PHYSICIANS' ELUSIVE PUBLIC HEALTH DUTIES*

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Law, consistent with bioethics and medical norms, directs physicians to "put patients first." To what extent do physicians have broader responsibilities for community health, beyond and even counter to those owed to their patients? More salient in the era of COVID-19, the question of physicians' obligations to safeguard the health of non-patients continually vexes courts, policy makers, and scholars.

This Article reveals how physicians' public health duties are confoundingly elusive. Elusive in the sense that while at times affirming physicians' special capacity and obligations to improve the health of the community, law more often obscures physicians' public health duties with limited, ad hoc recognition and insufficient theorization. These public health duties are also elusive in actual application. Physicians can point to individual patient obligations as reasons to evade compliance with certain public health laws or to discount public health considerations in clinical decision-making.

Putting patients first also masks less patient-centered justifications for physician disengagement with public health, including financial considerations and professional authority concerns. The strong patient-primacy directive has underappreciated costs. It frequently overrides physicians' more elusive public health duties in ways that facilitate externalization of health risks to the general public. This Article analyzes the COVID-19 pandemic, antibiotic resistance, infectious disease reporting, the opioid crisis, and gun violence as disturbing examples. It further identifies important justifications, including, most importantly, role indispensability for amplifying physicians' public health responsibilities. While difficult doctrinal and pragmatic challenges arise in recalibrating physicians' duties, requiring community physicians to pay greater heed to the population's health seems unavoidably necessary.

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INTRODUCTION

As the coronavirus 2019 ("COVID-19") crisis worsened in March of 2020, some physicians continued to perform elective procedures like spinal decompression and "Tommy John" surgery, creating opportunities for virus transmission and potentially exacerbating shortages of oxygen, personal protective equipment, personnel, and other critical resources needed for fighting the pandemic.[1] These actions contradicted public health recommendations from influential authorities, including the Centers for Disease Control and Prevention ("CDC"), the American College of Surgeons ("ACS"), and the Centers for Medicare and Medicaid Services ("CMS").[2] It may seem counterintuitive that physicians would disregard public health to this degree. Yet, these physicians cannot simply be dismissed as outliers. A common justification was that the physicians had duties to their patients. Indeed, these physicians could credibly say that law, bioethics, and professional norms supported their conduct.

Surely physicians have obligations to protect the health of the community? Improving public health seems socially desirable, right within doctors' wheelhouse, and an implicit condition of their professional licensure.[3] But the question of physicians' responsibilities for the health of non-patients, more salient in the era of COVID-19, continually vexes courts, policy makers, and scholars. Actions to protect public health are in constant tension with

1. Mackenzie Bean, Laura Miller & Anuja Vaidya, *These Hospitals and Physicians Aren't Stopping Elective Surgery: Here's Their Thinking*, BECKER'S HOSP. REV., https://www.beckershospitalreview.com/patient-flow/these-hospitals-and-physicians-aren-t-stopping-elective-surgeries-here-s-their-thinking.html [https://perma.cc/Z5MR-LZF9] (Mar. 19, 2020, 4:15 PM); Jordan McPherson, *An MLB Pitcher Is Able To Get Tommy John Surgery in Florida During COVID-19 Outbreak. Why?*, MIA. HERALD (Mar. 25, 2020, 11:21 AM), https://www.miamiherald.com/sports/mlb/article241482786.html [https://perma.cc/23AW-RLV9]. "Tommy John" surgery, or ulnar collateral ligament reconstruction, repairs a torn ligament that helps secure the elbow joint. Athletes who play throwing sports often have this surgery. *Tommy John Surgery (Ulnar Collateral Ligament Reconstruction)*, JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/tommy-john-surgery-ulnar-collateral-ligament-reconstruction [https://perma.cc/HAQ5-J938]. It is associated with baseball pitcher Tommy John, the first athlete to successfully return to baseball pitching after the procedure. *Id.*

2. Bean et al., *supra* note 1; *CMS Releases Recommendations on Adult Elective Surgeries, Non-Essential Medical, Surgical, and Dental Procedures During Covid-19 Response*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 18, 2020), https://www.cms.gov/newsroom/press-releases/cms-releases-recommendations-adult-elective-surgeries-non-essential-medical-surgical-and-dental [https://perma.cc/696H-8DFG]. The CDC initially recommended that health care providers reschedule elective procedures. *See Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 29, 2020), https://stacks.cdc.gov/view/cdc/85502 [https://perma.cc/Z84S-PDHR]. For the recent CDC guidance about managing health care facility operations, see *Healthcare Facilities: Managing Operations During the COVID-19 Pandemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-hcf.html [https://perma.cc/4CGB-FMZQ] (last updated Mar. 17, 2021).

3. *See infra* Section I.C.

physicians' duties to their individual patients. Law, bioethics, and medical norms typically consider physicians' duties to individual patients supreme, reflected in the ubiquitous health care mantra of "putting patients first."[4] Meanwhile, physicians' responsibilities for the health of the community, while technically acknowledged, frequently end up muddled or neglected.

Conventional wisdom holds that law and policy should ensure that physicians attend to the individual patient's needs, preferences, and values. This push for a more "patient-centered" health care system dominates much legal and medical scholarship as well as reports from expert advisory bodies.[5] Putting patients front and center has considerable appeal for many reasons, including promoting patient trust, deterring physicians from conflicting interests, and shielding the intimate healing process between doctor and patient from outside interference. However, as some commentators have observed, this bias in favor of relationships with existing patients also frustrates serving the broader public interest.[6] Addressing matters of collective importance, such as health care cost control, often requires standardized, regulatory approaches and looking beyond relational obligations to patients.

This Article further cautions about always putting patients first and challenges the generally accepted dominance of patient-centered duties. It is the first to comprehensively analyze how patient primacy paradoxically crowds out needed attention to the critical public health space. It highlights the underappreciated costs of privileging the individual patient by considering the health vulnerabilities of the populace. Physicians can all too easily discount community health considerations because their public health duties under law are confoundingly elusive, both in theory and in application. Elusive in the sense that while law at times affirms physicians' special capacity and obligations to improve the health of the community, it more often obscures physicians'

4. *See, e.g.*, Coombes v. Florio, 877 N.E.2d 567, 577 (Mass. 2007) ("To a physician, it is the patient . . . who must always come first."); David Orentlicher, *The Physician's Duty To Treat During Pandemics*, 108 AM. J. PUB. HEALTH 1459, 1459 (2018) ("Physicians assume a primary ethical duty to place the welfare of their patients first, above their own interests."); *see also* Thomas R. Viggiano, Wojciech Pawlina, Keith D. Lindor, Kerry D. Olsen & Denis A. Cortese, *Putting the Needs of the Patient First: Mayo Clinic's Core Value, Institutional Culture, and Professionalism Covenant*, 82 ACAD. MED. 1089, 1089 (2007) (articulating the "guiding principle of the practice: 'the needs of the patient come first'" (citing William J. Mayo, *The Necessity of Cooperation in Medicine*, 75 MAYO CLINIC PROC. 553, 556 (2000))).

5. *See, e.g.*, INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 39–40 (Rona Briere ed., 2001); Ronald M. Epstein, Kevin Fiscella, Cara S. Lesser & Kurt C. Strange, *Why the Nation Needs a Policy Push on Patient-Centered Health Care*, 29 HEALTH AFFS. 1489, 1489 (2010); Maxwell J. Mehlman, *Dishonest Medical Mistakes*, 59 VAND. L. REV. 1137, 1144–53 (2006).

6. *See, e.g.*, William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497, 500 (2008) ("[F]ar more legal issues in health care are approached as relational than as regulatory problems, making it very difficult for law to serve truly 'public' policy.").

public health duties with limited, ad hoc recognition and insufficient theorization for the source and strength of such duties. These public health duties are also elusive in their actual operation. Because their public health responsibilities are viewed as inevitably inferior to their duties to individual patients, physicians have considerable discretion to evade public health laws or disregard public health implications of their treatment decisions. Thus, public health duties may theoretically exist, but it is debatable whether they pragmatically matter much when they hold such marginal sway over physician decision-making.

A significant divide exists between medicine and public health. A physician provides specifically tailored treatment within the confines of a special doctor-patient relationship. In contrast, public health embraces a population perspective, seeking to understand the root causes of illness in the community and identify conditions for wellness and health promotion for the populace.[7] The practice of public health typically involves epidemiological analysis and disease control measures.[8] Public health also focuses more on prevention whereas medicine principally aims to cure existing illness.[9] Moreover, public health services are usually associated with public health agencies, safety-net providers, and governmental health care programs—not regular clinicians.[10] A perhaps necessary tension exists between medicine and public health as there are "inevitable tradeoffs that arise in trying to optimize health at both levels."[11]

The elusivity of physicians' responsibilities to public health arises in part because law, reinforced by bioethics and medical norms, clings to the medicine/public health divide and envisions physicians' duties as almost exclusively arising through formation of treatment relationships with individual patients. In favoring physicians' connections to individual patients, U.S. law enforces an atomistic version of health care that matches American society's traditionally strong embrace of individualism and liberty. Yet, as the COVID-19 pandemic has shown, this also makes for a lousy public health response because of the "refusal . . . to think in terms of the social whole — of what's best

7. LAWRENCE O. GOSTIN & LINDSAY WILEY, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 12 (3d ed. 2016).

8. *What Is Public Health?*, AM. PUB. HEALTH ASS'N, https://apha.org/what-is-public-health [https://perma.cc/T2KQ-RRCN].

9. *Id.*

10. *See* LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 16–18 (2d ed. 2008).

11. Arnold J. Rosoff, *Policy Challenges in Modern Health Care*, 26 J. LEGAL MED. 523, 525 (2005); *see also* Bruce A. Barron, *Conflicts Between Public Health and Medical Care*, HUFFPOST, https://www.huffpost.com/entry/health-care-costs_b_3037450 [https://perma.cc/M3DL-AF48] (June 16, 2013).

for the community."[12] Heightened emphasis on physicians as agents of individual health detracts from the common good by glossing over the interconnectedness of health care system stakeholders. As this Article explores, it is not so easy to cabin individualized medical considerations from public health. For example, a physician's failure to counsel a patient with infectious disease about transmission risk may expose community members to the contagion. Physicians' general disengagement with public health exacerbates the larger silo problem confronting the nation's public health system—public health care remains underfunded, undervalued, and viewed as distinctly apart from an already fragmented health care delivery system.[13]

Against this backdrop of elusivity and concerning threats to public health, this Article makes several important contributions. First, it addresses current confusion about the extent of physicians' responsibilities for community health under current legal standards. It canvasses existing law to identify and critically evaluate the multiple sources of authority for physicians' public health duties, their precise scope, their significance, and the discrete contexts in which they arise. Second, it analyzes how bioethics and medical norms reinforce the indeterminate yet ultimately inferior status of physicians' public health duties under law. Third, it reveals how the strong patient-primacy directive frequently overrides physicians' more elusive public health duties in ways that facilitate externalization of health risks to the general public. Moreover, it exposes how the broad patient-primacy directive can mask less patient-centered justifications, including financial considerations[14] and professional authority concerns,[15] for physician disengagement with public health. Fourth, this Article argues that it is high time to bring not only greater clarity but greater weight to physicians' public health obligations under law. It evaluates possible objections and also identifies important justifications, as a matter of legal theory, policy, and ultimately pragmatic need, that support such a recalibration of physicians' duties.

Some immediate qualifications are necessary. This Article considers the duties and obligations of "private" physicians treating patients in the course of ordinary care. It is these physicians in the clinical trenches for whom the public health-duties question is particularly elusive. In contrast, a smaller number of "public" physicians work in governmental agencies and wear official hats as health officers of the state. These public physicians, not the subject of this

12. Damon Linker, *Coronavirus Is Revealing a Shattered Country*, THE WEEK (July 1, 2020), https://theweek.com/articles/922812/coronavirus-revealing-shattered-country [https://perma.cc/W4LR-GXET].

13. Eileen Salinsky & Elin A. Gursky, *The Case for Transforming Governmental Public Health*, 25 HEALTH AFFS. 1017, 1017–19 (2006).

14. *See infra* Section III.A (discussing elective procedures during COVID-19).

15. *See infra* Section III.D (discussing opioid prescribing and prescription drug monitoring).

Article, can be more easily and readily understood to have obligations to work for community health, by virtue of their official positions and the enabling statutory and regulatory directives for their respective agencies.[16]

Another qualification concerns the interaction of medical and public health duties. If the medicine/public health divide presents a false dichotomy, then individual health and public health need not always be in tension. Frequently, a physician who works to improve the health of her individual patients also helps to better community health. For example, a physician who zealously ensures that her patient promptly completes a treatment regimen for a sexually transmitted disease ends up protecting the patient but also public health by reducing the risk of transmission to sexual partners in the community. In many instances "putting patients first" aligns with public health. However, it is too deceptively simple to say that physicians who fulfill duties to individual patients also protect the health of the community. While the dual purposes need not always be in tension, divergence at times remains inevitable. It is these difficult, contestable situations of misalignment, and the impact of the elusiveness of private physicians' public health duties, that form the focus of this Article.

Part I describes the legal background, mapping out the limited instances where law imposes duties on community physicians to protect the public health, the common law and statutory sources of authority for these obligations, their imprecise scope, the contexts in which they arise, and how such duties remain secondary to physicians' individual patient obligations. Part II analyzes how bioethics and medical norms amplify law's patient-primacy directive and seemingly obscure and enfeeble physicians' public health obligations. Part III reveals how the elusiveness of physicians' public health duties presents insidious problems by enabling externalization of health risks from patients to the population at large. Part III then discusses examples across the wide public health space including the COVID-19 pandemic, antibiotic resistance, infectious disease reporting, opioid prescribing, and gun violence. Part IV acknowledges the difficult challenges, both doctrinal and pragmatic, in making community physicians' public health duties more cognizable and influential. It also identifies various justifications for this shift. The most important reason is instrumental: physicians' role indispensability. The private physician is strategically embedded between her patient, other patients, and society and performs critical sentinel, gatekeeper, and learned intermediary functions

16. *See, e.g.*, N.C. GEN. STAT. § 130A-45.5 (LEXIS through S.L. 2021-4 of the 2021 Reg. Sess. of the Gen. Assemb.) (providing duties of a public health authority director to include investigating causes of communicable disease and disseminating public health information); TEX. HEALTH & SAFETY CODE ANN. § 121.024 (Westlaw through 2019 Reg. Sess. of the 86th Leg.) (providing duties of a state health officer, or "health authority," to include establishing quarantines and aiding the public health department in "disease prevention and suppression").

essential to an effective public health system. These rationales may not fully address the legitimate concerns with recalibration of physicians' public health duties. But, as this Article concludes, requiring private physicians to pay greater heed to the population's health seems unavoidably necessary.

I. LIMITED LEGAL DUTIES TO PROTECT PUBLIC HEALTH

Physicians' public health duties arise from a confusing patchwork of overlapping sources of authority, including common law governing the doctor-patient relationship and statutory and regulatory requirements. At times, law acknowledges that private physicians play an important public health role and imposes community health responsibilities on clinicians in isolated, discrete contexts. Yet the obligations imposed are hardly robust and seemingly hold marginal sway over physician decision-making. More frequently, law has difficulty recognizing physicians' duties beyond the relational obligations formed with specific patients.

A. *Fiduciary Duties, Non-Patients, and Dual-Loyalty Problems*

The usual starting place in understanding physicians' duties is fiduciary law. Numerous courts recognize the doctor-patient relationship as fiduciary in nature because physicians, as trusted professionals with expert knowledge, may abuse their superior position over dependent patients.[17] Perhaps the most important duty in a fiduciary relationship, and most central to the question of medicine/public health conflict, is the duty of loyalty. This duty obligates the fiduciary to focus on the beneficiary's interests and avoid conflicts where self-interest and the interest of other parties detract from pursuit of the beneficiary's goals.[18]

However, the reach of fiduciary law to police the doctor-patient relationship is limited for several reasons. To start, there is considerable debate on how broadly fiduciary doctrine even extends to the doctor-patient relationship. Among other reasons, the doctor-patient relationship arguably lacks certain classic fiduciary features such as the fiduciary's control over monetary assets.[19] In addition, fiduciary causes of action have often been

17. *See, e.g.*, M.A. v. United States, 951 P.2d 851, 854 (Alaska 1998) ("[W]e have recognized that the unique nature of the physician-patient relationship confers upon physicians a fiduciary responsibility toward their patients."); Witherell v. Weimer, 515 N.E.2d 68, 73 (Ill. 1987) ("A physician and his patient stand in a fiduciary relation . . . .").

18. *See* RESTATEMENT (THIRD) OF TRS. § 2 cmt. b (AM. L. INST. 2003) ("Despite the differences in the legal circumstances and responsibilities of various fiduciaries, one characteristic is common to all: a person in a fiduciary relationship to another is under a duty to act for the benefit of the other as to matters within the scope of the relationship.").

19. *See, e.g.*, Joan H. Krause, Skilling *and the Pursuit of Healthcare Fraud*, 66 U. MIA. L. REV. 363, 389–90 (2012) ("[T]he physician, for example, lacks the fiduciary's traditional control over the beneficiary-patient's money.").

confusingly intermingled with more traditional claims of medical negligence and informed consent.[20] Some leading treatises refer to the doctor-patient relationship as a "confidential," rather than a fiduciary, relationship.[21] Further, while numerous U.S. court rulings affirm that the doctor-patient relationship has fiduciary characteristics, courts in a small number of states have expressly disagreed.[22] Other case law recognizes fiduciary duties for physicians in only very limited circumstances, such as obligations to maintain confidentiality, but has stopped short of applying fiduciary principles to all aspects of the doctor-patient relationship including, importantly, financial conflicts of interest.[23] Under some commentators' views, physicians cannot be classic fiduciaries because this would unduly interfere with their competing responsibilities to society, including controlling health care costs.[24] Meanwhile, other scholars insist that physicians are traditional fiduciaries and criticize the nonfiduciary interpretation as based on misunderstanding of precedent and confusion about the types of personal interests fiduciaries may still pursue.[25]

Nonetheless, to the extent that the treating physician is a fiduciary in some respects, certain loyalty obligations exist. As a fiduciary, the physician generally must act for the patient's benefit, provide individually appropriate treatment, and avoid elevating other interests above the patient's welfare unless there has been proper disclosure.[26] Thus, the physician's primary common-law duties are to act for the welfare of patients within individualized treatment relationships.

Indeed, physicians' traditional legal duties beyond the duty of loyalty, such as the duties of care, nonabandonment, and confidentiality, arise only from the formation of a treatment relationship with a specific patient. As the *Restatement (Third) of Torts* explains: "Unlike most duties, the physician's duty to the patient is explicitly relational: physicians owe a duty of care to *patients*."[27] A more open-ended duty to improve and safeguard the health of the larger community, and therefore individuals who are non-patients, rests on less firm footing within the common-law tradition.

20. *See, e.g.*, Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 464–66 (2000).

21. RESTATEMENT (THIRD) OF TRS. § 2 cmt. (b)(1).

22. *See* Carlson v. SALA Architects, Inc., 732 N.W.2d 324, 331 (Minn. Ct. App. 2007); Gunter v. Huddle, 724 So. 2d 544, 546 (Ala. Civ. App. 1998).

23. *See, e.g.*, MARC A. RODWIN, MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST 210–11 (1993).

24. E. Haavi Morreim, *Redefining Quality by Reassigning Responsibility*, 20 AM. J.L. & MED. 79, 92 (1994).

25. Maxwell J. Mehlman, *Why Physicians Are Fiduciaries for Their Patients*, 12 IND. HEALTH L. REV. 1, 17–30 (2015).

26. Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195, 251–52 (2003).

27. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL & EMOTIONAL HARM § 41 cmt. h (AM. L. INST. 2012).

Even if common law arguably acknowledges physicians as agents of more than just individual health because of their special skills and capabilities in population health promotion,[28] physicians might be considered to have a dual-loyalty problem—with simultaneous obligations to their individual patients and to the public. But this offers little leeway for physicians to pursue public health goals that are in tension with individual patient welfare. The dual-loyalty problem for physicians is hardly new. In a variety of contexts physicians may find that they owe concurrent obligations to a third party or to society as a whole and also to the patient, such as providing employment fitness exams, caring for team athletes, and providing medical assistance to the state in administering wartime interrogations.[29] However, the message to physicians in most dual-loyalty scenarios has invariably been to restructure their roles to minimize dual-loyalty conflicts[30] or resolve the dual-loyalty problem by putting patients first.[31]

B. *Common-Law Duties to Third Parties*

Common law has, at times, recognized a quasi-public health role for physicians in considering the welfare of third parties potentially endangered by the patient. Much of this case law concerns physicians treating patients with infectious disease and whether the physician needs to warn and/or protect third parties exposed to the patient's contagion. While this case law occasionally uses expansive wording in describing physicians' public health obligations, the actual contexts in which the duties arise remain quite limited. Moreover, demonstrating concern with burdening physicians with obligations outside their relationships with patients, courts have seemed reluctant to impose open-ended, affirmative duties to act for the welfare of the community.

28. *See infra* Section I.B.

29. *See, e.g.*, Steve P. Calandrillo, *Sports Medicine Conflicts: Team Physicians vs. Athlete-Patients*, 50 ST. LOUIS U. L.J. 185, 190–92 (2005); Rahul Rajkumar, *A Human Rights Approach to Routine Provider-Initiated HIV Testing*, 7 YALE J. HEALTH POL'Y, L., & ETHICS 319, 364–65 (2007).

30. *See, e.g.*, I. Glenn Cohen, Holly Fernandez Lynch & Christopher R. Deubert, *A Proposal To Address NFL Club Doctors' Conflicts of Interest and To Promote Player Trust*, HASTINGS CTR. REP., Nov.–Dec. 2016, at S2, S3 (arguing for severing the sports doctor's dual loyalties to team and patient by creating two professional roles: a medical staff doctor with exclusive loyalty to the patient and a club evaluation doctor with exclusive loyalty to the team).

31. *See, e.g.*, PHYSICIANS FOR HUM. RTS., DUAL LOYALTIES: THE CHALLENGES OF PROVIDING PROFESSIONAL HEALTH CARE TO IMMIGRATION DETAINEES 5 (2011) ("While the term 'dual loyalty' may imply equivalence between a medical professional's loyalty to the patient and loyalty to third party interests, no such equivalence exists. Ethically, with very rare and well-circumscribed exceptions, a health professional is obligated to act in the interest of the patient above all other concerns."); Solomon R. Benatar & Ross E.G. Upshur, *Dual Loyalty of Physicians in the Military and in Civilian Life*, 98 AM. J. PUB. HEALTH 2161, 2161 (2008) (noting that one approach to resolving physician dual-loyalty problems is that the physician's "professional responsibility to individuals is always considered to override responsibility to society").

1. Classic Infectious Disease Cases

When a patient has a highly contagious disease, such as tuberculosis or scarlet fever, courts have traditionally recognized a duty on the physician to address health risks to the patient's very close contacts, often family members.[32] Similarly, courts have acknowledged that sexual partners exposed to a patient's sexually transmitted disease may bring a claim against the physician for alleged negligence in advising the patient about the risk of transmission.[33] However, the case law is somewhat uneven as not all courts have recognized the physician's duty to third parties even with highly contagious diseases.[34]

Courts seem more likely to sustain claims by infected third parties when there is an underlying disease-reporting law imposing a statutory obligation on the physician to notify public health authorities about the illness. This indicates some legislative intent to protect third parties, providing greater justification for imposing a legal duty, enforceable under common law, on the physician to act. As an illustration, courts have recognized a potential cause of action by an infected neighbor, based in part on a state disease-reporting statute, for the physician's alleged failure to diagnose a patient's smallpox, thus putting the patient's neighbors at risk.[35]

2. Noninfectious Diseases and Physicians' Special Role in Public Health

Physicians' limited legal obligations to non-patients have also been recognized at times in situations of noninfectious disease. In one case, a court found a spouse had an actionable claim against a physician for failure to warn her of her husband's contraction of Rocky Mountain Spotted Fever.[36] Although the underlying illness was not considered contagious, the court looked at the clustering effects and commonly shared sources of exposure, and ultimately found that the husband's disease status indicated her increased risk for contracting the disease.[37] Similarly, courts have analogized to infectious disease-reporting obligations in finding a physician has a duty to protect the

32. *See, e.g.*, Skillings v. Allen, 173 N.W. 663, 663 (Minn. 1919) (scarlet fever); Hofmann v. Blackmon, 241 So. 2d 752, 753 (Fla. Dist. Ct. App. 1970) (tuberculosis); *see also* 43 AM. JUR. 2D *Proof of Facts* § 3 (2020) ("[A] physician who treats a patient for a communicable disease may be under a duty to diagnose the disease's contagious and infectious nature . . . .").

33. *Cf.* DiMarco v. Lynch Homes—Chester Cnty., Inc., 583 A.2d 422, 424 (Pa. 1990) ("[I]t is imperative that the physician give his or her patient the proper advice about preventing the spread of the disease.").

34. *See, e.g.*, Britton v. Soltes, 563 N.E.2d 910, 912–13 (Ill. App. Ct. 1990).

35. Jones v. Stanko, 160 N.E. 456, 457 (Ohio 1928). *See generally* Tracey A. Bateman, Annotation, *Liability of Doctor or Other Health Practitioner to Third Party Contracting Contagious Disease from Doctor's Patient*, 3 A.L.R. 5th 370 § 2b (1992) (describing facts and circumstances tending to establish a physician's liability to a third party due to the physician's failure to exercise the requisite degree of care to protect against exposure to a patient with a contagious disease).

36. Bradshaw v. Daniel, 854 S.W.2d 865, 872–73 (Tenn. 1993).

37. *Id.* at 872.

driving public when prescribing medication that increases the risk of injury to third parties from the impaired patient's driving.[38]

In these cases addressing physicians' potential obligations to third parties, courts have at times used seemingly broad language recognizing and affirming a critical public health role for private physicians. The Supreme Court of Pennsylvania has observed that physicians can powerfully safeguard health beyond the patient as "[p]hysicians are the first line of defense against the spread of communicable diseases, because physicians know what measures must be taken to prevent the infection of others."[39] More recently, the Connecticut Supreme Court stated "that such [sanctity of the doctor-patient relationship] concerns are at their nadir, and a physician's broader public health obligations are at their zenith, with respect to the diagnosis and treatment of infectious diseases."[40] Indeed, some commentators interpret this case law as recognizing "a physician *has a duty to protect public health*."[41]

3. Ultimate Constraints on Public Health Duties

However, a more generalized duty to protect public health lacks a clear foundation in common law. First, the infectious disease line of cases typically extends the physician's duty to a spouse, sexual partner, or other third party intimate with or in very close nexus to the patient. In other words, the physician's duty extends to a specific third party, rather than the public at large. For example, in *Tenuto v. Lederle Laboratories*,[42] the New York State Court of Appeals held that a physician prescribing an infant an oral polio vaccine had a duty to warn the infant's parents of the risk of transmission of the virus to the parents.[43] The court emphasized the physician's duty extended to the parents because of their close relationship to the patient, reasoning that

> an attending physician is, in a certain sense, in custody of a patient afflicted with infectious or contagious disease. And he owes a duty to those who are ignorant of such disease, and *who by reason of family ties, or otherwise*, are liable to be brought in contact with the patient, to instruct and advise . . . them as to the character of the disease.[44]

38. *See, e.g.*, Gooden v. Tips, 651 S.W.2d 364, 370–71 (Tex. App. 1983).

39. DiMarco v. Lynch Homes—Chester Cnty., Inc., 583 A.2d 422, 424 (Pa. 1990).

40. Doe v. Cochran, 210 A.3d 469, 488 (Conn. 2019) (finding physician who incorrectly told patient he tested negative for herpes had actionable duty to patient's girlfriend who later contracted the disease).

41. Caitlin A. Schmid, *Protecting the Physician in HIV Misdiagnosis Cases*, 46 DUKE L.J. 431, 447 (1996) (emphasis added).

42. 687 N.E.2d 1300 (N.Y. 1997).

43. *Id.* at 1303.

44. *Id.* (emphasis added) (citation omitted) (quoting Davis v. Rodman, 226 S.W. 612, 614 (Ark. 1921)).

This is very different than recognizing a duty to the community at large, where many individuals may have only more indirect connections to the physician's patient.

Second, to the extent there is a legal duty on the physician to act for identifiable third parties in close nexus to the patient, the common-law duty described is usually narrowly limited to advising or warning the patient about her risk to others, as opposed to requiring broader steps.[45] If there were a generalized, robust duty to protect public health, then one might expect the duty to be articulated as needing to control the patient to protect the public at large, which courts have sometimes expressly avoided.[46]

Judicial sensitivity to limiting legal duties to defined, fixed orbits, and not overburdening physicians with infeasible liability pressures to "a prohibitive number of possible plaintiffs,"[47] has led some later courts to try to clarify and narrow the scope of earlier infectious disease case law. These later cases try to make clear that the physician's duty is usually limited to accurately advising the patient about the communicable disease and the risk it presents to others.[48] A Supreme Court of Pennsylvania case, *Seebold v. Prison Health Services, Inc.*,[49] reflects this patient-centered duty.[50] In *Seebold*, a corrections officer claimed he was infected with methicillin-resistant staphylococcus aureus ("MRSA") after prison physicians' allegedly failed to control a MRSA outbreak among patient-inmates.[51] The court concluded the physicians' legal obligation did not extend to reaching out to third parties, even by warning, and was reluctant "to extend the requirement for affirmative physician interventions *outside the physician-patient relationship*."[52] Indeed, some courts have exhibited clear discomfort in imposing a broad duty to third parties if this would cause the physician to disfavor the interests of the patient. For example, in *Webb v. Jarvis*,[53] involving a third party injured by a patient, allegedly as a result of the patient's aggressive

45. *See Doe*, 210 A.3d at 491 (holding that although defendant physician had a duty to third-party plaintiff, the physician "was under no obligation to contact the plaintiff, to otherwise ensure that she was made aware of [the patient's] test results, or to do anything other than fulfill his undisputed professional obligation to accurately convey his patient's test results to the patient himself").

46. *See, e.g.*, Gooden v. Tips, 651 S.W.2d 364, 370 (Tex. App. 1983) ("[The physician] *may* have had a duty to *warn* his patient not to drive. We do not hold he had a duty to *prevent* her from driving . . . ." (first emphasis added)).

47. McNulty v. City of New York, 792 N.E.2d 162, 166 (N.Y. 2003) (finding doctor treating patient with meningitis owed no duty of care to patient's friend who eventually contracted the disease).

48. *See* Walters v. UPMC Presbyterian Shadyside, 31 Pa. D. & C.5th 281, 292–95 (2013) (summarizing previous cases).

49. 57 A.3d 1232 (Pa. 2012).

50. *Cf. id.* at 1243 (refraining from "redefin[ing] the nature of the duty at issue to require physicians to undertake interventions outside the confidential physician-patient relationship").

51. *Id.* at 1234.

52. *Id.* at 1248 (emphasis added).

53. 575 N.E.2d 992 (Ind. 1991).

reaction to medication treatment, the Indiana Supreme Court declined to impose a duty and reasoned,

> A physician's first loyalty must be to his patient. Imposing a duty on a physician to predict a patient's behavioral reaction to medication and to identify possible plaintiffs would cause a divided loyalty. Were we to impose a duty on a physician to consider the risk of harm to third persons before prescribing medication to a patient, we would be forcing the physician to weigh the welfare of unknown persons against the welfare of his patient. Such an imposition is unacceptable. The physician has the duty to his patient to decide when and what medication to prescribe to the patient, and to inform the patient regarding the risks and benefits of a particular drug therapy.[54]

Third, the case law recognizing a physician's duty to third parties in infectious disease cases is decidedly mixed and uneven.[55] Some courts have difficulties extending a physician's legal obligations to non-patients, even if they have been in quite foreseeable contact with the physician's actual patient and are easily identifiable.[56] Thus, a physician faced no duty to warn the spouse in a case alleging the physician's failure to diagnose the patient's tuberculosis, because, the court reasoned, "'[A] physician's duty of care is ordinarily one owed to his or her patient' and *does not extend to the 'community at large*.'"[57]

4. *Tarasoff*'s Impact

Discussion of physicians' duties to protect community health must, of course, include the infamous *Tarasoff v. Regents of University of California*[58] and related case law. In *Tarasoff*, the Supreme Court of California held that a psychologist has a duty to protect foreseeable third-party victims when reasonably determining that a patient poses a serious danger of violence to others.[59] The *Tarasoff* court noted its holding was consistent with the earlier infectious disease case law in other jurisdictions imposing liability on physicians to third parties who contracted the patient's contagious disease.[60] Foreseeability of harm seemed very important to the court's imposition of a duty, despite

54. *Id.* at 997.

55. *See* RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL & EMOTIONAL HARM § 41 cmt. h (AM. L. INST. 2012) ("Some of the obligations of physicians to third parties, such as with patients who are HIV-infected, have been addressed by legislatures. In other areas, the case law is sufficiently mixed, the factual circumstances sufficiently varied . . . .").

56. Ellis v. Peter, 211 A.D.2d 353, 353 (N.Y. 1995).

57. *Id.* at 356 (emphasis added) (citations omitted) (first quoting Purdy v. Pub. Adm'r of Westchester Cnty., 526 N.E.2d 4, 8 (N.Y. 1988); and then quoting Eiseman v. New York, 511 N.E.2d 1128, 1135 (N.Y. 1987)).

58. 551 P.2d 334 (Cal. 1976).

59. *Id.* at 346.

60. *Id.* at 344.

uncertain therapeutic standards for accurately predicting patient violence.[61] This foreseeability emphasis, as well as the opinion's linking to earlier infectious disease cases, and that the facts involved noninfectious mental illness,[62] seemingly opened the door to imposing duties on health care providers to non-patients in many situations where action could possibly mitigate risk and safeguard community health.

However, *Tarasoff* and its progeny really do not support the notion of a physician's broader duty to protect the health of the population. Despite its wide renown, a fair number of jurisdictions decline to follow *Tarasoff* and do not recognize a duty on mental health care providers in similar situations.[63] Meanwhile, certain courts following *Tarasoff* hold that the duty of protection and/or warning is owed only to victims "who are identifiable with a significant degree of specificity."[64] This undercuts the notion that the physician owes a duty to protect the community's health as there is a big leap from specifically identifiable third parties at risk to general members of the public. Additionally, some courts have distinguished *Tarasoff* and its progeny as limited to the unique, special relationship between a mental health provider and the patient, and state that such case law "cannot reasonably serve as a springboard for the imposition of new and broader duties upon healthcare providers vis-à-vis third-party non-patients."[65]

One way to understand the distinctiveness of the special relationship recognized in *Tarasoff* arises from the mental health care provider's assumption of some degree of control over and highly personal connection with the patient, elements not necessarily existing to the same extent in other doctor-patient relationships.[66] For example, the typical mental health patient has "some degree of decreased capacity of self-control"[67] and the therapist has the option of civilly committing the mental health patient.[68] In contrast, the regular physician does

61. *Id.* at 345.

62. *Id.* at 344.

63. Kuligoski v. Brattleboro Retreat, 156 A.3d 436, 469 (Vt. 2016) (noting that many states have departed from *Tarasoff* through statutory limitations on the mental health professional's duty).

64. Peter H. Schuck & Daniel J. Givelber, Tarasoff v. Regents of the Univ. of Cal.*: The Therapist's Dilemma*, *in* TORTS STORIES 99, 127 (Robert L. Rabin & Stephen D. Sugarman eds., 2003).

65. Seebold v. Prison Health Servs., Inc., 57 A.3d 1232, 1244 (Pa. 2012).

66. *Cf., e.g.*, Shortnacy v. N. Atlanta Internal Med., P.C., 556 S.E.2d 209, 214 (Ga. Ct. App. 2001) (finding no duty in a case where an injured third party alleged the physician owed him a duty when prescribing patient-driver a narcotic analgesic—the court recognized "control over the patient as the touchstone for imposing this [physician] duty to third parties" and finding no duty because such control was lacking in this doctor-patient relationship).

67. W. Jonathan Cardi, *A Pluralistic Analysis of the Therapist/Physician Duty To Warn Third Parties*, 44 WAKE FOREST L. REV. 877, 889 (2009).

68. *Id.* at 891.

not have an "intimate knowledge of a patient's life," and the patient may be just as capable of exercising self-control to address the harm to others.[69]

Relatedly, the *Restatement (Third) of Torts* expressly recognizes affirmative duties by mental health providers to third parties at risk from patients, but treats nonmental health professionals differently.[70] Instead, it "leaves to further development the question of when [nonmental health] physicians have a duty to use reasonable care or some more limited duty—such as to warn only the patient—to protect third parties."[71] This further suggests that the grounds are weak for extending a *Tarasoff*-like duty beyond the unique mental health setting to a wider range of potential public health scenarios.[72]

C. *Medical Practice Acts and Professional Licensure*

Physicians have statutory and regulatory duties connected with the legal authority the government grants them to practice medicine. But this does not necessarily encompass broad public health obligations. Most state medical practice acts are patient focused and condition a physician's ability to engage in the licensed practice of medicine on maintaining minimum quality standards in connection with services rendered to actual patients. For example, Ohio's medical practice act provides that physicians can face licensure restriction for grounds primarily tied to direct patient care such as "inability to practice according to acceptable and prevailing standards of care by reason of mental illness or physical illness," departure from minimal standards of care followed by similar physicians, failure to follow standards related to drug selection and administration, and violating patient confidentiality.[73]

Only a handful of state medical practice acts extend further and expressly envision the licensed physician engaging in public health protection. As discussed further below, some licensing statutes provide that a physician's failure to comply with infectious disease-reporting laws can trigger licensure discipline.[74] Beyond this link to disease reporting, very few physician licensure

69. *Id.*

70. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL & EMOTIONAL HARM § 41(b)(4) (AM. L. INST. 2012).

71. *Id.* § 41 cmt. h.

72. The *Restatement (Third) of Torts* commentary discusses possible public health duties to third parties, such as when a physician cares for an HIV patient who poses risk to others. *Id.* But it notes that statutes may address some of these duties and that the case law and policy considerations are mixed when considering whether physicians have clear affirmative duties under common law to non-patient third parties. *Id.* ("Physicians' reporting obligations for patients who are HIV-positive have been addressed by statute in virtually all states.").

73. OHIO REV. CODE ANN. § 4731.22(B) (LEXIS through File 3 (SB 22) of the 134th (2021–2022) Gen. Assemb.).

74. *See, e.g.*, N.J. STAT. ANN. § 45:1-21 (Westlaw through L.2021, c. 32 and J.R. No. 1) (providing that engaging in professional misconduct is punishable by license suspension); N.J. ADMIN. CODE

statutes expressly address other public health conduct, and those situations seem to be ad hoc. An increasing number of medical practice acts, such as North Carolina's, permit physicians to prescribe opioid antagonists, such as naloxone, to non-patients, including family members of individuals at risk of opioid overdose and others who are likely to be in a position to assist individuals at risk, to prevent overdoses.[75] New York's medical practice act permits physicians to prescribe generalized regimens to nurses and pharmacists for administering immunizations and performing identification tests with non-patients for infectious diseases such as influenza, pertussis disease, and hepatitis C virus.[76]

On the one hand, licensure provisions as in New York and North Carolina provide a direct legal connection between physician action and non-patients. On the other hand, the statutory language is permissive, rather than a binding obligation. Thus, the familiar pattern occurs yet again: physicians' public health duties are ephemeral in contrast to their more salient, binding obligations to actual patients.

There is open-ended "harm to the public" language in some medical practice acts that could be expansively read to impose additional public health obligations on physicians. For example, Illinois' medical practice act provides that physicians should avoid "unprofessional conduct of a character likely to deceive, defraud or harm the public."[77] Similarly, the Federation of State Medical Boards ("FSMB") published a model medical practice act provides that a physician may face licensure discipline for "conduct likely to . . . harm the public," or "any conduct that may be harmful to the patient or the public."[78]

Such language arguably makes attention to population health risks a physician's statutory responsibility, as disregard for these risks can materialize as harm to the public. However, the ultimate impact of these statutory provisions is in fact quite modest. First, a fair number of physician-licensing statutes do not follow the FSMB model and avoid the very broad "harm to the public" disciplinary standard. Second, even if on the books, medical boards do not regularly enforce a harm-to-the-public standard. To start, physician discipline for *any* licensure statute violation remains quite rare. Estimates suggest that state medical boards discipline only 5 in 1,000 physicians per year, and only approximately 1.1 per 1,000 physicians receive severe sanctions such

§ 13:35-6.24 (LEXIS through the New Jersey Reg., Vol. 53 No. 7, Apr. 5, 2021) (providing that failure to comply with disease-reporting requirements can be considered professional misconduct).

75. N.C. GEN. STAT. § 90-12.7(b) (LEXIS through Sess. Laws 2021-4 of the 2021 Reg. Sess. of the Gen. Assemb.).

76. N.Y. EDUC. LAW § 6527(6)–(7) (Westlaw through L.2021, chs. 1 to 49, 61 to 91).

77. 225 ILL. COMP. STAT. 60/22(A)(5) (Westlaw through P.A. 101-659).

78. ESSENTIALS OF A STATE MED. & OSTEOPATHIC PRAC. ACT § IX(D)(4), (52) (FED'N OF STATE MED. BDS. 2015), https://www.fsmb.org/siteassets/advocacy/policies/essentials-of-a-state-medical-and-osteopathic-practice-act.pdf [https://perma.cc/G66H-JVU8].

as revocation or suspension of their license.[79] The overwhelming majority of serious medical licensure actions involve complaints of physicians impaired by drugs and alcohol, engaged in sexual relations with patients, and other quality of care concerns.[80] There is a noteworthy dearth of professional licensure actions for conduct involving harm to non-patients and the health of the community.

Finally, a fair number of medical practice acts condition the physician's license on complying with the ethics of the medical profession. Ohio's licensing statute, for example, provides that physicians may face licensure discipline for violating the American Medical Association's Code of Medical Ethics ("AMA Code").[81] Similarly, North Carolina's licensing statute subjects a physician to potential discipline for "failure to conform to . . . the ethics of the medical profession, irrespective of whether or not a patient is injured thereby."[82] Thus, if medical ethics and the honorable standards of the profession direct physicians to safeguard public health, then failure to do so could also be considered a licensure violation. This would be the case even if no patient harm occurred.

The extent to which medical ethical directives can be considered binding legal obligations, because medical practice acts reference such ethical standards, is much debated. Some commentators assert that private professional associations, such as the American Medical Association ("AMA"), have no legal role in directing the practice of medicine through licensing statutes and that violations of such associations' ethical codes are not strong grounds for jeopardizing the physician's license.[83] However, other commentators see a firmer legal foundation, particularly for the AMA Code, and contend that it has "been adopted as an authoritative source of a physicians' professional responsibilities by many state licensing boards and courts."[84]

To the extent these ethical standards are at least influential in understanding the full scope of physicians' legal duties, it is helpful to consider medical ethics guidance regarding physicians as agents of community health.

79. James M. Dubois, Emily A. Anderson, John T. Chibnall, Leanne Diakov, David J. Doukas, Eric S. Holmboe, Heidi M. Koenig, Joan H. Krause, Gianna McMillan, Marc Mendelsohn, Jessica Mozersky, William A. Norcross & Alison J. Whelan, *Preventing Egregious Ethical Violations in Medical Practice: Evidence-Informed Recommendations from a Multidisciplinary Working Group*, 104 J. MED. REG. 23, 23 (2018).

80. James M. Dubois, Emily E. Anderson, John T. Chibnall, Jessica Mozersky & Heidi A. Walsh, *Serious Ethical Violations in Medicine: A Statistical and Ethical Analysis of 280 Cases in the United States from 2008–2016*, 19 AM. J. BIOETHICS 16, 16 (2019).

81. OHIO REV. CODE ANN. § 4731.22(B) (LEXIS through File 3 (SB 22) of the 134th (2020–2021) Gen. Assemb.).

82. N.C. GEN. STAT. § 90-14(a)(6) (LEXIS through Sess. Laws 2021-4 of the 2021 Reg. Sess. of the Gen. Assemb.).

83. Carl H. Coleman, *Beyond the Call of Duty: Compelling Health Care Professionals To Work During an Influenza Pandemic*, 94 IOWA L. REV. 1, 22 (2008).

84. Orentlicher, *supra* note 4, at 1459.

Moreover, in situations where the law may not provide a clear answer about physicians' public health duties, the ethical provisions become all the more important, pragmatically, as a source of authority in directing physician behavior because parties may turn to the ethical standards for additional guidance. Thus, more detailed consideration of how medical ethics addresses physicians' public health duties is in order, and the next part takes up this analysis.[85]

D. *Other Statutory Duties*

In contrast to medical practice acts, various other statutes provide clearer legal foundation for physicians' public heath responsibilities, albeit in narrow contexts. First, some statutes impose direct public health surveillance responsibilities on treating clinicians, such as laws that require reporting of communicable disease,[86] child abuse and neglect,[87] and elder abuse.[88] Failure to comply with reporting obligations can subject a physician to licensure discipline in several states.[89] However, as discussed further below, compliance with disease-reporting laws has been poor and enforcement weak.[90]

Some statutes permit commandeering the services of private physicians in the declaration of a public health emergency. For example, the Model State Emergency Health Powers Act,[91] adopted in varying form in several states, provides state public health authorities the power to require physicians to assist with vaccination, testing, examination, and treatment of individuals.[92] But such commandeering statutes typically apply only in the context of a discrete, declared public health emergency, not to the more mundane, daily treatment

85. *See infra* Part II.

86. *See infra* Section III.C.

87. S*ee, e.g.*, CAL. PENAL CODE § 11166(a) (2021) (requiring physicians to report known or suspected instances of child abuse or neglect).

88. *See, e.g.*, CAL. WELF. & INST. CODE § 15630 (2021) (requiring physicians to report known or observed instances of elder abuse or neglect).

89. *See, e.g.*, N.Y. EDUC. LAW § 6530 (Westlaw through L.2021, chs. 1 to 49, 61 to 91) (stating that failure to report constitutes professional misconduct); N.Y. PUB. HEALTH LAW § 230-a (Westlaw through L.2021, chs. 1 to 49, 61 to 91) (providing that engaging in professional misconduct subjects a physician to licensure revocation).

90. *See infra* Section III.C.

91. MODEL STATE EMERGENCY POWERS ACT (CTR. FOR L. & THE PUB.'S HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIVS., Discussion Draft 2001), https://www.aapsonline.org/legis/msehpa2.pdf [https://perma.cc/L5JK-DNE3].

92. *See* NETWORK FOR PUB. HEALTH L., THE MODEL STATE EMERGENCY HEALTH POWERS ACT: SUMMARY MATRIX 1–8, https://www.networkforphl.org/wp-content/uploads/2020/01/Emergency-Declaration-Authorities.pdf [https://perma.cc/8TAV-X6QB] (providing "state statutory and regulatory authorities for emergency declarations in all 50 U.S. States and the District of Columbia"); *see also* Judith C. Ahronheim, *Service by Health Care Providers in a Public Health Emergency: The Physician's Duty and the Law*, 12 J. HEALTH CARE L. & POL'Y 195, 229 (2009).

decisions arising in clinical practice that, nonetheless, may also impact community health significantly.

Physicians providing on-call service at a Medicare-participating hospital may also have an obligation to treat individuals during a public health emergency under the Federal Emergency Medical Treatment and Active Labor Act ("EMTALA").[93] But the ultimate reach of this statutory duty remains quite constrained as EMTALA applies only when individuals present at a hospital emergency room.[94] In regular clinical practice, outside of the emergency room context, the common-law view of the doctor-patient relationship as contractual in nature gives physicians considerable leeway to decline to start a treatment relationship for any reason or no real reason at all.[95] This presumably grants physicians discretion to refuse to care for an individual, even when the underlying health condition, if left untreated, poses additional health risks to the community.

II. MEDICAL ETHICS AND PROFESSIONAL NORMS AMPLIFYING PATIENT PRIMACY

Law is not the only, or even most significant, influence on physician behavior. Among other factors, physicians' sense of their professional ethical obligations, as well as what they perceive their peers do, can matter considerably. Thus, in accounting for the elusiveness of physicians' public health responsibilities, it is also important to consider these additional perspectives. Medical ethics and professional norms reinforce and amplify law's patient-primacy directive. While nominally acknowledging physicians' public health obligations, medical ethics and professional norms more frequently downgrade physicians' public health activities when in tension with patient-centered responsibilities.

A. *Traditional Medical Ethics*

According to traditional medical ethics, the doctor-patient relationship serves as the linchpin for the origin and scope of a physician's ethical obligations.[96] The AMA Code treats the physician's role as inherently patient-centered because "[t]he practice of medicine . . . is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate

93. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164–67 (codified as amended at 42 U.S.C. § 1395dd).

94. *Id.*

95. *See, e.g.*, Oliver v. Brock, 342 So. 2d 1, 3 (Ala. 1976).

96. As previously noted, there are differing opinions on whether professional ethical codes and directives are considered binding legal obligations on physicians. *See supra* Section I.C.

suffering."[97] Interestingly, the AMA Code has not always been so feeble regarding the physician's public health role. The first version of the AMA Code, from 1847, took a rather firm stand on the necessity of physicians addressing infectious disease outbreaks threatening the community, even if this meant putting themselves at risk.[98] It advised that "when pestilence prevails, it is [physicians'] duty to face the danger, and to continue their labors for the alleviation of the suffering, even at the jeopardy of their own lives."[99]

In contrast, the current AMA Code makes physicians' public health duties more obscure. Among the AMA Code's nine core principles is a seemingly bold endorsement of a robust public health role for the physician: "A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health."[100] Note the rather weakened effect of the indirect phrasing, however, as the physician is advised merely to *recognize* a public health responsibility as opposed to actually having to undertake it to a meaningful degree. Further, the next immediately following core principle significantly undercuts physicians' obligations to improve public health as it instructs that "[a] physician shall, while caring for the patient, *regard responsibility to the patient as paramount*."[101] Thus, any public health role envisioned by the AMA Code's core principles is fairly read to be secondary and inferior to the clearer command for the physician to act primarily for the patient being treated. More to the point, the AMA Code regards the doctor-patient relationship as so sacrosanct and rooted in trust that it obligates physicians to "place patients' welfare above the physician's own self-interest *or obligations to others*."[102] Thus, physicians' responsibilities to safeguard the health of the community take a backseat to caring for individual patients.

The AMA Code underwent significant revisions in 2016, including, importantly, a reorganized series of ethics opinions in Chapter 8 that addresses "Opinions On Physicians [and] the Health of the Community."[103] These opinions describe various public health obligations for physicians, such as participating in routine universal patient screening for HIV, assessing patients' fitness to drive, providing urgent medical care during disasters, and participating in use of quarantine and isolation procedures to control infectious

97. CODE OF MED. ETHICS ch. 1, Ethics Op. 1.1.1 (AM. MED. ASS'N 2017), https://www.ama-assn.org/delivering-care/ethics/patient-physician-relationships [https://perma.cc/47R8-TSUT].

98. CODE OF MED. ETHICS art. 1, § 1 (AM. MED. ASS'N 1847).

99. *Id.*

100. CODE OF MED. ETHICS, AMA PRINCIPLES OF MED. ETHICS § VII (AM. MED. ASS'N 2001), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-of-medical-ethics.pdf [https://perma.cc/5X6Z-4URQ].

101. *Id.* § VIII (emphasis added).

102. CODE OF MED. ETHICS ch. 1, Ethics Op. 1.1.1 (emphasis added).

103. CODE OF MED. ETHICS, ch. 8.

disease outbreaks.[104] The AMA webpage introducing this revised Chapter 8 promotes physicians as strong public health guardians by explaining "[p]hysicians have a long-recognized responsibility to participate in activities to protect and promote the health of the public."[105]

Yet much of this guidance pays mere lip service to physicians' public health role. The "long-recognized" public health duties are immediately attenuated by the physician's need to care for her patients. The Chapter 8 webpage further cautions that "[p]hysicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient and to protect public safety."[106] This suggests the physician has dual duties—to the patient and to public health—without much guidance as to how to reconcile any tensions. The actual ethics opinions within Chapter 8 go further, however, in making clear that the public health role remains necessarily inferior. For example, Ethics Opinion 8.1, dealing with the importance of physician participation in routine universal screening of patients for HIV, begins the analysis with the starting assumption that "[p]hysicians' primary ethical obligation is to their individual patients"[107] and thus advises that HIV screening include opt-out provisions for patients and that physicians should respect a patient's informed refusal to be tested for HIV as part of routine screening.[108]

Likewise, Ethics Opinion 8.4, addressing physicians' public health responsibilities to consider use of quarantine and isolation to reduce infectious disease outbreaks, makes clear that physicians' obligations to the patient remain superior.[109] The opinion notes that "*[a]lthough physicians' primary ethical obligation is to their individual patients*, they also have a long-recognized public health responsibility. . . . [T]his may include the use of quarantine and isolation to . . . protect the health of the public."[110] Elsewhere in the Chapter 8 ethics opinions, physicians' public health duties are ambiguously referenced as concurrent with their obligations to individual patients, but again no guidance is given about how to reconcile any dual-obligation problems.[111] More importantly, nowhere within the Chapter 8 ethics opinions is there any

104. *Id.*

105. *Code of Medical Ethics: Physicians & the Health of the Community*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-physicians-health-community [https://perma.cc/T7X4-G6CT].

106. *Id.*

107. CODE OF MED. ETHICS ch. 8, Ethics Op. 8.1.

108. *Id.*

109. *Id.* ch. 8, Ethics Op. 8.4.

110. *Id.* (emphasis added).

111. *See, e.g.*, *id.* ch. 8, Ethics Op. 8.2 ("In deciding whether or how to intervene when a patient's medical condition may impair driving, physicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient, and to protect public safety.").

indication when physicians' public health duties will ever eclipse and outweigh their obligations to individual patients.[112]

Analogous to public health protection is the expectation that physicians should adopt conscious practice strategies in order to help control health care spending. In this context, the AMA ethics guidance offers some support for relaxing patient primacy in favor of larger societal interests.[113] It is not clear, however, that this guidance is intended to apply to physician's specific public health activities. Moreover, recognizing physicians have dual obligations, without providing clearer indication when societal interests must take center stage, still results in underpowered public health obligations.

The failure of traditional medical ethics to support more robust public health duties for physicians, and its seeming enfeeblement of such duties by obfuscation, should not surprise. Organized medicine has historically had a tense relationship with public health. In earlier decades, private physicians viewed public health workers' attempts at professionalization with suspicion and warily regarded the public health movement's appeals to community protection as a means to introduce controversial health insurance programs and to assert control over individual medical practice.[114] Also contributing to this tension was public health linking disease prevention to the "higher rights" of the community, and its advocacy for mass intervention programs, which seemingly undercut the doctor-patient relationship so central to medical practice.[115]

In addition, traditional medical ethics' emphasis on values such as autonomy, civil liberty, and antipaternalism remains at odds with public heath's more communitarian orientation.[116] Traditional medical ethics' strong concern with individual autonomy and patient beneficence, in particular, contrasts with public health's attention to how health-related risks and benefits impact entire

112. *See id.* ch. 8.

113. *See* AM. MED. ASS'N, *Opinion 9.0652 - Physician Stewardship of Health Care Resources*, *reprinted in* 17 AMA J. ETHICS 1044, 1044 (2015); AM. MED. ASS'N, REPS. OF THE COUNCIL ON ETHICAL & JUD. AFFS., PHYSICIAN STEWARDSHIP OF HEALTH CARE RESOURCES (2012), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/hod/a12-ceja-reports_0.pdf [https://perma.cc/MM76-95PY]. According to the AMA report, the singular patient welfare view does not reflect the realities of clinical practice and overlooks physicians' distinct obligations to promote public health and access to care generally. *Id.*

114. Daniel M. Fox, *From TB to AIDS: Value Conflicts in Reporting Disease*, 16 HASTINGS CTR. REP. 11, 13 (1986).

115. *Id.* at 13; A.R. Ruis & Robert N. Golden, *The Schism Between Medical and Public Health Education: A Historical Perspective*, 83 ACAD. MED. 1153, 1154 (2008).

116. Daniel Callahan & Bruce Jennings, *Ethics and Public Health: Forging a Strong Relationship*, 92 AM. J. PUB. HEALTH 169, 170 (2002).

populations.[117] Public health ends up placing higher ethical priority on utility and intrinsic outcomes than traditional medical ethics.[118]

In some respects, medical ethics guidance resembles ethical standards from other professions because of the shared emphasis on relational obligations and loyalty to the professional's "client." For example, traditional legal ethics generally instructed the attorney to put the client's interests first and expected very little of lawyers in terms of the interests of the community. Under the traditional view, "the only ethical duty distinctive to the lawyer's role is loyalty to the client. Legal ethics impose no responsibilities to third parties or the public different from that of the minimal compliance with law that is required of everyone."[119] The updated American Bar Association Model Rules of Professional Conduct ("ABA Model Rules") are more ambivalent about the lawyer's primary role as zealous advocate, contending that a lawyer, in addition to a representative of the client, acts as "a public citizen having special responsibility for the quality of justice."[120] Attorneys also have duties as "officers of the court" that may conflict with zealous client representation, such as not making false statements to a tribunal and not advising opposing parties unrepresented by counsel.[121] These extra client responsibilities are largely about the lawyer's conduct in preserving the integrity of the adjudicative process and legal institutions.[122]

One might question why determining physician's responsibilities beyond the patient is really any different or more difficult than how the legal profession addresses the question of duties beyond the client. However, the physician's role is not really comparable to the lawyer's more constrained function of advocacy within a dispute resolution system, raising doubts about the usefulness

117. Lawrence O. Gostin & Lindsey F. Wiley, *Public Health Ethics and Law*, HASTINGS CTR. BIOETHICS BRIEFINGS (Sept. 23, 2015), https://www.thehastingscenter.org/briefingbook/public-health/ [https://perma.cc/7HZS-HBTP].

118. Anna C. Mastroianni, Jeffrey P. Kahn & Nancy E. Kass, *Public Health Ethics: An Introduction and Overview*, *in* THE OXFORD HANDBOOK OF PUBLIC HEALTH ETHICS, at xxxii (Anna C. Mastroianni, Jeffrey P. Kahn & Nancy E. Kass eds., 2019).

119. WILLIAM H. SIMON, THE PRACTICE OF JUSTICE: A THEORY OF LAWYERS' ETHICS 8 (1998).

120. MODEL RULES OF PRO. CONDUCT pmbl. § 1 (AM. BAR ASS'N 2020). The ABA Model Rules also temper the lawyer's zealous advocacy role by stating such advocacy must still be "within the bounds of law, while maintaining a professional, courteous and civil attitude toward all persons involved in the legal system." *Id.* pmbl. § 9; *see also* David Luban, *Reason and Passion in Legal Ethics*, 51 STAN. L. REV. 873, 883–84 (1999).

121. *See* MODEL RULES OF PRO. CONDUCT r. 3.3; MODEL RULES OF PRO. CONDUCT r. 4.3; Eugene R. Gaetke, *Lawyers as Officers of the Court*, 42 VAND. L. REV. 39, 60–61 (1989).

122. One possible exception is Rule 1.6(b)—the ethical rule permitting lawyers to breach client confidences to prevent reasonably certain death, substantial bodily harm, or crime/fraud in which the lawyer's services were used. MODEL RULES OF PRO. CONDUCT r. 1.6(b). Rule 1.6(b) more directly prevents community members from harm, as much as it helps preserve the integrity of legal dispute resolution. However, Rule 1.6(b) is permissive, not a binding duty, and in any event applies only in very limited factual scenarios.

of generalizing from legal ethics to medical ethics.[123] Also, private physicians might be thought to have more robust societal obligations because of their quasi-public status, given their participation in governmental health care programs like Medicare and their role as gatekeeper to limited health care resources. Further, medical ethics is ultimately distinguishable from legal ethics in how it treats the professional's responsibilities to society. Lawyers' ethical responsibilities to society seem largely directed at preserving the institutional integrity of the judicial system and the quality of the adjudicative process, so that all deserving parties using legal services may secure justice. But conventional medical ethics expressly mentions physicians' obligations to better public health as an independent responsibility of the professional, not necessarily connected to caring for the patient or safeguarding particular health care institutions.[124] Medical ethics seemingly endorses a larger, autonomous role for physicians to act for the interests of the populace, yet significantly undermines this role by also insisting that physicians always prioritize patient care. Thus, medical ethics ultimately makes the question of the professional's community responsibilities far more elusive. Following this guidance, physicians must struggle with the incongruity of "being a perfect agent for the patient and being the protector of society."[125]

B. *Public Health Ethics*

Newer professional guidance, beyond the AMA Code, attempts to address more squarely the ethical tensions that arise in public health practice and safeguarding the community at large. For example, the Public Health Leadership Society Code ("PHLS Code") developed by the Public Health Leadership Society,[126] and formally adopted by the American Public Health Association,[127] notes that "[t]he concerns of public health are not fully consonant with those of medicine, . . . thus we cannot simply translate the [traditional] principles of medical ethics to public health. . . . [I]n contrast to medicine, public health is concerned more with populations than with

123. *See* William M. Sage, *Physicians as Advocates*, 35 HOUS. L. REV. 1529, 1532 (1999) ("To a lawyer, advocating for clients means playing a focused, instrumental part in a broader social system of dispute resolution. Doctors do not see their role as similarly limited. Rather, physicians have served as counsel, judge, and jury—articulating possibilities, presenting and weighing evidence, balancing competing considerations, and arriving at a decision as to the manner in which the resources of the health care system should be brought to bear on illness or injury.").

124. *See supra* notes 100–05 and accompanying text.

125. Sage, *supra* note 123, at 1578.

126. *See* PUB. HEALTH LEADERSHIP SOC'Y, PRINCIPLES OF THE ETHICAL PRACTICE OF PUBLIC HEALTH (2002), https://www.apha.org/-/media/files/pdf/membergroups/ethics/ethics_brochure.ashx [https://perma.cc/PAL9-6XEV].

127. *See* James C. Thompson, Michael Sage, Jack Dillenberg & V. James Guillory, *A Code of Ethics for Public Health*, 92 AM. J. PUB. HEALTH 1057, 1058 (2002).

individuals."[128] As previously noted, the AMA Code recognizes physicians have public health and individual patient responsibilities, but in rather wishy-washy fashion states these dual obligations should be "balanced" without saying much more how to do so or, alternatively, makes quite plain the higher priority of individual patient welfare. In contrast, the PHLS Code provides support for tipping the balance more readily in favor of community interests:

> [There is] the common need in public health to weigh the concerns of both the individual and the community. There is no ethical principle that can provide a solution to this perennial tension in public health. We can highlight, however, that the interest of the community is part of the equation, *and for public health it is the starting place in the equation; it is the primary interest of public health*.[129]

While offering a provocative alternative perspective to the AMA Code about the dual-obligation problems for physicians in addressing individual versus public health, the PHLS Code likely holds little sway over community physicians. It is not even necessarily applicable to private physicians in ordinary clinical settings. The PHLS Code follows the longstanding sharp division between individual medicine and public health, stating that it is intended primarily for "public and other institutions . . . that have an explicit public health mission," whereas regular clinicians are advised merely that they "may also find the [PHLS] Code relevant and useful."[130]

C. *Medical Norms*

Medicine's professional norms also slight the health needs of the community in favor of patient primacy. New physicians become members of a medical culture that emphasizes fidelity to, and doing the best possible for, the patient at hand. Indeed, most medical school graduates take formal pledges to put the patient's welfare first, with common language such as "[t]he health and life of my patient will be my first consideration."[131] Acting as a gatekeeper and other public health-oriented actions fit awkwardly with this sense of professional mission.[132]

Part of medical culture's discomfort with public health arises from how physicians are educated and trained. Medical education historically paid little attention to public health topics. Influential groups such as the Institute of Medicine have called for medical schools to provide greater training in public

128. PUB. HEALTH LEADERSHIP SOC'Y, *supra* note 126, at 5.

129. *Id.* at 7 (emphasis added).

130. *Id.* at 1.

131. *See* Audiey C. Kao & Kayhan P. Parsi, *Content Analyses of Oaths Administered at U.S. Medical Schools in 2000*, 79 ACAD. MED. 882, 884 (2004).

132. JEROME GROOPMAN, HOW DOCTORS THINK 82 (2007) ("Alas, serving as a gatekeeper to limit access is not what most doctors envisioned when they chose primary care.").

health and population-based prevention strategies.[133] Indeed, there is a growing consensus that "contemporary health challenges facing physicians will not be solved by clinical care alone. In our increasingly complex healthcare environment, physicians will need to integrate population-based management strategies . . . to optimally meet direct care needs . . . ."[134] However, effective integration of public health into the medical school curriculum has proven quite challenging for many reasons, including competing demands of more conventional medical topics, and medical students report dissatisfaction with their training in core public health competencies.[135]

Further, the fact that much of physicians' work is treatment oriented around particular episodes of care makes it harder for physicians to adopt population-based perspectives in their decision-making. The understandable default norm is to deal with the patient at hand, case by case. As the ACS noted in its COVID-19 pandemic guidance:

> Most physicians . . . are used to making decisions based on what is best for each individual patient. . . . [Now i]t is no longer a matter of what will be best for each individual patient, but rather, what is best for the group. . . . [I]t is an approach to which many of us are unaccustomed.[136]

Indeed, medical norms encourage physicians to treat individual patients differently from abstract groups of patients or the "community" at large. Studies indicate that physicians have stronger feelings of obligation to help individually known patients, as opposed to more diffuse groups like future patients or the general public.[137] This reflects the centrality of the healing relationship with patients to physicians' sense of professional identity. Just as health law more readily finds the physicians' duties arising from and defined in relation to an individual patient, physicians themselves apparently feel a greater sense of obligation to patients actively under their care, not other groups and, therefore, not the populace. This is consistent with the higher value often placed

133. INST. OF MED., WHO WILL KEEP THE PUBLIC HEALTHY?: EDUCATING PUBLIC HEALTH PROFESSIONALS FOR THE 21ST CENTURY 135 (Kristine Gebbie, Linda Rosenstock & Lyla M. Hernandez eds., 2003).

134. Christopher P. Morley, Scott R. Rosas, Ranit Mishori, William Jordan, Yumi Shitama Jarris, Fam. Med./Pub. Health Competencies Work Grp. & Jacob Prunuskee, *Essential Public Health Competencies for Medical Students: Establishing a Consensus in Family Medicine*, 29 TEACHING & LEARNING MED. 255, 255 (2017) (footnote omitted).

135. Kevin Correll Keith, Bethany Carlos, Michele Friesinger, Kemp Anderson, Kelsey Wilson, Donna Kern, Debra Hazen-Martin & Chanita Hughes-Halbert, *Student Perspectives on Public Health Education in Undergraduate Medical Education*, 15 DIVERSITY & EQUITY HEALTH CARE 234, 239 (2018); Morley et al., *supra* note 134, at 261–62.

136. *Ethical Considerations*, AM. COLL. SURGEONS (Mar. 24, 2020), https://www.facs.org/covid-19/newsletter/032420/ethics [https://perma.cc/A3KU-RWWQ].

137. *See* Donald A. Redelmeier & Amos Tversky, *Discrepancy Between Medical Decisions for Individual Patients and for Groups*, 322 NEW ENG. J. MED. 1162, 1163 (1990).

on identifiable rather than statistical lives, a bias that complicates effective policy making in public health.[138]

III. RISK EXTERNALIZATION TO THE PUBLIC

The patient-primacy directive, combined with the elusiveness of physicians' public health duties, enables externalization of health risks from patients to the population at large. This problematic risk externalization occurs not only during times of public health crisis like the COVID-19 pandemic, but also in more seemingly stable periods. Indeed, the risks are often insidious, presenting ongoing threats to community health. This part considers examples across the wide public health space: COVID-19, antibiotic resistance, infectious disease reporting, opioid prescribing, and gun violence.

A. *COVID-19*

One important public health strategy deployed during the COVID-19 pandemic has been delay of elective procedures for non-COVID-19 patients. This can help minimize virus transmission opportunities and preserve the health care system's limited capacity, including equipment and staffing, for fighting COVID-19. Of course, the term "elective" is somewhat misleading and highly contestable, as seen by controversies and differing court opinions regarding attempts by some states to halt abortions as elective procedures.[139] Rather than a binary choice between clearly elective and nonelective, most medical procedures likely align on a spectrum from emergency to urgent to essential to nonessential, and delays present varying degrees of impediment and risk to different patients undergoing the same procedures.

In March 2020, a growing public health consensus emerged favoring a pause in nonessential care. Governmental agencies like the CDC and professional associations like the ACS issued recommendations along these lines.[140] Eventually, many states moved beyond the advisory stage and imposed

138. *Id.* at 1164.

139. *Compare* S. Wind Women's Ctr. LLC v. Stitt, 455 F. Supp. 3d 1219, 1231 (W.D. Okla. 2020) (holding abortions to be elective, but counter to the governor's COVID-19 directive, that prohibiting them would cause imminent, irreparable harm, thus permitting some abortions to be performed), *with In re* Rutledge, 956 F.3d 1018, 1031 (8th Cir. 2020) (upholding an Arkansas COVID-19 emergency directive that all nonemergency surgical procedures, including surgical abortions, be postponed).

140. *COVID-19: Recommendations for Management of Elective Surgical Procedures*, AM. COLL. SURGEONS (Mar. 13, 2020), https://www.facs.org/covid-19/clinical-guidance/elective-surgery [https://perma.cc/4QZD-VMEW]. For the more recent CDC guidance, see *Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States*, *supra* note 2.

uniform restrictions on elective procedures, often through executive orders from governors and state health departments.[141]

Interestingly, before states imposed more uniform restrictions, and yet while the community health risks of elective procedures were highlighted in vigorous public debate,[142] several physicians continued to perform procedures generally considered less essential and nonurgent, like spinal decompression and Tommy John surgery.[143] These physicians defended their conduct based on doing the best for the patients under their care. For example, Dr. Neal ElAttrache, a highly regarded orthopedic surgeon and president of the American Orthopaedic Society for Sports Medicine, performed Tommy John surgery on several athletes during this period.[144] Acknowledging the public health risks, he maintained that he was obligated to cure his patients and remained focused on how delays would affect them personally, observing, "[Y]ou have somebody's career at stake and they lose two seasons instead of one."[145] Likewise, many dermatology practices remained open in late March, despite public health calls to limit such in-person care, and in apparent contradiction of guidelines from the American Academy of Dermatology to reschedule all nonessential visits or instead switch to telemedicine.[146]

Reasons beyond patient primacy likely motivated these providers to keep offering such nonessential services amid a pandemic, such as physicians' desire to stay active and hopes that treatment protocols could be improved with experience. Undoubtedly, economic considerations mattered as physician practices faced significant financial losses from restricting services. Many of the dermatology practices that remained open in this period were owned by private

141. *See, e.g.*, Colo. Exec. Order 2020 009 (Mar. 19, 2020), https://www.colorado.gov/governor/sites/default/files/inline-files/D%202020%20009%20Ordering%20Cessation%20of%20All%20Elective%20Surgeries_0.pdf [https://perma.cc/QLH6-NQHA]; Fla. Exec. Order No. 20-72 (Mar. 20, 2020), https://www.flgov.com/wp-content/uploads/orders/2020/EO_20-72.pdf [https://perma.cc/ZW4C-UTHH]; N.Y. Exec. Order No. 202.10 (Mar. 23, 2020), https://www.governor.ny.gov/sites/default/files/atoms/files/EO_202.10.pdf [https://perma.cc/V4SQ-WYFD].

142. *See, e.g.*, Tara Bannow, *UPMC Defends Decision To Continue with Some Elective Surgeries*, MOD. HEALTHCARE (Mar. 23, 2020, 4:43 PM), https://www.modernhealthcare.com/providers/upmc-defends-decision-continue-some-elective-surgeries [https://perma.cc/52XY-UL8M].

143. *See supra* notes 1–2 and accompanying text. For more about Tommy John surgery, see *supra* note 1.

144. Henry Schulman, *Top Tommy John Surgeon Defends Procedures Done During Coronavirus Outbreak*, S.F. CHRON., https://www.sfchronicle.com/giants/article/Top-Tommy-John-surgeon-defends-procedures-done-15154721.php [https://perma.cc/F25L-RXFR (dark archive)] (Mar. 24, 2020, 4:46 PM); *Los Angeles-Based Surgeon, Neal ElAttrache, MD Inducted as AOSSM President*, AM. ORTHOPAEDIC SOC'Y FOR SPORTS MED., https://www.sportsmed.org/aossmimis/Members/About/Press_Releases/2018-Annual-Meeting/ElAttrache-Inducted-President.aspx [https://perma.cc/JS4X-EP5X].

145. Schulman, *supra* note 144.

146. Katie Hafner, *Many Dermatology Practices Stay Open, Ignoring Public Health Pleas*, N.Y. TIMES (Apr. 8, 2020), https://www.nytimes.com/2020/04/08/health/coronavirus-telemedicine-dermatology.html [https://perma.cc/A8DL-QF97 (dark archive)].

equity firms and faced pressures to generate practice revenues for investors.[147] But the physicians' stated reasons, even if somewhat pretextual, for continuing these services predictably referenced the patient-primacy directive and doing what was best for their patients. Thus, it would be wrong to dismiss these physicians as outliers. The more general and concerning point is that because their public health responsibilities were so elusive, these physicians had considerable discretion to downgrade public health concerns to an alarming degree and faced no legal repercussions for doing so. Meanwhile, the "patients first" rationale was so broad and seemingly beyond reproach that it could obscure financial incentives and other questionable reasons at odds with community health protection.

In urging physicians to delay less-essential procedures, professional societies like the ACS issued thoughtful guidance about how surgeons should prioritize services amid a pandemic.[148] However admirable, the ACS guidance also reflected the still overwhelming influence of patient primacy. It argued that "in periods of absolute scarcity of resources, public health ethics is the far more responsible framework to adopt."[149] This reasoning, unfortunately, ignores how insufficient attention to public health effects can endanger the health of the community even in mundane periods between declared emergencies.[150] If physicians recognize and embrace public heath duties only when resources are already significantly limited, it will likely be too little, too late.

Likewise, during the COVID-19 surge in December 2020, the National Academy of Medicine ("NAM"), the AMA, and other provider organizations called for regulatory support for shifting from typical delivery methods to "crisis standards of care."[151] They argued that because the pandemic had severely strained resources, decisions needed to be made, such as canceling nonemergency procedures, "to do the most good possible for the largest number."[152] Yet even with this call for a more express public health orientation in practice standards, ensuring public health concerns command sufficient physician attention still has proven difficult. This is due to the considerable orbital pull of patient primacy. For example, NAM's more specific guidance to individual health care providers about incorporating crisis standards of care expects, somewhat incongruously, that a physician account for community

147. *Id.*

148. *COVID-19: Recommendations for Management of Elective Surgical Procedures*, *supra* note 140.

149. *Ethical Considerations*, *supra* note 136.

150. *See infra* Sections III.B–E.

151. *National Organizations Call for Action To Implement Crisis Standards of Care During COVID-19 Surge*, NAT'L ACAD. MED. (Dec. 18, 2020), https://nam.edu/national-organizations-call-for-action-to-implement-crisis-standards-of-care-during-covid-19-surge/ [https://perma.cc/6LDC-MU9R].

152. *Id.*

needs while also assuming a duty of care "for each patient, without bias, *to the best of your ability*."[153]

At the other end of the spectrum, heightened attention to COVID-19 patients in certain instances may have unintentionally endangered community health by glossing over negative spillover effects for the population. For example, pediatric vaccination rates dangerously plummeted during the early months of the pandemic, increasing community health risks due to potential loss of herd immunity and transmission of vaccine-preventable diseases.[154] While this was in part due to parental fears about children acquiring COVID-19 in doctors' offices, health care providers' reduced availability of well-child visits likely also interfered with needed vaccination schedules.[155]

Many public health interventions focus on prevention. Health researchers worry that the delay of preventive care during the pandemic, such as colonoscopies and mammograms, will end up posing serious long-term health risks for the population, with potentially higher incidence rates of cancer and other diseases.[156] Similarly, to preserve resources and manpower for COVID-19 patients, several medical centers mandatorily suspended all their ongoing clinical trials in the early months of the pandemic.[157] Such aggressive action seems justified when focused on doing what is best for COVID-19 patients. But it discounts resulting health risks for the population as "[o]ngoing trials have potential to benefit millions of people with debilitating chronic diseases long after the coronavirus pandemic has ended."[158]

153. DAN HANFLING, JOHN HICK, RICK HUNT & ERIC TONER, CRISIS STANDARDS OF CARE: QUICK GUIDANCE FOR HEALTH CARE PROVIDERS (2020), https://nam.edu/wp-content/uploads/2020/12/csc-provider-guide_updated.pdf [https://perma.cc/DCJ5-GLBN] (emphasis added).

154. Jeanne M. Santoli, Megan C. Lindley, Malini B. DeSilva, Elyse O. Kharbanda, Matthew F. Daley, Lisa Galloway, Julianne Gee, Mick Glover, Ben Herring, Yoonjae Kang, Paul Lucas, Cameron Noblit, Jeanne Tropper, Tara Vogt & Eric Weintraub, *Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration — United States, 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 591, 591 (2020); Melissa Jenco, *AAP Urges Vaccination as Rates Drop Due to COVID-19*, AAP NEWS (May 8, 2020), https://www.aappublications.org/news/2020/05/08/covid19vaccinations050820 [https://perma.cc/QM2N-BZ74].

155. Jan Hoffman, *Vaccine Rates Drop Dangerously as Parents Avoid Doctor's Visits*, N.Y. TIMES (Apr. 23, 2020), https://www.nytimes.com/2020/04/23/health/coronavirus-measles-vaccines.html [https://perma.cc/6H7G-6M5K (dark archive)].

156. Sarah Kiff, *Missed Vaccines, Skipped Colonoscopies: Preventative Care Plummets*, N.Y. TIMES (Sept. 11, 2020), https://www.nytimes.com/2020/09/11/upshot/pandemic-decline-preventive-care.html [https://perma.cc/M5W6-EK8W (dark archive)].

157. Mary M. McDermott & Anne B. Newman, *Preserving Clinical Trial Integrity During the Coronavirus Pandemic*, 323 JAMA 2135, 2135 (2020).

158. *Id.*

B. *Antibiotic Prescribing*

The "antibiotic paradox" means that prescribing an antibiotic can have dual, contradictory effects—combatting targeted illness for one patient while also increasing resistant bacterial strains in the community and jeopardizing the medication's effectiveness when used again for future health threats.[159] Thus, for public health reasons, physicians must sometimes conserve use of antibiotics when the medication might offer only marginal benefit to the patient, because of the larger concern of minimizing bacterial resistance.

Yet physicians have performed poorly as prudent stewards of the antibiotic supply.[160] Studies suggest that physicians frequently engage in inappropriate antibiotic prescribing, over ordering the drugs by as much as fifty percent and contributing to resistance pressures.[161] Inappropriate prescribing includes not only ordering antibiotics for viral infections, for which the drugs are ineffective, but also prescribing the medications at incorrect dosage and intervals, failure to monitor patients' use of the medications after ordered, and using broad-spectrum agents when narrower-spectrum drugs would suffice.[162]

Taking on the necessary gatekeeping responsibilities runs counter to physicians' preferred and seemingly simpler role as zealous healers for individual patients. Indeed, evidence suggests that physicians privilege their patients and do not attach sufficient weight to public health concerns when deciding on a course of antibiotic therapy.[163] In a study of attitudes about antibiotic prescribing, researchers asked a national sample of physicians to opine about which types of drugs they would order for a sample patient with

159. STUART B. LEVY, THE ANTIBIOTIC PARADOX: HOW THE MISUSE OF ANTIBIOTICS DESTROYS THEIR CURATIVE POWERS, at XII–XIV (2002).

160. *See generally* Richard S. Saver, *In Tepid Defense of Population Health: Physicians and Antibiotic Resistance*, 34 AM. J.L. & MED. 431 (2008) (discussing the physicians' poor track record, and limited incentives, in conserving antibiotics).

161. Katherine E. Fleming-Dutra, Adam L. Hersh, Daniel J. Shapiro, Monina Bartoces, Eva A. Enns, Thomas M. File Jr., Jonathan A. Finkelstein, Jeffrey S. Gerber, David Y. Hyun, Jeffrey A. Linder, Ruth Lynfield, David J. Margolis, Larissa S. May, Daniel Merenstein, Joshua P. Metlay, Jason G. Newland, Jay F. Piccirillo, Rebecca M. Roberts, Guillermo V. Sanchez, Katie J. Suda, Ann Thomas, Teri Moser Woo, Rachel M. Zetts & Lauri A. Hicks, *Prevalence of Inappropriate Antibiotic Prescriptions Among US Ambulatory Care Visits, 2010-2011*, 315 JAMA 1864, 1869 (2016).

162. Labeling Requirements for Systematic Antibacterial Drug Products Intended for Human Use, 68 Fed. Reg. 6062, 6068 (Feb. 6, 2003) (codified at 21 C.F.R. pt. 201); *cf.* Ross J. Simpson, Jr., *Challenges for Improving Medication Adherences*, 296 JAMA 2614, 2614 (2006) (discussing how patient education and structural support could help improve medication adherence in elderly patients).

163. *See, e.g.*, Bernadine Dao, Thomas Douglas, Alberto Giubilini, Julian Savulescu, Michael Selgalid & Nadira S. Faber, *Impartiality and Infectious Disease: Prioritizing Individuals Versus the Collective in Antibiotic Prescription*, 10 AJOB EMPIRICAL BIOETHICS 63, 64 (2019) ("There is evidence that doctors frequently prioritize individual patient health over public health when deciding whether to prescribe antibiotics . . . .").

community-acquired pneumonia.[164] The physicians were more likely to order new broad-spectrum drugs even though infectious disease guidelines recommended use of other antibiotics to minimize resistance pressures.[165] Even more revealing, when asked to rank which factors (such as side effects, efficacy, and cost to patient) mattered most in their decision-making, most physicians placed the societal risk of antibiotic resistance at or very near the bottom.[166] The study authors concluded from the data that whenever faced with the tension between following the interests of the individual patient and population health concerns about antibiotic resistance, physicians discounted the public interest.[167]

Antibiotic resistance dramatically demonstrates the fallacy of the medicine/public health divide. Decisions within the confines of an individual doctor-patient relationship cannot be neatly sequestered from the health of the population. Indeed, antibiotic resistance problems usually start in local regions, such as a single hospital or clinic through institution-acquired infection or in small geographic areas, and then spread outward. In these localized environments the actions of just a small number of physicians with sufficient patient load can introduce strong selection pressures for resistant disease strains that affect the entire community.[168]

Law's patient-primacy directive seems to discourage physicians from engaging in antibiotic conservation. First, consider informed consent. Informed consent doctrine generally requires a physician to advise the patient about a proposed treatment's material risks. But the law is so patient focused that courts conceive of these risks as the harms that may materialize for the patient, not the populace.[169] A physician is under no legal obligation to inform the patient about the resistance risks and dangers to community health from inappropriate antibiotic use, such as if the patient fails to adhere to the medication schedule.[170]

Second, fiduciary duty obligations also may be at odds with prudent antibiotic stewardship. For example, antibiotic resistance concerns would counsel physicians to restrict antibiotic use to only high-value uses for their patients and to avoid initially prescribing where the patient only *might* benefit

164. Joshua P. Metlay, Judy A. Shea, Linda B. Crossette & David A. Asch, *Tensions in Antibiotics Prescribing: Pitting Social Concerns Against the Interest of Individual Patients*, 17 J. GEN. INTERNAL MED. 87, 87 (2002).

165. *Id.*

166. *Id.*

167. *See id.*

168. INST. OF MED., ANTIMICROBIAL RESISTANCE: ISSUES AND OPTIONS 37 (Polly F. Harrison & Joshua Lederberg eds., 1998); David M. Livermore, *Bacterial Resistance: Origins, Epidemiology, and Impact*, 36 CLINICAL INFECTIOUS DISEASES S11, S15–S16 (2003).

169. *See* Wendy E. Parmet, *Unprepared: Why Health Law Fails To Prepare Us for a Pandemic*, 2 J. HEALTH & BIOMEDICAL L. 157, 174 (2006).

170. *Id.* at 176.

and where the degree of benefit is likely small.[171] Another antibiotic conservation technique is to cycle medications, deliberately altering and rotating different classes of antibiotics in episodes of care for particular patients.[172] But fiduciary duty problems can arguably arise if a physician follows these strategies. A physician is not clearly acting as a fiduciary in advancing the patient's interests above all others if the physician restricts the patient from even marginal benefits of using a medication. Likewise, a physician who cycles medications may override a patient's legitimate preferences for one drug over another, given differences in side effects and costs among other reasons.

C. *Disease Reporting*

Disease surveillance, a fundamental public health activity, provides the critical foundation for contact tracing, resource mobilization, education, planning, and other control and prevention measures.[173] As part of disease surveillance, every state has statutory and regulatory requirements that physicians, clinical laboratories, and select other health care providers report various infectious disease cases to public health authorities.[174] Penalties for noncompliance are usually modest. As an illustration, Florida's statute provides for misdemeanor civil fines up to $500.[175] A few disease-reporting statutes also impose potential criminal sanctions, but the penalties are rarely applied.[176] As previously noted, a few states' medical practice acts expressly condition physician licensure on compliance with disease-reporting obligations, although actual licensure discipline for nonreporting seems quite rare.[177] Finally, the existence of a disease-reporting statute may be used to establish a duty and

171. *See* Ben Parsonage, Philip K. Hagglund, Lloyd Keogh, Nick Wheelhouse, Richard E. Brown & Stephanie J. Dancer, *Control of Antimicrobial Resistance Requires an Ethical Approach*, 8 FRONTIERS MICROBIOLOGY 1, 2 (2017) (discussing the dilemma in helping patients and the public).

172. *See* Geraldine Mary Conlon-Bingham, Mamoon Aldeyab, Michael Scott, Mary Patricia Kearney, David Farren, Fiona Gilmore & James McElnay, *Effects of Antibiotic Cycling Policy on Incidence of Healthcare-Associated MRSA and* Clostridioides difficile *Infection in Secondary Healthcare Settings*, 25 EMERGING INFECTIOUS DISEASE 52, 52 (2019).

173. Maxim Gakh, Brian Labus & Brittany Walker, *Characteristics of Laws Requiring Physicians To Report Patient Information for Public Health Surveillance: Notable Patterns from a Nevada Case Study*, 43 J. CMTY. HEALTH 328, 328 (2018) ("Reporting information for public health surveillance purposes is imperative for public health practice, including disease and injury investigation, pattern identification, treatment, and control.").

174. *See, e.g.*, N.C. GEN. STAT. § 130A-135 (LEXIS through Sess. Laws 2021-4 of the 2021 Reg. Sess. of the Gen. Assemb.); 10A N.C. ADMIN. CODE 41A.0101 (Westlaw through Feb. 10, 2021).

175. FLA. ADMIN. CODE ANN. r. 64D-3.029, -3.047 (LEXIS through Mar. 31, 2021).

176. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, PUBLIC HEALTH LAW 101: A CDC FOUNDATIONAL COURSE FOR PUBLIC HEALTH PRACTITIONERS 18, https://www.cdc.gov/phlp/docs/phl101/PHL101-Unit-5-16Jan09-Secure.pdf [https://perma.cc/8WNH-ZSNR].

177. *See, e.g.*, N.J. STAT. ANN. § 45:1-21 (Westlaw through L.2021, c. 32 and J.R. No. 1); N.J. ADMIN. CODE § 13:35-6.24 (LEXIS through the New Jersey Reg., Vol. 53 No. 7, Apr. 5, 2021); *see also supra* text accompanying note 74.

define the standard of care in private common-law claims against physicians for third-party exposure to infectious disease.[178]

Despite the clear statutory mandates, community physicians show little enthusiasm for following disease-reporting requirements. Compliance has been characterized as "inconsistent, infrequent, and delayed."[179] Physicians have historically performed poorly as mandatory reporters.[180] Surveys show compliance rates ranging from about forty to fifty-six percent for common sexually transmitted diseases such as chlamydia and AIDS.[181]

Physician noncompliance may, at first blush, seem largely a problem of lax enforcement and insufficient deterrence incentives. As noted, the direct and indirect sanctions for noncompliance are limited and rarely applied. In this respect, physicians' disease-reporting duties follow the elusivity pattern. The legal requirements are more law-in-books than law-in-action: acknowledged but not really commanding influence. But the noncompliance problems indicate deeper problems of physician disengagement. After all, individuals adhere to mandates and statutory obligations, even when infrequently enforced, when they have more intrinsic motivations for compliance.[182] With regard to disease reporting, however, physicians apparently have limited intrinsic motivation, reflecting the underweighting of public health considerations. The stated reasons for physician noncompliance have varied over time, including concerns of patient confidentiality, technical questions about the utility of the case reports themselves, and confusion as to which diseases are reportable.[183] Additional factors frequently mentioned include the burdensome time and resource commitment, insufficient rewards for reporting, and physicians relying

178. *See supra* Section I.B.1.

179. Mary-Margaret A. Fill, Rendi Murphree & April C. Pettit, *Healthcare Provider Knowledge and Attitudes Regarding Reporting Diseases and Events to Public Health Authorities in Tennessee*, 23 J. PUB. HEALTH MGMT. PRAC. 581, 582 (2017).

180. Rene Bowser & Lawrence O. Gostin, *Managed Care and the Health of a Nation*, 72 S. CAL. L. REV. 1209, 1259 (1999); *see* Timothy J. Doyle, M. Kathleen Glynn & Samuel L. Groseclose, *Completeness of Notifiable Infectious Disease Reporting in the United States: An Analytical Literature Review*, 155 AM. J. EPIDEMIOLOGY 866, 871 (2002) (finding that reporting completeness for diseases other than AIDS, sexually transmitted diseases, and tuberculosis is only forty-nine percent).

181. *See* Janet S. St. Lawrence, Daniel E. Montaño, Danuta Kasprzyk, William R. Phillips, Keira Armstrong & Jami S. Leichliter, *STD Screening, Testing, Case Reporting, and Clinical and Partner Notification Practices: A National Survey of US Physicians*, 92 AM. J. PUB. HEALTH 1784, 1787 (2002) (indicating that only slightly more than half of physicians make required case reports for sexually transmitted diseases such as syphilis and HIV and that many physicians prefer to rely on their patients for partner notification).

182. *See, e.g.*, Kristen Underhill, *When Extrinsic Incentives Displace Intrinsic Motivation: Designing Legal Carrots and Sticks To Confront the Challenge of Motivational Crowding-Out*, 33 YALE J. REGUL. 213, 219–20 (2016).

183. Fox, *supra* note 114, at 14; Gakh et al., *supra* note 173, at 329.

on other health care team members—particularly clinical laboratories conducting disease testing—to make the required reports.[184]

Some of these reasons seem pretextual. For example, complaints about breaching confidentiality are likely overstated as public health officers have historically treated physician case reports as strictly confidential.[185] Further, the federal medical privacy law, the Health Insurance Portability and Accountability Act ("HIPAA"),[186] has a broad public health exception that permits provider reporting of infectious disease incidents to public health agencies.[187]

Other reasons seem evasive. Physicians' inclination to delegate reporting responsibilities to clinical laboratories, for example, neglects the importance of physician involvement. Many disease-reporting statutes apply broadly to include instances of *suspected* disease incidents, not just confirmed cases resulting from laboratory tests.[188] Physicians' clinical impressions matter greatly when classifying an individual as a suspected case. Further, certain diseases and syndromes like pediatric influenza deaths do not have confirmatory laboratory tests available at all, so effective public health surveillance depends largely on physicians' clinical judgment to identify these incidents.[189]

The varied reasons offered for physician noncompliance obscure a more fundamental problem: many physicians perceive their core professional obligations as largely distinct from basic public health practices. Indeed, public health practitioners and private physicians view disease reporting through very different perspectives. Public health practitioners envision effective disease reporting as instrumental for necessary surveillance. They consider participation in disease reporting as part of each provider's shared accountability for the health of the populace. But private physicians have been far more wary of disease reporting, in particular how it may intrude upon individual treatment relationships: "Public health professionals see their first duty as protecting the population, and they justify reporting by invoking science and the ethics of collective responsibility. Private physicians, on the other hand, see their first duty as safeguarding patients; they accord a higher priority to the sanctity of their therapeutic relationships."[190]

A public health-surveillance system can only be as good as the information inputted. The long-standing problem of physician noncompliance with disease-

184. Fill et al., *supra* note 179, at 582–83; Gakh et al., *supra* note 173, at 329.

185. Fox, *supra* note 114, at 14.

186. Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 18, 26, 29, and 42 U.S.C.).

187. *See* 45 C.F.R. § 164.512(b) (2019).

188. *See, e.g.*, N.C. GEN. STAT. § 130A-135 (LEXIS through Sess. Laws 2021-4 of the 2021 Reg. Sess. of the Gen. Assemb.).

189. Fill et al., *supra* note 179, at 587.

190. GOSTIN, *supra* note 10, at 297.

reporting laws, resulting in part from privileging relationships with patients and physician indifference to weak statutory reporting duties, dangerously elevates health risks for the community.

D. *The Opioid Epidemic*

The alarming rates of opioid abuse and overdoses present a severe public health threat. Many root causes have been identified, including aggressive marketing and financial incentives offered to prescribers by pharmaceutical companies; flawed reimbursement programs that encourage prescribing-based interventions to manage chronic pain compared to safer behavioral alternatives; accreditations standards for health care institutions that stressed pain management obligations; a fragmented health care system that fails to track patients' prescriptions from a holistic perspective; and inadequate training of physicians in recognizing and treating addiction.[191] Because the opioid crisis involves many actors and moving parts, it defies easy narratives of accountability and blame.

But while many complex factors are in play, lurking less visibly beneath the surface is a familiar pattern: physicians' underweighting of the public health implications of their treatment decisions. Certain physicians are easy targets for disapproval. Physicians who prescribed large amounts of opioids, egregiously breaching standards of care,[192] as well as physicians who engaged in "pill mill" schemes to exchange prescriptions for cash,[193] certainly contributed to the current opioid crisis. But a fair number of physicians engaged in problematic opioid prescribing for less nefarious reasons. Many community physicians were swept up into, and exacerbated the opioid epidemic because of, their blinkered devotion to their individual patients.

First, physicians prescribed opioids in patterns and amounts that foreseeably permitted diversion of the medications to non-patients, fueling negative downstream effects and potential black-market dangers for the community. As Dr. Anna Lembke describes in *The New England Journal of Medicine*, one puzzle of the opioid crisis is that "[i]n many instances, doctors are

191. *See, e.g.*, Ronald Hirsch, *The Opioid Epidemic: It's Time To Place Blame Where It Belongs*, 114 MO. MED. 82, 83–84 (2017); Mark A. Rothstein, *Ethical Responsibilities of Physicians in the Opioid Crisis*, 45 J.L. MED. & ETHICS 682, 683 (2017); Mukul Mehra, *Why Opioid Addiction Will Persist Until Physicians Have a Panoramic View of Opioid Exposure*, HEALTH AFFS. (Oct. 4, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180928.934819/full/ [https://perma.cc/L7XY-3WY5].

192. *See, e.g.*, Tony Messenger, *Messenger: St. Louis Jury Verdict Sends $17.6 Million Message in Opioid Abuse Verdict*, ST. LOUIS POST-DISPATCH (June 28, 2016), https://www.stltoday.com/news/local/columns/tony-messenger/messenger-st-louis-jury-sends-17-6-million-message-in-opioid-abuse-verdict/article_b7628f83-0e94-5bc7-a2a8-38a12ab6d7d6.html [https://perma.cc/B3GP-MXTX] (discussing a physician receiving a verdict against him for prescribing opioids far above those recommended by the CDC).

193. Hirsch, *supra* note 191, at 82.

fully aware that their patients are abusing these medications or diverting them to others for nonmedical use, but they prescribe them anyway."[194] In fact, the common tendency for physicians was to prescribe thirty to ninety opioid pills per prescription even though much smaller amounts would have been medically indicated and "[i]t is the leftover pills that sit forgotten in the medicine cabinet which often lead to trouble, stolen by a relative or visitor and abused."[195] Physicians could rationalize such excessive prescribing for patient convenience, avoiding patient hassle in pursuing multiple refills. Further, physicians most interested in securing their patients' satisfaction above all else could be tempted to "just sign another prescription" for a patient rather than take on the more difficult task of confronting patients with suspected abuse problems or gatekeeping access to opioids.[196]

It is worth repeating that a fair number of physicians contributed to the opioid crisis inadvertently, but precisely because they focused so much on patient welfare. Following the newer professional guidance to take pain seriously, these physicians desired to be "good" doctors in providing relief for their patients.[197] The imperative "we don't want our patients to experience pain" commanded so much physician attention that it obscured the negative downstream public health effects of long-term opioid prescribing.[198] Believing their first priority was to their patients, and that "all suffering is avoidable," these well-meaning physicians allowed "the patient's subjective experience of pain . . . [to] take[] precedence over other, potentially competing, considerations."[199] Competing considerations that were sublimated certainly include community health risks from widespread, chronic use of opioids, such as increased rates of addiction and blood-borne, bacterial, and sexually transmitted infections.[200]

Illustrating the elusivity problem regarding physicians' public health duties, some scholars writing about the opioid crisis have aggressively advanced a message of patient primacy that bafflingly eclipses community health concerns. Worried about denying patients' access to needed pain relief, these scholars argue that in prescribing opioids, "harm to society *should weigh little, if*

194. Anna Lembke, *Why Doctors Prescribe Opioids to Known Opioid Abusers*, 367 NEW ENG. J. MED. 1580, 1580 (2012).

195. Hirsch, *supra* note 191, at 82.

196. Nicole Gastala, *Denial: The Greatest Barrier to the Opioid Epidemic*, 15 ANNALS FAM. MED. 372, 373 (2017).

197. Vernon Williams, *Are Doctors To Blame for Prescription Opioid Overuse in America?*, U.S. NEWS & WORLD REP. (Mar. 25, 2019, 6:00 AM), https://health.usnews.com/health-care/for-better/articles/are-doctors-to-blame-for-prescription-opioid-overuse-in-america [https://perma.cc/XF93-E8FL (staff-uploaded archive)].

198. Hirsch, *supra* note 191, at 82.

199. Lembke, *supra* note 194, at 1580.

200. *See* NAT'L ACAD. OF SCIS., ENG'G, & MED., OPPORTUNITIES TO IMPROVE OPIOID USE DISORDER AND INFECTIOUS DISEASE SERVICES 1 (2020).

at all, in the treating physician's assessment."[201] Such commentary reinforces the notion that physicians' duties are solely patient directed, while glossing over their public health responsibilities.

To be clear, this is not a general critique of the medical movement to treat pain seriously. In earlier eras, physicians were rightly criticized for being unconcerned with patient discomfort and for viewing pain relief as "nobody's job."[202] And physicians otherwise inclined to treat pain seriously were wary of prescribing opioids because of fear of regulatory scrutiny and professional disciplinary action for ordering controlled substances.[203] Instead, this is just recognition that however welcome the new push to relieve patient suffering, it also raised countervailing implications for public health. Rather than delicately balancing these community concerns against patient need, individual clinicians seem to have given short shrift to public health.

Particularly revealing is how physicians have reacted to prescription drug monitoring programs ("PDMPs"). PDMPs, electronic databases that track prescriptions of certain medications and often require physician query before prescribing, have been implemented by law in many states as a means to combat the opioid epidemic.[204] Yet this form of public health regulation has engendered physician resistance.[205] Part of the opposition stems from concerns that PDMPs limit physician autonomy, expose physicians to greater liability, and may open the door to displacing professional self-regulation with greater state control of medical practice. Debates about PDMPs, however, invariably include claims that this form of regulation interferes with the doctor-patient relationship. Under this view, PDMPs impede physicians' ability to provide individually tailored care by limiting treatment choices.[206] This illustrates why the patient-primacy directive exerts such strength and attraction for physicians compared to public health obligations. Patient welfare becomes deeply intertwined with, and may even provide appealing cover for, underlying anxieties about physician autonomy. In making claims about putting patients first and protecting the

201. Kate M. Nicholson & Deborah Hellman, *Opioid Prescribing and the Ethical Duty To* Do No Harm, 46 AM. J.L. & MED. 297, 299 (2020) (emphasis added).

202. DAVID W. BAKER, JOINT COMM'N, THE JOINT COMMISSION'S PAIN STANDARDS: ORIGINS AND EVOLUTION 2 (2017), https://www.jointcommission.org/assets/1/6/Pain_Std_History_Web_Version_05122017.pdf [https://perma.cc/KV2P-LJGY].

203. Diane E. Hoffmann & Anita J. Tarzian, *Achieving the Right Balance in Oversight of Physician Opioid Prescribing for Pain: The Role of State Medical Boards*, 31 J.L. MED. & ETHICS 21, 21 (2003).

204. *See Prescription Drug Monitoring Programs*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/pdmp/states.html [https://perma.cc/86E7-EHVN].

205. See Joanne Finnegan, *Why Many Doctors Oppose Mandatory Use of PDMPs*, FIERCE HEALTH CARE (Jan. 17, 2017, 10:39 AM), https://www.fiercehealthcare.com/practices/reasons-why-many-doctors-oppose-mandatory-use-pdmps [https://perma.cc/8QM8-C7CU].

206. Mark Barnes, John Giampa & Minal Caron, *Opioid Prescribing and Physician Autonomy: A Quality of Care Perspective*, 15 HSS J. 20, 21 (2019).

doctor-patient relationship from outside interference, physicians can resist laws that do not defer to their wide exercise of professional authority and judgment.

Further, public health laws may be more readily discounted by physicians because of their seeming inapplicability to patient circumstances. Many public health regulatory interventions, like PDMPs, address population-wide effects and therefore rely on uniform, standardized approaches. Physicians tend to be indifferent to or even suspicious of this form of regulation because they remain focused on individual patient health and "[a]pparent solutions of general applicability may result in individual cases of suboptimal medical care."[207]

While public health concerns in the initial stages of the opioid epidemic were largely about overprescribing, now there is danger of the pendulum swinging back yet again. Some physicians are creating new public health problems because of *insufficient* opioid prescribing. Because of increased scrutiny arising from the opioid crisis, these physicians have dramatically cut down on their use of opioids. Yet they are not necessarily providing adequate alternative pain-relief interventions for their chronic pain patients, while other physicians have abruptly stopped treating any patients suspected of abusing opioids.[208] This imperils not only the health of patients who may be going through withdrawal, but also the health of the community because of the downstream effects of such drastic limitations of care, including increased risk of infectious disease and other health-harming behavior. This is because "[l]eft to their own devices, many of these individuals begin using heroin or illegally obtained synthetic opioids, become infected with hepatis B or C or HIV, or suffer the catastrophic effects of an overdose."[209]

Physicians who engage in insufficient prescribing are not exactly prioritizing their patients' needs, so in this context it is not yet again the patient-primacy directive exerting dominance. But neither are these physicians optimally protecting the health of the community. It seems that private physicians' public health duties and internalization of a public health-oriented mission are so elusive and ephemeral that even when consciously turning away from the end goal of relieving suffering of individual patients, these physicians remain largely inattentive to the full impact of their treatment-withdrawal decisions on public health.

E. *Gun Violence*

The alarmingly high number of individuals killed or injured each year as the result of firearms has led public health officials to identify gun violence as

207. *Id.* at 22.
208. Williams, *supra* note 197.
209. Rothstein, *supra* note 191, at 683.

a public health crisis.[210] Advocates believe a public health approach is warranted not only because of the aggregate numbers of death and injuries, but also because epidemiological analysis suggests gun violence may share features with communicable diseases; exposure to gun violence can predict other incidents, and gun violence often diffuses like a contagion through connected social networks.[211] Physicians also are being asked to step up. Various medical groups including the AMA and the American Academy of Pediatrics have issued policy statements calling for greater physician involvement in combating gun violence.[212]

Physician engagement can take various forms. For example, physicians can counsel patients about the risks of guns in the home and recommend safe storage practices. Although there is a dearth of well-designed studies, research suggests physician counseling in this manner may mitigate injury risk.[213] Physicians can also conduct screenings and implement interventions for risk of suicide, given the high correlation between gun ownership and deaths involving suicide.[214] Physician screening and intervention can also reduce harms for additional high-risk populations when guns are in the home, including children, patients with dementia, patients experiencing alcohol abuse, and domestic violence victims.[215]

Although well positioned to address gun injury, physicians "ask infrequently about firearms and counsel poorly, if at all, although they are aware that the high lethality of firearms makes prevention efforts particularly important."[216] A number of barriers have been identified. Some physicians

210. *Gun Violence*, AM. PUB. HEALTH ASS'N, https://www.apha.org/topics-and-issues/gun-violence [https://perma.cc/XJ9T-V2KT].

211. *See, e.g.*, Ben Green, Thibaut Horel & Andrew V. Papachristos, *Modeling Contagion Through Social Networks To Explain and Predict Gunshot Violence in Chicago, 2006 to 2014*, 177 JAMA INTERNAL MED. 326, 327 (2017).

212. AM. ACAD. OF PEDIATRICS, *Firearm-Related Injuries Affecting the Pediatric Population*, 130 PEDIATRICS e1416, e1421 (2012); *Firearm Safety Counseling in Physician-Led Health Care Teams: H-145.976*, AM. MED. ASS'N (2018), https://policysearch.ama-assn.org/policyfinder/detail/H-145.976%20?uri=%2FAMADoc%2FHOD.xml-0-533.xml [https://perma.cc/DM6E-4KRV].

213. Brendan Parent, *Physicians Asking Patients About Guns: Promoting Patient Safety, Respecting Patient Rights*, 31 J. GEN. INTERNAL MED. 1242, 1242 (2016).

214. Howard Bauchner, Frederick P. Rivara, Robert O. Bonow, Neil M. Bressler, Mary L. (Nora) Disis, Stephan Heckers, S. Andrew Josephson, Melina R. Kibbe, Jay F. Piccirillo, Rita F. Redberg, John S. Rhee & June K. Robinson, *Death by Gun Violence—A Public Health Crisis*, 318 JAMA 1763, 1763 (2017); David M. Studdert, Yifan Zhang, Sonja A. Swanson, Lea Prince, Jonathan A. Rodden, Erin E. Holsinger, Matthew J. Spittal, Garen J. Wintemute & Matthew Miller, *Handgun Ownership and Suicide in California*, 382 NEW ENG. J. MED. 2220, 2220 (2020).

215. Marian E. Betz & Garen J. Wintemute, *Physician Counseling on Firearm Safety: A New Kind of Cultural Competence*, 314 JAMA 449, 449 (2015); Melissa Bailey, *Doctors Need To Talk to Families About Guns and Dementia*, N.Y. TIMES (Oct. 9, 2018), https://www.nytimes.com/2018/10/09/well/live/doctors-need-to-talk-to-families-about-guns-and-dementia.html [https://perma.cc/NHW3-TWGQ (dark archive)].

216. Garen J. Wintemute, Marian E. Betz & Megan L. Ranney, *Yes, You Can: Physicians, Patients, and Firearms*, 165 ANNALS INTERNAL MED. 205, 205 (2016).

report uncertainty about how to communicate with patients about guns and concerns that interventions will be ineffective.[217] Also, apprehension of legal liability has taken on outsized importance. Florida enacted a highly publicized "gag" law that sought to restrict physicians' ability to ask patients about the presence of guns in their homes and to document this information in medical records. [218] Physicians nationwide, following coverage of the Florida controversy, likely perceived that laws prevented them from talking to their patients about gun ownership and risk of injury.

Yet legal restrictions cannot fully explain the significant physician hesitancy. First, perceptions about significant legal impediments are likely mistaken. After lengthy litigation, and multiple appeals, the Eleventh Circuit held that major provisions of the Florida statute violated the First Amendment rights of physicians and struck down key provisions of the law.[219] Also, the highly publicized gag law, even before being struck down, only applied in Florida, and posed no restrictions to physicians in other states. Moreover, even in Florida, physicians were rarely asking patients about guns *before* the enactment of the gag law, so the concerns with legal liability seem somewhat of a red herring.[220]

Clearly patient primacy is also a significant part of the picture. Some physicians report hesitancy to discuss guns with patients because they worry that such inquiries damage the doctor-patient relationship.[221] Other physicians indicate concern that such discussions may infringe on their patients' privacy.[222] Such heightened concern for patient sensitivity and privacy seems oddly misplaced however. As noted, no law generally restricts physicians from asking about gun ownership and the information once gathered would be subject to usual doctor-patient confidentiality restrictions. In addition, patients are not compelled to answer the physician's questions. More importantly, physicians routinely ask patients about quite personal and sensitive information, including drug and alcohol use, sexual activity, and mental health.[223]

In addition, some physicians perceive combatting gun violence as beyond their professional scope of practice, further illustrating the elusiveness of their

217. *Id.* at 208.

218. Act of June 2, 2011, ch. 2011-112, 2011 Fla. Laws 1776 (codified as amended at FLA. STAT. §§ 381.026, 395.1055, 456.072, 790.338 (Westlaw through chs. from the 2020 2d Reg. Sess. of the 26th Legis.)).

219. Wollschlaeger v. Governor of Fla., 848 F.3d 1293, 1301 (11th Cir. 2017).

220. *Id.* at 1312 ("Here the Florida Legislature, in enacting [the firearm gag law], relied on six anecdotes and nothing more. There was no other evidence, empirical or otherwise, presented to or cited by the Florida Legislature.").

221. Wintemute et al., *supra* note 216, at 208.

222. Parent, *supra* note 213, at 1243.

223. *Id.*

public health obligations.[224] As gun ownership is a highly charged issue in the United States, both culturally and politically, it should not surprise that without clearer guidance about their professional role, physicians would opt to avoid the issue of gun-violence prevention altogether. The National Rifle Association ("NRA") has also been very adept in pushing the "scope of practice" angle. The NRA has publicly warned physicians to "stay in their lane."[225] The rationale apparently is that gun violence is not sufficiently connected to actual medical care and is therefore inappropriate for physician involvement.[226]

It is unclear why gun-violence prevention should seem so disconnected from responsible physician engagement. Physicians have direct expertise with the medical care needs that result from gun violence. They are also well positioned to identify and screen for high-risk populations, such as patients with dementia or suicidal ideation.[227] Moreover, physicians have not always limited themselves to treating existing illness. They have long adopted counseling and safety-education roles regarding external threats, conditions, and behaviors that can be potentially health harming. For example, pediatricians routinely inquire about use of car seats for their young patients[228] and physicians screen for possible exposure to lead poisoning from paint and other sources in the home.[229] Gun-violence prevention, therefore, seems equally within physicians' scope of practice. Yet uneasiness about taking on uncertain public health obligations, along with the default privileging of patient interests over community health protection, have contributed to physician hesitancy.

IV. RECALIBRATING PHYSICIANS' PUBLIC HEALTH DUTIES

Identifying the problematic risk externalization associated with physicians' elusive public health duties does not answer what to do about it. A legal shift in physicians' duties raises difficult challenges, both pragmatic and doctrinal. This part evaluates the potential obstacles to making physicians' public health duties more robust and cognizable under law. To address the insufficient theorization underlying physicians' community health obligations,

224. Wintemute et al., *supra* note 216, at 208.

225. Matthew Haag, *Doctors Revolt After N.R.A. Tells Them To 'Stay in Their Lane' on Gun Policy*, N.Y. TIMES (Nov. 13, 2018), https://www.nytimes.com/2018/11/13/us/nra-stay-in-your-lane-doctors.html [https://perma.cc/Z5J4-2MD5 (dark archive)].

226. *See, e.g.*, *Report Suggests that Doctors Are a Leading Cause of Death*, NRA-ILA (May 13, 2016), https://www.nraila.org/articles/20160513/report-suggests-that-doctors-are-a-leading-cause-of-death [https://perma.cc/4JWY-BZL6].

227. Darren Taichman, Sue S. Bornstein & Christine Liane, *Firearm Injury Prevention: AFFIRMing that Doctors Are in Our Lane*, 169 ANNALS INTERNAL MED. 885, 885 (2018).

228. *See* Dennis R. Durbin, Benjamin D. Hoffman & Council on Injury, Violence, & Poison Prevention, *Child Passenger Safety*, 142 PEDIATRICS 1, 4 (2018).

229. *See* Crista Warniment, Katrina Tsang & Sim S. Galazka, *Lead Poisoning in Children*, 81 AM. FAM. PHYSICIAN 751, 751 (2010).

this part also explores various justifications for recalibrating physicians' public health duties including, most importantly, role indispensability.

A. *Challenges in Making Public Health Duties More Robust*

Strengthening physicians' public health duties raises many potential difficulties, including unlimited liability, common law's traditional reluctance to impose affirmative duties on nonfeasant parties, and the undermining of physicians' fiduciary obligations.

1. Too Many Plaintiffs/Liability Without Limits

If law imposes stronger public health responsibilities, does this mean that each physician owes to every member of the public an actionable duty to safeguard community health? This shift might counterproductively move from limited accountability to an even worse state of overdeterrence. Rather than optimally incentivizing private physicians to take public health action, the heightened liability exposure could lead to distorted decision-making and severe limitations in the supply of physician services.

This concern with obligations to too many plaintiffs runs through the infectious disease case law. Courts have been very reluctant to extend physicians' duties to foreseeable third parties harmed by their patients' infectious diseases. The fear is that once the physician's duty extends beyond the doctor-patient relationship, no principled method exists for demarcating where the physician's duty ends. For example, in *McNulty v. City of New York*,[230] physicians treated a patient with infectious meningitis. A friend of the patient also contracted the disease. The friend alleged that the physicians breached a duty in failing to advise that she might need treatment after being in close contact with the patient.[231] The court held that the physicians owed no actionable duty to the friend. As the court observed, "[U]nderlying this reluctance [to extend duty to non-patients] is the danger that a recognition of a duty would render doctors liable to a prohibitive number of possible plaintiffs."[232] While acknowledging that it might be wise public policy for physicians to advise non-patients of their health risks from possible exposure, the court concluded that enlarging physicians' duties this broadly would go against the strong principle of "limit[ing] the legal consequences of wrongs to a controllable degree."[233]

While a challenge, the "too many plaintiffs" problem is not necessarily insurmountable. In other contexts, courts have deployed various doctrinal rules,

230. 792 N.E.2d 162 (N.Y. 2003).

231. *Id.* at 163.

232. *Id.* at 166.

233. *Id.* at 167 (Kaye, J., concurring) (quoting Tobin v. Grossman, 249 N.E.2d 419, 424 (N.Y. 1969)).

such as privity, to fix the "orbit of duty . . . to protect against crushing exposure to liability."[234] Courts in public health disputes likewise could use line-drawing rules. For example, a physician's public health duties could be held to run only to particularly foreseeable parties connected to either the physician or patient in a manner that goes beyond mere exposure to the risk emanating from the doctor-patient relationship. These connections could be close familial, social, or business relationships with either the physician or patient. Geographic proximity with the physician or patient could also be considered as a duty-defining factor, which would serve as a proxy for local community ties. Thus, the physician might owe a duty to the patient's close family, friends, coworkers, and immediate neighbors, but not necessarily to other foreseeable third parties, such as copatrons of the same retail establishments, who end up exposed to the patient's health risk. Such distinctions admittedly run the risk of arbitrariness, but no more so than other line drawing courts have regularly engaged in to set limits on otherwise unbounded duty.[235]

If such line drawing does become too arbitrary, or fails to limit physicians' liability exposure to feasible levels, courts and/or legislators could instead establish that the physician's breach of public health duties is not actionable by individual community members, but only by intermediaries and proxies for the public, such as state attorneys general or state medical boards.[236] Under this approach, while physicians would be recognized as having more robust legal duties to protect community health, breaches of such duties would be enforced in the public's interest only by such appropriate intermediaries, who would be expected to act as prudent representatives and remain sensitive to overburdening ordinary physicians with inordinate liability exposure.

Moreover, undue liability exposure associated with more robust public health obligations may be overstated. At least for common-law claims, individual members of the public bringing actions as plaintiffs would still have the burdens of proof and persuasion concerning causation. For many public health hazards, such as incidents of gun violence or infectious disease outbreak, it becomes daunting to prove causation with a clear enough nexus between the physician's conduct and the public health risks that injure the individual third party. Inevitable causation complications arise, including the ways the risk emanating from the doctor-patient relationship intermingle with other risks in

234. Strauss v. Belle Realty Co., 482 N.E.2d 34, 36 (N.Y. 1985) (citations omitted).

235. *See, e.g.*, *id.* (using privity as a duty-limiting factor); Portee v. Jaffee, 417 A.2d 521, 528 (N.J. 1980) (holding that duty owed to bystanders experiencing emotional harm due to defendant's negligence is limited to when bystanders contemporaneously observe the death or serious injury of an intimately related family member at the scene and go on to experience severe emotional distress).

236. Relatedly, in several jurisdictions the state attorney general acts as proxy for and represents the public's interest in reviewing transactions involving acquisition and conversion of nonprofit hospitals, ensuring that hospital assets are deployed sufficiently for charitable health care purposes. *See, e.g.*, N.J. STAT. ANN. § 26:2H-7.11.b (Westlaw through L.2021, c. 32 and J.R. No. 1).

the population; identification problems concerning which causal factors were root causes; the numerous community members involved; potentially long exposure and latency periods; and the many intervening casual factors that might be considered superseding causes, such as contacts with other individuals and health-harming actions by the potential plaintiffs.[237]

Analogous causation hurdles can be seen in related debates on whether persons who contract infectious disease can recover from members in the community who choose to go unvaccinated. Commentators note that significant factual and proximate causation problems may frustrate vindication of such claims. Plaintiffs may not be able to satisfy traditional civil standards of proof when identifying which unvaccinated person in the community actually infected them because other unvaccinated persons and additional sources of causation remain highly plausible in many situations of community transmission.[238] Health authorities might have good evidence concerning the suspect "index case" who likely served as the triggering event for initial community transmission and a local outbreak.[239] But even then, difficult questions arise whether the index patient can be considered the proximate cause of secondary and tertiary infections because of intervening steps, actions of other infected parties, and geographic and temporal remoteness.[240]

2. Common Law Reluctance To Impose Affirmative Duties

At least as a matter of common law, more robust recognition of physicians' public health duties seemingly represents a radical shift in doctrine. In relation to non-patients, physicians are arguably in the same position as ordinary individuals and, as such, they generally have no duty unless they are risk creating or misfeasant.[241] This distinction between risk emanating from the physician's own treatment plan (more likely leading to duty because of misfeasance)[242] versus risk already occurring with the patient (harder duty

237. *See, e.g.*, Stubbs v. City of Rochester, 124 N.E. 137, 138 (N.Y. 1919) (concerning a claim against the city for contaminated drinking water where independent factors presented multiple theories of causation).

238. *See* Arthur L. Caplan, David Hoke, Nicholas J. Diamond & Viktoriya Karshenboyem, *Free To Choose but Liable for the Consequences: Should Non-Vaccinators Be Penalized for the Harm They Do?*, 40 J.L. MED. & ETHICS 606, 607 (2012).

239. Dorit Rubinstein Reiss, *Compensating the Victims of Failure To Vaccinate: What Are the Options?*, 23 CORNELL J.L. & PUB. POL'Y 595, 622–23 (2014).

240. *Id.*

241. *See, e.g.*, RESTATEMENT (SECOND) OF TORTS § 314 cmt. c (AM. L. INST. 1965) ("The origin of the rule [of no duty to rescue] lay in the early common law distinction between action and inaction, or 'misfeasance' and 'non-feasance.'"); RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL & EMOTIONAL HARM § 37 (AM. L. INST. 2012); *see also supra* note 27 and accompanying text.

242. *See, e.g.*, Davis v. S. Nassau Cmtys. Hosp., 46 N.E.3d 614, 617 (N.Y. 2015). In *Davis v. South Nassau Communities Hospital*, 46 N.E. 614 (N.Y. 2015), the plaintiff was injured when a patient allegedly became unconscious while driving and struck the plaintiff as a result of medications prescribed by the

question because of nonfeasance) becomes significant when thinking about the full scope of physicians' public health duties. In many public health contexts, such as disease reporting or gun violence, the physician might be seen as nonfeasant in failing to prevent harm already emanating from the patient, rather than generating additional risk as part of the treatment provided.

Doctrinally, therefore, broad public health duties for physicians seemingly run counter to the common-law tradition. This is a tradition that emphasizes autonomy and allowing persons to choose to be instruments of good, rather than having them answer to compelled societal obligations. This also reflects the law's preference for limited governmental intrusion into private affairs and a negative state.[243] Public health's more communitarian orientation, in contrast, considers the populace's baseline health as a necessary predicate to individual exercise of autonomy. The public health perspective emphasizes the interconnectedness of community members and each individual's obligation to account for the health needs of the population.

Common-law duty has been imposed in particular instances of nonfeasance, such as *Tarasoff* situations when a doctor has a special relationship with a patient whose mental health condition poses a specific risk of violence to others.[244] But courts have recognized such affirmative duties on an incremental basis and as exceptions to the ordinary no-duty rule. This is because "the longstanding general duty/no-duty framework is an engrained one, solicitations for new affirmative duties represent exceptions which require concrete and substantial justification." [245] Moreover, there is judicial sensitivity to institutional competence. Legislatures and regulatory bodies may be better equipped than courts to consider the social and policy consequences of broadening duty rules and the full range of interests at stake beyond those of the immediate litigants.[246]

These considerations have significant merit and reveal the formidable doctrinal challenges in enlarging the scope of physicians' common-law public health duties. But they do not completely preclude such a shift. First, significant harms may be avoided if courts recognize stronger public health duties by physicians. With public health duties underpowered at present, insidious externalization of health risks from patients to the community occurs unabated.[247] Extensive fact finding and prudent inquiry will hopefully account

physician. *Id.* at 616. The court held that the physician had an actionable duty to third parties to warn the patient that the medications might affect the patient's safe operation of a vehicle. *Id.* at 617.

243. *See* Phillip W. Romohr, *A Right/Duty Perspective on the Legal and Philosophical Foundations of the No-Duty-to-Rescue Rule*, 55 DUKE L.J. 1025, 1043–44 (2006).

244. Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 345 (Cal. 1976); *see also supra* Section I.B.1.

245. Seebold v. Prison Health Servs., Inc., 57 A.3d 1232, 1246 (Pa. 2012).

246. *Id.*

247. *See supra* Part III.

for these largely unexamined costs associated with the patient-primacy directive inevitably overriding public health concerns.

Second, as a doctrinal matter, the distinction between misfeasance and nonfeasance is often misleading. Conduct characterized as one can readily be reinterpreted as the other.[248] In addition, courts have expanded the special relationship exceptions to the nonfeasance, no-duty rule in ways that make it unclear why certain relationships—such as employer-employee and business-public invitee—fit into the exception but not others.[249] Therefore, it may be better that the duty question not turn rigidly on characterizing a particular physician's conduct as misfeasance or nonfeasance, or whether the physician had a "special relationship." Instead, the duty question should more openly consider the underlying policy considerations for imposing legal responsibility. In many public health situations, as explained further below, physicians are in the best position to address the community health risk, equivalent to the cheapest-cost avoider.[250] Common-law courts have relied on such instrumental rationales as which party can best control risk for imposing duty in other contexts.[251] With physicians in particular, there are strong policy reasons to treat them, even outside the doctor-patient relationship, as different from ordinary individuals. Their actions and inactions with regard to public health risks have more significant, wide-ranging consequences for the community because of their role indispensability to safeguarding the health of the populace.[252] Although not an entirely satisfactory answer to the doctrinal concerns of expanding physicians' common-law public health duties, courts might ultimately justify such a move as a form of "'benign commandeering' . . . [where] we impose special altruistic responsibilities on [particular defendant classes such as] health care professionals and places of public accommodation" for overall general welfare.[253]

248. *See, e.g.*, John. M. Adler, *Relying upon the Reasonableness of Strangers: Some Observations About the Current State of Common Law Affirmative Duties To Aid or Protect Others*, 1991 WISC. L. REV. 867, 878.

249. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL & EMOTIONAL HARM § 40 cmt. h (AM. L. INST. 2012) ("The term 'special relationship' has no independent significance. It merely signifies that courts recognize an affirmative duty arising out of the relationship where otherwise no duty would exist . . . .").

250. *See infra* Section IV.B.

251. *See, e.g.*, Dalury v. S–K–I, Ltd., 670 A.2d. 795, 799 (Vt. 1995) (holding that premises liability imposes duty on those who own or control the land because they have "the expertise and opportunity to foresee and control hazards" arising from use of the premises).

252. *See infra* Section IV.B.1.

253. Kenneth S. Abraham & Leslie Kendrick, *There's No Such Thing as Affirmative Duty*, 104 IOWA L. REV. 1649, 1692 (2019).

3. Fiduciary Duty Constraints

Recalibrating physicians' public health duties also runs the risk of eviscerating their fiduciary obligations to patients. As previously noted, to the extent the doctor-patient relationship has fiduciary characteristics, physicians' fiduciary responsibilities generally direct them to maximize patient welfare, not to disadvantage patients in favor of the health of the community.[254] However, fiduciary duty constraints are not necessarily so restrictive. Under more flexible interpretations of fiduciary law, a pathway exists for accommodating more vigorous physician engagement in public health.

Fiduciary duty law likely does not alter the actual standard of care physicians owe their patients, it may just require more elevated disclosure through the informed consent doctrine.[255] The standard of care is usually determined by medical custom and what reasonable physicians in the relevant peer community ordinarily do. Thus, to the extent physicians more frequently account for the public's health in their treatment interactions with patients, and inform patients of their public health reasons, the physician-fiduciary's duty of care is more easily satisfied. This would be the case even when a physician acts as a gatekeeper to a critical resource or takes on other public health responsibilities that do not singularly advance patient welfare.

Of course, the most troubling potential legal barrier is not the fiduciary duty of care but the fiduciary duty of loyalty. How to square physicians favoring community health with loyalty to the patient? Despite the strong rhetoric surrounding the fiduciary's duty of loyalty, absolute fidelity to the beneficiary is not always required as courts occasionally modify the trust-based rules when the maximalist position is at odds with policy and societal concerns.[256]

Fiduciary law in the health care context has likewise been applied flexibly to allow for financial incentives directed at physicians that otherwise might present duty of loyalty concerns because the incentives help advance other societal imperatives, such as controlling ever-escalating health care costs.[257] Further, courts have been reluctant to recognize broad causes of action against physicians for breach of the fiduciary duty of loyalty due to conflicting financial interests.[258] If fiduciary law can tolerate use of potentially conflicting financial

254. *See supra* notes 17–27 and accompanying text.

255. Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 762 (1994).

256. *See* John H. Langbien, *Questioning the Trust Law Duty of Loyalty: Sole Interest or Best Interest?*, 114 YALE L.J. 929, 977–78 (2005); D. Gordon Smith & Jordan C. Lee, *Fiduciary Discretion*, 75 OHIO ST. L.J. 609, 621 (2014).

257. *See, e.g.*, Robert Gatter, *Communicating Loyalty: Advocacy and Disclosure of Conflicts in Treatment and Research Relationships*, *in* OXFORD HANDBOOK OF U.S. HEALTH LAW 242–47 (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017); Sam F. Halabi, *Against Fiduciary Utopianism: The Regulation of Physician Conflicts of Interest and Standards of Care*, 11 U.C. IRVINE L. REV. 433, 446–47 (2020).

258. Neade v. Portes, 739 N.E.2d 496, 500 (Ill. 2000).

incentives to engage physicians in important social objectives like controlling health care costs, it would likewise seem able to accommodate physician engagement in essential activities like public health protection.

Further, the question of the physician's fiduciary duty of loyalty becomes more complex when one recognizes that the typical physician has multiple patients. Some actions taken by a physician to protect community health, such as limiting antibiotic prescriptions, may disfavor the one patient denied access while helping the physician's *other patients* as members of the community who benefit from reduced risk of antibiotic resistance. By analogy, fiduciary doctrine in other contexts such as trust law recognizes that because the trustee has a duty to multiple beneficiaries, there is latitude for deploying trust assets in unequal shares to account for differing needs and priorities among the group as a whole.[259] As such, the physician embracing more robust public health actions that may favor certain patients over others can often credibly argue that she is trying to discharge loyalty obligations to multiple patients.

Moreover, a physician can also credibly argue that in discharging her duty of loyalty to a patient, she should have flexibility to account for both the patient's current and future health needs. Actions that disfavor a current patient may in some instances actually advantage the same patient in the future. Returning to antibiotic conservation, for example, physician gatekeeping that limits antibiotic use of only marginal benefit to a patient helps preserve the medication's effectiveness generally. Thus, if the same patient has more compelling need for the same drug in a future health care episode, the antibiotic is then more likely to offer benefit.

B. *Possible Justifications for Stronger Public Health Duties*

Notwithstanding the inherent challenges in strengthening physicians' public health duties, countervailing justifications support such a move. These considerations include physicians' role indispensability, the expertise they can apply in discharging such duties, social contract theory, validating social expectations, and ensuring equitable distribution of physician burden in combatting public health threats.

1. Role Indispensability

Perhaps the strongest justification for law to impose enhanced public health duties on physicians is role indispensability. The argument is not that physicians are particularly suited for the role of public health stewards. But, pragmatically, they are still likely better than the alternatives. Simply put, the public health system cannot effectively operate without broad, engaged

259. Theodore W. Ruger, *Can a Patient-Centered Ethos Be Other-Regarding? Ought It Be?*, 45 WAKE FOREST L. REV. 1513, 1522 (2010).

participation of private physicians. The traditional medicine/public health divide typically overlooks private physicians as part of the public health space. However, as the COVID-19 pandemic has revealed, traditional public health personnel such as contact tracers and epidemiologists are quite limited in number and work for state and local health departments that have been consistently underfunded and understaffed.[260] To a surprising degree, "[t]he rest of the [public health] response is in the hands of thousands of private militias — hospitals, insurers, doctors, nurses, respiratory technicians, pharmacists and so on . . . ."[261]

Physicians work at the critical nerve center of this private/public response force. Their uniquely advantageous position—strategically embedded between their patient, other patients, and society—makes private physicians' engagement critical for effective public health protection. First, physicians perform a sentinel function. As frontline practitioners, they are often patients' first contact with the delivery system. They have the initial opportunity to interact with individuals and identify illnesses and concerning patterns, such as antibiotic-resistant infections, opioid abuse, or novel viral cases, that suggest larger threats to community health. Community physicians become "privy to social trends long before those trends become epidemics in our communities[, and w]hen they observe patient after patient with the same diagnosis, they're the first to see the patterns."[262] Private physicians have been recognized as "critical partners in monitoring community health" because, in their patient interactions in the clinical trenches, they regularly "encounter diseases, conditions, and injuries that may be important not only for an individual patient but also for the community as a whole."[263]

Physicians may not only be the first to observe and identify warning signs of community health threats, but they also are usually in the best position to act on the information when limited time windows exist. For example, as mandatory reporters of infectious disease cases to public health authorities, community physicians are arguably more important responders than clinical laboratories and other secondary providers who also have statutory reporting

260. *See generally* TR. FOR AM.'S HEALTH, THE IMPACT OF CHRONIC UNDERFUNDING ON AMERICA'S PUBLIC HEALTH SYSTEM: TRENDS, RISKS, AND RECOMMENDATIONS, 2019 (2019), https://www.tfah.org/wp-content/uploads/2020/03/TFAH_2019_PublicHealthFunding_07.pdf [https://perma.cc/YB6K-JHK7] (examining federal, state, and local public health funding trends and recommended investment and policy actions to prioritize prevention to address twenty-first century health threats).

261. Donald G. McNeil Jr., *American Public Health Infrastructure Needs an Update*, N.Y. TIMES (June 18, 2020), https://www.nytimes.com/article/coronavirus-facts-history.html [https://perma.cc/NY3Z-MNKQ (dark archive)].

262. Elizabeth Métraux, *Health Care Providers: Canaries in the Coal Mines of American Society*? STAT (Sept. 19, 2019), https://www.statnews.com/2019/09/19/social-change-health-care-providers-canaries-coal-mines-american-society/ [https://perma.cc/B3Q6-6B6G].

263. Gakh et al., *supra* note 173, at 336.

obligations. Physicians can make quick professional judgments based on clinical examination of patients, whereas other providers may need more testing time and "a reporting delay . . . to providers waiting for laboratory-confirmation could have a substantial public health impact by permitting further spread of a highly communicable disease."[264]

Second, community physicians perform the key role as gatekeeper. As agents of their patients with superior knowledge and discretionary authority to order care and make referrals, community physicians are in a position to monitor, influence, and even induce demand for health care products and services. Health policy analysts advise that there is no more powerful lever in the health care market than the "physician's pen" because physicians' discretionary orders[265] and prescriptions account for seventy to ninety percent of all health care costs.[266]

Gatekeeping has most often been associated with cost control. The ideal gatekeeper physician balances particular patient needs and potential benefits of interventions with the efficiency and cost-effectiveness of care, sometimes limiting care plans in order to conserve resources for other patients.[267] But there is a clear connection between gatekeeping and public health. For example, in the case of antibiotic resistance, physician gatekeeping is critical. By limiting antibiotic orders for only high-value uses and engaging in other conservation strategies, physicians can minimize community health threats, such as resistant bacteria and ineffective medications.[268] Likewise, the negative downstream effects for the populace of indiscriminate opioid prescribing can be understood as physicians performing poorly as gatekeepers to powerfully addictive medications.[269] In short, physicians' gatekeeping function makes them uniquely positioned to direct the use of limited societal resources for safeguarding the health of the community.

Third, physicians perform key roles as learned intermediaries, distilling and shaping complex medical information for their patients' particular situations and needs. Informed consent law envisions a counseling role for the physician in educating the patient about a proposed treatment's material risks

264. Fill et al., *supra* note 179, at 585.

265. William M. Sage, *Fracking Health Care: How To Safely De-Medicalize America and Recover Trapped Value for Its People*, 11 N.Y.U. J.L. & LIBERTY 635, 642 & n.22 (2017).

266. Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 434 (1988).

267. *See generally* Hall, *supra* note 255 (arguing for lifting the ethical taboo against physician bedside rationing); Jessica Mantel, *A Defense of Physicians' Gatekeeping Role: Balancing Patients' Needs with Society's Interests*, 42 PEPP. L. REV. 633 (2015) (arguing that physicians have a duty of care both to individual patients and society at large, and that health care rationing is called for to balance these two duties).

268. *See supra* Section III.B.

269. *See supra* Section III.D.

and benefits and the medically viable alternatives.[270] Physicians frequently have to explain not only the risks and benefits of proposed treatments, but also more basic diagnostic details about what is medically occurring with the patient and how the patient's body may be responding. In this respect, a fair share of health care might be considered "credence" goods and services, rather than more common "experience" or "search" goods and services in the marketplace.[271] Rather than form impressions largely based on her own experiences with treatment, a patient depends on the physician, as learned intermediary, to explain what has been working or not. Further, the learned intermediary doctrine under products liability law recognizes that pharmaceutical suppliers can discharge their duty to warn about medication risks by alerting prescribing physicians through drug label inserts, "Dear Doctor" letters, and otherwise, rather than directly warning the end-user patients.[272] Physicians are legally expected to, in turn, discuss some, but not all, of this information with their patients. Physicians mediate the risk information exchange, using their expert medical knowledge and understanding of the patient's situation to provide information about the drug and its risks that is tailored to the patient's condition.[273]

As learned intermediaries, physicians can also engage in significant public health protection. They can call attention to public health implications that their patients may not otherwise understand or heed. For example, a physician who does not consider public health obligations could simply inform a patient that prescribing an antibiotic for a viral infection will be ineffective and offer the patient no curative effects. But if the physician were attentive to her public health role, she could lean into her learned intermediary status and further counsel that prescribing in these situations endangers community health because of increasing selection pressures for resistant bacteria in the community.

Physicians are successful learned intermediaries not only because they have expertise but because they command significant public trust.[274] As such, they can be very effective public health counselors when interacting with their patients and members of the community. Of course, trust in health care is somewhat fragile and can be easily squandered.[275] It is possible that a legal shift

270. Canterbury v. Spence, 464 F.2d 772, 786–88 (D.C. Cir. 1972).

271. Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 929 (1994).

272. *See, e.g.*, Centocor, Inc. v. Hamilton, 372 S.W.3d. 140, 154–59 (Tex. 2012).

273. *Id.*

274. *See* Megan Brenan, *Nurses Keep Health Lead as Most Honest, Ethical Profession*, GALLUP (Dec. 26, 2017), http://news.gallup.com/poll/224639/nurses-keep-healthy-lead-honest-ethical-profession.aspx?g_source=CATEGORY_SOCIAL_POLICY_ISSUES&g_medium=topic&g_campaign=tiles [https://perma.cc/J24V-LFPT] (presenting polling information indicating that physicians are among the most highly trusted professions).

275. *See* Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 508–09 (2002).

requiring stronger physician duties for public health protection could erode patient trust if patients perceive their physicians are no longer as devoted to individual patient welfare. However, powerful intrinsic reasons for patients to have confidence in their physicians exist, even in the face of legal regulation that seemingly threatens trust in the doctor-patient relationship.[276]

2. Expertise

Related to their role indispensability, physicians have a particular expertise to apply in addressing public health threats. Difficulty of discharging a legal duty and extent of the burden it imposes on a potential class of defendants are usually critical policy considerations in determining whether to impose affirmative legal duties.[277] Community physicians' relevant expertise makes it more likely that they can feasibly discharge stronger public health responsibilities.

To start, physicians have a comprehensive understanding of medical processes to evaluate how public health risks interact with biologic systems and human physiology.[278] In wide-ranging public health matters such as smoking, using motorcycle helmets, and wearing masks, physicians can also directly relate the health experiences of their own patients to the health threats of the community.[279] In addition, physicians have special capabilities because of their training in differential diagnosis and iterative, flexible diagnostic processes. For example, physicians' clinical judgment and diagnostic skills are needed for public health surveillance to identify certain threatening diseases and syndromes, like fungal meningitis and pediatric influenza, that do not have confirmatory laboratory tests available.[280] Even for diseases and syndromes that can be confirmed through lab tests, physicians may have access to other important information by handling specimens and identifying unusual symptom indications and other relevant clinical evidence. Skilled interviews with patients and expert diagnostic skills enable physicians to recognize "clusters of illness as well as urgent, suspected diseases."[281]

Admittedly, there are increasingly expansive demands on physicians to address all sorts of societal problems, especially with the new interest in social

276. *Id.* at 507.

277. *See, e.g.*, Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 342 (Cal. 1976).

278. Robert S. Lawrence, *The Role of Physicians in Promoting Health*, 9 HEALTH AFFS. 122, 124 (1990).

279. Russell L. Gruen, Steven D. Pearson & Troyen A. Brennan, *Physician-Citizens—Public Roles and Professional Obligations*, 291 JAMA 94, 96 (2004).

280. Fill et al., *supra* note 179, at 581.

281. Gakh et al., *supra* note 173, at 329 (quoting Colleen M. McClean, Benjamin J. Silk, James W. Buehler & Ruth L. Berkelman, *Disease Reporting Among Georgia Physicians and Laboratories*, 16 J. PUB. HEALTH MGMT. & PRAC. 535, 535 (2010)).

determinants of health.[282] Thus, some advocates urge physicians to write prescriptions for food and housing,[283] to promote affordable health care,[284] to fight climate change,[285] and otherwise to tackle larger socioeconomic issues affecting the health of their patients and the population. At some point, one must question whether physicians really have sufficient expertise to address so many wide-ranging social problems, many of which seem several levels removed from ordinary decision-making in the clinic.

However, with many of the public health risks contemplated in this Article, a clearer connection exists between the community harms at issue and physician expertise. Risks such as antibiotic-resistant infections, as well as indications of dementia or suicidal ideation among gun owners, are fundamentally clinical health risks in origin. These are hazards where community physicians' specialized skills and abilities in clinical diagnosis and health communication more likely matter and have real impact. As such, their highly relevant expertise cuts in favor of amplifying physicians' public health duties.

3. Social Contract

Social contract theory envisions citizens consenting to give power to the state as part of an assumed, theorized bargain.[286] Citizens will receive certain benefits from the state, such as protection of their liberty and property. In return, citizens owe society something back and, some commentators contend, this can extend to helping others avoid harm, especially if the state cannot do so alone.[287] As the state cannot safeguard community health alone, and because private physicians are indispensable to an effective public health system, social contract theory supports stronger affirmative obligations on physicians to protect public health.

282. *See, e.g.*, Paula Braverman & Laura Gottlieb, *The Social Determinants of Health: It's Time To Consider the Causes of the Causes*, 129 PUB. HEALTH REPS. 19, 19 (2014); Jessica Mantel, *Tackling the Social Determinants of Health: A Central Role for Providers*, 33 GA. ST. U. L. REV. 217, 217 (2017).

283. Alice Park, *Why Food Could Be the Best Medicine of All*, TIME (Feb. 21, 2019, 6:10 AM), https://time.com/longform/food-best-medicine/ [https://perma.cc/ESG2-SJCZ]; Aaron Shroyer, *Writing a Prescription for Housing*, URB. INST. (July 5, 2017), https://housingmatters.urban.org/articles/writing-prescription-housing [https://perma.cc/37VJ-7WG5].

284. Gruen et al., *supra* note 279, at 96.

285. Leonid Eidelman, *Why Doctors Need To Join the Fight Against Climate Change*, FORTUNE (Dec. 8, 2018, 9:00 AM), https://fortune.com/2018/12/08/climate-change-doctors-physicians/ [https://perma.cc/YHQ2-S5V4].

286. *See, e.g.*, Ani B. Satz, *Overcoming Fragmentation in Disability in Health Law*, 60 EMORY L.J. 277, 305–08 (2010).

287. *See* Steven J. Heyman, *Foundations of the Duty To Rescue*, 47 VAND. L. REV. 673, 706 (1994) ("Although the state generally fulfills this duty [of protection] through its own officers, on some occasions an officer will not be present or will require assistance. In such situations, the state reasonably may impose an obligation on every citizen present to assist in preserving the life of a fellow citizen.").

Further, social contract perspectives view physicians as more than just ordinary citizens in terms of what they may owe back to the state as part of an assumed, theorized bargain. In addition to the basic benefits every citizen enjoys from the state, physicians receive additional advantages and privileges. They are granted a special license to provide professional services. They also receive expensive medical education and graduate medical training that the government significantly subsidizes.[288] In addition, physicians enjoy high social status and the perks of membership in an elite, guild-like profession that commands much deference from society, including in setting standards of care, disciplining professional members, and determining which services even require medical licensure.[289] In return for these particular benefits, physicians arguably have obligations to "provide care when needed by the public."[290]

However, it is debatable whether social contract theory can be relied upon to require broader public health measures of physicians that are outside ordinary doctor-patient relationships. For example, some commentators question whether social contract obligations justify expectations that physicians work, at much personal risk to themselves, during a pandemic.[291] To the extent social contract theory arguments heavily depend on some quid pro quo for the societal benefits physicians enjoy, the difficult question is whether physicians understand what their end of the bargain is and thus voluntarily assume broad public health responsibilities when entering the medical profession. [292] Physicians could credibly argue they did not believe they had robust public health duties when deciding to practice medicine. Indeed, expansive public health obligations are not expressly enumerated in physician licensure laws.[293]

Moreover, medical ethics and norms so emphasize the patient-primacy directive that physicians could justify regular patient care activities as fulfilling their end of any implicit social contract bargain, without needing to provide more open-ended public health protection to the community at large. Indeed, the way physicians pay back the state for their societal benefits can take many forms, including sharing knowledge gained from medical research, volunteering for some uncompensated care, training the next generation of physicians, and

288. *See* ELAYNE J. HEISLER, BRYCE H.P. MENDEZ, ALISON MITCHELL, SIDATH VIRANGA PANANGALA & MARCO A. VILLAGRANA, CONG. RSCH. SERV., R44376, FEDERAL SUPPORT FOR GRADUATE MEDICAL EDUCATION: AN OVERVIEW 3–5 (2018), https://fas.org/sgp/crs/misc/R44376.pdf [https://perma.cc/B8YJ-ML3Q]; Catherine Rampell, *How Medicare Subsidizes Doctor Training*, N.Y. TIMES: ECONOMIX (Dec. 17, 2013, 10:00 AM), https://economix.blogs.nytimes.com/2013/12/17/how-medicare-subsidizes-doctor-training/ [https://perma.cc/QL2H-8NJ2 (dark archive)].

289. Gruen et al., *supra* note 279, at 95.

290. Orentlicher, *supra* note 4, at 1461.

291. *See, e.g.*, Coleman, *supra* note 83, at 30–32.

292. *Id.* at 30.

293. *See supra* Section I.C.

participating in prudent administration of the health care delivery system. Also, to the extent subsidized medical education is the primary societal benefit many physicians enjoy, this is an economic benefit, and arguably physicians' quid pro quo obligation in return could also be limited to items of economic value, not necessarily working to safeguard the public's health.[294] Accordingly, if physicians really owe something to society, it is not clear that the payback encompasses assuming public health duties to any degree.

4. Social Expectations

As legal duties often mirror and reinforce social attitudes, an important consideration is whether imposing more vigorous public health duties on physicians vindicates or frustrates societal expectations about the medical profession. The patient-primacy directive is so well ingrained that individuals find considerable comfort from the idea that their physicians put patients first. Indeed, both the public and most physicians likely agree on the dynamic of "the good doctor who cares for the one patient at any one time, and the patient who expects that the best will be done for him or her."[295] Under this view, physicians who "prioriti[ze] public health care . . . would devalue the expectation of patients."[296]

On the other hand, is patient primacy really all that the public envisions for physicians? Social expectations might actually be more nuanced. The public does regularly observe community physicians working to safeguard public health, with common activities such as vaccination and assessing impaired patients' fitness to drive. And throughout history, the public has observed self-sacrificing behavior by physicians during public health crisis periods in combatting spread of infectious disease.[297] Under this view, "[h]istorically, medicine as a learned profession has been understood to have a social responsibility to use knowledge and skills to enhance the common good, *including obligations to protect public health and safety*."[298]

Thus, honoring social expectations in shaping physicians' public health duties becomes tricky. The public likely holds somewhat contradictory, even unrealistic views about physicians—that clinicians should always do what is best for the patient *and* should vigorously safeguard the health of the community. This should not surprise as the public regularly has fickle, inconsistent views

294. *See, e.g.*, Coleman, *supra* note 83, at 31.

295. Heinz-Harald Abholz, *Conflicts Between Personal and Public Health Care: Can One GP Serve Two Masters?*, 57 BRIT. J. GEN. PRAC. 693, 693 (2007).

296. *Id.* at 694.

297. Orentlicher, *supra* note 4, at 1459–60.

298. COUNCIL ON ETHICAL & JUD. AFFS., AM. MED. ASS'N, CEJA REP. 1-A-12, PHYSICIAN STEWARDSHIP OF HEALTH CARE RESOURCES 142 (2012) (emphasis added) (footnotes omitted).

when it comes to health care, such as an expectation that the delivery system should offer the best care possible but at low cost and unrestricted access.

Further, from the ex ante perspective, before knowing what their particular circumstances will be, most individuals would likely prefer a regime where physicians have more robust public health duties that sometimes trump patient welfare concerns. Yes, an individual patient may suffer loss if his physician at times prioritizes public health over doing the best possible for the patient. At the same time, however, that same patient enjoys offsetting benefits when *other patients' physicians* pay greater heed to *their* public health roles. In other words, if *other patients' physicians* are empowered and expected to act more readily to protect the health of the populace, the individual patient still benefits from the enhanced health protections the community now enjoys.

Certainly, better explanation to the public about why private physicians at times need to act as agents of community health would help adjust social expectations going forward. Further, if physicians were also required to notify patients in advance about their practice operations and the individual patient welfare/public health balance as part of the informed consent process, this would also help align social expectations with physicians' enhanced public health responsibilities. Adjustment to patient expectations by advance disclosure already occurs in some public health contexts. For example, standard HIPAA notifications from health care providers advise patients that otherwise-confidential patient health information may be shared with public health agencies.[299]

5. Equitable Distribution of Physician Burden/Collective Action

Legal recognition of more robust public health duties for physicians also would make application of such duties more visible and uniform, helping address concerns of inequitable physician burden. Physicians who directly take on public health challenges shoulder a very large responsibility if not supported by their professional peers. For example, during pandemics, "it is much more feasible for any one physician to assume the risks of providing care . . . when all physicians are sharing the risks."[300] Concerns about inequitable physician burdens apply equally well to many other public health problems. Efforts to address community health risks such as gun violence and opioid abuse become more manageable when the onus is spread more evenly among doctors in the clinical trenches. Imposing public health duties more uniformly also helps advance physicians' professional solidarity. As members of the same profession,

299. *See* 45 C.F.R. § 164.512(b) (2019); DEP'T OF HEALTH & HUM. SERVS., NOTICE OF PRIVACY PRACTICES 6, https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/npp_booklet_hc_provider.pdf [https://perma.cc/C48G-3U2V] ("We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health . . . .").

300. Orentlicher, *supra* note 4, at 1460.

physicians arguably have some obligation to assist fellow physicians who endure significant hardship in addressing public health threats.[301]

Further, combating many public health threats necessarily raises collective action challenges. The efforts of only some community physicians, however vigorous, will not have much effect if other physicians are not on board because of the interconnectedness of the health care system's components and the manner in which public health risks propagate. For example, in the case of antibiotic resistance, a few physicians' inappropriate prescribing patterns can introduce strong resistance selection pressures in the community that may render future uses of medications ineffective, even if other physicians prudently conserve antibiotics.[302] Similarly, indiscriminate prescribing of opioids by a few physicians can have devastating effects for a local community, even if other physicians are more mindful of the dangers of opioid access. Addicted patients will doctor shop and gravitate towards the few physicians prescribing widely. And patients still able to abuse opioids will generate exponentially greater health risks for the community through needle sharing and other health-harming activity.

Given such enormous collective action challenges, "the survival of the community" demands that physician responsibility for public health matters be shared broadly.[303] Moreover, letting some physicians "off the hook" by not recognizing and uniformly applying more robust public health duties invites further collective action problems of free riders and insufficient coordination. This encourages the view among private physicians that they should "stay in their lane," that all will be fine if they simply take care of their individual patients, and that other doctors and public health workers will take care of particular public health risks. The problem is that the more disregard of public health matters becomes tolerated, the more physicians are likely to neglect their public health duties.[304]

C. *Possible Ways Forward*

The exact formulation of recalibrated public health duties for physicians is beyond the intended scope of this Article. Its principal aim has been to call attention to the harmful risk externalization occurring when law's patient-primacy directive overrides physicians' elusive public health duties. It also has sought to provide deeper theoretical foundations for making physicians' public health duties more cognizable and influential. Nonetheless, this final section

301. Gruen et al., *supra* note 279, at 97.

302. *See* INST. OF MED., *supra* note 168, at 37; Livermore, *supra* note 168, at S15–S16.

303. Ahronheim, *supra* note 92, at 233.

304. *See* Orentlicher, *supra* note 4, at 1460 (noting that exceptions to a physician duty to treat during pandemics "can trigger a self-reinforcing cycle of physician withdrawal that ultimately would defeat the duty").

concludes by offering some preliminary considerations for moving forward with a legal shift in physicians' obligations.

First, adjusted expectations are in order regarding how to balance patient and public health duties. It is acknowledged that enhancing physicians' public health duties, while still demanding strong obligations to each patient, may lead to much variability in practice. Physicians could point to either patient or public health as justification for different conduct. However, *any* adjustment in physicians' legal duties, if it brings more accountability and visibility to public health considerations flowing from physician decision-making, would still represent an improvement over the status quo where public health seems to be consistently given short shrift in favor of patient primacy. Further, many legal duties are not capable of being stated with rule-like precision as the duty analysis often ends up balancing a number of shifting factors and policy considerations. "[D]uty is not sacrosanct in itself . . . but is only an expression of the sum total of those considerations of policy [which] lead the law to say that the plaintiff is entitled to protection."[305] Thus, it should be expected that even with a move towards more robust public health duties for physicians, there will still be variability in similar situations of patient-public health tension in how forcefully the public health obligations are applied.

Second, lawmakers and regulators ideally should, through statutes and regulations, identify clearer pathways where private physicians can enter the public health sphere, move beyond their heavy relational orbit with patients, and protect non-patients from health risks. For example, as previously noted, some medical practice acts permit physicians to prescribe opioid antagonists, such as naloxone, to non-patients to prevent overdoses.[306] What is needed are more statutory provisions of this type, which clearly embrace a public health role for private physicians in taking action for the community, including expectations that are binding and not just permissive. Such codification would be welcome to counter perceived barriers because of patient primacy. It also might have larger impact because of the expressive effect of law in changing norms.[307] Clearer legal recognition of physicians' connections to non-patients would help shift professional norms about physician engagement in matters of public health.

Third, also critical is stronger enforcement of the minimal public health obligations for physicians already existing under law, such as addressing physicians' poor compliance with statutory obligations to report communicable-

305. Doe v. Cochran, 210 A.3d 469, 478 (Conn. 2019) (second alteration in original) (quoting Jarmie v. Troncale, 50 A.3d 802, 809–10 (Conn. 2012)); *see also* DAN B. DOBBS, PAUL T. HAYDEN & ELLEN M. BUBLICK, THE LAW OF TORTS § 255 (2d ed. 2020).

306. *See supra* note 75 and accompanying text.

307. Cass R. Sunstein, *On the Expressive Function of Law*, 144 U. PA. L. REV. 2021, 2022–23 (1996).

disease cases.[308] Importantly, stronger enforcement does not necessarily mean severe licensure discipline or increased civil fines. More consistent enforcement of the modest sanctions already existing under these laws might prove just as effective, especially if other physicians take note of the uptick in actions against noncompliant physicians as cautionary tales. Further, higher compliance can also be achieved through targeted education, auditing, positive rewards, and leveraging physicians' intrinsic reasons for compliance, not just threat of heavy sanction. In this respect, lawmakers might consider adding additional financial incentives under governmental health care programs such as Medicare and Medicaid for physicians meeting targeted public health goals. This could include, for example, bonuses for prescribing antibiotics within recommended resistance-control guidelines or engaging in a threshold number of gun-violence screenings with patients. It may also be, as previously discussed, that because of unbounded liability concerns some public health duties are better enforced by prudent intermediaries such as medical boards instead of through private actions.[309] However, medical boards will need to really step up their enforcement activity. Physician oversight from licensing authorities has been traditionally lax in public health matters, but "this largely under-resourced system"[310] may ultimately have greater beneficial effect if deployed more vigorously.

Finally, nonmaleficence serves as a helpful guiding principle for thinking about the dual-loyalty problem between patient welfare and public health. Nonmaleficence, often known as the "duty to do no harm," is one of the four commonly recognized core principles of bioethics along with beneficence, autonomy, and justice.[311] Nonmaleficence generally requires that a physician's intervention not harm the patient.[312] While autonomy has often overshadowed the other core bioethics principles in recent discourse,[313] nonmaleficence still offers valuable instruction in this context. In many instances of potential dual-loyalty conflict, physicians could better justify actions taken for public health protection by ensuring such conduct, even if not maximizing patient welfare, at least does not further harm their individual patients or such harm is minimized as much as possible. This may not be practicable in all patient/public health

308. *See supra* Section III.C.

309. *See supra* note 236 and accompanying text.

310. Barnes et al., *supra* note 206, at 23.

311. *See generally* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (7th ed. 2012) (developing an approach to medical ethics based on four prima facie moral principles and attention to these principles' scope of application).

312. *See, e.g.*, Thomas R. McCormick, *Principles of Bioethics*, UNIV. WASH. MED., https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/articles/principles-bioethics [https://perma.cc/R6G6-7U9F].

313. Lois Shepherd, *Sophie's Choices: Medical and Legal Responses to Suffering*, 72 NOTRE DAME L. REV. 103, 117–18 (1996).

conflicts. When respecting nonmaleficence is feasible with concurrent public health protection, however, physicians' public health duties should be interpreted to incorporate the principle. Physicians should be deemed to faithfully discharge their reinvigorated public health duties only if, in doing so, they also have managed harm avoidance/harm minimization with their individual patients.

CONCLUSION

Law generally obscures physicians' public health duties with limited, ad hoc recognition and insufficient theorization for the source and strength of these duties. The strong patient-primacy directive often overrides physicians' elusive public health obligations in ways that facilitate externalization of health risks from patients to the community. This problematic pattern, more salient as a result of COVID-19, threatens an already fragile public health system.

Legal change alone will not be sufficient to ensure optimal physician engagement in public health protection. A variety of reforms, such as more education, training, and positive rewards, including, importantly, stronger financial incentives for physicians' public health actions, are also needed. However, clearer legal recognition of physicians' public health duties can also have extra-legal impact to the extent it helps shift professional norms about physician engagement in matters of public health.

While amplification seems warranted, where law gives greater visibility to and puts more weight on physicians' obligations to safeguard community health, such a legal shift raises difficult challenges, both practical and doctrinal, such as potential unbounded liability exposure and overcoming law's general reluctance to impose affirmative duties outside special relationships. Various justifications support this shift, including social contract theory and equitable distribution of physician burden, although they may not fully address all concerns with recalibrating physicians' duties.

At bottom, the most compelling reason to amplify physicians' public health duties is instrumental. Law needs to appropriate physicians for public health protection because, as a practical matter, there are no better choices. The nation's public health system largely depends upon nongovernmental actors, and private physicians are at the center of this public/private response. Physicians occupy a unique strategic role embedded between the patient, other patients, and society and perform critical sentinel, gatekeeper, and learned intermediary functions that are indispensable to effective public health protection. Requiring physicians to pay greater heed to the population's health, even to the occasional detriment of doing all possible for individual patients, has become an unavoidable imperative.