2

Patients First, Public Health Last

Richard S. Saver

I INTRODUCTION

If a crisis is a terrible thing to waste, the COVID-19 pandemic will hopefully stimulate a needed reexamination of physicians' public health obligations. Law, bioethics, and medical norms consider physicians' duties to individual patients supreme, reflected in the ubiquitous health care mantra of "putting patients first."[1] As a result, public health inevitably ends up last. The generally accepted dominance of patient-centered duties crowds out physician attention to non-patients and the larger public health space. Patient primacy, while appealing for many reasons, is incomplete; addressing problems of collective importance often requires standardized, regulatory approaches and looking beyond relational obligations to patients.[2] This is especially true for public health.

Physicians can all too easily discount community health considerations because their public health duties under the law are confoundingly elusive. At times, the law affirms physicians' special capacity and obligations to improve the health of the community. More often, though, physicians' public health duties are recognized on only a limited, ad hoc basis and without thoughtful justification for the reasons why physicians should have obligations for the health of non-patients. Meanwhile, the directive to put patients first means that physicians have considerable discretion to evade public health laws or disregard the public health implications of their treatment decisions.

Part I of this chapter describes the legal background concerning physicians' duties to patients and to the community. Part II analyzes how bioethics and medical norms amplify the law's patient-primacy directive. Part III illustrates how the elusiveness of physicians' public health duties enables the externalization of health risks from patients to the population at large, considering COVID-19 and other

[1] See, for example, Coombes v. Florio, 877 N.E.2d 567, 577 (Mass. 2007); David Orentlicher, The Physician's Duty to Treat During Pandemics, 108 *Am. J. Pub. Health* 1459, 1459 (2018).

[2] See, for example, 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).

https://doi.org/10.1017/9781009265690.005 Published online by Cambridge University Press

examples. Part IV evaluates the difficult challenges, as well as countervailing justifications, in making physicians' public health duties more cognizable. The most important reason is instrumental and policy-driven: physicians play an indispensable role in public health protection. The private physician is strategically embedded between his/her patient, other patients, and society, and performs critical sentinel, gate keeper, and learned intermediary functions essential to an effective public health system.

II LEGAL DUTIES TO PROTECT PUBLIC HEALTH

Physicians' public health duties arise from a confusing patchwork of overlapping sources of legal authority. At times, and seemingly ad hoc, the law acknowledges that private physicians play an important public health role. Yet the obligations imposed are hardly robust and, more frequently, the law has difficulty recognizing physicians' duties beyond the relational obligations formed with specific patients.

A *Relationship-Based Duties, Including Duty of Loyalty*

Physicians' core common law responsibilities – such as the obligation of loyalty and additional duties of care, nonabandonment, and confidentiality – arise only from the formation of a treatment relationship with a specific patient.[3] As a quasi-fiduciary to his/her patient, the physician generally must act for the patient's benefit and avoid elevating other interests above the patient's welfare unless there has been proper disclosure. Physicians sometimes act as agents for other parties in addition to their patients, as in the provision of employment fitness examinations. But this still offers little leeway for physicians to pursue public health goals with sufficient vigor. Invariably, the message to physicians in most dual-loyalty scenarios is to restructure their roles to minimize dual-loyalty conflicts,[4] or to resolve the dual-allegiance dilemma by putting patients first.[5]

B *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. When a patient has a contagious illness, such as tuberculosis or scarlet fever, courts have traditionally recognized a duty on the physician to address the health risks to the

[3] See, for example, Kelley v. Middle Tenn. Emergency Physicians, P.C., 133 S.W.3d 587, 592 (Tenn. 2004).
[4] See, for example, I. Glenn Cohen et al., A Proposal to Address NFL Club Doctors' Conflicts of Interest and to Promote Player Trust, 46 *Hastings Cent. Rep.* S2 (2016).
[5] See, for example, Solomon R. Benatar et al., Dual Loyalty of Physicians in the Military and in Civilian Life, 98 *Am. J. Pub. Health* 2161, 2161 (2008).

patient's very close contacts, often family members.[6] 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.[7]

Courts have at times used seemingly broad language affirming a critical public health role for private physicians. As the Supreme Court of Connecticut recently stated, "[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."[8]

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 specific third party in close nexus to the patient, rather than the public at large. Second, the common law duty described is often narrowly limited to advising or warning the patient about the risk to others, as opposed to requiring broader steps, and courts have often been reluctant "to extend the requirement for affirmative physician interventions *outside the physician-patient relationship*."[9] Third, courts have displayed concern with not overburdening physicians with infeasible liability exposure to many potential plaintiffs.[10]

C *Medical Practice Acts/Professional Licensure*

Only a handful of state medical practice acts expressly envision the licensed physician engaging in public health protection. Some licensing statutes provide that a physician's failure to comply with infectious disease-reporting laws can trigger licensure discipline. Beyond this link to disease reporting, the situations seem to be ad hoc, such as licensing laws permitting physicians to prescribe opioid antagonists to non-patients to prevent overdoses.[11] There is a noteworthy dearth of physician disciplinary actions involving conduct harming non-patients and the health of the community.[12]

D *Other Statutory Duties*

Other statutes provide clearer legal foundations for physicians' public health responsibilities, albeit in narrow contexts. First, some statutes impose direct public health surveillance responsibilities on treating clinicians, such as communicable

[6] See, for example, Skillings v. Allen, 173 N.W. 663 (Minn. 1919) (scarlet fever); Hofmann v. Blackmon, 241 So.2d 752 (Fla. Dist. Ct. App. 1970) (tuberculosis).
[7] Jones v. Stanko, 160 N.E. 456, 456 (Ohio 1928).
[8] Doe v. Cochran, 210 A.3d 469, 488 (Conn. 2019).
[9] Seebold v. Prison Health Servs., 57 A.3d 1232, 1248 (Pa. 2012) (emphasis added).
[10] McNulty v. City of New York, 792 N.E.2d 162, 166 (N.Y. 2003).
[11] N.C. Gen. Stat. § 90-12.7 (2019).
[12] James M. Dubois et al., Serious Ethical Violations in Medicine: A Statistical and Ethical Analysis of 280 Cases in the United States from 2008 to 2016, 19 *Am. J. Bioethics* 16, 16 (2019).

disease-reporting laws and elder abuse-reporting laws. Failure to comply with reporting obligations can subject a physician to licensure discipline in several states. However, as discussed further later, compliance with disease-reporting laws has been poor and enforcement weak.[13]

Other statutes permit commandeering the services of physicians during a public health crisis.[14] But such commandeering statutes typically apply only in the narrow context of a discrete, declared public health emergency, not daily treatment decisions.

Physicians may also have an obligation to treat individuals during a public health emergency under the federal Emergency Medical Treatment and Active Labor Act.[15] But the Act applies only when individuals present at a hospital emergency room. 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, with little regard for the impact on public health.

III MEDICAL ETHICS AND PROFESSIONAL NORMS AMPLIFYING PATIENT PRIMACY

Medical ethics and professional norms reinforce and amplify the law's patient-primacy directive, often to the detriment of public health. The nine core principles of the American Medical Association's Code of Medical Ethics (AMA Code) include 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."[16] But significantly undercutting this obligation to non-patients, the AMA Code further instructs physicians to "place patients' welfare above the physician's own self-interest *or obligations to others*."[17]

The AMA Code underwent significant revisions in 2016, including, importantly, a reorganized series of ethics opinions in Chapter 8 that addresses "Ethics for Physicians [and] the Health of the Community."[18] Yet many of the Chapter 8 ethics opinions make clear a physician's public health responsibilities remain necessarily inferior to patient obligations. For example, Ethics Opinion 8.1, dealing with the importance of physician participation in routine universal screening of patients for

[13] See infra Section IV.C.
[14] Model State Emergency Powers Act, Dec. 21, 2001 draft, www.aapsonline.org/legis/msehpa2.pdf.
[15] 42 U.S.C. § 1395dd (2018).
[16] Am. Med. Ass'n, Code of Medical Ethics, Principles of Medical Ethics § VII, www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics.
[17] Am. Med. Ass'n, Code of Medical Ethics, Ethics Opinion 1.1.1 (emphasis added), www.ama-assn.org/system/files/code-of-medical-ethics-chapter-1.pdf.
[18] Am. Med. Ass'n, Code of Medical Ethics, Chapter 8: Opinions on Physicians and the Health of the Community, www.ama-assn.org/system/files/2020-12/code-of-medical-ethics-chapter-8.pdf.

HIV, assumes that "[p]hysicians' primary ethical obligation is to their individual patients" and thus advises that physicians should respect a patient's informed refusal to be tested for HIV.[19]

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 and professional rivalry with public health. Further, public health's more communitarian orientation remains at odds with the emphasis in traditional medical ethics on values such as autonomy, civil liberty, and anti-paternalism.[20]

Medicine's professional norms also slight the health needs of the community in favor of patient primacy. Most medical school graduates take formal pledges to prioritize the patient's welfare, with common language such as "the health and life of my patient will be my first consideration."[21] Public health actions fit awkwardly with this sense of professional mission.

Physician discomfort with public health arises in part from the limited public health education they receive as part of their training.[22] Further, the fact that much physician work is oriented around particular episodes of care makes it harder to adopt population-based perspectives in decision-making. The understandable default is to deal with the patient at hand, case by case.

IV RISK EXTERNALIZATION TO THE PUBLIC

The patient-primacy directive, combined with the otherwise elusiveness of physicians' public health duties, enables the externalization of insidious health risks from patients to the population at large. Several examples across the wide public health space reflect this troubling pattern.

A *COVID-19*

An important public health strategy deployed during the COVID-19 pandemic was delay of certain procedures. This was intended to minimize virus transmission opportunities and preserve the health care system's limited resources for fighting COVID-19. In March 2020, a growing public health consensus emerged favoring a

[19] Am. Med. Ass'n, Code of Medical Ethics, Ethics Opinion 8.1: Routine Universal Screening of HIV, www.ama-assn.org/delivering-care/ethics/routine-universal-screening-hiv.

[20] Daniel Callahan & Bruce Jennings, Ethics and Public Health: Forging a Strong Relationship, 92 *Am. J. Pub. Health* 169, 170 (2002).

[21] See Audiey C. Kao & Kayhan P. Parsi, Content Analyses of Oaths Administered at US Medical Schools in 2000, 79 *Acad. Med.* 882, 882–84 (2004).

[22] Kevin Correll Keith et al., Student Perspectives on Public Health Education in Undergraduate Medical Education, 15 *Diversity & Equity in Health Care* 234, 239 (2018).

pause in nonessential care. The Centers for Disease Control and Prevention (CDC) and professional associations such as the American College of Surgeons issued recommendations along these lines.[23] Eventually, many states imposed restrictions on elective procedures.[24]

Despite the public health guidance, some physicians continued to perform procedures generally considered less essential, such as spinal decompression. They defended their conduct as doing the best for their patients. 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.[25] Although acknowledging the public health risks, he maintained that he was obligated to treat his patients and remained focused on how delays would affect them personally.[26] Likewise, many dermatology practices remained open in late March of 2020, in defiance of public health calls to limit such in-person care and guidelines from the American Academy of Dermatology to reschedule all nonessential visits or switch to telemedicine.[27]

Undoubtedly, economic considerations likely motivated these providers to keep offering such nonessential services. Many of the dermatology practices that remained open in this period were owned by private equity firms and faced pressures to generate practice revenues for investors.[28] But the physicians' stated reasons, even if somewhat pretextual, predictably referenced doing what was best for their patients.

Thus, it would be wrong to dismiss these physicians as outliers. Because their public health responsibilities were so elusive, these physicians had considerable discretion to downgrade public health concerns to an alarming degree. 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.

[23] Am. Coll. of Surgeons, COVID-19: Recommendations for Management of Elective Surgical Procedures (Mar. 13, 2020), www.facs.org/covid-19/clinical-guidance/elective-surgery; Ctrs. for Disease Control & Prevention, Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States (Feb. 29, 2020), https://stacks.cdc.gov/view/cdc/85502. The CDC's interim guidance was later revised to provide greater flexibility concerning elective procedures. See Ctrs. for Disease Control & Prevention, Managing Healthcare Operations During COVID-19, www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-hcf.html (last updated Feb. 8, 2021).

[24] See, for example, N.Y. Exec. Order No. 202.10 (Mar. 23, 2020), www.governor.ny.gov/sites/default/files/atoms/files/EO_202.10.pdf.

[25] Henry Schulman, Top Tommy John Surgeon Defends Procedures Done During Coronavirus Outbreak, SF Chronicle (Mar. 24, 2020), www.sfchronicle.com/giants/article/Top-Tommy-John-surgeon-defends-procedures-done-15154721.php.

[26] Id.

[27] Katie Hafner, Many Dermatology Practices Stay Open, Ignoring Public Health Pleas, NY Times (Apr. 8, 2020), www.nytimes.com/2020/04/08/health/coronavirus-telemedicine-dermatology.html.

[28] Id.

B *Antibiotic Prescribing*

The "antibiotic paradox" means that prescribing an antibiotic can have dual, contradictory effects – combating targeted illness for one patient while also increasing resistant bacterial strains in the community and therefore jeopardizing the medication's effectiveness when used again for future health threats.[29] Thus, for public health reasons, physicians must sometimes limit the use of antibiotics when the medication might offer only marginal benefit to the patient.

Yet physicians engage in much inappropriate antibiotic prescribing, including over- ordering the drugs by as much as 50 percent.[30] 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. A study of physician attitudes concerning antibiotic prescribing indicated that most physicians placed the societal risk of antibiotic resistance at or very near the bottom of the list of factors (such as side effects, efficacy, and cost to patient) that mattered most in their decision-making.[31]

The law's patient-primacy directive seems to discourage physicians from engaging in antibiotic conservation. For example, informed consent doctrine generally requires a physician to advise the patient about a proposed treatment's material risks. The law is so patient-focused that courts conceive of these risks as the harms that may materialize for the patient, not the populace. A physician is under no legal obligation to inform the patient about the resistance risks and dangers to community health from inappropriate antibiotic use.[32] Fiduciary duty obligations also may be at odds with prudent antibiotic stewardship. A physician arguably may run afoul of the fiduciary's duty of loyalty if the physician restricts the patient from even the marginal benefits of using a medication.

C *Disease Reporting*

Every state has statutory and regulatory requirements that physicians, clinical laboratories, and select other providers report various infectious disease cases to public health authorities. Despite the clear statutory mandates, physicians have historically performed poorly as mandatory reporters.[33] Surveys show compliance rates ranging

[29] Stuart B. Levy, The Antibiotic Paradox: How the Misuse of Antibiotics Destroys Their Curative Powers XII-XIV (2002).

[30] Katherine E. Fleming-Dutra, Prevalence of Inappropriate Antibiotic Prescriptions Among US Ambulatory Care Visits, 2010–2011, 315 *JAMA* 1864, 1869 (2016).

[31] Joshua P. Metlay et al., Tensions in Antibiotics Prescribing: Pitting Social Concerns against the Interest of Individual Patients, 17 *J. Gen. Internal Med.* 87, 87 (2002).

[32] Wendy E. Parmet, Unprepared: Why Health Law Fails to Prepare Us for a Pandemic, 2 *J. Health & Biomedical L.* 157, 176 (2006).

[33] Timothy J. Doyle et al., Completeness of Notifiable Infectious Disease Reporting in the United States: An Analytical Review, 155 *Am. J. Epidemiology* 866, 871 (2002).

from about 37 to 57 percent for common sexually transmitted diseases such as chlamydia and AIDS.[34]

Physician non-compliance may seem largely a problem of lax enforcement and insufficient deterrence. But the non-compliance 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.[35]

The stated reasons for physician non-compliance have varied over time, including concerns over patient confidentiality, burdensome time and resource commitments, and physician reliance on other health care team members to make the required reports.[36] Some of the reasons offered for physician non-compliance seem pretextual. For example, complaints about breaching confidentiality are likely overstated. The federal medical privacy law, the Health Insurance Portability and Accountability Act, has a broad public health exception that permits provider reporting of infectious disease incidents.[37]

The varied reasons offered for physician non-compliance obscure a more fundamental problem: public health practitioners and private physicians view disease reporting through very different perspectives. Public health practitioners envision disease reporting as instrumental for necessary surveillance and as part of each provider's shared accountability for the health of the populace. But physicians have been far more wary of disease reporting, in particular how it may intrude upon the "sanctity of their therapeutic relationships."[38]

D *Opioid Epidemic*

The opioid epidemic has multiple root causes, including aggressive marketing and financial incentives offered to prescribers by pharmaceutical companies, flawed reimbursement programs, which encourage prescribing over behavioral alternatives, and inadequate training of physicians in recognizing and treating addiction.[39]

[34] Janet S. St. Lawrence et al., 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).

[35] See, for example, Kristin Underhill, When Extrinsic Incentives Displace Intrinsic Motivation: Designing Legal Carrots and Sticks to Confront the Challenge of Motivational Crowding-Out, 33 *Yale J. Reg.* 213, 220 (2016).

[36] Mary-Margaret A. Fill et al., Heath Care Provider Knowledge and Attitudes Regarding Reporting Diseases and Events to Public Health Authorities in Tennessee, 23 *J. Pub. Health Mgmt. Prac.* 581, 582–83 (2017).

[37] 45 C.F.R. § 164.512(b).

[38] Lawrence O. Gostin, Public Health Law: Power, Duty, Restraint 313 (2d ed. 2008).

[39] See, for example, Mark A. Rothstein, Ethical Responsibilities of Physicians in the Opioid Crisis, 45 *J. L. Med. Ethics* 682, 683 (2017).

But lurking less visibly beneath the surface is a familiar pattern: physicians' underweighting of public health. A blinkered devotion to their individual patients has allowed many physicians to exacerbate the opioid epidemic.

First, physicians prescribe opioids in patterns and amounts that foreseeably permit diversion of the medications to non-patients, fueling potential health 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 fully aware that their patients are abusing these medications or diverting them to others for nonmedical use, but they prescribe them anyway."[40] Physicians can rationalize such excessive prescribing on the grounds of patient convenience. These well-meaning physicians also allow concerns of patient pain to override attention to the serious community health risks from widespread, chronic use of opioids, such as increased rates of addiction and bloodborne, bacterial, and sexually transmitted infections.

Particularly revealing is physician resistance to prescription drug monitoring programs (PDMPs). PDMPs, electronic databases that track prescriptions of certain medications and require physician query before prescribing, have been implemented by law in many states as a means to combat the opioid epidemic. Yet debates about PDMPs invariably include claims that this form of regulation interferes with the doctor–patient relationship and impedes physicians' ability to provide individually tailored care.[41] Patient welfare becomes deeply intertwined with, and may even provide appealing cover for, underlying anxieties about physicians' professional autonomy.

Further, many public health regulatory interventions, such as PDMPs, rely on uniform, standardized approaches. Physicians, zealously focused on individual patient health, tend to be suspicious of this form of regulation, because "[a]pparent solutions of general applicability may result in individual cases of suboptimal medical care."[42]

V RECALIBRATING PHYSICIANS' PUBLIC HEALTH DUTIES

Considerable obstacles arise in making physicians' public health duties more robust and cognizable under the law. Yet countervailing justifications support this shift, including, most importantly, role indispensability.

[40] Anna Lembke, Why Doctors Prescribe Opioids to Known Opioid Abusers, 367 *New Eng. J. Med.* 1580, 1580 (2012).

[41] Mark Barnes et al., Opioid Prescribing and Physician Autonomy: A Quality of Care Perspective, HSS J. 20, 23 (2019), www.ehidc.org/sites/default/files/resources/files/Barnes2019_Article_OpioidPrescribingAndPhysicianAutonomy.pdf.

[42] Id. at 22.

A *Challenges*

1 Too Many Plaintiffs/Liability Without Limits

If the law imposes stronger public health responsibilities, would each physician owe to any 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.

While a challenge, the "too many plaintiffs" problem is not necessarily insurmountable. In other contexts, courts have deployed various doctrinal rules, such as privity, to protect against crushing exposure to liability. Courts in public health disputes likewise could use line-drawing rules. Alternatively, courts and 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 attorney generals or state medical boards. These intermediaries would be expected to act as prudent representatives and remain sensitive to overburdening ordinary physicians with inordinate liability exposure.

2 Common Law Reluctance to Impose Affirmative Duties

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.

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 and intrusive governmental regulation. Moreover, as a matter of institutional competence, legislatures and regulatory bodies may be better equipped than courts to consider the social and policy consequences of broadening duty rules.

These concerns, while meritorious, do not completely preclude broadening physicians' common law public health duties. At present, with physicians' community health obligations underpowered, the insidious externalization of health risks from patients to the populace occurs unabated. In addition, the distinction between misfeasance and nonfeasance is often arbitrary and misleading. Instead, the extent of physicians' duties should turn more openly on the underlying policy considerations for imposing legal responsibility.

In many public health situations, as explained later, physicians are in the best position to address the community health risk, equivalent to the cheapest-cost-avoider.[43] Their actions and inactions with regard to public health risks have more significant

[43] See infra Section V.B.1

https://doi.org/10.1017/9781009265690.005 Published online by Cambridge University Press

consequences because of their indispensable role in safeguarding the health of the populace. Courts might ultimately justify strengthening physicians' public health duties 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.[44]

3 Fiduciary Duty Constraints

Recalibrating physicians' public health duties also runs the risk of eviscerating physicians' fiduciary obligations to patients. However, despite the strong rhetoric surrounding the fiduciary's duty of loyalty, absolute fidelity to the beneficiary is not always required. Fiduciary law has, for example, been applied flexibly to allow deployment of financial incentives directed at physicians for controlling health care costs.[45]

Moreover, the question of physicians' fiduciary duties 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 a reduced risk of antibiotic resistance.

B *Possible Justifications*

Countervailing justifications support strengthening physicians' public health duties.

1 Role Indispensability

Perhaps the strongest reason is the physician's critical and indispensable role in protecting the health of the community. 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. The conventional 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. 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."[46]

[44] Kenneth S. Abraham & Leslie Kendrick, There's No Such Thing as Affirmative Duty, 104 *Iowa L. Rev.* 1649, 1692 (2019).

[45] See, for example, Robert Gatter, Communicating Loyalty: Advocacy and Disclosure of Conflicts in Treatment and Research Relationships, in Oxford Handbook of U.S. Health Law 242–47 (2017).

[46] Donald G. McNeil, Jr., American Public Health Infrastructure Needs an Update, NY Times (June 18, 2020), www.nytimes.com/article/coronavirus-facts-history.html#link-5d80e42a.

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 front-line practitioners, they have the initial opportunity to identify illnesses and patterns that threaten the entire community. Physicians also are usually in the best position to act on alarming information when limited time windows exist.[47]

Second, community physicians perform a key role as gatekeepers. They are in an advantageous position to monitor, influence, and induce demand for health care products and services. There is a clear connection between gatekeeping and public health. For example, the negative downstream effects of indiscriminate opioid prescribing can be understood as community physicians performing poorly as gatekeepers to powerfully addictive medications.

Third, physicians perform key roles as learned intermediaries. Informed consent law and the learned intermediary doctrine under product liability law require that physicians distill and shape complex medical information for their patients' particular situations and needs. As learned intermediaries, physicians can call attention to the public health implications that their patients may not otherwise understand or heed.

Physicians are successful learned intermediaries because they command significant public trust. Of course, a legal shift requiring stronger physician duties for public health protection could erode patient trust if patients perceive that 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.[48]

2 Social Contract

In addition to the basic benefits every citizen enjoys from the state, physicians are granted a special license to provide professional services. They also receive expensive medical education and graduate medical training that the government significantly subsidizes. Physicians also enjoy high social status and membership in an elite, guild-like profession. In return for these many benefits, physicians arguably have public health obligations.

However, it is debatable whether social contract theory can be relied upon to require broader public health measures of physicians. To the extent that 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 voluntarily assume broad public health responsibilities when

[47] Fill et al., supra note 36, at 581.
[48] Mark A. Hall, Law, Medicine, and Trust, 55 *Stan. L. Rev.* 463, 507 (2002).

entering the medical profession.[49] Moreover, many physicians could justify their regular patient care activities as fulfilling their end of any implicit social contract bargain.

3 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 public and most physicians likely agree on the reassuring dynamic of the faithful doctor who acts zealously for his or her patient. Under this view, physicians who "prioritize public health care … would devalue the expectations of patients."[50]

On the other hand, social expectations might actually be more nuanced. The public does observe community physicians working to safeguard public health, for example in common activities such as vaccination and assessing impaired patients' fitness to drive. 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.

4 Equitable Distribution of Physician Burden/Collective Action

Legal recognition of more robust public health duties for physicians would also help address concerns of inequitable physician burden. 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 public health risks propagate through the interconnectedness of health care system stakeholders. For example, in the case of antibiotic resistance, a few physicians' inappropriate prescribing patterns can introduce strong resistance selection pressures into the community, rendering future uses of medications ineffective, even if other physicians prudently conserve antibiotics.[51] Letting some physicians "off the hook" by not recognizing and uniformly applying more robust public health duties invites further problems of insufficient coordination.

C *Moving Forward*

How should the law move forward with a legal shift in physicians' public health obligations? Admittedly, enhancing physicians' public health duties, while still

[49] Russell L. Gruen et al., Physician-Citizens-Public Roles and Professional Obligations, 291 *JAMA* 94, 95 (2004).

[50] Heinz-Harald Abholz, Conflicts Between Personal and Public Health Care: Can One GP Serve Two Masters?, 57 *Br. J. Gen. Prac.* 693, 694 (2007).

[51] David M. Livermore, Bacterial Resistance: Origins, Epidemiology, and Impact, 36 *Clinical Infectious Diseases* S11, S15–S16 (2003).

demanding strong obligations to each patient, may lead to much variability in practice. However, *any* adjustment in physicians' legal duties would still represent an improvement over the status quo.

Next, lawmakers and regulators ideally should, through statutes and regulations, identify clearer pathways whereby private physicians can enter the public health sphere, move beyond their heavy relational orbit with patients, and protect non-patients from health risks. As previously noted, some medical practice acts permit physicians to prescribe opioid antagonists to non-patients to prevent overdoses. Such codification on a broader scale would be welcome to counter perceived barriers because of patient primacy.

Also critical is stronger enforcement of the minimal public health obligations for physicians already existing under the law, such as addressing physicians' poor compliance with obligations to report communicable disease cases. Importantly, higher compliance can be achieved through targeted education, auditing, financial rewards, and leveraging physicians' intrinsic reasons for compliance, not just the threat of heavy sanction.

Finally, non-maleficence serves as a helpful guiding principle for thinking about the dual-loyalty problem between patient welfare and public health. Non-maleficence generally requires that a physician's intervention not harm the patient. In many instances of potential dual-loyalty conflict, physicians could better justify actions taken for public health protection by ensuring that such conduct at least does not further harm their individual patients. This may not be always practicable. When respecting non-maleficence is feasible, however, with concurrent public health protection, physicians' public health duties should be interpreted to incorporate the principle.

VI CONCLUSION

The traditional pattern of patients first, public health last facilitates the externalization of health risks to the community. It has become unavoidably necessary to reconsider physicians' duties and ensure that they pay greater heed to the population's health. The law needs to appropriate physicians for public health protection because, as a practical matter, there are no better choices.

Their unique strategic role, embedded between the patient, other patients, and society, makes physicians indispensable to effective public health protection.