

Bioterrorism, the Public's Health, and the Law

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FOLLOWING THE ANTHRAX LETTER attacks of fall 2001, legislators and public health officials throughout the nation began to take a closer look at the legal authorities and duties of their public health systems, and to consider whether and how to alter their laws to enable more effective responses to bioterrorism. Many began their efforts by reviewing the Model State Emergency Health Powers Act ("Model Act"), a draft law commissioned by the Centers for Disease Control and Prevention (CDC) and designed to serve as a template for new state laws establishing or clarifying the role and the power of public health systems in emergencies.¹ By October 1, 2002, 37 states had considered public health legal reform based at least in part on the Model Act, and 21 states had enacted final legislation.² In North Carolina, a new public health bioterrorism law was enacted that addressed some of the legal issues raised by the Model Act.³

These legal reform efforts have sparked a new debate about an old issue: whether, and to what extent, the rights of individuals should yield to the health needs of the public. The Model Act includes a number of provisions that have fueled the controversy. It was designed to address not only bioterrorism but also naturally occurring events that create public health emergencies. Among other things, the Model Act would authorize public health officials in a public health emergency to require individuals to submit to medical tests or examinations, to isolate or quarantine infected or exposed persons, to close or evacuate buildings contaminated with disease-causing agents, and to require healthcare providers to make their facilities available for the care of ill persons. Critics of the Model Act have described it as giving "exceptionally broad" powers to public health authorities,⁴ as providing a "blank check" for government intrusion into civil

liberties,⁵ and as lacking in fundamental safeguards.⁶ The principal authors of the Model Act have countered with the argument that, in order to contain disease outbreaks, public health officials must have the authority to prescribe and enforce disease control measures, even when those measures intrude on individual liberties. They have also contended that the protections required to ensure that governmental actions are not arbitrary or unjust are contained within the due process provisions of the Act, which permit individuals to challenge orders requiring them to submit to the directives of public health officials.⁷

A New Level of Public Health Authority

Is it true that the Model Act, and state legislation based on it, is a brave new world of unprecedented public health authority? Parts of the Model Act would indeed have public health venturing onto new terrain. The provisions authorizing public health officials to seize and direct the use of private properties, including healthcare facilities, appear unprecedented. But the provisions authorizing public health to require individuals to submit to disease control measures are neither extraordinary nor new. Quarantine was a commonly used disease control strategy around the turn of the 20th century. Although large-scale quarantine has not occurred in the United States in decades, legal authority to quarantine or isolate individuals with communicable diseases still exists in many states, including North Carolina.⁸ In states with up-to-date public health laws, the quarantine and isolation authority is limited to circumstances in which it is the least restrictive means for achieving disease control, and there are procedures by which an individual can challenge an isolation or quarantine order. Another disease control measure, mandatory immunization, has been a public health strategy since the late 1800s and maintains its legal currency. Mandatory disease control measures may be legally enforced by measures ranging from exclusion from school of unimmunized chil-

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dren to criminal penalties for persons who refuse to comply with the measures.

Historical Basis for Expanded Public Health Authority

The philosophical underpinning of laws that allow government to require individuals to act, or refrain from acting, in the interest of the public health is the idea of the “public health contract”—that is, the notion that individuals agree to limit their rights and liberties in order to gain the benefits of living in a healthy and safe society.⁹ The US Supreme Court lent legal support for the idea of the public health contract in *Jacobson v. Massachusetts*,¹⁰ an early 20th-century case that upheld the authority of a local board of health to require smallpox vaccination. In explaining its decision, the Court stated, “the liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members.”

Jacobson is an old case, and the law has changed in many ways, some quite dramatic, since it was decided. Critics of new state bioterrorism legislation have been quick to point out the most significant of those changes: the shift in dominant legal views regarding constitutional protections for civil liberties.¹¹ This is an important point, and legislatures enacting public health laws in the 21st century should heed it. It is indeed possible, perhaps even likely, that public health laws that fail to provide protections for individual rights and freedoms would fall to a constitutional challenge. However, this does not mean that public health laws may never require individuals to act, or refrain from acting, when those actions are necessary to protect the public. Rather, it means that lawmakers and public health officials should be aware of the importance of assuring that legal requirements are not arbitrary or unjust, either in general or in application to a particular individual, and should build protections for individual liberties into both law and public health practice.

Other Criticisms of the CDC's Model Act

Other important ideas have emerged from the criticism of the Model Act and other legislative efforts. Public health bioterrorism laws should be founded upon the assumption that the public and the healthcare professions will cooperate with public health authorities in an emergency.¹² At the same time, however, it is foreseeable that some individuals will

choose not to cooperate and that their noncooperation could endanger others. Laws need to take account of that possibility as well. Some critics have pointed out the importance of respecting individuals' health privacy rights and providing legal protections to assure that information acquired by public health systems in its disease control efforts is protected and not improperly redisclosed.¹³ Finally, the critics have made the crucial point that the public health system cannot operate effectively without the public trust, and laws must be crafted that will promote rather than undermine that trust. If legal provisions grant authorities that are widely perceived as too intrusive or too likely to be abused, public trust in public health is jeopardized.¹⁴

New Legislative Actions in North Carolina

In North Carolina, the General Assembly has enacted three laws in response to the events of fall 2001: one imposing new criminal penalties for the use of biological, chemical, or nuclear weapons;¹⁵ one requiring laboratories and industries that maintain or use certain biological agents to report specified information to a biological agents registry;¹⁶ and one providing new authorities and duties to state and local public health officials to detect and control public health threats caused by bioterrorism.¹⁷ The latter law addressed some of the issues raised by the Model Act, but did not adopt any portion of the Model Act as written. It also included “due process” provisions explaining how individuals can have orders of public health officials reviewed by a court.

North Carolina's new public health bioterrorism law gives the state health director several new authorities, which may only be exercised when a health threat is known or reasonably suspected to have been caused by bioterrorism. In such events, the director may require individuals suspected of being infected or exposed to an infectious agent to submit to examinations or tests or to be quarantined, may isolate or quarantine infected or exposed individuals, and may order the evacuation and temporary closing of buildings or other properties in order to investigate their possible contamination. Due process protections for individuals affected by these actions are built into the law. Individuals may challenge the health director's orders in court. Indigent individuals are entitled to court-appointed representation. Orders of quarantine or property closure may not extend beyond ten days without a court's approval.

The new law also has several new provisions designed to help public health officials detect a health threat caused by bioterrorism. As Dr. Cline describes elsewhere in this issue,¹⁸ early detection of a health problem caused by an act that is likely to be covert is a particularly important element of an effective public health response. The provisions of the new law supplement existing North Carolina laws that require

physicians and others to report communicable diseases—including diseases that bioterrorists may be particularly likely to use, such as anthrax and smallpox—to public health officials.¹⁹ One new provision authorizes the state health director to temporarily require healthcare providers to report certain symptoms or conditions in a known or suspected bioterrorist event. Another authorizes, but does not require, healthcare providers to report symptoms or illnesses that are not on the required disease reporting list when the providers have reason to believe the symptoms or illness indicate that a bioterrorist attack may have occurred. Public health officials who receive the information are bound by an existing state confidentiality law that allows them to further disclose

the information only as necessary to contain the disease threat.²⁰ Another existing law imposes criminal penalties for unauthorized redisclosures of the information.²¹

The new law addresses some of the criticisms of the Model Act and appears to seek a balance between public health goals and individual liberties in a bioterrorist attack. Public health authorities are empowered to issue orders, but individuals are simultaneously empowered to challenge them. Public health officials are entitled to obtain an individual's private health information but are constrained from using or disclosing it inappropriately. Will the balancing act work? Since the major provisions of the new law will only apply in a bioterrorist attack, we can only hope we never find out.

REFERENCES

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- 10 197 US 11 (1905).
- 11 Annas, supra note 4, at 1340.
- 12 Idem at 1338.
- 13 Goldman, supra note 6.
- 14 Annas, supra note 4, at 1340-41; see also Hall, supra note 5; Goldman, supra note 6.
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- 16 SL 2001-469, codified at NC Gen Stat 130A-479.
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- 18 Cline JS. North Carolina public health responds to bioterrorism. *NC Med J* 2002;63:XXXX.
- 19 NC Gen Stat §§ 130A-135 through 130A-139; 15A NC Admin Code § 19A.0101.
- 20 NC Gen Stat § 130A-143.
- 21 NC Gen Stat § 130A-25.

Erratum

The Editors of the Journal wish to acknowledge a regrettable error in our last issue (Volume 63, Number 4) on "The Place of Primary Care." In the Introduction by Gordon H. DeFries, credit is mistakenly given to Kerr L. White for authorship of the 2001 article appearing in the *New England Journal of Medicine*, updating data pertaining to the famous diagram by Kerr White, T. Franklin Williams, and Bernard G. Greenberg. The article mentioned, and correctly cited except for author credits, was published by Larry A. Green, George E. Frayer, Jr., Barbara P. Yawn, David Lanier, and Susan M. Dovey. This article, published as an "Occasional Note" in *NEJM*, adds both clarity and an important extension of the White-Williams-Greenberg analysis, as well as further demonstrating the validity of the original idea first published more than forty years ago. Our apologies to our readers, and to the authors of this important paper.