




2004

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Michael Boylan

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### Recommended Citation

Michael Boylan, *Justice in Times of Crisis*, 4 YALE J. HEALTH POL'Y L. & ETHICS (2004).

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Citation: 4 Yale J. Health Pol'y L. & Ethics 415 2004

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## BOOK REVIEWS

### Justice in Times of Crisis

Michael Boylan, Ph.D.\*

*In the Wake of Terror: Medicine and Morality in a Time of Crisis.* Edited by Jonathan D. Moreno. Cambridge, MA: M.I.T. Press, 2003. Pp. 229.

In the United States, we are currently consumed by the threat of future terrorism. Our barometer of danger vacillates between different colored assessments of how likely it is that some catastrophic event is about to occur.<sup>1</sup> Is this merely hype, or do we face an imminent threat? To some degree, the answer to that question is irrelevant. Guided by the precautionary principle,<sup>2</sup> most would argue that the nation must prepare itself for the worst case scenario.

Most of the current literature on our response to terrorism examines policy initiatives that purportedly seek to protect the public good.<sup>3</sup> These policy initiatives aim to strike the proper balance between achieving the directives of the general will and sufficiently protecting individual liberties.<sup>4</sup> To date, most scholars and public thinkers have been primarily

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\* Professor of Philosophy and Chair of the Department of Philosophy, Theology, and Religious Studies at Marymount University.

1. See Press Release, White House Office of the Press Sec'y, Homeland Security Presidential Directive-3 (Mar. 2002), <http://www.whitehouse.gov/news/releases/2002/03/20020312-5.html> (discussing the color-coded Homeland Security Advisory System).

2. A good discussion of the principle of precautionary reason can be found in Deryck Beyleveld & Shaun Pattinson, *Precautionary Reason as a Link to Moral Action*, in *MEDICAL ETHICS* 39 (Michael Boylan ed., 2000).

3. This Book Review will focus its discussion specifically on civil security measures.

4. See, e.g., DAVID COLE, *ENEMY ALIENS: DOUBLE STANDARDS AND CONSTITUTIONAL*

concerned with assessing the best way to strike this difficult balance.

As important as such works are, a crucial component of our national preparation against terrorism has not yet been adequately addressed: namely, the involvement of the medical community. The medical community must be viewed as an essential part of this effort since they are among the first responders in times of emergency. Yet, this has not been a particularly fruitful area of scholarship, perhaps because many assume that plans already in existence for natural disasters will be sufficient to address any incident of terrorism. Such logic is mistaken. Terrorist incidents and the preparation for such incidents constitute new challenges for the national health care system. For this reason, the threat of terrorism should prompt us to reconsider some of the ethical questions posed by health care delivery in times of crisis.

*In the Wake of Terror* is a fine introduction to the questions we must address and the issues we must consider as we prepare ourselves for any future terrorist attacks.<sup>5</sup> Through a series of original essays, the book discusses many of the public health, medical, and policy questions that the nation faced in the aftermath of 9/11 and that the nation will face again in the event of future terrorist attacks. *In the Wake of Terror* does not insist upon a particular answer or approach, but rather sketches the broad penumbra of approaches from which policy specifications will be chosen. While its presentation of these different options is valuable, *In the Wake of Terror* does not offer clear guidance on which option is best because it does not provide an ethical framework for evaluating these different policy options. This Book Review briefly describes the essays in this book and then examines how two salient issues involving public health and medical awareness (i.e., the protection of individual rights and the allocation of resources to the ill and injured) might be evaluated within the context of a rights-based theory of justice.

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FREEDOMS IN THE WAR ON TERRORISM (2004); DAVID DAGE, CASUALTY OF WAR: THE BUSH ADMINISTRATION'S ASSAULT ON A FREE PRESS (2004); NAT HENTOFF, THE WAR ON THE BILL OF RIGHTS—AND THE GATHERING RESISTANCE (2003); PHILIP B. HEYMANN, TERRORISM, FREEDOM, AND SECURITY: WINNING WITHOUT WAR (2003); LOST LIBERTIES: ASHCROFT AND THE ASSAULT ON PERSONAL FREEDOM (Cynthia Brown ed., 2003); CHRISTIAN PARENTI, THE SOFT CAGE: SURVEILLANCE IN AMERICA FROM SLAVERY TO THE WAR ON TERROR (2003); JEFFREY ROSEN, THE NAKED CROWD: RECLAIMING SECURITY AND FREEDOM IN AN ANXIOUS AGE (2004); THE WAR ON OUR FREEDOMS: CIVIL LIBERTIES IN AN AGE OF TERRORISM (Richard C. Leone & Greg Anrig, Jr. eds., 2003).

5. IN THE WAKE OF TERROR (Jonathan D. Moreno ed., 2003).

## I. THE ESSAYS

The first section of the book, “Public Health,” begins with an introductory essay by Paul A. Lombardo. The essay offers a historical perspective on the possibility of research abuses in times of national crisis and sets a cautionary tone for the present.<sup>6</sup> Lombardo argues that the balance between biomedical progress and a protectionist ethic is often skewed by wartime’s unwitting recruits for science: Concerns about vulnerable populations and protections for research subjects have often given way to the needs of defense. However, as Lombardo argues, it is not always clear that protecting the public safety required these trade-offs to be made.

The second essay,<sup>7</sup> written by current policy-makers James G. Hodge, Jr. and Lawrence O. Gostin, begins, “Perhaps no duty is more fundamental to American government than protecting the public’s health.”<sup>8</sup> Indeed, the imperative to protect the public’s health establishes a utilitarian justification for the government’s exercise of very strong powers in the name of the general will; these powers include involuntarily inoculating and quarantining individuals, thereby sacrificing people’s personal liberties in the name of protecting the many. Hodge and Gostin argue that the exercise of some of these powers can be permissible, so long as they do not go too far: “The rights of individuals may be balanced with societal interests provided the balance does not support restraints that are excessive, arbitrary, or egregious (e.g., based upon racial or ethnic grounds).”<sup>9</sup> The question, of course, is where to draw the line. Gostin was instrumental in working on the Model State Emergency Health Powers Act (MSEHPA)<sup>10</sup>—one attempt to strike such a balance for the public’s good. This model legislation creates wide-ranging powers that permit state governments to engage in testing, mandatory vaccination, and involuntary quarantine. These practices would be permitted at the discretion of each

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6. Paul A. Lombardo, “Of Utmost National Urgency”: *The Lynchburg Colony Hepatitis Study, 1942*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 3.

7. James G. Hodge, Jr. & Lawrence O. Gostin, *Protecting the Public’s Health in an Era of Bioterrorism: The Model State Emergency Health Powers Act*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 17.

8. *Id.*

9. *Id.* at 19.

10. THE CTR. FOR LAW & THE PUBLIC’S HEALTH AT GEORGETOWN AND JOHNS HOPKINS UNIVS., *THE MODEL STATE EMERGENCY HEALTH POWERS ACT (2001)*, <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>.

state governor.<sup>11</sup> While governments may want these powers, it remains important to ask: Does the MSEHPA strike the proper balance? Gostin and Hodge do not help us to answer this question, and it is unsurprising that they do not. The only way to answer such a question is by reference to a comprehensive moral/social theory that *In the Wake of Terror* unfortunately lacks.<sup>12</sup>

*In the Wake of Terror's* lack of theoretical grounding does not mean that none of the essays attempt to answer this difficult question. In the third essay of this section, George J. Annas argues that the MSEHPA does not strike the proper balance.<sup>13</sup> Annas believes that we must take human rights seriously even in war—and especially in a quasi-war, like the war on terrorism.<sup>14</sup> Thus, Annas criticizes the Bush-Rumsfeld decision to ignore the requirements of the Geneva Conventions in determining what rights to provide to alleged members of Al Qaeda and the Taliban held at Guantanamo Bay,<sup>15</sup> as well as the Centers for Disease Control's proposal to force medical treatment upon Americans in the event of biological attack.<sup>16</sup> Finally, he questions the handling of the anthrax crisis; he is particularly critical of the administration of experimental vaccines to many individuals who were only *potentially* exposed.<sup>17</sup> Yet, while Annas offers reasons for his opposition to these specific policies, he does not offer a comprehensive ethical framework for evaluating these and other policies.

The fourth essay, by Ronald Bayer and James Colgrove, steps back and places the previous essays' debate about how to balance the need to recognize individual liberties and to maintain the public good into a critical historical context.<sup>18</sup> The results of this tug of competing interests

11. *Id.* at 42.

12. For discussion of a comprehensive moral/social theory, see *infra* Part II.

13. George J. Annas, *Terrorism and Human Rights*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 33.

14. Though Annas does not explain his argument for why the current "war on terrorism," is only a "quasi-war," one must assume that Annas holds to the standard "just war" doctrine, see Alex Moseley, *Just War Theory*, The Internet Encyclopedia of Philosophy, <http://www.iep.utm.edu/j/justwar.htm> (last visited Apr. 10, 2004), and believes that wars can only be fought between states. Since the 9/11 terrorists are not a country and do not aspire to be one, there can be no war against them.

15. George J. Annas, *Terrorism and Human Rights*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 37 (citing Katherine Q. Seelye, *A P.O.W. Tangle: What the Law Says*, N.Y. Times, Jan. 29, 2002, at A14).

16. *Id.*

17. *Id.* at 43.

18. Ronald Bayer & James Colgrove, *Rights and Dangers: Bioterrorism and the Ideologies of*

have not always been admirable. As Bayer and Colgrove note, the MSEHPA law may be viewed as a modern equivalent to the quarantine laws passed in previous times of crisis because both MSEHPA and the quarantine laws rest upon a utilitarian justification to aid the public.<sup>19</sup> The authors argue that, to a large extent, such an approach received support in the United States because of fears about Iraq and the lethal nerve gas attack perpetrated by a Japanese cult.<sup>20</sup> While such approaches may work and may also receive some public support, there is also much public resistance. This resistance results from the recognition that we may be able to achieve the same results without sacrificing as many individual civil liberties as the MSEHPA would.<sup>21</sup> Any future policy must take this possibility into account. However, Bayer and Colgrove do not go far enough in suggesting a model for assessing the trade-offs.<sup>22</sup>

Part two, “Resource Allocation,” represents the strongest section of the book because it comes closest to providing an ethical framework for the book’s policy discussions. The section begins with an essay by James F. Childress.<sup>23</sup> Childress is a utilitarian and argues that triage (i.e., the allocation of scarce resources according to a formula that treats each individual identically according to a distributional calculus) is a just way of allocating resources. Like all classical utilitarians, Childress emphasizes that each person should count only as one: The rich industrialist and the common farmer are to be treated identically, and resources should be allocated to each of them so as to maximize medical utility.<sup>24</sup> While

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*Public Health*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 51.

19. *See id.* at 52-53. Bayer and Colgrove note that “[t]he courts almost always deferred to public health authorities who deprived individuals of their liberty in the name of public health.” *Id.* (citing *Jacobson v. Mass.*, 197 U.S. 11 (1905); *In re Halko*, 54 Cal. Rptr. 661 (1966); and Wendy Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 *HOFSTRA L. REV.* 53, 61 (1985)).

20. *Id.* at 55.

21. *Id.* at 61.

22. For some preliminary suggestions in this regard, see *infra* Part II.

23. James F. Childress, *Triage in Response to a Bioterrorist Attack*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 77. Childress is co-author of a widely respected textbook on bioethics. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (5th ed. 1994).

24. Maximizing medical utility requires taking actions that will secure “the greatest good for the greatest number” among those with medical needs. Childress, *supra* note 23, at 80. Obviously, calculations of how to do this can take a number of forms. For a discussion of how these calculations are to be made, see MICHAEL BOYLAN, *BASIC ETHICS* 76-79 (2000).

supporters of egalitarian justice might favor a lottery,<sup>25</sup> Childress argues that attempting to maximize medical utility is a better way to allocate resources.<sup>26</sup>

The second essay of this section, written by Kenneth Kipnis, contains the strongest analysis in the book<sup>27</sup> because Kipnis recognizes that there is not just one form of triage. Kipnis begins the essay by describing various allocation strategies<sup>28</sup> and then tri-furcating triage into: (a) clinical triage in which the basis of need dictates the priority of care,<sup>29</sup> (b) battlefield triage in which those with minor injuries are treated first so that they can go out and fight another day,<sup>30</sup> and (c) disaster triage in which one creates a horizontal line beginning with the walking wounded; followed by those who are seriously injured, but can be treated with relatively simple procedures; and then those who are seriously injured and will require complicated and risky solutions for their medical needs. Disaster triage argues that the middle group should be treated first.<sup>31</sup> Since terrorism creates scenarios that are most like the scenario presented by disaster triage, Kipnis argues that this middle group should receive care first, and he provides suggestions of policy initiatives that would implement what he deems to be this ideal allocation strategy.<sup>32</sup>

The third part of the book, "Health Care Workers," turns from questions of resource allocation to the roles of those who will be doing the allocating. Lisa A. Eckenwiler examines the task of emergency management as a complicated systems problem.<sup>33</sup> This view is necessary because many agencies already have some jurisdiction over health care delivery in times of crisis.<sup>34</sup> For these agencies to work together effectively,

25. Egalitarianism is a theory of distributive justice in which all goods are distributed equally without regard to merit or need. This theory is predicated on the existence of a supporting moral theory which sanctions the grounds of the claimed right. For one version of this theory, see MICHAEL A. BOYLAN, *A JUST SOCIETY* 137-98 (2000).

26. Childress, *supra* note 23, at 79-84.

27. Kenneth Kipnis, *Overwhelming Casualties: Medical Ethics in a Time of Terror*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 95.

28. *Id.* at 96-100.

29. This form is used in emergency rooms in hospitals that are able, for the most part, to match patient need with therapeutic support.

30. Battlefield triage is the opposite of clinical triage.

31. Kipnis, *supra* note 27, at 99-100.

32. *Id.* at 105-06.

33. Lisa A. Eckenwiler, *Emergency Health Professionals and the Ethics of Crisis*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 111.

34. These agencies include EMS teams, public health officials, epidemiologists,



it is necessary to integrate their services with a systems approach. However, such a complicated operation can also raise ethical problems that require policy decisions.<sup>35</sup> Dr. Eckenwiler identifies key questions faced by health care workers in times of crisis: When should health care workers mobilize, and how should they intervene once they have made that decision?<sup>36</sup> She provides a preliminary framework for answering these questions and also identifies key challenges faced by health care workers. She notes that the possibility that health care workers might be made agents of the law is a particularly significant problem and one that is a “source of significant moral distress for many health professionals”;<sup>37</sup> this is a problem that Bayer and Colgrove also mention.<sup>38</sup>

In the next essay, Griffin Trotter discusses connections between health care reform and terrorism and recognizes the idealistic nature of many past reforms.<sup>39</sup> Trotter points out that when market forces are used to allocate resources, concerns about “equality” do not factor into the allocation; as a result, the current medical system in the United States is not friendly to the poor and the uninsured.<sup>40</sup> For example, one significant problem that occurs in the present system is the transfer of patients. These transfers can take the form of diverting ambulances to other hospitals, thus increasing the time before the patient can be seen by any medical personnel, or transferring patients who have been seen but not treated, thereby delaying treatment because of the need for additional paperwork to be completed.<sup>41</sup> Obviously, such transfers are not in the best interests of patients who need emergency care. Uninsured patients, usually the indigent, are at greater risk for being subject to patient transfers.<sup>42</sup> Since many emergency room doctors act as primary care physicians for the poor, many needy individuals could be denied basic health care in the event of a national emergency if emergency room doctors are called to aid those affected by the national disaster. The author suggests that if we had universal healthcare, we would be better prepared for a terrorist

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laboratory staff, and clinicians called by local authorities, state and federal agencies, and the Center for Disease Control. Eckenwiler, *supra* note 33, at 112-13.

35. *Id.* at 111, 113-18.

36. *Id.* at 114-21.

37. *Id.* at 125.

38. See Bayer & Colgrove, *supra* note 18, at 52.

39. Griffin Trotter, *Emergency Medicine, Terrorism, and Universal Access to Health Care: A Potent Mixture for Erstwhile Knights-Errant*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 134.

40. *Id.* at 134.

41. *Id.* at 136-37.

42. *Id.* at 138.

emergency.<sup>43</sup> Under this view, universal healthcare could be considered a part of our national defense.<sup>44</sup>

Part Four, "Industry Obligations," is a particularly valuable section of the book because it begins to explain how industry may help to ameliorate the problems set out in the previous parts. In her essay, Evan G. DeRenzo begins by questioning whether a market-based approach to terrorism will be sufficient.<sup>45</sup> This concern derives from the fact that the generally espoused motive of business is to make a profit.<sup>46</sup> However, DeRenzo suggests that businesses can also see achieving the public good as their co-motive for being.<sup>47</sup> Indeed, the ethical goal of business, in this case the pharmaceutical industry, must include more than simply making a profit or else every company would be engaged in illegal and lucrative ventures. The fact that businesses do not go that far in pursuit of the profit motive provides support for DeRenzo's point. Like the founder of the Bank of America,<sup>48</sup> DeRenzo cites support of the public good as a legitimate goal, since a strong public can aid policy makers when they face future crises.

In the final essay in this part, Ann E. Mills and Patricia H. Werhane, one of the premier philosophers of business ethics in the United States, address the issue of organizational ethics.<sup>49</sup> They implicitly respond to the question raised by the previous essay: How should we ask businesses to contribute? Any discussion of that question must first acknowledge that the mission of the healthcare industry changes in times of terrorism.<sup>50</sup> Traditionally, the health care industry has been forced to balance concerns about cost versus concerns about quality of care. Recently, the industry has begun to use vertical integration as a cost-cutting strategy, as "[t]he dominant logic of the for-profit health care industry changed from providing care to providing quarterly profits."<sup>51</sup> However, in the event of

43. *Id.* at 142-45.

44. *Id.* at 143.

45. Evan G. DeRenzo, *The Rightful Goals of a Corporation and the Obligations of the Pharmaceutical Industry in a World with Bioterrorism*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 149.

46. *Id.* at 150.

47. *Id.* at 152.

48. *Id.* at 156-57.

49. Ann E. Mills & Patricia H. Werhane, *After the Terror: Health Care Organizations, the Health Care System, and the Future of Organization Ethics*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 167.

50. *Id.* at 168.

51. *Id.* at 170. Vertical integration, like vertical monopolies, combine control over the various phases of rendering a service or producing a product. Some form of vertical strategy

crisis, the healthcare industry will have to emphasize concerns about quality of care over concerns about cost. In fact, in the case of a crisis, there will likely be a large influx of patients; some estimates suggest that it will cost hospitals \$11.3 billion to prepare for such an influx.<sup>52</sup> Hospitals will not be able to prepare sufficiently under the current system. Rather, they must shift to a community service model that incorporates public health goals. This shift can be achieved by developing systems, or “networks of relationships between individuals, between individuals and organizations, among organizations, and among individuals, organizations, institutions, agencies, and government.”<sup>53</sup> These systems begin from the bottom-up, are adaptive to change, and are designed to integrate the resources of all stakeholders.<sup>54</sup> The element of the stakeholder gives accountability to the whole process.<sup>55</sup>

In the first essay of the last section of the book, “Research and Genetics,” Alan R. Fleischman and Emily B. Wood argue for research standards for the use of human subjects.<sup>56</sup> They make points that should be salient to researchers and those who supervise their research. They argue that research on humans should ensure respect for persons (via informed consent), beneficence (via an effective cost-benefit calculus), and justice (via fairness and equitability).<sup>57</sup> They remind us that in research we must never forget vulnerable populations.

By using a history lesson to identify challenges for the future, Eric M. Meslin ends the book where it began.<sup>58</sup> Meslin observes that while times

is necessary for any large operation. But if a company can control or obtain *ownership* in these phases, then that company’s power to control prices greatly increases. The mechanics of this are discussed in Pamela Jones Harbour, *Vertical Restraints: Federal and State Enforcement of Vertical Issues* (2004) (unpublished written materials), <http://www.ftc.gov/speeches/harbour/0403vertical.pdf>. Because it is also possible that such an entity can fix prices to the detriment of the consumer, we have passed laws against vertical monopolies such as the Sherman Anti-Trust Act, 15 U.S.C. § 1 (2000).

52. Ann E. Mills & Patricia H. Werhane, *After the Terror: Health Care Organizations, the Health Care System, and the Future of Organization Ethics*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 173.

53. *Id.* at 175.

54. *Id.*

55. *Id.* at 177.

56. Alan R. Fleischman & Emily B. Wood, *Research Involving Victims of Terror—Ethical Considerations*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 185.

57. *Id.* at 188-89.

58. Eric M. Meslin, *Genetics and Bioterrorism: Challenges for Science, Society, and Bioethics*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 199.

change and new agendas emerge, we are plagued by classic problems such as the balancing of secrecy and freedom, research aims and human subject autonomy. These tensions inevitably complicate any new policy. However, Meslin urges us to evaluate new policies and practices according to time-tested criteria for addressing such problems, and he reminds us not to ignore input from the scientific community. As he notes, disruption in one area of our health delivery system will inevitably affect other parts.<sup>59</sup> Finally, Meslin addresses the issue of secrecy versus scientific freedom. As he notes, science does best in the sunlight, while national security seeks the shadows.<sup>60</sup> These are all traditional concerns; they are simply resurfacing in slightly modified forms in light of the new problems at hand. While the situations may change, the criteria for evaluating them are timeless. But as all of the essays in *In the Wake of Terror* suggest, sometimes the various criteria for evaluating these policies are in tension with each other. This tension suggests the need to establish an ethical framework against which to assess these policy considerations.

## II. THE NEED FOR AN ETHICAL FRAMEWORK

While *In the Wake of Terror* introduces and facilitates important discussions about preparations for a terrorist disaster within the national medical and public health community, it fails to present the ethical framework that is necessary for the development of sound policy. In particular, the collection of essays raises two compelling themes that merit further discussion as we make these preparations: the protection of individual rights and the principles of allocation. Though various essays in the book touch on these issues, there is a conspicuous lack of grounding in ethical theory.<sup>61</sup> This omission is unfortunate because this sort of grounding is essential if the reader is to be able to assess and recommend medical and public health policy responses in the wake of a terrorist attack. In this Part, I suggest a possible ethical framework against which such policy considerations could be assessed and illustrate how the choice of framework can affect one's policy decisions.

*Protection of individual rights.* During a terrorist onslaught, ordinary rules that emphasize the need to protect individual rights are often replaced by emergency codes and protective strategies that are less sensitive to such needs. As Bayer and Colgrove discuss, the MSEHPA is just

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59. *Id.* at 208.

60. *Id.* at 208-10.

61. The sole exceptions are Childress's and Kipnis's discussions of utilitarianism.

one in a long series of examples. If we assume that society's legal framework follows from accepted moral principles, then the protective strategies of the society during crises should also flow from those same ethical principles.<sup>62</sup> Thus, it is important to identify the moral theory and corresponding principles that will drive public policy.

Many would argue that utilitarianism, a theory that aims to please the greatest number by maximizing their utility,<sup>63</sup> is the appropriate foundational theory since it coheres nicely with the values that support free markets and democracy. In this sense, this theory seems to be both very American and quite consonant with the theoretic underpinnings of public health. Certainly, it is important to work at defending our country via reasonable means, such as searches of airline passengers and their baggage, sea shipping containers, and other means of foreign entry, as well as domestic protections such as screening mail. All of these implementation strategies seem to make sense when seen in the light of precautionary reason.<sup>64</sup>

However, it is important to heed the cautions of George J. Annas: Minority populations and vulnerable groups often fare poorly under zealous utilitarian-based policies.<sup>65</sup> Indeed, practices such as profiling are particularly problematic.<sup>66</sup> Despite the concerns about profiling, it has made a strong comeback in the aftermath of 9/11,<sup>67</sup> with increased

62. Every serious moral system creates a decision-making procedure that will provide an answer for every eventuality. The question is why we accept one procedure over another.

63. See generally BOYLAN, *supra* note 24, at 66-87.

64. In contrast to the policies that I describe as "racial profiling," these practices are not—or at least need not be—targeted toward specific groups of people. Of course, even the reasonableness of these non-targeted policies can be subject to dispute. See, e.g., *Expert Believes Airport Screening Must Be Fixed Before It's Changed*, ORLANDO SENTINEL TRIB., June 2, 2003, at CFB3 (noting the criticism of one aviation consultant that the "government's plan to use extensive background checks on passengers is troubling from a privacy standpoint"). A full defense of their reasonableness is beyond the scope of this Review.

65. IN THE WAKE OF TERROR, *supra* note 5; Annas, *supra* note 13, at 37-40, 43-47; cf. Bayer & Colgrove, *supra* note 18, at 58-64; Eckenwiler, *supra* note 33, at 122-24; Fleischman & Wood, *supra* note 56, at 191-93; Lombardo, *supra* note 6, at 4-6, 9-11; Meslin, *supra* note 58, at 212.

66. For discussions of the existence of, and concerns about, racial profiling, see generally MILTON HEUMANN & LANCE CASSAK, *GOOD COP, BAD COP: RACIAL PROFILING AND COMPETING VIEWS OF JUSTICE* (2003); Richard J. Lundman & Robert L. Kaufman, *Driving While Black: Effects of Race, Ethnicity, and Gender on Citizen Self-Reports of Traffic Stops and Police Actions*, 41 *CRIMINOLOGY* 195 (2003).

67. Irene Jung Fiala, *Anything New? The Racial Profiling of Terrorists*, 16 *CRIM. JUST. STUD.*

detentions and arrests of people of Arabic or Middle Eastern descents.<sup>68</sup> Are these actions legally justified? It is hard to know since so much is still cloaked in secrecy.<sup>69</sup> Even if we knew more, the legal and ethical propriety of racial profiling would likely remain the subject of contentious debate.

Among the many problems that profiling presents,<sup>70</sup> it has the potential to negatively affect the practice of medicine and public health: Profiling risks marginalizing minority groups such that communication between members of those minority groups and the medical community is hampered.<sup>71</sup> As a result of this hampered communication, medical professionals often know little about the values and lifestyles of these groups, and misunderstandings often result from different uses of language, different understandings of the meanings of facts, and different value determinations. For example, if a physician is unaware of one Muslim view on male physicians examining females, he would not understand the patient's reluctance to seek medical care. This could lead to a serious condition going untreated. Alternatively, a physician might be aware of this worldview, but dismiss it as primitive or parochial or simply fail to understand it. Whatever its cause, this lack of communication impairs the clinical processes of diagnosis, prognosis, and treatment, resulting in differential medical care.<sup>72</sup>

If such difficulties can impair diagnosis and treatment in normal settings, the possibility for detrimental effects on medical care are only greater when the physician-patient interaction occurs in settings emotionally charged by the threat of an imminent terrorist incident. Concerns of this kind have always been present with immigrant

53 (2003).

68. Salah D. Hassan, *Enemy Arabs*, 17 *SOCIALISM & DEMOCRACY* 175 (2003); Liam Braber, Comment, *Korematsu's Ghost: A Post September 11th Analysis of Race and National Security*, 47 *VILLANOVA L. REV.* 451, 452-53 (2002).

69. See Michael Welch, *Ironies of Social Control and the Criminalization of Immigrants*, 39 *CRIME, LAW & SOCIAL CHANGE* 319, 323-25 (2003) (discussing the use of secret evidence in immigration cases); cf. Ayse Ceyhan, *Terrorism, Immigration and Patriotism under Surveillance*, 44 *CULTURES ET CONFLICTS* 117 (2001).

70. There is an extensive literature evaluating the legality of racial profiling, but those issues are beyond the scope of this Book Review. See, e.g., Albert W. Alschuler, *Racial Profiling and the Constitution*, 2002 *U. CHI. LEGAL F.* 163. For a discussion of the problem from the point of view of classes and mathematical logic, see BOYLAN, *supra* note 25, at 93-112.

71. See Michael A. Boylan, *Culture and Medical Intervention*, *J. CLINICAL ETHICS* (forthcoming 2004).

72. *Id.*

populations,<sup>73</sup> but if profiling creates stigmatized populations among non-immigrants, these sub-populations may suffer from the same harms that have historically been inflicted on immigrant populations. This is particularly troubling when the groups affected are small because then it becomes more difficult for those group to become self-sufficient in areas such as health care delivery. In the public health setting, utilitarian calculations may underestimate the effect that practices such as racial profiling have on marginalized populations because the mainstream population can tend to ignore, or devalue, considerations relevant to those populations.

One way to protect those without a resonant public voice is to introduce a rights-based approach into the public dialogue. Many proponents of rights-based moral theories<sup>74</sup> have challenged some of the premises that underlie classic utilitarianism.<sup>75</sup> Under this view, there should be procedures that ensure that the least advantaged should not be called upon to forfeit their individual liberties except in the most extreme scenarios. Such procedures are necessary under a rights-oriented moral theory, which requires the establishment of both base-line protections for individuals' needs and the correlative duties of society that protection of those needs entail.<sup>76</sup> This argument assumes that human beings' primary aim is to act. Therefore, certain fundamental rights are protected because of their critical role in facilitating action.<sup>77</sup> Under this view, racial profiling would not be justified because it interferes with an individual's ability to act freely in society as an individual, rather than as a member of a stereotyped group. Thus, while profiling might be justified under a utilitarian approach, it would not be justified under a rights-based theoretical orientation. Clearly, then, our choice of theoretical ethical approach can play a critical role in determining what protective law enforcement strategies are justified in times of emergency.

Indeed, police strategies should be of concern to the medical and public health communities—especially since, as Eckenwiler notes, many of

73. *Id.*

74. John Rawls, Alan Gewirth, and I are all proponents of such a theory.

75. See generally BOYLAN, *supra* note 25, at 53-58; ALAN GEWIRTH, REASON AND MORALITY 312-22 (1978); JOHN RAWLS, A THEORY OF JUSTICE 4 (1971) (“[Justice] does not allow that the sacrifices imposed on a few are outweighed by the larger sum of advantages enjoyed by many.”). Each of these writers develops a different argument for why a deontological, rights-based theory of ethics is superior to a utilitarian-based theory. These arguments are beyond the scope of this Book Review.

76. See Wesley N. HOHFELD, FUNDAMENTAL LEGAL CONCEPTIONS 41 (1919).

77. For discussion of this argument, see BOYLAN, *supra* note 25, at 53-69.

the scenarios being discussed in the public health sphere include a *de facto* enrollment of the medical community into policing of our population.<sup>78</sup> Certainly, the medical community could be an efficient addition to law enforcement organizations' activities. But is that the proper role of our health care workers?

I would suggest that it is not. On the one hand, it is essential to integrate the various components of our society in our fight against terrorism. On the other hand, this effort should not require individuals to do jobs unnatural to them. Curing the sick while doing no harm<sup>79</sup> is natural to medicine, but becoming law enforcers would put physicians in a different position—one that they are unprepared to fill. It is not hard to imagine situations in which the health care worker qua policeman might be forced to act contrary to the medical needs of the patient, thereby abnegating her professional duties as a physician.<sup>80</sup> Surely, it works to no one's benefit for such an important societal profession to compromise itself. It weakens the profession just at the time when we all count upon its strength.

*The principles of allocation.* As with protection of individual rights, principles of allocation will also be colored by the ethical system that we choose. Childress argues for a utilitarian system.<sup>81</sup> This might make sense since such a system would be closely aligned with the cost-benefit analysis that seems to drive the prominent triage formulae. Moreover, it is true that the rights-based theories are principally designed to work under normal circumstances and have an "ought implies can" caveat.<sup>82</sup> In other words,

78. Eckenwiler, *supra* note 33, at 125.

79. This is a paraphrase of the Hippocratic Oath. For a discussion of the Hippocratic Oath in the context of professional ethics, see MICHAEL BOYLAN & KEVIN E. BROWN, *GENETIC ENGINEERING: SCIENCE AND ETHICS ON THE NEW FRONTIER* 12-25 (2002). For a discussion of the oath in the context of the Hippocratic corpus, see Michael Boylan, *Hippocrates (c. 450 BCE to 380 BCE.)*, The Internet Encyclopedia of Philosophy, at <http://www.iep.utm.edu> (last visited Apr. 9, 2004).

80. For example, what if an attending physician suspected that a patient had material information that could aid in an investigation, but also believed that a comprehensive debriefing of the patient would put the patient's life in danger. In this situation, the physician qua healer would have a responsibility to attend to the medical needs of the patient. However, physician qua agent of the law should interrogate the patient to prevent the potential harm to many others. Thus, the individual physician simultaneously has a duty to interrogate and not interrogate the patient.

81. James F. Childress, *Triage in Response to a Bioterrorist Attack*, in *IN THE WAKE OF TERROR*, *supra* note 5, at 77, 79ff.

82. Obviously, a lot rides on "reasonably." The policy dimensions of this are discussed



under this view, no duty can be ascribed to any agent or group that cannot, given the circumstances, *reasonably* fulfill it. Thus, when the “can” is called into question—as it would be in the case of an act of terrorism—the “ought” becomes weakened.

Yet this does not mean that rights-based theories cannot provide guidance in allocating resources. As Kipnis notes in his essay, there is not just one way to allocate resources; rather, there are at least three forms of triage.<sup>83</sup> Which is most appropriate for instances of terrorism? Under a rights-based theory, care should be allocated on the basis, at least in part, of need. Therefore, the battlefield triage approach would contradict a rights-based theory because medical attention is meted out in the opposite order of need in order to clear the hospitals of people as quickly as possible.

But what about the other two options? Our choice depends upon which factor we wish to emphasize: numbers of people being treated and discharged or the satisfaction of those most in need. One possibility would be to employ clinical triage within parameters: A small unit that would take the most extreme cases under a lottery system would treat as many of those requiring over  $x$  percentage of medical resources (as measured by time and materials expended) as possible, while the majority of the medical care would be devoted to treating everyone else. The order in which members of this latter group would be treated would be determined solely on the basis of need. The advantage of a lottery system that is employed for the very ill and injured is that everyone can understand that such extraordinary times will not allow for everyone to be treated. Since all people’s lives are of equal importance, random measures will be taken to attend to these individuals. While the losers in this class will surely die at a very high rate, they are being attended to in a way that does not make any utility calculations regarding whom should be saved.

This sort of triage arrangement is an amalgam of Kipnis’s clinical and disaster triage, but because it is based on a rights-oriented moral theory, it has a slightly different outcome measurement. Arguably such an allocation formula is ultimately fairer to all because it recognizes all people’s right to medical care, while also admitting that the extraordinary circumstances of the terrorist attack has made rationing of some sort a practical necessity. However, what is driving this sort of rationing is not an attempt to achieve the greatest good for the greatest number, but rather an attempt to create a system that, to the greatest extent possible, respects the fundamental

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by BOYLAN, *supra* note 25, at 143-44, 162, 174-75, 202, 213, 240.

83. Kipnis, *supra* note 27, at 97-100.

rights of all people equally according to the strength of their need.

Obviously, this is an important question that should be engaged in the public sphere. So, too, are all of the other questions raised and policy issues discussed in *In the Wake of Terror*. Thus, *In the Wake of Terror* provides an excellent introduction to the connections between the threat of bioterrorism and public health because it identifies all of the issues salient to this discussion. Unfortunately, *In the Wake of Terror* can serve only as an introduction to this discussion because while it identifies the important issues, it does not tell the reader how to evaluate them. In this Review, I have not set out to provide definitive answers to any of the questions *In the Wake of Terror* raises; rather, I have hoped to show that the ethical framework one chooses can significantly alter the policy outcomes one reaches. While I have used only two examples—the protection of individual rights and the allocation of resources—to illustrate this point, it is equally true of all of the issues discussed in *In the Wake of Terror*. As we continue to live in a world in which a terrorist threat seems imminent, the questions raised in *In the Wake of Terror* will continue to be of paramount importance. But identifying the important questions is obviously not enough. Identifying an appropriate ethical framework is a critical next step as we try to determine how best to answer those questions.