Commentary: Beyond Historical Precedent

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BY GIVING LISTS OF PATIENTS' A1C LEVELS TO PHYSICIANS and health care institutions, the New York City Department of Health and Mental Hygiene is engaging not simply in surveillance but is altering the health system as well. Yet because of the ways in which we have historically discussed surveillance—either in terms of the state as intruder or state as provider—we risk missing the true import of the measure.

The State as Intruder

Much of the discussion about the advent of diabetes surveillance has focused on privacy and public health's unwarranted invasion of a civil liberty and whether or not such a trespass falls within its traditional mandate. To be sure, when surveillance was questioned during the past century, the opposition often turned on the issue of privacy. Indeed, the very word *surveillance* provokes anxieties, and during the cold war Alexander Langmuir, to underscore the threat of bioterrorism and the need to amplify the nation's epidemiologic radar, made the term of art at the Centers for Disease Control. Yet even when words like *notification* or *reporting* or *sanitary surveillance* were more in vogue, doctors and citizens alike found reason to object to health officials having records containing patients' names, from those with tuberculosis in the late nineteenth century to those with sexually transmitted diseases as the twentieth

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century unfolded and HIV as the twentieth century came to a close. Diabetes surveillance is now the subject of debate (Fairchild, Bayer, and Colgrove 2007).

The State as Protector

We can, however, call on history to support the tradition of surveillance. When challenged, public health surveillance has, with one exception, been upheld by the courts. In the 1970s in the case of *Whalen v Roe*, which, though narrowly focused on the reporting of Schedule II drug prescriptions to public health officials, the U.S. Supreme Court gave broad endorsement to many traditional disease surveillance activities. Although, then, we can show that surveillance offers an opportunity to question the legitimacy of the state, we can more often point to instances in which public health has undertaken bold surveillance measures with the full support, and sometimes at the insistence, of a public seeking the protection of the state. That is, the public called for disease surveillance as the first line of defense in such instances as the notification of occupational diseases and birth defects, as well as cancer registries (Fairchild, Bayer, and Colgrove 2007).

If history has taught us anything, it is that the public's acceptance of surveillance for A1C levels depends on whether it perceives it as a benefit (opening the door to treatment or research or perhaps just accountability) or an unwarranted intrusion (interference in the relationship between doctor and patient, a data security risk that threatens reputation, livelihood, housing, or even liberty).

How surveillance is framed, then, is important. Is it vital to "supporting patient care," as the New York Department of Health and Mental Hygiene asserts? Is it a "third set of eyes" that allows public health to fulfill a vision of social justice (Fairchild and Alkon 2007)? Or is it a kind of social experiment that, in the absence of ethical oversight or prior empirical evidence of efficacy, threatens to make "guinea pigs of us all" (Daniels 2006; Tierney 2009)?

If it is important politically to *frame* surveillance as a means of summoning the protective arm of the state, it also is important to *situate* it within the broader context of health system reform. Both the federal and state governments are allocating significant resources to health information systems, of which electronic medical records are a crucial component (Alderman 2009; Santora 2008). What makes New York City's diabetes

surveillance system remarkable is not that it is an example of chronic disease surveillance, with or without historical precedent, but that it has the potential to *change the system*. Thus, the importance of this initiative is not that it raises questions about privacy and the balance between civil liberties and individual rights but that it represents a transformation of the health system that is taking place right under our noses.

The State as Agent of Change

To grasp the extent of its impact, we need only look at one of the decisions the department must make:

Because some individuals who might benefit from outreach may be excluded if their providers do not participate in the program, the department is also considering sending letters directly to patients whose last A1C was >9 percent and who have not had a subsequent test in twelve months and may no longer be in care. (Chamany et al. 2009, p. 555)

In sum, the department is considering not only whether to try to support clinical care but also when and how to manage clinical disease directly.

Privacy questions are, of course, important, but in the end, they could cause us to overlook the larger impact of the New York City Department of Health and Mental Hygiene's reporting requirements regarding hemoglobin A1C. The election of a new U.S. president has made health care reform more likely, and New York City has made it a reality. This does not mean, however, that we have decided how public health should relate to clinical medicine, whether in a supportive or a directive role. New York City's pilot project should tell us that the time has come for the whole nation to begin a deliberate and sustained discussion about the place of public health in our health system in the twenty-first century.

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