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A Model for Medical Tyranny

The Model State Emergency Health Powers Act Violates Numerous Rights

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Health Care

In the wake of September 11, every state has been asked to enact a law providing for unprecedented, comprehensive health surveillance and medical martial law.

The Model State Emergency Health Powers Act, proposed by the Centers for Disease Control and Prevention (CDC), would provide a state's governor with sole discretion to declare a public-health emergency. Once the emergency was declared, public-health officials would assume police powers, the militia would be mobilized, and the legislature would be prohibited from intervening for 60 days. Any new orders and rules issued by the governor would have the full force of law. Existing laws and individual rights could be suspended.

To promote the legislation, state officials and legislators have related it almost exclusively to the threat of bioterrorism. But broader authority is proposed. The new powers would be authorized during any declared public-health emergency. An emergency could be declared with the occurrence or imminent threat of a health condition or illness that is believed to be caused by bioterrorism, or the appearance of a novel, previously controlled, or previously eradicated infectious agent or biological toxin. That belief is the only criterion. And although there must be potential for a large number of people to be affected, there is no

definition of “large number.” The governor, in consultation with health officials, would decide.

The 40-page proposal would require individuals to submit to state-ordered vaccinations, examination, testing, treatment, and specimen collection. Resisters would be charged with a misdemeanor and quarantined. Physicians and other health-care professionals would be required to perform medical procedures or be charged with a misdemeanor.

Quarantine, or isolation, could be imposed without a court order, although an order would have to be obtained “promptly” thereafter. Medical care could be rationed or withheld; private property could be taken or destroyed; compensation for loss of property would be limited; and no person acting under the orders of government officials would be held liable for death, injury, or property damage.

The names, addresses, and physical conditions of, and any other necessary information about, individuals suspected of harboring diseases or health conditions that might have been caused by bioterrorism or an epidemic would have to be reported immediately by doctors and pharmacists. No patient consent or notification would be required.

The public first got wind of the government’s plan when the CDC published a draft proposal last October. What began as a murmur of concern through e-mail soon became a wave of opposition around the country. The Health Privacy Project at Georgetown University took the first shot. It sent a letter to Lawrence Gostin, author of the proposal and director of the CDC’s Center for Law and the Public’s Health at Georgetown University. The letter attacked the draft’s lack of definitions for “epidemic” and “pandemic,”

terms critical to determining when an emergency could be declared. It also expressed concern over the "breathtakingly expansive scope of the definition of 'public health emergency.'"[1]

Final Details Unveiled

On December 21, the CDC unveiled its final proposal. Responding to public criticism, the wording had been softened and the definitions made less vague, but there were few substantive changes. In fact, some sections are more egregious than before.

Due process is virtually eliminated. Health officials could pluck citizens out of their homes, place them in quarantine, and need not apply for a court order until ten days later. Nothing specifically would prevent officials from using quarantine or its threat to coerce individuals into submitting to medical procedures they would otherwise refuse. And although a court hearing would be required 48 hours after the court order was received, health officials could request a delay.

Doctors, other health professionals, and health-care institutions would also face coercion. If they refused to follow state-ordered medical directives, officials could strip them of their licenses to practice or operate in the state. On the order of an official, those who take an oath to protect patients might be compelled by state law to harm them (such as by administering a vaccine or performing a high-risk procedure). If a physician questioned directives, followed his conscience, advised citizens to refuse, or obstructed the plans of state officials, he could end up flipping burgers to support his family.

Additional provisions of the final proposal are just as alarming. Isolation of the sick and quarantine of the exposed must be in different locations, assuring the separation of children and parents. As in the first draft, state officials could ration care, initiate continuing health surveillance, commandeer and control medical supplies, and confiscate personal property. And although the misdemeanor charges were dropped for citizens who don't comply with medical procedures, those who refuse to submit to quarantine and isolation could still be charged with a crime.

The media soon sounded the alarm. By January 2002, the *San Francisco Chronicle* had warned of endangered civil rights. *Investor's Business Daily* called the bill "unhealthy tyranny." Jewish World Review said it is a "prescription for disaster," and the *Wall Street Journal* reported that a "new battleground" had been created between health officials and civil libertarians. In early April, *Time* magazine covered the issue of detention powers in an article aptly titled "Mr. Quarantine, meet Miss Liberty."

Public-policy groups began to rally their constituents. The American Legislative Exchange Council (ALEC), a group of 2,400 conservative state legislators, opposed the model act and set up a Web page to track the legislation in every state.[2] The Eagle Forum dedicated an entire radio program to the issue. The Free Congress Foundation denounced the act as a "bad idea." The Association of American Physicians and Surgeons expressed concern about granting governors "dictatorial power." And the Institute for Health Freedom warned of "new state medical police powers."

Proposal Defended

Gostin defended the proposal's purported modernization of the public-health laws. In the December *Insight* magazine he claimed the September

11 attack had one silver lining: “The political community is coming together with a clear determination to protect the civilian population from harm.”[3]

In a classic doublespeak, Gostin also claimed that data-privacy safeguards would be in place. But his proposal would permit state public-health agencies to share an individual’s medical information with law-enforcement officials, other government agencies, and public-health officials in other states.

The CDC reportedly agreed to pay Gostin $300,000 a year for up to three years to write the model act.[4] He is professor of law at Georgetown and Johns Hopkins universities and sits on the Institute of Medicine’s Committee on Assuring the Health of the Public in the 21st Century.

Expanded health powers have long been on Gostin’s agenda. The CDC Center for Law and the Public’s Health, which he heads, spent the past couple of years culling existing state public-health laws in order to write a uniform comprehensive law that all states could enact. In 1998 Gostin co-wrote a paper proposing that states provide health officials with “a broad and flexible range of powers. By equipping public health authorities with graded powers ranging from isolation, quarantine, and directly observed therapy to cease-and-desist orders or mandated counseling, education, or treatment, authorities will be able to tailor interventions to the specific situation and disease threat.”[5]

Health surveillance is the key. To identify emerging health threats, Gostin claims government officials must be empowered to monitor the most minuscule medical details of American life. “If there’s a run on anti-diarrhea medications, how would [the federal government] know that?” Gostin

asked.[6] Therefore, the health-powers proposal would require an active disease-surveillance system, forcing doctors, hospitals, and pharmacists to share patient data with state health officials.

The Bush administration likes the idea of health surveillance, and in January the Department of Health and Human Services made $1.1 billion available for bioterrorism preparedness. Federal funding will be directed to, among other things, the development of round-the-clock disease-reporting systems involving hospital emergency departments, state and local health officials, and law enforcement.[7]

Thus far, Arizona, Florida, Georgia, Louisiana, Maine, Maryland, Minnesota, New Hampshire, South Dakota, and Utah have passed versions of the CDC proposal. Nine states-Connecticut, Idaho, Kentucky, Mississippi, Nebraska, Oklahoma, Washington, Wisconsin, and Wyoming-have defeated similar legislation. In 13 states, bills are pending in the legislature, and officials in five more are considering whether to introduce legislation.[8]

Battle in Minnesota

In Minnesota, where several citizen health-policy organizations exist, the legislative battle was intense. While the commissioner of health tried to shepherd the bill to passage by personally attending every hearing, citizens repeatedly testified against it. Health-care professional associations were unethically silent, asking only for immunity from lawsuits.

The original 44-page bill was cut to nine pages in the Senate and 11 pages in the House. Requirements that health-care professionals provide, and citizens submit to, medical examinations, vaccination, and treatment were deleted. A right to refuse such procedures was added. Legislators

demanded authority to rescind the governor's declaration. And a provision allowing the governor to endow a "designee" with the governor's authority to issue orders and write rules was removed.

The legislature initially voted to return the bill to conference committee–a signal that the bill was dead. However, last-minute amendments to appease gun owners and AIDS activists were added and the bill passed on the final day of session. The legislation allows broad declaration authority for public-health emergencies, commandeering of private property, unprecedented empowerment of the governor, and year-around authority to impose quarantine and isolation-without a court order or declaration of a public-health emergency.

The potential effectiveness, or lack thereof, of the CDC's heavy-handed proposal has received little attention. The inauspicious, at times violent, history of martial law has been ignored. Disregarding human nature and all wisdom to the contrary, health officials continue to march a top-down command-and-control proposal across the nation.

Public trust requires thoughtful contingency plans that uphold constitutional rights and freedom of conscience, support medical ethics, and encourage voluntary cooperation with disease containment strategies. State legislatures should not rush to enact ill-conceived, ineffective legislation. Public policy must always recognize and respect the rights, dignity, and intelligence of individuals. An angry public is not a cooperative public. If health officials are empowered to harm the very people legislators want to protect, a public-health emergency may soon become a crisis of the public's trust.

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Notes

1. Letter from Health Privacy Project to Lawrence O. Gostin, November 7, 2001.

2. See www.alec.org.

3. Lawrence O. Gostin, "YES: New Laws Are Needed to Enable Federal and State Agencies to Work Together in an Emergency," Insight, December 18, 2001.

4. Meryl Nass, "The Model Emergency Health Powers Act Creates Its Own Emergency," redflagsweekly.com, April 8, 2002; www.redflagsweekly.com/nass/2002_april08.html

5. Lawrence O. Gostin et al., "Improving State Law to Prevent and Treat Infectious Disease," Milbank Memorial Fund, 1998, p. 2.

6. Quoted in Matt Mientka, "CDC Releases Model Bioterrorism Law," U.S. Medicine, December 2001.

7. "HHS Announces $1.1 Billion in Funding to States for Bioterrorism Preparedness," HHS Press Release, U.S. Department of Health and Human Services, January 31, 2002.

8. See the map at the American Legislative Exchange Council website, www.alec.org.

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