Bioterrorism, Public Health, And Human Rights

Taking human rights seriously is our best defense against terrorism and fosters both the federalization and globalization of public health.

by George J. Annas

ABSTRACT: It is unnecessary and counterproductive to sacrifice basic human rights to respond to bioterrorism. Constructive public health legislation, which must be federal, cannot be carefully drafted under panic conditions. When it is, like the “model act,” it will predictably rely on broad, arbitrary state authority exercised without public accountability. Public health should resist reverting to its nineteenth-century practices of forced examination and quarantine, which will simply encourage people to avoid physicians, hospitals, and public health practitioners they now trust and actively seek out in emergencies. Upholding human rights is essential to public trust and is ultimately our best defense against the threat of terrorism in the twenty-first century.

A central lesson from 9/11 is that threats to public health are national and global. Unfortunately, public health as a field has an unappealing tendency to look backward when planning for the future. Even the influential 1988 report of the Institute of Medicine, The Future of Public Health, ignored the need for federal public health leadership and financing.1 Rather than “moving public health into the 21st century [the report tried to] return it to the 19th century,” leaving us poorly prepared for bioterrorism.2 As Lawrence Gostin’s paper outlines, the Centers for Disease Control and Prevention’s (CDC’s) request to develop a state emergency powers act in the wake of the anthrax attacks reflects this regressive tendency. Its exclusive concentration on the state level misses an important opportunity to exercise national public health leadership and instead promotes a return to the paternalistic pre–human rights days of nineteenth-century public health practices such as forced examination and quarantine.

In this brief commentary I make three arguments: (1) Bioterrorism should move us toward a more federalized and globalized public health system, (2) protecting basic human and constitutional rights is essential to effective coordination of medicine and public health, and (3) 9/11 and the suggested act should prompt thoughtful reflection, debate, and action to modernize public health practice.

Federal (and global) public health. State public health laws are often antiquated, but their most antiquated feature is their underlying premise that public health is exclusively a state-level concern. A bioterrorist attack on the United States, for example, is inherently a matter of national security, making it a federal matter. That is why the FBI, not state or local police, took almost immediate control in the wake of the anthrax attacks. State laws regarding bioterrorism should be primarily aimed at preparing state and local authorities for their important job of assisting...
federal agencies, such as the new U.S. Department of Homeland Security, in the response. Biological attacks are different in kind from nuclear and chemical attacks, and they require specially tailored defenses.1

Public health policy should be national, and the addition of national security to federal financing and interstate commerce provides sufficient constitutional authority for Congress to enact legislation giving the federal government the leadership role in public health in the twenty-first century. In response to bioterrorism, in particular, it is imperative that the federal government develop a national plan that individual states can help implement, and that the federal government supply the states with badly needed financial and other resources to improve their public health infrastructure, training, and coordination.

At the outset of the twenty-first century, bioterrorism, although only one threat to public health, can be the catalyst to effectively “federalize” and integrate much of what are now uncoordinated and piecemeal state and local public health programs. This should include a renewed effort for national health insurance; national licensure for physicians, nurses, and allied health professionals; and national patient-safety standards. Federal public health leadership will also help us look outward and recognize that prevention of future bioterrorist attacks and even ordinary epidemics will require international cooperation.4 In this regard, the threat of bioterrorism joins HIV/AIDS and other epidemics to demonstrate the need to globalize public health.

Public health and medicine. A major planning question in responding to a bioterrorist attack is the relationship between medicine and public health. It is almost certain that any attack will first be recognized by physicians working in a hospital emergency room.5 Therefore, proposals to train emergency room personnel to recognize patients exposed to the most likely bioterrorist agents make perfect sense, as do up-to-date communication systems that can track relevant disease occurrences quickly and accurately (although there is no necessity to report data that identify patients). But who should be in charge after an outbreak has been confirmed?

The suggested act assumes that a state’s governor will designate “public health officials” to be in charge and that these officials—who will be issued badges—will be empowered to take over hospitals and order physicians to examine and treat (and quarantine) individuals against their will, even when there is no evidence at all that the individual is either sick or contagious. The act’s first draft was even more extreme, making it a crime for any individual to refuse to be examined or treated and a crime for a physician to refuse an order by a public health official to examine or treat a patient.6 Moreover, should any patient be injured, or even killed, by the treatment (as, for example, immunocompromised individuals could be by smallpox vaccine), the public health officials and state would be immune from lawsuit.

This approach is likely to be counterproductive. Despite its talk about balancing human rights with disease prevention, the suggested act unnecessarily ignores basic human rights. Physicians, on the other hand, have effectively incorporated the doctrine of informed consent into their core medical ethics precepts. Public health still favors legal mandates and government-backed paternalism. Public health should be abandoning paternalism, rather than attempting to use 9/11 to increase it. Public health officials are likely to be much more effective in responding to emergencies if they work with both physicians and the public, rather than trying to exercise arbitrary and unaccountable power over them.

As evidenced by both 9/11 and the anthrax...
attacks, U.S. hospitals and physicians stand ready to help in any way they can in a mass emergency. The public is also eager—often too eager—to accept medications and line up to seek screening and care at hospitals. The real problem in a bioterrorist event will be supplying medical care, drugs, and vaccines to those who demand them. Nonetheless, the prospect of arbitrary forced treatment and quarantine would rightly engender distrust in government and public health officials and could actually discourage those who might have been exposed from seeking treatment at all—even encourage them to escape to another state. As 9/11 demonstrated, most people want to protect their families first and are likely to avoid public health officials who they believe might arbitrarily separate them from their families. As long as the public trusts its physicians and public health professionals, the problem will not be getting Americans to accept treatment, it will be persuading the worried well that they don’t need treatment.

- **Democracy and public health.** The suggested act has been criticized by both civil liberties and libertarian groups. But they are hardly alone. As the act’s authors note on the cover page of their second (21 December 2001) and apparently final draft, not one of the groups involved in any way with the original draft and the revision, including the authors themselves, have endorsed the proposal as written.7 The original “model” act has been relabeled as simply a “draft for discussion,” prepared “to facilitate and encourage communication,” and does “not represent the official policy, endorsement, or views” of the Center for Law and the Public’s Health, the CDC, the National Governors Association (NGA), the National Conference of State Legislatures (NCSL), the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), or the National Association of Attorneys General (NAAG), or anyone else.8

There is no chance that every state, or even many states, will adopt the suggested act, so if uniformity is seen as necessary, only a federal statute can provide it. So far, only Delaware and South Carolina have embraced the suggested act. More typically, states have ignored it, or like California, have considered it and rejected it outright. Other states, like Minnesota, have adopted some of its provisions but have rewritten them to be consistent with contemporary medical ethics and constitutional rights.

Under the new Minnesota law, for example, even in a public health emergency, “individuals have a fundamental right to refuse medical treatment, testing, physical or mental examination, vaccination, participation in experimental procedures and protocols, collection of specimens and preventive treatment programs.”9 Of course there are extreme circumstances under which isolation or quarantine can be employed. But the Minnesota legislature permits such measures only under much more limited conditions; the right to refuse all interventions continues in isolation and quarantine; and family members are permitted to visit. Most of the other provisions of the suggested act, including the immunity provisions, were referred to the Minnesota commissioner of health, who was instructed to study them and report back to the legislature, after having solicited public comment on any recommendations.10 The Minnesota legislature properly recognized that human rights and health are not inherently conflicting goals that must be traded off against each other; they are, as Jonathan Mann and colleagues first articulated in the context of the international HIV/AIDS epidemic, “inextricably linked.”11

The suggested act was drafted under extreme, albeit self-imposed, time constraints in the immediate aftermath of 9/11 and the anthrax attacks, when fear ruled reason. This is a predictable prescription for disaster. Sensible
public health and bioterrorism legislation must be drafted in a calm atmosphere, in a transparent, public process.\textsuperscript{12} Most importantly, as Ken Wing has noted, “statute drafting is a technical and instrumental job—one that should follow, not precede the more fundamental task of deciding what the statute ought to say.”\textsuperscript{13}

Ultimately, public health must rely not on force but on persuasion, and not on blind trust but on trust based on transparency, accountability, democracy, and human rights. There is plenty of time to draft and debate a twenty-first-century federal public health law that takes constitutional rights seriously, unites the public with its medical caretakers, treats medicine and public health as true partners, and moves us in the direction of global cooperation.

The author happily acknowledges the value of numerous discussions with members of the New England Coalition for Law and Public Health on the subject of bioterrorism and public health in helping him to formulate his views, which do not necessarily reflect those of all members of the coalition.

NOTES
7. “The Model State Emergency Health Powers Act, as of December 21, 2001,” www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf (28 August 2002). Text of the suggested act is also available in the Journal of Law, Medicine, and Ethics (Summer 2002): 322–348, although the disclaimer has been moved to the end in this publication.
9. 2002 Minnesota Chapter Law 402 (signed by the governor 22 May 2002).
10. Ibid.