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Bioterrorism: Cases When Public Health Agencies Should Have Sweeping Powers

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Abstract

The dispersal of anthrax spores in October, 2001 showed Americans that they are vulnerable to bioterrorism. The ineffective response to bioterrorism demonstrates that public health agencies do not have plans or training exercises in place to deal with this emerging threat. Although the CDC asked that the Model State Emergency Health Powers Act (MSEHPA or Model Act) be drafted to prepare the states for these emerging risks, critics like George Annas assert that the acts are "blatantly unconstitutional" (MSEHPA,2005,p.1). In this paper, I intend to explore the conflict between individual rights and sweeping powers of public health agencies as described by the Model State Emergency Health Powers Act.

Introduction

Americans, accustomed to personal security, are now faced with a new reality that forces us to balance our rights of liberty and individual autonomy with the threat of terrorism.

The tragic events of September 11th and the threats of biological terrorism that followed transformed the focus of public health agencies back to prevention, detection, management, and containment of new and emerging health emergencies. In the aftermath of September 11th, the reality of larger, more sophisticated attacks against the US created a sense of vulnerability and the inherent need to strengthen the health infrastructure of this country.

After these events unfolded, the Centers for Disease Control and Prevention (CDC) requested that the Model State Emergency Health Powers Act (MSEHPA or Model Act) be drafted to shore up the Public Health System in the US in October 2001. The Act was intended to serve as a guide to help states update their legal infrastructures to prepare for and deal more effectively with acts of bioterrorism.

In response to this request, the Center for Law and the Public's Health at Georgetown and Johns Hopkins University collaborated with governors, state legislatures, health officials, and attorney generals across the country to

develop a comprehensive plan to respond to a national emergency crisis.

Lawrence O. Gostin, law and public health professor at Georgetown University, was a member of the planning team for the Model Act. He asserts that in a bioterrorism threat, our public health system should have sweeping powers over the individual liberty of the citizens of the US. "Gostin believes that the communitarian tradition of American thought, rather than the individualistic strain, must govern the appropriate balance between public health and individual liberty" (Gostin, in Levine,2006,p.351).

The topics addressed in the Model State Emergency Health Powers Act include:

- Management of property
- Data and record collections through surveillance
- Communication to the public
- Exchange of health information to prevent, identify, and investigate public health issues
- Control of health care suppliers
- Tracking of prescription drugs, including "unusual" trends
- Protection of individuals regarding mandatory examinations, vaccinations, and quarantine, and isolation

The Model Act also addresses the principles and requirements necessary to protect and safeguard the personal rights and property of citizens.

Because the power to act to preserve the public's health is constitutionally reserved primarily to the states as an exercise of their police powers, the Model Act is designed for state, not federal, legislative consideration. It provides the responsible state actors with the powers they need to detect and contain a potentially catastrophic disease outbreak, and at the same time, protect individual rights and freedoms (Gostin, et al ,2002,p.2).

The committee that drafted MSEHPA (2001) concluded that this policy balanced the public health goals of detection, management, and containment against the need to safeguard the civil rights, liberties, and property of American citizens. The first draft, intended to support the functions of public health agencies, provided overwhelming powers to state governments. This created much opposition because the ability to mitigate a massive attack was not addressed and therefore created concern for governmental abuse of power.

Gostin, et al, contend the Model Act serves as a critical tool for reform of the state public health laws and does serve its intended purpose of balancing civil liberties and the public good. It "provides a modern framework for effective planning, prevention, identification, and response to emerging health threats, while guarding against the potential excesses of government power" (Gostin & Hodge,2003, p.479). He further states that the final draft of the Act creates a delicate balance between the philosophy of public health issues and a rights-oriented perspective.

Although the act may not totally balance freedom with public good, it does recognize the tradeoffs and seeks to establish a fair resolution by defending personal and collective interests.

In opposition, George Annas, a lawyer at Boston University School of Public Health and leading critic of the MSEHPA, published an article in JAMA stating the Act does "not represent the official policy, endorsement, or views of anyone, including the US Centers for Disease Control and Prevention (CDC), or any of the organizations listed in the acknowledgements"(Annas,2002,p.1). He also stated that it was intended simply as a "draft for discussion," rather than the actual emergency plan that should be implemented by the US Public Health System.

In the JAMA article, Annas verbalized the following three objections to the Model Act:

- Bioterrorism is primarily a federal issue, not a state issue

- In a bioterrorist attack, Americans do not have to trade their freedom for the sake of security; if properly informed, physicians and the public will cooperate and comply with public health measures.
- "The arbitrary use of force by public officials with immunity from liability is incompatible with medical ethics, constitutional principles, and basic democratic values" (Annas,2002,p.2685). Annas (2002) feels the law was "blatantly unconstitutional"(MSEHPA,2005,p.1) and that it is "unnecessary and counterproductive" (Annas in Levine,2006,p.351) to sacrifice human rights when responding to a bioterrorism attack.

Annas challenges Gostin, et al, regarding the implied support of the Act and contends that every state except Minnesota has rejected it or has made major modifications. The state of Minnesota did, however, make provisions to protect the fundamental right of its citizens to refuse medical treatment, examinations, preventative programs, and vaccinations (Annas,2002,p.2685).

Annas contends the MSEHPA is a seriously flawed and inconsistent proposal that should be regularly discussed and amended as better provisions are adopted or proposed by the legislature.

Jane Orient M.D., editor of the Association of American Physicians and Surgeons newsletter (AAPS News), also published a response in JAMA in opposition to the MSEHPA proposal written and advocated by Gostin, et al. Orient asserts the Act would do nothing to improve governmental mitigation in the event of a massive bioterrorism attack. Although the original and revised versions of the Act were revised in response to criticism, she contends that state governments are given "unbridled power to seize property, commandeer resources, and force potentially misdirected treatment or quarantine on the population" (Orient,2002,p.2686).

Further, the Act would give unlimited discretion and enormous power to governors, allowing them the ability to define the public health emergency and the response to it. Orient contends the MSEHPA has the potential to create a mechanism for massive governmental abuse and does nothing to address or correct the pervasive unpreparedness that currently exists in the public health system.

Sue Blevins, President of the Institute for Health Freedom, also responded unfavorably to MSEHPA and cites the following objections to the proposal.

The initial proposal, drafted on October 23, 2001, "will impact our individual freedoms and civil liberties for years to come. Such legislation could affect citizen's individual freedoms and property rights" (Blevins, 2002, p.1). She contends that the model act contains coercive provisions; that "we can and must find a better way to defend citizens against bioterrorism while protecting our precious individual freedoms" (Blevins,2002,p.4).

When the proposal was posted, several of these groups listed issued strong denials of their participation and collaboration in preparation of the proposed law. In addition, it was disclosed that Gostin, et al, did not consult with the public, public health officials, or constitutional law experts when drafting this proposal.

The Association of American Physicians and Surgeons claimed the law changed existing public health laws and could allow governors to turn into dictators by empowering them to violate fundamental rights and liberties. Phyllis Schlafly described it as "an unprecedented assault" (MSEHPA,2005,p.1) on the rights of American people.

Gostin countered by stating that "the threat of bioterrorism makes it imperative to reframe the balance between individual interests and society's need to protect itself so that the common good prevails" (Gostin in Levine,2006,p.350).

In response to criticism, the proposal was rewritten by Gostin,et al, and re-issued in December, 2001. The second draft deleted "in collaboration" and changed the verbiage to "assist" the various associations in a public health emergency. In spite of these changes, Annas verbalized that all the fundamental problems, core concerns, and vague standards still remained, allowing for "arbitrary and capricious decisions" which can undermine the public's trust in public health authorities (Annas,2002,2685).

Analysis

The events of September 11th underscored our vulnerabilities and created a call to action for every citizen in the United States. As citizens, it is our right and responsibility to demand that our local, state, and federal government provide the necessary security in our communities by creating a stronger public health system that can respond quickly and efficiently to an attack by bioterrorists.

After 9/11, few disagreed that the states had a weak foundation and framework for effective public health response and action. In response, the Department of Health and Human Services, the CDC, the Institute for Medicine, and the Turning Point Public Health Statute Modernization Collaborative recommended improvement of

inadequate existing public health laws (established early to mid-20th century) citing the following reasons:

- Antiquated current laws predate modern health practice and science
- Inconsistencies within the states and inconsistencies regarding treatment of similar conditions (STDs and HIV/AIDS)
- Inadequate planning, communication, and coordination among responsible agencies
- Ineffective chain of command established for detection and response

Amid much controversy following the final release of the MSEHPA in December 2001, Gostin and Hodge (2002) reflected in an article in Public Health Reports that: The Model Act rectifies these and other deficiencies in existing public health emergency laws. The Act reflects modern constitutional standards for protection of liberty and property interests. MSEHPA authorizes government to prevent and ameliorate a bioterrorism event or other public health emergencies (p.477).

According to Blevins (2002), great concerns arose when the MSEHPA provided governors and public health officials with unprecedented powers once a public health emergency was declared:

- To force individuals to undergo examinations if suspected of harboring "infectious disease"
- To require examination and treatment, even if against one's will; imprisonment for those who refuse
- To require individuals to be vaccinated, treated, or quarantined for infectious diseases
- To seize, without compensation, private property, foods, medicine
- To control health care facilities and communication devices
- To impose fines and penalties in order to enforce commands

The attacks on our homeland clearly demonstrated the need for public health agencies to focus more on public interest than the individual rights we have become accustomed to over the previous 200 years. Traditionally, Americans have focused disproportionately on individual rights over the common good of society.

In order to reach a proper balance in the public health system, there is a continuous need to strengthen security, assess public safety, and review public health policies.

Public health agencies require a strong infrastructure to meet and conduct essential public health services at the

highest level of performance in order to match and exceed the constantly evolving threats that face our nation. Laws are necessary to protect public health.

Repair of the nation's public health system can only be accomplished with political will and economic resources. "A constitutional democracy must balance the common good with respect for personal dignity, toleration of groups, and adherence to principles of justice" (Gostin, et al., 2002, p. 10).

Conclusion

In order to test government response and raise public awareness of bioterrorism, the government simulated two biological attacks called Dark Winter (2000) and TOPOFF (2001). Both simulations revealed serious weaknesses in the public health system's response to bioterrorism and naturally occurring infectious diseases. These simulations showed that there was a lack of information systems to provide rapid dissemination of medical information; inadequate supplies of vaccines and preventative drugs; unpreparedness for mass casualty response; and a need to federalize the National Guard to maintain order.

Although both of these simulations occurred several years ago (2000, 2001), we still remain highly vulnerable and under-prepared. A seamless public health agency response still does not exist between federal, state, and local health systems.

Even though there have been other simulations since 2001, public health response to Hurricane Katrina confirmed major flaws in government agencies. The response to Katrina demonstrated a catastrophic failure in coordinating, communication, and management efforts. The failure was at all levels of government. In the first 72 hours there appeared to be no immediate action, creating a tremendous loss of confidence in the ability of our public health agencies to respond to a disaster.

Under our federalist system of government, states and localities possess public health power. Annas (2001) believes that our state laws are antiquated and that "bioterrorism should move us toward a more federalized and globalized public health system" (Annas in Levine, 2006, p. 358). Since bioterrorism is a matter of national security, it becomes a federal concern requiring specially adapted defenses.

The Model Act clearly delegates empirical powers to the governors. Although public health officials should exercise limited power over physicians and healthcare providers, the system would work more effectively and efficiently if public health officials worked together with physicians and public authorities.

At the 2003 National Congress on Public Health readiness, Dr. Julie Geberding, Director of the Center for Disease Control and Prevention, stressed the importance of a partnership between the public health and the healthcare delivery systems. She discussed the public health agency's responsibilities of planning, surveillance, communication, education, and training of the public health workforce. Preparation and response to bioterrorism requires a collaborative team approach at every level of the government.

Should public health agencies have sweeping powers over individual liberty during the threat of bioterrorism? Not if that means a delay in action by physicians and healthcare delivery systems. The lack of a speedy and effective response after Hurricane Katrina showed that the government does not have the ability to coordinate efforts by using the Model Act's paradigm of "sweeping powers."

If the government cannot respond in four days to an event that could be anticipated, how can they handle bioterrorism? The hurricane was a "well modeled situation" and there is little wonder how the public health system would respond and coordinate efforts to a biological event.

Perhaps the best way to handle future catastrophic events would be to assign control to the highest ranking stateside military general. He or she could assume the leadership role and direct the operations of FEMA, Homeland Security, and the Public Health System and coordinate all operations within the disaster area with local healthcare providers.

In fact, this happened when Vice Admiral Thad Allen, Chief of Staff, U.S. Coast Guard, was finally brought in to command the operations in New Orleans. His immediate focus was response, coordination of rescue efforts, and communication. His experience, insight, and expertise were apparent immediately, and for the first time since Katrina hit, people felt a sense of security and confidence.

In summary, improvements of the public health system are needed to respond and react to the threat of bioterrorism. Communication is critical. There must be a state-of-the-art computerized communication system that will link local, state, and federal public officials, healthcare facilities, and providers to allow for the sharing of information.

When the public health system achieves this level of expertise, organization, and preparedness, people may be more willing to relinquish their personal autonomy and individual liberties for the good of the public health. In closing, a quote from Senator Bill Frist, MD., summarizes our future challenges:

Our benchmark will be the changes we incorporate to ensure that each day, we are more able to respond because we have thought about our vulnerabilities, assessed appropriate actions, and taken steps to ensure that the next biological

attack will be met with the full force of a coordinated, well-developed, expertly trained disaster response team (Frist,2002,p.171).

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