Introduction

Purpose

The Proceedings of the National Summit on Legal Preparedness for Obesity Prevention and Control is based on a two-part conceptual framework composed of public health and legal perspectives. The public health perspective comprises the six target areas and intervention settings that are the focus of the obesity prevention and control efforts of the Centers for Disease Control and Prevention (CDC).

This paper presents the legal perspective. Legal preparedness in public health is the underpinning of the framework for the four “assessment” papers and the four “action” papers that are integral to the application of public health law to any particular health issue. In addition, this paper gives real-world grounding to the legal framework through examples that illustrate the four core elements of legal preparedness in public health that are at work in obesity prevention and control.

Law in Public Health

Law, a traditional and indispensable public health tool, made important contributions to all 10 “great public health achievements” in the United States during the 20th century. These achievements include control of infectious diseases, motor vehicle safety, and a decline in deaths attributed to coronary heart disease and stroke.

At a fundamental level, law operates as a public health tool by establishing public health agencies and programs focused on preventing disease and promoting health. The Public Health Service Act, for example, authorizes many federal public health agencies and programs. States and many tribes and localities have enacted similar authorities. Laws also can support public health interventions directly, such as through tobacco excise taxes, rules requiring restaurants to label menu items with calorie information, and school immunization requirements.

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Public health laws are rooted in the U.S. Constitution and state constitutions, in statutes enacted by legislative bodies and regulations adopted by executive branch agencies, in municipal ordinances, in policies promulgated by government bodies such as boards of education and planning commissions, and in judicial rulings.

Defined most broadly, public health laws include any law that has important consequences for the health of populations. They encompass laws that focus explicitly on prevention and health promotion as well as laws that are adopted for other purposes but that nonetheless influence the public’s health. As policymakers intensify their search for tools to address the nation’s mounting chronic disease burden — including the burden caused by obesity — they are giving active attention to laws that indirectly influence public health (e.g., zoning and land use regulations) and laws that shape transportation systems and opportunities for physical activity.

Conceptual Framework for Public Health Legal Preparedness

The concept of legal preparedness in public health encompasses the multifaceted role law plays in public health and is applicable across all the domains of public health such as chronic and infectious disease, injury, emergency preparedness, and environmental health.

Public health legal preparedness was defined in 2003 as “the attainment by a public health system...of specified legal benchmarks or standards essential to the preparedness of that system” to address specific public health threats such as those posed by the obesity epidemic. Public health legal preparedness has four core elements:

1. Laws and Legal Authorities

Laws are foundational to public health legal preparedness, including legal preparedness for obesity prevention and control, because they define the authority of government bodies and specify rights and responsibilities of private parties.

2. Competency of Public Health Professionals to Apply Laws and Legal Authorities

Laws are not self-enforcing; therefore, public health policymakers and professionals and their counterparts in relevant sectors need to understand their legal authorities, how to apply them effectively, and how to shape necessary new laws and implementation tools.

3. Coordination of Legal-Based Interventions across Jurisdictions and Sectors

Effective design and implementation of most legal interventions require close coordination across sectors (e.g., public health and land use agencies) and across jurisdictions (e.g., state, tribal, local, and federal governments).

4. Information on Public Health Law Best Practices

Policymakers and public health practitioners in many sectors and jurisdictions need up-to-date information on public health law best practices that reflect scientific knowledge and accepted legal principles in use of legal interventions.

These core elements were the organizing framework for the 2007 National Action Agenda for Public Health Emergency Legal Preparedness, which focused on public health emergencies. They, along with the setting- and target-specific focus detailed in the accompanying public health framework paper, guided the deliberations of the 2008 National Summit on Legal Preparedness for Obesity Prevention and Control.

Law as a Tool for Chronic Disease Prevention

Policymakers, public health professionals, advocacy groups, and researchers increasingly recognize law as a valuable tool for the prevention of chronic diseases and of obesity in particular. Much of the heightened policy-making activity pertinent to obesity prevention is reported in the four assessment papers included in the proceedings of the 2008 National Summit on Legal Preparedness for Obesity Prevention and Control as well as in the monthly CDC Public Health Law News (http://www.cdc.gov/phlp), the Robert Wood Johnson Foundation’s periodical News Digest – Childhood Obesity (http://www.rwjf.org), publications of the National Conference of State Legislatures (http://www.ncsl.org), and resources developed by many other stakeholders in obesity prevention and control.

Researchers have illuminated the role law can play in preventing chronic diseases and obesity in a growing body of published work. Research on the impact of public health laws is strengthening the scientific basis for that role. Notable, in this context, is a systematic review by the CDC-sponsored Task Force on Community Preventive Services. The Task Force concluded that law-based urban design and land use policies are effective tools to encourage physical activity and address obesity.
A two-part 2004 article, “Law as a Tool for Preventing Chronic Diseases: Expanding the Range of Effective Public Health Strategies,” articulates CDC’s commitment to take a systematic approach to identifying legal tools for chronic disease prevention and to strengthening the capacity of its National Center for Chronic Disease Prevention and Health Promotion to apply those tools directly and through its many partners. The 2008 national summit and the resulting white papers are a direct outgrowth of that commitment.

Application of Core Elements to Obesity Prevention and Control
In shaping and applying law and legal tools to obesity prevention and control, policymakers and practitioners in public health and related sectors can use the framework of the four core elements: laws and legal authorities, competency in applying laws and legal authorities, coordination across multiple sectors and jurisdictions, and information on public health law best practices. The examples presented here reflect recent innovations relevant to many of the target areas and settings in which CDC focuses its obesity prevention efforts. Many of these examples are mentioned in the assessment and action papers from the 2008 national summit.

Laws and Legal Authorities
In recent years, many jurisdictions have adopted new laws aimed at the twin goals of preventing obesity and assisting obese people to engage in important life functions. This section describes relevant laws to nutrition, physical activity, and obesity prevention and control in the priority intervention settings and in the cross-cutting dimension of discrimination experiences of people who are obese.

- School and Daycare Settings
  Several states and municipalities have adopted laws to regulate the nutritional value of food available to students and to children in child care programs. Kentucky enacted legislation in 2005, for example, to limit beverages available in schools to water, 100 percent juice drinks, low-fat milk, and beverages with no more than 10 grams of sugar per serving. In 2006, Indiana enacted legislation requiring that food sold in schools must meet specified standards and that all elementary schools provide daily physical activity. By June 2008, a total of 25 states had established nutritional standards for “competitive foods” — foods and beverages available in schools but not approved for reimbursement under the National School Lunch Program. Restrictions in 27 states on sale of competitive foods were more stringent than federal requirements, and 18 states had stricter nutritional standards for school meals than those required by the U.S. Department of Agriculture. Local governments, too, have been active in this area. In 2006, for example, the New York City Board of Health adopted new requirements for the nutritional value of food and beverages served in group day care facilities licensed by the agency.

State and local health departments, along with school boards, have mandated physical activity in schools and child care settings and have set limits on television viewing. As of 2006, nine states had capped television viewing time in child care settings. Among the relevant provisions enacted in 2007 by the Mississippi legislature was the Healthy Students Act which set minimum standards for physical activity and health education for students in grades K-12. In January 2007, New York City’s Department of Health and Mental Hygiene implemented a Board of Health rule mandating that day care services provide at least 60 minutes of specified types of daily physical activity; proscribed television, video, and “other visual recordings” for children younger than 2 years of age; restricted viewing to 60 minutes daily for older children; and limited viewing to “educational programs or programs that actively engage child movement.”

Additional requirements were approved in September 2008 for outdoor activity and play equipment.

- Community Setting
  Cities are using zoning and land use laws to improve neighborhoods’ access to affordable healthy foods and limit access to high-calorie foods and beverages. In July 2008, the Los Angeles City Council, as part of a plan to encourage grocery stores to locate in underserved neighborhoods, approved a one-year moratorium on new fast-food restaurants in South Los Angeles where 30 percent of all children were found to be obese. Several other cities in California, Rhode Island, and Massachusetts have used zoning authorities to exclude fast-food restaurants from designated neighborhoods; the city of Detroit, Michigan, has prohibited location of fast-food restaurants closer than 500 feet to schools. In September 2008, California became the first state to require chain restaurants to post the calorie content of menu items; once the law is fully implemented, more than 17,000 restaurants are expected to be covered.
As of July 2004, 17 states and the District of Columbia had enacted taxes on foods with low nutritional value. No other states adopted such taxes in the next four years, apparently reflecting controversy over their effectiveness, their impact on the poor, general aversion to increased taxes, and related factors. In 2008, Maine voters even repealed new taxes on soft drinks, beer, and wine that had been enacted by the state legislature and approved by the governor.

• Medical Care Setting
Several states include incentives for prevention and control in obesity in Medicaid programs, either through legislation or agency regulation. As of mid-2008, researchers concluded that 11 states showed "strong evidence that they provide reimbursement for nutritional and behavioral therapy to children with overweight and obesity" in Medicaid programs. In eight states, Medicaid programs covered three types of obesity treatment: assessment and consultation, drug therapy, and bariatric surgery.

• Workplace Setting
Mothers who wish to continue breastfeeding after returning to work often face significant barriers. As of June 2008, 21 states, the District of Columbia, and Puerto Rico had enacted legislation requiring employers to offer some accommodation for breastfeeding. Among the most recent of such measures is Indiana’s legislation that requires state agencies, political subdivisions, and organizations with 25 or more employees to provide employees, where reasonable, paid breaks to express breast milk, a private place to use breast pump equipment, and refrigeration for storing expressed milk.

A number of states have enacted legislation creating incentives to offer or enroll in wellness programs. In 2007, Indiana enacted a tax credit to give small businesses incentives to provide employees state-certified wellness or health promotion programs that include services to encourage weight loss. By mid-2008, 51 small businesses with a total of 2,500 employees had qualified for this incentive. At least three states — Florida, Michigan, and Vermont — have passed legislation to give rebates on insurance premiums to employers or employees who participate in wellness programs. Several states require health insurance plans to include treatment for morbid obesity. In 2006, new Indiana law required physicians who perform surgical treatment for morbid obesity to discuss with patients all possible complications and side effects in advance, to monitor patients for five years after surgery, and to report any deaths, side effects, or major complications to the state health department.

• Cross-Cutting: Discrimination
Discrimination in educational, health care, and workplace settings against people who are obese is a serious problem. Federal and state laws do not address the problem systematically. More attention has been given to this issue at the state and local levels. As of late 2008, laws designed to prevent discrimination against obese persons were adopted by one state (Michigan), the District of Columbia, and three municipalities (San Francisco and Santa Cruz, California, and Binghamton, New York).

Competency in Applying Law
The policymakers, practitioners, and legal counsel who shape and implement legal-based interventions for obesity need a broad understanding of effective public health interventions and of ways in which law can support them. Public health proponents should understand how the legal powers of urban planning, transportation, education, and other agencies can be used to address obesity. By the same token, professionals in those sectors should understand how the legal powers at their disposal can support obesity prevention in the community.

One critical competency is the skill to partner with diverse stakeholders to design and apply law-based strategies. Even an intervention as seemingly simple as limiting students’ access to high-calorie and sugar-sweetened foods and beverages from vending machines may involve school administrators and board members, parent organizations and student councils, the local public health agency, the city or county executive officer or legislative body, community-based organizations, and local businesses.

Three examples illustrate high-level competency in shaping and implementing law to support obesity prevention and control across multiple sectors.

• Focus on Nutrition in the Community Setting
Today, Americans purchase an estimated one-half of all their meals outside of the home. However, although food consumed at home typically is labeled with nutritional information required by the federal Nutrition Labeling and Education Act (NLEA), restaurants and fast-food establishments have not been required to provide nutrition labeling of food on menus. Thus, customers are denied information critical to making healthier food choices. To address this problem, the New
York Department of Health and Mental Hygiene adopted a rule to require fast-food establishments serving standardized meals to post calorie information on the menus and menu boards. The authorizing health code, which requires restaurants to have permits from this city department, provided a vehicle to put the menu labeling rule into effect.

The Bureau of Chronic Disease took the first step by presenting the proposal to the Board of Health. Emphasizing that obesity is a risk factor for four of the five leading causes of death in New York City and that obesity is due mainly to excess calories consumed, increasingly outside of the home, scientists from the Bureau explained that giving customers information about calorie content likely would help prevent obesity. Among other information, the bureau used data showing that many customers pay attention to nutrition information posted in restaurants and purchase healthier meals as a result.

In December 2006, the Board of Health adopted a rule mandating calorie labeling and requiring any food service establishment that had voluntarily published calorie information to post the same information on menus and menu boards. The state restaurant association challenged the rule in a lawsuit before it went into effect. In defense, the health department produced declarations attesting to the need for calorie labeling and worked with allies throughout the country who filed amicus curiae briefs. In September 2007, a federal court ruled that, to the extent that New York City’s rule applied to restaurants that had voluntarily provided calorie information, it was preempted by the NLEA. The decision, however, recognized the agency’s general authority to mandate calorie labeling. Rather than appeal, agency legal counsel and senior leadership proposed that the board amend the code to exercise its authority to mandate calorie labeling, as outlined by the court. In January 2008, the board adopted a rule requiring restaurants belonging to chains with 15 or more restaurants nationally that sell menu items standardized for portion size and content to post the calorie content of meals on menus and menu boards. The restaurant industry brought a second lawsuit, but the board’s rule was upheld in court and was implemented. This case illustrates the impact a coalition across sectors — composed of policymakers, public health professionals, legal counsel, and community advocates — can have when its members understand the relevant laws and how to use them effectively.

- Focus on Physical Activity in the Community Setting

Beginning in 2006, the health department of Contra Costa County, California, and the City of Richmond planning department made a commitment to incorporate into the city’s new general plan goals to reduce risk factors for chronic diseases. (California state law mandates that every city and county adopt a “general plan” with which “virtually all land use regulations and approvals must conform.”) High proficiency in technical and collaborative competencies led to identification of eight consensus goals. Two of these goals were the following: (1) to “[e]nsure that the city has an extensive system of parks, playgrounds and open space” (e.g., that 75 percent of city households live within one-quarter mile of an “active community park or open space”) and (2) to “[p]romote joint-use projects and programs in collaboration with the School District.” The technical competency of public health professionals in gathering local epidemiological data about obesity, physical activity, and injury was invaluable to the city planners, who found the data added credibility to their proposals to elected officials. (Data on injury was included because automobile collisions with pedestrians and bicycles had discouraged physical activity.) The planners’ technical competency in their discipline was equally valuable to the public health advocates. Also important were the collaborative skills the involved public health and planning professionals had acquired through engagement in earlier projects and activities. As a result of this successful collaboration, the elected Richmond City Council anticipates adopting the new general plan, including its explicit goals to expand opportunities for physical activity and improve access to healthy food and nutrition.

Coordination in Implementing Legal-Based Interventions

Effective coordination across sectors and jurisdictions is critical for virtually all public health interventions. Public health practitioners routinely interact with a host of partners as they monitor community health trends, lead programs for community health education, investigate disease outbreaks, and conduct a host of other activities.

The vital role of coordination was underscored during investigation of the 2001 anthrax attacks and of the many subsequent “white powder” incidents. The authority of public health officials to collect samples and the authority of law enforcement officials to seize evidence and maintain a secure chain of custody for
potential criminal prosecution were not easily reconciled. This experience catalyzed development of new training curricula to improve coordinated implementation of law-based actions during public health emergencies across public health, law enforcement, and emergency management agencies.42

Similar tools are needed to strengthen the capacity of public health agencies and their partners to design and implement coordinated, law-based interventions for obesity prevention and control. Two cases show that excellent examples of such coordination already exist in the community setting and offer models for broader adaptation.

• Focus on Nutrition in the Community Setting
Pennsylvania’s Fresh Food Financing Initiative is notable because it has achieved successful coordination across levels of government and across the public and private sectors, including private investors.

Residents of many low-income, inner-city communities must buy their food from neighborhood convenience stores that typically sell packaged, high-calorie foods at relatively high prices. Supermarkets generally offer a broader range of affordable and nutritionally sound food, but many supermarkets have found it difficult to succeed in these neighborhoods. A national 1995 study found this problem to be especially acute in Philadelphia where high-income neighborhoods were served by 156 percent more supermarkets than were the lowest-income neighborhoods.43

To address this problem, Philadelphia’s nonprofit Food Trust conducted research in coordination with the city’s public health department and the University of Pennsylvania and, in a 2001 report, called for location of more supermarkets in low-income neighborhoods. A task force, co-chaired by a supermarket executive and the chief executive officer of the United Way of Southeastern Pennsylvania, issued policy recommendations and stimulated action by the city council and state legislators representing Philadelphia and other cities.

In 2004, Pennsylvania appropriated funds to support the newly created Fresh Food Financing Initiative, a coordinated initiative of the Food Trust; the Reinvestment Fund, a community development bank that mobilizes private investment through state-authorized tax credits, and the Greater Philadelphia Urban Affairs Coalition, a nonprofit, public-private, community-based organization. By mid-2008, the cross-sector initiative had provided financial incentives for 52 new supermarket projects in low-income neighborhoods of Philadelphia, Pittsburgh, and other cities.44

• Focus on Physical Activity in the Community Setting
The movement for safe routes to school illustrates sophisticated coordination in developing law-based interventions to encourage physical activity. Catalyzed by grass-roots initiatives, states and the federal government have adopted laws that authorize program for safe routes to schools, establish multi-sector advisory committees, and provide funding for sidewalks, bicycle paths, pedestrian and traffic signals, and crosswalks. California adopted legislation to allocate state transportation funds for local safe routes to school construction projects as early as 1999.45 A 2004 Colorado statute requires the state transportation department to establish a program for safe routes to school and gives funding priority to local projects endorsed by “school-based associations, traffic engineers, elected officials, law enforcement agencies, and school officials.”46

Federal participation began with creation of the Safe Routes to School Program in the Federal Highway Administration through the 2005 legislation reauthorizing the Federal Transportation Act.47 The act authorized $612 million in grants to state programs for safe routes to school, which were the first federal funds for this purpose. In addition, the act required appointment of a task force with membership representing three sectors typically involved in local and state activities related to safe routes to school: health, transportation, and education. The members of the task force appointed in 2007 represented an even broader spectrum of collaboration, including public health, health care, education, transportation and highway safety, mass transit, law enforcement, local elected officials, state and local organizations promoting safe routes to school, and advocacy organizations for walking and bicycling.48

Information on Public Health Law Best Practices
A practical way to capture the essence of this core element of legal preparedness is to ask the question, Do the policymakers and practitioners active in obesity prevention and control have ready access to the many types of information they need to make effective use of law and legal tools for that purpose?

The answer almost certainly is that they do not have this access. The information resources available to practitioners and policymakers active in tobacco control may be a benchmark for this core element. Research conducted over several decades has built a
strong scientific basis for law-based tobacco control strategies and laws. An extensive network of public and private organizations translates this knowledge into information that can be readily used by government officials and public health advocates. CDC’s Best Practices for Comprehensive Tobacco Control Programs presents empirically based recommendations for state and local legislative action, programs, and funding for tobacco control.\textsuperscript{49} Technical assistance is available from nonprofit legal centers, professional societies, and organizations involved in the tobacco control movement such as the Campaign for Tobacco-Free Kids. Also, information on legal innovations and best practices is actively disseminated through tobacco control conferences, newsletters, and periodicals.

While not yet at the level attained by the tobacco control community, valuable information resources on law and obesity prevention and control have been developed for policymakers and more are in preparation. Selected examples include:

- The proceedings of the 2008 National Summit on Legal Preparedness for Obesity Prevention and Control is an important reference on the status of law as a tool supporting obesity prevention. Most important are the practical action options the action papers presented for consideration by policymakers and professionals throughout the country.

- A portfolio of technical assistance resources is being developed by legal researchers and analysts with support from the Robert Wood Johnson Foundation. Among these resources are model laws for menu labeling and nutritional requirements, model agreements for community groups’ use of school facilities for physical activity, model contracts for school vending machines, and related fact sheets.\textsuperscript{50} These resources will be disseminated nationally by the organization Public Health Law and Policy as were its existing products, “General Plans and Zoning: a Toolkit on Land Use and Health,”\textsuperscript{51} and “How to Create and Implement Healthy General Plans.”\textsuperscript{52}

- Information materials recently prepared by the National Center for Safe Routes to Schools exemplify the kind of rounded resources federal agencies, foundations, and other groups may consider developing for broader use in obesity prevention: a “toolkit,” technical guidance, and information on key issues such as liability protection for local organizations that sponsor safe routes to school.\textsuperscript{53}

- The new analytic tool of health impact assessments (HIAs) gives policymakers and practitioners access to valuable information about the consequences of many types of law on nutrition and physical activity. HIAs are prospective analyses of the impact specified policies and projects may have for the public’s health. Several HIAs related to diverse initiatives, such as redevelopment of the Derby District of Commerce City, Colorado.\textsuperscript{54} In addition, a California ballot proposition to expand after-school programs would examine the impact of such programs on level of physical activity, among other health considerations.\textsuperscript{55} HIA toolkits are available from CDC\textsuperscript{56} and the School of Public Health, University of California at Los Angeles.\textsuperscript{57}

**Application of Core Elements to Obesity Prevention and Control**

The examples presented here are purely illustrative. Many more examples could be offered as evidence that public health proponents across the country are actively exploring and using law to address the obesity epidemic. These cases also make the point that the work underway focuses on each of the four core elements of public health legal preparedness. This consideration is important because a balanced strategy—one that strengthens all four elements—will yield the greatest health benefit. The simple adoption of laws, even those with documented efficacy, is unlikely to be beneficial if the concerned officials do not know how to apply them effectively, do not coordinate their efforts, and lack up-to-date information on best practices.

Against this backdrop, the four action papers in the proceedings of the 2008 National Summit on Legal Preparedness for Obesity Prevention and Control are a product of the first systematic attempt to identify practical options for legal preparedness for consideration by policymakers and practitioners working to prevent and control obesity. The action options presented in the white papers were discussed and refined during and after the summit. Each action paper focuses on one of the four core elements of public health legal preparedness and presents action options to address gaps highlighted in the corresponding assessment paper.

**Structural** public health interventions, which use law and other types of policy, shape the environment in which people live, creating society-wide conditions conducive to better health. In the domain of chronic disease prevention, statutes on smoke-free air and ordinances instituting fluoridation of drinking water exemplify this type of intervention, which works by making healthy living a default option.\textsuperscript{58} The health benefits of these statutes have been documented extensively. The central purpose of the Summit pro-
ceedings is to give policymakers and practitioners practical, grounded information they can use to shape law-based interventions for the same purpose — and with similar success — in addressing the full spectrum of health threats posed by the obesity epidemic.

Note
The views expressed in this paper are those of the authors and do not necessarily reflect the policies or positions of the organizations with which they are affiliated.

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22. See Trust for America’s Health, supra note 12, at 8.
24. See Trust for America’s Health, supra note 22 at p. 60.
25. Id., at 64.
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28. Indiana Code, § 6-3-1.312.
31. Indiana Code, § 5-10-8-7.
33. Elliott-Larsen Civil Rights Act of 2000; Michigan Statutes Annotated § 3,548(102)


