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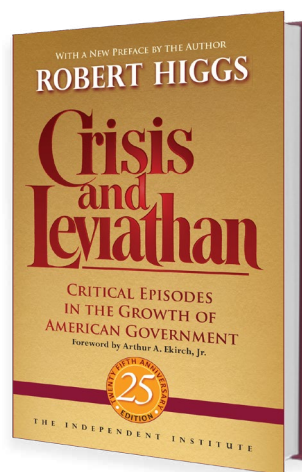
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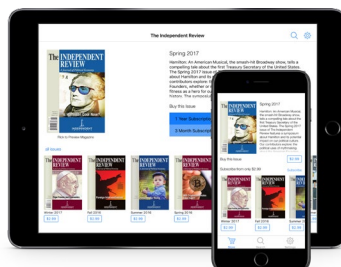
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REFLECTIONS

The Quarantine Quandary

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BECKY AKERS

When globetrotting groom Andrew Speaker was discovered to be carrying tuberculosis (TB) germs in May 2007, virtually no one questioned that the state should and could protect us from him. Apparently, healthy citizens suddenly lose their rights upon becoming ill; contagious folks who disobey public-health officials may be forcibly quarantined and isolated—that is, imprisoned without a trial. Like tribesmen throwing virgins into volcanoes, Americans assume that sacrificing one unlucky person’s rights will preserve their lives.

But does quarantine really protect the healthy? Or is it smoke and mirrors, designed to convince us that rulers are looking out for us when they are actually helpless? After all, Speaker easily outfoxed governments on two continents during his homeward odyssey. When the Centers for Disease Control and Prevention (CDC) suggested that he surrender himself to Italian authorities and claimed to have added him to the federal No-Fly List, Speaker booked tickets on a foreign airline instead. He and his wife flew to Canada, rented a car, and drove across the border into New York State. Speaker was finally hospitalized where he wanted to be and only because he chose to be, with no thanks to bureaucrats. But then, with help from a complicit media, they were busy exaggerating his infectiousness—just as they did with Typhoid Mary a hundred years ago.

More than mere historical and philosophical curiosity is at stake here. The Department of Homeland Security (DHS) and the CDC eagerly await their chance to quarantine us in the event of bioterrorism or a pandemic. Spokesmen for both bureaucracies have enunciated the moral of Speaker’s story, lest anyone misinterpret it: the government needs more and stronger laws, more and stronger authority. Is

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The Independent Review, v. XII, n. 4, Spring 2008, ISSN 1086-1653, Copyright © 2008, pp. 591-605.

“public health” yet another of Leviathan’s inexhaustible excuses for controlling Americans?



Rulers have long tried to persuade their citizens that they can stave off maladies. These attempts follow a common, callous pattern: the state turns people afflicted with certain illnesses into pariahs who may be exiled, imprisoned, or even executed. The abuse often extends to their families, friends, and neighbors, regardless of their health.

European and Asian countries were among the first to experiment with quarantines when they posted armed men around infected regions in the 1300s. These guards were permitted to murder anyone fleeing—and spreading—the contagion. Milan’s government forced those suffering from plague to forsake the city for the surrounding forest until they recovered or died. Ragusa quarantined newcomers from areas cursed with plague in facilities that must have been primitive at best: victims endured “purification by sun and wind” for a month, surely the longest of their lives (“History of Quarantine” 2004). New York City’s government topped this inhumanity in 1916 when it ripped children diagnosed with polio from poor parents. Wealthier families remained intact because they supposedly could hire nurses—and lawyers to fight such tyranny.



Dead men pay few taxes, which may be one reason that the state almost always sides with the healthy against the ill. Then, too, even at the height of the most severe epidemic, those who are well usually outnumber the stricken.¹ Moreover, almost all sufferers will not only seek medical advice, but follow it. Government can safely play the numbers game against the few who do not.

If we grant rulers the power to police contagious people, where do we draw the line? Should the state not only imprison the victim, but also doctor him against his will? Who will treat him: physicians the government appoints or those the patient chooses? What happens if their opinions conflict as to whether the patient is contagious—or even ill at all?

When ABC’s Diane Sawyer interviewed Andrew Speaker, he said that public-health officials told him he “wasn’t contagious, not dangerous.” He “repeatedly asked doctors, ‘Is my family at risk.’ . . . I was not advised to take special precautions around them” (Muir 2007). Speaker mentioned his plans to travel to Greece for his wedding, but no one prohibited his going (“Global Health Scare” 2007).

1. Scholars generally agree that the bubonic plague that struck the eastern Roman Empire in A.D. 542 and spread throughout much of the world was history’s worst pandemic. It probably killed half the earth’s population, or about 100 million people, over fifty years (see <http://www.trivia-library.com/b/natural-disasters-plague-of-justinian-at-constantinople-part-1.htm>). Procopius was a court historian under Justinian, the emperor during the catastrophe; his account of the devastation can be read at <http://procopius.net/theplague.html>. Most epidemics have lower infection and mortality rates, ranging from 10 percent to 40 percent.

Yet the hysteria that greeted the asymptomatic Speaker's return to the United States had bureaucrats scrambling to change the story. Dr. Martin Cetron of the CDC tried to make the newlywed sound like a fugitive from medical justice: "When we . . . finally caught up with this individual in Rome, [we] share[d] the information about the progressive culture results and [made it] clear that under no uncertain terms [*sic*] should he use aircraft." Yet even as Cetron pandered to the public's fears, he admitted, "We believe that his degree of infectiousness is quite low" ("People Potentially Exposed" 2007).

Dr. Neil Schluger, who treats tuberculosis at Columbia Medical Center in New York, pointed out that Speaker's "wife apparently has not been infected with tuberculosis and presumably she's had close contact with him for an extended period of time. . . . Secondly, when he coughs up phlegm and it's examined under the microscope, we don't see a lot of TB germs in the phlegm—and that's also a sign that he's probably not very infectious" (Muir 2007). Skeptics might question whether he was sick at all: after Speaker was hospitalized in Denver, his doctors "announced that a third consecutive test of his sputum—called a smear test—failed to find any TB bacteria. Speaker has consistently been 'smear negative' since he was diagnosed with TB in January" (Deans and Young 2007). Ironically—some might say criminally—the federal bureaucracy so anxious to apprehend Speaker may have been the source of whatever germs he carried. Speaker's father-in-law, Bob Cooksey, is a doctor at the CDC. He announced on May 31, 2007, "I do work at the Centers for Disease Control and Prevention. I have worked at CDC for 32 years. I am a research microbiologist in CDC's division of tuberculosis elimination." How coincidental that the son-in-law of a man who plays with tuberculosis germs contracted the disease. But of course an august bureaucrat at the CDC would never transmit infection. "As part of my job, I am regularly tested for TB," Cooksey continued. "I do not have TB, nor have I ever had TB. My son-in-law's TB did not originate from myself, or the CDC labs, which operate under the highest levels of security" (Slevin 2007). Let us pray that the security of labs housing specimens of smallpox, ebola, and other deadly germs is better than their managers' judgment. After tests revealed that Speaker actually suffered from MDR TB, a milder form than the XDR TB that the CDC had misdiagnosed, "the CDC said it still would have publicized the case even if it had known the true diagnosis when Speaker was traveling in Europe" (Roos 2007). Talk about your bullheaded bureaucrats.

From the state's perspective, how infectious Speaker was—or even *if* he was—does not matter. Far more useful was the public's panic, its belief that Speaker might kill with a cough anyone within spitting distance, and its certainty that only the government can save hapless citizens from annihilation. These ideas allow public-health boards to pose as heroes rescuing us from the selfish sick who insist on interaction rather than isolation.

Government's pretension of protecting the public's health bamboozles almost everyone, even those who love liberty. However much people loathe Leviathan, they

are willing to trust it in this one instance. But medical bureaucrats are as political and manipulative as any others. We see this in Speaker's story and in the tale of another asymptomatic whom New York City's Board of Health exploited early in the twentieth century.



Mary Mallon was a single woman and Irish immigrant who worked as a cook for wealthy families in the 1900s. Not only did she seem wholesome and healthy, but she was a skilled chef whose peach ice cream was everyone's favorite. Mallon was thirty-five years old when her employers took her with them to their summer rental on Long Island. Within a few weeks, half the household took sick with typhoid—as had other households for whom Mallon cooked.

Public-health officials eventually fingered her as the source. But “Typhoid Mary” vehemently denied that she was sick or ever had been. And she wasn't. Medical historians theorize that she may have either inherited typhoid bacteria from her mother or suffered a bout of it as an infant of which she was never told. In any event, she apparently carried typhoid bacteria all her life, infecting others while remaining healthy herself (as do approximately 3 to 5 percent of recovered typhoid victims). New York's health department arrested her, hauled her kicking and screaming to a hospital to test her urine and stool for typhoid, and then exiled her to an islet in the East River.

Not only did Mallon fight literally for her liberty as she was dragged away, but she later fought legally when she sued the health department. At trial, she presented the findings of an independent lab to which she had sent samples of her waste for a year. The lab's results consistently showed her free of typhoid. However, the health department had continued its tests as well, and it contended that three-fourths of her samples were positive for typhoid. The judge favored the board's analysis. Mallon remained on her islet.

How skillfully did the state care for its involuntary patient? Mallon charged its employees with ignoring the other, very real ailments that afflicted her in favor of the typhoid that obsessed them: “My eyes began to twitch, and the left eyelid became paralyzed . . . for six months. There was an eye specialist [who] visited the island three and four times a week. He was never asked to visit me. I did not even get a cover for my eye. I had to hold my hand on it whilst going about. . . . [M]y eye got better thanks to the Almighty God and in spite of the medical staff.” She also hinted at malpractice: “Dr. Wilson ordered me urotropin. I got that on and off for a year. Sometimes they had it, and sometimes they did not. I took the urotropin for about three months all told during the whole year. If I should have continued [it], it would certainly have killed me for it was very severe. Everyone knows . . . that it's used for kidney trouble [which was not among Mallon's complaints].” Not surprisingly, Mallon distrusted her government overseers. “At first I would not take [a prescribed medicine], for I'm a little afraid of the people and I have a good right for when I came

to the Department they said [the typhoid germs] were in my [intestinal] tract. Later another said they were in the muscles of my bowels. And latterly they thought of the gallbladder.” She resisted when her captors pressed an unethical bargain on her: “Dr. Studdiford said to this man ‘Go and ask Mary Mallon and inveigle her to have an operation performed to have her gallbladder removed. I’ll have the best surgeon in town to do the cutting.’ I said ‘No. No knife will be put on me. I’ve nothing the matter with my gallbladder.’ . . . Also the supervising nurse asked me to have an operation performed. I also told her no, and she made the remark ‘Would it not be better for you to have it done than remain here?’” As Mallon summarized the bureaucrats’ attitude toward her, “There was never any effort by the Board authority to do anything for me excepting to cast me on the island and keep me a prisoner” (“The Most Dangerous Woman in America” 2004).



A century later, public-health officials also considered Andrew Speaker their prisoner, even if they had not yet remanded him to an armed guard: “experts were trying to figure out how Speaker was able to jet off on his honeymoon with the knowledge of government officials”— as though “officials” should have stopped him (Young and Morris 2007). Few patients are likely to elude authorities in the future, however. Michael Greenberger, a professor of law and the director of the Center for Health and Homeland Security at the University of Maryland, opines, “I think this is going to be a lesson learned nationwide of the importance of local and county health departments being the front line of protection for the rest of the population” (qtd. in Young and Morris 2007).

Speaker lives in Atlanta. Georgia’s state epidemiologist Susan Lance took Greenberger’s lesson and ran with it. “I think the Fulton County Department of Health and Wellness [which supervised Speaker’s case] did their job to the best of their ability,” she told the *Atlanta Journal-Constitution*. But “there probably needs to be a review’ of the state’s laws and procedures governing restricting an ill person’s travel” (qtd. in Young and Morris 2007).

CDC director Dr. Julie Gerberding testified before a U.S. Senate panel “that despite Speaker coming back to the U.S. on his own . . . [against] CDC warnings, he was very cooperative when he returned. She admitted, however, the CDC had more legal authority to keep Speaker in the U.S., but that they assumed he would follow medical advice, as most patients do.” In a chilling post script, she warned that “patients may no longer be given the benefit of the doubt” (“Speaker Contradicts CDC on TB Warnings” 2007).

If Gerberding prevails, a trip to the emergency room may hereafter land a sick or injured person in quarantine: Speaker’s TB was discovered when he was X-rayed for a bruised rib sustained during a fall. Regardless of one’s reason for seeking medical help, despite one’s plans, priorities, duties, or a second opinion, one may face imprisonment for an incidental diagnosis. The “list of quarantinable communicable

diseases” extends well beyond TB. Executive Order 13295, which “provid[es] for the apprehension, detention, or conditional release of individuals” at “the [Health and Human Services] Secretary’s discretion,” names “Cholera; Diphtheria; infectious Tuberculosis; Plague; Smallpox; Yellow Fever; and Viral Hemorrhagic Fevers (Lassa, Marburg, Ebola, Crimean-Congo, South American, and others not yet isolated or named),” as well as “Severe Acute Respiratory Syndrome (SARS)” (White House 2003.) As if that order were not enough, another, more recent one adds “[i]nfluenza caused by novel or reemergent influenza viruses that are causing, or have the potential to cause, a pandemic” (White House 2005). A touch of flu may one day turn you into a quarantinable criminal.

This situation puts virtually everyone at risk of imprisonment. “The world is a very small place,” Dr. Shluger warns, “and undoubtedly, there are people with tuberculosis who get on airplanes and go on trains and buses in all corners of the world everyday and we just don’t know about it. And I think it really points out that TB some place is TB every place” (qtd. in Muir 2007).

Dr. Cetron of the CDC explained that the bureaucracy was tracking passengers who sat near Speaker on his flights, but the airlines had not yet provided complete rosters. In the meantime, “anyone who was on those flights who wishes further information for contact and follow-up . . . can call CDC info.” And what happens if those passengers do not volunteer for “contact and follow-up”? “We will also actively be reaching out to those individuals once we have the full manifests and the passenger information,” Cetron threatened (qtd. in “People Potentially Exposed” 2007).



Even those Americans most convinced that bureaucrats should safeguard public health might well reconsider this opinion when they read the government’s blueprints for protecting them. The DHS “has agreed that its personnel will assist with surveillance for quarantinable or serious communicable diseases of public health significance among persons arriving in the United States from foreign countries, with the understanding that *DHS personnel may not have medical training* and therefore are not expected to physically examine or diagnose illness among arriving travelers” (U.S. DHS 2007, emphasis added). Be forewarned: when returning from journeys in Scotland, Iceland, and other chilly climes, or if you suffer from allergies, you will want to stifle your sniffles and sneezes when U.S. Customs agents interrogate you.

“Surveillance by DHS personnel would generally consist of the recognition and reporting of overt visible signs of illness or information about possible illness provided to them in the course of their routine interactions with arriving passengers, and does not include eliciting a medical history or performance of a medical examination” (U.S. DHS 2007). One man’s “overt visible signs,” however, are another man’s clean bill of health. When the feds learned that Andrew Speaker had “fled” Italy and presumed he was on his way home, they flagged his passport to alert Customs and Border Protection. The agency’s employees were to “detain” Speaker when he applied for

entry into the country, but the guard at the Canadian border waved Speaker through because he showed no “overt visible signs of illness.” The DHS of course made a scapegoat of this unidentified agent, slapping him with administrative leave, while his boss lamented to a congressional committee, “I can offer no defense about what happened that day in Champlain.” Meanwhile, the DHS’s chief medical officer bragged that “[t]he system works as intended,” despite Speaker’s having made it a laughingstock. He also called the guard’s failure to apprehend Speaker “a single point of human failure” (qtd. in Maxwell 2007). That description seems a harsh one for an agent who “worked as intended,” but the DHS’s credibility was at stake. In September 2007, a “congressional investigation into officials’ inability to stop a tuberculosis patient from leaving the country found significant security gaps.” These gaps caused even a dedicated statist such as the committee’s chairman Bennie Thompson (D., Miss.) to doubt the government’s abilities: “If we can’t counter TB, how can we counter terrorism[?]” He added, “This was a real world incident and there was a breakdown at the intersection of homeland security and public health. The government has numerous plans and policies in place to secure our communities, but they just didn’t follow the playbook” (qtd. in Sullivan 2007). We citizens can only hope they will not follow it next time, either.

Salivating in the wings is one of the DHS’s sillier agencies, the Transportation Security Administration (TSA). This agency’s personnel, best known for their airport checkpoints, believe that cramming liquids and gels into Ziploc baggies renders them less explosive. The TSA also considers fingernail scissors lethal weapons that must be confiscated lest passengers manicure one another to death. These eccentricities and others apparently entitle it to protect American aviation from sick people: “The fact that the introduction or spread of a communicable disease through the transportation system is not necessarily a threat involving criminal violence or other unlawful interference with transportation does not preclude TSA from exercising its authority to address such a threat. TSA’s authority is not limited to dealing only with threats of intentional terrorist acts against the transportation system. TSA is charged with assessing all threats to transportation and executing such actions that may be appropriate to address those threats” (U.S. DHS 2007). If a passenger who may not even be infectious is a “threat to transportation,” what isn’t?

The TSA has seldom been accused of competence. The agency itself, DHS, and the inspector general of the Government Accountability Office constantly test airport screening, and all agree: the TSA has improved airline security about as much as it has on-time departures. Not only has it *never* passed any of these tests, but its rates of failure hover in the stunning 90 percent range, even when the screeners cheat. DHS’s acting inspector general, Richard Skinner, told the Senate Committee on Homeland Security and Governmental Affairs that “the ability of TSA screeners to stop prohibited items from being carried through the sterile areas of the airports fared no better than the performance of [privately employed] screeners prior to September 11, 2001” (U.S. DHS 2005).

The TSA also screens for more than bombs. It has occasionally grounded passengers who protest government policies, even as it vehemently denied blacklisting anyone (Rothschild 2002; Gross 2007). Now imagine that cholera fells you in Acapulco a week after your letter protesting the Bush administration's warrantless wire-taps appears in the *New York Times*: Should the incompetent and politically motivated TSA decide whether you may catch a flight home to your doctor?

The TSA will control passengers even more tightly with a "new program scheduled to begin implementation in 2008. . . . Under the domestic passenger screening program known as Secure Flight, airlines must send TSA passenger manifest information 72 hours before a flight's takeoff and the agency would continue to collect data for any passengers who purchase a ticket over the final three days before the flight's departure" (Johnson 2007). With Secure Flight, your chances of making it home from Acapulco shrink even further. "When we have Secure Flight," TSA spokeswoman Ellen Howe threatens, "we will be vetting that stuff in-house and you won't be worried about updates and when they go out to carriers" (qtd. in Johnson 2007). That procedure will save the passengers time for worrying about far more realistic dangers than infection from noncontagious passengers, such as kowtowing to bureaucrats for permission to travel.

Neither the DHS nor the CDC is satisfied to quarantine the lone citizen here and there. Like medieval governments that confined residents to infected areas even if doing so meant their deaths, both agencies have hatched dark plans for "restrictive measures such as *widespread or community-wide quarantine*" (CDC n.d., emphasis in original).² This scheming proceeds despite DHS secretary Michael Chertoff's admission that "the issue of quarantine" can "break our economy or result in unintended consequences that would cause as much havoc and as much harm as the disease itself" (U.S. DHS 2006).

Nevertheless, for "communities" facing an epidemic of SARS, the CDC advises "community-wide temperature monitoring, temperature screening before entering public buildings, or recommended or mandatory mask use," though "the effectiveness of these interventions has not been quantified." Still, "they might enhance public awareness and facilitate early detection of cases." Americans, like children, must be fooled and watched for their own good. They need "public health and healthcare officials" to dispense motherly reminders about "hand hygiene and respiratory hygiene/cough etiquette." If nagging does not work, the state will "address" "enforcement (e.g., controlling entry into and exit from narrowly defined geographic areas; border surveillance/monitoring; travel permits and credentials)." A preoccupation with freedom should not hamper "enforcement": "Although control measures should

2. The DHS has a number of pamphlets and pdf downloads that deal with "community quarantine." Browse their titles at http://search.fema.gov/search?q=community+quarantine&btnG=Go&sort=date%3AD%3A%3Ad1&output=xml_no_dtd&ie=UTF-8&oe=UTF-8&client=dhs&proxystylesheet=dhs&site=dhs. Access the CDC's batch at <http://www.cdc.gov/search.do?queryText=quarantine&searchButton.x=42&searchButton.y=10&action=search>.

never be used indiscriminately or in a manner out of proportion to the situation, undue caution should not inhibit the bold and swift implementation of the interventions upon which effective control depends” (CDC n.d.). Unfortunately, the CDC “continues to learn lessons from the [Speaker] incident and is completing its own review,” spokesman Tom Skinner told the Associated Press in September 2007. He added, “Preparedness is a process and not an event and people need to realize that we are light years ahead of where we were six years ago. . . . Each instance, such as the one last May, is a way to test and exercise the government’s systems” (Sullivan 2007). Each instance is also a way to see how far those systems can coerce a panicked public.



The CDC and the DHS’s butchery of freedom seems like a mercy killing, however, when compared with the Model State Emergency Health Powers Act (MSEHPA). The tax-funded CDC paid an attorney at the Center for Law and the Public’s Health at Georgetown and Johns Hopkins Universities to hatch this monstrosity in 2001. The author’s credentials alone warn us that his legislative model, intended as a prototype for states to adapt, will not deal gently with freedom: Lawrence Gostin headed Hillary Clinton’s notorious Health Care Task Force on Privacy and the Health Care Infrastructure in 1993. The intervening years have not softened his radical authoritarianism. He laments that “[e]xisting laws thwart public health officials in rapidly identifying and ameliorating health threats, thus jeopardizing the public’s safety” (qtd. in Dougherty 2002).

In fact, “existing laws” merely thwart doctors and bureaucrats from easily coercing sick people such as Andrew Speaker. No law prevented them from “rapidly identifying and ameliorating” Speaker’s TB—with his consent. And there’s the rub. Gostin believes “governors and public health officials” should have “the power to act decisively [read: dictatorially] in the event of a bioterrorist attack or emerging infectious disease” (Dougherty 2002). Neither decency nor humanity seem to trouble Gostin: in any conflict between obedience to authority and compassion, he sides with obedience. He advocates financial ruin for rebels, even those already suffering from a fatal disease. Referring to Speaker, he intoned, “There are a number of cases that say a person who negligently transmits an infectious disease could be held liable. So long as he knew it was infectious, and knew about the appropriate behavior but failed to comply, he could be held liable” (qtd. in Slevin 2007). Speaker, who practices personal-injury law, got a taste of his own medicine in July 2007 when three of his fellow passengers filed a lawsuit against him (Montpetit 2007). Meanwhile, lawyers muttered about whether he should be disbarred (Giacolone 2007). Have some mercy, counselors: How will Speaker pay the circling vultures if he can’t earn a living?

As breathtaking as Gostin’s lack of compassion is his ignorance of history. He justifies the sweeping powers his “model” hands state governments by emphasizing the “danger to [the nation’s] health, safety, and security from biological agents that

is unprecedented” (qtd. in Dougherty 2002). This claim would be news to American Indians and settlers on the frontiers during the eighteenth century who occasionally gave or sold blankets infested with smallpox to each other, unless the British army beat them to it. As one of the few actual cases of bioterrorism in our history, this inhumanity killed whole villages. Yet Gostin discounts it in favor of the specters conjured to excuse his legislation.

When the MSEHPA was published in October 2001, it rang alarms across the political spectrum. Gostin’s mendacity probably accounts for some of the ruckus. He named several organizations as collaborators, such as the National Governors Association and the National Conference of State Legislatures. Though no doubt guilty of other sins, these groups had nothing to do with his proposed act. He also implied that the MSEHPA was a response to the catastrophes of 9/11. Actually, it repackages tired old schemes beloved of the public-health bureaucracy but feared by normal folks; Gostin and his colleagues capitalized on tragedy to revive measures rejected in more rational times, as political opportunists always do.

The MSEHPA enables governors to declare the equivalent of martial law in the event of a “health emergency,” but instead of the army, governors and public-health officials are in charge. The governor alone decides when to announce such an emergency, and no one—not the legislature, the courts, or an honest public-health official (if any exists)—may override that decision for sixty days. What constitutes an emergency under the MSEHPA? Just about anything: “an occurrence or imminent threat of an illness or health condition, caused by bioterrorism, epidemic or pandemic disease, or novel and highly fatal 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. Such illness or health condition includes, but is not limited to, an illness or health condition resulting from a national disaster” (MSEHPA 2001, §104[1]).

As sweeping as this definition are the powers bestowed on health officials. They may examine, treat, vaccinate, and quarantine us against our will—after confiscating our firearms. They may ration food, fuel, and alcohol. They may rob us of our property, from cars and computers to nursing homes and pharmacies. Nor need they return what they snatch: labeling our belongings either a danger or a necessity to public health is their version of eminent domain. Both police forces and the National Guard will report to health officials for orders; doctors and citizens who do not cooperate will be charged with misdemeanors.

The MSEHPA riled so many people that a second, supposedly less incendiary draft was released a few months after the first. As the Association of American Physicians and Surgeons points out, however, the “changes” changed very little; they merely shuffled the powers and the rights they destroy. Resisting treatment is no longer a crime, for example, but anyone who refuses to be tested for illness may still be quarantined indefinitely (Orient and Schlafly 2002).

Despite the initial outcry, much of the MSEHPA has quietly infected statute

books throughout the country. “As of July 15, 2006, . . . forty-four (44) states, the District of Columbia, and the Northern Mariannas Islands” had “introduced” it “in whole or part through 171 bills or resolutions. . . . Thirty-eight (38) states [Alabama, Arkansas, Arizona, California, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Wisconsin, and Wyoming] and DC [had] passed a total of 66 bills or resolutions that include provisions from or closely related to the Act” (Center for Law and the Public’s Health n.d.).



The “implementation” that this Hydra-headed legislation authorizes is undoubtedly as “bold and swift” as the CDC could wish. Yet even the most severe epidemic does not call for such tyranny, especially when we consider two facts. First, many people, especially those whose immune systems are weakest, such as the elderly and infants, voluntarily quarantine themselves anytime illness strikes. On a winter’s day when cold or flu germs rage through a neighborhood, many retirees stay home, and parents refuse to take their babies out of doors. How many more people would hibernate if the threat were as serious as diphtheria or yellow fever? Second, the CDC admits that “the effectiveness of containment measures [does not] require 100% compliance. . . . Even partial or ‘leaky’ quarantine can reduce transmission. . . . Modeling studies of the relative contributions of quarantine and vaccination in control of smallpox outbreaks suggest a benefit from quarantine even when compliance is as low as 50%. The incremental benefit of quarantine approaches a maximum at a compliance rate of approximately 90%” (CDC 2004). In the event of a smallpox epidemic, we would likely fail to find ten out of one hundred people willing to open their front door, much less venture outside.

The private sector offers a fairer, more practical, much less intrusive, and cheaper alternative to quarantine and isolation than does government. First, modern antibiotics and inoculation have dramatically reduced any need for either quarantine (which the CDC defines as “the separation and restriction of movement of persons who, while not yet ill, have been exposed to an infectious agent” [CDC 2004]) or isolation (separating those who are ill). Maladies such as bubonic plague that were once assumed to spread from person to person are now known to have other primary carriers.

Even more rarely can force be justified. Most victims readily follow medical advice when ill—and often even beforehand. Indeed, Speaker was obeying doctors when he flew home from Europe. He had been told that a hospital in Denver, Colorado, was the one best equipped to handle his particular strain of TB. The CDC subsequently tried to overrule that advice, suggesting that for the sake of public health, Speaker turn himself in to Italian authorities for isolation and treatment there. As would most people, Speaker rejected orders that clearly put others’ welfare ahead

of his, orders that might cost him his life: “I thought to myself: ‘You’re nuts’” (qtd. in Young 2007).

Nor does Speaker’s refusal to fall on his sword negate his efforts to reach Denver and the isolation unit that awaited him there—or the federal attempt to thwart the very action that would best protect both Speaker and the public. No wonder the sick man complained, “This is insane to me that I have an armed guard outside my door when I’ve cooperated with everything other than the whole solitary confinement in Italy thing” (qtd. in Young 2007).

Suppose, however, that he had not cooperated. What if he had persisted in his travels, sowing illness in his wake? What about Typhoid Mary (assuming the Board of Health correctly diagnosed her)? Again, such incidents are exceedingly rare. Much of Mallon’s notoriety resulted from her unique refusal to isolate herself voluntarily. When a new health commissioner freed her after three years’ exile on the condition that she never again prepare food for others, she agreed, but promptly resumed cooking under an alias. (A biographer defends these actions by emphasizing that Mallon never believed herself to be an asymptomatic carrier. She also owned no other skills as remunerative as cooking [Leavitt 2004].) For the next five years, she cooked in New York City, until officials followed a trail of typhoid victims to her door. This time, they imprisoned her for life on the island.

Hardly any other such cases have arisen, and those few could have been better handled through free-market publicity. In the age of the Internet and twenty-four-hour news, someone whose doctors deemed him contagious but who refused isolation would likely reconsider if told that his picture would be featured on “IllAndDangerous.com” and the evening news. The victim’s ability to sue for libel would keep doctors, Web sites, newspapers, and broadcasters honest.

This scenario is not merely hypothetical; something similar actually occurred in the Speaker saga. The CDC coyly refused to identify Speaker at first because of its previously hidden concern for “individual freedom.” Dr. Gerberding told the press, “We’re balancing both the needs to protect individual freedoms and the responsibility to protect the public” (qtd. in Young 2007), and Dr. Cetron announced, “We cannot and won’t talk further about this individual patient or the specifics of his medical care out of respect for his privacy” (“People Potentially Exposed” 2007). Reporters challenged their claims: “What about people who work with him,” one asked, “[who] spend eight hours or more in a confined space with him? . . . [Y]ou’re not revealing his name for privacy reasons. Is that a legal or is that a medical decision, and at what point does the public have the right to know, for instance, co-workers, et cetera, versus the personal privacy rights?” Another insisted, “When do you cross that level to say OK, it’s better to let people know who this person is so they know immediately that they were in contact with them, publicly releasing his name, public health issue versus maintaining his privacy?” (qtd. in “People Potentially Exposed” 2007).

Cetron smugly responded, “I think we can achieve the public health objectives without disclosing this individual’s name and invading his privacy. And that’s an

important principle for us to uphold.” It’s also an arrogant principle. Doctors are often wrong, even those who wear the CDC’s badge. The agency chose to notify only “close family contacts and immediate, work contacts, plus this group of two rows in front [and] the row behind [Speaker’s seats in the planes in which he flew home]” (“People Potentially Exposed” 2007). What about Speaker’s neighbors in Atlanta, the people who occupied elevators with him during his honeymoon, taxi drivers, waiters and waitresses, his barber? Should federal authorities unilaterally decide that these people need not be advised of their brush with a potentially fatal illness? Should a supposedly free government deprive them of the chance to take whatever precautions their own peace of mind or their doctors require? Only in totalitarian regimes does a handful of bureaucrats determine everyone else’s fate.

The autonomy of a contagious person may at first seem incompatible with society’s safety, but only because government has insinuated itself into the debate. It pits us against each other in the hope that we’ll cling to it for protection. Yet the sweeping powers it claims for protecting the public’s health are simply another excuse to continue its malignant growth. Rather than quarantining the sick, we ought to quarantine the state.

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