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Bioethics and COVID-19: the Tension of Quarantine and Civil Liberties

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COVID-19 variant and coronavirus awareness are recent events in the eyes of the general public, but human strains of coronavirus have long been identified as causes of upper respiratory infections, a.k.a. “colds”¹. As a species we have lived a long time with colds, with infectious events. Disease and illness associated with civilization are older than written history. In public health parlance we have gone through the “Epidemiologic Transition”, defined as the statistical switch from the “untreatable” contagions and the great historic calamitous pandemic plagues of our ancestors (such as bubonic plague, smallpox, cholera, dysentery, the Black Death, typhus, syphilis, poliomyelitis, etc.) to the “modern” problems of deterioration and aging: cancer, heart disease, lung disease, dementia, metabolic diatheses, and physical accidents², amongst others. Infectious events have fallen off the public’s radar as untreatable issues, are seen as treatable, or solvable, which may explain why COVID-19 is so frightening: a brand new infectious agent that transmits quickly and efficiently and threatens to engulf us.

Coronaviruses in addition to causing the common cold are suspected of causing diarrheal and other gastrointestinal illnesses in humans. They have a singular talent for recombination, for absorbing stray bits of genetic material. In 2003, Dr. Susan Baker, a virologist at Loyola University in Chicago, observed that “with high frequency recombination, you always have potential for a new virus to emerge.” She was referring at that time to SARS, linked to the coronavirus family, determined to be of Chinese origin, with a lethality of 3 to 5%. One day, virologists warned, the recombination tendency of coronavirus family might suddenly turn a benign coronavirus into a deadly one³.

Foundations of Current Public Health Law

It is the legacy of the events of late 2001 that revealed our nation’s vulnerability to the threats of biological, chemical, nuclear and radiological assaults. Consequent extensive efforts to prepare for such contingencies became the focus of the Department of Homeland Security. The arena of preparation addressing the safety of Americans from modified infectious diseases (such as Anthrax or Smallpox as “weapons”) became the responsibility of the Department of Health and Human Services. Efforts to address these concerns were described by A. Fauci et al in the May 20, 2004 *New England Journal of Medicine*. The emphasis was to be on surveillance plus activities to promote public health awareness, led by the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), particularly the National Institute of Allergy and Infectious Diseases (NIAID)⁴.

Americans were directed on preparation for a potential infectious disease event through assorted public health agencies (both federal and state) that advocated increased surveillance and mandated reporting of PUI (Persons Under Investigation) by providers to LHD (Local Health Departments)⁵ and epidemiological methods. It had been asserted that isolation and quarantine would provide an adequate response to an infectious event.

The threat of a pandemic and the legacy of the post-9/11 anthrax attacks changed public health regulations in the United States. The responsibility for public health is a primary defined duty and responsibility of the states ever since the founding of the Republic. The former colonies delegated powers to the federal government in the U.S. Constitution while they retained the authority to protect the public’s health and safety, referred to as the state’s “police powers”⁶. The federal government affects the public’s health and safety through its constitutional authority to spend

money, regulate commerce, and provide for the national defense. The Congress established the Public Health Service and CDC with federal money and used its authority under the commerce clause of the Constitution to establish the FDA. The creation of these federal agencies, however, did not alter or preempt the states' responsibilities for public health. The post-9/11 anthrax attacks did.

Driven by concern over the use of weaponized microbes, such as anthrax or smallpox or plague, broadly described as “bioterrorism”, and under the aegis of the CDC as the coordinating agency to develop our responses to bioterrorist activity, the CDC developed the *Interim Smallpox Response Plan and Guidelines*. This provided direction to state and local health officials for “responding” to an intentional infectious event, such as smallpox. In their own words: “the document ... (defined) the CDC’s strategies and approaches for **responding** (CDC emphasis) to a smallpox emergency.”⁷ The plan calls for post-exposure vaccination and monitoring of a “ring” of people around each identified case (of smallpox) and thereby preventing the spread of disease.

The scenario developed from deployment of a contagious infectious agent in the unprotected public was predicted to result in medical and social chaos, according to experts⁸. The prediction was that physicians and hospitals would bear the brunt of the health nightmare. Mass casualties and the “worried well” would swamp hospitals and health care facilities that barely cope with normal health care needs. Confusion and fear would dominate physicians called upon to respond. “Contaminated” hospitals, ER’s, doctor’s offices, medical walk-in clinics would suddenly close to the public under rules of quarantine. Isolation hospitals and clinics would be created as designated by local or state health authority. Vaccination clinics would need to be opened in school gymnasiums or armories.⁹ Supplies of antibiotics and equipment would likely be rapidly used up. Efforts to treat the sick and control contagion would be hampered by shortages of competent trained and vaccinated personnel. Public order would be imperiled. Local and state police supported by militia would enforce restrictions on public travel and access.

The COVID-19 public health response is based on law and concepts developed to address an act of bioterrorism. In the absence of a specific treatment or vaccine for an identified patient with COVID-19 this is fundamentally a statistical approach to preserve the general healthy population rather than address the needs of the individual patient.

Public Health Law and Individual Liberty

What is often neglected in thinking about the threats an infectious agent might pose to public health is the foundation that law provides for effective public health activities. Any pandemic constitutes a grave threat to each and every citizen, rich or poor, empowered or enfeebled, but it also constitutes a grave threat to the role that law plays in regulating public and private behavior.¹⁰ The very bedrock of freedoms we so identify as “American freedoms” would be, if not destroyed, then at least suspended, for in effect every infected or exposed citizen’s rights would evaporate in the public health paradigm to protect the remaining well. Such would in effect turn every patient or potential patient into an enemy of the state, along with their husbands or wives or children or friends or business associates who know them, want to see them, or merely want to interact or help them and be with them. Would the soccer mom who wanted to pick up her daughter at school be detained for trying to enter a containment zone or school declared “contaminated”?

National emergencies push the rule of law: the concept that laws and not the arbitrary exercise of power beyond the principal of “fairness” or equity govern us.⁹ History and war favor the notion that rules must be made to serve the majority interests. Examples abound. The precedent of suspending the writ of habeas corpus (guarantee against unlawful detention or restraint) brought Abraham Lincoln into direct confrontation with Chief Justice Taney in April 1861. Lincoln could simply not allow the state of Maryland to secede from the Union at the onset of the Civil War, thus isolating the federal capital from what remained of the Union. A contemporary newspaper stated that “no power in executive hands can be too great, no discretion too absolute, at such moments as these.”¹¹ Many citizens of Maryland were arrested for suspicion of harboring confederate sympathies, just as 80 years later at the onset of World War II Japanese-Americans were incarcerated after Pearl Harbor was attacked.

The COVID-19 pandemic calls for legal responses to circumstances that have limited precedent in America. Public health law seeks to protect the unaffected by isolating the sick, identified either by virtue of a positive test or symptom profile. Since anti-viral treatment or vaccines are not offered or are unavailable, the ethics of isolation and containment of those who are ill to “benefit the healthy well” is questionable. The existing legal frameworks exacerbate pressure on governments to take drastic actions that might sweep away the rule of law in the midst of panic or uncertainty⁹ such as requiring physicians or providers to act as police and report patients as “PUI” while limiting autonomous medical treatment decisions, such as restrictions in prescribing medications.

The COVID-19 pandemic has caused death and disease on a large scale provoking mass disruption, is transmitted from person to person, lacks effective or available vaccines, treatments or antidotes, and spreads as an aerosol constituting a threat to public health that differs from any other threat to public health in recent experience. All levels of government, state and federal, have responsibilities in dealing with COVID-19. What must be established with regard to these responsibilities amounts to a task worthy of the wisdom of the Founding Fathers for not only is the health and safety of the public at risk, so too are all the rights and duties of citizens as potential victims. What can be said of the ethics of quarantine of an unprotected and poorly informed public that is twice victimized: once, by the disease, then subsequently by its own public officials?

Let’s examine crisis management now that various states and agencies have evoked “Declaration of Health Emergency” status to cope with “sheltering-in-place” enforcement, control of public travel, public behavior, influence over personal compartment and hygiene, in the setting of inadequate or unavailable screening tests coupled with limited and/or rationed treatment options.

Existing public health statutes actually exacerbate these circumstances. They are derivative of public health law as developed from The Model State Emergency Health Powers Act⁸ and its offspring, the Turning Point Model State Public Health Act¹². In effect, the law allows, once an emergency is declared, that the public health authority can control treatment decisions, enforce travel restrictions, commandeer, ration, and otherwise control water, food and medication supplies, and use medical and/or public facilities as deemed necessary for the management of the health crisis. The language and recommendations are derived from Lawrence Gostin’s Model State Emergency Health Powers Act⁸.

The Act permits the governor to declare a “state of public health emergency,” and this declaration, in turn, gives the state public health officials the authority to take over all health care facilities in the state, order physicians to act in certain ways, and order citizens to submit to examinations and treatment, with those who refuse to do so subject to quarantine or criminal punishment. Public health officials and those working under their authority are immune from liability for their actions, including actions that cause permanent disability or death; the only exceptions are in cases of gross negligence or proven willful misconduct. A public health emergency is defined as “an occurrence or imminent threat of an illness or health condition, caused by bioterrorism, epidemic or pandemic disease, or a novel and highly lethal infectious agent or biological toxin, that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability.”⁸

The governor is permitted under the act to suspend state regulations, change the functions of state agencies, and mobilize the militia. Under the act, all public health personnel will be issued special identification badges, to be worn “in plain view,” that “shall indicate the authority of the bearer to exercise public health functions and emergency powers...”⁸ Public health personnel may compel “a health care facility to provide services or the use of its facilities if such services or use are reasonable and necessary for emergency response... including the transfer of ... the health care facility to the public health authority.”

According to the act, failure of physicians and citizens to follow the orders of the public health authority is a crime. Section 502 of the act states:

“Any person refusing to submit to the medical examination and/or testing is liable for a misdemeanor. If the public health authority is uncertain whether a person who refuses to undergo medical examination and/or testing may have been exposed to an infectious agent or otherwise poses a threat to public health, the public health authority may subject the individual to quarantine or isolation... Any (health care provider) refusing to perform a medical examination or test as authorized herein shall be liable for a misdemeanor... An order of the public health authority given to effectuate the purposes of this subsection shall be immediately enforceable by any peace officer.”¹³

Many of the provisions of this act, especially those giving public health officials blanket authority over physicians and hospitals seem based on the assumption that neither physicians nor citizens are likely to cooperate with public health authority in a pandemic. The high level of cooperation on the part of professionals and the public during the current COVID-19 pandemic certainly argues against such an arbitrary assumption.

In the opinion of George Annas¹², there are several problems. First, public health law should respond to real problems. It is not clear what problem the act is intended to solve. Second, the authority to respond to a new epidemic that the model act provides is much too broad granting *carte blanche* authority to public health functionaries in nonemergency conditions as diverse as annual influenza epidemics, SARS or the AIDS epidemic.¹⁴

Annas’ third concern is with the arbitrary use of governmental authority by public health or elected officials (who enjoy legal immunity from liability) to exercise control over civil liberties. Such actions are incompatible with medical ethics, constitutional principles and basic democratic values.

Although it may make sense to put public health officials in charge of responding to a pandemic, it may not make sense to place them in charge without oversight of all possible scenarios. The state's public health department has the role of limiting the public's exposure to the agent, but not to limit autonomous medical decisions, or informed consent, or treatment options. Taking away one's civil liberties because he or she has the misfortune of becoming infected cannot be construed as ethical.

But the task of identifying affected persons, of maintaining the clinical index of suspicion in diagnosis, then reporting those suspicions, then trying to treat them, plus taking preventive actions will all be performed by physicians, nurses, emergency medical personnel, and hospitals. The primary role of public health authorities should be to provide guidance to the public and other government officials in identifying and dealing with the disease and to provide laboratory facilities where exposure can be evaluated and diagnoses definitively established.¹⁵

There is absolutely no compelling evidence either from September 11th or from the anthrax episode or, now, the COVID-19 pandemic that physicians, nurses, or members of the public are in any way unwilling or reluctant to cooperate in the response to the event or are reluctant to take the medications or vaccines recommended by public health or medical officials or their health care teams. Indeed, the medical personnel in the affected areas volunteer their time and expertise to help the victims. And the public literally demands testing for COVID-19 and help and information to deal with the disease to such an extent that the CDC has recommended limitations on testing and specific guidelines of medication use or deployment, such as hydroxychloroquine.

Coronavirus is spread from person to person. It has recently been reported that transmission of novel coronavirus (SARS-CoV-2) can occur before symptom onset occurs clinically in a vector and thus confounding efforts to limit spread.¹⁶ The key to an effective public health response is identifying and helping those that have been exposed. Clearly, quarantine in a virgin turf epidemic like this pandemic requires an educated and prepared public. A defined treatment strategy for those likely to be "sheltered in place" and/or "isolated and contained" should not be withheld or obfuscated by the public health bureaucracy. The necessity to shelter-in-place and maintain social distancing as a parallel policy is also undeniably clear.

There exists federal quarantine law based on the commerce clause of the Constitution (with special provisions mentioning cholera, plague, smallpox, typhus, and yellow fever). Congress could examine and update it to deal with pandemics.¹⁷

Each of the states, the governors and the assorted public health agencies have developed policy or issued administrative orders that currently place limitations on prescribing and/or dispensing medications, establishing protocol for sheltering-in-place, public comportment (social distancing, use of masks, hand washing), hospitalization rules and utilization, school closings, designation of "essential versus non-essential" businesses, etc. As an example, the State of New Jersey, Department of Law and Public Safety, Division of Consumer Affairs has issued "Limitations on Prescribing and Dispensing Medications for Treatment of COVID-19"¹⁸ defining what, when, where and why (including documentation) any prescription(s) for infected patients is allowable. The reasons are several, but essentially the governor and director of consumer affairs (the professional licensing agency in NJ) fear hoarding and an impact on medication availability based

on the CDC's therapeutic guidelines¹⁹. Neither the governor of NJ nor the director of consumer affairs have any formal medical training.

Civil Liberties, the Concept of Autonomy and Public Health Emergencies

The public health law assumes a trade-off between the protection of civil rights and effective public health interventions, and that a threatened public may not cooperate or is inherently uneducable with regard to the key issues involved with crisis management in the absence of legislative authority. Precedent is cited: *Jacobsen v. Massachusetts* involving a state statute requiring vaccination when "deemed necessary for the public health or safety".²⁰ At that time (more than 100 years ago) when hospitals, medication, technology and physicians were neither universally trusted, universally available nor necessarily effective, such tradeoffs between civil liberties (right to refuse treatment) and public health interventions (mandatory vaccinations) were somehow reconcilable.

The Constitution gives the government wide latitude to respond in times of crisis and war. But is such paternalism and arbitrariness consistent with twenty-first century science and knowledge? As Annas inquires, can we not rely upon Americans to follow reasonable instructions issued by knowledgeable and trustworthy experts?²¹

In the 100+ years since *Jacobsen* and both medicine and constitutional law have evolved. We now accept the right of a competent adult to refuse any medical treatment, even life-saving treatment.²² And we still permit health officials to quarantine persons with serious communicable diseases; such as multi-drug resistant tuberculosis but only if they do not or will not accept treatment. Even so, we require health officials to employ "least restrictive alternatives" and resort to quarantine only after failure of alternatives. And provisions for quarantine are accompanied by due-process protections, including the right to legal representation and a hearing.²³

The current law appears more appropriate to America of the nineteenth century. Autonomy in medical decision-making is essential for both physician and patient. All Americans today have the right to refuse examination and treatment. In America of the 21st Century, a citizen should be able to pick the physician of his or her choice, and the method and means of treatment appropriate to circumstances and informed choice, such as off-label use of a medication recommended by their physician. Similarly, the physician must have professional autonomy in medical judgment and decision-making unencumbered by arbitrary administrative code promulgated by non-medical bureaucrats, and based primarily on statistical assessments. Centrally planned and determined health care does not and cannot provide individual patient care.

It is also worth remembering that the science of epidemiology is inherently retrospective, and data based post-event analysis is *de rigueur*.²⁴ For naturally occurring diseases, this has been the very foundation for nearly all modern medical advances. But can a physician and clinician be satisfied that quarantine automatically and arbitrarily accords with the best standard of care for an individual patient as well as the greater good of society? Such an approach deserves the closest of scrutiny and professional and intellectual criticism since it appears to be so singularly narrow in perspective.

Conclusion

The Centers for Disease Control and Prevention (CDC) have expanded on the measures *responding* to emerging threats to the public health. It is understandable that the primary role of public health is to recognize, report and thus contain the outbreak.

The primary roles of public health authorities is to provide guidance to the public and other health professionals and government authorities in identifying and dealing with the disease, meaning the promise of an effective treatment, as well as provide laboratory facilities where exposure can be evaluated, diagnoses definitively established, and treatment plans proposed. That is what the public seeks and expects, and has shown itself as clearly engaged in cooperating with the public health authorities.

The use of public health law to dominate the entire spectrum of clinical decisions, to modify professional behavior, to control the public's comportment, to dominate all commerce and interpersonal interactions and to ration or control medication choices needs clear thinking and apolitical judgement based on objective factual determinations and ethical standards. Methods used by the public health community should respond to the mechanics of the pandemic in a global sense while at the same time respecting and permitting professional judgement and the medically trained caregiver to operate at the bedside unencumbered by arbitrary centralized decisions.

Limiting the spectrum of legitimate clinical choices regarding patient treatment before they are even made denies autonomy for the professional as well as the patient. Such cannot serve either the general good or the individual patient. The prism of public health law and regulations that are advanced to achieve the goal of "protecting the health, safety, and welfare" of Americans¹⁶ can and should abide by the same ethical standards to which all of the healing arts are held.

Submitted by Jeffrey Hall Dobken, MD MPH
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¹ Hoeplich P. *Infectious Diseases*. Harper & Row, publishers. Hagerstown, MD. 1972

² Coreil J. *Social and Behavioral Foundations of Public Health, Second Edition*. Sage Publications, Thousand Oaks, CA. 2010

³ Broad W. Natural causes emerge as key to mystery illness. *NY Times* April 6, 2003. Available at www.nytimes.com/2003/04/06/international/asia/06GERM.html?pagewanted=print&... accessed 04/06/2003

⁴ Hirschberg R, La Montagne J, Fauci A. Biomedical research—an integral component of national security. *N Engl J Med* 2004; 350:2119-2121

⁵ CDC Health Update and Interim Guidance on Outbreak of 2019 Novel Coronavirus. January 17, 2020-CDCHAN-00426. available at <https://www.cdc.gov/coronavirus/novel-coronavirus-2019/downloads/pui-form.pdf> accessed January 17, 2020.

⁶ Wing, K.R. *The Law and the Public's Health*; 5th Edition; Chicago, Health Admin Press, 1999

⁷ *Interim Smallpox Response Plan & Guidelines plus ACIP Vaccine Recommendations, November 26, 2001*: National Immunization Program; Centers for Disease Control, Atlanta, GA. www.cdc.gov/nip/smallpox

⁸ Miller J, Engleberg S, Broad W: *Biological Weapons and America's Secret War- Germs*; Simon and Schuster, 2001: ISBN 0-684-87158-0

⁹ **The Model State Health Powers Act**, Draft of December 21, 2001; CDC as prepared by the Center for Law and the Public Health at Johns Hopkins and Georgetown Universities. <http://www.publichealthlaw.net/MSEHPA/MSEHPA.pdf> accessed 04/21/2004

¹⁰ Fiddler, D.; The malevolent use of microbes and the rule of law: legal challenges presented by bioterrorism: *Clinical Infectious Diseases* 2001; 33:686-9; available at <https://academic.oup.com/cid/article-abstract/33/5/686/468354>.

¹¹ Catton, B.; *The Coming Fury, The Centennial History of the Civil War*; Washington Square Press, 1961, p355-361

¹² Meier B, Hodge J, Gebbie K. Transitions in state public health law: *American Journal of Public Health*. 2009, Vol 99(3), 423-430.

¹³ Annas G. Legal issues in medicine: bioterrorism, public health, and civil liberties: *N Eng J Med* Vol 346 (17): 1337-1342, April 25, 2002

¹⁴ Mariner, W. Bioterrorism Act: the wrong response. *Nat'l Law J*. Dec 17, 2001

¹⁵ Dobken J. COVID-19 coronavirus needs apolitical truth-telling. *KevinMD.com* 03/13/2020.

www.kevinmd.com/blog/2020/03/covid-19-coronavirus/needs/apolitical-truth-telling.html

¹⁶ Wei WE et al. Presymptomatic transmission of SARS-CoV-2—Singapore, January 23. March 16, 2020. *MMWR Morb Mortal Wkly Rep* 2020 Apr 1; [e-pub] available at <https://doi.org/10.15585/mmwr.mm6914e1>

¹⁷ Public Health Service Act, 42 USC 264(1983) and Quarantine, Inspection, Licensing: interstate quarantine 42 C.F.R. 70.1-8(2000)

¹⁸ State of NJ DCA Administrative Order No. 2020-01 & 2020-03. available at www.njconsumeraffairs.gov or njprofessionalboards@dca.njoag.gov

¹⁹ CDC therapeutic guidelines available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html>

²⁰ *Jacobsen v. Massachusetts*, 197 U.S. 11 (1905)

²¹ Annas, George (ibid): *NEJM* 346: 1337-1342, April 2002

²² *In re Quinlin*: 70 NJ 10, 1976

²³ Annas, G. *Control of Tb: the law and the public's health*. *N. Eng J Med* 1993; 328: 585-588

²⁴ Friis R., Sellers T. *Epidemiology for Public Health Practice* 4th Edition. Jones and Bartlett Publishers, Sudbury, MA 2009.