The Professions of Public Health

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Law has been an essential tool of public health practice for centuries. From the 19th century until recent decades, however, most histories of public health described, approvingly, the progression of the field from marginally useful policy, made by persons learned in law, to effective policy, made by persons employing the methods of biomedical and behavioral science.

Historians have recently begun to change this standard account by documenting the centrality of law in the development of public health practice. The revised history of public health offers additional justification for the program of public health reform proposed in this issue of the Journal by Gostin and by Moulton and Matthews, who describe the new program in public health law of the Centers for Disease Control and Prevention.

IN THE SPECIAL SECTION ON PUBLIC HEALTH LAW

Gostin and Moulton and Matthews argue that law and lawyers should be more important in public health practice. Gostin’s commentary (and the book on which it is based—Public Health Law: Power, Duty, Restraint) makes the first sustained argument since the early 19th century that law is an essential tool to protect and promote the public’s health. The new public health law program of the Centers for Disease Control and Prevention (CDC), described by Moulton and Matthews, is a pioneering program, because it identifies laws as interventions to prevent disease rather than as technical requirements imposed on public health officers who are applying the results of biomedical science. Here I will set these important contributions to public health practice in historical and contemporary context.

THE STANDARD HISTORY OF PUBLIC HEALTH

For many years the literature on public health history described public health practice as a progression from marginally useful policy, made mainly by civil servants learned in law, to effective policy, made by persons trained in disciplines that rely chiefly on biomedical and behavioral science. This progress began with revolutionary advances in epidemiology and bacteriology in the late 19th century. As a result of these advances, physicians became more prominent in public health practice than lawyers and other professionals who had previously been their peers, especially social reformers, engineers, and what we now call city and regional planners.

For example, according to the standard history of British public health, a powerful lawyer, Edwin Chadwick, made environmental sanitation the priority of policy in the 1830s. Then, in the 1850s, physicians—notably William Farr and John Simon—introduced policies grounded in increasingly effective medical science.

Similarly, the conventional story of public health in Germany is that lawyers designed public health policies in the 17th and 18th centuries to stabilize authoritarian regimes and their tightly controlled mercantilist economies. As government in Germany began to liberalize in the 19th century, reformers such as the physician-scientist-legislator Rudolf Virchow insisted that physicians, not lawyers in civil service, were the “natural attorney(s) for the poor.” By the end of the century, medical scientists had gained control of public health practice in Germany and introduced policies grounded in bacteriology and eugenics.

Public Health in the United States

Public health innovators in the United States drew heavily first on British and then on German experience. Reformers in Massa-
icin e and citizens who feared loss of liberty.

The standard history also describes how the scientific basis of public health practice expanded in the second half of the 20th century as a result of the increasing incidence of chronic disease and successful campaigns against infections. Most historians of contemporary public health practice describe renewed interest in the role of environmental factors and individual behavior in controlling chronic disease.7 But they characterize law and regulation, when they address them at all, merely as mechanisms for legitimating the findings of scientific research.

**Personal Experience Reinforces the Standard History**

The personal experience of many contemporary public health practitioners reinforces the subordinate role accorded to law and lawyers by these historians. Lawyers and physicians often have tense relationships. Members of the 2 professions frequently disagree about the definition of appropriate evidence, the value of adversarial proceedings, and the social utility of due process.8 Officials at all levels of government frequently experience lawyers as sources of delay and rarely as sources of assistance. Moreover, most officials who become targets of lawyers for individual plaintiffs or classes of plaintiffs discover that the formal clients of attorneys general and agency counsel are governing boards and governors rather than individual public employees. Nevertheless, law has for 500 years been an essential discipline of public health. What Gostin recommends and the new CDC law program aims to achieve restores lawyers to the eminent role in public health that they had in the past.

**LAW IN THE NEW PUBLIC HEALTH HISTORY**

Historians who are revising the standard account of public health document the importance of law to the development of public health practice. Revisionism begins with accounts of the 16th and 17th centuries, when the countries of Western and Northern Europe experienced what Raeff calls a “profound transformation—really a revolution in political attitudes and practices” that included the creation of a “new elite” who inaugurated the “reign of the expert professional.”9(p220) These experts, lawyers as well as physicians, wrote public health statutes that embraced a “fundamentally optimistic belief that proper knowledge will help overcome the most inexorable aspect of human existence, its fragility in the face of nature.”9(p220) The authors of public health legislation addressing both the control of persons with infectious diseases and the regulation of the environment shared a “universal belief in [the] ability [of science] to improve the quality of life.”9(p225) The advance of science since the 19th century reinforced this belief; it did not initiate it.

The linkage of law and medicine in public health practice persisted into the 19th century, according to the revisionists. Baldwin, for instance, challenges historians who argue that public health policy under authoritarian regimes pursuing mercantilist economic policies was fundamentally different from policy under later democratic regimes committed to market economies. “The pertinent distinction is not that between conservative interventionism and liberal laissez-faire,” Baldwin writes, “but rather between different sorts of intervention.”10(p529)

In the most influential revisionist work to date, Hamlin challenges scholars of British public health policy who held that, beginning in the 1850s, proponents of advancing scientific knowledge defeated Chadwick and other lawyers who accorded priority to environmental sanitation. “Public health is everywhere and always contingent,” Hamlin insists, employing a word used by social scientists who employ historical methods to suggest the interrelatedness, complexity, and unexpected consequences of any past event. Because public health policy is contingent, scientific or technical advances have never been its sole determinants.11(p341)

Hamlin found new evidence that progress in science did not cause the declining influence of lawyers in the formulation of British policy. Members of the medical profession had all along offered an alternative to the environmentalism of Chadwick and his colleagues in law and political economy. Many leading physicians in early 19th century Britain “stated as issues of health . . . the great social issues . . . hunger, public order, population and conditions of work.” But the medical profession, for reasons Hamlin explores, made no systematic “effort to become public guardians of the people’s health.” Public health officials and historians subsequently took no notice of this incipient social medicine as a result of the “rise of disease-centered pathology in the second half of the 19th century.”11(p522)

Similarly, Fee and Porter emphasize the intense and productive relationships among experts in public health from a variety of disciplines, including law, from the mid-19th into the early 20th centuries in both the United States and Britain. Porter documents the leadership of the British Medical Association in pressing for a “parliamentary inquiry into chaotic public health laws” that led to “great codifying legislation.” Fee argues that until the early 20th century, “a mixture of lawyers, philanthropists, engineers, evangelicals and some concerned doctors” dominated public health reform in the United States.12(p261) In another volume, Fee and Acheson argue that the “mix of contributing disciplines [to the field] constantly changes.”13(p5)

Tomes recently analyzed the motives of public health leaders in the United States who between the 1890s and 1940s dismantled the coalition of professions that Fee describes. “Leaders of the public health movement felt that it was essential to adhere to a more stringent laboratory-based standard of knowledge,” she writes, in order “to improve their professional credibility.” They also regarded laboratory science as “more manly” than social reform. Moreover, they believed that by limiting public health practice to science they could “remove medicine from partisan politics.”13(p240–241)

**THE NEW HISTORY AND CONTEMPORARY LAW REFORM**

This revisionist history justifies the program of public health law reform proposed by Gostin and the work of research and implementation identified by Matthews and Moulton. Because these historians restore contin-
gency to the history of public health, they reject a heroic story of progress toward ever more effective public health practice as a result of applied science.

The new historiography also justifies the reconception of which professions contribute to public health practice and what each of them professes. In the new conception, public health practice is the result of ongoing sociopolitical negotiations that involve experts in a variety of disciplines, officials of each branch of government, the leadership of business and unions, the news media, and the general public. Lawyers who understand public health—as well as persons in other professions who understand and respect the law—are essential participants in these negotiations.

The replacement of a heroic history of progress in public health by accounts that emphasize contingency also forces recognition that public health professionals are among a minority who at any moment make health their highest priority. Employers may value the health status of their employees, but they are accountable to their boards for earnings and stock prices. Planning officials who believe for cowardice. Improvements in the health of populations may be achievable, for example, as a byproduct of law and regulation that has another primary purpose, to which public health officials accommodate. Many of the goals that Gostin sets for public health law reform, and that the CDC law program shares, are likely to be attained through laws and regulations that address, for example, economic development, transportation, housing, income for workers and retirees, patients’ rights, and the responsibilities of health plans and provider organizations. Making such laws and regulations will require collaboration among disciplines and, occasionally, deference by practitioners of each discipline. Gostin, Matthews, Moulton, and many of their colleagues embrace this broad definition of the professions of public health.

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