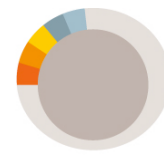


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Ethics and compulsory powers

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Isolation, quarantine and compulsory treatment all restrict individuals' rights. Our "European" or more broadly Western understanding of the importance of individual and rights balanced against the public good is not universal. Working in Hong-Kong in 2003 during the SARS outbreak, I observed that Hong Kong's response to SARS was based on the importance of respect for family and community solidarity, reflecting in part Confucian health ethics. In the West, we tend to prize autonomy as a primary principle of ethics, not only in relation to bioethics but also in the practice of public health. Differences in the cultural context of health will be an important influence on the ethics of public health responses to a pandemic.

One positive effect of the threat of pandemic influenza is the renewed interest in and focus on public health ethics as distinct from bioethics. SARS and the threat of pandemic influenza have provided the opportunity to engage in a critical examination of public health ethics with a view to developing principles that will serve the global public health community in generations to come. At the same time, we must not let our reflections be "hijacked" by the issue of pandemic influenza. The principles we develop must be equally valid once we have ceased to be concerned about the threat of pandemic influenza.

The PHLawFlu project (<http://www.ephln.org>)

PHLawFlu is a project with funding from the European Union. Its purpose is to determine the extent to which interventions proposed in the pandemic plans of 32 European states are supported or constrained by national, European or international laws. We are looking also to identify interventions that might potentially infringe human rights conventions, principles of non-discrimination or

protection of privacy. Laws that are not underpinned by ethics are likely to breed mistrust and to encourage non-compliance. History shows that unethical public health laws can, despite their good intentions, lead to public health harms.

National preparedness plans

Our research confirmed the existence of a wide range of approaches to pandemic planning across Europe, and significant gaps and inconsistencies between plans. For example the plan for one European country might deny health care to undocumented migrants, while another might be prepared to provide it. Some plans suggest that countries may close their borders in the case of a flu pandemic while other countries intend to keep their borders open, which might create problems in relation to the Schengen agreement. The interventions of any one country will reverberate across the other states of Europe.

Four models of disease control

In 2004 we undertook a preliminary study that identified four models of communicable disease law in Europe:

- the 'authoritarian' model, in which the state imposes a high number of compulsory control and prevention measures (mainly in Eastern and some Northern European states);
- the 'moderate' approach where predominantly compulsory control measures such as quarantine and isolation are provided, rather than prevention powers such as compulsory vaccination or population screening (the UK for example);
- the 'preventive' approach provides mainly compulsory preventive provisions, including screening, medical examination and/or vaccination, rather than compulsory treatment or detention (France is an example of this approach);
- a '*laissez-faire*' approach, in which states have few compulsory powers (Spain is an example of this last category).

In response to SARS and the threat of pandemic influenza, many states have upgraded their public health laws to add compulsory powers to their repertoire. **There has been a noticeable move towards the authoritarian model of disease control legislation. If we undertook the same study of public health laws today, we would struggle to find an example of the *laissez-faire* approach to public health powers.** Some states for example have introduced criminal penalties for persons who fail to comply with compulsory measures or who expose others to risk of disease. Many states now

authorize invasive medical examination without consent, or authorize vaccination or treatment without consent.¹

The balance between public good and private right will depend on the culture of the state. Some populations are more prepared to accept compulsory measures than others. Each nation will respond to a pandemic in the context of its own specific history, politics and social mores.

Social distancing, treatment and information proposals in pandemic plans

Among the main measures that might be undertaken to respond to a pandemic, some are common across states, such as:

- isolation of persons suffering from disease at home or in a hospital;
- quarantine of contacts of infected persons and groups;
- quarantining crews and passengers of flights from affected countries;
- imposing conditions of entry through borders;
- interrupting or suspending air, sea and land links, airports;
- surveillance, tracing , tracking, monitoring and identification of potentially contaminated persons.

Others are less common, and might raise difficult ethics issues, for example:

- isolation of non-nationals;
- closing of borders;
- compulsory treatment/prophylaxis/vaccination;
- police/army powers of enforcement of non-compliance offences;
- media control.

The role of the media in disease prevention and control must not be underestimated. It was interesting to compare the coverage of SARS and of tuberculosis in the British media in March and April 2003. Each day, there were a large number of articles on SARS, suggesting that SARS was a major public health threat to the British population, while there was virtually no media coverage of tuberculosis. Yet there was a significant number of deaths from tuberculosis, and no case of SARS in the UK in that time period. The media does much to shape, and sometimes distort, the public

¹ See for example the pandemic plans and laws of Finland, Malta, Estonia, Slovenia and Norway.

perception of risk. Hence some states have suggested control of the media to avoid the creation of panic and to ensure the promotion of public health messages.

Restriction of activities

Many proposed restrictions raise ethics questions, for example:

- restrictions on the use of public transport;
- prohibition of visitors to in-patients in hospitals and to the dying;
- restriction on trade union activities;
- closing of diplomatic and consular representations;
- compulsory cremation of bodies, which may infringe some religious or personal beliefs.

Provision of goods and services

Issues of ethics may arise from the following proposals :

- suspension of provision of healthcare for non-nationals (asylum seekers or undocumented migrants);
- obligation to work overtime, and more broadly the duty to treat, where workers might be exposed to risk of harm;
- requisition of premises, goods and persons for use in a pandemic;
- authorized use of unlicensed medicines and unlicensed staff.

Tensions in pandemic planning

Not all measures proposed in pandemic plans across Europe are reflected in national laws. There is a clear need for law reform to support pandemic planning. But it must also be said that much pandemic planning does not address the ethics of proposed interventions, and there is little attempt to situate pandemic planning within an ethics framework.

What does emerge is **a tension between on the one hand Western bioethics principles of autonomy, liberty and rights, and on the other hand the preparedness focus on utilitarianism and communitarianism as justification for measures that would not normally be acceptable.** Most state plans recognize that some advocated measures might result in an infringement of human rights. Some states have placed limits on interventions in recognition of European and international human rights conventions. Other states recognize a potential infringement of human rights, but justify such infringement on the grounds of public benefit.

Is a rights framework appropriate?

A feature of pandemic preparedness planning in Europe is that while there is concern about infringement of rights, less has been said in plans about responsibilities, about normative ethics obligations such as ensuring equitable access to healthcare, and about protection and social care. It is questionable whether a rights framework is the appropriate mechanism for examining compulsory public health powers.

Planning is predicated on the assumption that all members of the population will be equally at risk in a pandemic. But the reality is that it will be disadvantaged communities that are hardest hit – the elderly, the homeless, ethnic minority groups, especially those persons who do not speak the national language. Plans have failed to address as a priority the care and protection of the most disadvantaged sections of our communities.

A rights framework, deriving from bioethics, is predicated on the notion of autonomy and tends to ignore the fact that a high proportion of the world's population in the world has no real autonomy. Are rights meaningful if we have no autonomy?

Justice as a public health ethics principle

Public health ethics is not just about rights. It is also about justice in the distribution of public health burdens, and about social justice in access to opportunities and goods. It is about normative responsibilities to redress inequalities, to care for those most at risk of public health harms, and to redistribute goods so that all members of the population have an equal opportunity to survive a public health disaster. **Most pandemic plans fail to acknowledge central public health values such as reciprocity, social solidarity and trust.**

Rights are by their nature individualistic and adversarial, and they exclude discussion of compromise, cooperation or sacrifice. They also exclude discussion of the burden of care, and some ethicists, particularly feminist ethicists,² would argue that theories of ethics of care might be more appropriate as the basis for a public health ethics framework. As the WHO recognizes, the burden of care in a pandemic will inevitably fall on women, caring for ill family members, providing food for ill neighbors, looking after the children of the ill. A care rather than a rights framework would recognize that people's position in their culture will dictate their options, their behaviors and their values, and that people's lives are interdependent. The isolation or quarantine of one person will impact on others, more especially if the person subject to the public health power is a caregiver. Perhaps it is worth noting that some states have addressed the issue of care as a public health value. New-Zealand, for example, has conducted a review of the ethics underpinning of public health practice,³ and in

² For example see Baylis F, Kenny N and Sherwin S. A Relational Account of Public Health Ethics. (2008) 1 Public Health Ethics, 196-209

³. NZ National Ethics Advisory Committee 2007: *Getting through together: Ethical values for a pandemic*

recognition of both western and Maori values, concluded that public health ethics should include not only rights but also values such as the need to care for vulnerable populations, respect, fairness, reciprocity, neighborliness, solidarity and minimizing harm.

Another issue: the evidence base for compulsory powers

It would of course be unethical to provide powers that infringe liberties if exercise of those powers were not thought to lead to some public good. The problem is that we do not have much of an evidence base for many of the compulsory powers proposed in pandemic planning. A recent US study⁴ concluded that there were few benefits from compulsory isolation of the sick during a pandemic. Viral shedding begins before the onset of symptoms, so the only effective measure is quarantine of contacts immediately after contact with an infected person. By the time a compulsory order is issued it would be too late. At the more advanced stage of a pandemic, when virus transmission is sustained, it is generally agreed that the quarantining of exposed persons will be ineffective. A more effective means of achieving disease prevention is through public health education, advising people to voluntarily quarantine immediately after contact, explaining that this is the best way to protect their family and their community.

We can learn a lot from SARS. In Taiwan for example, during the SARS epidemic 130,000 persons were placed in compulsory isolation for more than ten days. Less than 0.3% of them were found to have suspected SARS. Enormous reserves of manpower and time were devoted to an exercise that achieved very little, but managed to anger and disillusion a large number of people. The US study⁵ also found that there is little evidence for effectiveness workplace closures, or restrictions on public gatherings and travel restrictions. These are included in nearly all European preparedness plans. Data on the restriction of school attendance was not conclusive. Some studies suggest that school closures are accompanied by lower rates of disease transmission, but other studies showed that the displacement of children to other settings had disease consequences. Furthermore, if schools are closed, we need to ensure that there is someone to look after the children.

Studies of responses to compulsory measures during the 1919 epidemic suggest that compliance dropped off after a time due to compulsory measures fatigue. When people are no longer convinced of the benefits of measures, they become cynical and begin to suspect that the risks are exaggerated.

⁴ Aledort J et al. Non-pharmaceutical public health interventions for pandemic influenza: An examination of the evidence base, 2007 *BMC Public Health*

⁵ op cit

There is also the issue of cost-benefits balance. During the 2003 SARS epidemic, many states introduced compulsory screening of travelers at airports, but screening was found to be both impractical and inefficient. At Hong Kong's international airport, where 90 million passengers were screened in this period. Only two possible suspected patients were identified.⁶ Screening requires vast resources which could be directed to other more effective interventions.

Why do pandemic plans place so much emphasis on compulsory powers?

Are states responding to the public perception of the risk, often distorted by the media, rather than basing interventions on scientific evidence? What is it about diseases such as SARS and human pandemic influenza that prompts such extreme reactions? Uncertainty about the nature and progress of the disease and the potential for large scale mortality and morbidity have created a climate of fear, as if the disease were an enemy about to attack. And this has led to the language of war and the concept of biodefence in pandemic planning. The former Federal Health Minister of Australia, Tony Abbott said of a disease pandemic: *"it would be more serious than any imaginable terrorist atrocity, short perhaps of a nuclear bomb in a major city"*.

Emergency powers and pandemic disease

Most European states (along with states all around the world) have upgraded their communicable disease laws to include a range of compulsory powers. But in addition, many states have also put in place emergency powers laws to apply to a pandemic.⁷ An emergency is defined as something unforeseen, temporal and finite, an aberration normally involving an aspect of violence such as war, rebellion or a violent natural disaster rather than an ongoing economic or health problem. Emergency powers have not until now been used as a tool for disease control.

Emergency powers are legal powers drafted to address unexpected threats, to authorize measures that would not normally be acceptable, or to provide powers as a last resort in the face of emergencies where existing legislation is insufficient.

The European Convention for the Protection of Human Rights and Fundamental Freedoms accepts that states may derogate from some of their obligations under the Convention in time of war or other public emergency threatening the life of the nation. The concept of a 'public emergency' is defined in Art. 15 as *"a situation of exceptional and imminent danger or crisis affecting the general public, as distinct from particular groups, and constituting a threat to the organized life of the community which composes the State in question."*

⁶ Cetron M, Simone P. Battling 21st-Century Scourges with a 14th-Century Toolbox. (2004) 10(11) Emerging Infectious Diseases

⁷ For example UK, US, Finland, Belgium, Norway, Slovakia, Sweden, Estonia, Czech Republic

Venice Commission 2006: an opinion on the protection of human rights in emergency situations

The legality of emergency powers was considered by the European Commission in the Venice commission in 2006 where it was stated that an emergency must be actual or imminent, its effects must involve the whole nation, and the continuance of organized life must be threatened. In addition, normal measures must be plainly inadequate⁸.

Why should measures contained in newly revised public health legislation not be adequate for a disease pandemic, given that the revisions have been undertaken with a pandemic in mind? In Hong-Kong, which there is considerable experience and expertise in pandemic disease, the extension of emergency powers legislation to cover disease has been rejected. Rather, Hong Kong's Prevention and Control of Disease Ordinance 2008⁹ was drafted to include all necessary powers in face of a pandemic. As the Venice commission pointed out: "practice shows that the gravest violations of human rights tend to occur in the context of states of emergency".

The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights

Similar provisions apply in international law. The Siracusa Principles¹⁰ state that, "*a state party may take measures derogating from its obligations only when faced with a situation of exceptional and actual or imminent danger which threatens the life of the nation*". A "threat to the life of the nation" is defined as "*one that threatens the physical integrity of the population, the political independence or the territorial integrity of the State or the existence or basic functioning of institutions indispensable to ensure and protect the rights recognized in the Covenant.*"

Is a pandemic a threat to the life of a nation? There is little case law on interpretation of the principles, but the term 'life of the nation' was considered by the English House of Lords in the case of *A v Secretary of State for the Home Department*,¹¹ in the context of terrorism laws. The Attorney General had submitted that a threat of serious physical damage and loss of life involved a threat to the life of the nation. Lord Hofmann disagreed: "*in my opinion this shows a misunderstanding of what is meant by 'threatening the life of the nation. Of course the government has a duty to protect*

8. The Greek Case, Opinion of the Commission

⁹ Cap 599

¹⁰ *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*

¹¹ [2004] UKHL 56.

the lives and property of its citizens. But that is a duty which it owes all the time and which it must discharge without destroying our constitutional freedoms”.

Not all threats to human welfare justify emergency measures. A disease pandemic, terrible as it may be, is not a state of exception. People will have to get on with their lives through the course of the pandemic, and we need interventions that support and not disrupt the continuation of normal life to the extent possible. We need laws that support the social order.

Concerns with the use of emergency powers for a public health threat

The appropriateness of using laws addressed to war and natural disasters for the purposes of disease control is questionable. Adversarial rights-based language engenders a fortress approach to disease control, in which a person affected with disease is characterized as the enemy. There is a conflation of public health and security in the notion of biodefence that brings to mind outdated public health approaches in which the purpose of public health laws was to build walls around the privileged to keep out the poor and less privileged, assumed to be carriers of disease.

There is also the danger that emergency laws, if in force for long enough, may become embedded in legal systems after a pandemic, an issue that concerned the Council of Europe in a roundtable meeting in Athens in 2006 in relation to emergency powers laws in Northern Ireland.

Emergency powers raise issues of discrimination in the application of powers. History shows that the people most likely to be the subject of emergency powers are those who are already the most disadvantaged, and because the living conditions of this segment of the population will be the poorest, they are the people most likely to be quarantined or detained in detention centres and will thus be more exposed to disease.

Coercive measures risk prompting evasive action and can be counterproductive, and can create distrust and distance between public health professionals and the population. Overuse of coercive powers may increase rather than decrease spread of disease.

Finally, bearing in mind the important role that the media play in public perceptions of disease risk, there is concern that the media may be even more scaremongering if the state portrays pandemic disease as a threat to security.

Conclusions

It is not helpful to critique compulsory powers using the language of rights, because a rights framework masks the real problems with compulsory powers. There are other principles of ethics, such as care and social justice, which are more important in a pandemic. Yet the only ethics principles that, in general, European pandemic plans have engaged with are rights principles. It is this focus on compulsion as a primary disease control tool, subject only to rights critique, that has led to perception of the need for emergency powers over the top of compulsory powers already provided by disease control laws.

Emergency powers are inappropriate for a pandemic we have had years to prepare for and that calls for community and individual responsibility, care and trust.

We need to rethink our public health ethics framework to reflect the task that public health is all about: the care and protection of the health of the population and all members of the population. And we need to do this now, in the calm before the storm. The public health ethics framework of each nation should reflect the values cherished by the culture of that nation. The protection of rights may well be one such value, but there will be other values such as responsibility to family and community, benevolence, reciprocity, solidarity, and social order that are valued within societies. A focus on rights as a framework for pandemic ethics is insufficient to guarantee the ethical management of a disease pandemic.