the patient's county of residence. If it isn't obvious, you can look it up if you know their street address. The US Postal Service offers a slick (and unadvertised) county finder masquerading as a ZIP+4 lookup at *http://www.usps.com/zip4/*.

Second, contact the local (county) health department by phone or fax and give them [at least] the following information: patient's name, date of birth, sex, home address, phone number or other contact information, date of symptom onset, and the disease/condition they have that you are reporting. If you can't remember all that, we've made a simple form that clinicians can use to fax in reports; it's posted on our web page (along with fax numbers for local health departments) at *http://www.ohd.hr.state. or.us/acd/morbrpt.pdf*. Use of the form is optional; you are welcome to create your own or you can just call and talk to someone if you prefer.

Q. *I just saw a patient who had been traveling in rural Nigeria for the 3 months before he got sick. I'm pretty sure he has Lassa fever. I checked on your poster, but Lassa isn't listed. Does that mean it isn't reportable?*

A. In a word, "no."

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Think about it this way. Reportable conditions include 1) specifically named diseases that are typically confirmable by lab tests (e.g., salmonellosis, plague, hepatitis B), 2) specifically named conditions that are typically clinically identified (e.g., PID, animal bites, pesticide poisoning), and 3) several catch-all categories of diseases that require a little judgment. Had we itemized every exotic disease known to medical science that we'd like to hear about, we wouldn't have had room on the poster for the gratuitous pictures of lizards, hamburgers, and so forth. So even though they aren't necessarily named, all arthropod-borne infections are reportable, all marine intoxications are reportable, all clusters of possibly common-source illness are reportable, and all "Uncommon Illnesses of Potential Public Health Significance" are reportable. We think Lassa fever would fall into that latter group; don't you?

Q. *I'm treating a patient for gonorrhea. He asked me to keep it confidential. If I report this case, it could impact his job, not to mention his marriage.*

A. Please don't use "impact" as a verb that way. It just sounds silly. Try "affect," or even "have an impact." As for not reporting, we guess if you wanted to risk your professional reputation in order to prevent tactful public health professionals from following up on the report and possibly identifying and treated other infected people you could, although we wouldn't recommend it. Remember that Nixon wasn't looking at imminent impeachment for the break-in; it was the cover-up.

Q. *I'd like to report, but with HIPAA taking effect, I'm afraid I'll be sued for disclosing confidential information.*

A. We can't keep you from being sued, but the law provides you with a good legal defense. State law requires you to provide this kind of information to public health agencies, and you are completely indemnified from liability for doing so. HIPAA, a new federal law now taking effect, includes a lot of stuff relevant to the exchange and disclosure of medical information. Whatever its other effects, rest assured that HIPAA does not affect your ability (and obligation) to report cases and to cooperate with ensuing public health investigations. The operative language—buried among hundreds of pages of gibberish—could hardly be more plain. To quote from the "Effects on State Law" section (42 USC §1320 (d) (7)):

"(b) PUBLIC HEALTH.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention."

So you'll need a better excuse than HIPAA—maybe the dog ate your charts?

Q. *Doesn't the lab report all this stuff anyway? Isn't it redundant for the clinician to report?*

A. Clinicians are not redundant. While many of these diseases will likely result in parallel lab reports (e.g., a positive stool culture for *Shigella*), our dual system helps prevent cases from falling through the cracks. It would be hard to rely on the lab for clinically diagnosed cases, obviously, and often clinical suspicions arise long before lab confirmation becomes available (if ever). Take meningococcal disease, for example. Blood cultures may take a day or more to grow out, or are sometimes negative. A prompt public health response to a clinical report may include the provision of prophylactic antibiotics to close contacts, which can prevent additional cases and save lives. So let the lab do their thing and you do yours. The health department folks will merge any "duplicate" reports.

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