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GEORGE J. ANNAS, WORST CASE BIOETHICS: DEATH, DISASTER, AND PUBLIC HEALTH

Michael Greenberger, J.D.*

It is a rarity when a highly regarded substantive expert writes a compelling book that addresses cogently some of the most important public policy issues of our time. George J. Annas has done so in his new book: Worst Case Bioethics: Death, Disaster, and Public Health.

To those unfamiliar with the field of public health law, Professor Annas is its undisputed dean. From his prestigious posts as Chair of Health Law, Bioethics & Human Rights and the William Fairfield Warren Distinguished Professorship at Boston University, Professor Annas is an eagerly sought after speaker and writer on critical legal and ethical issues in public health.

Professor Annas’s book is a tour de force. It addresses and wisely resolves what is the key conundrum of our times: in the post-9/11 world, how do we balance the need for effective governmental response to a host of man-made acts of terrorism and devastating natural catastrophes while maintaining our commitment to individual liberties and human rights?

It first must be said that this book sweeps so broadly and deeply into critical areas of public health that those of us who teach in this field will have to seriously consider it for required course reading. Professor Annas glides effortlessly through trenchant discussions of, inter alia, bioterrorism, torture, war, cancer, abortion, assisted suicide, pandemics, and genetics, all the while highlighting and analyzing key cases, statutes, treaties, and scholarship relating to these subjects. One can be assured that if you master this book, you will be a full and thoughtful participant in any policy discussion or any classroom that tackles these difficult subjects.

However, what is most important about this book (and, indeed, most important about Professor Annas’s constant message in academia) is that any discussion attempting to address crises in public health must not only be geared toward the government’s response to a crisis, but must also be accompanied by deep concerns for liberty, privacy, and human rights.

To the untutored that may sound obvious. But, for those of us who have labored in the catastrophic health vineyard know only too well, civil liberties and human rights are often not only given short shrift, they are given no consideration at all.

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It has fallen on the shoulders of Professor Annas (and two other key colleagues in the Boston academic legal community, Professors Wendy Mariner of Boston University and Wendy Parmet of Northeastern University – both of whose scholarship make prominent appearances in the book) to serve as the conscience of the public health legal community by consistently raising the importance of individual rights in addressing emergencies and, even more importantly, by cogently explaining the manner in which we can respond effectively to emergencies while protecting liberty.

While the breadth of this book includes a plethora of important lessons across an impressive array of subject matter, I want to focus on the following seven key messages that have special resonance in our post 9/11 crisis-driven era.

I. **WORST-CASE SCENARIOS ARE OFTEN NOT REALLY WORST-CASES**

Especially when confronting the legal and ethical dilemmas posed by terror threats, Professor Annas repeatedly makes clear that “worst case scenarios” often owe more to the imagination than to reality. In this regard, he points to famous table top exercises, through which participants discuss potential responses to hypothetical emergencies that are part of the emergency response literature. The extreme nature of these highly fictional scenarios, which he calls “bioart” rather than “bioterror,” suggest that the table top organizers are more determined to instill panic than engage in plausibility.

One example of a scenario “gone wild” that Professor Annas highlights is the now infamous “Dark Winter” smallpox scenario. That exercise consisted of a pre-9/11 two-day simulation conducted at Andrews Air Force Base, positing a smallpox attack on the United States that resulted in an outbreak of the disease to twenty-five other states and fifteen countries, and “resulted in over 16,000 cases of smallpox in the United States alone.”

The Dark Winter participants (all prominent national security experts and former government officials) threw up their hands in despair at the overwhelming nature of that fictionalized attack, leading to an admonition that there was, *inter alia*, a need for tough new mandatory vaccine and quarantine laws. It also led Vice President Dick Cheney, a participant in

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3. See id. at 260.
the scenario, to conclude that every American needed to be vaccinated immediately against smallpox.4

Professor Annas makes the cogent point that when government officials are constantly made to think about responding to crises that are unimaginably difficult, panic rather than reason is the likely result, thereby "predictably do[ing] more harm than good"5 and predictably provoking responses "based more on fear than logic."6 Thus, Professor Annas says in developing policies to respond to emergencies "[e]mphasize the ordinary,"7 rather than the extraordinary.

II. IMPLAUSIBLY DIFFICULT WORST-CASE SCENARIOS UNNECESSARILY LEAD TO DEMANDS FOR AUTHORITARIAN GOVERNMENT

As the despair of the Dark Winter participants makes clear, a major result of the unreasoned fear instilled by unrealistic "worst case scenarios" is the calling into question of the "scope and substance of their legal authorities" relating to the handling of public health emergencies.8

One of the many examples of Professor Annas's moral leadership was his shaping of the intellectual fight to discredit the highly ill-conceived movement for the passage in every state of The Model State Emergency Health Powers Act (Model Act).9 In its initial proposed 2001 form, the Model Act was widely viewed as necessitating the imposition of something akin to martial law when an exceedingly low triggering threshold is met—purportedly creating an emergency.10 For example, the definition of an "emergency" under that version of the Model Act was so loose that it

4. See ANNAS, supra note 1, at 228.

5. Id. at xxiii-xxiv.

6. Id. at 23.

7. Id. at 232.

8. Id. at xvii.


allowed for the establishment of authoritarian powers upon the outbreak of a seasonal flu, which would essentially allow a state to use emergency powers for four to five months every year during flu season. Moreover, under the original Model Act, the state legislature could only terminate the emergency upon a two-third vote of both Houses.

As Professor Annas explained at the time:

The original model act permits the governor to declare a “state of public health emergency,” and this declaration, in turn, gives 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.

Self evidently proposed in the shadow of the panic instilled by the 9/11 attacks and the anthrax episode of the Fall of 2001, some degree of reason to this proposal was restored when a second version of the Model Act was promulgated on December 21, 2001 based on the abundance of critical comments that were filed on the initial proposal in the intervening period.

Nevertheless, in a thoughtful response to what was considered in important parts of the public health law community to be a highly draconian proposal, Professor Annas wisely concluded:

All sorts of proposals were floated in the wake of the September 11 attacks — some potentially useful, such as irradiation of mail at the facilities that had been targeted, and some potentially dangerous, such as the use of secret military tribunals and measures that would erode lawyer–client confidentiality, undermine our constitutional values, and make us less able to criticize authoritarian countries for similar behavior. I think the Model State Emergency Health Powers Act is one of the dangerous proposals.

But, even as tempered, the December 21, 2001 version of the Model Act still incurred the wrath of widely respected members of the public health law

11. Id. at § 104(l).

12. Id. at § 305(c).


15. Annas, supra note 13, at 1337.
Thankfully, because of the advocacy of Professor Annas and others, the most controversial aspects of the Model Act were largely ignored by the states.

III. THE CONFLICT BETWEEN SECURITY AND LIBERTY IS OFTEN A FALSE DICHOTOMY

As a further example of accommodations made to the normal rule of law in order to deal with catastrophic public health emergencies, Professor Annas cites the frequent refrain that state laws must be "reformed" to relieve health care professionals of the "burdens" of the traditional common law standards of care. The relief most often sought — and most often delivered by state legislatures — is removing healthcare professionals from being subject to any claim of negligence during a declared state of emergency. The justification for this legal relaxation is that health care professionals will be resistant to responding to emergencies if they are held to an unreasonable standard of care (e.g., negligence) during the chaos of a catastrophe.

Professor Annas argues, however, that legislative accommodations of this kind are unnecessary:

Health care professionals are obligated to act in a manner consistent with what a reasonably prudent healthcare professional (of their same specialty) would do in the same or similar circumstances. This standard takes into consideration the emergency conditions themselves, as well as the resources available to render assistance.

Thus, he concludes that "[w]orst case scenarios justify flexible rescue rules, but do not require abandonment of accountability which is likely to make a bad situation worse." Therefore, he argues there is no real need to alter the standard of care applied. And, as Professor Annas notes, besides robbing patients of the benefits and protections of the traditional common law legal

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17. ANNAS, supra note 1, at 28.

18. MD. CODE ANN., PUB. SAFETY § 14-3A-06 (West Supp. 2009). Pursuant to Maryland's Catastrophic Health Emergencies Act, a health care provider acting under a proclaimed catastrophic health emergency is "immune from civil or criminal liability if the health care provider acts in good faith[.]" Id.

19. ANNAS, supra note 1, at 28.

20. Id. at 38.
standard of care, eliminating negligence may also interfere with the overarching goal that, even in emergencies, "[s]ociety must be able to trust its physicians."

If patients know that physicians can act negligently with impunity, patient "trust" may very well dissipate.

IV. AUTHORITARIANISM AND COERCION ARE NOT NEEDED

Professor Annas also correctly perceives the counter-productiveness of other oft-requested authoritarian responses to public health crises. He correctly identifies the two poster children for ineffective governmental coercion: mandatory quarantines and compelled vaccinations. Lay persons asking about legal questions concerning the response to public health emergencies will almost always begin by asking how to implement a broad scale mandatory quarantine. In this regard, Professor Annas correctly summarizes the wisdom of the ages: mandatory quarantines are virtually impossible to enforce or to sustain logistically. Yet, the Model State Emergency Health Powers Act has led many states to develop the most

21. Id. at xviii.

22. Id. at 219-20.

23. Id. at 219-23.

24. The history of quarantines is replete with examples of those quarantined often resorting to violence, including the use of shotguns, to resist those restrictions even when imposed by state National Guard forces. See, e.g., Bioterrorism: Civil Liberties Under Quarantine, NPR (Oct. 23, 2001), http://www.npr.org/news/specials/response/anthrax/features/2001/oct/011023.quarantine.html (recounting an 1893 smallpox outbreak in Muncie, Indiana, during which quarantined citizens defended themselves with guns); Editorial, Work of the Anti-Vaccinists, 23 JAMA 281 (1894) (documenting that opposition to the Milwaukee Health Department's attempt in 1894 to quarantine people infected with smallpox resulted in a 3,000 person riot that injured twenty rioters and six police officers); Carlos E. Cuéllar, Laredo Smallpox Riot, TEX. STATE HISTORICAL ASS'N, http://www.tshaonline.org/handbook/online/articles/jcl01 (last viewed May 8, 2011) (describing an 1898 quarantine followed by a riot that resulted in one death, thirteen injuries, and twenty-one arrests).

25. It is self evidently nearly impossible to provide for the care and feeding of those many mandatorily quarantined citizens contemplated by the worst-case public health scenarios. However, many states glibly impose this near impossible obligation on states who invoke broad geographical quarantines. See, e.g., N.J. STAT. ANN. § 26:13-15(c)(1) (West 2011) ("The following isolation and quarantine procedures shall be in effect during a state of public health emergency . . . . Adequate food, clothing, medication, means of communication, other necessities and competent medical care shall be provided.").
intricate structures to impose broad scale mandatory quarantines, which are often enforced by imposition of harsh criminal penalties. Professor Annas observes that "[m]ass quarantine is a relic of the past that seems to have outlived its usefulness." Again, as Professor Annas correctly points out, while forced quarantines are problematic, the 2003 SARS experience in Toronto demonstrates the likely viability of voluntary "shelter in place" programs that are supported by informed and reasonable guidance by public health agencies. In sum, experience demonstrates that with effective advice from public health professionals, the chances are good that those potentially exposed to a deadly flu virus, for example, will voluntarily self-quarantine.

Moreover, as Professor Annas notes, the history of public health is replete with examples of failed mandatory vaccination programs. For example, in 2003, President Bush ordered the mandatory small pox vaccination of 500,000 state and local emergency responders in anticipation of a small pox attack arising from the invasion of Iraq. This sweeping federal order (accompanied with no logistical strategy for implementation) faced massive resistance by state and local healthcare workers. Only 40,000 agreed to be vaccinated. Indeed, the need for widespread vaccination was questioned as a public health matter at the outset of the Bush effort and in short order it proved wholly unnecessary after the Iraqi invasion. The attempted coercive action was needless.

Similarly, at the outset of the second wave of the H1N1 flu outbreak, the State of New York instituted a mandatory vaccination program for state nurses. The nurses sought and were granted a temporary restraining order.

26. **MD. CODE ANN., PUB. SAFETY §§ 14-3A-03(b)(3)(iii)–(iv) (West Supp. 2009).** Once a catastrophic health emergency is proclaimed under Maryland's Catastrophic Health Emergencies Act, the Governor may order the Secretary of Health and Mental Hygiene or another designated official to establish places of isolation and quarantine and to require individuals to go to and remain in them. *Id; see also MD. CODE ANN., PUB. SAFETY §§ 14-3A-08(a)-(b) (an individual who "knowingly and willfully fail[s] to comply with an order" issued under the CHE Act "is guilty of a misdemeanor and on conviction is subject to imprisonment not exceeding 1 year or a fine not exceeding $5,000 or both.").

27. **ANNAS, supra note 1, at 227.**


29. **See id. at 21.**

30. **See PARIS NOURMOHAMMADI & BRIDGID RYAN, CAN MY BOSS STICK IT TO ME? COURTS MAY GIVE A SHOT IN THE ARM TO EMPLOYER-MANDATED H1N1 VACCINES 2**
The hostility of the trial court at the interlocutory hearing to the state’s argument for coercion ultimately led New York to abandon its mandate. On the other hand, once the safety and effectiveness of the H1N1 vaccine was made clear, and while the epidemic still appeared to be serious, there was widespread acceptance of the need by medical personnel to take the vaccine.

V. PREVENTION RATHER THAN RESPONSE

Professor Annas also correctly makes clear that the emphasis on authoritarian public health law response often leads policy makers to ignore prevention as the key to combating emergencies. For example, in terms of fighting deadly influenzas, he argues that policy makers need to place greater emphasis on developing a universal flu vaccine rather expending energy on devising and funding schemes for mandatory quarantine.

Annas is not engaging in wishful thinking here. One of the overlooked successes in combating and limiting the H1N1 flu epidemic was the development in an astonishingly short period of time of a safe and effective H1N1 vaccine. The National Institute for Allergy and Infectious Diseases has, with Congressional direction, funded sophisticated research to develop other medical countermeasures for dangerous biological agents and deadly influenzas. Great strides have been made by medical researchers in these fields. The concept of a universal influenza vaccine is a goal that appears


31. See id. at 2-3.


33. See ANNAS, supra note 1, at 211.


35. MARCE (Middle Atlantic Regional Center of Excellence for Biodefense and Emerging Infectious Diseases) was one of the original centers funded by NIAID’s Biodefense Network to research biodefense and emerging infectious diseases. UNIFORMED SERVS. UNIV. OF THE HEALTH SCI., Alison O’Brien Appointed to Lead Biodefense Research Consortium, NEWSWISE.COM (May 18, 2006), http://www.newswise.com/articles/view/520639?print-article.
reachable in the near future. Again, if bioterror and deadly influenzas can be defeated by medical countermeasures, the worry about coercing conduct that limits liberty interests largely disappears.

VI. PROFESSIONALISM RATHER THAN PANIC

Throughout the book, Professor Annas focuses on the exacerbation of emergencies by professionals who choose to abandon well accepted standards of ethical behavior in order to purportedly "save lives."

He discusses the ethical short cuts taken by both lawyers and medical personnel to justify the United States' engagement in torture to combat terrorism. He describes the strained analysis of the U.S. Department of Justice's lawyers attempt to justify highly questionable, painful and degrading interrogation tactics as being something less than torture. The Justice Department's Office of Professional Responsibility, while concluding that no criminal conduct was involved, made it clear that these highly questionable memos approving these tactics misstated U.S. law, breached a duty to exercise independent legal judgment, and flouted ethical obligations.

Similarly, recent Wikileaks disclosures have corroborated Professor Annas' conclusions that U.S. Department of Defense medical personnel turned a blind eye to well-accepted medical ethics to offer solace to detainee interrogators engaging in what can only be deemed to be torture.

In sum, had the well-accepted ethics of these professions been followed, the national disgrace accompanying revelations, for example, about harsh prisoner treatment by the U.S. at Abu Ghraib in Iraq could have been avoided.

Moreover, as Professor Annas implies, military and intelligence agency interrogation "best practices" have long taught that the effective extraction of useful intelligence information from prisoners is a direct by product of


37. See ANNAS, supra note 1, at 48-49.


interrogators establishing relationships of trust with prisoners — rather than by using cruelty.\textsuperscript{40}  

VII. SOUND PRINCIPLES OF HEALTH LAW REFORM

Perhaps the most practical guidance within the book is Professor Annas's restatement of principles to guide public health law reform that he devised in conjunction with Law Professors Wendy Mariner and Wendy Parmet (otherwise referred to by their academic peers as the "Boston Public Health Law Trinity"). The recommended principles to guide public health reform:

1. [S]hould emphasize the ordinary, leaving behind its obsession with one percent solutions and public health emergencies, and concentrate on promoting the publics' health in ordinary times by, for example, strengthening immunization programs, ensuring access to medical care, and improving public health education.

2. [S]hould recognize that law alone cannot solve complex public health problems, nor can emergency powers make up for the lack of resources or trusting relationships between public health personnel and the public. Cries of plague and bald assertions of authority must be replaced with recommendations based on science and respect for the rule of law.

3. [S]hould recognize that public health law must be grounded in the communities that public health serves. Top-down draconian authority is antidemocratic and likely to prove counterproductive. Persuasion and reasonable recommendations based on facts are much more likely to be effective.

4. [S]hould value transparency and accountability, instead of granting broad legal immunity to officials, workers, volunteers, and drug companies for abusing their authority. The public is the client, not the enemy, and is much more likely to trust those who take responsibility for their actions.

5. [S]hould recognize that legal rights can themselves promote public health protection — the Constitution is not an obstacle to effective public health planning, it expresses our deepest-held values that should guide all official actions.

6. Law should be used to enable people to be healthy, not to coerce their actions, both every day and in emergencies. Instead

of empowering officials to treat people against their will, for example, it should emphasize the rights of people to have access to the treatments they need. In this respect, developing an equitable system of healthcare available to all Americans would be a much more effective public health intervention than, for example, having the legal authority and military ability to quarantine every man, woman, and child in America.\footnote{ANNAS, supra note 1, at 232-33.}

These principles can be extracted from many of the book’s points that I have outlined above. They also stand in stark contrast to the authoritarian school of public health law, which emphasizes coercion as the basis of effective emergency response – at great and needless expense of civil liberties and human rights, as well as the establishment of effective care of U.S. citizens.

VIII. CONCLUSION

There can be no question that Professor Annas’s book is as important as it is complete. It is accessible to lawyers and students and is filled with wisdom. Those are attributes that are too rare in academic scholarship. For that reason alone, the book should become a mainstay of the public health law curriculum.