COMMENTARY

ON PUBLIC HEALTH INTERVENTION

EUGENE FEINGOLD, PHD JD

Public Health versus Civil Liberties

Dr. Feingold is Professor Emeritus of Health Management and Policy, University of Michigan School of Public Health, and a Past President of the American Public Health Association.

The programs described by Siegal et al.[1] and Shah et al.[2] bring the reader face-to-face with the question of reconciling individual liberties and public health. A classic tension exists between public health programs intended to benefit the community at large and the protection of individual rights and liberties. In 17th- and 18th-century Germany, the "medical police" were not concerned with this tension. Their surveillance and enforcement activities sought to encourage and maintain the largest population possible. Underlying this effort were mercantilist theories that saw national power as based on a large population that could produce goods, engage in trade, and provide increased revenue to the state. They were thus "grounded on a primary calculation to augment the power of the state rather than to increase the welfare of the people."[3]

Early 20th-century Progressives, in contrast, wanted to improve public welfare by using scientific knowledge to increase social efficiency (parallel to their image of business efficiency) and improve the lot of the poor. They paid no attention to the coercive aspects of their programs, perhaps because they saw no antagonism between the state and the public. More modern views also see public health intervention as a vehicle for achieving social reform, or at least amelioration, but are more conscious of the conflict between individual liberties and the well-intentioned state.

Benevolently intended public health programs raise the issue of paternalism. Individual freedom may be infringed upon in the name of promoting public good. On the one hand, that the subject may benefit is a justification for requiring or encouraging him or her to participate. On the other hand, if the intervention is only for the benefit of the individ-

Address correspondence to:
Dr. Feingold, 352 Hilldale Dr., Ann Arbor MI 48105; tel. 734-662-8788; fax 734-662-2713; e-mail <feingold@umich.edu>.

ual and doesn't involve the rest of society, does requiring participation violate our commitment to individual autonomy? Isn't the individual a better judge of his or her own interests than the public health busybodies? Moreover, is public health's claim of benevolence suspect—a cloak for the imposition of the claimant's values on the supposed beneficiary? Are we more attentive to what we see as *needs*, the individual's or society's, than to what we see as the individual's *rights*?

And there's another, related, issue. Too often, public health interventions focus on individual behavior and personal responsibility, often with a moralistic bent, instead of looking at the broader social and environmental causes of illness. This can shift responsibility to the individual for situations that are only partly his or her responsibility. It's of particular concern if the burden of the intervention is concentrated on individuals or groups that are the focus of public disfavor.

Both the Siegal and Shah studies used law enforcement-related programs to reach populations that could then be screened for public health purposes. The participants in these programs were not there voluntarily but rather because they had violated the law or were unable to take care of themselves. They may have hesitated to assert their desires for privacy or their unwillingness to participate in the supposedly voluntary public health programs piggy-backed onto activities that were required of them. Yet there is no doubt that the programs in which they were enrolled presented opportunities for public health access to populations that might otherwise have been difficult to reach.

Siegal et al. told the participants in a drunken driver education program that screening for sexually transmitted diseases was voluntary and that no report would be made to legal authorities; Shah et al. don't provide information about what their study population of women admitted to a detoxification program—usually for drunkenness—was told, although there were refusals to participate in their study, as in the Siegal et al. study. Even if subjects in both studies were not required to participate in the screening and were told that there would be no untoward consequences for refusal, their situations were nonetheless potentially coercive. Subjects can be expected to discount these assurances and to feel some pressure to participate, having concerns about the consequences of failure to cooperate. This is particularly likely for those who generally feel powerless to resist authority.

Despite this undertone of possible coercion, I personally find the Siegal and Shah screenings acceptable. Neither was very intrusive. Presumably, neither study screened individuals without their consent, and both maintained the confidentiality of responses. Each study identified those participants who might themselves benefit from further intervention and noted the effects that might also benefit others, including sex partners and future children of the participants as well as future participants in similar screening programs. In addition to these health benefits, some participants may have been persuaded to be more supportive of public health programs (and of government more generally) if they felt that the program in which they were required to participate had an additional associated benefit for them. (Note that some participants were pleased at being asked to participate in the Siegal et al. screening program because it made them feel that they counted and that the program was less punitive.)

We should permit such minimally intrusive programs that have the potential for achieving significant improvement in public health. We should, however, always be aware that public health programs have the potential to infringe upon individual freedoms in an unacceptable way. This is particularly true of programs that involve sexual behavior and pregnancy, two areas in which moralistic motivation has often overridden both individual freedom and efforts to improve public health.

Too often we deal with the potential for unacceptable infringement on individual freedom by describing a given situation in terms of a tension between promoting the public good, or the public interest, and protecting individual rights. This formulation often anticipates and signals how we want to resolve a problem. After all, it seems inappropriate to let something that benefits only an individual, or a small group, stand in the way of something that benefits society as a whole. We might come closer to focusing on the real issue if we asked ourselves whether the public interest in protecting civil liberties outweighs the public interest served by the particular public health program.

References

1. Siegal H, Leviton L, Cole P, Wang J, Bachmann L, Hook E. Feasibility of obtaining sexual risk and STD history in the context of a drinking drivers' program. Public Health Rep 1998 113:341-5.
2. Shah S, Hoffman R, Shinault R, LaPoint S. Screening for pregnancy and contraceptive use among women admitted to Denver detoxification center. Public Health Rep 1998 113:336-40.
3. Rosen G. From medical police to social medicine: essays on the history of health care. New York: Science History Publications; 1974. p. 155. ■