

## The Role of the Police Power in 21st Century Public Health

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The police power is the right of the state to take coercive action against individuals for the benefit of society. The companion article by Potterat et al., "Invoking, monitoring, and relinquishing a public health power: the health hold order," is a classic use of the police power in the control of a communicable disease, yet one that is increasingly controversial. Reaching an acceptable balance between the rights of society and those of individuals is the central issue facing public health in the next millennium, and the police power is at the center of this balance. This article reviews the constitutional basis of the police power, its historical use in public health, and the structural reasons why health departments preoccupied with personal health care cannot effectively use the police power to carry out public health enforcement.

THE CENTRAL DILEMMA in public health is balancing the rights of the individual against those of the society. From the colonial period on, the tension between our inherent distrust of government and our concern with the collective welfare has made finding this balance a particularly difficult task in the United States. Whether the issue is quarantining persons with infectious tuberculosis, contact tracing for HIV, or limiting the rights of smokers in public places, public health practice must coexist with political considerations, and the power of interest groups often outweighs scientific decision making. Ironically, the success of public health has undermined the societal consensus necessary for that success. As we enter the next century, we confront the reemergence of traditional foes, such as tuberculosis, and the emergence of new agents such as HIV and Ebola seeking their niche in the human ecological system. Increasing population density, combined with ever greater dependence on common path sources for food and water and the wide use of rapid international transportation, create unprecedented opportunities for the global spread of disease.

Our ability to prevent and manage communicable diseases in the future is dependent on broadening the under-

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standing of the legal and scientific basis for public health among public health professionals and the general public. This article focuses on the police power, the core constitutional authority for public health practice. The courts have been steadfast in their affirmation of the continued vitality of the use of the police power to protect the public health and safety, even when it conflicts with individual rights. The greatest threat to effective public health practice is ignorance of the legal and scientific basis for public health, with a resulting paralysis in the willingness of public health professionals to act for the good of the community.

### The Special Problem of Infectious Disease

Modern public health lumps all health threats together and seeks to deal with them through a general integrated system of services. Thus, programs such as injury prevention, hypertension management, and prenatal care are viewed the same way as infectious disease control. Yet, history and science tell us that infectious disease control is fundamentally different from other public health concerns. In *Plagues and Peoples*,<sup>1</sup> William H. McNeill developed the now generally accepted theory that epidemic disease played a pivotal role in decimation of indigenous cultures in the Americas and in ending the hold of feudalism in Europe. As Hans Zinsser wrote in his classic essay, *Rats, Lice, and History*:

In earlier ages, pestilences were mysterious visitations, expressions of the wrath of higher powers which came out of a dark nowhere pitiless, dreadful, and inescapable. In their terror and ignorance, we did the very things which increased death rates and aggravated calamity. . . . Panic bred social and moral disorganization; farms were abandoned, and there was shortage of food, famine led to civil war, and, in some instances, to fanatical religious movements which contributed to profound spiritual and political transformations.<sup>2</sup>

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Infectious diseases are unique in that they tap into deep-seated human fears and threaten society itself, rather than just the well-being of individuals. This is not to denigrate the importance of chronic diseases and other preventive medicine concerns, but to recognize that infectious diseases are qualitatively different from other public health concerns, both psychologically and legally. Whatever the cumulative statistical threat to the health of the nation posed by chronic illness, the afflicted individuals pose no threat to others—they are not dangerous people. This is a key legal distinction. In the United States legal system, as well as those of most nations, the state has a special duty to protect its citizens from dangerous people, and special legal rights when it is doing so. In the United States, this power and duty to protect the health and safety of the general public is called the police power.

### The Police Power

The police power is very broad, encompassing not only traditional public health, but environmental law, and any other area where the government acts to protect health and safety. The Constitutional roots of the police power are deep. The colonies were ravaged by communicable diseases. There was a yellow fever epidemic raging during the writing of the Constitution. The flavor of that period was later captured in an argument before the Supreme Court, discussing the end of that period of epidemic:

For ten years prior, the yellow fever had raged almost annually in the city, and annual laws were passed to resist it. The wit of man was exhausted, but in vain. Never did the pestilence rage more violently than in the summer of 1798. The State was in despair. The rising hopes of the metropolis began to fade. The opinion was gaining ground, that the cause of this annual disease was indigenous, and that all precautions against its importation were useless. But the leading spirits of that day were unwilling to give up the city without a final desperate effort. The havoc in the summer of 1798 is represented as terrific. The whole country was roused. A cordon sanitaire was thrown around the city. Governor Mifflin of Pennsylvania proclaimed a non-intercourse between New York and Philadelphia.<sup>3</sup>

It is not surprising that the Constitution, shaped in this environment, would grant the states great latitude in enforcing laws to protect the public health. Yet, the Constitution has been amended to change many original provisions, and the United States Supreme Court has interpreted others in ways that provide much more protection for the individual than was the intent of the Framers. Interestingly, the police power, as it relates to the public health, has not been amended or greatly limited by later construction. The most recent United States Supreme Court case delineating the extent of the police power as it relates to public health dealt with individuals identified as sexual predators, rather than a

more traditional public health issue. In *Hendricks v. Kansas*,<sup>4</sup> the United States Supreme Court was asked to determine if a state could refuse to release prisoners who had served their sentence if these prisoners were found to be sexual predators. Although the state argued that it would provide some treatment to these individuals, it essentially conceded that there was no expectation that the treatment would cure them and thus lead to their release. It also conceded that these persons did not have a mental illness as it has been conventionally viewed in mental health commitments. Thus, the case became one of pure police power: can the state involuntarily confine an individual in a prison to prevent the commission of future crimes, i.e., because he is dangerous to others?

The United States Supreme Court found that the Kansas law was constitutional and allowed the civil detention of persons who are dangerous because of a mental defect. This is a critical public health case because of the law the court relied on in supporting its holding:

[T]he liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly free from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members.

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

*Jacobson* is the leading United States Supreme Court case on the use of the police power for public health enforcement involving human disease control. Mr. *Jacobson* was contesting the Massachusetts law requiring that all persons be immunized against smallpox. This enforcement proceeding arose under the rules of the Board of Health of Cambridge Massachusetts, which provided the immunizations for free and which had appointed a physician to see that they were enforced. (This was simply done by checking for the vaccination scar on the arm.) *Jacobson* believed that the scientific basis for vaccination was unsound and that he would suffer if he was vaccinated, thus unconstitutionally forcing him to choose between putting himself at risk for the common good or paying a \$5 fine. The Massachusetts Supreme Court found the statute consistent with the Massachusetts state constitution, and *Jacobson* appealed to the United States Supreme Court. The Supreme Court examined the issue of whether involuntary vaccination violated *Jacobson's* "inherent right of every freeman to care for his own body and health in such way as seems to him best. . . ." The Court bifurcated this question, first considering the right of the state to invade *Jacobson's* person by forcing him to submit to vaccination:

This court has more than once recognized it as a fundamental principle that "persons and property are subjected to all kinds of restraints and burdens, in order to secure the

general comfort, health, and prosperity of the State; of the perfect right of the legislature to do which no question ever was, or upon acknowledged general principles ever can be made, so far as natural persons are concerned."

This is the bargain that makes public health possible: an individual must give up some personal freedom in exchange for the benefits of being in a civilized society. Jacobson sought to enjoy the benefit of herd immunity arising from his neighbors being vaccinated for smallpox, without personally accepting the risks inherent in vaccination. The Court rejected Jacobson's claim, which it viewed as an attempt to be a freerider on society:

We are not prepared to hold that a minority, residing or remaining in any city or town where smallpox is prevalent, and enjoying the general protection afforded by an organized local government, may thus defy the will of its constituted authorities, acting in good faith for all, under the legislative sanction of the state. If such be the privilege of a minority, then a like privilege would belong to each individual of the community, and the spectacle would be presented of the welfare and safety of an entire population being subordinated to the notions of a single individual who chooses to remain a part of that population.

Critically for the use of the police power in modern public health enforcement, the Court rejected Jacobson's right to contest the scientific basis of the Massachusetts vaccination requirement. Accepting that some reasonable people still questioned the efficacy of vaccination, the Court nonetheless found that it was within the legislature's prerogative to adopt one from many conflicting views on a scientific issue. Many public health actions necessarily involve imperfect, statistical approaches to disease control and choices from among competing approaches. Without such authority, state action in contemporary society would be paralyzed by court proceedings contesting whether the state had chosen the best approach to the problem. This was specifically affirmed in the context of sexually transmitted diseases (STDs) in *Reynolds v. McNichols*,<sup>5</sup> which upheld the constitutionality of the health hold orders relied on by Potterat et al., and in *City of New York v. New St. Mark's Baths*,<sup>6</sup> which upheld the closing of the gay bathhouses against claims that it would be better to leave them open as a place to do education: "The St. Mark's Baths court relied on older precedent: 'The judicial function is exhausted with the discovery that the relation between means and end is not wholly vain and fanciful, an illusory pretense. Within the field where men of reason may reasonably differ, the Legislature must have its way.'"

### Legal Standards for Public Health Decision Making

The Constitution, as interpreted by the United States Supreme Court, gives the states broad power to enforce

public health restrictions. The Courts have put certain important limits on this power to ensure that it is not used in a tyrannical way.<sup>8</sup> The courts contemplate that a health officer, expert in medical science and disease control, will be making public health enforcement decisions. If these decisions result in the confinement of an individual, that individual has the right to a habeas corpus hearing to have a judge determine if his confinement is proper. This occurs after the confinement. It is not a precondition to confinement. It reflects the old usage of habeas corpus, which literally means "bring me the body." The writ of habeas corpus requires the jailer to bring the prisoner before a judge so the judge can determine for himself if the person is properly confined. The person will remain confined during the proceedings because, as one court said: "To grant release on bail to persons isolated and detained on a quarantine order because they have a contagious disease which makes them dangerous to others, or to the public in general, would render quarantine laws and regulations nugatory and of no avail."<sup>9</sup>

The most important restriction on the public health police power is that it cannot be used for punishment or other purposes unrelated to the public health. Thus, in *Hendricks*, the state had to convince the United States Supreme Court that their sexual predator law was not a subterfuge to punish *Hendricks* without having to prove he was guilty of a crime. If the state wants to use confinement to punish, it must give the accused the following: trial by a independent judge or jury; some presumption of innocence that requires the state to prove the guilt; linkage of the severity of punishment with the intent to violate the law; some form of representation by counsel; the right to present evidence; and some form of appeal. Most also provide that the person may remain free until conviction, and sometimes through the appeals process, unless there is a significant risk of flight or additional criminal acts. The public health laws also allow searches and seizures with limited due process protections. Because the protections are much less stringent than those required in criminal law, the information obtained on these searches cannot be used as evidence in a criminal trial.

### Health Hold Orders for Disease Control

The gonorrhea control program described by Potterat et al. is a valuable model of the use of public health enforcement powers. As discussed later in this article, it also is a powerful cautionary tale for the future of effective public health enforcement in the United States. The key to the success of this program was a staff with expertise in disease control, a health director committed to disease control, effective legal support from the District Attorney's office, and the political support of the community. This article focuses on the parts of the program with special legal

significance and how it fits into a general model for public health restrictions.

A disease control program that includes personal restrictions needs to meet these standards to survive a legal challenge. It must:

- 1) Address a real problem that poses a direct threat to third parties;
- 2) Develop a scientific control strategy;
- 3) Implement that strategy in the most effective way, with the least restrictions consistent with the resources available;
- 4) Evaluate the program periodically to show that it is working; and
- 5) Phase out the program when it is no longer epidemiologically sound.

Except in very unusual circumstances, every one of these requirements involves a value judgment made on a continuum. Public health seldom has clear and simple answers. Even wondrously effective strategies such as childhood immunizations become problematic when they have achieved such great success that the risks of the immunization exceed the residual risk of the disease. The courts never demand perfection in public health, nor do they demand the least restrictive approaches if those are not compatible with the resources available to the program or with minimizing the risk to third parties.

#### *Standard 1: Is it a Real Problem?*

The Colorado Springs program began with the epidemiologic observation that gonorrhea cases were increasing among prostitutes. In a community with the demographics of Colorado Springs in 1970—extensive military personnel moving through the community as part of the Viet Nam mobilization—gonorrhea in prostitutes meant gonorrhea spread in the community. Given the potential sequela of gonorrhea and its risk of transmission to others, it is a legitimate public health problem. The health department should be prepared to show the court the local epidemiologic data or state or federal data illustrating the magnitude of a specific problem and its potential risks. In this case, the program was based on data on the incidence and prevalence of gonorrhea in Colorado Springs. The risks of gonorrhea could be demonstrated by expert testimony using medical texts and journal articles.

#### *Standard 2: Is the Control Strategy Scientifically Valid?*

The basic strategy was simple and proven: test and treat prostitutes for gonorrhea, using commonly available, safe antibiotics. This could be demonstrated with Centers for Disease Control (CDC) recommendations on gonorrhea

treatment and with expert testimony using the medical literature.

#### *Standard 3: Is the Strategy Implemented Properly?*

This is where the Colorado Springs program posed the most difficult legal questions. Had the problem been caused by a stable cadre of community-based prostitutes, it might have been dealt with using informal referrals to medical care and the systematic use of contact tracing, with an occasional health hold for a recalcitrant prostitute, as was the practice in many cities at that time. Unfortunately, it was caused by a mobile group of prostitutes who drifted in and out of town with the military payroll. These prostitutes were also less concerned about disease control and less willing to comply with informal treatment recommendations. It was clear that they had to be evaluated and treated when they were arrested, because it was the only time they could reliably be found. This increased the level of restriction in two ways. First, it meant that in some cases they would be held in detention longer to allow the health department personnel to see them. Second, in theory they would be tested against their will, in that the detention coerced the testing. (Potterat et al. are silent on what happened if the prostitute tested positive for gonorrhea but refused treatment. Given that they report that few if any prostitutes resisted testing, it is assumed that the situation did not arise.) In the *Reynolds v. McNichols* case, a similar program in Denver was sued by civil rights attorneys on behalf of a prostitute who alleged: 1) that the program violated her 4th amendment rights because it involved involuntary detention, and 2) that it denied her the equal protection of the law because it was not applied in the same way to the male customers of prostitutes. The court found that this temporary detention for the diagnosis and treatment of venereal disease was a proper response and did not violate the plaintiff's constitutional rights. Critical to the court's analysis was the nature of the detention. In Denver, as in Colorado Springs, any detention was secondary to an arrest for prostitution. The health hold order might extend the detention, but it was not the occasion for the detention. The court did not need to consider the more difficult issue of whether it would have been proper to pick up and detain the prostitutes on a health hold order alone. The court's opinion seems to intimate that it would have allowed this as well, but it did not rule directly on the issue.

The Colorado Springs program was able to show the court that the detention was reasonable, generally only a few hours, with a maximum in most circumstances of overnight. Although not necessary to the legal basis for the program, it was clearly beneficial that few prostitutes complained about the detention. In this case, the program also directly benefited the prostitute by treating her for gonorrhea. Again, preventing harm to the community is the legal standard, but

benefit to the individual does influence the court when balancing the risks and benefits of the program. More generally, a health department should be prepared to explain why they have chosen a particular strategy and why it is best under the circumstances. The court will also consider the available resources. Colorado Springs could have obviated the extension of the detention by having 24-hour physician coverage at the jail, but this was beyond their economic and personnel resources. The court did not demand this, because the reduction in the inconvenience to the individual was not worth the cost of community resources it would require.

#### *Standard 4: Is the Program Still Working?*

Although not strictly required by the courts, this is demanded by good disease control practices. It is also a waste of resources to keep examining prostitutes if they are no longer a significant source of gonorrhea. Potterat et al. did continuous surveillance to evaluate the effectiveness of the program. It would make sense that any program that justifies personal restrictions also justified the collection and analysis of data about each restricted individual. Such data can be very important in showing the court that the program works and that it is being properly managed. Epidemiologically, the information and insights generated by a long-term disease control program can be its most valuable outcome. As the United States Supreme Court held in *Whalen v. Roe*,<sup>10</sup> the collection of epidemiologic data alone justifies the exercise of the police power.

#### *Standard 5: Is the Program Still Justified?*

When the ongoing evaluation shows that a program is no longer cost effective, the program should be stopped. As in the Colorado Springs program, this may mean that the disease risk has decreased. However, it may simply mean that the money and resources of the health department can be better used in other programs.

### **Political Factors and the Police Power**

In general, the courts have not stood in the way of legitimate public health enforcement unless their rulings were driven by a specific state or federal law that limits the constitutional scope for the police power. A major problem with the U.S. public health system is the lack of effective direction by public health professionals who are skilled in disease control. What is unusual about the work of Potterat et al. is not that the courts accepted their health hold system, but that a team of dedicated epidemiologists and disease control specialists would be together more than 20 years and would be allowed to continue their work.

The most detailed study of the U.S. public health system is presented in the Institute of Medicine's (IOM) 1988 Report, *The Future of Public Health*,<sup>11</sup> which described the

system as "... a hodgepodge of agencies, and well-intended but unbalanced appropriations—without coherent direction by well-qualified professionals." When the IOM's Committee on Emerging Microbial Threats to Health revisited the issue in 1992,<sup>12</sup> it reported:

It is the committee's view that there has been little positive change in the U.S. public health system since the release of that [the 1988 IOM] report. The recent rapid increases in the incidence of measles and tuberculosis are evidence of these continuing problems. . . . Steps have been taken to address inadequacies in these programs, but these responses are reactive, not proactive. It is the committee's belief that the prevention of infectious diseases must be stressed if the health of this nation's inhabitants is to be maintained or improved.

Since these reports, the CDC has expanded its initiative on controlling emerging infections,<sup>13</sup> but the overall U.S. public health system is in worse disarray than when the IOM last studied it. The administration's childhood vaccine program failed to address infrastructure problems that prevent long-term gains in immunization rates.<sup>14</sup> The states have only retreated further into politically balkanized disease control efforts, and the current climate in Congress is not supportive of increased federal control of state programs. Continued disintegration of public health programs is inevitable unless policy makers address the fundamental conflicts of interest in its organization and funding. The interests of the individual and the community are often in conflict in public health enforcement.

### **Conflicts of Interest in Public Health**

Although many factors underlie the failures in our public health system, it is the perspective of the authors that public health policy analysts often overlook a key issue: there is a fundamental conflict of interest between providing medical care to individuals and providing public health services to a community. The patient-autonomy model that underlies personal health care is incompatible with the subrogation of individual interests that is necessary for effective public health. As long as this conflict is ignored, there can be no meaningful progress in reorganizing public health services to combat emerging infectious diseases.

In the United States, the law measures conflicts of interest from the client's perspective. Potential problems arise when the interests of the client differ from the interests of the professional, or from the interests of another client. Conflicts of interest are nothing new in medicine.<sup>15</sup> The fee-for-service model for medical practice has always posed the problem of whether providers should be permitted to offer profitable treatments that were not medically indicated. In managed care plans, the question has become whether patients will be denied appropriate treatments to reduce costs.

These financial conflicts are obvious and are the subject of extensive legal and policy debate.

The conflicts in public health are much more subtle, because they involve only the best of intentions. They arise because the patient is the client for personal health services, but society is the client for public health services. It is the perspective of the authors, drawn from research and personal experience in running public health programs, that when personal health services are delivered by the public health system, the medical care providers favor the interests of the patients over those of society. Unfortunately, the compromises that this requires often harm the patients as well as society in general.

### How is Public Health Different?

Public health is different from other medical practice areas because it deals with statistical, rather than identified, lives. In emotional terms, physicians, other medical care providers, and laymen see medicine in terms of flesh-and-blood individuals needing care. A sick child commands our attention in ways that epidemiologic surveillance programs do not. A patient worried about the consequences of being diagnosed with a communicable disease, especially a deadly one, presents a compelling case for compassion and understanding, even if the consequences of that kindness bring harm to society and to the patient.

Medical care providers are taught the patient-autonomy model for the provider-patient relationship. This model considers the patient's interests and is based on the assumption that free choice is the preeminent value to be protected. In the ideal case, patients make an informed choice of therapies from those recommended by their medical care providers. Patients are free to seek alternative care from other medical care providers or from nonmedical healers, or patients may even choose to forgo care entirely.

This model is reinforced in most of the current ethical debates, and is pervasive in the right to die debate. Even in the most extreme cases, the question is not whether the patient has the right to refuse care, but whether the right has been knowingly exercised. Legal inquiry is limited to whether the patient is mentally competent to make a decision, whether the decision is based on full information, and whether it is coerced or freely made.

Public health, however, puts the community's interests before those of the individual patient. Although the health and the autonomy of the individual are protected to the extent possible, they are secondary.<sup>16</sup> Public health rejects the patient's right to have sole control of his/her treatment. The patient does not have the right to refuse diagnosis or treatment and still remain free to spread the disease. In extreme cases, such as pan-drug-resistant tuberculosis, this may mean patients will remain in isolation for the rest of their lives.

### The Ethos of Personal Health Services

Public health programs have expanded to include personal health issues such as heart disease prevention and wearing seatbelts. In many communities, public health departments have become the vehicle for the delivery of personal health services for the indigent population. This creates cognitive dissonance, because the health department personnel must shift between individual care and public health responsibilities. It should not be surprising that professionals steeped in the ethos of patient autonomy cannot make this shift easily.

Integrated programs tell the patients that they are in a personal medical services environment. The patients expect to have their autonomy respected and to control their own care. Patient demands pull the staff away from society's interests. The same tension is present in the general medical community: Are you betraying the patients when you report their communicable diseases? Should you respect the patient's wish to be anonymous? Should you ignore the signs of a communicable disease because the patient does not want to be diagnosed? The patient-autonomy model says these are the patient's choices. But who protects the rights of the uninfected? Personal health services consume more resources than do public health activities. The cost of medical care for one patient with pan-drug-resistant tuberculosis can drain the entire tuberculosis control budget for a city. A single premature baby can be more expensive than a communitywide prenatal care program. In any community that is not in the throes of an epidemic, more people need personal medical services than disease control interventions. If personal health funds are fungible with public health costs, that is if they come from the same revenue stream, personal health services will consume the public health moneys. This is inevitable. Few health care providers or politicians will put immediate human needs aside in favor of preventing future harm.

The more personal health services a public health program delivers, the smaller the percentage of its staff that will be public health professionals oriented toward disease control. At some point, the department will become hostile to professionals with a public health orientation because of the profound cultural differences between the public health emphasis on the protection of society and the personal health emphasis on the individual. The displacement of disease control professionals with personal health services professionals has greatly weakened the public health system in the United States. It has undermined the credibility of public health professionals. When legislatures and courts look to health departments for public health expertise, they get pleas for personal health services, not for disease control. The public health authority becomes just another voice in the chorus of personal health interests, rather than speak-

ing for the unique interests of the community in being free of controllable communicable diseases.

### *The HIV Epidemic*

One example should suffice to show the effects of personal health thinking on disease control. It is generally agreed that surveillance is the cornerstone of infectious disease control,<sup>17</sup> but only if it is combined with disease control interventions. The 1992 IOM Report opined that it is hard to tell if a worldwide surveillance network would have changed the face of the HIV epidemic. This is an important question, because policy makers will be reluctant to fund and support a surveillance system if it will not mitigate future epidemics. The HIV epidemic illustrates how surveillance in a personal health system leads to the Cassandra effect: the ability to see the future without the ability to affect it.

In the 1970s, STDs became so prevalent among gay men that big city STD clinics became gay men's health centers. This explosion of STDs was driven by the bathhouses, where men could have multiple anonymous sexual contacts. It was soon evident that bathhouses were extraordinarily effective in spreading communicable diseases of all types. The worst of the common diseases was hepatitis B, which became pandemic in the bathhouse patrons.

During this time, public health physicians worried about what else might take hold in such an effective system for transmitting disease.<sup>18</sup> The answer came a few years later: the high-frequency sexual encounters in the bathhouses had allowed HIV to gain an unshakable foothold before it was even detected. If the IOM is asking if we could have detected HIV earlier if we had looked harder, and would it have mattered, the answer is probably no. However, this is the wrong question. What we did detect in the 1970s was a cultural change that dramatically improved the efficacy of transmission of infectious diseases, because ultimately, most diseases are STDs, even if they have other means of transmission. The question should be, "Could we have predicted the spread of a new disease and taken steps to prevent it?" The answer is yes.

We failed to close bathhouses in the 1970s because too many public health professionals were caught in the rhetoric of patient-autonomy and protecting patient's rights.<sup>19</sup> When New York finally closed its bathhouses in 1985, the court's opinion upholding the closure seems to lament that action was not taken earlier.<sup>15</sup> Ironically, bathhouses are reopening in many cities,<sup>20</sup> and the same individual health rationales are again being used to defend them.<sup>21</sup> We not only missed our chance in the 1970s, but we also missed the lesson. Surveillance done in a personal health environment is useless when it is not used to support the restrictions necessary to mitigate the spread of disease. Even without HIV, the long-term consequences of the hepatitis B epidemic in the bathhouses would have been dire.

### **A Modest Proposal**

Public health is not about making individuals healthy; it is about keeping society healthy by preventing individuals from doing things that endanger others. Persuading people to wear their seatbelts, treat their hypertension, eat a healthy diet, and stop smoking is personal health protection. Stopping drunk drivers, treating tuberculosis, condemning bad meat, and making people stop smoking where others are exposed to their smoke is public health. Contrary to the recommendations of the 1988 IOM Report, the public health department should not be used as a comprehensive community health resource. Many personal health services still need to be delivered by a governmental agency, but it should not be the one that delivers public health services. Public health should be narrowly defined in terms of controlling the spread of communicable diseases in society. This should include food and water sanitation, immunizations, vector control, sewage treatment, and individual disease control actions such as antibiotic treatment and isolation.

Public health training should be restructured, starting with the schools of public health. No MPH program in the United States requires students to have a course in communicable disease control, as opposed to epidemiology. Public health law and enforcement are not required courses for an MPH. Because the MPH has moved away from its original purpose of providing the special skills to carry out communicable disease control, a new degree or additional certification should be developed in disease control and public health enforcement. The CDC should expand its teaching materials in these areas and should encourage medical schools to include disease control in their core curriculums.

Public health programs that are tied to personal health systems will face more problems as the health care system is restructured. It is clear that many states and the federal government are moving away from providing personal health services through governmental agencies. Funding is going to private sector models such as health maintenance organizations (HMOs) for the poor. We must act quickly to protect public health resources. As personal health services shift to these new private entities, we must preserve and strengthen the core public health functions in public health departments. If we fail to accept this challenge, we can only blame ourselves for the continuing disintegration in public health.

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The 4th...

THE CLINICAL...

At the...

0.002 to 64 µg/ml, tetracycline 0.002 to 64 µg/ml, cipro-

...and the...

**Protein Profile**

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