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The Medical Waste Tracking Act of 1988: An Analysis of Its Provisions and Its Effect on New York State

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THE MEDICAL WASTE TRACKING ACT OF 1988: AN ANALYSIS OF ITS PROVISIONS AND ITS EFFECT ON NEW YORK STATE

INTRODUCTION

The United States is running out of acceptable locations in which to dispose of its solid waste.[1] Present locations are closing becuase of over-use and poor management, while new locations are being resisted by local residents.[2] Evidence of this problem can even be seen on our beaches.[3] During the summers of 1987 and 1988, beach communities from "Massachusetts to Florida and New York to Ohio"[4] were plagued with all types of garbage that washed ashore.[5] However, medical waste, including hypodermic needles and vials of blood, caused the most concern.[6] This Comment discusses the issues surrounding medical waste disposal; analyzes the impact and effectiveness of the Medical Waste Tracking Act of 1988 (MWTA),[7] as well as the New York program[8]; stresses the importance of an effective inspection and enforcement program; and suggests alternatives to the present system.

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1. Solid Waste Disposal Act, 42 U.S.C. § 6901(a)(8) (1988).

2. Meltz, *State Discrimination Against Imported Solid Waste: Constitutional Roadblocks*, 20 ENVTL. L. REP. (ENVTL. L. INST.) No. 9, at 10,383 (1990).

3. *See infra* note 9 and accompanying text.

4. 134 CONG. REC. H10,105 (daily ed. Oct. 12, 1988) (statement of Rep. Luken).

5. 134 CONG. REC. S15,328 (daily ed. Oct. 7, 1988) (statement of Sen. Lautenberg).

6. 134 CONG. REC. H10,105 (daily ed. Oct. 12, 1988) (statement of Rep. Luken); *20/20: Putting the Heat On* (ABC television broadcast, Sept. 9, 1988) (transcript on file at the offices of the *Touro Law Review*).

7. Medical Waste Tracking Act of 1988, Pub. L. No. 100-582, § 1, 102 Stat. 2950 (codified at 42 U.S.C. §§ 6992-6992K and 18 U.S.C. § 3063 (1988)).

8. *See infra* notes 151-66 and accompanying text.

I. BACKDROP

A. The Need for Federal Regulation

The media's focus on the beach wash-ups of medical waste along the eastern seaboard during the summers of 1987 and 1988[9] has highlighted the need for an extensive tracking and treatment program. Problems existed in virtually every East Coast[10] and Great Lake State[11] and extended far beyond illegal ocean dumping to include inland dumping as well.[12]

These incidents focused the public's attention on the value and delicate balance of our ecosystem.[13] Medical waste not only offend one's senses, it also poses a serious risk to the health of the general public and the environment.[14]

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9. *See Ocean Dumping Investigation In Trouble*, U.P.I., Trenton, N.J., Aug. 21, 1987; Gutis, *Separating Facts from Hyperbole in Reports on Hospital Waste on L.I.*, N.Y. Times, July 9, 1988, at 30, col. 1; Baker, *Blood in the Water*, NEWSWEEK, July 18, 1988, at 35; Christian Science Monitor, *Garbage on the Beach*, Aug. 2, 1988, at 13; Koch, *Medical Waste Source Identified Next Week*, U.P.I., Providence, R.I., Aug. 19, 1988; Weimer, *Southern Governors Urge Crackdown on Ocean Dumping*, U.P.I., Sea Island, Ga, Sept. 27, 1988; Riley, *Schaeffer Seeks National Medical Waste Disposal Rules; Subcommittee Hearing Focuses on Summer of Concern About Ocean Dumping Hazards*, Washington Post, Oct. 4, 1988, at B5; *Medical Waste Blamed on New York City*, U.P.I., Providence, R.I., Oct. 4, 1988.

10. 134 CONG. REC. E2539 (daily ed. July 28, 1988) (statement of Rep. Florio).

11. 134 CONG. REC. H9543 (daily ed. Oct. 4, 1988) (statement of Rep. Davis); 134 CONG. REC. H9542 (daily ed. Oct. 4, 1988) (statement of Rep. Smith); 134 CONG. REC. E2539 (daily ed. July 28, 1988) (statement of Rep. Florio).

12. In Youngstown, Ohio, and Indianapolis, Indiana, 134 CONG. REC. H9536 (daily ed. Oct. 4, 1988) (statement of Rep. Luken), and New York City, *20/20: Putting the Heat On* (ABC television broadcast, Sept. 9, 1988) (transcript on file at the offices of the *Touro Law Review*), children playing near dumpsters found needles and vials of blood. One group played "doctor" with these items, splattering the blood and giving each other injections. 134 CONG. REC. H9536 (daily ed. Oct. 4, 1988) (statement of Rep. Luken). It was fortunate that none of the children contracted any infectious diseases, but such a possibility is not out of the question. *Id.* In a landfill in Oklahoma, a human arm and leg were discovered. 134 CONG. REC. S15,327 (daily ed. Oct. 7, 1988) (statement of Sen. Baucus). And in Ohio, on the shores of Lake Erie, hundreds of syringes washed up, some with the needles still intact. 134 CONG. REC. H9542 (daily ed. Oct. 4, 1988) (statement of Rep. Eckart).

13. 134 CONG. REC. E3262 (daily ed. Oct. 6, 1988) (statement of Rep. Sikorski).

14. 134 CONG. REC. E2539 (daily ed. July 28, 1988) (statement of Rep. Florio).

While the hospitals and clinics that generate this waste have tried to make it safe for their workers[15] through the use of rubber gloves, as well as other specialized equipment and procedures,[16] those who work with wastes as collectors or treatment and disposal personnel face increased danger. The Federal Centers for Disease Control reported that about "200 to 300 health care workers, some of them waste handlers,"[17] die each year of hepatitis B.[18] Many of these cases can be traced back to contact with infectious waste through routine handling.[19]

B. EPA's Inaction

The improper and illegal dumping of medical waste stems from an overloaded medical waste system.[20] This lack of "proper treatment and disposal"[21] resulted in the widespread loss of control over these substances. Until recently,[22] no federal mechanism existed to track medical waste from its point of generation to its point of disposal, though this type of "cra-

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15. 134 CONG. REC. H9540 (daily ed. Oct. 4, 1988) (statement of Rep. Florio).

16. *See* Garner & Simmons, *CDC Guideline for Isolation Precautions in Hospitals*, 4 INFECTION CONTROL 245, 254 (1983).

17. 134 CONG. REC. H9541 (daily ed. Oct. 14, 1988) (statement of Rep. Wyden).

18. *Id.* Another recent federal study stated that "as many as 18,000 people each year may contract hepatitis B from accidental contact with medical waste." 134 CONG. REC. H9536 (daily ed. Oct. 4, 1988) (statement of Rep. Luken). Thus, medical waste is not just unsightly and offensive, it can kill. *Id. Contra* Kolata, *A Low Risk of Disease From Syringes on Beaches*, N.Y. Times, July 12, 1988, at B4, col. 1.

19. 134 CONG. REC. H9541 (daily ed. Oct. 4, 1988) (statement of Rep. Wyden).

20. *Id.*

21. 134 CONG. REC. E2539 (daily ed. July 28, 1988) (statement of Rep. Florio).

22. *See* Standards for the Tracking and Management of Medical Waste, 40 C.F.R. §§ 259.1-.91 (1989). The system created tracks medical waste by requiring generators to use only certified haulers. *Id.* § 259.51. To ensure each shipment of medical waste reaches its final destination the manifest system used requires those at each phase of generation, transportation, treatment, and disposal to complete a portion of a multi-part form and to retain their respective copy. *Id.* §§ 259.52, 259.74, 259.81. Upon final disposition of the medical waste, a copy of the form must be sent back to the generator, thus confirming the waste's proper disposal. *Id.*

dle to grave"[23] tracking system was already being used to track other hazardous wastes.[24]

Since 1976, when the Solid Waste Disposal Act (SWDA)[25] was amended by the Resource Conservation and Recovery Act (RCRA),[26] the Environmental Protection Agency (EPA) has been authorized to regulate infectious medical waste,[27] but failed to perform the basic research crucial to implementation of an effective regulatory program.[28] Though the EPA developed a reference guide for effective management of medical waste,[29] it failed to take emergency measures as permitted under section 6973 of the SWDA.[30] This provision empowers the EPA to bring suit to enjoin any person from improperly handling, storing, treating, transporting, or disposing of any solid or hazardous waste resulting in "an imminent and substantial"[31] danger to the "public health and the environment."[32]

The EPA, however, believing that its role was "education, not intervention,"[33] stressed that regulation would be most effective on the state and local levels.[34] While this might be true, only because each community could more effectively monitor

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23. 134 CONG. REC. S15,327 (daily ed. Oct. 7, 1988) (statement of Sen. Chafee).

24. *See* Solid Waste Disposal Act, 42 U.S.C. §§ 6922-6924 (1988).

25. *Id.*

26. Resource Conservation and Recovery Act of 1976, Pub. L. 94-580, 90 Stat. 2795 (codified as amended at 42 U.S.C. §§ 6901-6992 (1988)). RCRA was designed "[to] provide technical and financial assistance for the development of management plans and facilities for the recovery of energy and other resources from discarded materials, and to regulate the management of hazardous waste." *Id.*

27. 42 U.S.C. §§ 6903(5), 6912(a) (1988).

28. 134 CONG. REC. H9541 (daily ed. Oct. 4, 1988) (statement of Rep. Wyden).

29. ENVIRONMENTAL PROTECTION AGENCY, EPA GUIDE FOR INFECTIOUS WASTE MANAGEMENT (1986). The EPA guide only "provide[s] *guidance* on the management of infectious waste[,]" *id.* at viii (emphasis added), and does not represent a body of binding rules or regulations. It is merely what the EPA considers "acceptable waste management practices." *Id.*

30. 42 U.S.C. § 6973 (1988).

31. *Id.* § 6973(a).

32. *Id.*

33. *20/20: Putting the Heat On* (ABC television broadcast, Sept. 9, 1988) (transcript on file at the offices of the *Touro Law Review*) "Senator Bradley says that's a lot of bureaucratic buck-passing." *Id.*

34. *Id.*

itself, without a set of minimum federal standards, there would be no measure of compliance with which to compare state and local systems. An overall view of the nation's medical waste problems could never be realized; consequently, the best methods of medical waste management and disposal might never be determined. In 1987, Senators Bradley and Lautenberg,[35] joined by twenty-five other coastal state senators, demanded that the EPA take action.[36] However, no action resulted.[37] Thus, Congress quickly enacted the MWTA, a two-year demonstration program[38] designed to temporarily regulate medical waste and to compel the EPA to develop practical permanent regulations.[39] The MWTA, among other things, required the EPA to take an active role in the program and to work closely with states and health care facilities to determine methods of reducing and treating the volume of medical waste produced.[40]

In enacting the MWTA, Congress provided all the necessary procedures and tools with which to gain short-term control over these substances. Additionally, Congress laid the foundation to formulate a fine-tuned, permanent regulatory system during the life of this program.

C. *Congressional Design*

The Medical Waste Tracking Act is officially known as "Subchapter X [ten] — Demonstration Medical Waste Track-

35. Senator Bill Bradley of New Jersey, one of the hardest hit states, is a member of the Committee on Energy and National Resources and was a major proponent of the Medical Waste Tracking Act of 1988. CONGRESSIONAL YELLOW BOOK. 101ST CONGRESS I-17 (Fall 1990). Senator Frank Lautenberg, also of New Jersey, is a member of the Committee on Environmental and Public Works and was also a major proponent of the MWTA. *Id.* at I-17.

36. Letter from Senator Bradley to Lee M. Thomas, Administrator of the EPA (Oct. 20, 1987) (discussing hospital waste management), *reprinted in* 134 CONG. REC. S10,738 (daily ed. Aug. 3, 1988).

37. 134 CONG. REC. S15,326 (daily ed. Oct. 7, 1988) (statement of Sen. Bradley); 134 CONG. REC. S15,327 (daily ed. Oct. 7, 1988) (statement of Sen. Baucus).

38. 42 U.S.C. § 6992(d) (1988).

39. *See id.* § 6992b(a).

40. *Id.* § 6992g(c); *see infra* notes 83-86 and accompanying text; *see also* 134 CONG. REC. H9539 (daily ed. Oct. 4, 1988) (statement of Rep. Saxton) (discussing EPA's requirement to work with health care facilities).

ing Program" of the Solid Waste Disposal Act.[41] The name itself indicates that the enactment is a demonstration program, designed to provide Congress with thorough research and empirical data on the issues surrounding medical waste.[42] The legislation is not a final regulatory structure intended to solve the entire nation's medical waste disposal problems.[43] It is only a first step in controlling the situation.[44] The information gathered during the program's duration will serve as a database from which Congress and the EPA can begin to develop a "strong and effective"[45] permanent regulatory scheme to control these wastes. The program was designed to resolve the current "lack of uniformity"[46] among the states that have enacted their own medical waste regulations by requiring, at a minimum, compliance with the federal standards.[47] The hope is that all phases of treatment, disposal, and management of medical waste will be improved as a result of this program's depth and scope of investigation.[48] Additionally, a strict system of accountability[49] and a severe penalty structure[50] is intended to deter illegal dumping.[51]

II. THE ACT AND REACTIONS

A. Defining Medical Waste, 42 U.S.C. § 6992a

Prior to the MWTA, the Solid Waste Disposal Act did not specifically define medical waste.[52] Thus, all "non-infectious" medical waste eluded regulation and no specific methods to

41. 42 U.S.C. § 6992 (1988).
42. *Id.* § 6992g (1988).
43. 134 CONG. REC. S15,327 (daily ed. Oct. 7, 1988) (statement of Sen. Baucus).
44. *Id.*
45. *Id.*
46. 134 CONG. REC. H9542 (daily ed. Oct. 4, 1988) (statement of Rep. Eckart).
47. 42 U.S.C. § 6992(b)(2) (1988).
48. *See* 134 CONG. REC. H10,106 (daily ed. Oct. 12, 1988) (statement of Rep. Schuette).
49. *See* 42 U.S.C. § 6992b(a) (1988); 40 C.F.R. §§ 259.39-.91 (1989).
50. 42 U.S.C. § 6992d (1988).
51. 134 CONG. REC. S15,328 (daily ed. Oct. 17, 1988) (statement of Sen. Lautenberg).
52. Medical Waste Tracking Act of 1988, Pub. L. No. 100-582, § 3, 102 Stat. 2950, 2958 (1988).

handle this class of waste were mandated by statute. Therefore, the MWTA filled the void in the SWDA when it both classified medical waste as a separate health problem[53] and created disposal regulations particular to the hazard.[54]

First, the MWTA defined medical waste, within the SWDA itself, as "any solid waste which is generated in the diagnosis, treatment, or immunization of human beings or animals, in research pertaining thereto, or in the production or testing of biologicals."[55]

Second, Congress presented an illustrative, but non-exhaustive list of medical waste to be included under the program.[56]

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53. 42 U.S.C. § 6903(40) (1988).

54. *See* Standards for the Tracking and Management of Medical Waste, 40 C.F.R. §§ 259.1-.91 (1989).

55. 42 U.S.C. § 6903(40) (1988). Note that this definition does not include the word "infectious" and thus does not preclude non-infectious medical waste from the tracking requirements.

A "sharp" such as a needle or scalpel blade, whether or not it has been used, could cause serious physical injury if stepped on; if used, it could carry an infectious disease. However, the MWTA only includes "sharps" used in "patient care or in medical, research, or industrial laboratories." 42 U.S.C. § 6992a(a)(4) (1988). It was left to the EPA to properly establish a category of "unused sharps." Standards for the Tracking and Management of Medical Waste, 40 C.F.R. § 295.30 (1989).

56. 42 U.S.C. § 6992a(a)(1)-(11) (1988). The listing of medical wastes includes:

> (1) Cultures and stocks of infectious agents and associated biologicals, including cultures from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biologicals, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures.
>
> (2) Pathological wastes, including tissues, organs, and body parts that are removed during surgery or autopsy.
>
> (3) Waste human blood and products of blood, including serum, plasma, and other blood components.
>
> (4) Sharps that have been used in patient care or in medical, research, or industrial laboratories, including hypodermic needles, syringes, pasteur pipettes, broken glass, and scalpel blades.
>
> (5) Contaminated animal carcasses, body parts, and bedding of animals that were exposed to infectious agents during research, production of biologicals, or testing of pharmaceuticals.
>
> (6) Wastes from surgery or autopsy that were in contact with infectious agents, including soiled dressings, sponges, drapes, lavage tubes, drainage sets, underpads, and surgical gloves.
>
> (7) Laboratory wastes from medical, pathological, pharmaceutical, or other research, commercial, or industrial laboratories that were in contact with in-

Congress provided the EPA with the authority to revise[57] or expand[58] the list of medical wastes, which was derived from the EPA's own guide.[59] To exclude items from MWTA regulation, the EPA must determine that the specific item does not "pose a substantial present or potential hazard to human health or the environment when improperly treated, stored, transported, disposed of, or otherwise managed."[60]

Congress suggested that the EPA use the services of the National Institutes of Health[61] and the Centers for Disease Con-

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fectious agents, including slides and cover slips, disposable gloves, laboratory coats, and aprons.

(8) Dialysis wastes that were in contact with the blood of patients undergoing hemodialysis, including contaminated disposable equipment and supplies such as tubing, filters, disposable sheets, towels, gloves, aprons, and laboratory coats.

(9) Discarded medical equipment and parts that were in contact with infectious agents.

(10) Biological waste and discarded materials contaminated with blood, excretion, exudates or secretion from human beings or animals who are isolated to protect others from communicable diseases.

(11) Such other waste material that results from the administration of medical care to a patient by a health care provider and is found by the Administrator to pose a threat to human health or the environment.

Id.

57. *Id.* § 6992a(b). The EPA may only exclude items (6) through (10) of Congress' list. *Id.*

58. 42 U.S.C. § 6992a(a)(11) (1988).

59. ENVIRONMENTAL PROTECTION AGENCY, EPA GUIDE FOR INFECTIOUS WASTE MANAGEMENT, at 2-1 to 2-6 (1986).

60. 42 U.S.C § 6992a (1988). Fearful that the EPA would abuse its authority, the Congressional Record is replete with statements giving guidance and limitation (though uncodified) to the EPA's discretion in excluding items. *E.g.*, 134 CONG. REC. H9540 (daily ed. Oct. 4, 1988) (statement of Rep. Florio) (to exclude a category, "sound technical information" must be offered in support); 134 CONG. REC. H9537 (daily ed. Oct. 4, 1988) (statement of Rep. Whittaker) ("specific findings" must be made before categorical exclusions are permitted).

61.

The mission of the National Institutes of Health is to improve the health of the American people. To carry out this mission, the agency conducts and supports biomedical research into the causes, prevention and cure of diseases; supports research training and the development of research resources; and makes use of modern methods to communicate biomedical information.

OFFICE OF THE FEDERAL REGISTER, NATIONAL ARCHIVES AND RECORD ADMINISTRATION, THE UNITED STATES GOVERNMENT MANUAL 1989/90, at 313 (1989) [hereinafter GOVERNMENT MANUAL].

trol,[62] to assist in the formulation of the EPA list.[63] The list of medical waste that appears in the EPA regulations[64] narrows the categories provided by Congress.[65] Lawmakers and environmental groups criticized the EPA claiming that the list "improperly excludes several types of infectious wastes."[66] Conversely, the health care industry expressed its concern that the categories are over-inclusive and imprecise.[67] The EPA, however, did not " 'believe all wastes pose a substantial threat to human health and the environment' "[68] and felt there was too much overlap between Congress' categories.[69]

At present, there is no agreement over the breadth and substance of the medical waste definitions and categories. Perhaps,

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62. The Centers for Disease Control "is the Federal agency charged with protecting the public health of the Nation by providing leadership and direction in the prevention and control of diseases and other preventable conditions and responding to public health emergencies." *Id.*

63. 134 CONG. REC. H9538 (daily ed. Oct. 4, 1988) (statement of Rep. Whittaker); 134 CONG. REC. S3265 (daily ed. Oct. 6, 1988) (statement of Rep. Fawell).

64. Standards for the Tracking and Management of Medical Waste, 40 C.F.R. § 259.30 (1989). The list includes: culture and stocks, pathological waste, human blood and blood products, sharps, animal waste, isolation waste, and unused sharps. *Id. Compare* 42 U.S.C. § 6992a (1988).

65. Only seven categories will be tracked under the EPA regulations. Standards for the Tracking and Management of Medical Waste, 40 C.F.R. § 259.30(a) (1989).

66. Tokarski, *EPA Sets Waste Tracking Plan*, MODERN HEALTHCARE, Mar. 17, 1989, at 4. *See* Garner & Favero, *CDC Guideline for Handwashing and Hospital Environment Control, 1985*, 7 Infection Control, 231, 241 (1986). The CDC's guidelines present recommendations for the types of medical wastes which should be treated as hazardous. Since the precise infectious nature of many hospital wastes is virtually impossible to determine, any waste that presents a "sufficient potential risk of causing infection during handling and disposal" requires special procedures and precautions. *Id.* The CDC definition includes "[m]icrobiology laboratory wastes, blood and blood products, pathology waste, and sharp items (especially needles) . . . ." *Id.*

67. Problems concerning interpretation have already arisen. For example, the third category in the EPA regulations contains: items saturated, dripping, or caked with human blood, Standards for the Tracking and Management of Medical Waste, 40 C.F.R. § 259.30(9) (1989). As a result, deciding whether a blood-stained item should be considered medical waste will " 'involve a judgment call' " by hospital employees. Tokarski, *Hospitals Brace for Waste-Tracking Costs*, MODERN HEALTHCARE, Apr. 14, 1989, at 58.

68. *Id.*

69. Tokarski, *EPA Sets Waste Tracking Plan*, MODERN HEALTHCARE, Mar. 17, 1989, at 4.

at this point in time, such imprecision is necessary. Imprecision will allow a broad analysis of the problems and will produce a body of reliable data during the demonstration program.

B. The Tracking Program, 42 U.S.C. § 6992b

The "centerpiece"[70] of the demonstration program is the uniform system for " 'cradle to grave' " tracking.[71] The system ensures that the waste gets from its point of generation to the selected treatment or disposal facility.[72] Those who handle the waste are held accountable for safeguarding this procedure.[73]

The program implements a tracking system creating a "paper trail"[74] from the "generator's premises, to the garbage truck, to the incinerator or landfill where it is finally disposed."[75] If the generator does not receive the appropriate portion of the manifest dispatched with each shipment from the facility accepting final disposition of the medical waste, the generator must notify the EPA that the waste did not reach the specified treatment or disposal facility.[76] The "trail" left by the manifest can then be traced to determine where the transport and/or disposal system has failed. Thus, providing law enforcement agencies with the necessary devices to identify and prosecute violators.[77]

The system also calls for segregation of medical waste from the "ordinary solid waste stream"[78] when it is first generated. Placing these wastes into properly labeled containers[79] will protect the hauler and the public.[80]

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70. 134 CONG. REC. H10,105 (daily ed. Oct. 12, 1988) (statement of Rep. Luken).

71. *Id.*

72. 42 U.S.C. § 6992b(a)(1) (1988).

73. *Id.* § 6992(d).

74. 134 CONG. REC. H9536 (daily ed. Oct. 4, 1988) (statement of Rep. Luken).

75. *Id.*

76. Standards for the Tracking and Management of Medical Waste, 40 C.F.R. § 259.55(b) (1989).

77. 134 CONG. REC. H9538 (daily ed. Oct. 4, 1988) (statement of Rep. Hughes).

78. 134 CONG. REC. H9536 (daily ed. Oct. 4, 1988) (statement of Rep. Luken); 42 U.S.C. § 6992b(a)(4)(A) (1988).

79. 42 U.S.C. § 6992b(a)(4)(C) (1988).

80. *Id.* § 6992b(a)(4)(B).

The regulations are long and detailed and require extensive measures by the generators, intermediate handlers, transporters, and destination facilities.[81] This author believes that initially, the system might take considerable effort to understand and implement. However, upon the completion of the demonstration program, the regulations should be fine-tuned and the procedures routine.[82] With a clear understanding of the requirements and procedures, the tracking system should successfully manage medical waste.[83]

The aim of these regulations should be to decrease the volume of medical waste generated.[84] Realization of this objective will require some insight and ingenuity. However, the costs and complexity of this system have created a stir within the health care industry.[85] Some believe that the reinstitution of reusable

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81. *See* Standards for the Tracking and Management of Medical Waste, 40 C.F.R. §§ 259.39-.91 (1989).

82. The regulations setting forth the procedures were promulgated on March 24, 1989, and became effective on June 22, 1989 for a period of two years. *Id.* § 259.2(a).

83. 134 CONG. REC. H9538 (daily ed. Oct. 4, 1988) (statement of Rep. Whittaker). To achieve this goal the requirements should be "simple, well organized, cost-effective and relatively non-intrusive." *Id.*

84. 42 U.S.C. § 6992g(12). "Currently, about 13,000 tons a day of medical waste . . . is generated by around 6,800 U.S. hospitals." Paul, *Combustion Engineering Inc. Affiliate Uses Microwave to Treat Medical Waste*, Wall St. J., Apr. 10, 1989, at B2, col. 5.

85. The EPA originally projected the average cost of compliance for individual hospitals to be about $3,750.00. Tokarski, *EPA Sets Waste Tracking Plan*, MODERN HEALTHCARE, Mar. 17, 1989, at 4. However, a more realistic forecast by the American Hospital Association, Division of Health Facilities Management, was "upwards of $100,000 annually" for a 250 to 300 bed hospital. Hinz, *Medical Waste Tracking Rules Seen Adding to Provider Costs*, AMERICAN MEDICAL NEWS, Apr. 14, 1989, at 13, 16.

"Hospital waste disposal was once a rather simple arrangement of either sterilizing or burning infectious waste, then turning it over to a hauler for dumping." Eubanks, *Tossing the Trash*, HOSPITALS, May 20, 1989, at 76. Today, however, " '[h]ospitals need to take care of their own businesses to protect themselves from liability.' " *Id.* It has been suggested that "hospitals create onsite task forces" to address their waste management needs. *Id.* "Hospitals must develop policies and provide the means to sort harmless garbage from dangerous waste." *Id.* at 77. "[D]isposal options—including using fewer disposable products," is one of the major questions these task forces must answer. *Id.*

products, which carries its own high costs and risks,[86] will prove to be a reliable method. Since the toxic nature of medical waste is borne out of disease, and a non-toxic alternative is simply not available, the industry must either invest the money in safe reusables or develop alternative systems of disposal. Suggestions such as "joint ownership of a state-of-the-art incinerator by hospitals in one region,"[87] should be seriously considered for the near future. This author believes that while these alternatives themselves carry significant costs, a comprehensive, uniform system assures that regulated medical waste will safely reach their disposal sites.

The category of small quantity generators, which appears to create significant management problems,[88] is also addressed in the MWTA.[89] This category includes doctors' offices, medical clinics, laboratories, and hospitals.[90] The system requires any generator that produces fifty pounds or more of medical waste each month to comply with all the regulations and to track their waste.[91] Additionally, the EPA may choose to subject even smaller quantity generators to this tracking program if it is determined to be a necessary measure.[92]

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86. The "high labor costs," and exposure of hospital employees to some of the dangerous gases used to sterilize reusable equipment, must be balanced against the "soaring disposal costs." Souhrada, *Reusables Revisited as Medical Waste Adds Up*, HOSPITALS, Oct. 20, 1988, at 82. Because it is difficult to project exactly what the actual "cost effect" of compliance with the MWTA will be, hospitals will hold off on this change-over. *Id.*

87. Eubanks, *supra* note 85, at 76, 77. For another innovative alternative, see Paul, *supra* note 84, at B2, col. 5.

88. 134 CONG. REC. H9540 (daily ed. Oct. 4, 1988) (statement of Rep. Florio).

89. 42 U.S.C. § 6992b(b) (1988).

90. 134 CONG. REC. S15,327 (daily ed. Oct. 7, 1988) (statement of Sen. Baucus).

91. 42 U.S.C. § 6992b(b) (1988).

92. *Id.* The American Hospital Association believes the entire program should be aimed at small quantity generators. *National Infectious Waste Plan Called For: Says Agency's Current Activities Suffice*, 19 Env't Rep. (BNA) No. 16, at 684, 685 (Aug. 19, 1988).

Some believe that to cut costs, small quantity generators are more likely to improperly dispose of medical waste and escape regulation. *Id.* There is currently an increase in the amount and use of small quantity generators, such as in outpatient and similar facilities, not associated with a large medical establishment. *Id.* Additionally, the costs of proper disposal can be prohibitive for many of these facilities, since these costs have recently more than doubled. McCarthy, *Hospital Refuse Gives Us Fits*, U.S.A. Today, Aug. 11, 1988, at 10a, col. 2.

Generators that incinerate their waste onsite also are subject to regulation under the tracking program.[93] These generators are required to report to the EPA on the volume and types of waste incinerated during the six-month period following the effective date of the regulation.[94]

Finally, since some waste is considered more hazardous than others, the regulations vary according to the types of waste.[95] The EPA is to carefully examine and evaluate all aspects and methods of packaging, labelling, treatment, handling, and disposal to determine the most effective method of tracking and then report back to Congress on its findings.[96]

C. *The Reports, 42 U.S.C. §§ 6992g and 6992h*

Under the MWTA, the EPA and the Agency for Toxic Substances and Disease Registry (ATSDR)[97] must furnish reports

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A representative of the American Hospital Association agrees that a monitoring system is necessary on a state level, but feels that the MWTA's tracking program will be " 'costly and burdensome [and] would be unlikely to prevent infrequent occurrences of gross negligence by unscrupulous waste processors.' " *National Infectious Waste Plan Called For; EPA Says Agency's Current Activities Suffice*, 19 Env't Rep. (BNA) No. 16, at 684, 685 (Aug. 19, 1988).

Additionally, he recommended "cost effective alternatives" applied equally to small and large quantity generators. *Id.* Other recommendations include:

> [a] uniform definition of infectious waste for use by all federal and state agencies; [m]odel state waste disposal regulations to eliminate confusion and inconsistencies; [f]unding for better assessment of existing technology and development of new cost-efficient disposal options; [p]rotection of public surface waters, such as oceans, from serving as disposal sites for any wastes; [r]equired adherence to prudent practices by all generators of medical waste, including outpatient sites that currently are exempt from regulation.

McCarthy, *supra* note 92, at 10a, col. 2.

93. 42 U.S.C. § 6992b(c)(1) (1988).

94. *Id.* § 6992b(c)(2).

95. *Id.* § 6992b(d).

96. 134 CONG. REC. E2539 (daily ed. July 28, 1988) (statement of Rep. Florio). *See* 42 U.S.C. §§ 6992g(b), 6992h (1988).

97. The Agency for Toxic Substances and Disease Registry (ATSDR) was established in 1983, and has various responsibilities under CERCLA and RCRA. Among its duties, the ATSDR must work closely with local, state, and federal agencies to "develop[] scientific and technical procedures for evaluating public health risks from hazardous substances," GOVERNMENT MANUAL, *supra* note 61, at 308, and "provide[] leadership and direction to programs and activities designed to protect both the public health and worker from exposure and/or the adverse health effects

to Congress.[98] The findings in these reports will serve as guidelines for Congress in its formulation and implementation of permanent regulations.[99]

The MWTA requires three reports to be submitted by the EPA, during the demonstration program: two interim reports[100] and a final report.[101] The first interim report should include all current information[102] to help define medical waste and determine the most practical methods of storage, transportation, treatment, and disposal.[103] The second interim report and the final report should "fill [the] gaps in the initial report,"[104] and provide a complete, up-to-date study upon which Congress can rely in evaluating the situation and implementing regulations to control it.[105] These reports are considered "imperative"[106] for a "complete assessment"[107] of the problems associated with medical waste.[108]

Congress seeks a "technical overview"[109] of the current status of medical waste management and generation, with special attention to the defined categories of waste included in the MWTA.[110] This author believes that to ensure the success of this program, any distortion of the statistics or findings, inadvertent or intentional, cannot be tolerated.

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of hazardous substances in storage sites or released in fire, explosion or transportation accidents." *Id.* Additionally, the agency "assists the Environmental Protection Agency in identifying hazardous waste substances to be regulated." *Id.*

98. 42 U.S.C. §§ 6992g(b), 6992h (1988).

99. 134 CONG. REC. H9538 (daily ed. Oct. 4, 1988) (statement of Rep. Whittaker).

100. The Administrator was required to submit the first report nine months after enactment of the subchapter, and the other report twelve months after the effective date of the subchapter. 42 U.S.C. § 6992g(b) (1988).

101. The final report is due no more than three months after completion of the two year demonstration program. *Id.* § 6992g(a).

102. 134 CONG. REC. H9540 (daily ed. Oct. 4, 1988) (statement of Rep. Florio).

103. *See* 42 U.S.C. §§ 6992g(b), 6992g(1) (1)-(12) (1988).

104. 134 CONG. REC. H9540 (daily ed. Oct. 4, 1988) (statement of Rep. Florio).

105. *Id. See* 42 U.S.C. § 6992g(a)(1)-(12) (1988).

106. 134 CONG. REC. H9540 (daily ed. Oct. 4, 1988) (statement of Rep. Florio).

107. *Id.*

108. 42 U.S.C. § 6992g(a)(1)-(12) (1988).

109. 134 CONG. REC. H9540 (daily ed. Oct. 4, 1988) (statement of Rep. Florio).

110. *Id. See supra* note 56.

Officially, the MWTA only requires a final report from the ATSDR.[111] However, in an effort to foster a more complete evaluation by Congress,[112] it was suggested that interim reports be submitted at the same intervals as those required of the EPA.[113] Essentially, Congress wants the ATSDR to focus on the "health effects of medical waste:"[114] the "occupational risk[s]"[115] of handling, segregating, treating, and disposing of medical waste;[116] the "incident[s] of injury;"[117] and the risk to the general public.[118] It is important to differentiate between these areas so that Congress can formulate effective regulations to control all of the dangers posed by medical and infectious waste.[119]

Finally, these reports will prove useful to Congress whenever future medical waste issues arise;[120] thus, there is good reason to require such thoroughness. Through proper investigation and implementation, this aspect of the program will prove invaluable in the development of useful regulations to effectively manage infectious and medical waste on the federal, state, and local levels.

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111. 42 U.S.C. § 6992h (1988). The report is to be prepared within two years from the date of enactment. *Id.*

112. 134 CONG. REC. H10,106 (daily ed. Oct. 4, 1988) (statement of Rep. Wyden).

113. 134 CONG. REC. H10,106 (daily ed. Oct. 12, 1988) (statement of Rep. Luken).

114. 42 U.S.C. § 6992h (1988).

115. 134 CONG. REC. H9538 (daily ed. Oct. 4, 1988) (statement of Rep. Wyden); *see* 42 U.S.C. § 6992h (1988).

116. 42 U.S.C. § 6992h(3) (1988).

117. 134 CONG. REC. H9538 (daily ed. Oct. 4, 1988) (statement of Rep. Whittaker); *see* 42 U.S.C. § 6992h (1988).

118. 134 CONG. REC. H9538 (daily ed. Oct. 4, 1988) (statement of Rep. Whittaker).

119. *Id.* Representative Wyden has suggested that case histories accompany these reports. 134 CONG. REC. H9541 (daily ed. Oct. 4, 1988) (statement of Rep. Wyden).

120. 134 CONG. REC. H9537 (daily ed. Oct. 4, 1988) (statement of Rep. Luken).

D. Inspections and Enforcement, 42 U.S.C. §§ 6992c and 6992d

The MWTA provides for a simple inspection system.[121] The primary function of the inspection system is to facilitate the preparation of the reports by the EPA;[122] however, inspection also serves the purpose of enforcement.[123]

This author suggests that Congress should implement a program of random inspections as a permanent feature of the federal MWTA. The advantages of such a program would be extensive. First, medical waste handling facilities would tend to comply in order to avoid the imposition of a severe fine, eventually making compliance routine and cost effective. Second, inspection would thwart potential hazards before they present risks to the public and the environment. Third, inspections would help ensure that proper procedure is followed and corners were not cut.

Strong and efficient methods of enforcement are also crucial to effective implementation of any environmental regulation. In an effort to encourage compliance, the federal MWTA sets forth severe civil and criminal sanctions.[124] Violations can result in fines up to $1,000,000 and prison terms up to fifteen years.[125]

Detractors of the program's penalty structure suggest that fines should be assessed relative to the seriousness of the danger posed by the violation.[126] They believe flexibility is essential because, for the first time, small quantity generators will

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121. 42 U.S.C. § 6992c (1988). There are few details involved in inspections, other than the inspector's duty to conduct the inspection at a reasonable time. *Id.* § 6992c(a)(1). He is permitted to take samples of waste from the facilities. *Id.* § 6992c(a)(3). If samples are taken, upon request, the owner/operator must be furnished with an equal portion of the substances taken. *Id.* § 6992c(b). Additionally, the owner/operator must be furnished with the results of any tests conducted on the samples. *Id.*

122. *Id.* § 6992c(a).

123. *Id.*

124. 42 U.S.C. § 6992d (1988). The orders for penalties are final, unless a public hearing is requested within 30 days. *Id.* § 6992d(3).

125. *Id.* § 6992d(b), (c).

126. 134 CONG. REC. H9538 (daily ed. Oct. 4, 1988) (statement of Rep. Whittaker).

be subject to tracking requirements.[127] However, the basic concept remains: the higher the penalties, the stronger the deterrent value. Such enforcement sends the clear message to the polluters that it is "more expensive to pollute than to legally dispose of these potentially lethal wastes." [128]

The possible imposition of severe penalties will deter many violations, but more is needed. Without the threat of detection, many health care facilities would devote little effort to compliance. Thus, effective enforcement must be augmented by a strong program of inspection and extensive enforcement powers. To that end, Congress has provided the EPA with the authority to carry firearms, execute warrants, and make warrantless arrests.[129]

E. States Included Under the Demonstration Program, 42 U.S.C. § 6992

Congress designated New York, New Jersey, Connecticut, and the states contiguous to the Great Lakes[130] to be included in the demonstration program.[131] As originally drafted, any of these states could "opt out" upon request.[132] This provision was deemed too lenient and a more practical amendment was proposed and included in the final version of the MWTA.[133] Thus, as passed, the governors of any state contiguous to the Atlantic Ocean could "opt out" only by satisfying a "no less stringent" test.[134] In this manner, Congress was successful in keeping

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127. 42 U.S.C. § 6992b(b) (1988); *see supra* notes 89-92 and accompanying text.

128. 134 CONG. REC. H10,106 (daily ed. Oct. 12, 1988) (statement of Rep. Schuette).

129. 18 U.S.C. § 3063(a)(1)-(3) (1988).

130. These states are Illinois, Indiana, Michigan, Minnesota, Ohio, Pennsylvania, and Wisconsin. Standards for the Tracking and Management of Medical Waste, 54 Fed. Reg. 24,310 (1989).

131. 42 U.S.C. § 6992(a) (1988).

132. H.R. 3515, 100th Cong., 2d Sess., 134 CONG. REC. 9531 (1988).

133. 42 U.S.C. § 6992(b) (1988).

134. *Id.* § 6992b(2). While all areas of medical waste management fall under this no less stringent test, examples were offered by Congress to indicate the nature of this requirement. Specifically, the small quantity generators requirements were discussed. 134 CONG. REC. S15,327-28 (daily ed. Oct. 7, 1988) (statement of Sen. Chafee). The Act permits, but does not require, the EPA to include all generators that do not exceed fifty pounds of medical waste each month. *Id.* Any generator

New York, New Jersey, and Connecticut,[135] the states "hardest hit"[136] by medical waste, in the program.[137]

The Great Lakes states, however, do not fall under this "no less stringent" test.[138] Since the federal program is only a demonstration, and the medical waste crisis is not as severe in these states, Congress reasoned it would have been unfair to require these states to satisfy the "no less stringent" test.[139] These states were given an unrestricted right to "opt out" and to examine their specific problems more closely.[140] The Great Lakes states took full advantage of this option.[141] As a result, they are no longer subject to the provisions of the Act.[142]

The MWTA also provides for any state, at the discretion of the EPA, to "petition in" to the federal program.[143] Louisiana, Puerto Rico, Rhode Island, and the District of Columbia wisely took advantage of this opportunity to alleviate their medical waste problems and are now included under the Act.[144] The inclusion of these areas will "provide a broader range of experience and information,"[145] than if only Connecti-

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which does produce fifty pounds or more each month must be included under the program. *Id.* Therefore, if a state's laws did not mandate compliance with a tracking system this stringent, they could not opt out. *Id.* A similar analysis can be applied to all of the remaining provisions of the Act as they relate to state programs.

135. Standards for the Tracking and Management of Medical Waste, 40 C.F.R. §§ 259.10(b), 259.20(b) (1989).

136. 134 CONG. REC. E3464 (daily ed. Oct. 14, 1988) (statement of Rep. Florio).

137. *Id.*; 42 U.S.C. § 6992(a) (1988).

138. 42 U.S.C. § 6992(b) (1988).

139. 134 CONG. REC. H10,105 (daily ed. Oct. 12, 1988) (statement of Rep. Luken).

140. 134 CONG. REC. S15,327 (daily ed. Oct. 7, 1988) (statement of Sen. Chafee).

141. Standards for the Tracking and Management of Medical Waste, 54 Fed. Reg. 24,310 (1989). This was quite unexpected, since the Council of Great Lake Governors initially requested to be included under the program. 134 CONG. REC. H10,105 (daily ed. Oct. 12, 1988) (statement of Rep. Luken).

142. Standards for the Tracking and Management of Medical Waste, 40 C.F.R. § 259.20(b) (1989).

143. 42 U.S.C. § 6992c (1988).

144. Standards for the Tracking and Management of Medical Waste, 40 C.F.R. §§ 259.10(b), 259.20(b) (1989).

145. Standards for the Tracking and Management of Medical Waste, 54 Fed. Reg. 24,310 (1989).

cut, New Jersey, and New York were participating in the federal program.[146]

III. NEW YORK'S MEDICAL WASTE LAWS

New York was one of the states most effected by the improper disposal of medical waste. The beach wash-ups during the summer of 1988 were a catalyst for enactment of the MWTA, since they created a "serious threat to public health and contributed to an estimated $1.25 million loss in tourism revenues."[147] The root of the problem was the volume of medical waste generated and the cost of its disposal.[148] A hospital with five hundred beds pays over $150,000 per year for carting costs.[149] If that hospital treats AIDS patients, it can expect to pay approximately twice that amount.[150] Such high costs can be attributed to the large amount of medical waste generated when treating AIDS patients, as well as the transporters' fears of contamination. These facts alone indicate that there is great incentive for improper waste disposal.

In 1985, New York City made it illegal to dispose of medical waste in the municipal sanitation and landfill system.[151] The regulations defined varieties of medical waste,[152] which were quite similar to the list of the MWTA, and penalties,

146. *Id.*

147. Legislative Report from Senator Jim Lack (Dec. 1988) (discussing medical waste disposal) (on file at the offices of the *Touro Law Review*).

148. Each week 1.7 million pounds of infectious waste are generated in New York State. N.Y. Times, Aug. 16, 1988, at A26, col. 3. Infectious waste constitutes twenty percent of a hospital's waste. Anderson, *To Burn or Not to Burn, The Medical Trash That's on the Beach is Only the Start*, N.Y. Times, Aug. 7, 1988, at E6, col. 1. This percentage is expected to rise over the next few years, and by 1991, medical waste will constitute forty percent of a hospital's waste due to the AIDS epidemic. *Id.* Currently, a New York-based waste transporter will pay 85 cents per pound to an incinerator company to burn infectious waste. Hirsh, *Disposal of Hospital Waste: A Struggle Over Regulation*, N.Y. Times, July 8, 1988, at B5, col. 5.

149. Hirsh, *Disposal of Hospital Waste: A Struggle Over Regulation*, N.Y. Times, July 8, 1988, at B5, col. 5.

150. *Id.*

151. NEW YORK, N.Y. ADMIN. CODE, ch. 1, § 16-120.1 (1986).

152. *Id.* § 16-120.1b.

which levied moderate fines[153] and provided for suspension of waste disposal permits.[154]

It was not until July 1987, that the New York State Legislature approved comprehensive state-wide laws aimed at controlling medical and infectious waste.[155] While these statutes became effective on April 1, 1988,[156] the regulations were not immediately enacted. In the meantime beach wash-ups worsened. On August 10, 1988, emergency adoption of the proposed regulations was effectuated,[157] but these needed procedures and deterrents were in place too late to save the 1988 summer season. On June 22, 1989, in response to the crisis, New York State approved further changes and additions to its laws controlling medical waste.[158] Under the new laws, the word infectious was eliminated from the definition of "regulated" medical waste.[159] This broadened the list of regulated materials to include such utensils as needles and scalpel blades.[160] These items had previously eluded New York's regulations because they were not necessarily "infectious." [161]

New York's new laws also tightened the grip on small quantity generators. The previous statute only mentioned quantity in the section addressing transporters;[162] there was no mention at all of small quantity generators.[163] The minimum amount

153. *Id.* § 16-120.1d.

154. *Id.* § 16-120.1e.

155. *See* Storage, Treatment and Disposal of Infectious Materials and Biological Wastes, ch. 446, 1987 N.Y. Laws 769 (codified as amended at N.Y. PUB. HEALTH LAW §§ 1389-aa to -gg (McKinney Supp. 1990)); Storage, Treatment and Disposal of Infectious Waste, ch. 431, 1987 N.Y. Laws 745 (codified as amended at N.Y. ENVTL. CONSERV. LAW §§ 27-1501 to -1517 (McKinney Supp. 1990)).

156. Storage, Treatment and Disposal of Infectious Materials and Biological Wastes, ch. 446, § 4, 1987 N.Y. Laws 769, 773; Storage, Treatment and Disposal of Infectious Waste, ch. 431, § 9, 1987 N.Y. Laws 745, 751 (codified as amended at N.Y. PUB. HEALTH LAW §§ 1389-aa to -gg (McKinney Supp. 1990)).

157. N.Y. St. Reg., Aug. 31, 1988, at 11.

158. Regulated Medical Waste-Storage, Transportation and Treatment, ch. 180, 1989 N.Y. Laws 445 (codified at N.Y. ENVTL. CONSERV. LAW §§ 27-1501 to -1517 and N.Y. PUB. HEALTH LAW §§ 1389-aa to -gg (McKinney Supp. 1990)).

159. *Id.*

160. N.Y. ENVTL. CONSERV. LAW § 27-1502(2)(d) (McKinney Supp. 1990).

161. *See* N.Y. ENVTL. CONSERV. LAW § 27-1501(1)(j) (McKinney Supp. 1989).

162. *Id.* § 27-1509(2).

163. *See id.* §§ 27-1501 to -1515.

subject to tracking had been one hundred kilograms (220 pounds).[164] The new statute, however, decreased this amount to fifty pounds for all phases of generation and tracking.[165] Thus, even the smallest quantity generators and clinics will be subject to the tracking requirements.[166]

As a result of these new implementations, New York's system now is consistent with the federal system.[167] However, to give these new laws sufficient force, New York has instituted a program of enforcement more detailed than the federal program.[168] This new program creates an extensive framework[169] written to apply specifically to "regulated" medical waste. The provisions structure a multi-tiered system of violations, misdemeanors, and felonies.[170] This system, buttressed by a strong

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164. *Id.* § 27-1509(2).

165. N.Y. ENVTL. CONSERV. LAW § 27-1509(2) (McKinney Supp. 1990).

166. In September 1988, bags of infectious medical waste found along the Madison Avenue Bridge were traced to a Manhattan dermatologist's office. *20/20: Putting the Heat On* (ABC television broadcast, Sept. 9, 1988) (transcript on file at the offices of the *Touro Law Review*). Under New York's current law, this dermatologist might be required to comply with tracking procedures, and could be prosecuted. N.Y. ENVTL. CONSERV. LAW §§ 71-4405 to -4408 (McKinney Supp. 1990).

167. N.Y. ENVTL. CONSERV. LAW § 27-1503 (McKinney Supp. 1990) *compare with* 42 U.S.C. §§ 6992-6992K and 18 U.S.C. § 3063 (1988).

168. *Id.* §§ 71-4405 to -4408. Previously, the lack of effective enforcement and inspection methods forced New York City to establish an environmental police unit, which spent most of its time "staking out," *20/20: Putting the Heat On* (ABC television broadcast, Sept. 9, 1988) (transcript on file at the offices of the *Touro Law Review*), clinics reportedly violating disposal requirements and trying to track waste before it was improperly disposed. *Id.* These methods were inefficient and ineffective. Often these efforts to detect and prosecute violators were frustrated when the cases reached the courts. *Id.*

169. N.Y. ENVTL. CONSERV. LAW §§ 71-4400 to -4412 (McKinney Supp. 1990).

170. *Id.* Civil penalties may not exceed more than $25,000 per day for first offenders, and in the case of repeat offenders, the penalty may not exceed more than $50,000 per day. *Id.* § 71-4402(1). Criminal sanctions start at $5,000 per day for violation of any provision of the Act or of its rules and regulations. *Id.* § 71-4402(2)(a). First time violation that is intentional, knowing, or reckless is a class B misdemeanor and is punishable by a fine of $15,000 per day. *Id.* § 71-4402(2)(b). Repeat offenders are subject to a class A misdemeanor, punishable by a fine of $150,000 per day. *Id.* The elements of unlawful possession, unlawful release, and unlawful dealing are also set forth. *Id.* §§ 71-4403 to -4409. The maximum fine attached to these crimes are $150,000 for a class D felony, $100,000 for a class E felony, $50,000 for a class A misdemeanor, and $15,000 for a class B misdemeanor. *Id.* § 71-4411(2).

inspection program and added enforcement personnel, will facilitate practical application of the laws, including capture and prosecution of violators. Variations such as these, between the regulations of the demonstration states and the federal program, will provide Congress and the EPA with a broad base of information and experience to evaluate in formulating permanent federal regulations.

CONCLUSION

Beach wash-ups, fear of contamination, a decline in tourism, and intense media coverage prompted Congress to implement legislation aimed at curbing the threats of medical waste. The Medical Waste Tracking Act of 1988 attempts to address the entire range of imaginable issues that might contribute to the mismanagement of medical waste and the further destruction of our environment. Because of its design as a demonstration program, the MWTA will surely identify new areas of concern and eventually provide data to help improve upon our present approach to medical waste disposal.

This program will help in the formulation of a uniform definition of regulated medical waste, create model waste-disposal regulations, and establish a strong and effective system of inspection and enforcement. The manifest system, high fines, and stringent enforcement methods, will deter blatant cases of illegal dumping. All of these elements are essential to the program's success. However, there are two factors which ultimately will determine whether the program is productive: first, the EPA's involvement and diligence, and second, the medical community's willingness to cooperate. The irony of this situation is that the medical community, charged with preserving the public health, has created a potentially devastating situation, yet is angered by the imposition of these regulations.

The findings of the federal program will likely: 1) indicate that *all* generators and handlers of regulated medical waste, large and small, should be regulated; 2) illustrate the need for effective regulation, especially on the state and local levels; and 3) establish the minimum standard guidelines for individual states or localities.

Finally, having failed to promulgate regulations itself, the EPA has been directed by Congress to take charge of the medical waste crisis. It is now the EPA's task to effectively implement this system. However, without cooperation of the entire medical community and the disposal industry, the EPA's task might be impossible, and medical waste problems will persist. Let us hope that both the EPA and the medical community will work with Congress to create a safe, healthy environment.

Laurence D. Granite