Bioethics and Defense

Of Terrorism and Healthcare: Jolting the Old Habits

GRIFFIN TROTTER

Please send any communication, ideas, proposals, or submissions for "Bioethics and Defense" to Griffin Trotter at trotterc@slu.edu.

Old habits die slowly. Hence there is little surprise that attorneys fashioning the Model State Emergency Health Powers Act preserved much of their own standard operating procedure. This model statute was designed for the worst of times—for horrific scenarios in which terrorism, infectious disease, or natural calamity threaten to derail the machinery of civilization while snuffing out thousands or even millions of human lives. Such grave threats seem to justify grave measures aimed at restoring order and maximizing survival. So, the model statute bestows sweeping power on state governors and public health officials, allowing them to seize private property, obtain clinical services through impressment, and enact quarantine and isolation measures without the usual due process. Yet amid all these drastic measures, certain standards persist. In Section 503 (subparagraph (e)(3)) of an October draft, the following stipulation appears:

> A person isolated or quarantined pursuant to the provisions of subparagraphs (1) and (2) shall have the right to a court hearing to contest the ex parte order. If such person or his or her representative requests a hearing, the hearing shall be held within seventy-two hours of receipt of such request, *excluding Saturdays, Sundays, and legal holidays*. The request must be in writing. A request for a hearing shall not stay the order of isolation or quarantine. [emphasis added][1]

Yes, horrific threats require weighty interventions, including even the involuntary detainment of law-abiding citizens thought to be possible disease vectors. But these exigencies are not so dire, according to the authors of this model statute, to compel attorneys to cancel their vacation plans. Weekends and holidays remain sacrosanct, reflecting the established habits of the American legal profession.

If the new War on Terrorism and the threat of nuclear, biological, and chemical (NBC) weapons is not enough to stimulate the judiciary to revise its calendar, then perhaps it is unrealistic to suppose that other professions or citizens will be inclined to respond or change in a significant manner. Just a few months out from September 11, and already the American economy is recovering nicely. And, despite the initial bravado, enthusiasm for rooting out terrorists seems to be dwindling among United States' allies and many of its leading intellectuals. The world is ready, it seems, to lapse once again into the old, comfortable habits.

This new column—Bioethics and Defense—is premised on the convic-

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tion that such a lapse is neither likely nor clearly desirable. In the wake of terrorist attacks and looming NBC threats, the world will change, and so will healthcare. Within our changing political landscapes, contemporary healthcare will be presented with a number of special opportunities, liabilities, and threats. The new column also rests on a belief that is endemic to bioethics, yet suspect within most of the academic community—the belief that deliberation is efficacious, that ideas change history. On this view, it is imperative that individuals, communities, and nations respond intelligently and creatively to the looming dangers, forging better, more effective habits. The hope of bioethics and of this column is that, given sufficient resolve, human ingenuity and clear thinking can win out over blind economic, political, and social forces.[2]

The War on Terrorism manifests a conjoint idea: (1) that noncombatants are not truly free unless they experience a very high level of security against violence; and (2) that the moral imperative for establishing this kind of security is so strong that it justifies enduring long periods of heightened insecurity. Like most ideas whose historical time has come, this idea is a reinterpretation of similar, older ideas that have been germinating for many years. Now, however, large numbers of people are apparently ready to fight for it. Many of these people reside in the United States, Great Britain, and other industrialized countries, where luxury and personal freedom have risen to historically unprecedented levels. Americans taking a stand against terrorism are in many ways akin to the Americans who took their stand against random taxation and other infringements of the British monarchy in the late eighteenth century. These contemporary Americans are not particularly afflicted by terrorism—just as the colonials were not particularly afflicted by taxation.[3] But when terrorism strikes savagely, as in the World Trade Center attack, they experience it as an intolerable affront. The received affront is a function of the tenacity with which citizens adhere to a specific ideal of freedom, and to its aforementioned corollary—the necessity of security against deadly malefactors. If this idea is destined to carve its niche in history, as I submit it will, then we can expect that its effects will ripple through all major institutions and practices—including healthcare.

Our concern in Bioethics and Defense will not focus on the justifications for a War on Terrorism, nor specifically on the grievances that precipitate hatred of Americans, Jews, capitalists, or other targets of terrorist activity. Instead, we will focus on healthcare values and how they are or might be affected by the War on Terrorism and other political/social events pertaining to the security of nations. We will undertake to include as broad an array of perspectives as possible, though always mindful that bioethics is a product of (and intrinsically biased toward) peculiar freedoms that are part of the issue in many international conflicts.

Of interest to bioethicists, several old healthcare habits may be up for revision. First, there is the long-standing deference to individual autonomy. The principle of autonomy, arguably bioethics' primary and most cherished value, has produced the centerpiece of clinical ethics—the doctrine of informed consent. Now, with the mandate for research and development in bioterrorism preparedness, with the emphasis on enhancing state quarantine and decontamination powers and with seismic social shifts toward solidarity over individualism, the primacy of autonomy and of individual patient rights in general may be challenged. Standard informed consent procedures, for

example, are incompatible with efficient and effective disaster medicine. And the doctrine of informed consent is abandoned altogether in certain provisions of the Model State Emergency Health Powers Act. For the most part, bioethicists have overlooked disaster and emergency medicine, and public health has only recently garnered a modicum of attention. All of that will change.

Freedom, the value that contributed so much to the current furor, is apt to undergo a parallel movement—from the concept of unencumbered individual choice (as per bioethics' autonomy theorists) to a notion of effective civic participation (as per James Madison, Thomas Jefferson, and the rest of that crew). Such shifts beget stentorian echoes. In narrative ethics, for instance, communal stories (of civic participation) would begin to crowd out private recollections (of autonomous experiences). This development, combined with a blossoming regard for efficiency (now celebrated not merely as a means to cost-containment, but also as a central virtue of disaster medicine), would transform the landscape of clinical ethics.

If it is suddenly OK in crisis situations for government officials to confiscate hospitals and clinics, and to impress physicians and nurses, then perhaps the new solidarity will also dictate that it is permissible to charge taxpayers for a system of universal healthcare access.[4] Hence, a second old habit of healthcare (or at least of American healthcare)—the emphasis on corporate solutions and government noninterference—may now be up for revision. This development would be a boon for bioethics, which has remained basically steadfast to its originative constituency—left-oriented, big government liberalism. However, even right-leaning bioethicists might be sanguine about government-sponsored healthcare, should this development be linked to national security.[5]

Within bioethics we can expect some shifting alliances. Market-oriented libertarians from the right, for instance, may find themselves substantially in agreement with civil libertarians from the left—and poised to confront a consensus-minded, solidarity-oriented bioethical middle that happily converts government grants into more justifications for government power.

Old habits may be stubborn—but, almost certainly, many of our most reflexive healthcare patterns will undergo great scrutiny, revision, and even transmutation, as we face the specter of international conflict and social change. I began this commentary with a swipe at health lawyers. And so perhaps it is only just that I look to this venerable profession for a parting ray of hope. On December 21, 2001, the previously cited Model Emergency State Health Powers Act was revised, and its authors scrapped a few more old habits. In the new version, courts were held to a 72-hour time frame in responding to challenges from isolated and quarantined individuals—with no extension for weekends or holidays.[6]

The permutations of incipient healthcare values, and the resulting countervalences, are indeed endless—and far beyond the scope of this brief prospectus. Bioethics, like the War on Terrorism, is an international event with a Western epicenter. As the academic field encounters the international conflict, new voices and novel ideas will arise. It is our desire that many of these ideas will find a discerning, attentive audience in the readership of *CQ*. Eventually, perhaps, new epicenters will form, and the world will reverberate with energetic, intelligent, and peaceable dialogue between its several communities of inquiry.

Notes

1. Model State Emergency Health Powers Act. Draft as of October 23, 2001. Available at: http://www.phppo.cdc.gov/phlawnet/. Accessed December 10, 2001.
2. According to philosopher Charles S. Peirce, economic, political, social, and psychological "laws" are merely petrified habits, as are even the laws of physics (which reflect the habitual behavior of matter). Although bioethics is anything but beholden to Peirce's metaphysics, it is nevertheless founded on a Peircean conviction (shared in various manifestations by Dewey, Habermas, and many other successors) that if we think critically about social conventions and established practices such as those that govern healthcare, we have the power to revise or reconstruct them for the better. Human spontaneity—as a countermeasure to ingrained habit—is alive and well on this view.
3. Many European, Middle Eastern, African, and Asian nations have experienced more numerous terrorist attacks and war casualties than the Americans have. Likewise, Americans of the late eighteenth century were among the lightest taxed people in history—and taxed less by the crown than citizens of Great Britain were. The affront to colonial Americans was that they were taxed without representation, and hence (in their view) unjustly. Likewise, what bothers twenty-first-century Americans is not merely the threat of dying in a terrorist attack. They are still far more likely to die in other disasters such as tornadoes, hurricanes, and earthquakes. The injustice and the malevolence are what disturb them.
4. In a similar vein, Jonathan Moreno writes, "A sense of social solidarity that this country has not experienced since the early 1950s and the advent of social security could alter the balance in favor of greater concern for equity in access to health care." See: Moreno J. Bioethics after the terror [Advance publication of selected excerpts]. *American Journal of Bioethics* 2002;2[Online version]. Available at: http://ajobonline.com/excerpts/excerpts_moreno. Accessed December 3, 2001.
5. See: Trotter G. Emergency medicine, terrorism, and universal access to healthcare: a potent mixture for erstwhile knights-errant. In: Moreno J, ed. *Bioethics after the Terror*. Cambridge, Mass.: MIT Press, forthcoming in 2003.
6. Model State Emergency Health Powers Act. Draft as of December 21, 2001. Available at: http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf. Accessed February 3, 2002. The section dealing with individual appeals of quarantine or isolation orders is located in Section 605 (c)(1) of this draft.