BOOK REVIEW

LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT, University of California Press, Berkeley (2000)

Reviewed by John V. Jacobi[*]

Broad issues of population health seem beyond the current discipline of health law. They are literally beyond it, as the tools of health law, focused on bilateral disputes over health finance, medical injury, and patients' rights, are not well suited to the analysis of population health issues. They are beyond it figuratively also, as legal practitioners and academics seem little engaged in many large issues of population health. Lawrence Gostin, one of the leading academics bucking this trend, has published an excellent book that provides a framework for a distinct discipline of public health law capable of taking on these neglected public health issues.[1]

Public health is a discipline dedicated to the scientific examination of the conditions affecting the health of populations. Public health practitioners employ scientific methods to understand the mechanisms of morbidity and mortality, and employ public education, voluntary service programs, and coercive social interventions to fulfill "society's interest in assuring conditions in which people can be healthy."[2] America's population health indicators have improved dramatically over the last century. Life expectancy in 1900 was forty-seven years; by 1994 it had risen to nearly seventy-six years, while the infant and child mortality rates were reduced by 95%.[3] Much of the improvement in life expectancy was due to steps taken in population health. Continuing efforts begun in the prior century, public health officials improved water supplies through chlorination and improved sewage disposal systems, sharply reducing the rate of diseases such as cholera and dysentery. Sanitation improvements, disease surveillance and follow-up, vaccination programs, and the use of

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[1] LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (2000).

[2] BERNARD J. TURNOCK, PUBLIC HEALTH: WHAT IT IS AND HOW IT WORKS 7-9 (1997) (quoting INSTITUTE OF MEDICINE, NAT'L ACAD. OF SCIENCES, THE FUTURE OF PUBLIC HEALTH 7 (1988)).

[3] *Id.* at 64-65.

antibiotics sharply reduced or eliminated the threat of infectious diseases such as typhoid fever, smallpox, yellow fever, malaria, plague, poliomyelitis, mumps, measles, and rubella. Rates of injuries caused by workplace conditions, unsafe foods, and tobacco use declined through public health education and regulatory interventions.[4]

Current health law and policy discussions do not focus on coordinated population health concerns. Instead, the focus is on bilateral disputes over payment for individuals' services, iatrogenic medical injury, and patients' rights issues. Current payment concerns include skyrocketing health insurance premiums, proposals to change the benefits design of Medicare, and disputes about managed care's "rationing" of care. Medical injury concerns are now debated in terms of various "patient protection acts," with their complex designations of judicial and administrative fora for adjudicating claims of negligent treatment in the managed care era. We continue to struggle with physicians' obligations to provide meaningful informed consent, and with patients' rights to terminate treatment, with or without physicians' assistance. The issues of payment, malpractice, and patient autonomy are genuinely significant, and health lawyers ought not be criticized for their attention to them. Indeed, there is substantial overlap between these core health law issues and the population orientation of public health law.

In the debate over health insurance reform, for example, a public health perspective can shift the focus of discussion. The current debate often centers on the desire of those covered by managed care to gain freer access to particular health providers, or to particular (often expensive) curative treatments. Scholars speaking from a public health perspective, however, argue that greater population health gains can be achieved by emphasizing primary and preventive care such as vaccinations and health education rather than exotic technical services. Further, they argue that it is ethically questionable to quibble over the extreme reaches of insurance coverage when over 40 million Americans are without any health insurance coverage at all.[5] In the debate over negligent medical injury, the Institute

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[4] *Id.*; *Achievements in Public Health, 1900-99: Changes in Public Health Systems*, 48 MORBIDITY & MORTALITY WKLY. REP. 1141-47 (1999); *Achievements in Public Health, 1900-99: Control of Infectious Diseases*, 48 MORBIDITY & MORTALITY WKLY. REP. 621-29 (1999).

[5] *See* Allen Buchanan, *Managed Care: Rationing Without Justice, But Not Unjustly*, 23 J. HEALTH, POL'Y & L. 617, 620 (1998) ("Indeed, what is most remarkable about the vociferous debate about managed care—from an ethical point of view—is that the issue of access for the uninsured seems to have dropped off the public's radar screen entirely."); Phyllis Freeman & Anthony Robbins, *National Health Care Reform Minus Public Health: A Formula for Failure*, *in* NEW ETHICS FOR THE PUBLIC'S HEALTH 285 (Dan E. Beauchamp & Bonnie Steinbock eds., 1999) (advocating an emphasis on coverage of primary health services in a federally regulated health insurance system).

of Medicine has published an influential report advocating the abandonment of our current emphasis on identification and blame of faulty physicians, in favor of a systems-oriented approach designed to reduce the number and severity of human injuries.[6] A public health perspective, then, counsels an egalitarian approach to the resolution of finance and patient injury concerns. Such a broadened perspective on these traditionally bilateral issues can advance the public health goal of improving the social conditions conducive to personal health. Some pressing health issues, however, seem not within the scope of mainstream health law, even tweaked for a broader population focus.

The growing incidence of antimicrobial resistance is one example. World health benefited greatly in the last century through the success of a variety of antibacterial drugs.[7] Health care workers are increasingly faced with bacteria resistant to many or most of the antibiotics previously effective in treating disease. Treatment with common antibiotics is simply ineffective in the treatment of resistant bacteria. Treatment is therefore more difficult, expensive, lengthy, and, at the extremes, impossible when the disease agent develops resistance to antibiotics.[8]

One cause of this growing resistance is the overuse and misuse of antibiotics in medical treatment. Doctors routinely prescribe antibiotics for viral infections for which they are completely ineffective, and pay too little attention to the risks of resistance in their selection of drug, dose, and duration of therapy.[9] Physician misuse is not the only cause of microbial resistance, however. Increasing use of non-prescription antibiotic ointments, antibiotic soaps and cleaning agents, and the massive use of antibiotics in food production all increase the level of drug resistance in bacteria.[10]

The health effects of the growing loss of antibiotic effectiveness are significant. The proper legal and public policy response is less clear.

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[6] INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (1999).

[7] *See* U.S. GENERAL ACCOUNTING OFFICE, ANTIMICROBIAL RESISTANCE: DATA TO ASSESS PUBLIC HEALTH THREAT FROM RESISTANT BACTERIA ARE LIMITED, GAO/HEHS/NSIAD/RCED-99-132, 3-4 (1999) [hereinafter ANTIMICROBIAL RESISTANCE]; WORLD HEALTH ORG., ANTI-INFECTIVE DRUG RESISTANCE SURVEILLANCE AND CONTAINMENT, *available at* http://www.who.int/emc/amr.html (last visited Aug. 2, 2001).

[8] *See* ANTIMICROBIAL RESISTANCE, *supra* note 7, at 9-14.

[9] *See* Jon S. Abramson & Laurence B. Givner, Editorial, *Bacterial Resistance Due to Antimicrobial Drug Addiction Among Physicians*, 8 ARCH. FAM. MED. 79 (1999); David P. Fidler, *Legal Issues Associated with Antimicrobial Drug Resistance*, 4 EMERGING INFECTIOUS DISEASES 169, 172-73 (1998); Donald E. Low & W. Michael Scheld, Editorial, *Strategies for Stemming the Tide of Antimicrobial Resistance*, 279 JAMA 394 (1998).

[10] *See* ANTIMICROBIAL RESISTANCE, *supra* note 7, at 14-19.

Congress, in response to advice from an interagency working group,[11] is now considering legislation that would address the issue.[12] The Action Plan proposed a broad range of voluntary, cooperative measures grouped into four categories: surveillance, prevention and control, research, and product development. It is avowedly a preliminary analysis of the problem, and acknowledges that even its initial implementation is dependent on the voluntary partnership of, among others, pharmaceutical and biotechnology companies, insurers, consumers, and professional societies.[13] The proposed legislation sounds an even greater note of reticence, stating that its purpose is to carry out the recommendations of the Action Plan, but "only to the extent that the activities involved are within the jurisdiction of the Department of Health and Human Services."[14] It is unclear whether the steps proposed by the Task Force would stem the tide of drug resistance, even if Congress were to embrace them in legislation. More to the point, the issue is not elbowing its way to the front of the line in public policy or academic circles.

Childhood lead poisoning is another health issue that fits poorly within mainstream health law. In its severe form, lead poisoning can result in seizures, coma, or death. Children with blood lead levels below those associated with dramatic physical symptoms nevertheless show effects in the form of cognitive delays and deficits.[15] The number of children with lead burden has gone down in recent years, probably due to the elimination of leaded gasoline and the prohibition of the use of lead-based paint in residences. The number is still significant, however. One large study reported that 7.6% of children tested had dangerous levels of lead in their blood, and the 2000 report of the President's Task Force on Environmental Health Risks and Safety Risks to Children estimated that 4.4% of all children have a significant lead burden.[16] Chelation agents, usually

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[11] INTERAGENCY TASK FORCE ON ANTIMICROBIAL RESISTANCE, A PUBLIC HEALTH ACTION PLAN TO COMBAT ANTIMICROBIAL RESISTANCE (2001), *available at* http://www.cdc/gov/drugresistance/actionplan/ (last visited Aug. 2, 2001) [hereinafter ACTION PLAN]. The Task Force was chaired by the Centers for Disease Control and Prevention, the Food and Drug Administration, and the National Institutes of Health. *Id.* Seven other federal agencies participated in the drafting of the report. *Id.*

[12] Antibiotic Resistance Prevention Act of 2001, H.R. 1771, 107th Cong. (2001).

[13] ACTION PLAN, *supra* note 11, at 2 & n.b.

[14] Antibiotic Resistance Prevention Act of 2001, H.R. 1771, 107th Cong. § 3(a) (2001).

[15] *See* John F. Rosen & Paul Mushak, Editorial Letter, *Primary Prevention of Childhood Lead Poisoning—The Only Solution*, 344 NEW ENG. J. MED. 1470 (2001).

[16] *Blood Lead Levels in Young Children—United States and Selected States*, 49 MORBIDITY & MORTALITY WKLY. REP. 1133 (2000); PRESIDENT'S TASK FORCE ON ENVIRONMENTAL HEALTH RISKS AND SAFETY RISKS TO CHILDREN, ELIMINATING CHILDHOOD LEAD POISONING: A FEDERAL STRATEGY TARGETING LEAD PAINT HAZARDS 2 (2000) [hereinafter PRESIDENT'S TASK FORCE] (drawing from a 1997 CDC report using data from 1991-94). These sources treat children as lead burdened when their lead level is 10

succimer, are used to reduce blood lead levels for children with high levels of lead burden. A recent study suggests, however, that chelation is not beneficial for children with moderate blood levels—levels at which the risk of cognitive impairment are very high. The study suggests that treatment *after* moderate lead poisoning is ineffective, and that attention must be turned to preventing lead poisoning in the first instance.[17]

About twenty-four million residential units still have lead paint hazards, and children continue to be poisoned. Poor children in inner cities bear the brunt, as they live in older, often poorly-maintained housing stock, and their families are without means to reduce or eliminate the lead hazard. These children should, at a minimum, be screened for lead to identify hazards, to signal the need for lead remediation in the home, and to permit remedial medical treatment to the extent it is effective. The good news is that Medicaid (which covers most at-risk low-income children) mandates periodic lead screening and treatment; the bad news is that states and participating physicians ignore this requirement, and four out of five Medicaid-enrolled children under age six have not received the mandated blood lead tests.[18] The housing stock containing dangerous lead conditions could be replaced or rehabilitated within ten years with federal financial support, public education, and enforcement of existing laws.[19] The money and political will are, however, nowhere to be found.

Other issues of substantial health significance, but largely unaddressed in the current health law and policy debate, are plentiful. Our society continues to have an ambivalent attitude towards tobacco even as it

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micrograms per deciliter of blood. *Id.* That number may be too high. Researchers now suggest that cognitive impairment is caused by lead poisoning at even lower levels. *See* Eric Nagourney, *New Warnings on Lead and Children*, N.Y. TIMES, May 8, 2001, at F8.

[17] Walter J. Rogan et al., *The Effect of Chelation Therapy with Succimer on Neuropsychological Development in Children Exposed to Lead*, 344 NEW ENG. J. MED. 1421 (2001). *See* Rosen & Mushak, *supra* note 15, at 1471 (citing Rogan study, recommending prevention of ingestion of lead as the only treatment for childhood lead poisoning).

[18] *Recommendations for Blood Lead Screening of Young Children Enrolled in Medicaid: Targeting a Group at High Risk*, 49 MORTALITY & MORBIDITY WKLY. REP. No. RR-14 (2000). State participation in Medicaid is voluntary, but states that participate must comply with federal law. Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498, 502 (1990). Periodic health examinations of children and the provision of care medically necessary to address the health concerns arising from those examinations are mandatory parts of the Medicaid program. *See* 42 U.S.C. §§ 1396a(a)(10)(A) and (43)(C) (1994). *See also* John A. Flippen, *The Early and Periodic Screening, Diagnostic, and Treatment Program and Managed Medicaid Mental Health Care: The Need to Reevaluate the EPSDT in the Managed Care Era*, 50 VAND. L. REV. 683, 689-91 (1997) (describing the screening and treatment requirements in Medicaid).

[19] *See* PRESIDENT'S TASK FORCE, *supra* note 16, at 29-33. *See also* Rosen & Mushak, *supra* note 15, at 1471 (arguing that elimination of residential lead hazards is an essential public health step to address lead poisoning in children).

remains one of our most deadly substances. We struggle with the proper decision-making methodology for the integration of genetically modified products into the food supply. In addition, we struggle to come to grips with the enormous effects of the international HIV pandemic.[20]

Our legal system, and health law in particular, seems not to have developed the tools or the perspective to deal with these population health issues, as it is oriented to concerns at the level of the individual. In the not-too-distant past, legal disputes over the environment also focused on the individual. Threats to the safety, adequacy, or wholesomeness of a person's surroundings were the subject of bilateral analysis, with trespass, contract, and nuisance law resolving disputes, and municipal and county governments expending resources to eliminate dangerous or ugly conditions. For the last forty years, however, since the publication of Rachel Carson's *Silent Spring*,[21] environmental law has changed. A web of state, national, and international environmental law begins with the premise that private conduct affects broad systems, and is therefore the proper focus of public policy and positive law. Presidents and legislatures may differ on implementation and emphasis, but there is no going back. Environmental law and theory, with its global and long-term emphasis, now colors all land use, development and energy policy, forming a population-oriented connective tissue. Individual interests and bilateral disputes must accommodate, and in some senses are subordinate to, this broader vision.

Health law has experienced no similar epiphany. The HIV pandemic has forced a reexamination of privacy law and some aspects of police powers doctrine, but it has not as yet led to a population focus in health law. Professor Gostin's book is a hopeful sign that population issues will come to the fore. It represents a substantial advance in recent scholarly attention to public health law.[22] It is not a lyrical book like Rachel Carson's. Rather, it is a practical primer and teaching tool, addressing the legal issues that arise when public authorities are called upon to act to "prevent injury and disease or . . . promote the health of the populace."[23]

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[20] *See* Kent A. Sepkowitz, *AIDS—The First 20 Years*, 344 NEW ENG. J. MED. 1764 (2001).

[21] RACHEL CARSON, SILENT SPRING (1962).

[22] *See, e.g.*, Rene Bowser & Lawrence O. Gostin, *Managed Care and the Health of a Nation*, 72 S. CAL. L. REV. 1209 (1999); Scott Burris, *Law as a Structural Factor in the Spread of Communicable Disease*, 36 HOUS. L. REV. 1755 (1999); Lawrence O. Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59 (1999); James G. Hodge, Jr., *The Role of New Federalism and Public Health Law*, 12 J.L. & HEALTH 309 (1998); Wendy Parmet, *Tobacco, HIV, and the Courtroom: The Role of Affirmative Litigation in the Formation of Public Health Policy*, 36 HOUS. L. REV. 1663 (1999).

[23] GOSTIN, *supra* note 1, at 22.

Gostin acknowledges that the boundaries between individual treatment issues (largely the concern of health law) and population health issues (largely the concern of public health law) can be indistinct.

Sometimes the dividing line between health care and public health is exceedingly difficult to draw. The medical treatment of an infectious disease, for example, benefits both the individual and the wider population. The boundaries between medicine and public health become obfuscated in such cases, and it is not unusual to see both the health care and public health systems accept responsibility for patient care, health education, and follow-up for infectious diseases.[24]

Gostin is determined, however, to define a distinct and rather narrow discipline called public health law, distinguishable from health care law or law and medicine:

> Public health law is the study of the legal powers and duties of the state to assure the conditions for people to be healthy (e.g., to identify, prevent, and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the protection or promotion of community health.[25]

The book is divided into three parts. The first, "Conceptual Foundations of Public Health Law," provides a theoretical framework for understanding the discipline. The second, "Public Health and Civil Liberties in Conflict," applies the tools from the first part to a series of six case studies. The third part is a very brief chapter providing suggestions for the reform of public health practice and public health law.

The first part provides, in 100 pages or so, an overview of public health practice and constitutional and administrative law. It is always the case that an overview of this sort will strike some readers as too basic and others as too detailed. Gostin gets it about right, striking a nice balance by providing foundational material while avoiding the temptation to delve in detail into interesting aspects of law not necessary for his task.

Perhaps the best section of this first part is that dealing with *Jacobson v. Massachusetts*,[26] a 1905 United States Supreme Court decision that still serves as a foundational case for understanding states' police power in the public health area. A core constitutional issue in *Jacobson* is the degree of deference a court applying federal constitutional standards must afford a state official's fact-finding. As Gostin points out, that is a question subject to shifting views, and evolution of doctrine in that area is "slow, cyclical

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[24] *Id.* at 12.

[25] *Id.* at 4.

[26] 197 U.S. 11 (1905).

and politically charged."[27] But he is correct in spending some time examining the structure of the Court's analysis, and in particular to focus on the requirement that the means chosen by the state must bear a "real or substantial relation" to the public health end.[28] This nexus or proportionality requirement serves as a focal point for much of Gostin's constitutional analysis of public health law.

The first part of the book will be tough going for lay readers or students without a constitutional law background—two of Gostin's target audiences.[29] But the material builds a necessary foundation. It does suffer, however, from an overemphasis on federal constitutional principles. While the United States Constitution does limit state actors' police powers, those powers are granted by the "positive" state constitutions under which state officials operate. One method of clarifying this point might be to read Chapter Four, which describes public health regulation mostly from a state law perspective, *before* the extensive discussion of the federal limitations on state power in Chapters Two and Three. This is a minor point, however; the first part of the book prepares the reader to get down to cases.

The second part is the heart of the book, in which Gostin examines six issues central to public health law. Chapters Five and Six crisply deal with privacy and expression, covering complex issues with clear prose and a consistently appropriate level of detail. Chapter Seven, on bodily integrity, is the best in the book. In the space of three pages within Chapter Seven, he presents three approaches for the conceptualization of public health risk reduction. The first, "germ theory," treats humans as the raw material on which microbes act, and the public health function is therefore the identification of "cases" and the breaking of the cycle of infection. The second, "behavior theory," treats people themselves as the determinants of public health, and the public health function is therefore to shape human behavior to good ends—by education where possible, but by coercion where necessary.

The third, "ecological theory," views society as an ecosystem, in which disease is not an isolated force, but a product of social conditions such as poverty and ignorance. This theoretical framework takes the widest perspective of the causes of illness, and inclines the public health practitioner to political and social activism in an effort to shape society to the ends of population health.[30] A passage in the description of ecological

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[27] GOSTIN, *supra* note 1, at 71.

[28] *Id.* at 69 (quoting *Jacobson*, 197 U.S. at 31).

[29] *Id.* at xxii.

[30] *Id.* at 177-79.

theory captures the subtlety and thoughtfulness of the book as a whole:

> Understanding the ecology of health and disease helps to explain why public health activists are so torn between routine disease prevention and a more radical critique of present social and economic arrangements. Of course, when public health challenges conventional thought on the distribution of wealth, social structures, and the environment, it is likely to meet fierce political opposition and claims of overreaching. It is important, however, to remember that public health began as a social reform movement and continues to challenge accepted social practices by identifying the status quo as a fundamental determinant of health and disease. Because of this, public health never loses its potency as a force for political change.[31]

In passages such as this, Gostin's passion, no doubt derived from his long involvement in cutting-edge issues of public health, lends immediacy and power to the material.

Chapter Eight, "Restrictions of the Person," addresses uses of quarantine and civil commitment, topics of renewed interest in an era of resurgent and sometimes drug-resistant communicable disease. Chapter Nine is as clear a brief description of administrative law as applied to professionals and businesses as one is likely to find. Chapter Ten does a great service to public health law by describing the regulatory function served by tort law—a body of law too often dismissed as a sideshow to public policy development. Gostin convincingly explains that tort law can be "an important tool for advancing the public's health."[32]

The book's third part is a single chapter, "Public Health Law Reform." Here, Gostin highlights through the lens of public health law some of the practical problems impeding the advance of population health. Social reforms can be expensive, and cost/benefit tradeoffs can raise nearly intractable problems. Political leaders have limited time to focus on each problem that comes before them, and often seek the simple solution—the sort of solution that this book convincingly establishes is not available in the realm of public health. Members of the public, like their elected leaders, are often inclined to act on immediate self-interest, often at the expense of their own and their community's long-term health.

Gostin sketches out three basic principles for the public health future. First, "public health authorities [should have] ample power to regulate individuals and businesses to achieve the communal benefits of health and security."[33] To temper this communitarian principle, the second would

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[31] *Id.* at 179 (footnotes omitted).

[32] *Id.* at 288. Wendy Parmet has also addressed this point in a fine recent article. *See* Parmet, *supra* note 22.

[33] GOSTIN, *supra* note 1, at 315.

"restrain government in the exercise of regulatory power"[34] through procedural and substantive restraints that hearken back to the earlier *Jacobson* discussion of proportionality constraints on the exercise of state power. Third, and the most important and original, directs that "the law should impose duties on government to promote health and social status within the population."[35] As is true in modern environmental law, government must bind itself to the task of acting affirmatively to provide the consistent coordination necessary to advance the public's health. Sound vague? Professor Gostin is not trying to answer all of the public health questions in one book. Rather, he is encouraging and enabling practitioners and academics in his field of public health law to weigh in.

This book appears at an opportune moment. The neglect of public health had deprived society of the tools needed to address some of our most pressing problems. The emergence of a robust discipline of public health law is a necessary step in achieving proper status for population health in the courts, legislatures and academy. Professor Gostin's book is an effective tool to that end.

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[34] *Id.*

[35] *Id.* at 316.