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**Perspective**

**Bioterrorism, Public Health, And The Law**

We must take rights seriously but consider the claims of public health with equal gravity.

by Ronald Bayer and James Colgrove

**ABSTRACT:** The controversy over the Model State Emergency Health Powers Act has underscored the enduring tension in public health between guarding the common welfare and respecting individual liberty. The current version of the act, crafted in response to extensive public commentary, attempts to strike a balance between these values but has failed to allay the concerns of many civil libertarians and privacy advocates. Although the debates over the model act have been triggered by the threat of bioterrorism, they illustrate broader philosophical differences, with profound implications for all realms of public health policy.

Tension between individual rights and the good of the community, and controversy over how far the government may go in limiting liberty to prevent the spread of illness, lie at the heart of the history of U.S. public health. One hundred years ago a smallpox epidemic in Massachusetts was the occasion for a court challenge to the state’s compulsory vaccination law that ultimately led to a landmark Supreme Court ruling in 1905 establishing the right of the government to use its “police powers” to control epidemic disease. Over the next several decades the courts almost always deferred to authorities who deprived individuals of their liberty in the name of public health. Such a plenary grant of authority could still be found to be constitutional in the 1960s. In upholding the detention of a tuberculosis patient pursuant to a statute that provided virtually no procedural protections, a California appellate court in 1966 declared, “Health regulations enacted by the state under its police power and providing even drastic measures for the elimination of disease...in a general way are not affected by constitutional provisions, either of the state or national government.”

**Transforming Public Health Law**

The breadth of public health powers that were virtually unchallenged throughout most of the twentieth century became subject to increasing scrutiny in the century’s last decades. The development of a robust jurisprudence of privacy and the “due process revolution” that extended rights to prisoners, mental patients, and others under the authority of the state would ultimately bring into question assumptions that had protected public health from searching constitutional scrutiny. But while the groundwork was prepared in the transformations of U.S. politics, law, and culture in the 1960s and 1970s, it was the AIDS epidemic that would force a fundamental rethinking of the dominant ideology of public health.

In the epidemic’s early years, a broad coalition of gay-rights activists and civil libertarians were largely successful in their efforts to...
place the protection of privacy and individual rights at the forefront of the public health agenda. In fierce battles over name reporting of HIV infection, informed consent for testing, and the use of quarantine for those whose behavior placed their sexual partners at risk, a new philosophy took shape. Given the unique biological, epidemiological, and political factors that shaped the public policy discussion, it became possible to assert that there was no tension between public health and civil liberties, that policies that protected the latter would foster the former, and that policies that intruded on rights would subvert the public health.

Larry Gostin was in many ways a principal architect in fashioning this “exceptionalist” perspective. What was true for AIDS was true for public health more generally. Indeed, the experience of AIDS provided the opportunity to rethink the very foundations of public health with its legacy of compulsory state powers. At an international level, this view was reflected in the endeavor to articulate a new understanding of the relationship between health and human rights. One striking formulation, coauthored by Jonathan Mann and Gostin, asserted that “it may be useful to adopt the maxim that health policies and programs should be considered discriminatory and burdensome on human rights until proven otherwise.”

Applying The Principle To Bioterrorism

Could this perspective, rooted in the experience of a disease that was not casually transmitted, inform public health policy when confronted with a deliberately planned biological threat that involved virulent communicable viral or bacteriological agents? The challenge would be faced in the period after 11 September 2001. Gostin and his colleagues at the Center for Law and the Public’s Health (CLPH), working in collaboration with the U.S. Centers for Disease Control and Prevention (CDC), drafted a Model State Emergency Health Powers Act (MSEHPA), intended to serve as a template to help state legislatures update their legal infrastructures to deal more effectively with potential acts of bioterrorism. A first draft of the act was released for public comment in October 2001; in the following months Gostin was forced to confront charges, launched from across the political and ideological spectrum, that the act’s sweeping provisions for quarantine, seizure of property, mandatory treatment, and vaccination as well as other restrictions represented unacceptable governmental overreaching that gravely threatened civil liberties. The final draft of the act, released in December 2001, reflects, in Gostin’s view (as stated in his paper in this issue), a delicate balance between the philosophy that dominated public health for most of the twentieth century and the more rights-oriented perspective that had supplanted it.

The opposition. Although some who expressed fierce opposition to the first draft of the emergency act acknowledged that the substantive changes had improved the legislation, core concerns remained, revealing a deep philosophical divide. Most interesting were the responses from the civil liberties and privacy organizations that had been Gostin’s ideological home in the 1980s and early 1990s. Thus, for example, the Health Privacy Project at Georgetown University continued to voice objections to the way in which the act would violate the privacy of medical information. Bluntly, it said, “The necessary changes…have not been made.”

George Annas, who helped to galvanize opposition to the first draft, revealed the gulf that separated those who saw limitations on liberty as central to the response to public health threats and those who were profoundly skeptical of this assumption. “We do not,” he wrote in the New England Journal of Medicine, “have to trade off civil liberties for public health to ef-
fectively respond to a bioterrorist attack.” Indeed, Annas viewed the constitutional premise upon which the act was predicated—the 1905 Jacobson v. Massachusetts decision—as part of a bygone era. Invoking the lessons of the AIDS epidemic, he concluded, “The promotion of human rights can be essential to deal effectively with an epidemic.”

The New York Civil Liberties Union (NYCLU) gave voice to the fundamental opposition that no cosmetic changes or limited adjustments could address. The act was an “anachronism,” the group said, and it failed to “fully anticipate the ways in which [it] would empower the state to violate fundamental rights and liberties.” The NYCLU challenged the revised version of the act in its every detail: The definition of what could trigger a public health emergency was still too broad; the requirement that names be used for disease reporting ignored the principle that without a demonstration of an overriding interest, such privacy-violating measures were unacceptable; the “protection of persons” clauses presumptively overrode the individual’s right to refuse medical treatment; and the act failed to incorporate procedural protections already available in some states, including New York. Finally, the limited scope of judicial review on matters of treatment, testing, isolation, and quarantine “constituted a fundamental and fatal” flaw in the act, in the NYCLU’s view.

A philosophical and political divide. In some measure the gulf between Gostin and the MSEHPA proponents and their antagonists might be thought of as empirical. How likely is a bioterrorist act? What degree of harm and suffering might follow such an assault? In the event of such an assault, how much coercion, and what degree of control, would be necessary to limit the disastrous consequences? What would be the least restrictive but still effective alternative? These are matters that in principle can be subject to careful analysis involving statistical modeling, as Edward Kaplan has so forcefully shown in his discussion of the options available to confront the possibility of a smallpox attack.

At a deeper level, the clash between Gostin and his allies and those who view their work as anathema is philosophical and political. It resides in very different perspectives on the appropriate posture in the face of the exercise of state power that would be rights-depriving, liberty-restricting, and privacy-limiting. For the opponents of the model act—on both the left and the right—skepticism was the appropriate stance. The entire history of public health and criminal law demanded nothing less. After all, the challenges of the 1970s that asserted the rights of individuals were often against authority exercised for putatively benign ends—in the interests of mental patients, juveniles, and other dependent populations. More important, the model act was being proposed at the very moment when, in the name of the struggle against terrorism, the U.S. attorney general had put forward a set of proposals with profound implications for the rights of citizens and noncitizen residents of the United States.

Proponents of the model act, like Gostin, believe that the critics have lost the capacity to understand the difference between docs and cops, between public health interventions and police dragnets. Most important, they have lost the capacity to trust in officials charged with the responsibility of protecting the people’s health. While in criminal law it might be appropriate to adopt the maxim, “Better that ten guilty men go free than one innocent man be deprived of liberty,” in public health the precautionary principle dictates an interventionist stance designed to forestall disaster.

No easy bridging of these worldviews is possible, and indeed efforts to paper over the difference—were this possible—would be a profound mistake. What we need now is to confront the clash of philosophical outlooks with candor, taking rights seriously but considering the claims of public health with equal gravity. Only then will the current moment serve to inform a public debate that all too easily can be suffused by cant.
NOTES


