POLICY FORUM: PUBLIC HEALTH

Public Health vs. Civil Liberties

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The history of American public health is punctuated by controversies over the extent to which government may legitimately impose restrictions on liberty in the name of the common good and over the extent to which protection of the public's welfare has served as a pretext for erosion of fundamental rights. The shattering of the illusion of American continental impregnability by the events of 11 September 2001, and by the subsequent anthrax scare have again provided the occasion for a debate over core values of public health, as proposals were made to enact a model emergency health powers act that would have radically enhanced the power of the state.

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In the late 1990s, the threat of bioterrorism surfaced as a concern of public health officials and experts (*1*, *2*). Of special concern were inadequacies of the existing public health legal infrastructure. After 11 September, the Centers for Disease Control and Prevention called on its Collaborating Center for Law and the Public's Health at the Georgetown Law Center and the Johns Hopkins University School of Public Health to quickly prepare a model public health emergency act as a template to assist state legislators in updating their laws. On 30 October, a model act was released to the public (*3*).

In the face of challenges that posed a "substantial risk of a significant number of human fatalities or incidents of permanent or long term disability," state governors were to be given the authority to declare a public health emergency, if necessary, without consulting public health officials. Governors could mobilize state militia and initiate a range of extraordinary measures that would last for 30 days and could then be renewed. The state legislature could intervene to override the executive decision only after 60 days and only by a two-thirds vote of both chambers. Health-care providers, medical examiners, and pharmacists would be required to report to public health authorities within 24 hours the name and other identifying information of individuals with conditions that could be related to bioterrorism or other fatal or dangerous infectious agents. The public health authority would be granted the right to "compel" individuals to undergo medical examination, testing, and vaccination or treatment. Those who refused were to be liable for misdemeanors and subject to isolation or quarantine. Health-care providers who refused to be party to such interventions were subject to criminal prosecution. In all, the act was a stark expression of the view that a public health emergency might necessitate the abrogation of privacy rights, the imposition of medical interventions, and the deprivation of freedom itself.

Although some lawmakers endorsed the model act and moved swiftly to introduce versions of it in their state legislatures, many policy-makers and health advocates viewed it as a grave threat. Notable were proponents of civil rights and liberties, those committed to protecting the privacy of medical information, and AIDS advocacy groups. George Annas of Boston University described the act as "the old Soviet model of public health (lots of power and no standards for applying it)" (*4*). The Association of American Physicians and Surgeons denounced the act, which "turns governors into dictators," permitting them to "create a police state by fiat" (*5*). Finally, with its authorization of mandatory vaccinations on penalty of criminalization and quarantine, it was inevitable that the act would draw the ire of antivaccination advocates (*6*).

Cosmetic and substantive changes were evident in the second draft, released at the end of 2001 (*7*). For example, the act's subsection that described "control" of property and concerned those who viewed it as an invitation to unwarranted seizures, was now softened to "management" of property. The subsection dealing with compulsory powers over individuals was no longer termed "control of persons," but "protection of persons." The new draft eliminated references to "epidemic and pandemic diseases" as events that could warrant declaring a public health emergency, as critics had asserted that the flu and AIDS could trigger such a declaration. The sweeping authority of the governor to impose a state of emergency with very limited legislative oversight was now subject to the possibility of an override by a simple majority of both legislative houses. Although mandatory reporting by name remained, some steps were taken to assure that the data would be protected from unwarranted disclosure and misuse. Criminalization of refusals to undergo treatment and vaccinations were gone, although those who declined such interventions would still be subject to isolation and quarantine. Gone, too, were criminal sanctions for physicians and other health-care providers who refused to impose treatment or vaccination, although their licensure could be endangered. The capacity to move swiftly was now surrounded by extensive due-process procedures.

These changes satisfied some of those who had opposed the first draft. However, the New York Civil Liberties Union challenged virtually every provision of the revised act, arguing that the changes that had been made were inadequate and that the limited procedural protections and judicial review left open the possibility that fundamental rights could be violated (*8*). The Association of American Physicians and Surgeons denounced the new draft as a "disingenuous effort to mute criticism." The new draft still imperiled clinicians and those who owned medical facilities whose property and talent could be "commandeered." The revised act was "still a prescription for tyranny" (*9*).

It was against a backdrop of such fervid attacks and more sober critiques that the work of state legislatures took place. Although some states considered legislation based on the revised version, others moved to adopt even more scaled-back versions. By July 2002 emergency health powers legislation had been passed in 19 states and introduced in 17 others (*10*).

The choice before us is the extent to which we are willing to limit liberty to face threats of uncertain but potentially catastrophic dimensions. In the 1980s, the AIDS epidemic had provided the occasion for the articulation of a new paradigm of public health, which contended that protecting public health and civil liberties were mutually compatible. For a behaviorally transmitted virus, it was a matter of strategic importance to engage those most at risk in the work of prevention. It was inevitable that, in the shadow of 11 September, the conflict over rights and dangers would resurface, shattering the illusion that public health and civil liberties can exist in a conflict-free relationship.

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