

Public Health and Individual Rights

Tuesday May 9

- Reading:* Wendy E. Parmet, Richard A. Goodman, and Amy Farber, "Individual Rights versus the Public's Health -- 100 Years after *Jacobson v. Massachusetts*," *New England Journal of Medicine* 352 (17 February 2005): 652-654.
- James Colgrove and Ronald Bayer, "Manifold Restraints: Liberty, Public Health, and the Legacy of *Jacobson v. Massachusetts*," *American Journal of Public Health* 95 (April 2005): 571-576.
- George J. Annas, "Bioterrorism, Public Health, and Civil Liberties," *New England Journal of Medicine* 346 (25 April 2002): 1337-1342.
- Mark Fritz, "A Doctor's Fight: More Forced Care for the Mentally Ill," *Wall Street Journal* (1 February 2006).
- Marc Santora, "City Orders Labs to Submit Data From Tests of Diabetics," *New York Times* (15 December 2005).

These readings open up a new set of questions. Last week we discussed (1) how to allocate scarce resources and (2) whether individual's responsibility for their illnesses should have consequences on health care decisions. Instead of asking who should have access to health care, these readings ask who can be forced to receive health care. Can the government force people to be vaccinated? Can it forcibly inject antipsychotic medications into non-consenting adults? How should the government respond to the growing burden of obesity, diabetes, and heart disease? At broader levels, these readings have many connections to last week's topics. What is the extent of the government's power to make individual-level health care decisions (e.g. about vaccination, organ allocation, or Terry Schiavo)? What consequences should there be for "irresponsible" behavior?

Although there are a bunch of readings -- five total -- they are all short, for a grand total of 18 pages. It should not take long to read each carefully. The article by Colgrove and Bayer is most important.

Parmet, Goodman, and Farber, "Individual Rights versus the Public's Health": This short article, by three legal scholars, discusses the events that led to one of the most important Supreme Court cases of the 20th century: *Jacobson v. Massachusetts*. The case began in Cambridge, which passed a compulsory vaccination ordinance during a smallpox outbreak in 1902. Why did the city Board of Health pursue this policy? Why were Henning Jacobson and other antivaccinationists so opposed to vaccination for smallpox? Smallpox vaccine is derived from cowpox, an infection of cows; the vaccine itself was produced by growing it on the skin of cows. How does this detail figure in the debate? Do you think there would be less resistance to a recombinant smallpox vaccine (which does not yet exist)?

Colgrove and Bayer, "Manifold Restraints": Colgrove and Bayer, both historians of public health policy, discuss the *Jacobson* case and situate it within the history of public health policy over the 20th century. This article is full of important material. It describes the legacy of the case, as with its use as a precedent in *Buck v. Bell* (if this case doesn't ring a bell, review your notes from April 4). It explains the reasoning of the US Supreme Court's decision to uphold compulsory vaccination: are you convinced by Justice Harlan's arguments? It then traces a curious history: once compulsory treatment was validated, it more or less disappeared from public health policy until the 1960s. Why did governments turn back to compulsory health policies in the 1960s? How did they move from concern with infections to concern with individual behaviors? -- John Knowles (this name should really ring a bell) plays a prominent role here. In 1972 a court in Massachusetts upheld laws that required motorcyclists to wear helmets: are you convinced by the logic of the decision? Will it ever be possible to remove the tension between individual health and civil rights?

Annas, "Bioterrorism, Public Health, and Civil Liberties": In the wake of the anthrax attacks in October 2001 (still unsolved), federal and state governments wanted to enact laws that would give them more powers in the event of future bioterrorist attacks (a public health equivalent of the Patriot Act). The CDC released a proposed law that all states could adopt, the "Model State Emergency Health Powers Act." Annas, and many other public health experts, thought the model act was a terrible one (this episode is discussed by Colgrove and Bayer on p. 575). He published this critique of the model act in April 2002 (just six months after the attack). What are his concerns with the proposed legislation? What does he see as the lessons and legacies of *Jacobson v. Massachusetts*? What kind of measures would Annas support to prevent and contain bioterrorism? Do you agree with Annas, or would you support the proposed model act?

Fritz, "A Doctor's Fight": As Colgrove and Bayer describe, public health law, which traditionally addressed infectious diseases, has diversified over the past fifty years to regulate a variety of non-infectious diseases. The most controversial area (not just because of Tom Cruise) has been mental illness. As described in this article from the *Wall Street Journal*, there is a widespread public perception that people with mental illness, especially schizophrenia, are violent and dangerous. There have also been a series of high-profile cases of people killed by patients with untreated schizophrenia. These cases led many states to adopt strict laws that allow forced treatment of patients who are potentially dangerous. Is it ever appropriate to force treatment on an individual? Does it matter whether or not the person has a history of being violent, or does potential violence justify intervention? What data would help you make these decisions?

Santora, "City Orders Labs": Diabetes, which was a rare disease in 1900, has emerged (hand-in-hand with obesity) as one of the major health challenges for the 21st century. There are two main types of diabetes: type I diabetes is an autoimmune disease (mix of genetic risks and environmental triggers) that often

begins in childhood; type II diabetes is usually an adult-onset disease that occurs when obesity disrupts normal physiological mechanisms. Both cause enormous suffering, disability, premature death. Type II diabetes is far more common and is a major cause of rising health care costs; most policy efforts focus on type II diabetes. In theory, there is excellent treatment available for both forms: careful control of diet, regular exercise, and very close monitoring of blood glucose levels (e.g. 4-6 fingersticks a day, adjusting insulin dose as needed). In reality, very few people are able to manage such a rigorous regimen, even though there is good data showing that it prolongs lives. Given the suffering, the costs, and the treatment, governments are interested in identifying the people having the most trouble managing their diabetes, and helping them to do a better job. This short piece from the *New York Times* describes New York City's first-in-the-nation program. It raises a host of questions for bioethics -- Santora only scratches the surface. Is this violation of privacy justified by the need to control the "epidemic" of diabetes? Does it matter if the government's motivation is to improve health or to decrease health care costs? Is this a slippery slope: will the government impose penalties on patients who are non-compliant with diabetes treatment, or start requiring doctors to report patients who are overweight? What responses are appropriate for managing the growing burden of behavior-related chronic disease? The readings by Knowles and by Colgrove and Bayer provide helpful perspective on these questions.