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POLICY FORUM

The Turning Point Model State Public Health Act—Emergency Public Health Law versus Civil Liberties

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The attacks on the World Trade Center in September of 2001 and the intentional dispersal of anthrax via the U.S. postal system during the same year illuminated the deficiencies of United States public health preparedness. In an attempt to resolve deficiencies in planning, coordination and communication, surveillance, management of property, and protection of persons during a public health emergency, the Turning Point Model State Public Health Act (MSPHA) was created. While the MSPHA has influenced the creation of legislation across the country since 2001, there continues to be controversy surrounding the act's infringement on civil liberties.

Background: Turning Point Model State Public Health Act

At the request of the Centers for Disease Control and Prevention, the Centers for Law and the Public's Health at Georgetown and Johns Hopkins Universities presented a draft of the Model State Emergency Health Powers Act (MSEHPA), which they explained was "designed to serve as a tool for state, local, and tribal governments to use to revise or update public health statutes and administrative regulations" [1], in October 2001. The original draft was revised due to criticisms and completed on December 21, 2001. The document was revised further by the Turning Point National Collaborative on Public Health Statute Modernization, funded by the Robert Wood Johnson Foundation as part of its Turning Point Initiative, and a final draft was released on September 16, 2003.

Believing that law has long been accepted as an important tool of public health [2, 3], the MSPHA's authors recommended that state public health laws be reformed to serve that purpose effectively. Current state laws are inconsistent across states [2], outdated in their understandings of disease, and predate changes in constitutional (e.g., equal protection and due process) and statutory (e.g., disability discrimination) law [2]. As the Centers for Law and Public's Health states, "The MSEHPA grants public health powers to state and local public health authorities to ensure a strong, effective, and timely planning, prevention, and response mechanisms to public health emergencies (including bioterrorism) while also respecting individual rights" [4].

Points of Contention

One of the most outspoken opponents of the MSEHPA, on which Article VI of the Turning Point Model is based, is George Annas, who eloquently outlines a few of the most popular objections to the act: (1) bioterrorism is inherently a federal issue, and

only secondarily a state issue; (2) the premise that Americans must trade freedom for security in the event of a bioterrorist attack is wrongheaded, as is the presumption that the public and physicians would not cooperate except under threat of law; and (3) the arbitrary use of force by public officials with immunity from liability is incompatible with medical ethics, constitutional principles, and basic democratic values [5, 6].

The authors of the MSEHPA responded to the objection that bioterrorism is exclusively a federal issue. They point out that, while the federal government has an important role in bioterrorism, states and localities would be the first to detect an outbreak and be critical in its containment.

In regards to Annas's third objection, the fear of public officials acting with immunity from liability is real, and the act goes partway toward addressing that possibility in recommending separation of power. While the governor is able to declare a state of public health emergency under a set of predetermined guidelines, the legislature can terminate this state of emergency at any time, and such termination will override any renewal by the governor [7]. Processes for discipline or punishment for abuse of power by the governor or any public health agency can be examined under each state's constitution. One of the most elegant constructions of the MSEHPA is the division of power among the different branches of government.

Annas's concern over the degree to which our civil liberties need to be restricted to protect the public as a whole during a state of a public health emergency is valid. It is easier to take away the civil liberties of someone who has committed a crime than to remove someone's freedoms because he or she had the misfortune to become infected with a deadly, contagious virus. Our society does, however, have a precedent for restricting civil liberties when persons are placing the health of others at risk—tobacco laws. We limit individuals' freedom to smoke tobacco in certain public areas, for example, because we deem it a health risk to innocent bystanders. But being infected with a deadly virus is a bit different. The victim did not choose to become infected or to infect others. The authors of the act recognize this ethical dilemma—penalizing people for circumstances beyond their control—and reply that “the MSEHPA provides carefully crafted safeguards of personal rights; indeed the standards and procedures in the MSEHPA are more rigorous than those in many current public health statutes” [8].

Another ethical concern raised by the act is compliance during a state of public health emergency. Is the public more likely to comply with state or agency orders if they are merely asked to do so or if there are legal consequences for noncompliance? People in the U.S. are not mandated, for example, to vaccinate themselves or family members. While one might think that this is a personal choice, it is not that simple. The unvaccinated person risks not only his or her own health, but also the health of others. Those who choose not to be vaccinated may become infected and act as reservoirs and vectors of disease. The unvaccinated person may even infect others who have been vaccinated because immunity wanes over time.

Certain illnesses remain in our communities because less than 100 percent of the public chooses to be vaccinated. That said, a good percentage of America does accept vaccinations voluntarily. In 2008, 76.1 percent of eligible American children completed the entire childhood vaccination series [9]. The level of trust in medical recommendations is high enough that our childhood vaccination recommendations have been successful. We have been able to limit infections such as diphtheria, *Haemophilus influenzae*, polio—even pneumococcus and more deadly diseases. Would compliance be improved if vaccinations were law? This is what the MSEHPA’s authors suggest.

Annas cites the example of the postal dissemination of anthrax to illustrate public acceptance of the medical community and government guidelines. During the anthrax infections in 2001, emergency departments and physicians’ offices were flooded with people looking for testing and prophylactic antibiotics. This was not mandated by the government at the time. The authors of the act believe that most people will comply with public health advisements, but that “common sense suggests that public health officials may need adequate authority to avert a significant risk” [8].

The danger of mandating vaccinations or treatments during a public health emergency is that it may increase mistrust in the government. Why would the government need to mandate a treatment that is in the public’s best interest? The enforcement of a mandate may backfire and result in less public compliance. The authors understand this delicate balance between mandate and guidelines to achieve the best rate of compliance and still believe the MSEHPA is needed.

The authors of the act should be applauded for their attempt to update public health policy for the current times; they produced a quality manuscript. But the MSPHA is not a one-size-fits-all model. It needs to be modified for each specific state and cause to which it is applied.

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