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COVID-19 Control: Disrupting Doctor-Patient Relationships

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ABSTRACT

The full-armamentarium of public health countermeasures came into play when COVID-19 emerged; a few examples are quarantine, closures, and social distancing. These countermeasures are intended to protect population health but trench on many important rights protected by ethical precepts and tort, constitutional, or other law. The measures studied here, orders to delay "elective" medical procedures to preserve resources, have been virtually ignored. Yet, they are uniquely broad, risky, and disruptive of doctor-patient relationships. Delay also can be shoddily promulgated or implemented, thus creating tort liability. Although medicine (speaking for the few) and public health (speaking for the many) traditionally have clashed, this article shows that medical and public health law and ethics combine to require strict (constitutional) or stringent (medical and public health ethics) scrutiny of delay actions. This scrutiny requires a showing that a countermeasure is necessary, effective, and the least intrusive way to further vital governmental goals. Delay orders trench on several fundamental or special liberties. This article focuses on those as well as the seldom-discussed fundamental right to purchase care (or insurance for it) available in the open market. Although delay regimes can be beneficial if properly promulgated and implemented, it is unlikely that the COVID-19-related actions can meet ethical standards or withstand constitutional strict or even certain types of intermediate scrutiny that require the government show the actions work or are the least restrictive alternative.

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I. INTRODUCTION

As the SARS-CoV-2 pandemic descended on the United States in early 2020 and the realization and shock of COVID-19 morbidity and mortality confronted the nation, federal, state, and professional groups began issuing orders, mandates, and recommendations for health care providers to delay so-called elective or non-essential health care.[1] The announced purpose of this move was to conserve

1. "Orders" or "mandates" are obligatory duties created by government or professional bodies. "Recommendations" are non-obligatory guidance provided by such bodies. Either can be used in legal, ethical, or policy analyses. Several of these pronouncements will be discussed in Part IV. This Article's focus is on tort liability, clinical medicine and public health ethics (including their interaction), and constitutional law concerning the delay of so-called elective procedures. Thus, legal and ethical issues related to more often-considered pandemic countermea-

both the healthcare workforce and resources, such as general medical and intensive care (ICU) beds, respirators, masks, and other personal protective equipment (PPE) to deal with COVID-19. Continuing shortages in medical resources suggest that delay directives did not achieve their goals and, in fact, have caused morbidity and mortality among individual patients, severe financial damage to health care providers, and risks to quality, cost, and access in the health care system. Beyond grave risks of mortality and morbidity, a delay directive is also unique among countermeasures in that it disrupts physician-patient relationships that foster proper care by familiarizing providers with the bodies and minds of patients and by engendering vital patient trust.[2] There are, moreover, several less intrusive alternatives: obtaining voluntary delays; well-planned and -implemented guidelines for delays; setting delays within an overall comprehensive mix of countermeasures; obtaining needed health care providers by rearranging, recruiting, conscripting, or activating; giving licenses to inactive or unlicensed health care providers; and insofar as the federal government is involved or can be approached for cooperation, conquering shortage of medical resources by forcing companies to mass produce needed items.[3]

Primarily, this Article explores benefits and problems presented by promulgation and implementation of delay pronouncements and, most importantly, discusses helpful legal and ethical approaches in reconciling the interests of public health and of individual patients. This entails: (1) examining a representative sample of early delay pronouncements; (2) discussing benefits and problems in their promulgation and implementation; (3) analyzing a hypothetical medical malpractice case that serves as a platform for application of the concepts and principles; (4) exploring ways delay pronouncements can be used by litigants, jurists, and policy decision-makers to advocate for or set standards in civil law, tort, or constitutional law; and (5) considering similar manners in which medical and public health legal and ethical precepts generally can be used by the same professionals.

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sures such as quarantine; isolation; social distancing; forced testing, screening, vaccination, or treatment; stay-at-home orders; closure of all but essential public or private activities of cities, economic sectors, or entire states unless they can be performed at home; and limitations on travel are referenced here only insofar as they provide insight into to the delayed care issue. Although liability and certain constitutional provisions are discussed, the Article does not address Fourth Amendment violations, eminent domain, statutory causes of action, or business litigation (even if it relies on constitutional theories). Only brief reference is made to the affiliated topics of immunities from liability and professional discipline.

2. *See infra* Part II. Regarding the multiple beneficial effects of patients' trust in their health providers, see Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 478–82 (2002).

3. Hall, *supra* note 2. Regarding mandatory production, see the Defense Production Act of 1950, 50 U.S.C. §§ 4501–4568.

This Article employs constitutional law to analyze, defend, or undercut the use of delay pronouncements, ethical codes, literature, and concepts. It also determines the constitutionality of delay actions under substantive due process and equal protection by characterizing the nature and weight of the asserted constitutional rights or interests and the degree of intrusion on those rights (by direct effect or through classifications) leading to a choice and application of the appropriate standard of scrutiny. The choices among the latter range from an extremely deferential rational basis test to strict scrutiny, with several intermediate tests between the extremes.[4] This analysis shows that constitutionally judging delay pronouncements is unique because, first, they are perhaps the harshest and most wide-ranging pandemic countermeasure due to the morbidity and mortality risks they pose. Second, it is particularly difficult to choose the appropriate standard of review. The landmark case relevant to judging public health measures—the United States Supreme Court's 1905 *Jacobson v. Massachusetts*[5]—can be read as applying a very deferential standard akin to the rational basis test. On the other hand, several commentators interpret it as containing several limitations that favor those challenging public health measures.[6] Third, contemporary authorities either

4. Substantive due process and equal protection are based in the Fifth and Fourteenth Amendments. See ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 727–29, 858–62 (6th ed. 2019), regarding the weight of rights or interests, the nature of intrusions or classifications, and levels of scrutiny.

5. 197 U.S. 11 (1905).

6. *See, e.g.*, Lindsay F. Wiley & Stephen I. Vladeck, *Coronavirus, Civil Liberties, and the Courts: The Case Against "Suspending" Judicial Review*, 133 HARV. L. REV. F. 179 (2020) (suggesting that the suspension of judicial review is comparable to the substantial deference given by the courts at all levels to governmental public health measures during emergencies as well as providing an insightful survey of cases, constitutional doctrine, and standards of review); Jeffery D. Jackson, *Tiered Scrutiny in a Pandemic*, 12 CONLAWNOW 39 (2020) (arguing that scrutiny should not be relaxed in public health emergencies and that courts should balance burdens on rights and public health achievements and applying the Constitution to various countermeasures—including making abortion an "elective" procedure—used in the current pandemic); Craig Konnoth, *Narrow Tailoring the COVID-19 Response*, 11 CALIF. L. REV. ONLINE 193, 206 (2020) ("The test I propose is a causal nexus between the offsets and the burdens that are imposed. That is, the offsets would not have been provided *but for* the regulatory burdens. It would not matter whether the legislation is in the same or different bill: sometimes provisions in omnibus bills are completely unrelated. And as with the COVID-19 response, related regulatory responses may pass weeks apart from each other."); Michael H. Shapiro, *Updating Constitutional Doctrine: An Extended Response to the Critique of Compulsory Vaccination,* 12 YALE J. HEALTH POL'Y L. & ETHICS 87, 93–95, 103–05 (2012) (suggesting that *Jacobson* probably applied a reasonable relationship test, setting forth an argument structure concerning compulsory hepatitis B vaccination of preschoolers, noting ambiguity concerning what standard would apply in the contemporary world, and hypothesizing that a vaccination requirement would be found constitutional); Mary Holland, *Compulsory Vaccination, the Constitution, and the Hepatitis B Mandate for*

argue that *Jacobson* is deferential and should be followed today, or that the case is a relic of history, given the Court's development over the last several decades of a tiered approach to standards of review. Those who embrace invigorated scrutiny argue that it should, but might not, be applied in cases involving severe public health measures.[7]

There should be either strict or substantially invigorated scrutiny of governmental delay pronouncements because of ethical concerns and because they substantially intrude on fundamental rights. As will be discussed in section VIII.C, these rights include life, physical health, bodily integrity, autonomy of decision-making in intimate affairs, and a right to purchase healthcare or medical insurance. This Article focuses on delay measures because they are unique and little-studied, even though they are one of the harshest and most wide-ranging public health measures. Although delay regimes can be helpful in preserving vital medical resources if carefully promulgated, specific pandemic countermeasures will not be effective unless implemented with other public health measures, such as isolation of carriers and quarantine of persons exposed to carriers, that comprise a sound package of public health measures. However, the current regime, in many respects, cannot withstand strict or invigorated scrutiny—legally or ethically. Ultimately, this Article concludes that in the context of delaying care and considering the interests of both society and individuals, governmental officials should prioritize individuals and their physician-patient relationships, as explained in the medical literature; should interrupt that relationship only with solid justification, coordination, communication, and care; and should have the burdens of presenting evidence and of persuasion when its tools seriously affect physician-patient relationships or related constitutional rights.

The justification for a presumption in favor of those who oppose delayed care is that, first, promulgation or implementation of a delay pronouncement is, as indicated above, unique among public health measures used to control COVID-19. This Article mentions general economic harms that government entities should consider in any ultimate decision regarding social welfare, but highlights the physical,

Infants and Young Children, 12 YALE J. HEALTH POL'Y L. & ETHICS 39, 48–65, 80–84 (2012) (canvassing cases before and after *Jacobson*, arguing that *Jacobson* applied scrutiny beyond the rational basis test, and seemingly arguing for either strict or intermediate scrutiny); Lawrence O. Gostin, *Public Health Theory and Practice in the Constitutional Design*, 11 HEALTH MATRIX 265 (2001) (suggesting a sliding scale of standards of review); Wendy E. Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53 (1985) (arguing intrusions must be carefully tailored and processes must comport with procedural due process; explaining that even closer scrutiny is required when administrative actions are at issue).

7. *See* sources cited *supra* note 6.

mental, and economic harms caused to individual patients and their families by delay pronouncements.

A second justification for the presumption against delayed care is that those who challenge public health measures usually lose in battles with those within the public health complex speaking for the many. To be sure, a presumption in favor of individuals could lead to equally drastic consequences. But there should be a checking function. At this point of the analysis, public health refers to a coalescence of traditional public health purposes and leanings in favor of the maximization of societal health, the powerful segment of society who readily embraces public health measures, and the entire governmental and private public health complex. Currently, many prominent public health mavens claim that traditional public health is changing into a "new public health" that cooperates with medicine and places civil, constitutional, and domestic and global human rights at the center of the discipline along with concerns for maximization of the health of populations and disadvantaged groups.[8]

A third justification is that the best reading of constitutional law, medical ethics, and public health ethics shows a consensus that the most potent public health measures should be strictly or stringently reviewed to determine whether they have been shown to be necessary, effective, and the least restrictive way to achieve vital governmental interests.[9] Meeting these proof requirements obviously requires the previous and concurrent collection of ideas, data, and other evidence concerning the relative safety and efficacy of public health countermeasures, and such proof, or its absence, will be considered.

This Article also discusses representative examples of "models" of the physician-patient relationship. Models are central to, and the primary source of, medical ethics. It also discusses representative public health ethics "frameworks" designed to address public health pandemic countermeasures. Models and frameworks all seek to reconcile individual interests with societal or group interests. Models give priority to the individual patient, while frameworks usually focus on the public—thus the name "public health."[10] To be sure, these perspectives are not rigid or monolithic, nor exhaustive or exclusive. They can differ within both fields and can form bridges between one another. They *necessarily* overlap in any rational social system that seeks to further all basic values—liberty, equality, fairness, justice, and utility (or, loosely, welfare). But each can freeze into unjustifiably hardened ideological positions. Although some things may be clearly forbidden

8. WENDY MARINER ET AL., PUBLIC HEALTH LAW 18 (3d ed. 2019).
9. *See* discussion *infra* Parts VI, VII and sections VIII.B–C, IX.E. Regarding enhanced constitutional judicial review of actions intruding on personal liberties, see *infra* note 144 and accompanying text.
10. *See infra* Parts VI, VII for analysis of models and frameworks.

or required, others require taking a powerful multiplicity of relevant variables into account. In some hands, starting with a presumption in favor of liberty, delay pronouncements are the bottom-line results of determining that societal needs *outweigh* individual needs. Also, without being reductive, "society" is a partial function of *aggregate individual needs, taken one at a time*. A society or corporate entity is not *just* people added up, but it does not exist, except as a shell, without people (or robots).

Additionally, this Article explores whether clinical medicine and public health are in fact separate spheres, examines pertinent legal and ethical precepts in those putative spheres to determine whether the two fields necessarily clash, and searches for analogous principles from both spheres that protect individuals from overly invasive public health measures. The discussions of medical and public health law and ethics elucidate the deep and principled respect for the physician-patient relationship in medical law and ethics; the circumscribed nature of any exception to this reverence that requires consideration of societal or third-party interests; the opposing fealty in public health law and ethics to population and group health under, most prominently, utilitarian calculations—it is primarily public health actors who stand behind the push for delay pronouncements and other severe pandemic countermeasures, although they have virtually ignored the former but paid attention to the latter. Analysis of whether medical and public health ethics are separate spheres requires brief reference to the interactions among bioethics, clinical ethics, and public health ethics.[11] These fields can be useful in studying, analyzing, advocating for, or adopting medical and public health law and ethics, and placement among the three can affect the approach of writers and shape readers' and listeners' receptivity to analyses. Although there is a tension between clinical medicine and public health, this Article ultimately finds that there is common ground with respect to the high degree of scrutiny that should be applied to review at least delay orders and any other equally intrusive public health interventions.[12]

Studying delay pronouncements is, in the patois of this Article, a "macro-triage" problem.[13] An example of macro-triage is deciding who should get scarce medical resources between a large and possibly nation-wide group of those who are seeking care that supposedly can be delayed, on one hand, and a larger national group of current and future COVID-19 patients. (A COVID-19 patient could be in both groups.) Macro- and micro-triage are distinct. Micro-triage involves one scarce resource distributed to one of two or a few patients. It is

11. *See infra* note 84 for discussion of bio-, medical, and public health ethics.
12. *See infra* Part X (regarding common ground between medicine and public health).
13. Here, macro-triage is used to indicate allocation of an array of scarce medical resources among large groups.

usually implemented by a committee populated by a small group of professionals and laypersons. Macro-triage involves an array of medical resources that might be weighed differently, and it is promulgated and issued by professional bodies or, more commonly, governmental officials—in the case of COVID-19, it was primarily state governors.[14] Macro-triage is the many against the few, micro-triage is the few against the few. This Article will only allude to micro-triage insofar as it informs the study of macro-triage and delay.

A roadmap: Part II discusses criticisms and situations that demonstrate how delay directives can be very damaging. Part III is a hypothetical medical malpractice case involving the implementation of orders and recommendations representative of the actual pronouncements surveyed in Part IV. Part V explores a tension between traditional medicine and public health. This includes discussion of the respective fields' traditional opposing perspectives and of the possible coordination of their concerns and concepts under a "new public health." This new field is arguably deeply concerned about population health and constitutional, human, and civil rights of individuals in domestic and global venues. Part VI is devoted to medical ethics, and Part VII covers public health ethics. Part VIII studies medical- and public health-related laws. Part IX applies the law and ethical precepts studied, referring to the hypothetical medical malpractice case (which, as elaborated, contains constitutional issues). Part X contains a summary of observations and recommendations. Part XI is a brief conclusion.

II. PROBLEMS RAISED BY DELAY PRONOUNCEMENTS

Improperly promulgated and shabbily implemented delay pronouncements can lead to morbidity and death and raise constitutional, tort, and ethical problems. Delay pronouncements can, if properly promulgated and implemented along with an appropriate set of accompanying public health measures, contribute to the set of measures by preserving the time of vital medical personnel and other medical resources necessary to protect health care providers and treat COVID-19 patients. They can meet enhanced review in the COVID-19 context only if that review does not require much proof of need, effi-

14. Similar terminology is used in Murray G. Brown, *Rationing Healthcare in Canada*, 2 ANN. HEALTH L. 101, 101 (1993) ("The central theme is that dispassionate-rationing decisions throughout the healthcare system indirectly influence micro-rationing decisions at the clinical level, which in extreme cases involve highly emotive and value-laden choices about which patients shall, or shall not, receive vital healthcare services."). Macro- and micro-triage have aliases such as "allocation" and "distribution." MICHAEL H. SHAPIRO, ROY G. SPECE, JR., REBECCA DRESSER & ELLEN WRIGHT CLAYTON, CASES, MATERIALS, AND PROBLEMS ON BIOETHICS AND LAW 1205 n.6 (2d ed. 2003).

cacy, or least restrictive alternative. As indicated, this Article concludes that there should be more robust scrutiny.

Potential damage can extend to persons not covered by delay pronouncements. Prominent public health authority Lawrence Gostin predicted at the outset of the COVID-19 pandemic that more people would die from delayed or disrupted urgent care than from COVID-19 itself, and he agrees there must be checks on invasive public health measures.[15] Other prominent public health ethics authorities join Gostin and argue that invasive public health measures should not be implemented unless they are necessary, effective, and the least restrictive alternative.[16] This showing would be difficult, especially given the dearth of studies or analyses that show delay actions, even within a well-conceived package of countermeasures, produce a net benefit. Policymakers should collect data before undertaking delay pronouncements, and one hopes data is being collected concerning COVID-19 countermeasures. At the least, proof of efficacy and precision could lie in a study of earlier pandemics and extrapolations from other analyses or data. The inadequacy of delay pronouncements is suggested by the scarcity of some medical resources that delay pronouncements were designed to preserve months after they were issued. As indicated above, there are several possible less restrictive alternatives.[17]

Criticisms of and litigation regarding delay pronouncements came quickly.[18] For instance, three major health care provider groups and a

15. Lawrence O. Gostin et al., *Responding to Covid-19: How To Navigate a Public Health Emergency Legally and Ethically*, 10 HASTINGS CENT. REP. 8, 8–12 (2020) ("Disruptions to the health system will likely cause more deaths of persons with a variety of urgent health needs than of patients diagnosed with COVID-19. . . . In the areas hardest hit so far, like Seattle and New York, hospital administrators have been canceling or postponing elective—and even some more serious—surgeries." (footnotes omitted)).

16. Lawrence O. Gostin & Benjamin E. Berkman, *Pandemic Influenza: Ethics, Law, and the Public's Health,* 59 ADMIN. L. REV. 121 (2007); Mark A. Rothstein, *From SARS to EBOLA: Legal and Ethical Considerations for Modern Quarantine*, 12 IND. HEALTH L. REV. 227, 249, 267 (2015); James F. Childress & Ruth Gaare Bernheim, *Beyond the Liberal and Communitarian Impasse: A Framework and Vision for Public Health,* 55 FLA. L. REV. 1191, 1201–02 (2003).

17. *See supra* text accompanying note 3.

18. A recent article argues that politics are the major reason behind stay-at-home orders, which suggests that the same could be true of delay pronouncements. *See* Lea-Rachel Kosnik & Allen Bellas*, Drivers of Covid-19 Stay at Home Orders: Epidemiologic, Economic, or Political Concerns?* 4 ECON DISASTERS & CLIMATE CHANGE 503 (2020). For example, some states have tried to place certain abortions on the list of procedures that must be delayed. Michelle Bayefsky et al., *Abortion During the Covid-19 Pandemic—Ensuring Access to an Essential Health Service*, NEW ENGLAND J. MED. e47(1) (2020). Some states' directives specifically included abortions as procedures that should not be delayed. *See, e.g.,* Proclamation from Jay Inslee, Governor of Washington, 20-24: Restrictions on Non Urgent Procedures (Mar. 19, 2020), https://www.governor.wa.gov/sites/default/files/proc-

patient-plaintiff sued Michigan Governor Gretchen Whitmer to strike her April 30, 2020 order extending the moratorium on elective procedures as violative of, among other theories, Fourteenth Amendment substantive due process.[19] The patient-plaintiff alleged that because of Whitmer's order, he lost post-operative care for a left knee replacement as well as an identical surgery that was scheduled for his right knee, leading to excruciating pain and a reduction in the hours he was able to work.[20]

Highlighting the ambiguity of so-called elective care, Arizona physician Marjorie Bessel, Banner Health's Chief Clinical Officer, commented: "Elective surgeries—they're a little bit of a misnomer. . . . These are necessary surgeries—they're medically necessary surgeries."[21] Delaying medically necessary procedures risks morbidity and mortality. The situation is exacerbated by the backlog that accrues among patients whose procedures are delayed and patients who are hesitant to go to the hospital even for urgent problems (and presumably, future once-delayed care). Delay directives can trigger mistaken patients to delay medically necessary care.[22] Delay would likely

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lamations/20-24%20COVID-19%20non-urgent%20medical%20procedures%20%28tmp%29.pdf [https://perma.cc/6N7H-LC6U]; *see also* B. Jessie Hill, *Essentially Elective: The Law and Ideology of Restricting Abortion During the COVID-19 Pandemic*, 106 VA. L. REV. ONLINE 99 (2020) (arguing abortion was "singled out for disparate treatment" during the COVID-19 pandemic). There is a bevy of reported cases most of which have been decided in favor of abortion defenders; a string cite would add nothing.

19. *See* Mary Anne Pazanowski, *Medical Providers Sue Michigan Governor over Shut-Down Orders*, BLOOMBERG L. (Apr. 13, 2020), https://news.bloomberglaw.com/health-law-and-business/medical-providers-sue-michigan-governor-over-shut-down-orders [https://perma.cc/Q5DE-4T45].

20. Complaint at 10, Midwest Inst. of Health, PLLC v. Whitmer, No. 20-cv-414, 2020 WL 3248785 (W.D. Mich. 2020). On appeal, the Sixth Circuit certified state law questions for decision by the Michigan Supreme Court. Midwest Inst. Of Health, PLLC v. Whitmer, No. 20-cv-414, 2020 WL 3248785 (W.D. Mich. June 16, 2020), *certified questions answered sub nom.*, *In re* Certified Questions from U.S. Dist. Ct., W. Dist. of Mich., S. Div., 958 N.W.2d 1 (2020).

21. Bob Christie, *Arizona Hospitals at 83% Capacity, Elective Surgery May Stop,* TUCSON (Sept. 28, 2020), https://tucson.com/news/local/arizona-hospitals-at-83-capacity-elective-surgery-may-stop/article_6b6c3ecc-0534-5518-b18e-e7e9238d3295.html#tracking-source=home-top-story [https://perma.cc/2YYH-EY9L]. The vague and incomplete nature of many of the directives probably contributed to attempts by governmental officials to put a moratorium on certain abortions. These attempts have already spawned a flurry of litigation. *See, e.g., supra* note 18.

22. *See* Jana M. Craig et al., *After the Surge: Prioritizing the Backlog of Delayed Hospital Procedures*, HASTINGS CTR. (June 19, 2020), http://www.thehastingscenter.org/after-the-surge-prioritizing-the-backlog-of-delayed-hospital-procedures [https://perma.cc/Y4FW-SSQW] (explaining factors that have contributed to a backlog of delayed procedures). It is plausible that elective patients who would have gone ahead with their scheduled procedures will develop fear or angst that will bring them to forego belated care.

exacerbate racial disparities in access to health care.[23] Public health measures, such as isolation and quarantine, have had disparate effects on minority groups, which some suggest may be protected through use of countermeasures.[24] Even if so, however, the argument for forced public health measures to protect minority populations does not apply to delay.

Consider a case described to a *New England Journal of Medicine* correspondent in April of 2020:

> In late March, Zoran Lasic, an interventional cardiologist . . . was finishing afternoon clinic when he was approached by a nurse colleague. . . . Her husband—a 56-year-old whose father died of sudden cardiac arrest at 55—had been feeling chest pressure. The pressure radiated down his arms and occasionally to his neck and, the previous day, had been accompanied by dyspnea and diaphoresis, making him worried enough to call an ambulance. The emergency medical technicians did an electrocardiogram, said it looked OK, and told him to call his primary care doctor. He did, and he was advised that given New York's Covid-19 outbreak, it was not a good time to go to the hospital. Now, a day later, his colleague asked Lasic, what should they do?
>
> Nearly apoplectic, Lasic advised urgent coronary angiography, which he performed a few hours later. The man had a thrombus extending from his proximal-to-midleft anterior descending artery and became hemodynamically unstable during the procedure. Nevertheless, revascularization was successful, and he was discharged the following day with preserved left ventricular function. Lasic, describing a precipitous decline across the New York region in patients presenting with acute coronary syndromes, worries that others won't be so lucky. "I think the toll on non-Covid patients will be much greater than Covid deaths."[25]

Additional problems reported to the same correspondent include:

> David Ryan, chief of oncology at Massachusetts General Hospital (MGH), [said certain] patient groups worry him most. The first are the subgroup of patients with lymphoma for whom CAR-T therapy is potentially curative. More than half these patients receive therapy in clinical trials, many of which have been paused amid society-wide shutdowns; even if enrollment could continue, there's concern about the need for ICU care in a resource-constrained system. A related concern is for patients requiring bone marrow transplants, given their high risk of infection and potential need for ICU care.[26]

The United Kingdom has the same delay problem, and a range of persons and entities report inquiries from allegedly damaged delay patients. Cases include metastatic cancer resulting from a months-long delay in a Magnetic Resonance Imaging (MRI) study, despite the

23. Ruqaiijah Yearby, *Racial Inequities in Mortality and Access to Healthcare*, 32 J. LEGAL MED. 77, 78–79 (2011).

24. Amy Fairchild, Lawrence Gostin & Ronald Bayer, *Vexing, Veiled, and Inequitable: Social Distancing and the Rights Divide in the Age of COVID-19*, 20 AM. J. BIOETHICS 55 (2020), https://doi.org/10.1080/15265161.2020.1764142 [https://perma.cc/TZ3D-DPXD].

25. Lisa Rosenbaum, *The Untold Toll—The Pandemic's Effects on Patients Without COVID-19*, NEW ENGLAND J. MED. (Apr. 17, 2020), https://www.nejm.org/doi/full/10.1056/NEJMms2009984 [https://perma.cc/VH7B-D4GP].

26. *Id.*

patient's plea for early diagnosis and serious depression caused by delay-associated pain.[27]

Although economic harms are not the focus here, they are worth mentioning because officials should consider economic harms when deciding, legally or ethically, whether to undertake or continue delay measures. The furloughs of health care providers and the interruption of a substantial portion of the health care system have economically damaged individual and institutional health care providers, leading some to declare bankruptcy. Economic harms could have long-term effects that might bankrupt many more care providers and exacerbate the cost and access crises in our health care system.[28]

To starkly illustrate how far the zeal to maximize the preservation of population health through macro-triage can be taken, consider an analogous micro-triage proposal issued by prominent physicians and experts in response to COVID-19. They proposed that persons be removed from ventilators, without consent by the removed persons or their families, in favor of different patients more likely to benefit in terms of health and life.[29] In most cases, the removed patient would likely die immediately or in a matter of days as a result (certainly within any one-year limitation). If so, assuming the withdrawn care is neither "futile" nor worthless, such action would be unethical and pos-

27. Dennis Campbell, *Man "Fighting for Life" After Covid-19 Crisis Delays NHS Cancer Scan*, GUARDIAN (June 9, 2020), https://www.theguardian.com/society/2020/jun/09/man-fighting-for-life-after-covid-19-crisis-delays-nhs-cancer-scan/ [https://perma.cc/TC2W-ELJX]; *see also* John Tingle, *Patient Safety in the United Kingdom After COVID-19,* HARV. L. SCH.: BILL HEALTH BLOG (May 20, 2020), https://blog.petrieflom.law.harvard.edu/2020/05/20/patient-safety-united-kingdom-nhs-covid19/ [https://perma.cc/9HHP-ZH4Z] (discussing the patient safety landscape following COVID-19).

28. Dhruv Khullar, *The Coronavirus Pandemic's Wider Health-Care Crisis,* NEW YORKER (June 29, 2020), https://www.newyorker.com/science/medical-dispatch/the-coronavirus-pandemics-wider-health-care-crisis [https://perma.cc/W3ZY-A9Q4] ("Hospitals in Massachusetts are losing $1.4 billion in revenue per month, and project total losses of five billion dollars by the end of July [a month away]. The Mayo Clinic alone, which runs twenty-three hospitals nationwide, is set to lose three billion dollars this year. The American Hospital Association estimates that, altogether, U.S. hospitals are bleeding fifty billion dollars a month during the pandemic. The hundreds of thousands of doctors in independent practice have more limited capital reserves, and many may be forced to shutter their operations or merge them with others.").

29. Ezekiel Emanuel et al., *Fair Allocation of Scarce Medical Resources in the Time of Covid-19,* NEW ENG. J. MED. (Mar. 23, 2020), https://www.nejm.org/doi/full/10.1056/NEJMsb2005114?query=recirc_curatedRelated_article (observing that many authorities have argued that this would not be homicide but also noting that, "undoubtedly, withdrawing ventilators or ICU support from patients who arrived earlier to save those with better prognoses will be extremely psychologically traumatic for clinicians").

sibly murder (or another illegal homicide) under present legal doctrine.[30]

III. A HYPOTHETICAL MEDICAL MALPRACTICE CASE

Here is a hypothetical that is analogous to cases mentioned in Part II. The hypothetical facilitates analysis by providing a context for application of the legal and ethical concepts covered.

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30. Valerie Kotch & Beth Roxland, *Unique Proposals To Limit Liability and Encourage Adherence to Ventilator Allocation Guidelines in an Influenza Pandemic*, 14 DEPAUL J. HEALTH CARE L. 467, 499–500 (2013) (calling for additional immunity provisions since few states provide immunity from criminal liability, and recognizing that taking a person off a ventilator without permission can reasonably be characterized as murder); TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 184 (8th ed. 2019) ("[W]ithdrawing treatment [e.g., a respirator] from a competent patient is not morally justifiable unless the patient has made an informed decision authorizing this withdrawal."). This is not a treatise on murder, but a basic definition of the concept is:

> The crime of murder is the killing of one human being by another that is: intentional, . . . unlawful (as opposed to the lawful killing by a police officer . . .), and done with "malice aforethought." Malice aforethought, which is sometimes erroneously called "premeditation" (a type of malice aforethought), describes a state of mind or actions that evidence an: intent to kill or intent to inflict very serious, or grievous bodily harm, extremely reckless indifference to the value of human life, or intent to commit a dangerous felony (which accidentally results in the death of another).

Deborah England, *Homicide: Murder and Manslaughter*, CRIM. DEF. LAW., https://www.criminaldefenselawyer.com/resources/murder-and-homicide.htm, [https://perma.cc/699Y-9F5F] (last visited July 25, 2020). Assuming it is certain to lead to quick death, withdrawal of a ventilator is killing of one human being by another, without legal justification (such as rehabilitation or punishment), and with malice aforethought in the sense that it is intended because death is certain to occur. Even euthanasia at the request of a suffering patient is said to be with malice in the sense of intent imputed because of the ineluctable effect. *See, e.g.,* Washington v. Glucksberg, 521 U.S. 793 (1997) (rejecting a right to physician-assisted suicide without specific legislative approval). I understand that there are challenges to bringing homicide cases in this context, not the least of which is the beyond a reasonable doubt standard of proof. Separate issues arise when a criminal defendant argues that taking organs for transplant after declaration of brain death constitutes an intervening, superseding cause, David Sweet, Annotation, *Homicide by Causing Victim's Brain-Dead Condition*, 42 A.L.R.4th 742 (1985), when it is alleged that harm caused by treatment or mistreatment of the condition caused by the defendant breaks the chain of causation, Carolyn MacWilliam, Annotation*, Homicide Liability Where Death Immediately Results from Treatment or Mistreatment of Injury Inflicted by Defendant*, 50 A.L.R.5th 467 (1977), a physician withdraws life support from a comatose patient, Gregory Sarno, Annotation, *Homicide: Physician's Withdrawal of Life Support from Comatose Patient*, 47 A.L.R.4th 18 (1986), or a physician administers pain-killing medication sufficient to induce unconsciousness to a terminally ill patient when that might hasten death, *Sedation to Unconsciousness in End-of-Life Care*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/ethics/sedation-unconsciousness-end-life-care# [https://perma.cc/JQX2-BFQN] (last visited Mar. 6, 2020).

Hypothetical: Patient Sam saw his cardiologist, Dr. Williams, on February 28, 2020. Dr. Williams charted: "history and current condition—history of hypertension, diabetes, a smoker, increasingly obese, and elevating chest pain." Sam was scheduled for a March 25, 2020 coronary angiogram at the General Hospital & Clinic. On March 15, 2020, the governor of Sam's state issued an executive order stating that physicians and medical institutions in the state should cancel and indefinitely defer all non-essential elective invasive procedures. "Non-essential invasive procedures" were defined as those procedures scheduled in advance because they do not require an emergency medical procedure. This order remained in effect through July of 2020. Noting that the definition of procedures that should be canceled and deferred was extremely broad, the hospital furloughed 100 doctors—including Sam's cardiologist Dr. Williams.

Dr. Hughes oversaw General Hospital's response to COVID-19. He occupied a high administrative position, but he did some clinical work. He was so busy, given the pandemic, he neither created a protocol requiring that physicians have thorough discussions with each patient subject to delay, nor demanded non-furloughed doctors communicate with the prior physicians to gather data pertinent to urgency determinations. Dr. Hughes agreed that there should have been a protocol and that it should have included these requirements. He did distribute a memorandum saying that physicians making urgency determinations should consider the needs of current and future COVID-19 patients.

Before the furloughs and while walking Sam and his wife to the exit of the facility, Sam's wife asked Dr. Williams why he had scheduled the angiogram when he did. The doctor replied, "We've been putting it off too long and cannot wait another three months." The doctor did not chart any such statement, and Sam's wife did not recall it for several months because she was in high anxiety over the COVID-19 imbroglio. Dr. Williams did not chart anywhere the urgency he perceived about the angiography. Only two of eight cardiologists were not furloughed, and they were assigned to work from home with access to patient records through a patient portal. Their responsibilities included reviewing furloughed doctors' patient charts to check whether those patients needed "expedited" care.

One of the non-furloughed cardiologists, Dr. Burton, reviewed Sam's records in light of professional association guidelines the hospital instructed him to use when determining whether re-assigned patients required expedited care. He determined the angiogram was elective although he could have communicated with Dr. Williams and further investigated ambiguity in the guidelines concerning patient classifications. Cardiologist Burton then sent Sam a patient portal message (a common provider amenity that allows both physicians and

patients to send messages, and patients to access their own records digitally) that his angiography was canceled and would be rescheduled. The hospital also mailed Sam an identical note. Three months went by without any additional communication with Sam. Sam suffered a fatal heart attack three months after cardiologist Burton reviewed his records. Do the hospital and physicians have any civil liability?[31]

IV. DELAY MANDATES, ORDERS, REQUESTS, RECOMMENDATIONS[32]

Describing a representative sample of the early COVID-19-inspired mandates or recommendations to delay by canceling or indefinitely suspending elective, voluntary, non-urgent, or non-essential care might be tedious.[33] The goal, however, is to give summaries that provide both a feel for the ambiguity and terseness of these pronouncements and background information that will facilitate understanding when examining their use legally and ethically. Consider first the Centers for Disease Control and Prevention's (CDC) February 29, 2020, *Interim Guidance for Healthcare Facilities.*[34] This document recommended that—when necessary and feasible—patient health care providers reschedule elective surgeries and shift urgent diagnostic and surgical interventions to outpatient facilities. On March 13, 2020, the American College of Surgeons (ACS) stated in its *COVID-19: Recommendations for Management of Elective Procedures*:

> Each hospital, health system, and surgeon should thoughtfully review all scheduled elective procedures with a plan to minimize, postpone, or cancel electively scheduled operations, endoscopies, or other invasive procedures until we have passed the predicted inflection point in the exposure graph and

31. Note that there can be rare instances of criminal liability. For example, New York Mayor Bill de Blasio's emergency order mentions the possibility of criminal sanctions under existing law. Executive Order from Bill de Blasio, Mayor of N.Y.C., Emergency Executive Order No. 100 (Mar. 16, 2020), https://www1.nyc.gov/assets/home/downloads/pdf/executive-orders/2020/eeo-100.pdf [https://perma.cc/BCF2-ZJ34].

32. For an excellent source on the substance and chronology discussed in this section, see Karen S. Sealander et al., *How To Handle Elective Procedures and Surgeries During the Covid-19 Pandemic*, McDermott Will & Emery, LLP: Insights Blog (Mar. 22, 2020), https://www.mwe.com/insights/how-to-handle-elective-surgeries-and-procedures-during-the-covid-19-pandemic [https://perma.cc/MKG4-VQEA].

33. Such vague terms were used in many of the pronouncements, while some ameliorated ambiguity by listing of specific situations and procedures. *See* discussion *supra* Part IV.

34. *Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States,* Ctrs. Disease Control & Prevention (Feb. 29, 2020), https://stacks.cdc.gov/view/cdc/85502 [https://perma.unl.cc/N2BY-DJPQ].

> can be confident that our health care infrastructure can support a potentially rapid and overwhelming uptick in critical patient care needs.[35]

The next day the Surgeon General retweeted ACS's recommendations, asked that they be followed, and pointed out that each elective surgery performed potentially brings COVID-19 to facilities, consumes protective equipment, and enervates personnel who could otherwise devote time to treating COVID-19 patients.[36] Thus, within a two-week period, three major health care offices issued parallel delay/shift/cancel recommendations.

Additional professional groups, federal and state government, and the White House Task Force issued mandates or recommendations in March 2020. There is ongoing monitoring of these pronouncements as well as of lapses of or new and modified orders or requests.[37] Spikes in what was, as of August 2020, the first wave of COVID-19 prevalence occurred in virtually every state and engendered additional mandates or requests that raise the issues discussed here. These issues will also arise in future pandemics.[38]

Governmental *mandates* issued in mid-March of 2020 include: (1) A March 15, 2020 Order of the Massachusetts Department of Public

35. *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/39XM-NC9Y]. The ACS subsequently released detailed guidelines pertinent to individual care categories. *Local Resumption of Elective Surgery Guidance*, AM. COLL. SURGEONS (Apr. 17, 2020), https://www.facs.org/covid-19/clinical-guidance/resuming-elective-surgery [https://perma.cc/37DB-D9PW].

36. Jerome Adams (@Surgeon_General), TWITTER (Mar. 14, 2020, 5:07 AM), https://twitter.com/Surgeon_General/status/1238798972501852160.

37. For a full listing of the early March 2020 pronouncements, see Sealander et al., *supra* note 32. Regarding subsequent developments, see Dena Bunis & Jenny Rough, *List of Coronavirus-Related Restrictions in Every State,* AARP (Mar. 4, 2021), https://www.aarp.org/politics-society/government-elections/info-2020/coronavirus-state-restrictions.html [https://perma.cc/RYZ6-52JS]; Tiffany Kung, *How Doctors Are Keeping Patients Safe as Elective Surgery Resumes*, ABC NEWS (May 2, 2020), https://abcnews.go.com/Health/doctors-keeping-patients-safe-elective-surgery-resumes/story?id=70316383 [https://perma.cc/7CRG-44XQ] ("Approximately 20 states have resumed elective surgeries . . . ."); Muriel Bowser, *Phase 1 Guidance: Coronavirus 2019 (COVID-19) Guidance for Elective Surgery*, GOV'T D.C. (May 26, 2020), https://coronavirus.dc.gov/sites/default/files/dc/sites/coronavirus/page_content/attachments/COVID-19_DC_Health_Guidance_for_Elective_Surgery_Reopening_DC_2020.05.26_FINAL.pdf [https://perma.cc/HLT3-8CVP]; *States with Elective Medical Procedures Guidance in Effect,* AM. COLL. RADIOLOGY (May 18, 2020), https://www.acr.org/-/media/ACR/Files/COVID19/States-With-Elective-Medical-Procedures-Guidance-in-Effect.pdf?la=en [https://perma.cc/96Z9-CVL6].

38. *See* Eli Y. Adashi & I. Glenn Cohen, *A Legislative Blueprint for the Next Pandemic*, JAMA HEALTH F. (July 24, 2020), https://jamanetwork.com/channels/health-forum/fullarticle/2768924 [https://perma.cc/S7D9-JEW7] (noting failure to prepare for COVID-19 pandemic in light of clear warnings and speaking to need for legislation to deal with coming pandemics).

Health requiring that all hospitals and ambulatory surgical centers create and implement procedures and guidelines regarding non-essential invasive procedures.[39] (2) The next day, New York's mayor promulgated an Executive Order directing all hospitals and ambulatory surgery centers in New York City to cancel or postpone all elective surgeries that may be canceled or postponed based on patient risk starting March 20, 2020.[40] (3) The next day, the Director of the Ohio Department of Health ordered that non-essential or elective surgeries and procedures that utilize PPE should not be conducted.[41] (4) On March 19, 2020, Alabama's Governor mandated that "[a]ll elective dental and medical procedures shall be delayed, effective immediately."[42] (5) The same day, Colorado's Governor promulgated an Executive Order suspending "all voluntary or elective surgeries or procedures, whether medical, dental, or veterinary, until April 14, 2020[,] at the earliest."[43] (6) Also that same day, Washington's Governor issued a Proclamation, which stated:

> I hereby prohibit all hospitals, ambulatory surgical facilities, dental, orthodontic and endodontic offices in Washington State from providing health care services, procedures, and surgeries that, if delayed, are not anticipated to cause harm to the patient within the next three months, with exceptions and as provided below. This does not include outpatient visits delivered in hospital based clinics. . . .
>
> . . . .
>
> . . . The above prohibition does not apply to the full suite of family planning services and procedures or to treatment for patients with emergency/urgent needs (examples of the latter include, but are not limited to, people with heart

39. Order from Monica Bharel, Comm'r, Massachusetts Dep't of Pub. Health, Order of the Commissioner of Public Health (Mar. 15, 2020), https://www.mass.gov/doc/march-15-2020-elective-procedures-order/download [https://perma.cc/32NH-L26Q].

40. *See* de Blasio, *supra* note 31 (mentioning the possibility of criminal sanctions under existing law).

41. Order from Amy Acton, Dir. of Health, Director's Order for the Management of Non-Essential Surgeries and Procedures Throughout Ohio (Mar. 17, 2020), https://coronavirus.ohio.gov/wps/wcm/connect/gov/e7cee147-0f86-438b-ae1f-c5922f46c47c/Director%27s+Order–on-essential§urgery+3-17-2020.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-e7cee147-0f86-438b-ae1f-c5922f46c47c-n3GxdDg [https://perma.cc/J979-4AZX].

42. *Governor Ivey Issues Statement on Statewide Public Health Order*, OFF. ALA. GOVERNOR (Mar. 19, 2020), https://governor.alabama.gov/newsroom/2020/03/governor-ivey-issues-statement-on-statewide-public-health-order/ [https://perma.cc/NNM4-T7CC].

43. Order from Jared Polis, Governor of Colorado, Executive Order D 2020 009: Ordering the Temporary Cessation of All Elective and Non-Essential Surgeries and Procedures and Preserving Personal Protective Equipment and Ventilators in Colorado Due to the Presence of COVID-19 (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/6B9G-4ALE].

> attacks, strokes, or motor vehicle accidents). Hospitals and ambulatory surgical facilities may perform any surgery that if delayed or canceled would result in the patient's condition worsening (for example, removal of a serious cancerous tumor or dental care related to the relief of pain and management of infection).[44]

(7) The next day, Florida's Governor signed an Executive Order prohibiting "any medically unnecessary, non-urgent or non-emergency procedure or surgery which, if delayed, does not place a patient's immediate health, safety, or well-being at risk, or will, if delayed, not contribute to the worsening of a serious or life-threatening medical condition."[45] (8) On March 19, 2020, Michigan's Governor issued an order listing medical and dental procedures that must be postponed and specifying that emergency or trauma-related procedures not be postponed where delay would significantly affect the health, safety, and welfare of patients.[46] (9) Finally, that day Vermont's Governor directed doctors to postpone "all non-essential adult elective surgery and medical and surgical procedures" in the most efficient and safe way.[47]

Once again, additional orders and requests were issued but are not covered here.[48] The various orders and requests (including those listed above) describe the care that should be postponed as "elective," "non-essential," "non-urgent," "non-medically necessary," "voluntary," and like terms. They all necessarily contain ambiguities—some more than others—and only some explicitly call for case-by-case determinations.[49] But the uncertainties are often excessive. Two examples of ex-

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44. Inslee, *supra* note 18.
45. Order from Ron Desantis, Governor of Florida, Executive Order Number 20-72: Emergency Management—COVID-19—Non-Essential Elective Medical Procedures (Mar. 19, 2020), https://www.flgov.com/wp-content/uploads/orders/2020/EO_20-72.pdf [https://perma.cc/YX2U-REXZ].
46. Gretchen Whitmer, *Executive Order 2020-17, Temporary Restrictions on Non-Essential Medical and Dental Procedures,* STATE OF MICH. OFF. GOVERNOR (Mar. 19, 2020), https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-522451--,00.html [https://perma.cc/8T6X-VQPA].
47. Order from Philip B. Scott, Governor of Vermont, Addendum 3 to Executive Order 01-20: Suspension of All Non-Essential Adult Elective Surgery and Medical and Surgical Procedures (Mar. 20, 2020), https://governor.vermont.gov/sites/scott/files/documents/ADDENDUM%203%20TO%20EXECUTIVE%20ORDER%2001-20.pdf [https://perma.cc/EQX5-B2GA].
48. *See* sources cited *supra* notes 32, 37 and accompanying text.
49. For example, an April 7, 2020 recommendation by the Centers for Medicare & Medicaid Services called for a case-by-case analysis to place patients in one of three tiers of acuity: low, intermediate, or high. *Non-Emergent, Elective Medical Services, and Treatment Recommendations,* CTRS. MEDICARE & MEDICAID SERVS. (Apr. 7, 2020) https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf [https://perma.cc/M6K2-BXC9]. The American College of Surgeons posted even more detailed guidance to facilitate individualized judgments. *COVID-19: Guidance for Triage of Non-Emergent Surgical Procedures*, AM. COLL. SURGEONS (Mar. 17, 2020), https://www.facs.org/covid-19/clinical-guidance/triage [https://perma.cc/4KHP-K5AM].

cessively ambiguous "definitions" come from the Massachusetts and Colorado pronouncements. Massachusetts' order defines "non-essential elective invasive procedures" as "scheduled in advance because they do not require an emergency medical procedure."[50] This can be read to cover an overly broad scope of procedures. Colorado's mandate defines "voluntary or elective surgeries or procedures" as those that "can be delayed for a minimum of three months without undue risk to the current or future health of the patient."[51] There is no attempt to explain "undue risk" (e.g., specifying the probability and magnitude) or the use of "three months" as the minimum length of delay (maybe there should not be a timetable). The Colorado mandate does, however, call for hospitals to promulgate specific guidelines.[52]

V. THE TENSION OR DISTINCTION BETWEEN TRADITIONAL CORE MEDICAL AND PUBLIC HEALTH LEGAL AND ETHICAL PRECEPTS

The traditional view is that medicine focuses primarily on individual physician-patient relationships, with some circumscribed consideration of societal or third-party interests, while public health is preoccupied with populations and vulnerable groups.[53] Proponents of a "new public health," such as scholar of health law, policy, and management Wendy Mariner and her colleagues, reject this dichotomy, stating: "People in public health traditionally distinguished their field from medicine by emphasizing that physicians treat individual patients while public health practitioners treat entire populations. This distinction is rapidly blurring."[54] Before COVID-19, supporters pointed to the ways that public health has moved its focus away from interventions to curb the spread of pathogens such as influenza as evidence of the blurred boundaries between medicine and public health.[55]

To be sure, there is some coordination between medicine and public health. But this melding process is a work in progress that scholars have not fully studied. If anything, the COVID-19 pandemic and what it portends have shown that those in public health have not and

50. *See* Adashi & Cohen, *supra* note 38.
51. *See* Polis, *supra* note 43.
52. *Id.* Ambiguous governmental pronouncements could be challenged on due process vagueness and lack of notice grounds under the Due Process Clauses of the Fifth and Fourteenth Amendments.
53. *See, e.g.*, James F. Childress et al., *Public Health Ethics: Mapping the Terrain*, 30 J.L. MED. & ETHICS 170, 171 (2002); Michael Keeling & Oliver Bellefleur, *"Principlism" and Frameworks in Public Health Ethics*, QUE., CAN. NAT'L COLLABORATING CTR. HEALTHY PUB. POL'Y (Jan. 2016), http://www.ncchpp.ca/docs/2016_Ethics_Principlism_En.pdf [https://perma.cc/3BFS-HY8F].
54. MARINER ET AL., *supra* note 8, at 13.
55. *Id.*

should not move away from curbing the spread of pathogens as a core of public health. The pandemic might, in fact, further divide medicine and public health by posing and portending more emergencies that present even more contentious issues concerning the many against the few. For example, physicians and the institutions that employ them may be bitter about the COVID-19-related financial hit, bankruptcies, mass furloughs, and directives to function outside specialties.[56] Similarly, patients whose care is delayed or disrupted might resent these moves and lose trust in the public health field or government generally.

Biomedical ethics scholar James Childress and his eminent colleagues offer a more accurate description of the relationship between medicine and public health than Mariner:

> How can we distinguish public health from medicine? While medicine focuses on the treatment and cure of individual patients, public health aims to understand and ameliorate the causes of disease and disability in a population. In addition, whereas the physician-patient relationship is at the center of medicine, public health involves interactions and relationships among many professionals and members of the community as well as agencies of government in the development, implementation, and assessment of interventions.[57]

Academic and practice-oriented perspectives place importance on the coordination of medicine and public health, but significant tension remains because of the contrast between medicine's traditional focus on individual patients or research subjects and public health's customary emphasis on populations and groups. Nevertheless, coordination of medicine and public health—and their respective law and ethics—each borrowing descriptive and prescriptive concepts from the other is essential. As an example of the beneficial effects of coordination, I will show how both medicine and public health can combine to provide substantial and equivalent legal and ethical protections to individuals subjected to delayed care.

Analyzing the intersection of medical and public health law and ethical perspectives in any setting is complicated by the numerous takes from authorities in both spheres.[58] A full analysis of these nu-

56. *See supra* note 19 and accompanying text. This illustration is not intended to deny that many clinicians worried over the delays but thought they were necessary under certain conditions. *See, e.g.*, Louise P. King & Sigal Klipstein, *When and How To Resume Non-Urgent Care During COVID-19*, HARV. L. SCH.: BILL HEALTH BLOG (May 6, 2020), https://blog.petrieflom.law.harvard.edu/2020/05/06/non-urgent-care-covid19-reopening/ [https://perma.cc/5Q3G-D8XV]; Karen Weise et al., *The Coronavirus Is Forcing Hospitals To Cancel Surgeries*, N.Y. TIMES (Mar. 16, 2020), https://www.nytimes.com/2020/03/14/us/coronavirus-covid-surgeries-canceled.html [https://perma.cc/KN7X-24HH].

57. Childress et al., *supra* note 53, at 170.

58. *See infra* Part VI (explaining the multiple ethical theories and models of the physician-patient relationship that have been linked to bioethics and clinical re-

merous views would require a book. Here, I focus on medical and public health law and ethics as they pertain to the delay and disruption issues and in an analysis of medical models of the physician-patient relationship and public health frameworks fashioned for the study of public health pandemic or catastrophic emergency measures.[59] The delayed care or interruption of physician-patient relationships context has been neglected even though it magnifies the putative clash between medical and public health law and ethics.[60]

Assuming that, at the least, public health and medicine are distinct legal or ethical spheres, there is an equal, central, and over-arching issue of reconciling powers, rights, and interests of the population with those of the individual.[61] One important related question in medicine is whether a physician can or should consider cost and general access to health care when making decisions concerning administration of high-cost, low-benefit treatments. There are various answers to this question, but they, at most, tolerate relatively limited consideration of societal and third-party interests (as in warning others of dangerous patients).[62]

The mandates and recommendations discussed above (and issues and concepts discussed below) demonstrate the tension between medical and public health law and ethics. In some instances, however, the public health mandates and requests studied here do show regard for individuals already within a physician-patient relationship. An example is the Colorado Governor's Executive Order mentioned above insofar as it demands that specific guidelines be created, presumably to protect patients who might be harmed by delay.[63] Likewise, many public health analyses contain ethical principles that can be invoked to protect individual patients because it is difficult for the regulated individual to win against the public. An example is Childress's argument, when analyzing Gostin's framework for dealing with pandemics, that the burden of proof should be placed on those who seek to impose coercive, invasive public health measures[64] because it is difficult for the regulated individual to win against the public. This is consistent with a moral-social-political tradition that allows one to

search ethics); *see also infra* Part VII (discussing different frameworks for public health ethics).

59. Other public health measures such as isolation and quarantine will be addressed insofar as they link to or provide guidance regarding delay.

60. The magnifying factors include intrusion on the physician-patient relationship at the core of medical ethics; the severe and coercive measures that are part of the menu of countermeasures; the individual and population focus of medicine and law, respectively; the chance for physical harm or death; and harm to the medical system judged by cost, quality, and access.

61. *See infra* Parts VI, VII.

62. *See* discussion *infra* Part VI.

63. *See supra* Part IV; Polis, *supra* note 43.

64. Childress & Bernheim, *supra* note 16, at 1194.

develop a presumptivist approach to reconciling liberty with governmental interests and eschews an absolutist or contextualist stance.[65] This Article ultimately shows that medical law, medical ethics, public health law, and public health ethics can all involve contributions from each other. They can combine to protect patients from shoddy promulgation or implementation of delay pronouncements. There are especially strong synergistic relationships involving constitutional law in both spheres.

VI. MEDICAL ETHICS

Laws concerning medical liability, constitutionality of medical regulatory actions, immunities from liability, admissibility of evidence in legal proceedings, and state medical board discipline are informed by medical ethical principles. The law and ethics have reciprocal relationships. The medical ethical principles most applicable to the delay pronouncement interruption of physician-patient relationships come from a rich literature exploring the ethical requisites associated with the physician-patient relationship. More than that, discussion of the physician-patient relationship was and is at the core of medical ethics in the thick sense.[66] This examination of medical ethics focuses on ethical models of the physician-patient relationship, which is salient in how these models favor individual patients and carefully circumscribe consideration of societal and third-party interests.[67] Writings about these models could, with proper foundation and court approval, serve as a foundation of experts' ethical or legal opinions.[68]

Physicians and scholars Ezekiel Emanuel and Linda L. Emanuel have discussed several models of the physician-patient relationship. The Emanuels define models as ideal types that might not reflect any particular physician-patient relationship and state neither legal nor ethical minimums; stripped of such considerations they can inform ei-

65. *See id.* at 1201–02. Childress is a leading authority in bioethics, clinical medical and research ethics, and public health. Gostin and Berkman agree with placement of the burden of proof on the government. *See* Gostin & Berkman, *supra* note 16, at 148 ("A policy that entails personal burdens and economic costs is only justified if the government can demonstrate that there is a reasonable chance of protecting the public health. Because it is extremely difficult to exactly define 'reasonable chance' for all potential situations, the government has the burden of proof and has to engage in ongoing evaluation of the public health intervention and its effectiveness."). The Gostin and Berkman argument is not as developed as the one by Childress and Bernheim, but the reference to ongoing research regarding efficacy is very important. Throughout, there will be discussion of the government's constitutional and ethical duty to show need, efficacy, safety, and minimal intrusiveness of public health measures that trench on liberty.

66. Childress et al., *supra* note 53.

67. *See* discussions *infra* subsections VIII.A.1–2, 4–5.

68. 2 CLIFFORD S. FISHMAN & ANNE T. MCKENNA, JONES ON EVIDENCE, § 9:9 (7th ed. 2020).

ther the legal or ethical decision-making.[69] They are higher than the law but not above it. There are four primary models: "First is the *paternalistic* model, sometimes called the parental or priestly model. . . . Second is the *informative* model, sometimes called the scientific, engineering, or consumer model. . . . The third model is the *interpretive* model. . . . Fourth is the *deliberative* model."[70] The Emanuels focus on four aspects of physician-patient relationships: (1) the goals of the physician-patient interaction, (2) the physician's obligations, (3) the role of patient values, and (4) the conception of patient autonomy.[71] The models illuminate what it means to favor or respect individual patients and suggest limited ways in which physicians can urge patients to consider societal or group interests.

Applying the four aspects of the physician-patient relationship, the models' respective views are:[72]

	Informative	**Interpretive**	**Deliberative**	**Paternalistic**
Patient values	Defined, fixed, and known to the patient	Inchoate and conflicting, requiring elucidation	Open to development and revisions through moral discussion	Objective and shared by physician and patient
Physician's Obligation	Providing relevant factual information and implementing patient's selected intervention	Elucidating and interpreting relevant patient values as well as informing the patient and implementing the patient's selected intervention	Articulating and persuading the patient of the most admirable values as well as informing the patient and implementing the patient's selected intervention	Promoting the patient's well-being independent of the patient's current preferences
Conception of patient's autonomy	Choice of, and control over, medical care	Self-understanding relevant to medical care	Moral self-development relevant to medical care	Assenting to objective values
Conception of physician's role	Competent technical expert	Counselor or advisor	Friend or teacher	Guardian

69. Ezekiel J. Emanuel & Linda L. Emanuel, *Four Models of the Physician-Patient Relationship*, 267 JAMA 2221, 2221 (1992).

70. *Id*. at 2221–22. The Emanuels also refer to an instrumental model, in which the physician acts to further her own interests, as a paradigm of what should be prohibited. *Id.* at 2222.

71. *Id.* at 2222.

72. *Id.* at 2222 tbl.1.

The Emanuels conclude that although different models might apply to different circumstances and each has its faults, the ideal model in terms of respecting the patients' interests and autonomy is the deliberative model.[73] They give six reasons for this choice:

> First, ... [f]reedom and control over medical decisions alone do not constitute patient autonomy. Autonomy requires that individuals critically assess their own values and preferences; determine whether they are desirable; affirm, upon reflection, these values as ones that should justify their actions; and then be free to initiate action to realize the values.
>
> Second, ... [t]he ideal physician . . . is a caring physician who integrates the information and relevant values to make a recommendation and, through discussion, attempts to persuade the patient to accept this recommendation as the intervention that best promotes his or her overall well-being.
>
> Third, the deliberative model is not a disguised form of paternalism. . . . [L]ike the ideal teacher, the deliberative physician attempts to *persuade* the patient . . . not to *impose* those values . . . .
>
> . . . .
>
> Fourth, physician values are relevant to patients and do inform their choice of a physician.
>
> Fifth, we seem to believe that physicians should not only help fit therapies to the patients' elucidated values, but should also promote health-related values. As noted, we expect physicians to promote certain values, such as "safer sex" for patients with HIV or abstaining from or limiting alcohol use.
>
> Finally, ... we must shift the publicly assumed conception of patient autonomy that shapes both the physician's and the patient's expectations from patient control to moral development.[74]

The Emanuels' only illustration regarding consideration of societal or third-party interests demonstrates that only the deliberative model allows urging a breast cancer patient to enroll in a research study because, in light of uncertainty as to the best treatment, it is within her best interests and also furthers a tradition of women participating in research trials to benefit future generations of breast cancer patients.[75] The informative model allows bare mention of the research study, while the paternalistic and interpretive models do not mention the study.[76]

Roy G. Spece, Jr. and David S. Shimm proffer a "good citizen" model.[77] It is a complementary, over-arching ethical construct that links other models applicable to direct physician-patient interactions. The good citizen model allows circumscribed consideration of societal and third-party interests. Invoking various ethical theories and con-

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73. *Id.* at 2225.
74. *Id.* at 2225–26 (emphasis added).
75. *Id.* at 2223.
76. *Id.* at 2222–23.
77. Roy G. Spece, Jr. & David S. Shimm, *Discovering the Ethical Requirements of Physicians' Roles in the Service of Conflicting Interests as Healers and as Citizens*, *in* CONFLICTS OF INTEREST IN CLINICAL PRACTICE AND RESEARCH 42, 52 (Roy G. Spece, Jr., David S. Shimm & Allen E. Buchanan eds., 1996).

cepts as well as constitutional and other law that might inform ethical analysis, they summarize:

> The [good citizen] physician always occupies this role, regardless of the model that characterizes his direct interaction with specific patients. As a *citizen*, the physician must act for the good of specific third parties or society when the patient poses a threat of disproportionate harm. What constitutes 'disproportionate' harm is an ethical judgment concerning the principle of justice . . . .[78]

What is required of the citizen physician is indicated by the examples of when doctors should draw the line and conclude that proposed care is disproportionate given the overall problem of access to medical care and the duties of administrative physicians. As to disproportionate care, Spece and Shimm observe that although the individual patient comes first and should be given the benefit of any doubt, physicians are ethically required or allowed to forego marginally beneficial and highly costly care—at least when there is disclosure.[79] Similarly, the law requires them to breach patient confidentiality to protect society from grave harms such as physical attacks and infectious diseases. Concerning administrative physicians such as institutional managers, utilization reviewers, and quality assurance monitors, they conclude that such persons can have primary duties to patients depending upon the precise circumstances.[80] This view was

78. *Id.* (emphasis added).

79. *Id.*

80. *Id.* Relevant cases concern the duties of treating doctors and third-party decisionmakers such as insurers and their personnel. In *Wickline v. California*, 239 Cal. Rptr. 810, 814 (Cal. Ct. App. 1986), a Medi-Cal utilization review doctor refused to grant the treating doctor's request for eight extra days of hospitalization but did grant a four-day extension. In language that was arguably dicta, the court reasoned: "Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms." *Id.* at 819. In *Wilson v. Blue Cross*, 271 Cal. Rptr. 876, 881 (Cal. Ct. App. 1990), a mental patient was covered by Alabama Blue Cross, which delegated its authority to California Blue Cross, which itself retained Western Medical as a utilization reviewer. The latter denied coverage for the decedent's hospitalization, and the court determined that Western Medical could face liability because the patient may have lived had he completed the recommended hospitalization. *Id.* at 883. The court held that language in *Wickline*, which could be read to place sole responsibility on the discharging doctor if his decision caused injury, was dicta. *Id.* The appellate court reversed the lower court's award of summary judgment because there remained questions of fact as to whether it was proper for utilization review to be pursued and whether Western Medical played a role in causing the decedent's death. *Id.* at 883–85. In *Murray v. UNMC Physicians*, 282 Neb. 260, 272, 806 N.W.2d 118, 126 (2011), the defendants decided to delay the administration of an expensive drug until it was approved by the insurer, and the court found that they did not violate the standard of care because the decision to wait was based on a reasonable *medical* judgment that it would be harmful to the patient if the drug were started and then withdrawn if the insurer ultimately denied coverage. In *Mintz v. Blue Cross*, 92 Cal. Rptr. 3d 422, 427–28 (Cal. Ct. App. 2009), an insured patient sued a healthcare insurance policy administrator for denying coverage of an experimen-

adopted in a report of the American Medical Association's House of Delegates.[81]

There are approaches that apparently oppose any physician consideration of societal or third-party interests unless imposed by law, and ones that give great weight to such interests.[82] The representative models by the Emanuels and Spece and Shimm's models of the physician-patient relationship indicate that the individual patient should be the presumptive winner when her interests clash with broader interests, and only in rare circumstances must (or can) there be consideration of societal or third-party interests.[83]

VII. PUBLIC HEALTH ETHICS

This Part will briefly address public health ethics generally and public health frameworks crafted by eminent public health authorities to ethically judge pandemic countermeasures. There is a substantial body of writing on public health ethics that draws, to a certain extent, on the longer-existing literature concerning medical ethics and bioethics. There is disagreement about the relationship between bioethics and public health (or among those and clinical ethics).[84]

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tal cancer treatment, alleging negligence and interference with his contract with the insurer. The court held that *Wilson* did not apply to the latter claim because interference was not relevant there. *Id.* at 432. As to negligence, however, the court observed: "[A] claims administrator owes a duty of due care to members of a health care plan to avoid physical harm to plan members resulting from its administration of benefits under the plan, and accordingly Blue Cross's demurrer to Mintz's cause of action for negligence should have been overruled." *Id.* at 428.

81. At the recommendation of the Council on Ethical and Judicial Affairs, the AMA House of Delegates adopted the following statement:

> Physicians in administrative and other nonclinical roles must put the needs of patients first. At least since the time of Hippocrates, physicians have cultivated the trust of their patients by placing patient welfare before all other concerns. The ethical obligations of physicians are not suspended when a physician assumes a position that does not directly involve patient care.

AM. MED. ASS'N, HOUSE OF DELEGATES PROCEEDINGS: 46TH INTERIM MEETING 189 (1992).

82. *Compare id.* (endorsing a restrictive approach), *with* Jessica Mantel, *A Defense of Physicians' Gatekeeping Role: Balancing Patients' Needs with Society's Interests*, 42 PEPP. L. REV. 633, 725 (2015) (supporting a more liberal approach in which physicians have dual duties, one to patients and another to society).

83. *See supra* Part VI.

84. Ronald Bayer & Amy L. Fairchild, *The Genesis of Public Health Ethics*, 18 BIOETHICS 473, 473 (2004) ("As bioethics emerged in the 1960s and 1970s and began to have enormous impacts on the practice of medicine and research . . . little attention was given to the question of the ethics of public health."). Public health ethics became a subject of serious study at the beginning of the twenty-first century, and there exists a deep divide between bioethics, which focuses on the individual, and public health ethics, which focuses on society. *Id.* at 474–75; *see also* Nancy E. Kass, *An Ethics Framework for Public Health,* 91 AM. J. PUB. HEALTH 1776 (2001) (proposing a six-step framework to analyze the ethics of pub-

Once again, the concern at this point is with frameworks that can guide public health on the ground; might be admitted, considered, or relied on in court or policy making venues; and, for research or practice purposes, give the reader a feel for how those in public health approach public health ethics. These frameworks are improved if they are linked to and draw on ethical theories and concepts familiar to philosophers.[85] Public health frameworks are not accompanied by definitions of "framework." They can be analogized to models in medical ethics. This Article considers frameworks as structures for ethical analysis. Although they contain more than the bare bones, these frameworks are not completed works consisting of precise ethical theories or finely grained context-situated arguments.

Public health ethics attends to the core problem of reconciling societal and individual interests. It has, however, a thread of primarily utilitarian analyses of societal health, and another strain that could be considered diametrically opposed that invokes specific civil liberties or human rights as expressed in global or regional declarations or covenants or in domestic law and constitutional rights.[86] Arguably, a turn to human rights at the global level that involves consideration of individual interests of entire populations in other countries should be at the core of public health ethics.[87]

One might argue that the two strains of utilitarianism and civil, constitutional, and human rights are inconsistent. The apparent contradiction can be explained, at least below the global level. The rights

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lic health measures); Childress et al., *supra* note 53, at 170 (distinguishing and relating medical ethics and public health ethics); Lisa M. Lee, *Public Health Ethics Theory: Review and Path to Convergence,* 40 J.L. MED. & ETHICS 85 (2012) (explaining that although public health initially drew upon the principles of bioethics, the two are different because bioethics focuses on the individual patient and her relationship with a physician, whereas public health focuses on populations protected by many mostly non-medical actors); Steven S. Coughlin, *How Many Principles for Public Health Ethics?*, 1 OPEN PUB. HEALTH J. 8, 8 (2008) (asserting that public health professionals should participate in identifying the "ethical and moral philosophic underpinnings" of public health); Keeling & Bellefleur, *supra* note 53 (surveying literature on this topic and arguing for categorizing public health ethics as a part of bioethics). The scope of bioethics itself is contested. Some define it seemingly to encompass ethical analyses applied to any living entity or its environment. Michael Shapiro and Roy Spece define it as the fragmentation and reassembly of vital life processes and concepts that pose fraught ethical questions that might not be amendable to traditional descriptive and normative analyses. SHAPIRO, SPECE, DRESSER & WRIGHT CLAYTON, *supra* note 14, at 5–11.

85. *See, e.g.*, Andrew W. Siegel & Maria W. Merritt, *An Overview of Conceptual Foundations, Ethical Tensions, and Ethical Frameworks in Public Health*, *in* THE OXFORD HANDBOOK OF PUBLIC HEALTH ETHICS 5, 5–7 (Anna C. Mastroianni et al., eds., 2019).

86. *See, e.g.*, Rothstein, *supra* note 16, at 249–50 (discussing utilitarianism).

87. *See supra* text accompanying note 9; *see also* Gostin & Berkman, *supra* note 16 (discussing international human rights principles regarding public health).

spoken of are most needed by populations or groups who are subject to harm because of racial, economic, or political vulnerabilities. The goals are to protect these populations and groups, maintain public trust, and promote domestic and global cooperation. Utilitarian calculations can consider these "individual" public health interests, just as medical ethics can employ utilitarian theories when considering individual rights. Childress and Bernheim insist that individual rights have a place within communitarian values.[88]

Moving from general comments to frameworks applicable in pandemic or emergency circumstances, this Article briefly describes and analyzes three representative frameworks. One is that of Mark Rothstein. In his relatively recent article, *From SARS to Ebola: Legal and Ethical Considerations for Modern Quarantine,* Rothstein develops an ethical framework that addresses pandemics.[89] Though focused on quarantine, it is of utility in analyzing all burdensome pandemic countermeasures and is the most helpful framework to use in the context of analyses by courts, medical and public health authorities and practitioners, and policy wonks. Another framework, discussed below, is that of Gostin and Berkman, which agrees with Rothstein's important requirements for judging public health measures—proving need, efficacy, and use of the least intrusive alternative. But it is not developed enough to be applied by courts, medical and public health practitioners, or policy makers, at least within the delay context. Childress and Bernheim supply yet another framework for judging public health measures. It too supports the requirements stated by Rothstein, but in the context of criticizing a different Gostin and Berkman framework, not discussed here. While perhaps too philosophically sophisticated and imaginative (involving many philosophical constructs and employing metaphors and rhetoric as tools of analysis) to expect use by courts, practitioners, and policy makers, it is illuminating for academic authorities, philosophers, and students in various fields. It also demonstrates how public health frameworks can be improved by linkage to or use of ethical theories and concepts.[90]

Atypically, Rothstein seems to ground his analysis on an underlying ethical theory, in this case utilitarianism, that incorporates public health and individual rights.[91] Rothstein focuses on quarantine, which he correctly describes as one of the most intrusive pandemic countermeasures.[92] Delay orders are unique and even more invasive than quarantines, but most of what Rothstein says can provide in-

88. Childress & Bernheim, *supra* note 16, at 1193–95.

89. Rothstein, *supra* note 16.

90. *See* sources cited *supra* note 16.

91. Rothstein, *supra* note 16, at 249–50.

92. *Id.* at 254.

sights into the former.[93] Rothstein alludes to other countermeasures, especially other forms of social distancing, and states the following regarding public health care ethics generally:

> The ethical basis of public health is utilitarianism. Efforts to prevent catastrophic diseases and alleviate mass suffering provide a broad justification for infringing on the rights of some members of the public through quarantine, property seizure, vaccination mandates, or other public health measures. Utilitarian concerns about maximizing benefits, however, are not a blank check for public health interventions. In the United States, with its strong libertarian tradition and its commitment to autonomy, justice, and procedural due process, the exercise of public health authority always must be preceded by a showing of necessity [and] minimal infringement on individual rights . . . .[94]

Rothstein's justificatory conditions for assessing quarantine include: "(1) necessity, effectiveness, and scientific rationale; (2) proportionality and least infringement; (3) humane supportive services; and (4) public justification."[95] Regarding necessity, effectiveness, and scientific rationale, Rothstein explains:

> "Necessity" means public health officials ought to impose quarantine only in the face of a demonstrable threat to public health.
>
> . . . .
>
> As with any public health measure, quarantine should not be invoked unless the best available scientific evidence indicates it is necessary and likely to be effective in controlling the epidemic.
>
> . . . .
>
> To be effective, a quarantine must be part of a scientifically compelling, overall strategy for battling the outbreak of infectious disease.[96]

As to proportionality and least infringement, Rothstein states:

> "Proportionality" means the public health response is appropriate in light of the threat; in other words, there is a reasonable relationship between the burdens and the expected benefits.
>
> . . . .
>
> Deciding whether quarantine is necessary and, if so, determining the appropriate length of quarantine, are only the first steps in tailoring quarantine to the specific public health conditions. Additional considerations include the type of quarantine . . . . The overall goal should be to adopt the least burdensome means necessary to accomplish the desired public health objective. Using narrowly tailored public health measures also leads to greater public support for the entire range of public health interventions needed in an epidemic.
>
> Quarantine planning should focus on the totality of effects on individuals and society, not merely on the projected effects on infection rates.[97]

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93. This is especially true regarding constitutional analysis because the intrusion involved in quarantine is of a high order, much above what the U.S. Supreme Court has required for strict scrutiny. *See infra* text accompanying notes 168–69.
94. Rothstein, *supra* note 16, at 249 (footnote omitted).
95. *Id.* at 250 (footnote omitted).
96. *Id.* at 250–53 (footnotes omitted). Rothstein appears not to have considered that his ethical analysis might be used by persons formulating or interpreting laws, including constitutional law.
97. *Id.* at 254, 261 (footnotes omitted).

The conditions thus far, also embraced by the other two frameworks discussed in this Part, are the ethical equivalent of constitutional strict or intermediate scrutiny. These ethical and constitutional requirements can each inform the other.[98]

Concerning humane supportive services, Rothstein observes: "In quarantine at home, food, medicine, and other supplies and services must be provided to people who are unable to leave their homes. . . . In monitoring the health status of the individuals in quarantine, public health officials need to strike a balance between public health and individual liberty."[99] From an ethical perspective, and by parity of reasoning, patients subject to delayed medically necessary procedures, even if not physically injured or otherwise holding a legal claim, should also be given support, but in the form of monitoring, stabilizing health care, education, counseling, and supply of essentials, if the delay causes their inability to work.

Next, consider Gostin and Berkman's framework that antedated Rothstein's. It is grounded in various human rights pronouncements that have formal status as part of international law or, as with the Universal Declaration of Human Rights, have become customary international law[100] and addresses basic tenets of public health ethics and specific ethical issues raised when implementing influenza pandemic countermeasures.[101] The Gostin and Berkman framework is representative but so diffuse that it can be characterized as a potpourri of issues, ideas, and concepts to think about when analyzing public health measures.[102] It does not sufficiently define the invoked concepts, show how they interrelate to construct a framework, or apply the framework to generate outcomes. It is probably not a framework that a policy maker or court might follow or adopt when making decisions.

98. They will be discussed when undertaking constitutional analyses in section VIII.C.

99. Rothstein, *supra* note 16, at 263.

100. Gostin & Berkman, *supra* note 16 at 142–46.

101. *Id.* at 141–54.

102. *Id.* at 139. The potpourri includes micro-triage criteria; civic engagement/fair process; social prevention; functioning of science/medicine; functioning of the social system and associated infrastructure (e.g., legal system, police, fire, and food distribution); medical necessity for treatment; medical need/vulnerability (often children and elderly persons are in greatest need); intergenerational equity (raising the issue of whether years likely added to life should be used as a rationing criterion); social justice/equitable access (including for vulnerable and disfavored groups of people) so as to protect public trust; domestic and global human rights; constitutional rights such as procedural justice, bodily integrity, autonomy, and privacy; international coordination and collaboration; and global justice, including the precept, drawn from human rights, providing that "[i]f all human life has equal value then there would be a strong moral justification for fair rationing from a global perspective." *Id.*

For instance, one can wonder about what "fair rationing from a global perspective" is; it could require global wealth redistribution of a sort that most Americans might not even support domestically. A robust version of this redistribution seems impracticable and anathema to certain core values embraced in the United States. As Rothstein points out, public health measures demand "self-sacrifice to benefit society, but America's public ethos of libertarianism has translated into a historical and pervasive distrust of government, with a strong preference for self-reliance and independence."[103] To be successful, a public health agenda must be palatable to the public. Gostin and Berkman do, as indicated, include Rothstein's important requirements of demonstrated need, effectiveness, and least infringement. The framework also incorporates Rothstein's concept of an extended research agenda, which is specifically intended to determine whether public health interventions work, an important precept.[104]

In *Beyond the Liberal Communitarian Impasse: A Framework and Vision for Public Health*, Childress and Bernheim establish a framework partially as a critical response to a parallel iteration of Gostin's framework, which is primarily set forth in his writing on terrorism rather than pandemics.[105] The article starts with a question:

> How can our society respect liberty and privacy, among other values, and, at the same time, protect public health and security? Our aim in this Commentary is to offer a deliberative framework that transcends the impasse created by overly simplistic liberal and communitarian perspectives. This framework is designed to provide a rigorous and imaginative way to address both individual liberty and privacy, on the one hand, and public health and security, on the other.[106]

They note that their framework is one of presumption and rebuttal and explain their link to philosophy:

> Our Commentary is an exercise in applied or practical political philosophy. Political philosophy, whether formal (e.g., a full-blown theory) or informal (e.g., a politically-embedded framework), provides an important foundation for and sets limits on public health law. It identifies the normative values that should structure the relationship between the state and the individual, the legal powers that enable officials, within defensible limits, to address public health threats, and the processes of reflection, deliberation, and justification that should direct the exercise of the legal powers. As a normative enterprise,

103. Rothstein, *supra* note 16, at 268.

104. Gostin & Berkman, *supra* note 16, at 140–43, 170–73.

105. Childress & Bernheim, *supra* note 16. Childress points out that although he criticizes Gostin's *When Terrorism Threatens Health: How Far Are Limitations on Personal Freedoms and Economic Liberties Justified?*, 55 FLA. L. REV. 1105, 1106 (2003), he also draws on other Gostin writings, including *Public Health Law in an Age of Terrorism: Rethinking Individual Rights and Common Goods,* 21 HEALTH AFFS. 79 (2002), and LAWRENCE O. GOSTIN & LINDSAY F. WILEY, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (2016).

106. Childress & Bernheim, *supra* note 16, at 1192.

> political philosophy shares much with both moral philosophy and social philosophy even when they address ostensibly distinct spheres of life.[107]

They also examine different forms of balancing, the related concept of principled versus procedural justifications for overriding individual rights, the content of and relationship between principled and procedural justifications, and proper specification of the weight and scope of balanced values—all endeavors in which they say Gostin falls short. Thus, Childress and Bernheim essentially position their framework as a critical opposition:

> [A]s we have argued, Gostin's framework, while helpful in several respects, is problematic in others. What is required is an alternative that moves beyond the liberal-communitarian impasse and beyond balancing liberty and public health/security. In our judgment, such a framework must recognize that liberty is part of our communal interests, along with public health; that tradeoffs between liberty and public health/security can usually be avoided; that, in the selection of means or measures to protect or promote the goal of public health, there is a presumption for liberty over coercion; that this presumption for liberty can be rebutted or overridden when several justificatory conditions are met—effectiveness, necessity, least restrictive or intrusive means, proportionality, impartiality, and public justification; that public justification takes place in the context of relationships that frame the meaning of public health actions; that the appropriate use of state liberty-limiting authority must be interpreted through the lens of the understanding and the expectations community members and public health professionals have of each other; and that public justification, deliberation, and other relationship-building activities may be more important for biopreparedness than state power because they maintain and nurture civic ideals, cooperation, and trust.[108]

Childress and Bernheim recognize that there must be more than broad principles to protect individual rights because public health's population or group perspective and purposes can allow disregard of individual rights too easily. They more carefully describe their principles and concepts in a way that is protective of population interests and individual rights (yet they contend, perhaps inconsistently, that individual rights can be considered communitarian values[109]). Importantly, they also argue that bias in favor of the public health side in a clash of individual liberty with community benefits justifies putting the burden of proof on the proponents for public health efforts.

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107. *Id.* (footnote omitted).
108. *Id.* at 1218–19.
109. *Id.* at 1194.

VIII. MEDICAL- AND PUBLIC HEALTH-RELATED STATUTORY, COMMON, AND CONSTITUTIONAL LAW

A. Medical Negligence, Malpractice, Breach of Fiduciary Duty, Crisis Standards of Care, Abandonment, and Informed Consent

The purpose of discussing the legal concepts in this section is to show how the law emphasizes and respects the physician-patient relationship almost solely to protect patients.

1. Negligence and Malpractice

A violation of the standard of care giving rise to liability for medical negligence is sometimes loosely referred to as medical malpractice. The specific elements of a negligence prima facie case are duty, breach of duty (an act or omission that fails to comply with the applicable standard of care), but-for and proximate causation, and (usually physical) damage.[110] There are numerous iterations of the standard of care within and among jurisdictions. Three prominent standards are: (1) What providers customarily do (e.g., do blood bankers customarily omit certain screening tests); (2) What a reasonable person would do given the circumstances (e.g., would a reasonable person not do cer-

110. Although often used interchangeably with medical negligence, malpractice refers to medical negligence, rarely breach of contract, and other torts or legal causes of action such as breach of fiduciary duty (does not require the patient to show "intent" and requires the physician to follow a higher standard than mere absence of negligence) and a set of intentional torts—including intentional infliction of emotional distress, fraud, battery, and false imprisonment. Although absence of informed consent is usually judged under the standards of negligence, there are nuances in various jurisdictions such as requiring a physician to disclose what a reasonable patient would consider material as opposed to invoking one of the three versions of the standard of care/medical negligence referred to immediately below. If a physician does not even an attempt to obtain consent, battery is the preferred tort. *See* JOSEPH H. KING, JR., THE LAW OF MEDICAL MALPRACTICE IN A NUTSHELL 3–4, 155–63, 253–60 (2d ed. 1986) (discussing medical malpractice, battery vs. negligence, standards of disclosures in informed consent, and contracts, respectively); *see also* 1 DAN DOBBS ET AL., DOBBS LAW OF TORTS 7–10, 80–97, 103–14 (2d ed. 2011) [hereinafter 1 DOBBS] (discussing contract, battery, and false imprisonment, respectively); 2 DAN DOBBS ET AL., DOBBS LAW OF TORTS 25–26, 48–49, 549–71 (2d ed. 2011) [hereinafter 2 DOBBS] (discussing fiduciary duty and intentional infliction of emotional distress); 3 DAN DOBBS ET AL., DOBBS LAW OF TORTS 638–62, 665–94 (2d ed. 2011) [hereinafter 3 DOBBS] (discussing fraud). Although the physician-patient relationship, even if not formalized in a written agreement, involves an implied contract that the physician will provide good care and the patient will be responsible for payment for that care, courts generally force the plaintiff suing for substandard care to solely pursue a negligence cause of action. The exceptions are for agreements to achieve a specific result, perform a specific procedure, personally provide care, or provide exceptional care (often accompanied by a requirement that the contract be written). *See* KING, *supra*, at 253–60.

tain screening tests); and (3) What reasonable and prudent doctors would be expected to do. Here, custom is only presumptive or pertinent evidence, i.e., even if defendant blood banker's expert testifies that blood bankers customarily omit a test, other experts and evidence will be admitted to challenge that custom—the latter given presumptive acceptance or relevance only as to what the standard of care requires.[111]

2. Fiduciary Law Applied to Physicians

Fiduciary duty concepts go back centuries and first had their primary modern use in financial and guardian-ward matters.[112] Although there are various terms to describe the fiduciary relationship, I use "principal" for the person protected by the theory and "agent" for the person bridled by it. To use this theory in court, one has to show how the defining characteristics of a fiduciary relationship apply to the persons in the relationship at issue. For example, that the agent has unique knowledge and power that places the principal in deep dependence on the agent; that the agent can provide something that is necessary to serve vital interests of the principal (or sometimes society); and that the agent's membership in a profession that benefits from societal respect, economic benefits, and considerable leeway for self-regulation calls for acceptance of a higher duty, as a quid pro quo. This quid pro quo of a higher duty protects the principal. The parameters of the enhanced duty depend on the specific facts and where the plaintiff sues.[113]

If the court has characterized a physician-patient relationship as a fiduciary one, the physician may be held to a standard of care that is a step above that used in negligence cases, perhaps enhancing disclosure in informed consent cases; imposing a vague duty of loyalty that limits the scope of tolerated conflicts of interest (especially financial

111. For an illustration of these standards, see *United Blood Servs. v. Quintana*, 827 P.2d 509 (Colo. 1992) (en banc), a suit against a blood services company for transmitting HIV. The trial court held that plaintiffs' experts could not testify because they were not offered to opine regarding what blood banks actually do. The appellate court said the experts should have been allowed to testify because the applicable standard was what a reasonable blood bank would do, not what blood banks customarily did. The Colorado Supreme Court held that the experts should have been allowed to testify because though the standard of care is determined by customary blood bank practice, this can be rebutted by a showing the custom itself was negligent. *See also* Eleanor Kinney, *The Brave New World of Medical Standards of Care,* 29 J. LAW MED. ETHICS 323 (2001) (noting the plethora of standards among "standard" standards of care and finding there "are virtually thousands of standards of care pertaining to health-care services in the United States today").

112. Maxwell Mehlman, *Why Physicians Are Fiduciaries for Their Patients,* 12 IND. HEALTH L. REV. 1, 60–61 (2015).

113. *Id.* at 12 n.12.

ones); requiring the physician to advocate for the patient in specific transactions or disputes with third parties (e.g., insurers); limiting when or how the physician can consider societal and third-party interests; requiring the physician to take some risk to further the patient's interests; once the plaintiff shows that there is a fiduciary relationship, switching to the physician the burden of proving there was no breach; or allowing recovery for dignitary harms.[114]

Maxwell Mehlman has thoroughly analyzed the fiduciary duty question. He has also surveyed the authorities (court opinions, restatements, legal treatises, scholarly articles, and monographs) that address whether physicians have fiduciary duties. His analysis concludes "yes."[115] Mehlman found the authorities split but attributed the naysayers' views to erroneous readings of prior analyses, confusion between law and equity, misguided policy objectives, and reasoning errors.[116]

Mehlman affirmatively supports his conclusion in favor of medical fiduciaries first, by establishing that the physician-patient relationship "obviously" meets the requirements of fiduciary relationships. Second, he argues recognition frees the patient from having to pay monitoring costs and conserves the ability to pay for additional care. Third, the fiduciary relationship is essentially embraced in authorita-

114. *See id.*; Moore v. Regents of the Univ. of Cal., 793 P.2d 479, 497 (Cal. 1990) (refusing to recognize conversion cause of action but holding that patient stated a cause of action based on fiduciary duty or informed consent because health care provider defendants failed to disclose their financial interest in using patient's cells to create valuable medical resources); Grimes v. Kennedy Krieger Inst., Inc., 782 A.2d 807, 817, 858 (Md. 2001) (Researchers performed non-therapeutic research on minors—for which their parents were held unable to consent—and the court concluded: "We hold that there was ample evidence in the cases at bar to support a fact finder's determination of the existence of duties arising out of contract, or out of a special relationship, or out of regulations and codes, or out of all of them, in each of the cases." The court did not use the label "fiduciary," but its reasoning parallels that in *Moore* and shows how common law, statutes or regulations, constitutional principles, and ethical precepts can coalesce to create legal duties.); Spece & Shimm, *supra* note 77, at 57 (explaining that even an employer-hired physician has a fiduciary duty to provide a letter stating his findings as to why an employee cannot work when the refusal to provide such evidence will lead to the employee not being able to work or collect on disability insurance).

115. Mehlman, *supra* note 112, at 15. Mehlman uses the terms intrustor and fiduciary, not principal and agent.

116. *Id.* Some authorities accept a quasi-fiduciary theory. *See* Tanya J. Dobash, Note, *Physician–Patient Sexual Contact: The Battle Between the State and the Medical Profession*, 50 WASH. LEE L. REV. 1725, 1746 (1993). Mehlman provides reasoned rejections of arguments that even if a fiduciary duty exists, it is contained within, and thus is redundant to, negligence; that it can support requiring physicians to ignore societal and third-party interests (including controlling the overall cost of care); that it is superfluous because any concern about patient exploitation is expiated by disclosure; and that it unfairly imposes a vague, capacious duty on physicians.

tive pronouncements by organs of the American Medical Association (AMA). Fourth, it allows physicians to advocate for their patients—even if it that poses limited costs or risks. Fifth, it gives physicians a tool with which to fight excessive private and governmental restraints on their choices in favor of patients' interests.[117]

This Article accepts all the arguments Mehlman makes except the proposition that physicians should never consider foregoing possibly marginally beneficial care, even when there is no significant patient interest at stake. As discussed above, this Article accepts such so-called rationing at the bedside, subject to the conditions just mentioned, with the additional requirement that any close calls should be decided in favor of the patient.[118] One justification for rejecting fiduciary duty is that it supposedly prohibits physicians from considering societal or third-party interests, such as the overall cost of health care, when making decisions about individual patients.[119] However, this is not true because a fiduciary relationship's primary effect is to assure that physicians do not place their own interests before those of their patients, and various laws command physicians to protect certain third parties by, for example, reporting venereal diseases and gunshot wounds and by warning others about dangerous patients.[120]

Now I turn to a truly murky concept that threatens harm to physician-patient relationships—"crisis standards of care."

3. Crisis Standards of Care

Crisis standards of care is a confused concept. The gist is that in a declared emergency, health care providers' usual loyalty to individual patients switches to populations or groups. This raises questions concerning when, where, how much, and in what manner crisis standards take effect. Crisis standards of care are, roughly, between ordinary standards of care (discussed above) and immunities from liability. Immunities (e.g., ones applicable to manufacturers of drugs in an emergency) completely or partially bar suits against the person or entity protected by the immunity.[121] Although immunities are numerous

117. Mehlman, *supra* note 112, at 53–63.
118. *See supra* text accompanying notes 77–82.
119. Mehlman, *supra* note 112, at 31–37.
120. *Cf.* Mantel, *supra* note 82, at 725–26 ("This Article . . . argues for a dual duty of care, with physicians permitted to balance the individual patient's needs with society's interest in constraining health care costs and ensuring the equitable allocation of limited medical resources. So, while patient loyalty would remain an important value, the physician's fiduciary obligations to patients would be limited by the physician's competing obligations to society. Therefore, law and medical ethics should be reformed to accommodate physicians' dual duty of care.").
121. MARK HALL ET AL., MEDICAL LIABILITY AND TREATMENT RELATIONSHIPS 467–79 (3rd ed. 2013); *see, e.g.*, Public Readiness and Emergency Preparedness (PREP) Act, 42 U.S.C. § 247d-6d–6e. The PREP Act is an example of a federal immunity

and important, they are beyond the scope of this Article except as a baseline for judging crisis standards of care. This baseline standard, if applied to the liability-creating conduct discussed here, undercuts efforts to deter sloppy promulgation or implementation of delay pronouncements and to achieve other purposes of tort and other laws.[122] If there were adequate specifications as to the precise applicability, scope, and nature of crisis standards of care, they would be properly characterized as limited immunities. The almost invariable vagueness of crisis standards of care means that health care providers practically never can count on them to change the standard of care in negligence or other cases. Nevertheless, there have been articles, pre- and post-COVID-19, focusing on the micro-triage aspects of crisis standards of care. There, one might find adequate specification to guide the parties and the court.[123]

Regardless, as George Annas has persuasively argued over many years and in the midst of the COVID-19 pandemic, crisis standards of care (and the overlapping idea of triage protocols as evidence that health care providers were not negligent) are not useful and are based on false premises. Specifically, crisis standards of care: (1) are based on the false premise that physicians will avoid providing care in emergencies; (2) are incoherent and have not given any guidance to health care providers (this might not be true concerning micro-triage decisions); (3) marginalize informed consent and its firm foundation in our common and constitutional law (the patient is not informed about her

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that applies to certain conduct within the COVID-19 pandemic. It allows the Secretary of Health and Human Services in declared emergencies to, through declaration, shield persons who prescribe, administer, or dispense pandemic countermeasures (mainly medical products) "from suit and liability under Federal and State law with respect to all claims for loss caused by, arising out of, relating to, or resulting from the administration to, or the use by, an individual of a covered countermeasure." *Id.* at § 247d-6d(a)(1).

122. KING, *supra* note 110, at 327–28.

123. *See, e.g.*, INST. OF MED., CRISIS STANDARDS OF CARE: A SYSTEMS FRAMEWORK FOR CATASTROPHIC DISASTER RESPONSE (Dan Hanfling, Bruce M. Altevogt, Kristin Viswanathan & Lawrence O. Gostin eds., 2012); James G. Hodge, Jr. et al., *Practical, Ethical, and Legal Challenges Underlying Crisis Standards of Care*, 41 J.L. MED. ETHICS 50 (2013); Nancy Berlinger et al., *Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic*, HASTINGS CTR. (Mar. 16, 2020), https://www.thehastingscenter.org/wp-content/uploads/HastingsCenterCovidFramework2020.pdf [https://perma.cc/U8SP-Q4PC]; Sharona Hoffman, *Responders' Responsibility: Liability and Immunity in Public Health Emergencies,* 96 GEO. L.J. 1913 (2008); Emily Cleveland Manchanda et al., *Inequity in Crisis Standards of Care*, 383 NEW ENG. J. MED. e16 (July 23, 2020), https://www-nejm-org.libproxy.unl.edu/doi/10.1056/NEJMp2011359 [https://perma.cc/BTK4-JNV5]; *see* Gostin & Berkman, *supra* note 16; Govind Persad, *Arizona's Crisis Standards of Care and Fair Allocation of Resources During COVID-19,* HARV. L. SCH.: BILL HEALTH BLOG (Aug. 6, 2020), https://blog.petrieflom.law.harvard.edu/2020/08/06/arizonas-crisis-standards-care-covid19/ [https://perma.cc/7NR6-CUUR].

diluted protection); (4) falsely assume that clinicians' ethics will rapidly change from the focus on physician-patient relationships and duties to individuals to a utilitarian focus on populations; and (5) are unnecessary because the definition of negligence among jurisdictions invariably includes the concept that unreasonableness must be judged in light of the particular circumstances. As to incoherence, Annas argues:

> There is a reason for the generality of this standard [moving focus on the individual victim to a population/group orientation]: it can be applied to every medical specialty, every medical decision, and each environment in which medicine is practiced. The alternative is to have a different [specified] standard of care for each medical specialty, each decision by the specialist, and each environment in which the specialist is practicing. But having each physician and each drug or device they are using come with its own "[crisis] standard of care" detailing indications, dosages, methods of administration, etc., is an incoherent and unworkable arrangement of circumscribed rules.[124]

I accept Annas's arguments and note they reject that crisis standards of care are necessary to allow physicians to act properly in emergencies. Crisis standards of care also, similarly to outright immunities, undercut the purposes of tort law such as fairness, compensation of victims, deterrence, cost-spreading, and moving resources to their highest use through internalization of external costs.[125] This Article now presents another theory—abandonment—that advances these purposes.

4. Abandonment

Abandonment is, *primarily*, a species of medical negligence. The justification for discussing it separately from negligence and breach of fiduciary duty is that both sides might exploit its nuances to potentiate the negligence and fiduciary theories or use it to independent advantage. If the court accepts abandonment as a distinct theory, it may provide distinct benefits, even as a tort of medical negligence. For instance, in the hypothetical above, Sam's widow would have an emotional advantage if allowed to use the damning abandonment label. Also, abandonment is exceptional because, given its simple elements, it can easily be conceived not to require expert testimony. Specifically, there is no need for an expert when the patient can make a simple showing that a physician terminated (or interrupted) an ongoing physician-relationship without giving the patient sufficient notice so she could arrange alternative treatment, preferably after the existing physician helps her find or refers her to appropriate doctors. Abandon-

124. George J. Annas, *Rationing Crisis: Bogus Standards Unmasked by Covid-19*, 20 AM. J. BIOETHICS 167, 167–69 (2020); George J. Annas, *Standard of Care—In Sickness and in Health and in Emergencies,* 362 NEW ENGL. J. MED. 2126, 2126–31 (2010).

125. KING, *supra* note 110, at 327–28.

ment can also apply if there is notice but no reasonable alternative health care provider or treatment.[126] At the discretion of the court, a jury can determine if these conditions are met and if the patient suffered damages, such as the untreated condition obviously becoming worse, without the help of an expert.[127]

Some authorities identify two genres of abandonment: knowing termination of the physician-patient relationship and termination in the sense that the physician unreasonably failed to determine that additional treatment was necessary.[128] (Both versions could apply to the hypothetical.) These authorities also claim that abandonment can be based on breach of an implied agreement (contract) to not abandon the patient.[129] The vast majority of authorities state that abandonment is presumptively embedded in negligence. Some authorities claim that abandonment is based on negligence and actually contains an additional prima facie case requirement that the termination of the relationship occur at an especially important moment.[130] (The urgency of Sam's angiogram could fulfill any such requirement here.) If the physician's abandonment is extreme and outrageous and causes serious emotional upset, the patient can sue for intentional infliction of emotional distress and possibly obtain punitive damages.[131]

A situation roughly analogous to our hypothetical was addressed in *Ascher v. Gutierrez*, where the defendant-anesthesiologist left an operating room when asked to consult regarding another operation.[132] The abandoned patient had serious complications that needed immediate attention, and the patient died.[133] The court held that a physician's primary duty is to his immediate patient and that he should not abandon the patient without assuring an adequate replacement.[134] In our

126. Angela R. Holder, *Physician's Abandonment of Patient*, 3 AM. JUR. PROOF FACTS § 1 (2020); 2 DOBBS *supra* note 110, at 158–62 ("The standard, or perhaps a rule of law, also requires that the physician will not abandon treatment of the patient. However, not every failure to attend or treat is an abandonment. Abandonment occurs only if the physician terminates needed service without adequate notice and without arranging for appropriate treatment by other qualified health care providers.").

127. *See* Holder, *supra* note 126; 2 DOBBS, *supra* note 110, at 193–201. It is possible but less achievable to forego experts in other, usually more complex, medical negligence contexts.

128. *See* Holder, *supra* note 126; 2 DOBBS, *supra* note 110, at 161–62.

129. *See* Holder, *supra* note 126; 1 DOBBS, *supra* note 110, at 7–10.

130. Holder, *supra* note 126; C.T. Dreschler, Annotation, *Liability of Physician Who Abandons Case*, 57 A.L.R. 432 (2020); Andrade v. Grady Mem'l Hosp. Corp., 707 S.E.2d 118 (Ga. Ct. App. 2011) (explaining that abandonment at critical stage constitutes negligence).

131. *See* Tuttle v. Silver, 21 Pa. D & C.4th 271, 274–76 (1993); Grimsby v. Samson, 530 P.2d 291, 295 (Wash. 1975); HALL ET AL., *supra* note 121, at 323–24.

132. Ascher v. Gutierrez, 533 F.2d 1235, 1236–37 (D.C. Cir. 1976).

133. *Id.*

134. *Id.*

hypothetical case, the defendants (and government, if sued) might have actually caused a situation in which the needed alternative care is not available.

5. Informed Consent

A legal theory cutting across negligence, abandonment (in whatever form), and various intentional torts is informed consent. The two most common informed consent claims are negligence, with varying standards of care, and battery (usually when there is no attempt to obtain consent).[135] The requirements to support a claim based on failure to obtain informed consent are a patient with capacity, absence of duress, breach of duty by not meeting the standard of care regarding disclosure, causation, and (usually physical) damages that are linked to the non-disclosure (with rare exceptions to the link demand). As to causation, it can be split into two additional requirements: factual, or but-for, cause—the patient would have refused or acted otherwise if there had been disclosure—and, rarely omitted, legal, or proximate, cause—a reasonable patient would have refused or acted otherwise if there had been disclosure. Concerning the disclosure duty, jurisdictions are equally split regarding the standard of disclosure between a physician-oriented standard—under the general standard of care in the jurisdiction—and a patient-oriented standard—what reasonable patients, or rarely, the plaintiff herself, would consider material to their decision-making.[136]

6. The Effect of Private and Governmental Orders and Requests

The COVID-19-driven mandates and recommendations outlined above are pertinent to civil liability. Insofar as they contain requirements to protect existing patients, are governmental mandates, and meet criteria imposed by legal rules, when not complied with they can have several effects. First, they might list specific sanctions.[137] Second, if a hospital or physician intentionally or unreasonably does not follow a clear and reasonable order, such as an order to promulgate internal guidelines concerning delay actions, and that order is clear and reasonable, it can establish negligence per se, create a presumption that there has been medical negligence, or serve as relevant evidence for the trier of fact.[138] In the reverse, mandates also apply to defendants using compliance with mandates and recommendations to justify their conduct. Third, any of the mandates or recommendations might be used as foundation for a plaintiff's or defendant's expert's

135. *See* 2 DOBBS *supra* note 110, at 158–62.
136. *Id.*
137. *See* de Blasio, *supra* note 31.
138. FISHMAN & MCKENNA, *supra* note 68.

opinion regarding the standard of care.[139] Fourth, if issued from, say, a specialty college, board, or association, those organizations might impose their own sanctions, which might include dismissal from the group.[140] Fifth, any discipline by a college, board, or association might also be considered in state medical board disciplinary proceedings.[141]

B. Public Health Laws that Authorize Coercion To Achieve Maximum Benefits for Populations and Groups

Much of public health law sets forth substantive and procedural rules concerning use of coercive techniques that can be implemented to deal with infectious pathogens, bioterrorism, and other emergencies. These laws authorize public officials to, among other countermeasures, isolate people carrying an infectious agent; quarantine individuals exposed to "infected" individuals; close facilities (whole businesses, other endeavors, and even entire cities or states); set curfews; test (individuals); screen (groups and populations); in some cases impose mandatory treatment or immunization; restrict travel; require social distancing; require health care providers (individuals and institutions) to *delay care of patients in existing physician-patient relationships* to conserve health care resources for dealing with the emergency; and even, to some extent, *force health care providers to treat certain ill patients.* Most of these and more have been carried out during the COVID-19 pandemic.[142] Once again, the exercise of power to delay care usually gets no more than a passing reference in the literature.

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139. This requires that the document is of the type customarily and reasonably relied upon by experts. *See id*.

140. *See, e.g.*, *Bylaws: VII Maintenance of Fellowship and Membership,* AM. COLL. SURGEONS (Nov. 8, 2017), https://www.facs.org/about-acs/governance/bylaws#s71[https://perma.cc/PG8Q-Q9WZ] (describing the procedures for discipline, discontinuance, and termination of fellowship).

141. The rules of evidence are sometimes relaxed in state medical board proceedings. *See* Laura J. Spencer, Comment, *The Florida "Three Strikes Rule" for Medical Malpractice Claims: Using a Clear and Convincing Evidence Standard To Tighten the Strike Zone for Physician Licensure Revocation*, 28 ST. LOUIS UNIV. PUB. L. REV. 317, 322 (2008). Covering discipline by professional groups or state medical boards is beyond the scope of this article.

142. Lindsay K. Cloud et al., *A Chronological Overview of the Federal, State, and Local Responses to COVID-19*, *in* ASSESSING LEGAL RESPONSES TO COVID-19, at 10, 18 (S. Burris, S. de Guia, L. Gable, D.E. Levin, W.E. Parmet & N.P. Terry eds., 2020), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3675780 [https://perma.cc/RHF3-W968] (referencing numerous federal guidance and state orders as well as actions by 850 counties and 500 cities, including social distancing, stay-at-home, closing businesses and schools, barring large gatherings). *See generally supra* notes 1, 6 and accompanying text (regarding measures and rights they trench on).

C. Constitutional Analyses

Constitutional analysis is important in both clinical medicine and public health. The central issue in both contexts is how deferential the courts will be. The early answer in public health was very deferential, despite the fact that public health measures can trench on the kinds of fundamental rights or important personal liberties that prompt the Supreme Court to apply strict or invigorated scrutiny. The landmark case on this issue is the Court's 1905 decision, *Jacobson v. Massachusetts*.[143] Jacobson was fined $5 for refusing to be vaccinated against smallpox. My reading, one among other reasonable ones, is that the Court adopted a deferential default rule that is currently known as the rational basis test, almost equivalent to no scrutiny.[144]

All of the Court's statements except one cry "extreme deference" in public health cases: (1) "There are manifold restraints to which every person is necessarily subject for the common good;"[145] (2) "[I]n every well-ordered society charged with the duty of conserving the safety of its members the rights of the individual in respect of his liberty may at times, under the pressure of great dangers, be subjected to such restraint, to be enforced by reasonable regulations, as the safety of the general public may demand;"[146] (3) It was for the legislature to choose between the views that vaccinations are efficacious or not, and such choices concerning health, public morals, and safety that are embod-

143. 197 U.S. 11 (1905).

144. It is beyond the scope of this Article to relitigate the issues of constitutional judicial review and Court capacity, but I accept enhanced review in cases involving personal liberties. For arguments pro and con, see CHEMERINSKY, *supra* note 4, at 727–29 (detailing the contours of rational basis review). The following arguments might have to be rethought if our political system continues its chaos. Some arguments against judicial review are that it is anti-democratic, that the political branches are better situated to determine moral, empirical, and medical/scientific questions, that the Court does not have the time or resources to hear many cases, that history and the text of the constitution cut against the notion, that it violates federalism and separation-of-powers principles, and that it cuts off political and civil discourse. *See, e.g.*, Gil Seinfeld, *Eighty Years of Federal Forbearance: Rationing, Resignation, and the Rule of Law*, 2020 WIS. L. REV. 155, 157, 162–64 (arguing that the Court retains relevance and maintains the rule of law through judicial review within the context of federalism); ANDREW COAN, RATIONING THE CONSTITUTION: HOW JUDICIAL CAPACITY SHAPES SUPREME COURT DECISION-MAKING (2019) (arguing that capacity in the form of lack of time is a primary driver regarding judicial review and that it interacts with other concepts calling for judicial restraint); Michael Klarman, *Rethinking Civil Rights and Civil Liberties Revolutions,* 82 VA. L. REV. 1, 1–6, 66–67 (1996) (noting that many scholars and justices accept the argument that judicial review is needed "to protect minority rights from majority over-reaching," but this operates less often than they think); JOHN HART ELY, DEMOCRACY AND DISTRUST: A THEORY OF JUDICIAL REVIEW (1980) (arguing that active judicial review is only appropriate when persons cannot protect their rights in the political process).

145. *Jacobson*, 197 U.S. at 26.

146. *Id.* at 29.

ied in law are valid unless the measure "has no real or substantial relation to [its] objects, or is, beyond all question, a plain, palpable invasion of rights secured by the fundamental law . . . ;"[147] (4) It is possible to construct hypothetical situations where the statute could permit the exercise of police power "in such circumstances or by regulations so arbitrary and oppressive in particular cases as to justify the interference of the courts to prevent wrong and oppression," but that is not a sensible construction of the statute and the Court does not hold that the statute "was intended to be applied in such a case, or, if it was so intended, that the judiciary would not be competent to interfere and protect the health and life of the individual concerned;"[148] (5) "So far as [health and safety] can be reached by any government, they depend, primarily, upon such action as the State in its wisdom may take; and we do not perceive that this legislation has invaded by right secured by the Federal Constitution;"[149] (6) "[N]othing clearly appears that would justify this court in holding it to be unconstitutional and inoperative in its application to the plaintiff in error;"[150] and (7) Referring to several state cases upholding vaccination of school children and quoting with approval to a recent New York Appellate Court opinion: "'In a free country, where the government is by the people, through their chosen representatives, practical legislation admits of no other standard of action; for what the people believe is for the common welfare must be accepted as tending to promote the common welfare, whether it does in fact or not.'"[151] The Court's only hint at stopping short of total deference is references to prohibited actions that are "cruel and inhuman in the last degree" or "arbitrary and oppressive."[152] Although some commentators read *Jacobson* as offering significant protections to individuals (the reference to inhumane care, the fine rather than forced vaccination, the exclusion of children, and the hint at an exception when vaccination poses extraordinary health risks), deference to public health authorities permeates the case.[153]

Over the last several decades, the Court has developed a tiered set of enhanced scrutiny standards of review between strict scrutiny and rational basis endpoints. Some commentators believe that a deferential test is still applied in public health despite developments subsequent to *Jacobson*, while others argue that the developments should and sometimes do lead to enhanced scrutiny of one sort or another when a case involves fundamental rights or important personal liber-

147. *Id.* at 38.
148. *Id.*
149. *Id.*
150. *Id.*
151. *Id.* at 24.
152. *Id.* at 38.
153. Shapiro, *supra* note 6; Holland *supra* note 6; Gostin, *supra* note 6; Parmet, *supra* note 6.

ties such as life, privacy, freedom of movement, reproductive choice, and autonomy of decision-making in sensitive personal and family matters.[154] The level of scrutiny in Fifth and Fourteenth Amendment substantive due process cases depends primarily on the nature of the right intruded upon and the degree of the intrusion. In equal protection cases brought under the same amendments, the degree of scrutiny depends on the nature of the right or interests intruded upon by the classification at issue, the degree of intrusion, and the suspiciousness of the classification.[155]

Public health measures to control COVID-19 are numerous and intrude upon even more constitutional rights and interests.[156] This Article mentions rights and interests intruded upon by delay, and it sketches the constitutional analysis of one relatively ignored fundamental right—the right to purchase health care available on the open market. Delay also intrudes on reproductive rights (some states have declared that certain abortions are elective procedures that should be delayed).[157] Enforcement of delay orders requires examining patients' files, and privacy protective measures might be inadequate.[158] Actual delay can intrude on life (see the hypothetical in Part III and the metastatic cancer case in Part II), bodily integrity (invaded by denial of treatment to prevent deterioration of one's condition), refusal of treatment (effected through forcing the use of dependence-inducing, pain-killing drugs as an alternative to delayed, medically necessary care), decision-making concerning intimate health interests (see the decisions denied to or forced on patients discussed here as to other rights), the right to control children's medical care (parents might be forced to subject their children to alternative care in the form of dependence-inducing, pain-killing drugs), freedoms of movement and travel (affected by denying travel or treatments necessary to allow ambulation), and mental well-being (see the depression case discussed in Part II).

Public health, medical, bioethics, and general legal literature have given attention to the several rights listed in the preceding paragraph, albeit mostly with respect to either public health measures other than delay or other intrusions attributable to government.[159] The focus here is on the right to purchase health care or health insurance. This

154. *See* sources cited *supra* note 6.
155. CHEMERINSKY, *supra* note 4.
156. *See supra* notes 1, 5, 6 and accompanying text.
157. *See* sources cited *supra* note 18.
158. Adam Schwartz, *Two Federal COVID-19 Bills: A Good Start and a Misstep,* ELEC. FRONTIER FOUND. (May 28, 2020), https://www.eff.org/deeplinks/2020/05/two-federal-covid-19-privacy-bills-good-start-and-misstep [https://perma.cc/C46E-5AVN] (noting deficiencies in current laws, and calling for an improved general privacy law or at least a COVID-19 privacy law).
159. *See supra* notes 5, 6, 142–58 and accompanying text (regarding constitutional analyses based on the various rights alluded to here).

right is very specific and circumscribed. It only applies to care available in the open market and does not necessarily contain a possible corollary right of persons who have qualified for and enrolled in an ongoing government healthcare insurance program.[160]

The right to purchase care does not require an exception to an existing law or regulation, as is the case with use of experimental drugs that have not been approved by the Food and Drug Administration[161] or drugs like marijuana that have been declared illegal by federal or state government.[162] This right is vital (implicating health and life), steeped in tradition, and specifically described and limited. It should, therefore, be considered fundamental under even the strictest test for discerning fundamental rights. That test is the one announced in *Washington v. Glucksberg*:

> First, we have regularly observed that the Due Process Clause specially protects those fundamental rights and liberties which are, objectively, "deeply rooted in this Nation's history and tradition," and "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if they were sacrificed." Second, we have required in substantive-due-process cases a "careful description" of the asserted fundamental liberty interest.[163]

It would also qualify under other tests, including the test that requires the right be one that allows individuals to make decisions about intimate aspects of their lives.[164] The asserted right to purchase care is vital, personal, and intimate.

Arguments against applying strict scrutiny to intrusions on a right to purchase care include the fact that myriad governmental regulations (especially professional licensing) already demand invigorated scrutiny; that care is allegedly only being postponed; and that existing case law denies access to experimental or allegedly harmful or addictive "treatments." Rebuttals are that the current delay actions can be distinguished from other contexts in that they risk life and health;

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160. I plan to explore the ancillary right in a separate article.

161. Roy G. Spece Jr., *A Fundamental Constitutional Right of the Monied To "Buy out of" Universal Health Care Program Restrictions Versus the Moral Claim of Everyone Else to Decent Health Care: An Unremitting Paradox of Health Care Reform?,* 3 J. HEALTH BIOMED. L. 1, 60–72 (2007).

162. *Id.* at 9 & n.28, 64 & n.182 (arguing there is no right to purchase care that the government has criminalized—e.g., marijuana); *cf.* Note, *Last Resorts and Fundamental Rights: The Substantive Due Process Implications of Prohibitions on Medical Marijuana*, 118 HARV. L. REV. 1985 (2005) ("This Note . . . argues that a law completely banning the use of marijuana will, as applied to some patients, infringe upon an array of fundamental rights, and that substantive due process obliges any such application of the law to survive strict scrutiny." These are "patients who seek relief from severe, and in some cases life-threatening, physical suffering . . . when traditional medicine utterly fails them.").

163. 521 U.S. 702, 720–21 (1997) (citations omitted) (first quoting Moore v. E. Cleveland, 431 U.S. 494, 503 (1977); then quoting Palko v. Conn., 302 U.S. 319, 325–26 (1937); and then quoting Reno v. Flores, 507 U.S. 292, 302 (1993)).

164. Spece, *supra* note 161, at 36.

that care is postponed indefinitely, and in the interim serious deterioration or death can occur; and that the alleged rights to purchase experimental (e.g., laetrile) and illegal treatments (like marijuana) are distinguishable as not touching access to care made available in the open market.[165]

The next question is whether the fundamental right to purchase healthcare is sufficiently intruded upon by delay to trigger strict scrutiny. Consider a comparison between the intrusion of the right to purchase health care and the intrusion involved in *Zablocki v. Redhail*,[166] where the Court struck down a law that denied marriage licenses to persons with support obligations for non-custodial children unless individuals supplied proof that they were in compliance with the support order and demonstrated that supported children were not and were unlikely to become public charges.[167] The Court treated the rights to marry and to procreate as fundamental rights. Even a possibly small expense *to persons who met the requirement* was held to be a sufficient intrusion to trigger strict or invigorated scrutiny.[168] If such an intrusion is sufficient to trigger invigorated review, then the risk of serious physical and mental deterioration, and even death, associated with delay actions is certainly a sufficient intrusion.

Even if courts recognized a fundamental right to purchase care and found that a delay pronouncement substantially intruded upon it, courts still might apply the rational basis or an intermediate test rather than strict scrutiny. This is explained in the above discussion of public health measures generally, by the deference established in *Jacobson v. Massachusetts*, the Court's tiered scrutiny approach over the last several decades, and authorities that address the appropriate degree of scrutiny. One consideration in choosing a standard of review is that delay is highly intrusive compared to all or most public health measures. The dispute might also become embroiled with the Court's inconsistent approach to how much deference courts should give governmental scientific experts.[169]

In addition to the articles reference above, authorities supportive of invigorated scrutiny in public health cases include the Canadian Supreme Court's decision in *Chaoulli v. Québec*,[170] regarding the right to purchase private health care insurance in response damaging

165. *Id.*
166. 434 U.S. 374, 386–87 (1978) (distinguishing *Califano v. Jobst*, 434 U.S. 47 (1977), as not involving a "significant" intrusion justifying invigorated scrutiny). In *Califano*, 434 U.S. at 50–52, plaintiffs challenged a Social Security Act provision that terminated a child's secondary benefits upon marriage unless the marriage was between two disabled persons who *both* received benefits.
167. *Zablocki*, 434 U.S. at 375.
168. *Id.* at 388.
169. *See infra* note 188 and accompanying text.
170. Chaoulli v. Québec, [2005] S.C.R. 791 (Can.).

delays in the public health care system. Three justices relied on a constitutional analysis similar to the one currently employed by the U.S. Supreme Court. They reasoned that a ban on access to private insurance in light of risky delays in the public program trenched on "security of the person."[171] This triggered invigorated scrutiny, requiring that such actions must comport with the principles of fundamental justice as demonstrated by a rational connection between the law and its goals, minimal impairment, and proportionality.[172] A fourth justice, who relied on the Québec charter alone, found that the law did not meet a requirement of least infringement because there were alternative ways to protect the public healthcare program.[173] This created a four-person majority to hold Québec's prohibition invalid. Three dissenters argued that the majority engaged in unwarranted enhanced review when it should have embraced a rational basis test.[174] In Canada, the decision triggered a one-year period in which the government of Québec was allowed to cure the constitutional deficiency. However, this proecedure does not invalidate use of *Chaoulli* as persuasive authority.[175]

This analysis will be continued in section IX.E below with an explanation and application of the elements of rational basis, intermediate, and strict scrutiny to the hypothetical from Part III and to delay generally.

171. *Id.* at 820.
172. *Id.* at 823, 826–27.
173. *Id.*
174. *Id.* at 896–99.
175. The subsequent history is beyond the scope of this Article. *See Due Process – Right to Medical Access – Supreme Court of Canada Holds that Ban on Private Health Insurance Violates Quebec Charter of Human Rights and Freedoms –* Chaoulli v. Quebec (Attorney General)*, 2005 S.C.C. 35, 29272 [2005] S.C.J. No. 33 Quicklaw (June 9, 2005)*, 119 HARV. L. REV. 677, 681–84 (2005). Readers might also gain some insight by reviewing an earlier article in which I consider the effect of *Chaoulli* on the analysis of a hypothetical law that did not allow persons to purchase certain marginally beneficial care. That article analyzed a regime—involving government withdrawal of marginally beneficial care from the open market—distinguishable from the delay context in which care purchased in the open market has been scheduled or planned, only to be deferred indefinitely. Spece, *supra* note 161, at 8 n.23 ("The Court's opinion was not definitive because one of the Justices comprising the four-person majority relied on the Quebec rather than the Canadian Charter, three Justice joined a dissent, two Justice did not participate, and both Charters contain provisions allowing legislators to set aside such rulings for a certain time period."). The argument developed in the cited article includes an argument similar to the one accepted by three Justices of the Canadian Supreme Court in *Chaoulli*. *Id.*

IX. APPLICATION OF MEDICAL- AND PUBLIC HEALTH-RELATED ETHICS AND STATUTORY, COMMON, AND CONSTITUTIONAL LAW

It will be assumed throughout this Part that the hypothetical medical liability case from Part III is a unique situation wherein the Hospital employs its physicians in house. This means that the hospital is vicariously liable for torts committed by its doctors.

A. Negligence

There would not be any problem if delays caused no damage. Acts of the hospital and the physicians involved in the hypothetical in Part III that *might* have caused damage include the following: First, as to the hospital, possibly negligent acts include failing to promulgate a proper protocol—especially in the face of the apparently vague professional association guidelines. A proper protocol could have prompted better communication among the providers and with the patient. Second, asking Dr. Burton to rely on apparently vague professional guidelines could be an unreasonable, harm-causing action. Clearer guidelines might have included information on how to avoid injuries—information that could have prompted protective action. Third, personnel decisions could be harm-causing, substandard acts, furloughing too many doctors and cardiologists and directing the possibly-too-few two non-furloughed cardiologists to care for an increased load of patients by only reviewing their medical records and applying the possibly unreasonable guidelines it supplied. If there were more providers to take the time to be more thorough, the actual gravity of delay might have been discovered in time to prevent Sam's death. Fourth, giving too much weight to the interests of future COVID-19 patients as compared to the weight given to Sam's interests could have tipped the urgency determination in favor of the fatal delay. As discussed, when considering the ethical conception of physician duties to societal or third-party interests, physicians are given little discretion to deny or delay care because its expense might affect the overall cost of health care. If the treatment offers virtually no chance of bettering the patient's ailments yet is extremely expensive, then the physician might ethically deny the patient's preferred care. It is very possible that these ethical conceptions will guide the application of negligence law. The care involved in the hypothetical—angiography and bypass surgery—are common, efficacious, and relatively safe when applied in appropriate circumstances. A final instance of possibly substandard conduct that might have caused harm is failure to give sufficient information to existing patients so they could advocate that delay should not be tolerated or seek alternative care from other providers or in different venues. This will be further discussed when covering informed consent.

Possibly harm-causing, unreasonable acts of Dr. Hughes include those listed for the hospital (remember that he was high enough in the governing hierarchy to be a contributing cause). Dr. Hughes might claim that he has no liability because he was just an administrative physician. There are, however, legal and ethical authorities that embrace the idea that even administrative physicians' primary duty is to patients.[176] Dr. Williams might be found to have caused harm by not charting the urgency of Sam's angiography and not communicating with Dr. Burton or Sam. Proper communication could have led to timely care. Possible harm-causing acts of Dr. Burton include not researching to resolve the ambiguity in the guidelines provided by the hospital (e.g., calling the office that issued the guidelines or researching on the internet). The research might have clarified the guidelines and led to appropriate action. Dr. Burton also possibly acted unreasonably and caused harm in assuming Sam had signed up for and periodically reviewed his portal files and in not consulting with Dr. Williams or Sam regarding the urgency of Sam's angiogram (an offhand, brief statement to Sam's wife does not negate causation).[177]

All the possibly negligent acts discussed above could be the foundation for recovery under a breach a fiduciary duty claim, especially given the pandemic. The pandemic is upsetting to virtually everybody. Sam's wife was distraught and frantic. Sam had ongoing pain and would likely have been stressed by his wife's problems. A loyal and reasonable provider might have attempted to learn about these problems and help Sam to deal with them. The same physician would presumably advocate no delay given the circumstances. It would be especially helpful if Sam's widow discovered that any of the providers had financial motivations, though the chances of this are not high because the delay regime has generally been financially catastrophic for many providers.

B. Abandonment

Once again, consider the hypothetical. (The analysis here differs only slightly from that in the section on negligence.) The possible defendants are the hospital and the three physicians. All the defendants can be conceived of as abandoning the patient either intentionally or through various acts of medical negligence—some of which are less amenable to conception as abandonment. For instance, Dr. Burton's liability would likely depend on the details regarding the furlough and capability to communicate with Dr. Williams. Recall the authority that abandonment can consist of explicit abandonment or failing to

176. *See supra* notes 77–80 and accompanying text.

177. I will revisit the arguably negligent acts of the Hospital and physicians in the hypothetical in the following abandonment subsection.

determine that the patient needs further care. The hospital could possibly be found to have de facto abandoned Sam by asking the covering cardiologist Dr. Burton to rely on apparently vague professional guidelines (possibly so flawed that they portend care even worse than doing nothing); furloughing 100 doctors (possibly leaving too few to handle communication with patients); cutting the number of cardiologists from eight to an arguably insufficient two; and directing those two cardiologists to care for an increased load of patients by reviewing their medical records, communicating through the patient portal, and using vague professional guidelines it supplied. A final instance of actionable conduct, applicable to each of the defendants, is failure to give patients notice that delay will be implemented, why, and the criteria for deciding who doesn't get medically necessary, non-emergency care. Such notice could enable patients like Sam to advocate that delay should not be tolerated or seek alternative care. Such failure too might be described as de facto abandonment.

Possibly negligent acts perhaps constituting abandonment by Dr. Hughes include those listed for the hospital, given that he was high enough in the governing hierarchy to be a contributing cause. Dr. Hughes might claim that he has no liability because he was just an administrative physician.[178] Nevertheless, as indicated, there are legal and ethical authorities that embrace the idea that administrative physicians' highest duty is to patients.[179] The original cardiologist, Dr. Williams, might be found liable for negligent abandonment for failing to chart the urgency of Sam's angiography, and since Dr. Williams failed to chart that fact, for not communicating it to Dr. Burton. The covering cardiologist, Dr. Burton, however, could have abandoned Sam by canceling the scheduled angiogram; not doing research (e.g., calling the office that issued the delay document or researching in the powerful libraries accessible by internet) to clear up ambiguity in the professional guidelines; and doing nothing to assure that the patient would be contacted before three months. For all he knew, the patient perhaps never signed up to use the patient portal. Most institutions provide this tool for looking at records and communicating with providers, although many persons can't or don't use it. Even if Sam had signed up for and checked the portal each month, he would have found nothing relating to what and when further care should be sought. (The hospital could be liable for abandonment by sending an identical note that could foreseeably lead to no care or worse.) Given that Dr. Williams felt that Sam's angiography should not be put off at all, or assuming the abandonment took place after the three months Dr. Williams specifically mentioned, these were especially important moments, and the "important moment" requirement would be met in ju-

178. *See* Wickline v. California, 239 Cal. Rptr. 810, 814 (Cal. Ct. App. 1986).
179. *Id.*

risdictions adopting it. None of the defendants' conduct seems intentional or extreme and outrageous. If on the whole helpful, the defendants might attempt to use the professional guidelines as the foundation of an expert opinion arguing that the guidelines were not unreasonable and set a reasonable medical standard that the defendants met. On the other hand, the plaintiff might attempt to use the guidelines if they are reasonable and were not met.

Of course, the acts described above could, independent from abandonment, constitute breaches of duty that simply constitute breach of fiduciary duty or negligence under whatever iteration of the standard of care is used.

C. Informed Consent

When the physician-patient relationship is subject to interruption or indefinite suspension, the health care provider must disclose to the patient the existence of any appeals mechanisms; the nature, benefits, risks (including the risks of contracting COVID-19) from the delayed care whenever the care is undertaken; alternatives to the delayed care at the time it is delayed and subsequently when the patient is likely to have the option to have the delayed care; the reason for the delay; the expected duration of the delay; the probability and nature of any more than de minimis risks, especially threat of significant pain and permanent harm, that might be caused by delay; the availability and contact information regarding, if there are any, alternative health care providers; the backlog of cases that will likely exist when the care is ultimately available; and all the foregoing regarding any reasonable medical alternatives. To avoid the risk of coercion, the physician should not aggressively push his patient to voluntarily accept delay; to facilitate understanding, there should be direct communication between a physician and the patient.

Turning to the hypothetical, it contains several possibly negligent failures of informed consent or reasonable communication. Some courts have limited the scope for informed consent saying, for example, that it does not apply to anything but surgery. If so, there can usually be an alternative of negligent communication, such as lack of communication among health care providers.[180] The possible liability-creating breaches here include the hospital's and Dr. Hughes's failure to promulgate a protocol that required communication with patients and sending a perfunctory note stating there would be a delay, Dr. William's failure to communicate the urgency of the angiogram to

180. *See* 2 DOBBS *supra* note 110, at 217–21 (discussing negligent communication). As to limits on the scope of informed consent, see S. GERALD LITVIN, ET AL., 3 WEST'S PENNSYLVANIA PRACTICE: TORTS, LAW & ADVOCACY § 8.7 (2019) (authority regarding informed consent applying to surgery only).

Sam, and Dr. Burton's inadequately giving notice of the delay via the patient portal (which Sam might have not even read). In some jurisdictions, it would likely be adequate for the widow to show that she or her husband would have considered the omitted information material and that an adequately informed, reasonable patient, would have pressured the health care providers not to delay the angiogram or sought to have the angiogram elsewhere, which would have led to preventive therapy.[181]

D. Fiduciary Duty

Applying fiduciary duty is somewhat of a wildcard. If the jurisdiction accepts the theory, *possible* effects of showing a breach are, again, elevating the standard of care beyond negligence, limiting consideration of societal or third-party interests, requiring advocacy for the patient, switching the burden of proof, and allowing recovery of dignitary damages. The particular effect(s) will depend on the authorities relied upon, particularly in-jurisdiction precedents, and on the judge's interpretation and application of the law. Elevating the duty beyond that in negligence cases presents similar problems to deflating the duty through crisis standards of care. The only difference is that physicians who rely on crisis standards of care as a future defense take a risk that a judge will apply an unfair standard under the fiduciary theory. Crisis standards of care are unnecessary, potentially unfair to doctors and patients, and disruptive of the purposes of tort law.

The across-the-board, undefined elevation of the standard of care seems unfair to physicians and might engender over-deterrence. Limiting consideration of societal and third-party interests poses similar vagueness problems. A heightened standard should be applied only if it supplies specific prohibitions. Requiring that the physician place the patient's best interests above personal interests is administrable, especially if it is limited to prohibiting financial conflicts of interest. For example, it might be advantageous to a physician, under existing financial incentives, to characterize certain procedures as elective. Requiring advocacy for the patient if there is a dispute, say, with an insurance company, is perhaps required simply by negligence standards, assuming the patient's position is correct.[182] Strengthening this effect seems fair and reasonable. Advocacy might be called for if a

181. *Coronary Artery Bypass Grafting*, NAT'L HEART, BLOOD & LUNG INST., https://www.nhlbi.nih.gov/health-topics/coronary-artery-bypass-grafting [https://perma.cc/9VEV-8BKT] (last visited Feb. 27, 2021); *NIH-Funded Studies Show Stents and Surgery No Better than Medication, Lifestyle Changes at Reducing Cardiac Events*, NAT'L HEART, BLOOD & LUNG INST. (Mar. 30, 2020, 8:00 AM), https://www.nhlbi.nih.gov/news/2020/nih-funded-studies-show-stents-and-surgery-no-better-medication-lifestyle-changes [https://perma.cc/86AZ-RHY2].

182. Spece & Shimm, *supra* note 77, at 57.

patient appeals a decision to delay and requiring physician advocacy does not make the doctor become a witness against herself. Switching the burden of proof if a court finds a fiduciary relationship is supported by the physician's greater access to evidence and expertise, and by the concept that patient interests are paramount over those of society or third parties. Certain authorities advocate for allowing dignitary damages in the informed consent context because of the overriding importance of patient autonomy.[183] This might translate to dignitary damages for fiduciary breaches, such as delay, that interfere with patients' autonomy, but it is doubtful that attorneys would take cases that only portend dignitary damages.[184]

E. Constitutional Analysis

Medical ethics supports strict or invigorated scrutiny for delay in that it flows from the physician-patient relationship models that make the patient primary and circumscribe consideration of societal or third-party interests.[185] Public health ethics supports the same approach, given its reliance on frameworks. Major frameworks by leading public health authorities discussed here require that public health measures be shown to focus on vital governmental interests and to be necessary, effective, and pursued in the least intrusive way.[186] Constitutional arguments can be informed by such ethical considerations as well as by values and interests embedded in statutes, administrative regulations, and common law rules. Among the latter are strong protections for individual patients embedded in, for example, law concerning negligence, abandonment, informed consent, and fiduciary duties.[187]

As explained above, the outcome of constitutional challenges against delay actions and other severe public health measures will be heavily influenced by the standard of review that is chosen. It is possible that our highest court and others might apply the rational basis test based on *Jacobson* and other cases that require deference to gov-

183. MARK HALL ET AL., *supra* note 121, at 217.

184. Eric Goodheart, Comment, *Two Tiers of Plaintiffs: How North Carolina's Tort Reform Efforts Discriminate Against Low-Income Plaintiffs,* 96 N.C. L. REV. 512, 528–29 (2018) (noting how limitations on damages impede attorneys' willingness to bring medical liability cases).

185. *See supra* Part VI (referencing strong ethical regard for patients in relationships with health care providers and a presumption that their interests should prevail when pitted against societal or third-party interests).

186. *See supra* Part VII (regarding public health ethical frameworks that require public health measures be shown to be necessary and effective in advancing vital governmental interests in the least restrictive way possible).

187. *See supra* subsections VIII.A.1–2, 4–5 (discussing these protections).

ernmental scientific experts.[188] It can be reasonably argued, however, that the Supreme Court would read *Jacobson* to require significant protections or apply invigorated scrutiny given its doctrinal developments subsequent to *Jacobson*. If the rational basis test were applied, successfully attacking delay actions would require a showing that delay actions cannot be conceived to advance legitimate state interests.[189] I cannot argue here that delay actions do not conceivably advance any legitimate state interests (one is preserving medical resources necessary to protect providers of COVID-19 care).

On the other hand, *Jacobson* hints at some review beyond the rational basis test, and developments in the Court's substantive due process and equal protection doctrine over the last several decades should lead to invigorated, if not strict, scrutiny of invasive public health measures. Several commentators have taken this position pre- and post-COVID-19.[190] It was demonstrated above why strict scrutiny should apply.[191] At least intermediate scrutiny of some form should apply. For illustrative purposes, I will apply strict scrutiny and the intermediate test applied in gender discrimination cases. Strict scrutiny requires that the government prove that its actual interest, is compelling and its action is the least intrusive way to substantially advance the interest (sometimes described as narrowly tailored).[192]

188. The Supreme Court has been inconsistent regarding deference to government in areas of alleged medical and scientific uncertainty. *See* DAVID L. FAIGMAN, LABORATORY OF JUSTICE: THE SUPREME COURT'S 200-YEAR STRUGGLE TO INTEGRATE SCIENCE AND THE LAW (2004); DAVID L. FAIGMAN, LEGAL ALCHEMY: THE USE AND MISUSE OF SCIENCE IN THE LAW 90–121 (1999). The uncertainty about uncertainty is salient given several Court opinions on different sides of cases that have cited *Jacobson v. Massachusetts*, 197 U.S. 11, 30–31 (1905), or other precedents to support the notion of deference to government in areas of uncertainty. *See* Gonzales v. Carhart, 550 U.S. 124, 162–64 (2007) (upholding restriction on partial birth abortions based on deference and citing numerous cases including *Jacobson*); Stenberg v. Carhart, 530 U.S. 914, 971–72 (2000) (striking restriction on partial birth abortion); *Id.* at 952, 980–1020 (Rehnquist, C.J., dissenting) (finding majority did not afford deference, citing *Jacobson* and other precedents); June Med. Servs. v. Russo, 140 S. Ct. 2103 (2020) (striking requirement that abortion doctors have admitting privileges at hospital within thirty miles of site of abortion); *Id.* at 2133–42 (Roberts, C.J., concurring) (citing the need for deference in areas of medical and scientific uncertainty); S. Bay United Pentecostal Church v. Newsom, 140 S. Ct. 1613, 1613–14 (2020) (denying church's application for injunctive relief from law prohibiting large gatherings because of COVID-19); *Id.* (Roberts, C.J., concurring) (invoking *Jacobson* in calling for deference to government attempts to control COVID-19); Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016) (striking several abortion restrictions). *Id.* at 2325 (Thomas, J., dissenting) (finding majority failed to allow deference because of alleged medical and scientific uncertainty).

189. *See* CHEMERINSKY, *supra* note 4.

190. *See* sources cited *supra* note 6.

191. *See supra* section VIII.C.

192. CHEMERINSKY, *supra* note 4; Roy G. Spece, Jr. & David Yokum, *Scrutinizing Strict Scrutiny*, 40 VT. L. REV. 285, 296, 312 (2015) (demonstrating that strict

The intermediate test requires that the government prove that its actual interest is important and is substantially advanced by its action—apparently supplemented (seldomly) with a requirement that the action is shown to be necessary.[193]

First applying strict scrutiny, it might be found that the purpose of delay actions is to serve political convenience rather than a weightier government interest. If the government's actual purpose is shown to be concern for protection of vital public health interests including avoidance of morbidity and mortality, it is virtually certain that such interests would be shown to be compelling, at least if that determination is made without balancing the benefits and detriments of its action. The government's challenge would be proving that any compelling interests are substantially advanced by delay or that delay is the least restrictive alternative. Reference has already been made to the absence of proof that delay works. The less restrictive alternatives include, again, obtaining voluntary delays; well-planned and implemented guidelines for delay; setting delay within an overall comprehensive mix of countermeasures; obtaining needed health care providers by rearranging, recruiting, conscripting, or activating licenses for inactive or otherwise prohibited health care providers; and insofar as the federal government is involved or can be approached for cooperation, conquering shortage of medical resources by forcing companies to mass produce needed items. If strict scrutiny is applied, delay actions should be found unconstitutional on the current record.

The analysis under intermediate scrutiny would be similar except that the government would only have to show an actual important interest, which it can probably do. Delay actions should still fail, however, because of inability to prove that they substantially advance the government's important interests.[194]

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scrutiny requires the government to prove (1) its actual interest; (2) is legitimate; (3) is compelling; (4) any classifications it has drawn are sufficiently precise to allow the conclusion that they substantially advance its interests (inclusiveness scrutiny); (5) its action substantially advances its interests without regard to classifications drawn (substantial advancement scrutiny); and (6) its action is necessary because it is aimed at an actual problem, that has not been dealt with already, and that cannot be addressed in ways less burdensome on individual rights (necessity scrutiny)); Roy G. Spece, Jr., *The Most Effective or Least Restrictive Alternative as the Only Intermediate and Only Means-Focused Review in Due Process and Equal Protection*, 33 VILL. L. REV. 111, 121–49 (1988); Roy G. Spece, Jr., *A Purposive Analysis of Constitutional Standards of Judicial Review and a Practical Assessment of the Constitutionality of Regulating Recombinant DNA Research*, 51 S. CAL. L. REV. 1281, 1294–1345 (1978) (discussing the purposes behind standards of review and ambiguities in strict and intermediate scrutiny).

193. CHEMERINSKY, *supra* note 4.

194. *See supra* text accompanying notes 18–19.

X. OBSERVATIONS AND RECOMMENDATIONS

It has been argued that, at their traditional cores, medical and public health laws and ethics are in conflict. Medical laws and ethics are generally based on protection of individual patients under the mantle of the physician-patient relationship; individual rights that consist of, or are generally based on, firm foundations in ethical models; and explicit personal liberties found in constitutional, tort, and legal rules generally. They reflect the individualistic perspective that seems to prevail in the United States.[195] Public health laws and ethics often require coercion to trump individual rights and are generally based on utilitarianism and population and group protection—sometimes extending to global human rights and utilitarian calculations that would require redistribution of wealth from Americans to all humans.

Childress argues, and street-smarts tell us, that populations or groups usually win when pitted against individuals, and thus the burden of proof should be placed on public health proponents.[196] Nevertheless, courts should often uphold public health measures as reflecting a proper reconciliation of societal and individual interests. The core of public health law and ethics that favors populations might explain why there has not been better planning for and implementation of disruptions of physician-patient relationships.[197]

Nevertheless, despite the clash of certain medical and public health laws and ethical principles, many physicians involved in clinical medicine support the public health agenda and call for solidarity, which is central in dealing with collective action problems. However, prominent public health frameworks require individual protections that are sometimes equal to or stronger than the constitutional scrutiny applied to the most fundamental of personal liberties.[198] Ironically, the lack of solidarity that allows collective action is perhaps the primary reason the United States has been one of the least successful advanced nations in dealing with the COVID-19 pandemic as exampled by early and sustained rejection of the slight, but effective, inconvenience of mask wearing by a significant part of the population. This began to subside somewhat in mid-July of 2020 be-

195. This does not mean that society will not instinctively support some public health measures when faced with possible annihilation.

196. Childress & Bernheim, *supra* note 16.

197. There has been, however, substantial guidance provided by earlier promulgation of concepts and guidelines for what this Article has referred to as micro-allocation problems, i.e., dealing with immediate and local problems of deciding who should be given a specific scarce resource such as a ventilator or intensive care room.

198. Recall especially Rothstein's framework that was analogized to constitutional strict scrutiny and, again, Childress's framework that puts the burden of proof on those who seek to implement coercive public health measures.

cause a number of states were breaking records for new cases. This resulted in expanded mask requirements and stronger sanctions.[199]

A similar lack of solidarity or coordination between medicine and public health might explain why the public and private mandates and requests discussed in this Article relating to delay and disruption of individual care often seem to have been created in the jaws of the pandemic rather than planned and perfected in advance of expected scourges. The delay and disruption discussed has been virtually ignored by almost every authority cited herein.

The utilitarian, population, and group perspectives could inform the usually loose nature of the delay mandates or recommendations discussed above. Conversely, medical law and ethics focus on the individual and existing protections of the physician-patient relationship. Drawing upon the best elements from medical and public health law and ethics, this Article recounts existing, and sketches new, protections and guidelines for future mandates and recommendations to conserve medical resources to fight pandemics or other catastrophic emergencies. This Article has also discussed law and ethics insofar as they might support actions by persons or families harmed by botched delays in care. The use of the rigorous scrutiny requirements seemingly agreed upon by medical ethics, public health ethics, and legal or constitutional concepts could support (1) damage suits against private and governmental entities for unreasonable mistakes pertaining to drafting or implementing mandates; (2) requests for declaratory judgments and injunctions; and (3) attacks on defendants' attempts to invoke a governmental mandate as a complete defense, a presumptive defense, or as some evidence of reasonable behavior.

Let's examine one of these remedies by assuming that the widow in our hypothetical case has filed a medical negligence claim, and that

199. Adam Taylor, *How the Split over Masks Sums up America's Chaotic Coronavirus Response*, WASH. POST (June 25, 2020, 6:13 AM), https://www.washingtonpost.com/world/2020/06/25/face-masks-america-divided/ [https://perma.cc/C7JE-FAKX]; Frank Miles, *Some Police in Arkansas Refuse To Enforce Coronavirus Mask Orders Because They Lack the Manpower*, FOX NEWS (July 20, 2020), https://www.foxnews.com/us/arkansas-police-coronavirus-mask-orders-refuse-enforce [https://perma.cc/KC9Y-56XH] (noting that over half the states have issued orders requiring mask wearing, that there is now clear public support for mask wearing, and that the long-standing objections to mask wearing is attributable to Republicans and their political leaders); Robert Gatter & Saema Mohaptra, *Covid-19 and the Conundrum of Mask Requirements*, 77 WASH. & LEE L. REV. ONLINE 17, 17 (2020), https://scholarlycommons.law.wlu.edu/wlulr-online/vol77/iss1/2 [https://perma.cc/2XX4-BJR7] ("This Article provides an overview of the legal and policy landscape and focuses on the potential for policing against black Americans when mask mandates are in place. Despite the public health benefits of mask usage, due to mask mandates likely being enforced discriminatorily, we advise caution against mask mandates."); *Id.* at 29 (explaining that if mask mandates are used, they should not be accompanied by sanctions or punitive actions).

the defendants have invoked a mandate that required delay as a complete or partial defense. The mandate can be constitutionally attacked because the government's issuance of a mandate constitutes state action. The widow can attack the "mandate defense" by arguing that the order is (1) unconstitutional; (2) supportive of negligence, abandonment, and failure to obtain informed consent as to its implementation by the private health care providers (wanton or reckless behavior could provide grounds for an intentional tort claim and possibly punitive damages); and (3) at odds with both medical and public health ethics. The strongest constitutional argument for the widow is that the order trenches on fundamental rights such as the right to purchase and use health care insurance. If this were accepted, the proponents of the mandate would likely be subject to, and not able to withstand, strict scrutiny.[200]

Plaintiffs who invoked the ethical precepts among the various medical and public health frameworks that parallel the requirements of constitutional strict scrutiny would likely buttress their constitutional arguments. Similarly, plaintiffs could support their arguments by referencing existing medical malpractice law, especially negligence and abandonment doctrine, as well as medical ethics' insistence that physician-patient relationships be disrupted only in extraordinary situations and pursuant to firm requirements. As to arguments that the defendants' conduct was below the standard of care (basically unreasonable), the plaintiff can possibly use medical and public health ethics concepts.

Among the possible non-constitutional legal and ethical requirements is the obligation that health care providers and others who promulgate and implement disruptions bear the burden of justifying those disruptions. They must make every effort to avoid or ameliorate disruptions. This includes giving adequate notice so patients can obtain alternative care with, if required, referral and other help from their existing providers. If these requirements cannot be honored, there should be a macro-triage plan that considers both existing patients and those from the at-risk population. There should also be preexisting guidelines that, if necessary, can be crafted to fit particular pandemics or other emergencies. There should also be internal provider protocols regarding how to address delay or disruption.

If there is a delay, it must be carefully explained to existing patients, including reasonable communication of the information outlined in the above discussion of informed consent. Under the doctrine of common law due process, there should be a chance for the patient to express any objections and at least have some opportunity to appeal any delay based on plausible claims of violation of common law due

200. *See supra* Part IX.

process and breach of fiduciary duty.[201] The appeal option must be made known to the patient. There must be communication between providers (both existing and replacement) and the patient as well as between the existing providers and any new providers. Alternatives—such as transferring the patient, personnel, and therapeutic and protective resources to other venues—must be undertaken if reasonably feasible. Even if there is delay, the patient must be updated in a timely fashion and provided any ameliorative care (via telemedicine when that is adequate). If challenged, the delay must be shown, with the best scientific evidence available, to be effective, necessary, and the least restrictive or burdensome intervention. The patient should have humane supportive care (such as pain control and financial support, without the requirement of filing a tort suit, if the delay causes inability to work beyond that which would have occurred had there not been any delay) as well as a reasonable mechanism to obtain damages caused by delay.[202]

XI. CONCLUSION

The Article's recommendations and the legal and ethical precepts underlying them illustrate the benefit of coordination between medicine and public health and the best aspects of their respective law and ethics to reconcile societal and individual rights and interests. There are reciprocal relationships among the medical and public health laws and ethics. This is despite the traditional individual versus population divide between medicine and public health. As best conceived, medical and public health law and ethics join to provide a reasonable mechanism to reconcile individual and population rights and interests. They provide for strict or invigorated scrutiny insofar as constitutional issues are concerned: strong protections against health care providers' unreasonable, unprofessional, or inappropriate actions through negligence, abandonment, fiduciary duty, and informed consent theories; ethical precepts that demand enhanced protections for patients who have relationships with physicians; and a showing that public health measures that interfere with patients' legal rights deal with an actual problem, are intended to protect vital governmental interests, actually achieve those vital interests, and do so in the least

201. Regarding common law due process, see Jane Taber & Janna King, *Caught in the Crossfire: Economic Credentialing in the Health Care War*, 1994 DET. C.L. REV. 1179, 1194 n.86 (1994) ("Depending upon the type of hospital involved - i.e., public or private, the source of a due process right varies. The Fourteenth Amendment governs public hospitals, but is inapplicable, absent some form of state action, to private hospitals. Private hospitals may, however, be governed by the theory of common law due process."). *See supra* text accompanying notes 112–15, 176–79 (concerning breach of fiduciary duty).

202. I leave to others or a later time the question whether the existing legal apparatus provides such a reasonable mechanism.

restrictive way possible. These strong requirements should encourage investment in public health research to determine and improve the efficacy and safety of various (sets of) public health pandemic countermeasures, especially including delay regimes.