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EBOLA AND HUMAN RIGHTS: POST-9/11 PUBLIC HEALTH AND SAFETY IN EPIDEMICS

George J. Annas[†]

In public health practice, the concepts of health and safety are often conflated. However, protecting and promoting health is radically different from protecting and promoting safety. Since 9/11, the distinctions between health and safety have changed and are in the process of merging. In our terrorism-obsessed world, public health has been increasingly militarized and enlisted, often without protest, into the service of protecting the safety of the public and the security of the nation. But safety and security are the proper purposes of law enforcement and the military, not of public health. More importantly, using public health to combat terrorism is often counterproductive to the population's health, and undermines human rights. Using the Ebola epidemic of 2014, this Article suggests how the post-9/11 reframing of public health goals as including disaster preparedness and counterterrorism, and the new military metaphors we have adopted to describe public health, have deformed our public health agencies, and have made them less trusted by the public. In turn, these agencies are therefore less able to prevent and respond to new infectious diseases. The United States' response to Ebola gives us an opportunity to reconsider the merger of public health and public safety domestically and globally. This Article suggests that a deeper commitment to human rights, especially to the right to health, has the theoretical and practical strength to act as a countervailing force and refocus public health on the health of populations rather than on safety and national security.

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I. INTRODUCTION

Salus populi supreme lex esto

Cicero, On the Laws, Book III, part 3, no. 8.

Cicero's injunction to the leaders of Rome has been used as a short hand to describe the primary obligation of a country's leader.[1] It is often translated to "[t]he health of the public is the supreme law,"[2] and this is the way many public health officials use it.[3] But an equally authoritative translation of *solus* is "safety" or "welfare."[4] In his *Leviathan*, for example, Thomas Hobbes adopts "the safety of the people."[5] Nonetheless, health and safety, although often paired and used interchangeably, are very different concepts. The word chosen can induce very different government actions. For example, when President Obama addressed the nation on the threat of ISIS in December 2015, he could have been channeling Cicero when he said, "[a]s Commander-in-Chief, I have no greater responsibility than the security [safety] of the American people."[6] And after the San Bernardino massacre, Donald Trump added to his election slogan, "Make America Great Again," the phrase, "Make America Safe Again."[7] Similarly, the Commissioned Officers Association of

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[1] *See* Elliot Sperber, *Why Our Good Health Should Be the Supreme Law of the Land: The US Constitution's Stated Purpose Is to Further "the General Welfare" – and That Starts with the Health of the People*, ALTERNET (July 8, 2013), http://www.alternet.org/visions/health-people-supreme-law [http://perma.cc/GX4Y-AMBC].

[2] *Id.* "Safety" fits the context better than "health" as well. The paragraph from which the quotation is taken is about the powers of the head of the government when "in the field" as commander of the military: "[i]n the field they shall hold the supreme military power; they shall be subject to no one; the safety of the people shall be their highest law." Marcus Tullius Cicero, *Laws: Book II, in* THE GREAT LEGAL PHILOSOPHERS 53 (Clarence Morris ed., 1959). Of course, Cicero's views on law were not universally appreciated as he was ordered beheaded by Mark Antony. *The Death of Cicero*, http://penelope.uchicago.edu/~grout/encyclopaedia_romana/calendar/cicero.html [http://perma.cc/SNH9-2ZSR]. As Mary Beard puts it in her history of ancient Rome "the Romans' were as divided about how they thought the world worked, or should work as we are. There is no simple Roman model to follow. If only things were that easy." MARY BEARD, SPQR: A HISTORY OF ANCIENT ROME 535 (2015).

[3] *See, e.g.*, HOWARD MARKEL, QUARANTINE! EAST EUROPEAN JEWISH IMMIGRANTS AND THE NEW YORK CITY EPIDEMICS OF 1892 186 (1997) ("[H]ealth officials interpreted [the phrase to mean], the health of the public outweighs that of the individual suspected of being ill . . . [and became] the immediate concern of those charged with epidemic containment.").

[4] *See, e.g.*, Phoebe E. Arde-Acquah, Note, *Salus Populi Suprema Lex Esto*†*: Balancing Civil Liberties and Public Health Interventions in Modern Vaccination Policy*, 7 WASH. U. JURIS. REV. 337, 337 n. † (2015) (quoting MARCUS TUILLIUS CICERO, DE LEGIBUS bk. III, part III, sub. VIII, at 241 (J. G. F. Powell ed., 2006) (c. 43 B.C.E.)).

[5] THOMAS HOBBES, LEVIATHAN: OR THE MATTER, FORME AND POWER OF A COMMONWEALTH ECCLESIASTICALL AND CIVIL 247 (Michael Oakeshott ed., Collier MacMillan Publishers 1977) (1651).

[6] Press Release, The White House, Office of the Press Secretary, Address to the Nation by the President (Dec. 6, 2015), https://www.whitehouse.gov/the-press-office/2015/12/06/address-nation-president [http://perma.cc/3SQ3-7N76] [hereinafter Address to the Nation Press Release].

[7] Michael Dorstewitz, *Trump Floats "New and Improved Slogan" to Chris Wallace*, BIZPAC REVIEW (Dec. 13, 2015), http://www.bizpacreview.com/2015/12/13/trump-floats-new-and-improved-slogan-to-chris-wallace-284012?hvid=1WlqnG [http://perma.cc/H8T8-UZUU]. It is not surprising that as the level of fear of a new terrorist attack on Americans increased, so did Donald Trump's poll numbers. Jonathan Martin & Dalia Sussman, *Fear of Terrorism Lifts Donald Trump in New York Times/CBS Poll,* N.Y. TIMES (Dec. 10, 2015), http://www.nytimes.com/2015/12/11/us/politics/fear-of-terrorism-lifts-donald-trump-in-new-york-times-cbs-poll.html?smid=pl-share&_r=0 ("Americans are more fearful about the likelihood of another terrorist attack than at any other time since the weeks after Sept. 11, 2001, a gnawing sense of dread that has helped lift Donald J. Trump to a new high among Republican primary voters, according to the latest New York Times/CBS News poll . . . . a plurality of the public views the threat of terrorism as the top issue facing

the United States Public Health Service has a mission statement to "protect and enhance the public health and safety of the United States," and the role of the Public Health Services Commissioned Corps is to "protect US security and safety."[8] In all of these contexts health of the public has been replaced by the safety or security of the public.

In this Article I am primarily interested in the difference between the health of the population and the safety of the population, and what the concepts of health and safety mean to the public and to public health officials. I will suggest that population safety is primarily the goal of law enforcement domestically, and of the military internationally, and that population safety is only tangentially a function of public health.[9] I also suggest that since 9/11 public health has become entangled with population safety and national security, and this entanglement has obscured its mission, making public health less effective and less trusted.[10] In our post-9/11 era, when an epidemic can be viewed as a terrorist attack,[11] it is relatively easy for public health officials to declare an "emergency" and use the emergency framework to replace their focus on population health with an often counterproductive focus on population safety.

Conflating health and safety is not just a post-9/11 phenomenon, but the events of 9/11 have made this conflation more apparent and more dangerous to human rights. In this Article, I use the Ebola epidemic of 2014 to illustrate the tendency in post-9/11 epidemics to merge public health and public safety, and even to favor safety and security over health. In the context of global terrorism, epidemics become a justification for public health and other government officials to adopt emergency powers that undermine human rights and human dignity,[12] the support of which should be at the core of public health. New concepts of a "public health emergency," suggest that legal rules, especially those protecting human rights, should be compromised during an emergency.[13] Public health officials, especially those in the Public Health Services Commissioned Officer Corps, are more likely to see themselves as soldiers in uniform, rather than physicians or public health practitioners—and so is the public.[14]

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the country."). "[T]error management" theory predicts exactly this result. *See* GEORGE J. ANNAS, WORST CASE BIOETHICS: DEATH, DISASTER, AND PUBLIC HEALTH xiii-xiv (2010).

[8] COMMISSIONED OFFICERS ASSOCIATION OF THE USPHS, *Mission & History*, http://coausphs.org/about/mission-history/ [http://perma.cc/K22D-9K4R].

[9] This is not to say that "safety" is never a public health concern; gun safety and patient safety are two examples of major public health problems. *See, e.g.*, George J. Annas, *The Patient's Right to Safety – Improving the Quality of Care Through Litigation Against Hospitals*, 354 NEW ENG. J. MED. 2063-65 (2006) (Even though lapses in patient safety in hospitals are one of the leading causes of death in the US, patient safety has generally been seen as a medical problem rather than as a public health problem). This is, I think, a major mistake. Another approach is more litigation.

[10] *See generally* ANNAS, WORST CASE BIOETHICS, *supra* note 7.

[11] *See, e.g.*, George Will, *When Nature Attacks: Epidemics Can Be Terror Weapons*, JEWISH WORLD REVIEW (Aug. 9, 2014) http://www.jewishworldreview.com/cols/will080914.php3 [http://perma.cc/EM2Y-2V6H] ("Nowadays, so many terrible deeds are reflexively called terrorism that the term is becoming a classification that no longer classifies.").

[12] *See generally* ANNAS, WORST CASE BIOETHICS, *supra* note 7.

[13] *Id*. at 27-28. WHO's designation of Zika causing an emergency epidemic of microcephaly is an over-reaction likely caused by its under-reaction to Ebola, and will fuel counterproductive responses. George Annas et al., *Zika Virus is Not Ebola*, BOSTON GLOBE (Feb. 1, 2016), https://www.bostonglobe.com/opinion/2016/02/01/zika-virus-not-ebola/gbBZA18ILkLcLK2VNM7XfM/story.html.

[14] *See, e.g.*, GUENTER B. RISSE, DRIVEN BY FEAR: EPIDEMICS AND ISOLATION IN SAN FRANCISCO'S HOUSE OF PESTILENCE 209 (2015) ("Since the military system and by extension most professional police forces are cohesive, rigid, and hierarchical, they can quickly respond in emergencies, [but] their tactics and orders are not subject to negotiations or consensus. Whether friendly or hostile, most civilians will be cast as the ununiformed 'other,' potential adversaries if they do not follow commands. This setup can be extremely

The post-9/11 reframing of federal and state public health agencies as part of disaster preparedness, with an emphasis on bioterrorism and counterterrorism—and the new metaphors deployed to describe public health—have deformed our public health agencies and made them less trusted by the public and thus less able to prevent and respond to new infectious diseases, like Zika.[15] This is a tragedy for the public, as well as for public health. The United States' response to Ebola, both at home and abroad, presents an opportunity to reconsider the merger of public health and public safety. This Article has five parts, each of which is focused on the merger of health and safety in the epidemic context: Public Health and Safety in the United States Supreme Court, Ebola in the United States, Ebola and its Metaphors, and Ebola and the World.

II. PUBLIC HEALTH AND SAFETY IN THE UNITED STATES SUPREME COURT

The merger of public health and public safety is usually viewed as a natural and necessary emergency reaction to both epidemics and terrorist attacks, especially since 9/11. It is most explicitly acknowledged in "public health preparedness" or "all-hazards preparedness," but can also be found in basic public health and scientific research, now referred to as "dual use" research.[16] For example, the decision to publish research on inducing flu transmission in ferrets rested primarily on the views of national security and biosafety experts.[17] Further, use of torture and "enhanced interrogation" for national security is also justified by the public health rationale of "saving American lives."[18]

In 2012, the United States Supreme Court explicitly endorsed this post-9/11 public health–public safety merger in a troubling opinion on the constitutionality of routine strip searches of arrestees prior to confinement in a jail or prison.[19] The question

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useful in instances of widespread social breakdown and chaos, but it has proved time and again counterproductive in less dire and more localized situations.").

[15] *But see* Kenneth W. Bernard, *Health and National Security: A Contemporary Collision of Cultures*, 11 BIOSECURITY & BIOTERRORISM 157, 162 (2013) (arguing that the public health community must learn to work more closely with the national security community, and "can start by speaking national security language and eliminating the self-important and sanctimonious lecturing for which global health advocates are known").

[16] *See* Nadja A. Vielot & Jennifer A. Horney, *Can Merging the Roles of Public Health Preparedness and Emergency Management Increase the Efficiency and Effectiveness of Emergency Planning and Response?* 11 INT'L J. ENVTL. RES. PUB. HEALTH 2911, 2912 (2014); *see generally* Jonathan E. Suk et al., *Dual-Use Research and Technological Diffusion: Reconsidering the Bioterrorism Treat Spectrum*, 7 PLoS 1 (2011).

[17] Editorial, *Publishing Risky Research*, 485 NATURE 5 (2012); *see also* Megan J. Palmer et al., *A More Systematic Approach to Biological Risk*, 350 SCIENCE 1471 (2015) ("The Ebola outbreak drove home the potential public health consequences of infectious agents, irrespective of whether they originate inside or outside the lab. The debate has widened as other dual-use experiments and technologies, such as gene drives, are pursued.").

[18] *E.g.*, JOSE RODRIGUEZ, JR. & BILL HARLOW, HARD MEASURES: HOW AGGRESSIVE CIA ACTIONS AFTER 9/11 SAVED AMERICAN LIVES XIII, 80 (2012) ("I am certain, beyond any doubt, that these [enhanced] techniques . . . . saved American lives."); *see also* George J. Annas & Sondra S. Crosby, *Post-9/11 Torture at CIA "Black Sites"- Physicians and Lawyers Working Together*, 372 N ENGL. J. MED. 2279, 2280 (2015) ("The CIA opened more than a dozen black sites around the world after 9/11, in which at least 117 prisoners were held; 39 of these prisoners were subjected to one or more torture techniques.").

[19] Florence v. Bd. of Chosen Freeholders of County of Burlington, 123 S. Ct 1510, (2012). Portions of the description of the *Florence* case are adapted from George J. Annas, *Strip Searches in the Supreme Court – Prisons and Public Health*, 367 NEW ENG. J. MED. 1653, 1653 (2012) (The facts of the case are straightforward and not in dispute. In 1998, Albert Florence, a thirty-eight year old black man, and his wife were stopped in their car by a state trooper, and based on an outstanding warrant that should have been

before the Court was whether routine strip searches violate the Fourth Amendment's prohibition of "unreasonable" searches.[20] The case was decided five to four.[21] The majority used public health and medical rationales, combined with post-9/11 fear, to justify routinely strip searching the thirteen million Americans arrested annually in this country.[22] Justice Anthony Kennedy, who wrote the opinion for the Court, described American jails and prisons as "crowded" and "dangerous," writing, "[m]aintaining *safety and order* at these institutions requires the expertise of correctional officials, who must have substantial discretion to devise reasonable solutions to the problems they face."[23] Under these circumstances, even a regulation that infringes on an inmate's constitutional rights must be upheld by the Court "if it is reasonably related to legitimate penological interests."[24]

The case begins with safety and security, but it quickly turns to health. The Court's first rationale for upholding routine strip searches is explicit public health danger: "[t]he danger of introducing lice or contagious infections" into the prison.[25] The Court cites public health literature for this proposition, including articles on MRSA and lice.[26] The second rationale is also health-related: "[p]ersons just arrested may have wounds or other injuries requiring immediate medical attention . . . .[which] may be difficult to identify and treat . . . until detainees remove their clothes . . . ."[27] The third and fourth rationales are related to safety and security: to identify gang

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rescinded, he was arrested. "He was held at the Burlington County Detention Center for 6 days, and then transferred to the Essex County Correctional Facility before the mistake was discovered and he was released. In court, he did not challenge either his arrest or confinement but only the strip searches performed at his admission to each facility." Burlington County jail procedure required every person to shower and "to be checked by prison guards for 'scars, marks, gang tattoos, and contraband'" when they were naked. "Florence says he was instructed to open his mouth, lift his tongue, hold out his arms, turn around, and lift his genitals. At the Essex County Correctional Facility, as described by the Court, all new arrestees were instructed to remove their clothing while an officer examined them, looking at 'their ears, nose, mouth, hair, scalp, fingers, hands, arms, armpits, and other body openings.' Florence says 'he was required to lift his genitals, turn around, and cough in a squatting position as part of the process' and then had a mandatory shower. Florence brought suit, alleging that the policies of [both prisons] . . . violated his Fourth Amendment rights which, he argued, prohibit routine strip searches of people arrested for minor offenses" in the absence of any "reasonable suspicion that the person [wa]s concealing contraband." His case made it to the Supreme Court .).

[20] *Florence,* 123 S. Ct 1510.

[21] *Id.* at 1510.

[22] *Id.* at 1512, 1518, 1520.

[23] *Id.* at 1515, 1520 (emphasis added).

[24] *Id*. at 1515 (quoting Turner v. Safley, 482 U.S. 78, 89 (1987)). The Court relied heavily *on Bell v. Wolfish*, a 1979 case which upheld a rule requiring strip searches of prisoners (including pre-trial detainees) in a federal prison each time they had a contact visit with a person from outside the prison. *Florence,* 132 S. Ct. at 1516 (citing Bell v. Wolfish, 441 U.S. 520 (1979)). The *Bell* Court "deferred to the judgment of correctional officials that [mandatory strip searches] served not only to discover but also to deter the smuggling of weapons, drugs, and other prohibited items inside." *Florence*, 132 S. Ct. at 1516 (citing *Bell*, 441 U.S. at 558). The Court also relied heavily on a 2001 case of a woman who was arrested and taken to jail for not wearing her seat belt—an offence for which she could not be sentenced to jail time. *Florence,* 132 S. Ct. at 1517 (citing Atwater v. Lago Vista, 532 U.S. 318 (2001)). The *Atwater* Court rejected her claim that she could not be arrested and put in jail as a matter of constitutional right under these circumstances. *Florence,* 132 S. Ct. at 1517 (citing *Atwater*, 532 U.S. at 354). The *Atwater* Court, however, concluded that "officers may make an arrest based upon probable cause to believe the person has committed a criminal offense in their presence." *Florence*, 132 S. Ct. at 1517 (citing *Atwater*, 532 U.S. at 354). "The Court has held that deference must be given to the officials in charge of the jail unless there is 'substantial evidence' demonstrating their response to the situation is exaggerated." *Florence,* 132 S. Ct. at 1518 (citing Block v. Rutherford, 468 U.S. 576, 584-85 (1984).

[25] *Florence*, 132 S. Ct. at 1518.

[26] *Id.*

[27] *Id.*

members by their tattoos, and to detect "concealed contraband" (e.g., weapons, drugs, alcohol, cell phones, lighters and matches, and money) that could be used to "disrupt the safe operation of a jail."[28]

The Court rejects the core argument that prison officials should be required to distinguish between those detained for minor offenses (who should not be strip searched without reasonable suspicion) and those arrested for serious crimes.[29] Justice Kennedy argues that corrections officials reasonably concluded that this distinction would be "unworkable."[30] He goes further, noting "[p]eople detained for minor offenses can turn out to be the most devious and dangerous criminals."[31] In support of this view, Kennedy cites three articles from the *New York Times*, two involving terrorists and one involving a serial killer.[32] The first terrorist, Timothy McVeigh, was stopped because "he was driving without a license plate"; the second, stopped two days before September 11, 2001, was stopped for speeding; and the third was also stopped for driving a vehicle without a license plate.[33] Kennedy concludes that most prison officials are simply not "well equipped" to make relevant legal distinctions during the intake process.[34]

Justice Stephen Breyer, who wrote the dissent, begins by looking at the privacy rights of the person being stripped and how these rights are violated: "A strip search that involves a stranger peering without consent at a naked individual, and in particular at the most private portions of that person's body, is a serious invasion of privacy . . . . [and] such searches are inherently harmful, humiliating, and degrading."[35] Breyer believes this is especially the case when the reason for the arrest is a minor infraction, such that a strip search would not be considered a possibility by the person arrested.[36] He gives a number of examples, taken from the Amicus briefs, of arrestees who were subjected to strip searches: an elderly nun "arrested for trespassing during an antiwar demonstration"; "women . . . strip-searched during periods of lactation or menstruation"; "victims of sexual violence"; people arrested for minor traffic offenses, including driving with "a noisy muffler" or "an inoperable headlight, fail[ure] to use a turn signal, and riding a bicycle without an audible bell"; and violation of the "dog leash law."[37]

In Breyer's view, "the 'particular' invasion of interests, must be 'reasonably related' to the justifying 'penological interest' and the need must not be 'exaggerated.'"[38] Unlike the majority, Justice Breyer found no "convincing" reason for strip searches of those arrested for minor offenses in the absence of reasonable suspicion.[39] Finding contraband on people arrested for low level crimes is virtually unheard of, and detecting disease, preventing lice, and identifying gang members can

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[28] *Id.* at 1518-19.

[29] *Id.* at 1520-22.

[30] *Id.* at 1520.

[31] *Id.* "It is not surprising that correctional officials have sought to perform thorough searches at intake for disease, gang affiliation, and contraband. *Jails are often crowded, unsanitary, and dangerous places*. There is a substantial interest in preventing any new inmate . . . from putting all who live or work at these institutions at even greater risk when he is admitted to the general population." *Id.* (emphasis added).

[32] *Id.*

[33] *Id.*

[34] *Id.* at 1522.

[35] *Id.* at 1526 (Breyer, J., dissenting).

[36] *Id.* at 1525-26 (Breyer, J., dissenting).

[37] *Id.* at 1527 (Breyer, J., dissenting) (citing Jones v. Edwards, 770 F.2d 739, 741 (8th Cir. 1985)).

[38] *Id.* at 1528 (Breyer, J., dissenting) (citation omitted) (internal quotation marks omitted) (citing Turner v. Safley, 482 U.S. 78, 87 (1987)).

[39] *Id.* at 1530 (Breyer, J., dissenting).

be accomplished by routine pat downs, metal detectors, showering, and searching inmates' clothing.[40]

Since 9/11, searches have become almost routine, and the opinion makes strip searches of Americans seem necessary to protect the public's health and the safety of correctional officers.[41] Since all Americans who want to board an airplane are subject to routine pat downs, virtual strip searches, and, if suspicious, full strip searches, it might seem trivial to subject all of those who are arrested to full strip searches. All of these searches have the same rationale: they are necessary for our safety. Theoretically, searches done at the airport are consensual—at least for people who have travel options. Searches conducted in jails and prisons are not consensual in any way, so a different rationale is needed, one which is largely supplied in *Florence* by using health justifications.[42]

Not only does Kennedy list the maintenance of health of the prisoners as the first two "significant interest[s]" correctional officials have in conducting routine strip searches, but he also gives three specific examples complete with medical or correctional literature citations.[43] First, "[t]he danger of introducing lice or contagious infections, for example, is well documented."[44] Kennedy gives four citations for this proposition, none of which have anything to do with strip searches.[45] The first is an article by Grant Deger and David Quick on MRSA in County Jails, which recommends routine culturing of all skin and soft tissue infections.[46] The second, by Joseph Bick, is more general, noting that "[m]ost jails and prisons were constructed to maximize public safety, not to minimize the transmission of disease or to efficiently deliver health care."[47] Bick's primary recommendation is for more "hand washing areas, isolation rooms, and personal protective equipment."[48]

The third citation is to the Federal Bureau of Prisons' ("BOF") "Clinical Practice Guidelines" on MRSA,[49] and the fourth to BOF guidelines entitled "Lice and Scabies Protocol."[50] The MRSA guidance has nothing to do with strip searches, but does

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[40] *Id.* at 1528-30 (Breyer, J., dissenting) (Breyer takes only one rationale seriously: detecting contraband. But even here Breyer argues, there is a "lack of justification" for routine strip searches. He reached this conclusion for three reasons. First, there is empirical evidence, documented by two prior courts, that no more than three instances of drug contraband in about 100,000 strip searches might not have been found by using a reasonable suspicion standard. Second, correctional associations and professional bodies that have studied the issue recommend against "suspicionless strip searches." Finally, "[l]aws in at least 10 states prohibit suspicionless searches", and at least seven Courts of Appeals do as well for persons arrested for a minor offense. Breyer then makes his strongest point: "neither the majority's opinion nor the briefs set forth any clear example of an instance in which contraband was smuggled into the general jail population during intake that could not have been discovered if the jail was employing a reasonable suspicion standard.").

[41] *See generally id.*

[42] *Id.* at 1512, 1518.

[43] *Id.* at 1518.

[44] *Id.*

[45] *See infra* text accompanying notes 46-55.

[46] *Florence,* 132 S. Ct. at 1518 (citing Grant E. Deger & David W. Quick, *The Enduring Menace of MRSA: Incidence, Treatment, and Prevention in a County Jail*. 15 J. CORRECTIONAL HEALTH CARE 174 (2009)).

[47] Joseph A. Bick, *Infection Control in Jails and Prisons*, 45 HEALTHCARE EPIDEMIOLOGY 1047, 1047 (2007); *see Florence*, 132 S. Ct. at 1518.

[48] Bick, *supra* note 47, at 1047.

[49] *Florence,* 132 S. Ct. at 1518 (citing FEDERAL BUREAU OF PRISONS, CLINICAL PRACTICE GUIDELINES: MANAGEMENT OF METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) INFECTIONS (2012), https://www.bop.gov/resources/pdfs/mrsa.pdf [http://perma.cc/RPV9-C8JY] [hereinafter MRSA GUIDELINES]).

[50] *Florence,* 132 S. Ct. at 1518 (citing FEDERAL BUREAU OF PRISONS, CLINICAL PRACTICE GUIDELINES: LICE PROTOCOL (2014), https://www.bop.gov/resources/pdfs/lice.pdf [http://perma.cc/BD7X-

recommend that "[a]ll inmates undergoing intake medical screening and physical examinations should be carefully evaluated for skin infections."[51] It also notes that MRSA "cannot be clinically distinguished from infections caused by other staphylococcal strains or other bacterial pathogens."[52] Finally, the lice protocol and the scabies protocol of the US Bureau of Prisons recommend lice and scabies screening on intake, but not by strip searches.[53] Instead, the lice protocol recommends "using a bright light and a magnifying glass" and "systematically comb[ing] the entire head . . . [with] a fine-toothed nit comb."[54] As for scabies, "diagnosis is often based on the following: . . . severe [itching], [and] typical distribution of lesions . . . . microscopic examination of mineral oil preparations can identify the mite."[55]

The second assertion from the corrections officials that Kennedy finds persuasive is that "[p]ersons just arrested may have wounds or other injuries requiring immediate medical attention. It may be difficult to identify and treat these problems until detainees remove their clothes for a visual inspection."[56] The citation for this proposition, which is not about strip searches and does not discuss them in the context of wounds or injuries, is a prison administration handbook.[57] The page of the text cited by Kennedy contains just one sentence on identifying medical problems: "[i]f an officer notes that an individual is bleeding . . . he or she would immediately notify the appropriate medical and supervisory personnel."[58] However, it is not the inmate's health that is the prime concern. The handbook continues:

> Once completed, the health screening report should be placed in the individual prisoner's file. A thoroughly completed health screening form is a valuable tool in preventing frivolous litigation, especially if an individual arrives with multiple superficial cuts and bruises and later claims that he or she was assaulted by jail staff. Further, this report will help medical personnel during their initial medical evaluation of the prisoner.[59]

This is the same rationale that CIA officers who tortured prisoners in black sites used for videotaping waterboarding sessions (to show that if the prisoner died, they did not kill him).[60] And, of course nakedness was widely used to humiliate and dehumanize prisoners not just in Abu Ghraib, but in many American interrogation sites during the war on terror.[61] Kennedy's own examples from the war on terror, which he employs to demonstrate that people stopped for routine traffic offenses could be very

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9MEL] [hereinafter LICE PROTOCOL]); FEDERAL BUREAU OF PRISONS, CLINICAL PRACTICE GUIDELINES: SCABIES PROTOCOL (2014), https://www.bop.gov/resources/pdfs/scabies.pdf [http://perma.cc/FP3A-PHAA] [hereinafter SCABIES PROTOCOL] (The Lice & Scabies Protocol has been divided into two separate documents)).

[51] MRSA GUIDELINES, *supra* note 49, at 2.

[52] *Id.* at 8.

[53] LICE PROTOCOL, *supra* note 50, at 1; SCABIES PROTOCOL, *supra* note 50, at 2.

[54] LICE PROTOCOL, *supra* note 50, at 2.

[55] SCABIES PROTOCOL*, supra* note 50, at 2.

[56] *Florence*, 132 S. Ct. at 1518.

[57] *Id.* (citing PRISON AND JAIL ADMINISTRATION: PRACTICE AND THEORY (Peter M. Carlson & Judith Simon Garrett eds., 2d. ed. 2008)).

[58] PRISON AND JAIL ADMINISTRATION: PRACTICE AND THEORY, *supra* note 57, at 142.

[59] *Id*. (emphasis added).

[60] *See* RODRIGUEZ & HARLOW, *supra* note 18 at 183-84.

[61] *See* SENATE SELECT COMMITTEE ON INTELLIGENCE, COMMITTEE STUDY OF THE CENTRAL INTELLIGENCE AGENCY'S DETENTION AND INTERROGATION PROGRAM 63 (2014), http://fas.org/irp/congress/2014_rpt/ssci-rdi.pdf [/http://perma.cc/99NT-9WEF].

dangerous, are particularly informative [62] He uses two examples, neither of which involved either a strip search or detection of a crime: Timothy McVeigh and one of the 9/11 suicide bombers.[63] McVeigh was stopped for a minor traffic offense—but the officer who stopped him saw a bulge under his windbreaker which turned out to be a "Glock 9-millimeter semiautomatic pistol."[64] No strip search was involved in his arrest.[65] September 11th hijacker, Ziad al-Jarrah was stopped on September 9, 2011 for driving ninety miles per hour in a sixty-five mile per hour zone, but he was given a speeding ticket and sent on his way.[66] No searches of any kind were conducted, and he died two days later on Flight 93.[67] Kennedy's third example, the serial killer, is not related to 9/11. Rather he was arrested after a high speed chase that led to a crash.[68] He had a dead body in his truck, which no strip search was needed to identify.[69] None of these examples—which Kennedy seems to use simply to dramatize his view that no one can tell whether or not someone is a terrorist by just by looking at them or knowing what they have been arrested for—demonstrate the reasonableness of routine strip searches in jails and prisons. The same can be said for the use of health justifications.

By merging safety and health goals, the majority of the Court conflates strip searches by prison guards with medical screening examinations by physicians or other healthcare personnel. This conflation is deeply disturbing in itself, but even more so because the Court uses it to increase the power of prison guards rather than to promote health. The Court not only mistakenly equates consensual medical screening by physicians with mandatory routine security screening by prison guards, but it also ignores the arguments of physician groups in the amicus briefs. For example, a brief filed on behalf of a group of psychiatrists persuasively argues that strip searches threaten to cause serious and lasting psychological harm, and are a fundamental attack on a person's privacy and dignity.[70] An amicus brief from the Medical Society of New Jersey also persuasively argues that prison officials have no health expertise, and that strip searches are ineffective for detecting MRSA.[71]

If *Florence* stands for anything, it is that the merger of public health and public safety furthers the agendas of neither medicine nor public health, but simply creates a rationale for the excessive and arbitrary use of government power. Routine strip

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[62] *See Florence*, 132 S. Ct. at 1520.

[63] *Id.*

[64] *See* David Johnston, *Terror in Oklahoma: The Investigation; Just Before He Was to Be Freed, Prime Bombing Suspect Is Identified in Jail*, N.Y. TIMES (Apr. 22, 1995), http://www.nytimes.com/1995/04/22/us/terror-oklahoma-investigation-just-before-he-was-be-freed-prime-bombing-suspect.html.

[65] *See* Brett LoGiurato, *The Supreme Court Cited Timothy McVeigh As an Example of Why New Inmate Strip Searches Are Needed*, BUSINESS INSIDER (Apr. 2, 2012), http://www.businessinsider.com/supreme-court-strip-search-case-cites-timothy-mcveigh-2012-4 [http://perma.cc/3NKQ-LU4U].

[66] *See A Nation Challenged: The Terrorists; Hijacker Got a Speeding ticket*, N.Y. TIMES (Jan. 9, 2002, http://www.nytimes.com/2002/01/09/us/a-nation-challenged-the-terrorists-hijacker-got-a-speeding-ticket.html.

[67] *See id.*

[68] John T. McQuiston, *Confession Used to Portray Rifkin as Methodical Killer*. N.Y. TIMES, Apr. 26, 1994, at B6.

[69] *Id.*

[70] *See generally* Brief for Psychiatrists as Amici Curiae Supporting Petitioner, Florence v. Bd. of Chosen Freeholders, 132 S. Ct. 1510 (2012) (No. 10-945).

[71] *See generally* Brief for Medical Society of New Jersey, The Center for Prisoner Health and Human Rights, and Medical Experts as Amici Curiae Supporting Petitioner, Florence v. Bd. of Chosen Freeholders, 132 S. Ct. 1510 (2012) (No. 10-945).

searches will not make jails or prisons safer or healthier. The use of real public health screening and decent medical care would simultaneously support, instead of undermine, basic civil and human rights. As the great American novelist E.L. Doctorow stated, once the Supreme Court decides "that the police of any and all cities and towns and villages have the absolute authority to strip-search any person whom they, for whatever reason, put under arrest . . . the reduction of America to unexceptionalism is complete."[72]

III. EBOLA IN THE UNITED STATES

Ebola in Sierra Leone, Guinea, and Liberia was a viral epidemic. In the United States Ebola was an epidemic of fear. As of March 2016, the CDC reported that there were 28,603 cases of Ebola with 11,301 deaths in Western Africa, but only four cases diagnosed and only one death in the United States.[73] Neither epidemic covered public health in glory. Both epidemics were made worse by merging public health with public safety. *Science* rightly called the Ebola epidemic the "breakdown of the year";[74] and *Politfact* labeled it the political "Lie of the Year."[75] The breakdown was both national and international. Doctors without Borders ("MSF") criticized the World Health Organization ("WHO") for its failure to recognize the epidemic and its inability to respond.[76] The WHO's *International Health Regulations,* strengthened in the wake of SARS, were shown to be more like aspirational guidelines than any form of law.[77] The WHO could declare a "Public Health Emergency of International Concern,"[78] but had no capacity to enforce the health "regulations" or to lead an international response to the Ebola epidemic.[79] Most of the mistakes were aided and abetted, if not outright promoted, by the promiscuous use of military and terrorism metaphors used to describe Ebola by the press, politicians, and even some scientists and physicians who should have known better.[80]

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[72] E.L. Doctorow, *Unexceptionalism: A Primer*, N.Y. TIMES (Apr. 28, 2012), http://www.nytimes.com/2012/04/29/opinion/sunday/unexceptionalism-a-primer.html?_r=0.

[73] *See* KEY MESSAGES – EBOLA VIRUS DISEASE, WEST AFRICA, CDC, 5-6 (last updated Feb. 10, 2016), http://www.cdc.gov/vhf/ebola/pdf/key-messages.pdf [http://perma.cc/73JN-ELNV].

[74] *See Breakdown of the Year: Ebola*, 346 SCIENCE 1450, 1450 (2014).

[75] Angie Drobnic Holan & Aaron Sharockman, *2014 Lie of the Year: Exaggerations About Ebola*, POLITIFACT (Dec. 15, 2014, 3:08 PM), http://www.politifact.com/truth-o-meter/article/2014/dec/15/2014-lie-year-exaggerations-about-ebola/ [http://perma.cc/XL79-XDFN].

[76] *See* MEDECINS SANS FRONTIERES, PUSHED TO THE LIMIT AND BEYOND: A YEAR INTO THE LARGEST EVER EBOLA OUTBREAK, 5-7 (2015), https://www.doctorswithoutborders.org/sites/usa/files/msf143061.pdf [http://perma.cc/C98Z-FVP7].

[77] *See* Press Release, WHO, Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola Outbreak in West Africa (Aug. 8, 2014), http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/ [http://perma.cc/73R6-CKHL]; *World Health Organization: Legal Responses to Health Emergencies*, LIBRARY OF CONGRESS, https://www.loc.gov/law/help/health-emergencies/who.php [http://perma.cc/H9H3-FFYF].

[78] *World Health Organization: Legal Responses to Health Emergencies*, *supra* note 77.

[79] *See, e.g.*, *Frequently Asked Questions About the International health Regulations (2005),* WHO, www.who.int/ihr/about/faq/en/ [http://perma.cc/2E2Z-UX5Z] ("[T]he IHR (2005) do not include an enforcement mechanism per se for States which fail to comply with its provisions . . . ."). Although called "Regulations" the International Health Regulations are more accurately described as "guidelines." As Article 3 makes clear, "[s]tates have, in accordance with the Charter of the United Nationas and the principles of international law, the sovereign right to legislate and to implement legislation in pursuance of their health policies. In doing so they should uphold the purpose of these Regulations." WHO, INTERNATIONAL HEALTH REGULATIONS 10 (2d ed., 2005) [hereinafter WHO, IHR]. The operative word, of course, is "should."

[80] See generally Ann Mongoven, *The War on Disease and the War on Terror: A Dangerous Metaphorical Nexus?*, 15 CAMBRIDGE Q. HEALTHCARE ETHICS 403 (2006) and Robert Riversong, *Ebola As Metaphor: The Ebola Virus Threatens Human Claims to Evolutionary Superiority,* TURNING THE TIDE:

There was general agreement among public health experts that the Ebola epidemic was symptomatic of the wider problem of extreme poverty in Western Africa, as well as a symptom of porous infection control and weak patient safety practices in the United States.[81] Although the epidemic began in late 2013, and the Ebola epidemic was recognized as an epidemic in June 2014, it was not until August 8 that the WHO finally declared the epidemic a public health emergency of international concern.[82] This was just a week after the first American patient, Kent Brantley, arrived for treatment at Emory Hospital.[83] Americans showed almost no interest in the Ebola epidemic until an Ebola patient arrived in the United States. Then everything changed. On learning that Brantley was coming to the United States, for example, Donald Trump tweeted: "The U.S. cannot allow EBOLA infected people back. People that go to far away places to help out are great-but must suffer the consequences!"[84] He was not, of course, the only one unable to distinguish the Ebola virus from the patient infected with the Ebola virus. In Trump's view, Brantley was the invader that threatened to make the United States the battlefield.

The WHO also used military metaphors, but they were somewhat more subtle. As WHO Director-General Margaret Chan stated at the end of August, "[t]he international community will need to gear up for many more months of massive, coordinated, and targeted assistance."[85] Two weeks later, the editors of *Nature* chimed in: "[t]he international community must mobilize now," and endorsed the call from MSF that countries should "immediately deploy their military and civilian biodefense teams—units that have been developed to respond to bioterror attacks."[86] The call for military assistance was extremely unusual for MSF, and was seen as "a desperate call of last resort": "[w]e considered that the only organizations in the world that might have the means to fill the gap immediately might be military units with some level of biological warfare expertise . . . ."[87]

Although the military has different missions and goals from the public health community, it is, as MSF conceded, sometimes necessary to call in the military. The point is that the CDC is not and should not be transformed into a military/counter-terrorism preparedness agency. The military has capabilities that no other public or private entity has, and it is sometimes necessary (and appropriate) to use military assets for humanitarian purposes (e.g., the Tsunami, the Haitian earthquake, and Katrina). Given the gravity of the Ebola epidemic and the inability of civilian organizations to respond effectively, it was reasonable and even commendable for the

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SHIFTING THE PARADIGM OF HUMAN CULTURE, https://riversong.wordpress.com/ebola-as-metaphor/ [HTTP://PERMA.CC/GB24-6N2Y] for discussions of terrorism metaphors for diseases.

[81] *See, e.g.*, Anthony S. Fauci, *Ebola - Underscoring the Global Disparities in Health Care Resources*, 371 NEW ENG. J. MED. 1084 (2014) (describing the countries most affected by Ebola as "resource-poor" and having "porous . . . borders").

[82] *See* MEDECINS SANS FRONTIERES, *supra* note 76, at 7, 11; Bahar Gholipour, *Ebola 'Patient Zero': How Outbreak Started from Single Child*, LIVESCIENCE (OCT. 30, 2014), http://www.livescience.com/48527-ebola-toddler-patient-zero.html [http://perma.cc/A33J-6TF6].

[83] *See* Elisha Fieldstadt et al., *Ebola Patient Dr. Kent Brantly Arrives at U.S. Hospital from Liberia*, NBC NEWS (Aug. 2, 2014), http://www.nbcnews.com/storyline/ebola-virus-outbreak/ebola-patient-dr-kent-brantly-arrives-u-s-hospital-liberia-n171241 [https://http://perma.cc/Z89T-JRWA].

[84] *See* Ed Mazza, *Donald Trump Says Ebola Doctors 'Must Suffer the Consequences'*, HUFFPOST MEDIA (Aug. 4, 2014, 11:47 PM), http://www.huffingtonpost.com/2014/08/03/donald-trump-ebola-doctors_n_5646424.html [http://perma.cc/WH53-DP7T].

[85] *WHO Chief Says No Early End to Outbreak*, GLOBAL TIMES (Aug. 21, 2014), http://www.globaltimes.cn/content/877393.shtml [http://perma.cc/J2AK-75LU] (internal quotation marks omitted).

[86] Editorial, *Ebola: Time to Act*, 513 NATURE 143, 144 (2014).

[87] MEDECINS SANS FRONTIERES, *supra* note 76, at 13.

President, at the request of the Liberian government, to send troops to Liberia to do logistical work, such as runway and road building and repair, and hospital construction.[88] But such deployment should be a last resort, both because military tactics are not generally citizen-friendly, and because our military (unlike our physicians and nurses) are not uniformly welcomed as helpers in all parts of the world.

On September 30, 2014 a visitor from Liberia, Thomas Duncan, was diagnosed with Ebola in Dallas, but only after having earlier been misdiagnosed in a hospital emergency department and sent home.[89] Duncan ultimately died of Ebola, and in mid-October, two of the nurses who treated him were also diagnosed with Ebola.[90] The Dallas incident produced both massive news coverage and sustained fear,[91] which was stoked by two mistakes made by the CDC. The first was the pre-Duncan incident assurance to the American people that "any hospital in the United States can safely provide care for a patient with Ebola . . . ."[92] The second was to blame the nurses who became infected with Ebola for "breach[ing] . . . protocol[s]"—when no protocols existed.[93] Whatever confidence the American public had in its public health officials was quickly lost, and demands for safety overwhelmed health messages.

We Americans compounded the fear of Ebola by identifying the virus as a possible terrorist threat, and deciding that it should be managed as such. Using terrorism metaphors to describe a naturally occurring disease has been a recurring post-9/11 mistake, which suggests that standard counterterrorism methods—not public health methods—should be employed to combat the disease. In this context, people with disease are seen as the enemy, and are subsequently deprived of their human rights and their humanity. In the fall of 2014, the threats of Ebola and ISIS were often paired.[94] Ebola was described by the President as a "national security . . . threat," and proposals were seriously discussed to control Ebola by adopting passport and visa controls, and no fly lists.[95]

Even Paul Farmer, the leader of Partners in Health, adopted the terrorist metaphor, saying of Ebola in Western Africa: "This isn't a natural disaster. This is the

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[88] *See id*. at 13-14.

[89] *See* Emily Schmall, *Review Faults Dallas Hospital in Ebola Case*, BOSTON GLOBE (Sept. 5, 2015), https://www.bostonglobe.com/news/nation/2015/09/04/review-cites-problems-texas-hospital-during-ebola-crisis/mcbD0jYuZOrCbkpE2UvHUI/story.html; Press Release, CDC, CDC and Texas Health Department Confirm First Ebola Case Diagnosed in the U.S. (Sept. 30, 2014), http://www.cdc.gov/media/releases/2014/s930-ebola-confirmed-case.html [http://perma.cc/4YA7-7PZQ].

[90] *See* Schmall, *supra* note 89.

[91] *See, e.g.*, Betsy McKay & Ana Campoy, *Ebola Diagnosed in Texas Patient; First U.S. Case*, WALL ST. J. Oct. 1, 2014, at A1 (discussing the first United States case of ebola).

[92] Catherine Saint Louis, *Hospitals in the U.S. Get Ready for Ebola*, N.Y. TIMES (Aug. 15, 2014), http://www.nytimes.com/2014/08/16/health/hospitals-in-the-us-get-ready-for-ebola.html?_r=0.

[93] Ford Vox, *Why CDC Chief Must Go*, CNN (Oct. 16, 2014), http://www.cnn.com/2014/10/16/opinion/vox-frieden-should-resign/ [http://perma.cc/KL35-X6UL] (internal quotation marks omitted); *see* Alice Park, *Nurses 'Infuriated' By Suggestion of Dallas Ebola Protocol Breach*, TIME (OCT. 14, 2014), time.com/3506907/nurses-protocol-breach-ebola/ [http://perma.cc/HSS5-9GAG].

[94] *See, e.g.*, Bruce Dorminey, *Ebola as ISIS Bio-Weapon?*, FORBES (Oct. 5, 2014), http://www.forbes.com/sites/brucedorminey/2014/10/05/ebola-as-isis-bio-weapon/#71781e3b1c7b ("ISIS may already be thinking of using Ebola as a low-tech weapon of bio-terror . . . . ").

[95] Press Release, The White House, Office of the Press Secretary, Remarks by President Obama at U.N. Meeting on Ebola (Sept. 25, 2014), https://www.whitehouse.gov/the-press-office/2014/09/25/remarks-president-obama-un-meeting-ebola [http://perma.cc/7BBM-XJP5] [hereinafter Obama Remarks Press Release]; George Annas, *What Ebola Teaches Us About Public Health in America*, HEALTH AFF. BLOG (Feb. 9, 2015), http://healthaffairs.org/blog/2015/02/09/what-ebola-teaches-us-about-public-health-in-america/ [http://perma.cc/6MA4-A9RW].

terrorism of poverty."[96] And the federal government's most credible spokesperson, Anthony Fauci of NIH, in response to a bizarre question of whether terrorists will use Ebola as a bioweapon, said "nature right now . . . is the worst bioterrorist."[97] Fauci's comments were in response to an especially strange suggestion, made on national television by Neurosurgeon Ben Carson, that a terrorist could collect urine from Ebola patients, bring it to the United States, and "cause 'a lot of damage'" here.[98] When asked where a terrorist would get the Ebola laced urine, Carson replied, "Someone comes up to a lab worker . . . . He knows he's got the urine; How would you like to have a million dollars?' A little transaction there . . . "[99] Scott Gottlieb of the American Enterprise Institute seemed to agree when he said, "[m]other Nature has created the perfect bioweapon in many respects, as long as the attacker has suicidal aspirations."[100] Washington Post writer Marc Thiessen suggested, "[i]n a nightmare scenario, suicide bombers infected with Ebola could blow themselves up in a crowded place—say, shopping malls in Oklahoma City, Philadelphia and Atlanta – spreading infected tissue and bodily fluids."[101]

All of these commentators can be considered extreme. Yet President Obama, usually the picture of calm and caution, used military and terrorism metaphors when he became personally involved in the United States Ebola response. First, he appeared before the United Nations Security Council, and for only the second time in history (AIDS was the first), made the case that the Ebola epidemic was a "national security" issue for the world and that the Security Council should authorize direct UN action.[102] It did.[103] Later, when the President found it politically expedient to designate an "Ebola Czar" to coordinate the American response, he did not pick a public health expert, but instead chose a lawyer, Washington, D.C. insider Ron Klain.[104] Following the national security-terrorism metaphor, the new "Ebola Czar" reported to the

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[96] Joel Achenbach, *Paul Farmer on Ebola: "This Isn't a Natural Disaster, This Is the Terrorism of Poverty,"* WASH. POST (Oct. 6, 2014), https://www.washingtonpost.com/news/achenblog/wp/2014/10/06/paul-farmer-on-ebola-this-isnt-a-natural-disaster-this-is-the-terrorism-of-poverty [http://perma.cc/DDZ6-KWRC] (internal quotation marks omitted).

[97] Melanie Hunter, *Dr. Fauci: 'Nature Is the Worst Terrorist'*, CNS NEWS (OCT. 6, 2014), http://www.cnsnews.com/news/article/melanie-hunter/dr-fauci-nature-worst-terrorist [http://perma.cc/554K-K4ZB].

[98] Ferdous Al-Faruque*, Ben Carson: Ebola Could Be Used for Terrorism* (Aug. 7, 2014, 12:44 PM), THE HILL, http://thehill.com/policy/healthcare/214596-ben-carson-ebola-could-be-used-for-terrorism [http://perma.cc/U5FT-T73D].

[99] Eddie Scarry, *Ben Carson's 'Worst-Case Scenario': Lab Worker Bribed $1 Million for Ebola Urine*, MEDIAITE (Aug. 7, 2014), www.mediaite.com/tv/ben-carsons-worst-case-scenario-hospital-lab-worker-bribed-1-million-for-ebola-urine/ [http://perma.cc/3TBX-3K7B].

[100] Marc A. Thiessen, *A 'Dark Winter' of Ebola Terrorism?*, WASH. POST. (Oct. 20, 2014), https://www.washingtonpost.com/opinions/marc-thiessen-a-dark-winter-of-ebola-terrorism/2014/10/20/4ebfb1d8-5865-11e4-8264-deed989ae9a2_story.html [http://perma.cc/FH3G-P26B] (internal quotation marks omitted).

[101] *Id.*

[102] *See* Obama Remarks Press Release, s*upra* note 95.

[103] *See generally* S.C. Res. 2177 (Sep. 18, 2014) (addressing "the outbreak of the Ebola virus").

[104] Juliet Eilperin & David Nakamura, *Obama Taps Ron Klain As Ebola Czar*, WASH. POST (Oct. 17, 2014), https://www.washingtonpost.com/news/post-politics/wp/2014/10/17/obama-taps-ron-klain-as-ebola-czar/ [http://perma.cc/E7AF-7RDZ] ("Klain, 53, is a longtime Democratic operative who served as Biden's chief of staff from 2009 to 2011 and as Gore's from 1995 to 1999. He helped oversee the Democratic side in the 2000 presidential election recount as its lead lawyer, a role that Kevin Spacey portrayed in the HBO film 'Recount.'"). In January 2016, Obama named another lawyer, Vice President Biden, to head the country's new "moonshot" initiative to cure cancer. Gillian Mohney, *President Obama's Cancer 'Moon Shot': How Scientists Are Trying to Cure the Disease*, ABC NEWS (Jan. 13, 2016), abcnews.go.com/Health/president-obamas-cancer-moon-shot-scientists-cure-disease/story?id=36268680.

President's homeland security adviser, Lisa Monaco, on Ebola in the United States, and to the President's national security adviser, Susan Rice, on Ebola in Africa.[105]

Coordination among the CDC, the states, and the country's hospitals really was needed in the United States, and lack of coordination is a recurring international problem in any catastrophe in which multiple NGOs respond, as they did in Western Africa.[106] With the appointment of an Ebola Czar,[107] the CDC (like the WHO) was left to pursue a supporting role as technical adviser on homeland security. CDC Director Tom Frieden later described the CDC's mission in the Ebola epidemic not in health terms, but in safety terms: "we will do everything in our power to protect Americans. That's our top priority."[108]

IV. EBOLA AND ITS METAPHORS

Susan Sontag has written most perceptively on the role of metaphors in shaping our response to both medical and public health crises.[109] In medicine, she was most interested in how metaphors shape public perception of the patient with disease, most notably, the patient with cancer.[110] Her goal was to free patients from the distortions caused by metaphors that stigmatized them and made the disease more terrible than it had to be.[111] In her words, "my aim was to alleviate unnecessary suffering. . . . "[112] Most centrally, the metaphors used in relation to cancer treatment are predominately drawn from the language of warfare. In her examples, cancer cells are "invasive" and "colonize"; the body's "defenses" are overwhelmed; "scans" are used to measure "tumor invasion"; chemotherapy is "chemical warfare" used to "kill" cancer cells; we are engaged in a "war on cancer."[113] Sontag also detailed how governments use medical metaphors to justify harsh actions against their citizens.[114] In 1979 she concluded that as cancer became more treatable, especially with immunotherapy, both the war metaphor and the cancer metaphor would recede from use: "[a]s the language of treatment evolves from military metaphors of aggressive warfare to metaphors featuring the body's 'natural defenses' . . . cancer will be partly de-mystified and it may then be possible to compare something to a cancer without implying either a fatalistic diagnosis or a rousing call to fight by any means whatever a lethal, insidious enemy."[115]

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[105] *See* Eilperin & Nakamura, *supra* note 104.

[106] *See, e.g.*, *Non-Governmental Organizations Responding to Ebola*, CENTER FOR INTERNATIONAL DISASTER INFORMATION, http://www.cidi.org/ebola-ngos/#.VtugsZMrLox [http://perma.cc/932V-62LJ] (listing the organizations that have come together to lend support during the Ebola outbreak).

[107] *See* Eilperin & Nakamura, *supra* note 104.

[108] *The Directors: The Ebola fighters in Their Own Words*, TIME (Dec. 10, 2014), http://time.com/time-person-of-the-year-ebola-directors/ [http://perma.cc/N87E-5DE3]. Frieden went further in adopting the military metaphor for Ebola. As TIME noted: "[e]arly in the epidemic, CDC director Frieden spoke of Ebola's 'fog of war.' Its shroud covers the battlefield. Eventually . . . the Ebola fighters are going to be victorious. The fog will clear, leaving the hard truth in view: this won't be the last epidemic. And when the next one comes, the world must learn the lessons of this one: Be better prepared, less fearful, less reactive." David Von Drehle & Aryn Baker, *The Ebola Fighters: The Ones Who Answered the Call*, TIME (Dec. 10, 2014), http://time.com/time-person-of-the-year-ebola-fighters/ [http://perma.cc/BY4H-NCBN].

[109] *See generally* SUSAN SONTAG, ILLNESS AS METAPHOR (1978) [hereinafter SONTAG, ILLNESS].

[110] *Id*. at 5.

[111] *Id.* at 3-4.

[112] *See* SUSAN SONTAG, AIDS AND ITS METAPHORS 13 (1988) [hereinafter SONTAG, AIDS].

[113] SONTAG, ILLNESS, *supra* note 109, at 64-66 (internal quotation marks omitted).

[114] *Id.* at 80-85.

[115] *Id.* at 87.

Sontag was cured of her cancer, but her view of the future was overly optimistic.[116] Cancer continues to be described by using military metaphors.[117] Political leaders also continue to use the cancer metaphor as a call to arms. When President Obama gave his address to the nation on ISIS in December of 2015, for example, he reverted to the cancer metaphor: "I know that after so much war, many Americans are asking whether we are confronted by a cancer that has no immediate cure."[118] Sontag was right about the power of the cancer/military metaphor, but wrong that it would wither on its own.

About a decade after her book on cancer, Sontag moved on to public health metaphors. Concentrating on the use of language related to the HIV/AIDS epidemic, Sontag found metaphors invoking pollution, contamination, and alien invasion; in her words, "the language of political paranoia."[119] Members of "risk group[s]" are singled out for isolation, harassment, and prosecution.[120] The principal metaphor Sontag identifies for AIDS is "plague . . . . [which has] long been used metaphorically as the highest standard of collective calamity, evil, scourge . . . ."[121] Like leprosy, cholera, and syphilis, AIDS "transform[s] the body," and it is therefore in the category of "[t]he most feared diseases" (as is Ebola).[122] It can also be seen as a judgment for past sins. One feature of plague script is that it inevitably "comes from somewhere else."[123] It is capable of producing, in Sontag's words, deep seated fear, including a revival of past political fears, "like fear of 'subversion' . . . uncontrollable pollution and of unstoppable migration from the Third World . . . something total, civilization-threatening. . . . [a] disease [that] menaces everybody . . . ."[124]

Public health must be based on science and facts, not fear or reassuring platitudes. It should strive to work with populations (both in the United States and globally) in an open and voluntary manner, which fosters public trust. Without public trust, effective public health is impossible, making fear-based public reactions more predictable. Public health officials must trust the public as well. Americans, for example, have no interest in spreading diseases to others, or in avoiding medical treatment when they are sick. Americans will cooperate with reasonable directions given by credible physicians, even government physicians, as long as they are told the truth, even if the truth involves uncertainty. On the other hand, use of force, or the threat of force, especially when seen as arbitrary, is likely counterproductive. This was true in Western Africa as well. The government of Liberia, for example, used military troops to quarantine the Monrovia slum of Freeport. The quarantine had to be abandoned when the people fought against it because it was based on the government's fear, and discrimination against the poor, with no public health rationale.[125] Nonetheless,

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[116] *See* SONTAG, AIDS, *supra* note 112, at 15.

[117] *See, e.g.*, VINCENT T. DEVITA, JR. & ELIZABETH DEVITA-RAEBURN, THE DEATH OF CANCER: AFTER FIFTY YEARS ON THE FRONT LINES OF MEDICINE, A PIONEERING ONCOLOGIST REVEALS WHY THE WAR ON CANCER IS WINNABLE – AND HOW WE CAN GET THERE 6 (2015) ("noting that "it [i]s time to invest large sums of money to *conquer* cancer") (emphasis added).

[118] Address to the Nation Press Release, *supra* note 6.

[119] *See* SONTAG, AIDS *supra* note 112, at 18.

[120] *Id.* at 25.

[121] *Id.* at 44.

[122] *Id.* at 45.

[123] *Id.* at 47.

[124] *Id.* at 63-64.

[125] *See* Norimitsu Onishi, *As Ebola Grips Liberia's Capital, a Quarantine Sows Social Chaos*, N.Y. TIMES (Aug. 28, 2014), http://www.nytimes.com/2014/08/29/world/africa/in-liberias-capital-an-ebola-outbreak-like-no-other.html; Norimitsu Onishi, *Clashes Erupt as Liberia Sets an Ebola Quarantine*, N.Y.

arbitrary emergency actions are often appealing to government officials, even in the United States. For example, screening travelers from the affected countries was adopted at major American airports, including JFK and Liberty; further, the screening measure was announced by both a CDC official in military uniform and by the Governors of New York and New Jersey.[126] This, coupled with threat of a twenty-one day mandatory quarantine,[127] was not only arbitrary but also threatened to cut off the supply of physicians and nurses from the United States going to Western Africa to help because the quarantine added three weeks to their volunteer time. As the editors of the *New England Journal of Medicine* forcefully and effectively noted: "[w]e think the governors have it wrong . . . . We should be honoring, not quarantining, health care workers who put their lives at risk not only to save people suffering from Ebola virus disease in West Africa but also to help achieve source control, bringing the world closer to stopping the spread of this killer epidemic."[128]

Thankfully, even in the midst of government panic, the United States Constitution was not suspended. Although only one person, nurse Kaci Hickox, challenged the Ebola quarantines in court, her case showed that fear did not completely dominate government officials during the epidemic. Hickox was quarantined in a New Jersey hospital after she returned from treating Ebola patients in Sierra Leone. [129] Lawyers helped get Hickox released to her home in Maine, and negotiated voluntary self-monitoring there.[130] The Constitution requires adopting the least restrictive alternative,

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TIMES (Aug. 20, 2014), http://www.nytimes.com/2014/08/21/world/africa/ebola-outbreak-liberia-quarantine.html?_r=0.

[126] *See* Marc Santora, *Cuomo and Christie Order Strict Ebola Quarantines*, N.Y. TIMES, Oct. 25, 2014, at A1; Sabrina Tavernise, *Newly Vigilant, U.S. Will Screen Fliers for Ebola*, N.Y. TIMES (Oct. 8, 2014), http://www.nytimes.com/2014/10/09/us/newly-vigilant-us-is-to-screen-fliers-for-ebola.html.

[127] *See* Santora, *supra* note 126.

[128] Jeffrey M. Drazen et al., Editorial, *Ebola and Quarantine*, NEW ENG. J. MED. 2029, 2029-30 (2014). This editorial was published electronically, and drew immediate praise from the New York Times. *E.g.*, Andrew C. Revkin, *How Unscientific Ebola Steps in U.S. Could Help Spread Virus Elsewhere*, N.Y. TIMES DOT EARTH (Oct. 28, 2014, 9:22 AM), http://dotearth.blogs.nytimes.com/2014/10/28/how-unscientific-ebola-steps-in-u-s-could-help-spread-virus-elsewhere/.

[129] Josh Dawsey et al., *Kaci Hickox, Nurse Under Ebola Quarantine, Returns to Her Maine Home: She Agrees Not Venture Into Large Public Spaces, Lawyer Says*, WALL ST. J. (Oct. 27, 2014), http://www.wsj.com/articles/nurse-being-held-under-ebola-quarantine-at-newark-hospital-will-be-discharged-1414418399?cb=logged0.3634139366913587.

[130] following has been excerpted from a contemporaneous unpublished summary written by Leonard Glantz, Wendy Mariner and me:

> Ms. Hickox's two-day flight from Sierra Leone arrived in New Jersey's Newark Liberty International Airport on October 25, 2014, less than two weeks before elections, just as fears of Ebola in the U.S. heightened. Newark is one of the airports charged with screening arrivals from countries with Ebola outbreaks. Dr. Craig Spencer, who had treated Ebola patients in Guinea, had been hospitalized with Ebola infection at Bellevue Hospital in New York City two days earlier. Reports of his riding the subway and bowling while asymptomatic upset many New Yorkers. People in New Jersey also objected when medical correspondent Nancy Snyderman, whose cameraman, Ashoka Mukpo became infected with Ebola in Liberia, left home to pick up takeout food on October 23. Governors Chris Christie of New Jersey and Andrew Cuomo of New York reacted by announcing that all passengers arriving from Ebola outbreak countries would be ordered into quarantine for the 21 day viral incubation period. Ms. Hickox was the first test of this policy.
>
> When Ms. Hickox gave an accurate history of her patient care activities in Sierra Leone, officials wearing gowns and face shields sequestered her for seven hours, repeatedly questioning her. They used a forehead scanner (which can be unreliable) to take her temperature. It first read 98°F, but later read 101°, which Ms. Hickox explained as the result of being flushed and upset. She requested an oral thermometer, which was not provided. Three hours later, a police motorcade escorted her to an isolation tent equipped with a port-a-potty but no shower, outside University Hospital. There, the hospital's

even in the face of a national epidemic, which the governors of New York and New Jersey imagined we were experiencing[131]

Thanks largely to a popular book by Richard Preston, *The Hot Zone,* which described Ebola in horrific detail, Americans were primed to fear Ebola.[132] Two decades ago Preston described Ebola in potentially apocalyptical terms, observing that while Ebola "had not yet made a decisive, irreversible breakthrough into the human

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> infectious disease specialist found her temperature to be 98.6°F on an oral thermometer, compared with 101° on a scanner. He told Ms. Hickox, "There['s] no way you have a fever. . . your face is just flushed.["] A laboratory test for Ebola was negative. Nevertheless, apparently relying on the scanner temperature at the airport, New Jersey officials insisted that Ms. Hickox must remain quarantined there for 21 days since her last contact with an Ebola patient, which would end November 10, 2014. Governor Christie relied on the airport scanner temperature to conclude that Ms. Hickox had a fever at some point.
>
> Protests arose from public health and medical professionals, including Médecins Sans Frontières (MSF) for which Ms. Hickox volunteered and which needs volunteer health professionals to care for Ebola patients. NIAID Director Anthony Fauci said he would not recommend quarantine, noting that the best policy is to stop Ebola at its source in African countries. President Obama called it unnecessary and counterproductive and later met with returning health professionals to congratulate them on their altruistic service. The CDC issued revised guidelines for different levels of risk of exposure to Ebola virus, which did not recommend involuntary quarantine unless a person is unable to follow the guidelines. Governor Cuomo quickly backed away from his policy. Governor Christie, however, said that his role was to protect the citizens of New Jersey and that if Ms. Hickox was unhappy she could sue him (she has since filed a lawsuit). Ms. Hickox's attorneys negotiated her release so she could return home to Fort Kent, Maine.
>
> Ms. Hickox returned to the house she shared with her partner, Ted Wilbur, in a small rural community near the Canadian border. Ms. Hickox apparently followed MSF and CDC guidelines for self-monitoring, and went beyond them by not going into town or meeting with anyone besides her partner, a public health nurse who came to their home, and talking to reporters now covering this very public drama. Nonetheless, Maine Governor Paul R. LePage insisted that Ms. Hickox stay quarantined inside her home. Ms. Hickox objected . . . .

Leonard Glantz et al., Quarantining Health Professionals: Lessons from Kaci Hickox's Case 2-4 (on file with author).

> On October 30, 2014, the Maine Department of Public Health petitioned for a court order requiring Ms. Hickox to submit to direct active monitoring and "exclu[ding her] from public places" and from using any "public conveyances", among other requirements. Verified Petition for Public Health Order at 5, Mayhew v. Hickox, No. CV-14-36 (D. Me. Oct. 30, 2014) [hereinafter Verified Petition]. The next morning, Judge Charles LaVerdiere denied the state's request to involuntarily quarantine Ms. Hickox in her home. Instead, he issued a temporary order requiring Ms. Hickox to "[p]articipate in and cooperate with 'Direct Active Monitoring' as that term is defined by the [CDC] . . . [,][c]oordinate her travel with public health authorities to ensure uninterrupted Direct Active Monitoring; and [to] [i]mmediately notify public health authorities and follow their directions if any symptom appears." Order Pending Hearing at 3, Mayhew v. Hickox, No. CV-2014-36 (D. Me. Oct. 31, 2014) (emphasis in original). The state declined to pursue the case and agreed to have the order end on November 10, 2014. Order, Mayhew v. Kickox, No. CV-2014-36 (D. Me. Nov. 3, 2014). The same result could have been achieved without the state going to court. Ms. Hickox had already agreed to – and had been voluntarily following – these conditions. *See* Verified Petition, *supra*, at ¶ 31.

[131] *See generally* Wendy K. Mariner et al., Jacobson v. Massachusetts*: It's Not Your Great-Great-Grandfather's Public Health Law*, 95 AM. J. OF PUB. HEALTH 581 (2005) ("[I]nvoluntary isolation and quarantine should be needed and used only in extremely rare cases . . . . even with the SARS epidemic, there provide to be almost no need to compel isolation, and quarantine was almost exclusively done in the individual's home.").

[132] *See generally* RICHARD PRESTON, THE HOT ZONE: A TERRIFYING TRUE STORY (1994).

race it seemed close to doing that."[133] The concern was that Ebola could become airborne and thereafter be unstoppable: "[a]n airborne strain of Ebola could emerge and circle around the world in about six weeks. . . ."[134] Perhaps even more frightening was Preston's description of how a person dies of the Ebola Zaire strain:

> Ebola Zaire attacks every organ and tissue in the human body except skeletal muscle and bone. It is a perfect parasite because it transforms virtually every part of the body into a digested slime of virus particles . . . . the blood thickens and slows . . . . causing dead spots to appear in the brain, liver, kidneys, lungs, intestines, testicles, breast tissue . . . . [y]our mouth bleeds, and you bleed around your teeth . . . . [t]he surface of the tongue . . . . may be torn off during rushes of the black vomit . . . . Ebola victims often go into epileptic convulsions during the final stage.[135]

Because of Preston's book, Ebola was already painted as a terrifyingly fatal illness that came from Africa and threatened the world Because it was usually fatal, and there was no treatment. It is not surprising that Ebola was treated more like SARS than the flu, and that safety and security concerns overwhelmed (public) health concerns. SARS was the world's first post-9/11 epidemic and was fought with a variety of "old" public safety measures, most notably, the use of quarantines enforced by the police.[136] There were arguments for "preemptive strikes" on SARS, including quarantine and isolation without due process—all of which were counterproductive because they caused potentially sick people to flee their homes rather than risk being confined to them.[137] In an after-SARS report done in the midst of the H1N1 flu scare, my colleagues, Wendy Mariner and Wendy Parmet, and I suggested six principles to set a non-military, non-national security agenda to reform post-9/11 public health law:

1. It should emphasize the ordinary, leaving behind its obsession with . . . public health emergencies, and concentrate on promoting the public's health in ordinary times by . . . improving health care and education[;]
2. It should recognize that law alone cannot solve complex public health problems. . . . [c]ries of plague and bald assertions of authority must be replaced with recommendations based on science and respect for the rule of law[;]
3. It should recognize that public health law must be grounded in the communities that public health serves. Top-down draconian authority is antidemocratic and likely to prove counterproductive. Persuasion and reasonable recommendations based on facts are much more likely to be effective[;]
4. It should value transparency and accountability, instead of granting broad legal immunity to officials, workers, volunteers and drug companies for abusing their authority. The public is the client, not the enemy, and is much more likely to trust those who take responsibility for their actions[;]
5. It should recognize that legal rights can themselves promote public health protection---the Constitution is not an obstacle to effective

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[133] *Id.* at 64.
[134] *Id.* at 65.
[135] *Id.* at 105-07.
[136] ANNAS, WORST CASE BIOETHICS, *supra* note 7, at 221-28.
[137] *Id.* at 221-228.

public health planning, it expresses our deepest-held values that should guide all official actions[;]

6. Law should be used to enable people to be healthy, not to coerce their actions, both every day and in emergencies. . . .[138]

These recommendations reject what I have called a "biosecurity future," which attempts to fuse public health not only with public safety, but also with national security; instead, these they seek a future public health agenda that can realistically protect the health of Americans.[139] These recommendations were, unfortunately, not always followed in either the United States or in Western Africa during the Ebola epidemic. Concentrating on the ordinary, for example, would make sure no patient was sent home from the emergency department of a hospital with a 103 degree fever, like what happened to Thomas Duncan.[140] "Cries of plague" would be discouraged, as would the arbitrary actions of many state governors, who called for increased screening and quarantine.[141] These recommendations would have provided basic due process rights to the people who were all unnecessarily quarantined,[142] and would have permitted all healthcare workers who had gone to Western Africa and returned to the United States to self-monitor their health, rather than be coerced into public monitoring or quarantine, like Kaci Hickox.[143] Finally, these recommendations would have discouraged CDC officials from wearing their military uniforms on TV when discussing Ebola with the public.[144]

V. EBOLA AND THE WORLD

Of course the United States is not alone in the world, and Ebola, perhaps even more than SARS, demonstrated that there is no global body capable of effectively responding to an international epidemic. In theory, the international rules mandating reporting of new diseases that could cause an international public health emergency were codified in amendments to the International Health Regulations in 2005, but in reality little has changed.[145] WHO member states retain their rights as sovereign countries to protect their citizens, protect their economies, and control their borders.[146]

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[138] *Id.* at 232-33.

[139] *Id.* at 233; *see also* GEORGE J. ANNAS ET AL., PANDEMIC PREPAREDNESS: THE NEED FOR A PUBLIC HEALTH—NOT A LAW ENFORCEMENT/NATIONAL SECURITY—APPROACH 23-24 (2008). https://www.aclu.org/report/pandemic-preparedness-need-public-health-not-law-enforcementnational-security-approach ("In the post-9/11 climate, public health policy has increasingly been viewed through the prism of, and indeed as a part of, law enforcement and national security.").

[140] Associated Press, *Dallas ER Doctor of Ebola Victim Thomas Eric Duncan Missed His High Fever During Initial Treatment*, N.Y. DAILY NEWS (Dec. 8, 2014), http://www.nydailynews.com/life-style/health/dallas-er-doctor-ebola-victim-missed-high-fever-article-1.2037885.

[141] *See* ANNAS, WORST CASE BIOETHICS, *supra* note 7, at 232; ANNAS ET AL., PANDEMIC PREPAREDNESS, *supra* note 139, at 20-21.

[142] *See* ANNAS, WORST CASE BIOETHICS, *supra* note 7, at 233; ANNAS ET AL., PANDEMIC PREPAREDNESS, *supra* note 139, at 23, 25-26.

[143] *See* Dawsey et al., *supra* note 129.

[144] *See* ANNAS, WORST CASE BIOETHICS, *supra* note 7, at 232 ("[Health law] should emphasize the ordinary, leaving behind its obsession with . . . public health emergencies . . . .").

[145] WHO, IHR, *supra* note 79, at 14 (Article 12 Determination of a Public Health Emergency of International Concern).

[146] WHO, IHR, *supra* note 79, at 10 ("States have, in accordance with the Charter of the United Nations and the principles of international law, the sovereign right to legislate and to implement legislation in pursuance of their health policies."); *see also*, Editorial, *Ebola: What Lessons for the International Health Regulations?*, 384 LANCET 1321, 1321 (2014) ("Although all WHO members have agreed to the IHR

Limiting trade made it more difficult for the international community to respond to the Ebola epidemic on the ground. During the summer of 2014, the WHO finally admitted that it did not have the financial resources or qualified personnel to respond to the Ebola epidemic.[147] Instead of providing leadership, the WHO left the NGO community to carry the burden of treating those suffering from Ebola. In terms of global leadership, the United Nations was ultimately called upon to take control.[148] The United States also sent almost 3000 military personnel to build field hospitals, but the epidemic was long over before their eleven field hospitals (of a planned seventeen) were completed, and only twenty-eight Ebola patients were treated in them—nine of the field hospitals had no patients at all.[149]

Perhaps most disturbing, the WHO unilaterally changed its public health mission and became much more involved in planning research projects during the epidemic than in planning treatment for those suffering from Ebola or planning prevention strategies for those who could be exposed.[150] Public health (and human rights) took a distinct second place to pharmaceutical research at the WHO.[151] Even in the midst of an international pandemic, the International Covenant on Civil and Political Rights ("ICCPR") requires informed consent for medical research.[152] The ICCPR remains the law even in times of war and emergencies, and many of its principles, including

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principles, countries were left to self-report their progress on core capacity development, such as surveillance, diagnostic, and containment demands.").

[147] *See* Somini Sengupta, *Effort on Ebola Hurt W.H.O. Chief*, N.Y. TIMES (Jan. 6, 2015), http://www.nytimes.com/2015/01/07/world/leader-of-world-health-organization-defends-ebola-response.html.

[148] *See* Lawrence O. Gostin & Eric A. Friedman, *Ebola: A Crisis in Global Health Leadership*, 384 LANCET 1323, 1323 (2014).

[149] Norimitsu Onishi, *Empty Ebola Clinics in Liberia Are Seen as Misstep in U.S. Relief Effort*, N.Y. TIMES (Apr. 11, 2015), http://www.nytimes.com/2015/04/12/world/africa/idle-ebola-clinics-in-liberia-are-seen-as-misstep-in-us-relief-effort.html?_r=0 ("Only 28 Ebola patients have been treated at the 11 treatment units built by the United States military, American officials now say. Nine centers have never had a single Ebola patient."); Kevin Sieff, *U.S.-Built Ebola Treatment Centers in Liberia Are Nearly Empty As Outbreak Fades*, N.Y. TIMES (Jan. 18, 2015), https://www.washingtonpost.com/world/africa/us-built-ebola-treatment-centers-in-liberia-are-nearly-empty-as-disease-fades/2015/01/18/9acc3e2c-9b52-11e4-86a3-1b56f64925f6_story.html.

[150] *See* Jon Cohen & Martin Ernserink, *As Ebola Epidemic Draws to a Close, a Thin Scientific Harvest*, 351 SCIENCE 12, 12 (2016) (Writers for *Science* described the effort to test vaccines and drugs during the Ebola epidemic as "frenzied" and this seems a fair description. With the blessing of a WHO committee, depending on how one counts, about a dozen studies of drugs, vaccines, and blood from survivors were conducted. The only success to date is a vaccine that has been described as "remarkably successful." None of the other studies found an effective agent, although the ZMapp study is still ongoing. Chimerix "pulled the plug" on its study of brincidofovir after only four patients were enrolled. Only nine patients enrolled in an interferon-beta study, and a vaccine study that need 9000 people recruited only 500. Most of the studies that were done had no control group, causing a US FDA official to complain: "[w]e're left with not knowing whether the products help, hurt, or do nothing.") (internal quotation marks omitted); see generally *id.* for more details on each study.

[151] *See, e.g.*, Andrew Pollack, *Testing for Ebola Vaccines to Start Soon, W.H.O. Says*, N.Y. TIMES (Oct. 22, 2014), http://www.nytimes.com/2014/10/22/business/testing-for-ebola-vaccines-to-start-soon-who-says.html ("Health authorities and pharmaceutical companies are planning to test several new vaccines to prevent Ebola infection over the next few months, including one that is taken as a tablet, making it easier to deploy in West Africa."); Press Release, WHO Media Centre, Ethical Considerations for Use of Unregistered Interventions for Ebola Virus Disease (EVD): Summary of the Panel Discussion (Aug. 12, 2014), http://www.who.int/mediacentre/news/statements/2014/ebola-ethical-review-summary/en/ [http://perma.cc/GKL2-EPU8] ("The large number of people affected by the 2014 west Africa outbreak, and the high case-fatality rate, have prompted calls to use investigational medical interventions to try to save the lives of patients and to curb the epidemic.").

[152] *See* International Covenant on Civil and Political Rights, art. 7, Dec. 19, 1966, 999 U.N.T.S. 171 ("[N]o one shall be subjected without his free consent . . . .").

informed consent for medical experimentation, remain in full force.[153] Informed consent is a principle of international law that no WHO group, no matter how distinguished and no matter how many times they meet in Geneva, can change on its own.[154] A WHO "Ethics Working Group" nonetheless thought the application of informed consent during the Ebola epidemic was debatable, and even suggested in October that "there is an ethical imperative to carry our research on potential therapeutic agents against [Ebola]."[155] It is always gratifying to find that ethics demands you do what you want to do, but this is seldom the case.

With the Ebola epidemic, there is an ethical obligation to treat people who have the disease, and to try to halt its spread. When currently available therapeutic agents, including IV fluids, are not being universally used, it is hard to argue that ethics requires you to find new ones, rather than using currently available treatments.[156] Public health actions, including identifying, isolating, and treating people with Ebola; identifying and quarantining their contacts to determine if they have the disease; public education; and changing burial practices ultimately brought the epidemic under control.[157] Of course, finding an effective drug treatment or vaccine is highly desirable, but public health actions and medical treatment must always take precedence over research in an epidemic.[158]

The Ebola experience suggests four principles that should guide a public health/human rights response to future epidemics:

1. Prevention should remain the primary goal so that research and other non-treatment interventions should not be pursued if they make prevention efforts less effective;
2. Government has the primary responsibility for the health of the people, and therefore must follow basic human rights, including non-discrimination, the right to health, and special protections for women and children;

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[153] *Id.* ("No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. *In particular, no one shall be subjected without his free consent to medical or scientific experimentation.*") (emphasis added).

[154] *See* George J. Annas, *Purple Dinosaurs and Victim Consent to Research in Disasters*, *in* DISASTER BIOETHICS: NORMATIVE ISSUES WHEN NOTHING IS NORMAL 138-39 (D. P. O'Mathúna et al. eds., 2014).

[155] Annas, *What Ebola Teaches Us About Public Health in America, supra* note 95 (internal quotation marks omitted).

[156] *See e.g.*, Donald G. McNeil, Jr., *Ebola Doctors are Divided on IV Therapy in Africa*, N.Y. TIMES (Jan. l, 2015), http://www.nytimes.com/2015/01/02/health/ebola-doctors-are-divided-on-iv-therapy-in-africa.html?_r=0. ("Medical experts seeking to stem the Ebola epidemic are sharply divided over whether most patients in West Africa should, or can, be given intravenous hydration, a therapy that is standard in developed countries. Some argue that more aggressive treatment with IV fluids is medically possible and a moral obligation.").

[157] Of course, all actions should be consistent with basic human rights doctrine, including nondiscrimination. It is in this regard that Ebola is similar to HIV, i.e., it can be an excuse to exclude infected persons as the enemy. *See, e.g.*, Patrick M. Eba, *Ebola and Human Rights in West Africa*, 348 LANCET 2091, 2091-92 (2014) (encouraging "embrac[ing] the tested lessons of proportionality, trust-building, and respect for human rights" during emergency situations).

[158] *See* Annas, *Purple Dinosaurs and Victim Consent to Research in Disasters*, *in* DISASTER BIOETHICS: NORMATIVE ISSUES WHEN NOTHING IS NORMAL, *supra* note 154, at 138-39; *see also* Annette Rid & Ezekiel J. Emanuel, *Ethical Considerations of Experimental Interventions in the Ebola Outbreak*, 384 LANCET 1896, 1898 (2014) ("[T]he international community needs more focus on strengthening of health systems and infrastructure and less on experimental treatments."); Jesse L. Goodman, *Studying "Secret Serums"- Toward Safe, Effective Ebola Treatments*, 371 NEW ENG. J. MED. 1086, 1088 (2014) ("As we move forward . . . we have already learned some lessons from this outbreak . . . [including,] the critical nature of the capacity both for public health intervention and to ethically field clinical studies under challenging conditions.").

3. Interventions should be sustainable and contribute to building a healthcare system and healthcare infrastructure, not increasing silos.
4. There are no disaster exceptions to informed consent for research.

As of early 2016, a number of distinguished groups had issued recommendations on how to reform the WHO to make it more accountable, transparent, and effective.[159] Future meetings will determine which, if any, of these recommendations will be adopted.[160] My own perspective is that technical "fixes" will not make much of a difference in preparing for and reacting to the next global epidemic. In fact, even before it could meet to discuss the recommended changes, the WHO caved to political pressure to declare its first post-Ebola "public health emergency of international concern" for the spread of the mosquito-borne Zika virus and its link to microcephalic children.[161] This was arguably an overreaction—a direct result of its failure to react in a timely manner to Ebola, and fear that failure to act on Zika would further undermine the role of the deeply damaged WHO going forward.[162]

The WHO, and perhaps the world, faces a much broader challenge than simply lurching from one "emergency" to the next: whether to see health as a human right and to construct a public health system in all countries that supports that right, including basic medical care, food, clean water, sanitation, housing, and education, or instead to continue on the current path that overreacts to recurrent epidemics, and marginalizes the creation of basic public health infrastructure around the world. Almost immediately after the Zika declaration, it was evident that the major problems associated with Zika were the result of poverty and the lack of reproductive rights among the most affected populations.[163] Put another way, the goal of all public health officials and agencies should be to protect and promote the health and human rights of the public; public safety is the goal of the police, and national security is the goal of the military and security agencies. Mixing our goals (and our metaphors) threatens us all.

VI. CONCLUSION

Ebola, like SARS and the flu, and even Zika, is fundamentally a public health problem, not a national security/terrorism problem, or even a legal one. Ebola will be defeated not by law or by imagining Ebola as a terrorist or as a bioterrorism weapon, but by treating it as an infectious agent made more threatening by poverty and lack of effective infection control measures. Diseases of poverty kill millions every year

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[159] *See, e.g.*, Suerie Moon et al., *Will Ebola Change the Game? Ten Essential Reforms Before the Next Pandemic. The Report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola*, 386 LANCET 2204 (2015) (recommending "[a] transparent and politically protected WHO Standing Emergency Committee should be delegated with the responsibility for declaring public health emergencies").

[160] *See, e.g.*, Laurie Garrett, *Can the Global Public Health System Learn from its Ebola Mistakes?*, COUNCIL OF FOREIGN RELATIONS (Oct. 8, 2015), http://foreignpolicy.com/2015/10/08/global-public-health-system-learn-from-ebola-mistakes-who/ [http://perma.cc/5JKT-EMP9] (suggesting that all the groups get together, and warning that unless they do "the din of pontificating and criticism will resound in a sort of global anarchy. Little will actually change").

[161] Annas et al., *Zika Virus is Not Ebola*, *supra* note 13 (internal quotation marks omitted).

[162] *See id.*

[163] *See, e.g.*, Simon Romero, *Surge of Zika Virus has Brazil Re-examining Strict Abortion Laws*, N.Y. TIMES (Feb. 3, 2016), http://www.nytimes.com/2016/02/04/world/americas/zika-virus-brazil-abortion-laws.html?_r=0 ("The surging medical reports of babies being born with unusually small heads during the Zika epidemic in Brazil are igniting a fierce debate over the country's abortion laws, which make the procedure illegal under most circumstances.").

globally,[164] and in the United States, hospital-acquired infections kill 75,000 to 100,000 Americans annually.[165] Ebola gives us another opportunity to adopt public health, human rights, and social justice strategies to confront the root causes of these deaths.

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[164] *See* PHILIP STEVENS, DISEASES OF POVERTY AND THE 10/90 GAP (2004), http://who.int/intellectualproperty/submissions/InternationalPolicyNetwork.pdf [http://perma.cc/V6DJ-6Q83].

[165] CDC, CDC AT WORK, http://www.cdc.gov/washington/~cdcatWork/pdf/infections.pdf [http://perma.cc/S69C-ZHYT].