



2003

A Tribute to Gene W. Matthews


Lawrence O. Gostin

Georgetown University Law Center, gostin@law.georgetown.edu

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31 J.L. Med. & Ethics 476-481 (2003)

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Preface

Emerging Issues in Population Health: National and Global Perspectives

A Tribute to Gene W. Matthews

Lawrence O. Gostin, Guest Editor

One afternoon in 1998 in the lobby of the Emory Conference Center, across the street from the Centers for Disease Control and Prevention (CDC) on Clifton Road in Atlanta, I sat on a leather sofa with one of my oldest, dearest friends—Gene Matthews, Legal Adviser to the CDC. Gene asked to meet me to talk about how we might invigorate the field of public health law. Matthews and his colleagues at CDC were hatching an idea to commence a grass-roots movement in public health law.

The movement would include all those disparate groups that saw law as a tool to promote the population's health. The potential constituents of the movement included legal counsel in public health agencies, partners in non-profit organizations, private attorneys involved with public health litigation, public health officials, legislators, and academics in schools of law, medicine, and public health. All these groups had been working on matters of population health, but rarely, if ever, came together to share ideas and strategize on their agendas. Jim Curran, Dean of the Rollins School of Public Health at Emory University, later called this idea a "Public Health Law Collaborative."

As Gene recently put it: "I had no idea when we sat down on that sofa in the lobby of the Emory Conference Center that things would go like they have. I owe most of what has happened positively in my professional world in the past 5 years to that which flowed out of that encounter. Still much to be done." Those were the words Gene used in announcing his retirement after precisely a quarter of a century of distinguished service to American public health. This symposium issue of the *Journal of Law, Medicine & Ethics* is dedicated to the career of Gene W. Matthews. The volume is appropriately titled: *Emerging Issues in*

Population Health: National and Global Perspectives.

I am humbled in the face of such a giant figure and such a gentle, wise man leaving his distinguished government service. Gene Matthews has meant everything to law and population health—he founded the modern field, nurtured it, and provided such profound leadership and wisdom that I cannot begin to express his contribution in words. His service at CDC will be sorely missed, but never forgotten. As Gene leaves his government service and moves his work to the private sector, he has the deep appreciation of everyone who cares about using law as a tool for promoting the public's health.

Gene Matthews became the Legal Advisor to CDC in 1979—he was the only attorney at that time, but the HHS Office of the General Counsel now has a staff of 24 attorneys serving CDC. He worked under 6 CDC Directors and has contributed to some of the most important milestones in public health history. (I have repeatedly urged Gene to write a book of contemporary history on the subject, and I hope his retirement from CDC will now allow him time to do that). He was in the room when the CDC staff was informed about the first 4 cases of AIDS in 1981. He witnessed remarkable events in the growth of CDC and public health, including the unfolding of the AIDS epidemic, the establishment of the Superfund environmental programs, the retooling of worker protective equipment, the maturing of our nation's immunization programs, and the implementation of tobacco prevention strategies. Since September 11, 2001, he also witnessed the new era in public health, as CDC has learned to handle such urgent demands as the anthrax attacks, West Nile virus, smallpox preparedness, SARS, and monkeypox.

I vividly recall Gene's last visit to Georgetown University Law Center in November, 2003, where he laid out a vision for global governance of SARS. His eyes glittering

Journal of Law, Medicine & Ethics, 31 (2003): 476–481.

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with excitement, Gene drew a map suggesting a new order of global governance based on David Fidler's brilliant work published in this volume. Armed with Gene's wise counsel, I left for Geneva the following week to talk about the World Health Organization's International Health Regulations.

So what did hatch at that eventful meeting at the Emory Conference Center in 1998? What is Gene's legacy? Gene, along with several "zealots" at CDC (Richard A. Goodman, Anthony D. Moulton and, more recently, Frederic Shaw and Montrece M. Ransom just to name a few) launched the Public Health Law Program within CDC's Public Health Practice Program Office.¹ The creation of the Public Health Law Program was CDC's recognition of the indispensable role that law has played in most of the great public health accomplishments of the 20th century, from smoking reduction to record-setting childhood vaccination rates. The Program has actively advanced the field: hosting the world's first conference on public health law, now an annual event; initiating a grant program for empirical research on public health law; and supporting two collaborating centers on public health law—one on research and the other on collaboration.²

The Public Health Law Association (PHLA) was founded at the CDC's annual meeting of public health law in the summer of 2003. The Association is dedicated to the promotion of healthy communities through dialogue, partnerships, education, and research in public health law. Robert M. Pestronk, Cynthia Honssinger, and Montrece Ransom offer a brief account of the PHLA in this volume.

The HHS Office of the General Counsel and the Public Health Law Program at CDC have emphasized public health law preparedness since the tragic events of September 11th. Indeed, on October 5th, 2001, the day after the first reported case of anthrax, Gene called me about the need for emergency preparedness. He had the foresight to understand that the White House and Governors would insist on strong emergency health powers in light of the attacks. Public health law scholars, he argued, should provide the tools for political leaders to make informed choices. During that conversation, we devised a strategy to draft the Model State Emergency Health Powers Act (MSEHPA) as a checklist which states could use to ensure adequate legal authority. The Center for Law and the Public's Health at Georgetown and Johns Hopkins wrote the MSEHPA with the guidance of a broad group of advisers. Currently, 32 states and the District of Columbia had passed bills or resolutions that include provisions from or closely related to the Act.³

Many legislators lamented the absence of a model law that could be used routinely by public health agencies, without the need for a declaration of a public health emergency. The Institute of Medicine, in its landmark report on *The Future of the Public's Health in the 21st Century*, lent its weight behind reform of antiquated public health laws to make them more uniform and effective.⁴ At the end of

2003, the Robert Wood Johnson "Turning Point" National Excellence Collaborative⁵ launched such a model law—the Model State Public Health Act (MSPHA).⁶ This model law provides a tool for states to revise their laws to comply with modern public health mission, functions, and essential services. The MSPHA was written by James G. Hodge Jr. and me with broad support from a nationally recognized advisory committee, chaired by Deb Erickson, and comprising members from the major governmental and non-governmental organizations in public health. A condensed version of the MSPHA is reproduced in an Appendix to this symposium, and the full Act is accessible at: www.publichealthlaw.net/Resources/Modellaws.htm. Similar public health law reform efforts are ongoing in Asia,⁷ Europe,⁸ and Australia,⁹ particularly in the aftermath of SARS.

A FIELD OF SCHOLARSHIP ON POPULATION HEALTH

The field of public health law and ethics needs a body of scholarship advancing its theory and practice at the global and national level. This *JLME* symposium, *Emerging Issues in Population Health: National and Global Perspectives*, offers the kind of rigorous and practical scholarship needed to begin the conversation. It is the second such *JLME* symposium,¹⁰ this time seeking to highlight the population-based perspective in international and national contexts. I have had the privilege of working with some of the most highly regarded public health law scholars and practitioners in assembling the articles and commentaries in this issue of *JLME*. I offer thanks to my colleagues at the Center for Law and the Public's Health, Lesley Stone and Lance Gable, for helping to assemble this collection of essays.

The Symposium is divided into four parts, representing some of the most vital and intriguing issues in the field today: Global Challenges in Population Health; International Trade and Health; National Challenges in Population Health; Population-Based Surveillance and Research; and Public Health Preparedness; Practice, and Teaching. In introducing each Part, and the chapters contained therein, I will give *JLME* readers a sense of the significance of the problems raised and contemporary initiatives in each area.

Julie L. Gerberding and colleagues from the CDC offer a characteristically thoughtful and dynamic *Foreword* for the Symposium. Their discussion of the many activities in public health law during the last year leave the reader with a sense of great achievement and even greater challenges for the future. In Julie Gerberding, America has one of the most talented public health leaders in the world—a person who has inspired and led with a steady hand.

PART I: GLOBAL CHALLENGES IN POPULATION HEALTH

This *JLME* symposium leads with global challenges to population health. One can identify at least four major pathways

to understanding global public health law and ethics that have captured the attention of policy makers and scholars. The first major pathway is ancient, constant and abiding diseases that kill such as tuberculosis and malaria. Whether based on false optimism or hubris, scientific leaders predicted the decline of infectious disease as a major cause of mortality in the later half of the 20th Century. Although infectious diseases are lessening, they are still the greatest cause of mortality globally. Indeed, old diseases have re-emerged in more virulent form (e.g., multi-drug resistant tuberculosis); diseases once endemic in the Third World have arrived in the First World (e.g., West Nile virus and monkeypox); new diseases have posed an overwhelming burden on major regions of the globe (e.g., HIV/AIDS); and new threats have brought us back to a pre-therapeutic era, without vaccines or treatments (e.g., SARS).

The second pathway is intentional dispersal of pathogens. Bio-Warfare and bio-terrorism certainly are not new. However, concerns about bioterrorism vastly increased in the aftermath of September 11th and the subsequent anthrax attacks. Reports of bioterrorism capacities in rogue states and among terrorist cells heightened awareness.¹¹ The looming threat of bioterrorism triggered government action—new laws to ensure adequate emergency health powers, new resources designated for bioterrorism preparedness, and reinvigorated debates about the appropriate balance between public safety and civil liberties.

The third pathway is through war, civil unrest, failed nation-states, and forced migration of populations. Numerous conflicts can be seen throughout the world today, which raise powerful threats to health. This problem is not only attributable to the tragic injuries and deaths caused by armed conflict itself. It is also attributable to the conditions of conflict, which exact a toll of suffering, disease, and death in the population. With armed conflict often comes inadequate supplies of safe and nutritious food and potable water; an unsanitary environment; lack of access to vaccines, medicines and health care; and mass migrations resulting in homelessness and exposure to the cold or heat. These conditions lead to starvation and dehydration, infectious diseases, as well as sexual and physical exploitation.

The final pathway is the rise of chronic, non-infectious diseases which are attributable to tobacco, diet, a sedentary lifestyle, and other behavioral causes of morbidity and mortality. Chronic diseases (e.g., cardiovascular disease, cancer and diabetes) are rising in importance particularly in developed countries. (The symposium addresses the problem of chronic diseases in Part II).

The authors in this symposium deal with each of these major pathways. David Fidler continues his penetrating international public health law scholarship by focusing his attentions on the recent SARS outbreaks. By examining global governance structures such as the International Health Regulations, Professor Fidler explores the inadequacy

of extant methods of controlling major infectious disease outbreaks. He proposes a new way of thinking about global governance of infectious disease that is not tied so inflexibly to state sovereignty.

Nicole Gastineau and Paul Farmer have been pioneers in humanitarian efforts to reduce the burden of disease in the midst of conflict. Their advocacy has been both in scholarship and on-the-ground service in resource-poor countries. In this important article Gastineau and Farmer examine the role and potential for humanitarian intervention in the context of violent conflict.

Victor W. Sidel and Barry S. Levy have been equally prominent voices in thinking about war, terrorism, and public health. They have reminded us not only about the imperative of health service delivery to displaced and excluded populations, but also about the ethical and legal dimensions of measured responses by governments and adherence to principles of freedom, respect for persons, and toleration of groups.

Finally, my Commentary explores one question that has pervaded scholarly and political discourse since September 11th: To what extent should human rights be limited to protect the community's health and safety? I endeavor to demonstrate why this is an imprecise question—because human rights are concerned both with civil and political entitlements (e.g., autonomy, privacy, and liberty) as well as social and economic rights (e.g., the right to health). I offer several proposals for balancing individual interests in freedom and collective interests in health: necessity, effective means, proportionality, and fairness.

PART II: INTERNATIONAL TRADE AND HEALTH

Globalism has become a lightning rod for public health activists. The international community appears fixated on questions of free markets, with the advent of the World Trade Organization and regional trade agreements such as the North American Free Trade Agreement (NAFTA). (Despite the rhetoric of free trade, one might note that the United States has often pursued parochial national interests—e.g., President Bush's imposition of tariffs on Chinese textiles). Those in the public health community, however, often see globalism as a subterfuge for policies designed to harm poor populations. They worry particularly about intellectual property norms making it harder to attain access to affordable vaccines and medications in resource-poor countries. The WHO, UNAIDS, and other international health agencies are currently seeking innovative policies for ensuring that intellectual property does not become an insurmountable barrier to health care access. The WHO, for example, has set a goal of providing antiretroviral drugs to 3 million HIV-infected people by 2005 (the "3 by 5" program).¹² In Africa, just 1% of HIV-infected people—50,000 out of 4.1 million who need it—have access to treatment.¹³

The authors in this part of the symposium address this issue. M. Gregg Bloche, a leader in health policy scholarship, and Elizabeth Jungman examine the political and legal aspects of the world trade system and their relationship to health. They focus on a problem that has captured the attention of international health and trade agencies—access to antiretroviral medications for treating persons living with HIV/AIDS.

Jason Sapsin and colleagues from the Johns Hopkins Bloomberg School of Public Health continue this exploration. The authors review the direct public health effects of international trade norms and examine policy structures to promote effective public health advocacy in trade discussions.

PART III: NATIONAL CHALLENGES IN POPULATION HEALTH

America is facing particular vexing health problems. Although infectious diseases continue to be important, the leading causes of death in the United States today are heart disease, cancer, cerebrovascular diseases (including stroke), chronic lower respiratory diseases (such as asthma, bronchitis, and emphysema), and unintentional injuries. These chronic health conditions are often associated with behavior and lifestyle, which makes public health interventions particularly controversial. Based on the success of tobacco policies, public health advocates are considering taxation, regulation, and tort litigation to address such issues as obesity and firearm violence.

Wendy Perdue, Lesley Stone, and I at the Georgetown University Law Center bring to bear historical perspective, empirical evidence, and theoretical argumentation to show how changes in the built environment could benefit the public's health. Wendy Perdue is not only a law professor but serves on the Planning Board for Montgomery County, Maryland where she has political and practical experience with the intersection of city planning and health. Here, she begins an exploration of the role of law in altering the built environment.

Jon Vernick at the Johns Hopkins Bloomberg School of Public Health is one of the leading national figures in gun control and injury prevention. Prof. Vernick and colleagues explore new technologies to detect concealed weapons. In a fascinating article, they pursue the idea of scanning persons to detect firearms—an issue that is fraught with controversy for civil libertarians and constitutional law scholars.

Cynthia Schneider and Michael McDonald have been working with Congress and the Bush Administration on bioterrorism preparedness. In this article, they examine the smallpox vaccination campaign. Although President Bush planned to vaccinate some 500,000 health care workers, only around 38,000 have actually received the vaccination. Schneider and McDonald ask whether the U.S. smallpox campaign was appropriately planned and how it could be

used as a lesson for future preparedness.

Preparedness for population health emergencies, of course, is not limited to public health agencies at the state and local level. The health care system plays a critically important role, particularly hospitals, which may have to bear the brunt of caring for sick or injured people. Sara Rosenbaum and Brian Kamoie, nationally respected leaders in health care policy, examine the Emergency Medical Treatment and Active Labor Act (EMTALA). They point out the implications of EMTALA for public health policy and practice.

The section on National Challenges ends with a commentary by Daniel M. Fox, President of the Milbank Memorial Fund and highly regarded scholar. Fox has an enduring interest in the intersection of law, policy, and politics. He offers the telling observation that the new politics in the United States is connecting areas of policy that, because they have had separate histories, are governed by distinct, usually uncoordinated, laws and regulations.

PART IV POPULATION - BASED SURVEILLANCE AND RESEARCH

This section is dedicated to public health surveillance and research, which is at the core of population-based science and policy. Amy L. Fairchild writes the lead article for this section, where she introduces readers to the concepts of population-based surveillance and research. She seeks to define the different, but related, ideas behind surveillance and research, offering cogent historical explanations. The distinction between surveillance and research is quite important. If an undertaking is viewed as surveillance, then the state is acting within its plenary police powers. Public health surveillance is a quintessential form of public health activity, and is subject to few external restraints. Public health research, however, is most likely governed by the Common Rule—a set of regulations designed to provide clear limits on human subject research conducted with federal dollars. These limits, notably, include examination by an Institutional Review Board (IRB). A controversy has swirled in recent years as to whether activities of state public health agencies should be categorized as surveillance or research.

Fairchild, James Colgrove, and Ronald Bayer at the Mailman School of Public Health at Columbia University examine the myth of “exceptionalism” in Sexually Transmitted Disease (STD) policy. Professor Bayer famously characterized HIV/AIDS as an “exceptional” disease that was not treated like other communicable diseases. In this paper, the group from Columbia explore whether the same arguments of “exceptionalism” could be made with respect to all STDs. Currently, Ron Bayer, Amy Fairchild and I are working on a set of ethical guidelines for public health surveillance with the help of the CDC.

Scott Burris and colleagues write the following two

articles. Burris, a celebrated thinker on public health law and policy, returns to the questions raised by Fairchild and colleagues concerning the distinction between public health research and practice. He makes the innovative, albeit controversial, argument that public health agencies should be exempted from the Common Rule system. Burris and colleagues suggest that state law (as it exists or in a reformed capacity) could provide the safeguards required.

The article by James G. Hodge concludes Part IV. Professor Hodge, Deputy Director of the Center for Law and the Public's Health at Georgetown and Johns Hopkins, has long been one of the nation's premier thinkers on public health privacy. In this article, Hodge and colleagues from the CDC examine the inevitable tensions between the need for population-based data and the protection of personal privacy.

PART V PUBLIC HEALTH LAW: PREPAREDNESS, PRACTICE, AND TEACHING

Part V in this symposium focuses on preparedness, practice, and teaching in public health law. The CDC's Public Health Law Program has emphasized the practical implications of public health law. In the lead article for Part V, Anthony D. Moulton and colleagues examine the idea of public health preparedness. This article articulates public health preparedness as a goal and offers a conceptual framework.

In the following article Richard A. Goodman and colleagues examine the intersection between public health and criminal investigations. Goodman coined the term "forensic epidemiology" and has developed coursework for public health and law enforcement officials. This initiative is important because it facilitates coordination between two traditionally separate institutions—law enforcement and public health. Both are necessary to protect the public's health and safety.

Wendy E. Parmet and Anthony Robbins, two dedicated public health scholars, have led the effort to expand teaching of public health law in schools of law, medicine, and public health. In this article, they tackle the particularly difficult problem of introducing population health into the curricula of law schools. They argue that an engaging scholarship that relies on the population perspective can stimulate the integration of public health into core law school classes.

Finally, Robert M. Pestronk, Cynthia Honssinger, and Montrece Ransom present a brief news report about the formation of the Public Health Law Association (PHLA). The PHLA is a new non-profit organization designed to bring together those interested in using the law to promote the population's health. The PHLA symbolizes the resurgence of public health law as a field with academic and practical importance in national and international contexts.

I hope that the pages of this Symposium will inspire

readers. What is needed is for talented individuals to begin teaching, scholarship, and practice in population-based law and ethics. The ultimate goal is to use the law as a tool to assure the conditions in which people can be healthier and safer.

THE LEGACY OF PUBLIC HEALTH LAW REFORM AND LITIGATION

At a recent meeting of the Institute of Medicine's Board on Health Promotion and Disease Prevention, Jim Curran made a telling comment, particularly coming from someone with vast experience in the field. He observed that history would show that public health law reform and litigation would be greatest public health legacy of our generation. That, in many ways, is the legacy of Gene W. Matthews and, as Gene so aptly put it, "there is still much to be done."

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