PHYSICIANS WHO DISSEMINATE MEDICAL MISINFORMATION: TESTING THE CONSTITUTIONAL LIMITS ON PROFESSIONAL DISCIPLINARY ACTION

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There have been increasing calls in the medical community for revoking the licenses of physicians who disseminate medical misinformation, such as false claims about the safety of vaccines or the effectiveness of nonpharmaceutical measures to prevent COVID-19. While no licensing board has yet imposed penalties on physicians for disseminating medical misinformation, there is evidence that boards are using the threat of disciplinary action to exert pressure on physicians who make public statements that conflict with professional standards of care. This Article argues that, in most cases, imposing disciplinary penalties on physicians for speech that takes place outside a physician-patient relationship would have dangerous policy implications and would almost certainly be unconstitutional. However, drawing on examples from the regulation of the legal profession, it argues that disciplinary actions would be appropriate under one set of circumstances: if a board can establish that a physician has disseminated information that she knows to be false or with reckless disregard as to whether it is true—i.e., with the "actual malice" standard applied to defamation cases brought by public officials and public figures. The Article considers the implications of this standard for different factual scenarios.

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INTRODUCTION

The World Health Organization has characterized the proliferation of medical misinformation as an "infodemic," with consequences ranging from jeopardizing the efficacy of public health campaigns to "threatening long-term prospects for advancing democracy, human rights and social cohesion."[1] Of particular concern is medical misinformation disseminated by licensed physicians, whose professional credibility gives their voices inordinate weight.[2] Within the medical community, there have been increasing calls for revoking these physicians' medical licenses or subjecting them to other disciplinary penalties.[3] While no licensing board has yet imposed penalties on a physician for disseminating medical misinformation to the public,[4] there is evidence that boards are using the threat of disciplinary action to exert pressure on physicians who make public statements that conflict with professional standards of care.[5]

In this Article, I argue that, in most cases, imposing disciplinary penalties on physicians for speech that takes place outside a physician-patient relationship would almost certainly be unconstitutional. Even if courts agree that such speech can lead to harmful public health consequences, they are unlikely to view disciplinary actions as the least restrictive way to respond to that risk.[6] Nor are they likely to agree that limitations on public speech can be justified under licensing boards' authority to regulate professional conduct[7] or to set conditions on how the benefits of a medical license are used.[8] In addition, giving licensing boards broad authority to regulate the content of physicians' public statements would have dangerous policy implications, as it could inhibit physicians from raising legitimate concerns about existing standards of care.[9]

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[1] Joint Statement, World Health Org. et al., Managing the COVID-19 Infodemic: Promoting Healthy Behaviours and Mitigating the Harm from Misinformation and Disinformation (Sept. 23, 2020), https://www.who.int/news/item/23-09-2020-managing-the-covid-19-infodemic-promoting-healthy-behaviours-and-mitigating-the-harm-from-misinformation-and-disinformation.

[2] Although this Article focuses on physicians, the analysis would also apply to other licensed healthcare professionals, such as nurses or physician assistants.

[3] *See infra* Part II.A.

[4] *See infra* notes 69–74 and accompanying text.

[5] *See infra* notes 76–77 and accompanying text.

[6] *See infra* note 87 and accompanying text.

[7] *See infra* Part III.B.

[8] *See infra* Part III.C.

[9] *See infra* notes 131–136 and accompanying text.

However, drawing on examples from the regulation of the legal profession, I argue that disciplinary actions should survive constitutional scrutiny under one set of circumstances: if a board can establish that a physician has disseminated information that she knows to be false or with reckless disregard as to its truthfulness—i.e., with the "actual malice" standard applied to defamation cases brought by public officials and public figures.[10] Physicians who knowingly or recklessly misrepresent medical information do more than simply encourage people to engage in unhealthy behavior; they also cause the independent harm of undermining the public's trust in the medical profession's commitment to truthfulness. States have a compelling interest in preserving the public's ability to trust in physicians, and disciplining physicians who knowingly or recklessly tell falsehoods to the public is a narrowly tailored means of achieving this goal.

Part I of this Article provides examples of physicians who have disseminated false or misleading medical information to the public, including physicians who have fomented fears about vaccine safety and efficacy, undermined public health measures to reduce the spread of COVID-19, and promoted unproven medical products. Part II reviews calls for disciplining physicians who disseminate medical misinformation, as well as existing professional standards and enforcement activities. Part III considers three potential analytical frameworks for assessing the constitutionality of professional discipline as a response to physicians who disseminate medical misinformation: disciplinary penalties as content-based limitations on speech, disciplinary penalties as the regulation of professional conduct, and disclaimer requirements as conditions on the use of a medical license. Based on this analysis, I conclude that disciplinary actions against physicians who disseminate medical misinformation can be justified in only one set of circumstances: when physicians disseminate misinformation with knowledge that it is false or with reckless disregard of whether it is true.

[10] *See infra* notes 107–118 and accompanying text.

I. EXAMPLES OF PHYSICIAN DISSEMINATION OF MEDICAL MISINFORMATION

Medical misinformation has been defined as "information that is contrary to the epistemic consensus of the scientific community regarding a phenomenon."[11] These claims can be spread either negligently or with a deliberate intent to deceive.[12] A large percentage of medical misinformation comes from individuals or entities with economic or political incentives to promote untruthful information.[13] Physicians are a relatively uncommon source of medical misinformation, but because of their professional status their claims tend to receive inordinate attention. This Part reviews some of the most prominent examples.

A. Fomenting Fears about Vaccine Safety and Efficacy

Vaccines are widely regarded as "one of modern medicine's greatest success stories."[14] They are responsible for eradicating smallpox[15] and nearly eradicating polio,[16] as well as substantially reducing the prevalence of once-common childhood diseases like

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[11] Briony Swire-Thompson & David Lazer, *Public Health and Online Misinformation: Challenges and Recommendations*, 41 ANN. REV. PUB. HEALTH 433, 434 (2019); *see also* Wen-Ying Sylvia Chou et al., *Where Do We Go from Here: Health Misinformation on Social Media*, 110 AM. J. PUB. HEALTH S273, S273 (2020) (defining health misinformation as "any claim of fact that is false based on current scientific consensus"). Some commentators have called for a broader definition of misinformation, arguing that requiring information to deviate from a scientific consensus sets too high a bar. For example, in a 2021 report, the U.S. Surgeon General defined misinformation as "information that is false, inaccurate, or misleading according to the best available evidence at the time," noting that "claims can be highly misleading and harmful even if the science on an issue isn't yet settled." DEP'T OF HEALTH & HUMAN SERVICES, CONFRONTING HEALTH MISINFORMATION: THE U.S. SURGEON GENERAL'S ADVISORY ON BUILDING A HEALTHY INFORMATION ENVIRONMENT 4, 17 (2021).

[12] *See* Yuxi Wang et al., *Systematic Literature Review on the Spread of Health-Related Misinformation on Social Media*, SOC. SCI. & MED., November 2019, at 2 (distinguishing between "misinformation," which "involves information that is inadvertently false and is shared without intent to cause harm," from "disinformation," which "involves false information knowingly being created and shared to cause harm").

[13] *See* Swire-Thompson & Lazer, *supra* note 11, at 438.

[14] *Immunization*, WORLD HEALTH ORG., (Dec. 5, 2019), https://www.who.int/news-room/facts-in-pictures/detail/immunization.

[15] *See History of Smallpox*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/smallpox/history/history.html (Feb. 20, 2021).

[16] *See History of Polio*, GLOB. POLIO ERADICATION INITIATIVE, https://polioeradication.org/polio-today/history-of-polio/ (last visited July 25, 2021) (noting that, thanks to a global vaccine campaign, "wild poliovirus continues to circulate in only two countries, and global incidence of polio cases has decreased by 99%").

measles, mumps, and rubella.[17] In all states, specific childhood vaccines are required as a condition of school enrollment, except for children eligible for an exemption.[18]

Despite the proven value of vaccines, a small but vocal minority of the public opposes vaccination, often based on the incorrect belief that vaccines are harmful.[19] Based on these beliefs, some parents seek exemptions from school vaccination requirements, while others avoid the requirements by home-schooling their children.[20] Communities with high levels of unvaccinated children are more likely to experience outbreaks of vaccine-preventable diseases.[21] For example, in 2019, 1,282 cases of measles were confirmed in 31 states, with the majority occurring in communities with groups of unvaccinated people.[22]

While most physicians recognize the value of vaccination,[23] a small minority has fueled anti-vaccination sentiments with

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[17] *See* Bettina Bankamp et al., *Successes and Challenges for Preventing Measles, Mumps and Rubella by Vaccination*, 34 CURRENT OP. VIROLOGY 110, 110 (2019) ("MMR vaccine has an outstanding safety record, and high coverage with MMR has led to the elimination of endemic measles and rubella in the US and to a substantial reduction in the number of mumps cases compared to the pre-vaccine era.").

[18] For a state-by-state summary of school immunization requirements and exemptions, see *States with Religious and Philosophical Exemptions from School Immunization Requirements*, NAT'L CONF. OF STATE LEGISLATURES, (April 30, 2021), https://www.ncsl.org/research/health/school-immunization-exemption-state-laws.aspx#Table1.

[19] *See* Cephra McKee & Kristin Bohannon, *Exploring the Reasons Behind Parental Refusal of Vaccines*, 21 J. PEDIATRIC PHARMACOLOGY THERAPEUTICS 104, 107–08 (2016).

[20] *See* Soumya Karlamangla, *Parents Who Won't Vaccinate Their Kids Turning to Homeschooling in California, Data Show*, L.A. TIMES (July 23, 2019, 5:00 AM), https://www.latimes.com/california/story/2019-07-22/california-homeschool-strict-vaccination-laws (noting a steep rise in unimmunized home-school children after California eliminated personal and philosophical objections to vaccine requirements in 2015).

[21] *See* Varun K. Phadke et al., *Association Between Vaccine Refusal and Vaccine-Preventable Diseases in the United States: A Review of Measles and Pertussis*, 315 JAMA 1149, 1155 (2016) (discussing studies suggesting "an association between high rates of vaccine exemption and the sustained transmission of vaccine-preventable diseases in the community").

[22] *See Measles*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/measles/cases-outbreaks.html (Oct. 21, 2021).

[23] As an example of the support for vaccination within the medical community, most major medical associations have called for the elimination of non-medical exemptions to school vaccination requirements. *See State Exemptions*, IMMUNIZATION ACTION COAL., https://www.immunize.org/laws/laws-exemptions.asp (Feb. 24, 2020). In addition, over 96% of physicians are fully vaccinated against COVID-19. *See* Press Release, Am. Med. Ass'n, AMA Survey Shows Over 96% of Doctors Fully Vaccinated Against COVID-19 (June 11, 2021), https://www.ama-assn.org/press-center/press-releases/ama-survey-shows-over-96-doctors-fully-vaccinated-against-covid-19.

claims that vaccines are dangerous and/or ineffective. For example, YouTube celebrity Dr. Andrew Kaufman has told his followers that vaccines are "syringes full of poison" and that "viruses are not a cause of human disease."[24] During a 2015 measles outbreak in Arizona, Dr. Jack Wolfson told the *Arizona Republic* that children have a "right" to "get[] measles, mumps, rubella, [and] chicken pox,"[25] and called a reporter a "bad mother" for not recognizing "all the harmful things in these vaccines."[26]

More recently, some physicians have been spreading misinformation about the vaccines against SARS-CoV-2, the virus that causes COVID-19. For example, Dr. Joseph Mercola, who has purportedly made a fortune selling natural health medicines, has called coronavirus vaccines "a medical fraud" that neither prevent infections nor stop transmission of the virus.[27] In testimony before the Ohio legislature, Dr. Sherri Tenpenny called the coronavirus vaccine a "deadly bioweapon" that could magnetize people,[28] a claim that is "demonstrably false."[29] Other examples include family physician Dr. Daniel Stock, who told a school board in Indiana that the vaccines were ineffective,[30] and Dr. Rashid Buttar, who shared an article on Twitter alleging that most people who took the COVID vaccine "would be dead by 2025."[31]

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[24] *See* Jonathan Jarry, *The Psychiatrist Who Calmly Denies Reality*, MCGILL UNIV. OFF. FOR SCI. AND SOC'Y (Sept. 24, 2020), https://www.mcgill.ca/oss/article/covid-19-pseudoscience/psychiatrist-who-calmly-denies-reality.

[25] Elizabeth Stuart, *Arizona Anti-Vaccine Doctor to Keep His License, Medical Board Rules*, PHX. NEW TIMES (July 24, 2015), https://www.phoenixnewtimes.com/news/arizona-anti-vaccine-doctor-to-keep-his-license-medical-board-rules-7511301.

[26] *See* Terrence McCoy, *Amid Measles Outbreak, Anti-Vaccine Doctor Revels in His Notoriety*, WASH. POST (Jan. 30, 2015), https://www.washingtonpost.com/news/morning-mix/wp/2015/01/30/amid-measles-outbreak-anti-vaccine-doctor-revels-in-his-notoriety/.

[27] *See* Sheera Frenkel, *The Most Influential Spreader of Coronavirus Misinformation Online*, N.Y. TIMES, https://www.nytimes.com/2021/07/24/technology/joseph-mercola-coronavirus-misinformation-online.html (Oct. 6, 2021).

[28] *See* Andrea Salcedo, *A Doctor Falsely Told Lawmakers Vaccines Magnetize People: "They Can Put a Key on Their Forehead. It Sticks,"* WASH. POST (June 9, 2021), https://www.washingtonpost.com/nation/2021/06/09/sherri-tenpenny-magnetized-vaccine-ohio/.

[29] *See* Ethan Siegel, *The Unfiltered Truth Behind Human Magnetism, Vaccines, and COVID-19*, FORBES (June 23, 2021), https://www.forbes.com/sites/startswithabang/2021/06/23/the-unfiltered-truth-behind-human-magnetism-vaccines-and-covid-19/?sh=6cdee2f540c8.

[30] Davey Alba & Sheera Frenkel, *Calls Grow to Discipline Doctors Spreading Virus Misinformation*, N.Y. TIMES (Aug. 27, 2021) https://www.nytimes.com/2021/08/27/technology/doctors-virus-misinformation.html.

[31] Victoria Knight, *Will "Dr. Disinformation" Ever Face the Music?* KHN (Sept. 22, 2021), https://khn.org/news/article/disinformation-dozen-doctors-covid-misinformation-social-media/.

B. Undermining Nonpharmaceutical Measures to Reduce the Spread of COVID-19

At the beginning of the COVID-19 pandemic, public health messages about the value of nonpharmaceutical interventions like masking and social distancing were sometimes conflicting, due in part to limited understanding of how the virus was transmitted.[32] Within a few months, however, strong epidemiological evidence supporting the benefits of these measures began to emerge. Experts now agree that compelling evidence supports the effectiveness of both masking and social distancing.[33] The World Health Organization[34] and the Centers for Disease Control and Prevention[35] strongly support the use of these measures, as do physician associations like the American Medical Association (AMA).[36]

Despite the medical consensus in favor of masking and social distancing, substantial segments of the population have resisted them.[37] While the reasons for this opposition are complex, at

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[32] *See* Marie Fazio, *How Mask Guidelines Have Evolved*, N.Y. TIMES (July 9, 2021), https://www.nytimes.com/2021/04/27/science/face-mask-guidelines-timeline.html.

[33] *See* John T. Brooks & Jay C. Butler, *Effectiveness of Mask Wearing to Control Community Spread of SARS-CoV-2*, 325 JAMA 998, 998 (2021) ("Compelling data now demonstrate that community mask wearing is an effective nonpharmacological intervention to reduce the spread of this infection . . . ."); Russell H. Fazio et al., *Social Distancing Decreases an Individual's Likelihood of Contracting COVID-19*, PNAS, Feb. 2021, at 1, https://www.pnas.org/content/118/8/e2023131118 ("[R]ecent epidemiological evidence . . . documents the effectiveness of social distancing at the societal level").

[34] *See Coronavirus Disease (COVID-19): Masks,* WORLD HEALTH ORG. (Dec. 1, 2020), https://www.who.int/news-room/q-a-detail/coronavirus-disease-covid-19-masks ("Masks are a key measure to suppress transmission and save lives.").

[35] Press Release, Ctrs. for Disease Control and Prevention, CDC Calls on Americans to Wear Masks to Prevent COVID-19 Spread (July 14, 2020), https://www.cdc.gov/media/releases/2020/p0714-americans-to-wear-masks.html ("[C]loth face coverings are a critical tool in the fight against COVID-19 that could reduce the spread of the disease, particularly when used universally within communities.").

[36] Press Release, Am. Med. Ass'n, AMA, AHA, ANA Release PSA Urging Masks to Stop COVID-19 Spread (July 31, 2020), https://www.ama-assn.org/press-center/press-releases/ama-aha-ana-release-psa-urging-masks-stop-covid-19-spread.

[37] Gavan J. Fitzsimons, Opinion, *To Help More Americans Adopt Social Distancing, Change the Message*, THE HILL (May 16, 2020), https://thehill.com/opinion/white-house/498038-to-help-more-americans-adopt-social-distancing-change-the-message (noting that "millions of individual Americans are not following the distancing guidelines designed to contain the coronavirus"); *see also* Edward D. Vargas & Gabriel R. Sanchez, *American Individualism Is an Obstacle to Wider Mask Wearing in the U.S.*, BROOKINGS (Aug. 31, 2020), https://www.brookings.edu/blog/up-front/2020/08/31/american-individualism-is-an-obstacle-to-wider-mask-wearing-in-

least some of them are based on the belief that masking and/or social distancing are unnecessary.[38] As with the anti-vaccination movement, a small number of physicians have publicly supported these beliefs. For example, in a December 2020 congressional hearing, Dr. Ramin Oskoui testified that masks and social distancing were ineffective in preventing transmission of the SARS-CoV-2 virus. As support for his claim, he cited a study published in the *New England Journal of Medicine*, but the authors of the study said that his interpretation of their research was either "mistaken" or "deliberately misleading."[39] Similarly, in Novembe*r* 2020, Oregon physician Dr. Steven LaTulippe gave a speech at a "Stop the Steal" rally for former President Donald Trump in which he urged attendees to "take off the mask of shame." Criticizing what he called "corona mania," he boasted that neither he nor his staff ever wore masks when treating patients.[40]

The most prominent example of a physician contesting public health recommendations related to COVID-19 is Dr. Scott Atlas, a neuroradiologist at Stanford University Medical Center, who served as an advisor on the White House Coronavirus Task Force under President Trump. During his tenure on the Task Force, he insisted that face masks and social distancing were not effective in protecting against transmission of the virus, that young people could not transmit the virus, and that allowing the virus to spread naturally would not result in more deaths than

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the-us/ (observing that "a large segment of the American public has been resistant to wearing a mask to reduce the spread of the coronavirus").

[38] *See* Steven Taylor & Gordon J.G. Asmundson, *Negative Attitudes about Facemasks During the COVID-19 Pandemic: The Dual Importance of Perceived Ineffectiveness and Psychological Reactance*, PLOS ONE, Feb. 17, 2021, at 3 ("The most common of the assessed reasons for not wearing masks were: Not believing that masks are effective, finding masks uncomfortable, difficulty establishing the habit of mask wearing, and lack of concern about COVID-19.").

[39] *See* Linda Qiu, *A Senate Hearing Promoted Unproven Drugs and Dubious Claims about the Coronavirus*, N.Y. TIMES (Dec. 8, 2020), https://www.nytimes.com/2020/12/08/technology/a-senate-hearing-promoted-unproven-drugs-and-dubious-claims-about-the-coronavirus.html.

[40] *See* Minyvonne Burke, *Oregon Doctor and Staff Refuse to Wear Masks During Pandemic, Calling Covid "Common Cold,"* NBC NEWS (Dec. 2, 2020), https://www.nbcnews.com/news/us-news/oregon-doctor-staff-refuse-wear-masks-during-pandemic-calling-covid-n1249737; *see also* Alba & Frenkel, *supra* note 30 (discussing Dr. Daniel Stock's claim that masks are ineffective and that "[e]verything being recommended by the C.D.C. is actually contrary to the rules of science").

attempts to contain it.[41] According to a commentary in the *Journal of the American Medical Association*, "[n]early all public health experts were concerned that his recommendations could lead to tens of thousands (or more) of unnecessary deaths in the US alone."[42]

C. Promoting Unproven Medical Products

Physicians who advertise are subject to federal and state consumer protection laws,[43] as well as restrictions imposed by medical licensing boards.[44] However, these rules do not prevent physicians from promoting medical products in which they have no direct financial interests. In some cases, physicians have taken advantage of this gap to promote medical products that do not meet prevailing standards of care.

For example, early in the COVID-19 pandemic, a group of physicians calling themselves "America's Frontline Doctors" claimed, without any evidence, that hydroxychloroquine and other interventions were an effective "cure" for the virus.[45] The doctors appeared to be driven primarily by political opposition to public health measures and support for President Trump.[46] Most of the doctors did not even treat COVID-19 patients.[47]

On a larger scale, television personality Dr. Mehmet Oz has "become infamous for promoting diet supplements and weight-

[41] *See* Philip A. Pizzo et al., Opinion, *When Physicians Engage in Practices that Threaten the Nation's Health*, 325 JAMA 723, 723 (Feb. 23, 2021).
[42] *Id.*
[43] *See* Lisa M. Schwartz & Steven Woloshin, *Medical Marketing in the United States, 1997-2016*, 321 JAMA 80, 85–87 (2019) (describing federal and state oversight of medical advertising).
[44] *See, e.g.*, N.Y. EDUC. LAW § 6530(27) (McKinney 2021) (defining professional misconduct to include "advertising or soliciting for patronage that is not in the public interest").
[45] *See* Isabel Togoh, *Facebook Takes Down Viral Video Making False Claim that "Hydroxychloroquine Cures Covid,"* FORBES (July 28, 2020), https://www.forbes.com/sites/isabeltogoh/2020/07/28/facebook-takes-down-viral-video-making-false-claim-that-hydroxychloroquine-cures-covid/?sh=419585305531.
[46] *See* Brandy Zadrozny & Ben Collins, *Dark Money and PAC's Coordinated "Reopen" Push Are Behind Doctors' Viral Hydroxychloroquine Video*, NBC NEWS (July 28, 2020), https://www.nbcnews.com/tech/social-media/dark-money-pac-s-coordinated-reopen-push-are-behind-doctors-n1235100.
[47] *See* Amanda D'Ambrosio, *"America's Frontline Doctors" Continue to Misinform on COVID,* MEDPAGE TODAY (Jan. 5, 2021), https://www.medpagetoday.com/infectiousdisease/covid19/90536.

loss programs with no evidence of their effectiveness."[48] According to the journal *BMJ*, out of 80 medical recommendations made on the *Dr. Oz Show*, nearly half had "either no evidence or [were] contradicted by the best available evidence."[49] In response to questioning at a congressional hearing, Dr. Oz acknowledged that his recommendations "oftentimes . . . don't have the scientific muster to present as fact."[50] Nonetheless, because Dr. Oz does not directly profit from the sale of the products, he has been able to escape legal accountability.[51]

II. THE ROLE OF PROFESSIONAL DISCIPLINARY BOARDS

Physicians who disseminate medical misinformation have been subject to widespread condemnation within the medical community. Several prominent physicians and bioethicists have argued that these physicians should lose their licenses or be subject to other disciplinary penalties. This Part begins by reviewing the arguments raised by proponents of disciplinary action. It then examines existing professional standards and relevant enforcement activities.

A. Calls for Subjecting Physicians Who Disseminate Medical Misinformation to Professional Discipline

Many commentators have called for licensing boards to take disciplinary action against physicians who disseminate medical misinformation. They emphasize that, even when physicians are speaking outside the clinical context, their statements "will be

[48] Jeffrey Cole, *Dr. Phil, Dr. Oz and Dr. Drew: Do No Harm (Unless It Is Good for Ratings)*, CTR. FOR THE DIGIT. FUTURE (April 7, 2021), https://www.digitalcenter.org/columns/doctors-do-no-harm/.

[49] Christina Korownyk et al., *Televised Medical Talk Shows—What They Recommend and the Evidence to Support Their Recommendations: A Prospective Observational Study*, BMJ, December 2014, at 1.

[50] Michael Specter, *Columbia and the Problem of Dr. Oz*, NEW YORKER (April 23, 2015), https://www.newyorker.com/news/daily-comment/columbia-and-the-problem-of-dr-oz.

[51] In 2020, a California court dismissed a lawsuit seeking to hold Dr. Oz liable for misrepresentation after the plaintiffs conceded that the suit lacked legal merit. *See* Emily Field, *Suit Dismissed over Dr. Oz's "Miracle" Diet Pills*, LAW360 (Jan. 14, 2021), https://www.law360.com/articles/1087559/suit-dismissed-over-dr-oz-s-miracle-diet-pills.

reasonably taken by the public as medical advice."[52] By "us[ing] the language and authority of their profession to promote false medical information," one commentator argues, "they have crossed the line from free speech to medical practice—or, in this case, something akin to malpractice."[53] These commentators argue that disseminating medical misinformation in public is even more dangerous than providing the same information in an individual patient encounter, given the number of people potentially at risk.[54]

For example, bioethicist Arthur Caplan argues that medical boards should rescind the licenses of physicians "who purvey views based on anecdote, myth, hearsay, rumor, ideology, fraud or some combination of all of these, particularly during an epidemic."[55] As an example, he points to physicians who urge parents not to vaccinate their children against measles during an outbreak. According to Caplan, it should not matter whether such physicians are counseling individual patients or speaking on TV. In either case, they "distort what patients need to know to preserve their health or that of their children."[56]

Some commentators express particular concern about physicians like Dr. Scott Atlas, who disseminate misinformation when carrying out official policy-making roles.[57] "When the voices of physicians are coupled with the power of national leaders and provide support for misguided policies," one group of commentators argues, "serious public harm can result."[58] Noting that physicians acting in public roles are not subject to liability for

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[52] Richard A. Friedman, Opinion, *We Must Do More to Stop Dangerous Doctors in a Pandemic*, N.Y. TIMES (Dec. 11, 2020), https://www.nytimes.com/2020/12/11/opinion/scott-atlas-doctors-misinformation.html; *see also* Arthur L. Caplan, Opinion, *Revoke the License of Any Doctor Who Opposes Vaccination*, WASH. POST (Feb. 6, 2015), https://www.washingtonpost.com/opinions/revoke-the-license-of-any-doctor-who-opposes-vaccination/2015/02/06/11a05e50-ad7f-11e4-9c91-e9d2f9fde644_story.html ("Physicians' speech invokes medical authority, so when they speak, patients tend to listen.").

[53] Friedman, *supra* note 52.

[54] *Id.* ("Arguably, the harm done by a doctor who knowingly pushes misleading medical information can be vastly more dangerous than whatever he or she does in a single patient encounter."); *see also* Cole, *supra* note 48 ("If anything, the standards to 'practice' on television where patients cannot be followed or personally evaluated should be even higher than for those who see patients in hospitals or private practice.").

[55] Caplan, *supra* note 52.

[56] *Id.*

[57] *See* Pizzo et al., *supra* note 41, at 723.

[58] *Id.* at 724.

professional malpractice, they suggest that professional disciplinary action is one of the only means of holding such physicians accountable for the consequences of their words.

One commentator distinguishes between physicians who advocate for policy positions and those who "address the general public on specific medical matters that implicate care choices."[59] While policy advocacy is entitled to full First Amendment protection, he argues, physicians who offer "specific medical guidance to the public" should be subject to professional discipline. Disciplinary action is appropriate, he suggests, if the information provided to the public would constitute malpractice if offered to a patient as part of medical care.[60]

B. Existing Professional Standards and Enforcement Activity

In all states, physicians can be subject to professional discipline for activities that occur outside the physician-patient relationship. For example, physicians have been disciplined for criminal conduct such as shoplifting, income tax fraud, and possession of marijuana for personal use.[61] In addition, some medical boards have pursued disciplinary actions against physicians for making false or misleading statements as expert witnesses in malpractice cases.[62] In all of these situations, the basis for discipline is typically a generalized allegation of "unprofessional conduct."[63]

Laws in some states explicitly authorize disciplinary action against physicians who make false, deceptive, or misleading statements to the public. While many of these statutes are limited to statements made in connection with advertising,[64] some

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[59] Jacob M. Appel, *If It Ducks Like a Quack: Balancing Physician Freedom of Expression and the Public Interest*, J. MED. ETHICS, April 2021, at 1, 3, https://jme.bmj.com/content/medethics/early/2021/04/27/medethics-2021-107256.full.pdf.
[60] *Id.* at 2.
[61] *See* Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285, 305–06 (2010).
[62] *See* Aaron S. Kesselheim & David M. Studdert, *Role of Professional Organizations in Regulating Physician Expert Witness Testimony*, 298 JAMA 2907, 2908 (2007).
[63] *See* Sawicki, *supra* note 61, at 305; *see also* Kesselheim & Studdert, *supra* note 62, at 2908.
[64] *See, e.g.*, N.Y. EDUC. LAW § 6530(27)(a)(1) (McKinney 2021) (prohibiting "advertising or soliciting" that is "false, fraudulent, deceptive, misleading, sensational, or flamboyant"); *see, e.g.*, CA BUS. & PROF. CODE § 651 (West 2021) (prohibiting licensees from making a "public communication containing a false, fraudulent, misleading, or

are worded broadly enough to cover falsehoods unrelated to the solicitation of patients or customers. For example, Minnesota authorizes disciplinary action against physicians who engage in "conduct likely to deceive or defraud the public."[65]

Voluntary professional associations have gone further than licensing boards in characterizing the dissemination of medical misinformation to the public as inconsistent with physicians' professional obligations. For example, the AMA cautions physicians making statements to the media to ensure that the information they provide is "accurate," "inclusive of known risks and benefits," "commensurate with their medical expertise," and "based on valid scientific evidence and insight gained from professional experience."[66] Recognizing the public's reliance on physicians for accurate medical information during the COVID-19 pandemic, the AMA issued a statement in April 2020 urging physicians "to be candid about the limits of their own expertise, and to acknowledge when there is lack of consensus within the profession."[67] Other professional associations have issued similar guidance.[68]

In a few cases, licensing boards have opened disciplinary investigations against physicians thought to be disseminating medical information, but none of these cases has yet resulted in the

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deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed"); *see also* Julia Belluz, *Why Dr. Oz Can Say Anything and Keep His Medical License*, VOX (June 24, 2014), https://www.vox.com/2014/6/24/5838690/why-is-dr-oz-still-a-doctor (noting that New York State's definition of professional misconduct "'prevents physicians from falsely advertising their own goods and services'" but "'not from making bogus claims about other people's goods and services, with no financial interest'" (quoting Stephen Latham, a lawyer and director at the Yale Interdisciplinary Center for Bioethics)).

[65] MINN. STAT. § 147.091(g)(1) (2021). Similarly, Kentucky defines unprofessional conduct to include "representations in which grossly improbable or extravagant statements are made which have a tendency to deceive or defraud the public." KY. REV. STAT. ANN. § 311.597(2) (West 2021). While the examples provided in the statute both relate to statements made in connection with the promotion of services, the statute indicates that these examples are meant to be illustrative only. *See id.*

[66] CODE OF MED. ETHICS OP. 8.12 (AM. MED. ASS'N 2002).

[67] *Physicians in the Media: Responsibilities to the Public and the Profession*, AMA, https://www.ama-assn.org/delivering-care/ethics/physicians-media-responsibilities-public-and-profession (April 17, 2020).

[68] *See, e.g.*, Thomas K. Varghese, Jr. et al., *Ethical Standards for Cardiothoracic Surgeons' Participation in Social Media*, 158 J. THORACIC & CARDIOVASCULAR SURGERY 1139 (2019); *see also* Am. Acad. of Ophthalmology, Advisory Op.—Social Media and Professionalism (2018), https://www.aao.org/ethics-detail/advisory-opinion-social-media-professionalism.

imposition of penalties.[69] For example, in 2004, the Illinois Department of Professional Regulation filed a complaint against Dr. Joseph Mercola,[70] based in part on his online publication of "false and potentially harmful medical advice,"[71] but the claim was voluntarily dismissed after the doctor modified his website and stopped treating patients.[72] In 2015, the Arizona licensing board closed an investigation against Dr. Jack Wolfson[73] for his anti-vaccine messages on the ground that none of the thirty-eight people who had filed complaints against him had alleged problems with his "actual medical care."[74]

However, some state licensing boards, as well as the Federation of State Medical Boards (FSMB), which represents state licensing agencies, have warned doctors that spreading medical misinformation could be grounds for disciplinary penalties.[75]

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[69] In 2020, the Oregon licensing board suspended the license of anti-masker Dr. Steven LaTulippe, discussed above at text accompanying note 40, but that decision was based on his failure to comply with masking requirements in the treatment of his patients, not on the statements about masking he made in public settings. *See In re* Steven Arthur LaTulippe, M.D., Or. Med. Bd., (Dec. 4, 2020), https://omb.oregon.gov/Clients/ORMB/OrderDocuments/ff970292-5807-41ba-9c1e-c2b81de89cd1.pdf.

[70] *See supra* text accompanying note 27.

[71] *See* Complaint at 1, Dep't of Pro. Reg. v. Mercola, D.O., No. 1:05-cv-04400 (State of Ill. Dep't of Pro. Regul., June 9, 2004), https://quackwatch.org/wp-content/uploads/sites/33/quackwatch/casewatch/board/med/mercola/complaint_2004.pdf. The complaint included a mix of claims related to Dr. Mercola's advertising and promotion, his treatment of patients, and general medical advice to the public, including descriptions of "links between vaccination and death." *Id.* at 3.

[72] *See* Stephen Barrett, *Dr. Joseph Mercola's Battle with His State Licensing Board*, CASEWATCH (Sept. 1, 2015), https://quackwatch.org/cases/board/med/mercola/board_battle/. Similarly, in 2021, Dr. Thomas Cowan, who had posted a viral video stating that 5G networks cause COVID, voluntarily agreed to surrender his medical license. However, it is not clear whether the Medical Board of California had initiated disciplinary action based on Cowan's statements about COVID, as he was already on probation for an earlier incident involving the prescription of unapproved medications. *See* Barbara Feder Ostrov, *Conspiracy Theory Doctor Surrenders Medical License*, CALMATTERS (Sept. 28, 2021), https://calmatters.org/health/2021/02/conspiracy-theory-doctor-surrenders-medical-license/.

[73] *See supra* text accompanying notes 25–26.

[74] *See* Stuart, *supra* note 25.

[75] *See* Michael Hiltzik, *A Warning to Doctors—Spreading COVID Misinformation Could Cost You Your License*, L.A. TIMES (Aug. 16, 2021), https://www.latimes.com/business/story/2021-08-16/doctors-coronavirus-misinformation-license. In addition to licensing boards, professional associations have warned physicians that disseminating misinformation about COVID-19 could "put their certification at risk." *See* Am. Bd. of Family Med. et al., *Joint Statement from the American Board of Family Medicine, American Board of Internal Medicine, and American Board of Pediatrics on Dissemination of Misinformation by Board Certified Physicians about COVID-19*, CISION PR NEWSWIRE (Sept. 9, 2021), https://www.prnewswire.com/news-releases/joint-statement-from-the-american-board-of-family-medicine-american-board-of-internal-medicine-and-american-

Moreover, in a January 2021 interview, the president and CEO of the FSMB suggested that the absence of formal disciplinary actions should not be interpreted as a sign of licensing boards' inactivity. He noted that boards have received complaints about "a number of doctors who are using social media and other public platforms to make certain claims" and that "[y]ou don't always hear about the steps that are taken behind the scenes to try to get the doctors to do the right thing."[76] In some cases, he stated, state officials "are warning doctors, with their licensing boards beside them, that if guidelines are not followed, then their license could be at risk."[77]

III. THE CONSTITUTIONALITY OF PROFESSIONAL DISCIPLINE AS A RESPONSE TO MEDICAL MISINFORMATION: THREE ANALYTICAL FRAMEWORKS

Under existing Supreme Court precedent, speech is not necessarily exempt from First Amendment protection simply because it is untruthful.[78] However, whether a particular restriction on false speech will survive constitutional scrutiny depends on the nature of the restriction and the applicable standard of review. Thus, the constitutionality of disciplinary actions against physicians who disseminate medical misinformation will depend in part on how courts characterize those actions. Are they content-based limits on expression, subject to the highest level of protection? Or are they subject to a more deferential standard, either because they are limitations on speech incidental to the regulation of professional conduct or because they are conditions on

board-of-pediatrics-on-dissemination-of-misinformation-by-board-certified-physicians-about-covid-19-301372024.html.

[76] John Whyte & Humayun J. Chaudhry, *Should Physicians Face Disciplinary Actions for Misinformation*, MEDSCAPE (Jan. 19, 2021), https://www.medscape.com/viewarticle/944302.

[77] *Id.*

[78] *See* United States v. Alvarez, 567 U.S. 709, 730 (2012) (plurality opinion) (striking down, on First Amendment grounds, a federal statute imposing criminal penalties on persons who falsely represented that they had been awarded military medals). Falsity is, however, relevant in categories of speech that enjoy reduced constitutional protection, such as commercial speech. *See infra* note 82. As commentators have noted, the Court's current approach to the First Amendment substantially complicates government's ability to regulate misinformation. *See, e.g.*, Richard Hasen, *Cheap Speech and What It Has Done (To American Democracy)*, 16 FIRST. AMEND. L. REV. 200, 201 (2018) (arguing that "[t]he Supreme Court's libertarian First Amendment doctrine did not cause the rise of cheap speech, but it may stand in the way of needed reforms").

how the government-provided benefit of a medical license may be used? This Part considers these three frameworks in turn.

A. Disciplinary Penalties as Content-Based Speech Limitations

Under the First Amendment, the most straightforward way of conceptualizing disciplinary penalties against physicians who disseminate medical misinformation is to view them as content-based limitations on personal expression. Content-based limitations on speech are presumptively unconstitutional and will be upheld only if they can satisfy "strict scrutiny," the highest standard of constitutional review. Strict scrutiny requires the government to show that the limitations are "the least restrictive means of achieving a compelling state interest."[79]

Although the Supreme Court has recognized a few types of content-based speech restrictions that do not trigger strict scrutiny, most medical misinformation does not fit into any of those categories. For example, medical misinformation is not defamatory, as it does not impugn the reputation of an identifiable person.[80] Nor is medical misinformation likely to incite imminent lawless behavior.[81] While medical misinformation might sometimes be subject to regulation under the more lenient standards applicable to the regulation of commercial speech,[82] the commercial speech doctrine is limited to speech "proposing a commercial transaction."[83] It would therefore not apply to any of the situations described in Part I of this Article, which involve physicians making claims about medical conditions or treatments without offering anything for sale.

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[79] McCullen v. Coakley, 573 U.S. 464, 478 (2014).

[80] *See* RESTATEMENT (SECOND) OF TORTS § 559 (AM. L. INST. 1977) ("A communication is defamatory if it tends so to harm the reputation of another as to lower him in the estimation of the community or to deter third persons from associating or dealing with him."). Defamation is one of the "historic and traditional categories" for which the Supreme Court has permitted content-based speech restrictions. *See* United States v. Stevens, 559 U.S. 460, 468 (2010).

[81] *See Stevens*, 559 U.S. at 468 (identifying incitement as another category of speech that can be limited based on its content).

[82] Most restrictions on commercial speech are subject to intermediate scrutiny, which asks whether the restriction "directly advances" a "substantial" governmental interest and is no more restrictive than necessary to achieve that interest. Commercial speech that is misleading or that concerns an unlawful activity is not entitled to any First Amendment protection. *See* Cent. Hudson Gas & Elec. v. Pub. Serv. Comm'n, 447 U.S. 557, 563–66 (1980).

[83] *See id.* at 562.

Nonetheless, while strict scrutiny establishes a high burden for licensing boards, it does not necessarily rule out all disciplinary activity. As Cassandra Burke Robertson and Sharona Hoffman suggest, licensing boards might prevail in actions against physicians who disseminate misinformation if they can demonstrate "a strong evidentiary record of the harms caused by the false statements as well as the lack of a narrower way to combat those harms."[84] They note, however, that the state would have the burden of establishing the falsity of the physician's statements, which would be complicated by the fact that "professional opinion may differ in areas without scientific consensus."[85]

The likelihood of satisfying strict scrutiny may depend on how states characterize the nature of the harm that they are seeking to remedy. As discussed in Part II, critics of physicians who disseminate medical misinformation typically emphasize the potential of medically inaccurate messages to harm public health.[86] However, from a constitutional perspective, focusing on the harms that could result from the content of physicians' statements is not a promising strategy. The problem is that, even if medical misinformation may contribute to risky behavior, disciplinary action is not the only way for states to mitigate this harm. A basic tenet of First Amendment law is that, rather than imposing penalties on persons who communicate potentially dangerous messages, the appropriate response to misinformation is to counter it with messages that are accurate—i.e., to engage in "counterspeech."[87] Because counterspeech is available as an alternative policy option, courts are unlikely to find that disciplinary action is the least restrictive means of achieving the state's public health goals.

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[84] Cassandra Burke Robertson & Sharona Hoffman, *Professional Speech at Scale*, 55 U.C. DAVIS L. REV. (forthcoming 2022) (manuscript at 58), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3830555.

[85] *Id.*

[86] *See supra* text accompanying notes 52–58.

[87] *See, e.g.*, United States v. Alvarez, 567 U.S. 709, 727 (2012) (plurality opinion) ("The remedy for speech that is false is speech that is true. This is the ordinary course in a free society. The response to the unreasoned is the rational; to the uninformed, the enlightened; to the straight-out lie, the simple truth."). Some commentators have questioned the effectiveness of counterspeech in an age of technological innovation and disinformation. *See, e.g.*, Daniela C. Manzi, *Managing the Misinformation Marketplace: The First Amendment and the Fight Against Fake News*, 87 FORDHAM L. REV. 2623, 2647 (2019) ("The counterspeech doctrine fails to address the ways that technological advancements have affected news consumption and that psychological predispositions cause people to hold onto incorrect beliefs, even when presented with evidence to the contrary."). Nonetheless, as a matter of First Amendment doctrine, counterspeech is still considered preferrable to suppressing expression.

States would be on stronger ground if they limit disciplinary action to physicians who *knowingly* spread medical misinformation or who do so despite having serious doubts as to whether the information is true. Physicians who knowingly or recklessly[88] misrepresent medical information do more than simply encourage people to engage in risky behavior; by demonstrating their lack of concern with the truth, they also cause the additional harm of undermining the public's ability to trust that physicians can be assumed to be honest.[89] As a result, individuals may be less inclined to seek medical care or to take physicians' treatment recommendations seriously. Unlike the harms stemming from the content of physicians' messages, loss of trust is a type of harm that cannot be mitigated through counterspeech. In fact, disseminating corrective messages could simply reinforce the public's perception that physicians have been lying to them. States could therefore make a strong argument that disciplinary action is the only remedy capable of restoring the public's trust.

Disciplinary action based on the knowing or reckless dissemination of falsehoods has long been accepted in the professional regulation of lawyers. All U.S. jurisdictions have adopted some version of the American Bar Association's (ABA) Model Rule of Professional Conduct (MRPC) § 8.4(c), which defines professional misconduct to include "conduct involving dishonesty, fraud, deceit or misrepresentation."[90] Rule 8.4(c) applies to "all of a lawyer's actions—whether they are related to representation or not."[91] The justification for the breadth of the rule is that dishonesty bears on a lawyer's "fitness to practice."[92]

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[88] As explained below, the Supreme Court has defined the concept of recklessness in the context of the First Amendment to require proof that the speaker "entertained serious doubts" as to whether a statement was true. *See infra* note 103.

[89] *Cf.* Griffiths v. Superior Court, 96 Cal. App. 4th 757, 770 (2002) (upholding disciplinary action against physician who had been convicted of two misdemeanors involving the consumption of alcoholic beverages partly on the ground that "[k]knowledge of such repeated conduct by a physician" could "undermine public confidence in and respect for the medical profession").

[90] MODEL RULES OF PRO. CONDUCT r. 8.4 (AM. BAR ASS'N 2016).

[91] *Rule 8.4(c)*, *in* LEGAL ETHICS & MALPRACTICE REP. 2 (Mike Hoeflich ed., Joseph Hollander & Craft LLC 2021).

[92] Josh Blackman, *Reply: A Pause for State Courts Considering Modle Rule 8.4(g)*, 30 GEO. J.L. ETHICS 241, 251 (2017) (arguing that Rules 8.4(b) and (c) "articulate a standard that a lawyer's actions, even when unconnected with the practice of law, must at all times promote honestly and trustworthiness, so there is no doubt about his or her fitness to practice law.").

Rule 8.4(c) has been applied in a variety of contexts, including a lawyer who submitted a plagiarized thesis as part of an LLM program[93] and a lawyer who made a false statement about a pending case in a letter to a newspaper.[94] In June 2021, the Appellate Division of the New York State Supreme Court relied in part on Rule 8.4(c) in ordering the interim suspension of former New York City Mayor Rudolph Giuliani's license to practice law, after finding that he knowingly made "demonstrably false and misleading statements" in connection with former President Trump's efforts to overturn the results of the 2020 election.[95]

Rule 8.4(c) applies with particular force to lawyers who hold official public positions. According to the MRPC, "[l]awyers holding public office assume legal responsibilities going beyond those of other citizens. A lawyer's abuse of public office can suggest an inability to fulfill the professional role of lawyers."[96] Citing these "higher obligations," in 2017 a group of legal ethics scholars filed a complaint against Kellyanne Conway, former Senior Counselor to President Trump, alleging that she violated Rule 8.4(c) by making intentional misrepresentations to the public.[97] While some commentators objected to applying Rule 8.4(c) to statements made "in a clearly political context,"[98] the drafters of the complaint argued that "lawyer speech, especially that which is the result of advising or counseling government officials," should be held to a higher standard.[99]

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[93] *In re* Lamberis, 443 N.E.2d 549, 552 (Ill. 1982).

[94] Iowa Supreme Ct. Bd. of Prof'l Ethics & Conduct v. Visser, 629 N.W.2d. 376, 378 (Iowa 2001).

[95] While Giuliani's statements were made in connection with the representation of a client, they included public comments that could not plausibly be construed to fall within the definition of the "practice of law," such as statements made to the media unrelated to any pending legal actions. As discussed in Part B, these statements are therefore not subject to the lower level of First Amendment protection applicable to the regulation of "professional practice." *See infra* text accompanying note 124.

[96] MODEL RULES OF PRO. CONDUCT r. 8.4 cmt. 7 (AM. BAR ASS'N 2016).

[97] *See* Brian Sheppard, *The Ethics Resistance*, 32 GEO. J. L. ETHICS 235, 246 (2019).

[98] Steven Lubet, *In Defense of Kellyanne Conway*, SLATE (Feb. 27, 2017, 9:22 AM), https://slate.com/news-and-politics/2017/02/the-misconduct-complaint-against-kellyanne-conway-is-dangerously-misguided.html.

[99] Ellen Yaroshefsky, *Regulation of Lawyers in Government Beyond the Client Representation Role*, 33 NOTRE DAME J.L. ETHICS & PUB. POL'Y 151, 172–173 (2019) (arguing that "[a] range of factors will determine whether and to what extent the speech is primarily political or lawyer speech," including "whether the person is readily identified as a lawyer, the extent to which the speech relies upon legal knowledge and judgment, the expectations in the role that the lawyer assumed and the clarity of those expectations, and the significance of the misrepresentation").

The Supreme Court has not yet ruled on the constitutionality of disciplining attorneys who make false statements outside the courtroom. However, several state supreme courts have upheld the constitutionality of MRPC Rule 8.2(a), which prohibits lawyers from making statements that "the lawyer knows to be false or with reckless disregard as to its truth or falsity concerning the qualifications or integrity of a judge."[100] Rule 8.2(a) mirrors the standard the Supreme Court adopted in *New York Times v. Sullivan*[101] for defamation claims brought by public officials. In that case, the Court found that criticism of official conduct is entitled to First Amendment protection,[102] but that this protection does not preclude holding speakers accountable for a statement made with "actual malice"—i.e., a statement made "with knowledge that it was false or with reckless disregard of whether it was false or not."[103] *Sullivan*, therefore, provides strong support for disciplining lawyers who criticize judges under MRPC Rule 8.2(a).

While *Sullivan* directly applies only to false statements about public officials (and, as later extended, public figures[104]), the decision also has implications for disciplinary actions based on other types of speech. For example, Erwin Chemerinsky argues that *Sullivan* permits disciplining attorneys for knowingly or recklessly making false statements about pending litigation, despite the fact that statements about pending litigation are entitled to full First Amendment protection.[105] This argument is consistent

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[100] MODEL RULES OF PRO. CONDUCT r. 8.2(a) (AM. BAR ASS'N 1983). For cases rejecting First Amendment challenges to Rule 8.2(a), *see, e.g.*, Lawyer Disciplinary Bd. v. Hall, 765 S.E.2d 187 (W. Va. 2014); Notopoulos v. Statewide Grievance Comm., 890 A.2d 509 (Conn. 2006); Off. of Disciplinary Counsel v. Gardner, 793 N.E.2d 425 (Ohio 2003). Several commentators have criticized some of these decisions for departing from the Rule's requirement that the lawyer make statements with knowledge they are false or with reckless disregard as to their truth. *See, e.g.*, Jovanna Grant, *"Cyberbullying the Judiciary": Model Rule 8.2 and Its Impact on Attorneys' Blogging Speech*, 29 GEO. J.L. ETHICS 1031, 1045 (2016) (criticizing courts for using "a less deferential, more speech restrictive objective test, which focuses its analysis on what the reasonable attorney, considered in light of all his professional functions, would say in the same circumstance"); Margaret Tarkington, *The Truth Be Damned: The First Amendment, Attorney Speech, and Judicial Reputation*, 97 GEO. L.J. 1567, 1587 (2009) (criticizing courts for adopting an "objective reasonableness standard").

[101] 376 U.S. 254, 280 (1964).

[102] *Id.* at 273 ("[N]either factual error nor defamatory content suffices to remove the constitutional shield from criticism of official conduct").

[103] *Id.* at 280. The concept of "reckless disregard" has been interpreted in this context to require proof that the defendant "entertained serious doubts" as to whether her statements were correct. *See* St. Amant v. Thompson, 390 U.S. 727, 731 (1968).

[104] *See* Curtis Publishing Co. v. Butts, 388 U.S. 130 (1967).

[105] *See* Erwin Chemerinsky, *Silence Is Not Golden: Protecting Lawyer Speech under the First Amendment*, 47 EMORY L.J. 859, 886 (1998).

with Daniel Farber's interpretation of *Sullivan* as an application of strict scrutiny, with the actual malice standard serving to ensure that liability is "sufficiently narrowly tailored" to achieve a compelling governmental goal.[106]

Relying on this logic, boards could argue that disciplining physicians who knowingly or recklessly disseminate medical misinformation is a narrowly tailored means of achieving the compelling interest in preserving trust in the integrity of the medical profession.[107] Whether courts accept this argument will depend in part on how well boards are able to substantiate their claims about trust with empirical support. To strengthen their position, boards would be well advised to work with social scientists to develop data in support of their arguments. Key questions to investigate include whether loss of trust in the medical profession really does deter individuals from seeking medical care or following treatment recommendations and whether physicians who knowingly or recklessly spread falsehoods do in fact contribute to an erosion in trust. In addition, boards should be prepared to demonstrate that disciplinary action is likely to remedy these problems, and that there are no less restrictive ways of achieving this goal.

It is important to recognize that, under the actual malice standard, boards would have the burden of establishing that a physician's statement was objectively untruthful. In many situations, this burden may prove insurmountable. As discussed above, medical misinformation is commonly defined as information that deviates from current medical consensus,[108] but not everything that deviates from professional consensus is indisputably false. For example, a position may lack evidentiary support but be theoretically plausible, or it may be supported by some evidence but not enough to convince the professional community. While such positions might satisfy the definition of medical misinformation, the fact that they remain unproven does not necessarily mean they are objectively wrong.

In fact, many examples of medical misinformation discussed in Part I of this Article could potentially fall into this epistemological grey area. This is particularly true in areas in which the

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[106] *See* Daniel A. Farber, *The Categorical Approach to Protecting Speech in American Constitutional Law*, 84 IND. L.J. 917, 930 (2009).
[107] *See supra* text accompanying note 89.
[108] *See supra* note 11 and accompanying text.

scientific information is less certain or rapidly evolving. For example, although the medical community now agrees that masking is an effective means to prevent the spread of COVID-19, just a few months before that consensus emerged, public health authorities were actively discouraging masking among the general public.[109] Physicians could point to the recent change in position as a sign that the evidence on masking is still in flux. Similarly, it might be difficult for boards to establish objective falsity when physicians make claims about unproven treatments or products unless they can point to evidence establishing that those interventions are ineffective or harmful.

However, some physicians have disseminated information that can readily be refuted. For example, it is quite clear that COVID-19 vaccines do not magnetize the human body.[110] Nor is there any basis for other statements some physicians have made about COVID vaccines, including the claims that they contain microchips or are connected to 5G communications networks.[111]

In addition, there are certain medical positions that, while perhaps plausible at one point, have come to be accepted as objectively erroneous.[112] For example, extensive research has refuted the suggestion that vaccines contribute to autism;[113] no credible physician would now suggest that such a connection exists.[114] Similarly, there is ample evidence to show that viruses

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[109] *See* Fazio, *supra* note 32.
[110] *See supra* text accompanying notes 28–29.
[111] *See* Michael Heltzik, *A Warning to Doctors—Spreading COVID Misinformation Could Cost You Your License*, L.A. TIMES (Aug. 16, 2021), https://www.latimes.com/business/story/2021-08-16/doctors-coronavirus-misinformation-license (quoting examples provided by the FSMB's CEO of false information disseminated by physicians).
[112] *See* Claudia Haupt, *Unprofessional Advice*, 19 U. PA. J. CONST. L. 671, 682 (2017) (characterizing physicians as members of "knowledge communities," and observing that, "while there is a range of valid professional opinions that members of the knowledge community may disagree on, there is also a universe of advice that is plainly wrong as a matter of expert knowledge").
[113] *See* The Coll. of Physicians of Phila., *Do Vaccines Cause Autism?*, HIST. VACCINES, https://www.historyofvaccines.org/content/articles/do-vaccines-cause-autism (last visited Nov. 8, 2021) (noting that a possible link between vaccines for measles, mumps and rubella "was studied exhaustively" and that "many well-designed studies" have found that no such link exists").
[114] *See* Clyde Haberman, *A Discredited Vaccine Study's Continuing Impact on Public Health*, N.Y. TIMES (Feb. 1, 2015), https://www.nytimes.com/2015/02/02/us/a-discredited-vaccine-studys-continuing-impact-on-public-health.html.

cause disease,[115] even if isolated physicians insist that they do not.[116] Physicians who assert claims that have been disproven through rigorous research can rightly be said to be disseminating positions that are objectively untrue.

As to the physician's mental state, the Supreme Court has made clear that proving actual malice does not require direct evidence of the defendant's intent to deceive. Rather, it can be established by evidence that the statements were "fabricated by the defendant," "the product of his imagination," or "so inherently improbable that only a reckless man would have put them in circulation."[117] A board might therefore be able to satisfy its burden by showing that a physician's statements not only have been disproven through research, but also that they were based on unverifiable sources or on no evidence at all. While it is theoretically possible that a physician might honestly believe unsupported statements that conflict with all available evidence, a board would be entitled to determine that a physician's claims of good faith are not credible under the circumstances.[118]

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[115] *See, e.g.*, MADELINE DREXLER, WHAT YOU NEED TO KNOW ABOUT INFECTIOUS DISEASE 5 (2011) ("Viruses are responsible for a wide range of diseases, including the common cold, measles, chicken pox, genital herpes, and influenza. Many of the emerging infectious diseases, such as AIDS and SARS, are caused by viruses.").

[116] *See supra* text accompanying note 24.

[117] St. Amant v. Thompson, 390 U.S. 727, 732 (1968); *see also* Hunt v. Liberty Lobby, 720 F.2d 631, 643 (11th Cir. 1983) (noting that "evidence which shows that the statement was inherently implausible or that there were obvious reasons to doubt the veracity of the informant is relevant to establishing actual malice").

[118] *Cf.* Lyrissa Barnett Lidsky & RonNell Andersen Jones, *Of Reasonable Readers and Unreasonable Speakers: Libel Law in a Networked World*, 23 VA. J. SOC. POL'Y & L. 155, 177 (2016) (noting the possibility that a libel defendant "suffered from a mental illness that caused her to have irrational, or even delusional, beliefs about the truth of a statement," but concluding that "this problem is likely to be solved by the skepticism of juries, who will rarely accept a defendant's argument that she truly believed her delusional and defamatory statements"). When a physician's statements are truly divorced from reality, the board might conclude that the physician lacks sufficient mental capacity to be entrusted with patients. An example might by one physician's recent claim "that the uterine disorder endometriosis is caused by sex with demons that takes place in dreams." Travis M. Andrews & Danielle Paquette, *Trump Retweeted a Video with False Covid-19 Claims. One Doctor in it Has Said that Demons Cause Illnesses*, WASH. POST (July 29, 2020), http://washingtonpost.com/technology/2020/07/28/stella-immanuel-hydroxychloroquine-video-trump-americas-frontline-doctors/. In such cases, the board might pursue disciplinary action on the basis of the physician's mental capacity to practice. *Cf.* Pickering v. Bd. of Educ., 391 U.S. 563, 573 n.5 (1968) ("We also note that this case does not present a situation in which a teacher's public statements are so without foundation as to call into question his fitness to perform his duties in the classroom. In such a case, of course, the statements would merely be evidence of the teacher's general competence, or lack thereof, and not an independent basis for dismissal.").

B. Disciplinary Penalties as the Regulation of Professional Conduct

Not everyone is likely to be satisfied with limiting disciplinary action to physicians who disseminate medical misinformation with knowledge of its falsity or with reckless disregard of whether it is true. As discussed in Part II, some critics argue that physicians who make public recommendations about medical matters are engaged in a form of professional practice.[119] They claim that these physicians should be subject to discipline if their recommendations deviate from accepted medical standards, just as they would if they provided the same information to a patient under their care.

Supporters of this argument might point to the 2018 case of *National Institutes of Family and Life Advocates (NIFLA) v. Becerra*.[120] That case involved a request for a preliminary injunction against a California statute that regulated so-called "crisis pregnancy centers" (CPCs), which are organizations that provide a limited menu of pregnancy-related services and exist primarily to "discourage and prevent women from seeking abortions."[121] The California statute required licensed CPCs to notify women that the state provided free and low-cost pregnancy-related services, including abortions, and required unlicensed centers to notify women that the facilities were not licensed to provide medical services. Reversing the lower court's denial of a preliminary injunction, the Court found that the challengers were likely to succeed on their claim that the statute was an impermissible content-based regulation of speech.[122] However, in reaching that conclusion, it distinguished the statute from laws that directly regulate the conduct of health care professionals, including "regulations of professional conduct that incidentally burden speech."[123] As an example, it cited the plurality opinion in *Planned Parenthood v. Casey*, which rejected a First Amendment challenge to a Pennsylvania law requiring physicians to make certain disclosures to patients receiving abortions. Although the Pennsylvania law involved speech, the Court noted, it "regulated speech only 'as part

[119] *See* Friedman, *supra* note 52.
[120] 138 S. Ct. 2361 (2018).
[121] *Id.* at 2368.
[122] *See id.* at 2378.
[123] *Id.* at 2373.

of the *practice* of medicine, subject to reasonable licensing and regulation by the State.'"[124]

NIFLA, therefore, lends support to the idea that some physician speech can be viewed as an aspect of professional practice, which can be subject to content-based limitations without having to satisfy the strict scrutiny standard. However, the decision provides little guidance on the kinds of speech that can be regulated as an aspect of professional practice. In fact, it is not clear why the California statute itself was not viewed as a regulation of professional practice, at least with respect to those portions of the statute applicable to licensed professionals.[125] The Court distinguished the statute from the Pennsylvania law at issue in *Casey* on the ground that the required notices were not "tied to a [medical] procedure."[126] However, many speech-related aspects of medical practice are not tied to specific procedures—for example, taking medical histories or counseling patients on health-related behaviors.[127] It would be surprising if the Court intended to exempt those aspects of practice from regulations designed to uphold a professional standard of care.

However, while the concept of medical practice may be broad enough to include speech unrelated to medical procedures, it cannot plausibly be extended to speech entirely unrelated to the practice of medicine, which is typically defined as the provision of diagnosis or treatment to individual patients.[128] The fact that licensing boards sometimes take disciplinary action against physicians for conduct occurring outside the physician-patient relationship[129] does not undermine this conclusion. Those ac-

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[124] *Id.* (quoting Planned Parenthood v. Casey, 505 U.S. 833, 884 (1992) (plurality opinion)).
[125] *See* Robertson & Hoffman, *supra* note 84, at 11.
[126] *NIFLA*, 138 S. Ct. at 2373.
[127] *See* Carl H. Coleman, *Regulating Physician Speech*, 97 N.C. L. REV. 843, 860, 857 (2019).
[128] *See, e.g.*, N.Y. EDUC. LAW § 6521 (McKinney 2021) ("The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition."). While a physician's public speech does not itself constitute the practice of medicine, in some cases it might be reasonable for a licensing board to rely on a physician's public statements as evidence that the physician is providing substandard clinical care. For example, a licensing board could reasonably infer that a pediatrician who urges members of the public to reject childhood vaccinations is providing similar advice to parents of children under her care.
[129] *See supra* text accompanying notes 61–63.

tions are based on the theory that the conduct in question is evidence of the licensee's "fitness and qualifications,"[130] not that the conduct is itself an aspect of the practice of medicine.

Characterizing physicians' public speech about medical matters as an aspect of professional practice would also have troubling policy implications. If disciplinary actions based on physicians' public statements were subject to the more deferential standards applicable to the regulation of professional practice, licensing boards would be free to penalize physicians whenever they express opinions that conflict with prevailing professional norms, even if those opinions cannot be shown to be objectively false.[131] Physicians who believe that the existing standard of care is misguided would therefore have no way to express their views publicly without exposing themselves to potential disciplinary action.

If physicians could not question prevailing standards without risking professional discipline, the result would be a substantial chilling effect on potentially valuable speech. The history of medicine contains numerous examples of once-accepted medical standards that were ultimately shown to be ineffective or harmful. For example, in the late 1980s, a large study found that a group of drugs that physicians had widely considered essential in the treatment of heart attack patients in fact increased these patients' risk of dying as compared to a placebo.[132] More recently, research has led to the rejection of once-standard practices like the routine prescription of hormone replacement therapy for postmenopausal women[133] and recommendations for children at high risk of peanut allergy to avoid peanut products in the first years of life.[134] Scholars describe these situations as "medical reversals," defined as practices that are rejected after research shows that they "did not work all along, either failing to achieve [their] intended goal[s] or carrying harms that outweighed the

[130] Griffiths v. Superior Court, 96 Cal. App. 4th 757, 771 (2002).
[131] *See* Appel, *supra* note 59 (suggesting that disciplinary action would be appropriate if a physician provided information to the public that would constitute malpractice if offered to a patient as part of medical care).
[132] *See* Vinay Prasad & Adam Cifu, *Medical Reversal: Why We Must Raise the Bar Before Adopting New Technologies*, 84 YALE J. BIOLOGY & MED. 471, 472 (2011).
[133] *See* D. Ashley Hill et al., *Hormone Therapy and Other Treatments for Symptoms of Menopause*, 94 AM. FAM. PHYSICIAN 884, 884 (2016).
[134] *See* George du Toit et al., *Effect of Avoidance on Peanut Allergy after Early Peanut Consumption*, 374 NEW ENG. J. MED. 1435, 1435 (2016).

benefits."[135] One study of over 3,000 randomized clinical trials in prominent medical journals found that approximately 13 percent involved medical reversals.[136]

Of course, as the examples in Part I of this Article show, not all physician statements that deviate from accepted medical standards are well-considered critiques with the potential to lead to medical reversals. However, allowing physicians' public statements to be regulated as an aspect of medical practice would give licensing boards too much discretion to prevent physicians from questioning prevailing medical views. Treating physicians' public statements as speech entitled to ordinary First Amendment protections avoids this problem by limiting disciplinary action to cases that are truly egregious—i.e., physicians who disseminate objectively false information with knowledge that it is false or with reckless disregard as to whether it is true.

Limiting the scope of boards' regulation of medical practice to physician-patient interactions is also consistent with the purpose of the medical licensing system, which is to protect *patients* from harm.[137] Patients are vulnerable to harm because they generally lack the knowledge and training necessary to independently assess the quality of the care they are receiving.[138] This lack of knowledge, combined with the trust patients typically place in their health care providers, explains why some patients may defer to physicians' recommendations even when they do not personally agree with them.[139] One way the licensing system protects vulnerable patients is by requiring physicians to provide "good advice as determined by the standards of the profession."[140] Although medical standards are typically broad enough

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[135] Prasad & Cifu, *supra* note 132, at 471–72.
[136] *See* Diana Herrera-Perez et al., *A Comprehensive Review of Randomized Clinical Trials in Three Medical Journals Reveals 396 Medical Reversals*, *in* META-RESEARCH: A COLLECTION OF ARTICLES 2 (Peter A. Rodgers ed., 2019).
[137] *See* Sawicki, *supra* note 61, at 295 ("As an extension of the state's police power, the medical board's disciplinary authority is aimed at protecting medical consumers from the harms they may incur at the hands of incompetent or dishonest physicians.").
[138] *See* Claudia Haupt, *Professional Speech*, 125 YALE L.J. 1238, 1243 (2016) ("The professional-client relationship is typically characterized by an asymmetry of knowledge. The client seeks the professional's advice precisely because of this asymmetry.").
[139] *See* Andrea D. Gurmankin et al., *The Role of Physicians' Recommendations in Medical Treatment Decisions*, 22 MED. DECISION MAKING 262, 267 (2002) (finding, in a study involving hypothetical medical treatment scenarios, that "[s]ome subjects were strongly influenced by the physicians' recommendations even when the recommendations clearly went against what maximized health, against what the subject knew was best, and against what the subject otherwise preferred").
[140] Claudia Haupt, *Licensing Knowledge*, 72 VAND. L. REV. 501, 555 (2019).

to give physicians some discretion in their approach with particular patients,[141] physicians must exercise this discretion with the bounds of reasonableness as determined by professional norms.[142]

By contrast, when physicians make public statements about medical matters, they are not speaking to an individual who has entrusted them with providing individually tailored medical guidance. Moreover, while their status as physicians may enhance the credibility of their message, they are likely to be just one of many medical voices competing for the public's attention. Unlike a patient receiving medical recommendations from her treating physician, an individual exposed to multiple, and potentially conflicting, views expressed by physicians in public has no reason to defer to one physician over another. To the extent licensing boards exist to protect vulnerable patients within the context of unequal relationships, there is therefore less justification for giving them broad control over the content of public statements unrelated to the provision of direct patient care.[143]

C. Disclaimer Requirements as Conditions on the Use of a Professional License

As discussed in Part II, one of the main concerns about physicians who disseminate medical misinformation is that they are able to draw on their professional status to lend credibility to their positions.[144] To address this concern, it has been suggested that physicians should be required to issue disclaimers when they provide information that conflicts with an established professional consensus. For example, one commentator proposes that licensing boards should have the option of requiring physicians

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[141] *See* Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 186 (2000) (arguing that, in medical malpractice cases, "the modern function of the respectable minority instruction is to remind the jury that more than one approach may be reasonable").

[142] *See* Haupt, *supra* note 112, at 710 (noting that "the knowledge community—rather than the courts or legislatures—determines what clears the bar of good advice").

[143] Jack M. Balkin, *Information Fiduciaries and the First Amendment*, 49 U.C. DAVIS L. REV. 1183, 1215 (2016) (arguing that, in contrast to speech that takes place within professional-client relationships, "[a]ll persons (or at the very least, all adults) are treated as equally competent and equally able to fend for themselves in the realm of public discourse").

[144] Cole, *supra* note 48 (observing that celebrity physicians in the media "use their professional credentials in the titles of their programs and rely on that authority for their credibility"); *see* Caplan, *supra* note 52 ("Physicians' speech invokes medical authority, so when they speak, patients tend to listen. Especially when they speak on TV.").

who make statements that conflict with professional standards "to issue a concrete disclaimer stating they are not offering clinical advice" or "to make clear to audiences the absence of medical authority or empirical evidence to justify their position—or even to explain to the public the actual standard of care."[145] Alternatively, physicians might be required to issue statements similar to those recommended by some professional psychology associations, which call on psychologists "to indicate when they are speaking as a matter of personal opinion as opposed to speaking as experts."[146]

Supporters of this approach might argue that disclaimer requirements can be justified as a condition on physicians' use of the benefit conferred by their professional status. A long line of Supreme Court cases recognizes that, while the government may not require individuals to give up their First Amendment rights as a condition of receiving a benefit,[147] it is free to avoid subsidizing speech by imposing restrictions on the manner in which the benefit is used.[148] Based on this distinction, it might be argued that, having granted physicians the benefit of professional status through the mechanism of licensure, licensing boards are entitled to ensure that the benefit is not used in support of positions that conflict with profession norms. Disclaimers achieve this goal because they make clear that the physician's statements do not reflect the views of the professional community. Moreover, they do this without restricting physicians from expressing themselves freely when speaking in their personal capacity.

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[145] Appel, *supra* note 59.

[146] Randolph B. Pipes et al., *Examining the Personal-Professional Distinction: Ethics Codes and the Difficulty of Drawing a Boundary*, 60 AM. PSYCH. 325, 329 (2005); 5 C.F.R. § 3601.108 (requiring Department of Defense employees who use their military rank, titles, or positions to identify themselves in connection with teaching, speaking, or writing to include a disclaimer stating that "the views presented are those of the speaker or author and do not necessarily represent the views of DoD or its components"); *cf.* 5 C.F.R. § 2635.807(b)(2) (requiring federal employees who publish articles in scientific and professional journals in connection with outside employment or outside activities to include "a reasonably prominent disclaimer . . . stating that the views expressed in the article do not necessarily represent the views of the agency or the United States").

[147] *See* Bd. of Cnty. Comm'rs v. Umbehr, 518 U.S. 668, 674 (1996) ("[T]he government may not deny a benefit to a person on a basis that infringes his constitutionally protected freedom . . . of speech even if he has no entitlement to that benefit"); *see also* FCC v. League of Women Voters, 468 U.S. 364, 364–365 (1894).

[148] *See* Agency for Int'l Dev. v. All. for Open Soc'y Int'l, Inc., 570 U.S. 205, 214–215 (2013) (finding that "the relevant distinction that has emerged from our cases is between conditions that define the limits of the government spending program—those that specify the activities Congress wants to subsidize—and conditions that seek to leverage funding to regulate speech outside the contours of the program itself").

However, there are two significant weaknesses with this argument. First, it is not clear that courts would agree that physicians' public speech is being "subsidized" by the government based solely on the benefit of professional licensure. In his plurality opinion in *Matal v. Tam*,[149] Justice Alito argued that the subsidized speech doctrine applies only to speech conditions attached to "cash subsidies or their equivalent."[150] Under this view, the benefit of receiving a professional license would be an insufficient basis for restricting physicians' speech. Second and more importantly, even if the benefit of professional licensure were considered a governmental subsidy, the subsidized speech cases distinguish between conditions on the use of subsidies to express governmental positions and conditions attached to private speakers' expression of their personal views. Specifically, while government may impose content-based restrictions on the use of subsidies in both situations,[151] it may not set conditions based on the *viewpoint* of private speakers unless they are using the subsidy to "convey a governmental message."[152] Thus, as long as physicians are not speaking as part of a government program or purporting to represent government policy, their receipt of a professional license would not entitle the government to impose disclosure requirements based on the messages the physicians convey.

Assuming that disclaimer requirements cannot be justified as a permissible condition of licensure, they would be subject to ordinary First Amendment standards applicable to government-imposed disclosure requirements. Outside the context of commercial speech, disclosure requirements are generally treated as a form of compelled speech subject to strict scrutiny.[153] Therefore, licensing boards would need to show that the required dis-

[149] 137 S. Ct. 1744 (2017).
[150] *Id.* at 1761.
[151] *See* Rosenberger v. Univ. of Virginia, 515 U.S. 819, 831 (1995) (acknowledging that the government may limit the use of its funds to subsidize a particular "subject matter").
[152] *See id.* at 833, 834 (holding that government "may not discriminate based on the viewpoint of private persons whose speech it facilitates").
[153] *See* Clay Calvert, *Wither* Zauderer*, Blossom Heightened Scrutiny? How the Supreme Court's 2018 Rulings in Becerra and* Janus *Exacerbate Problems with Compelled-Speech Jurisprudence*, 76 WASH. & LEE L. REV. 1395, 1415 (2019) (describing the Supreme Court's opinion in *NIFLA* as standing for the proposition that "strict scrutiny generally applies when the government compels professionals to convey content-based messages").

closures are narrowly tailored to achieve a compelling governmental interest, and that it would not be possible to satisfy that interest through less restrictive means.

It seems unlikely that boards would be able to make such a showing. The rationale for requiring physicians to issue disclaimers when they make statements that deviate from professional consensus would have to be that, without such disclosures, the public might assume that the physician is representing the views of the professional community. It is doubtful, however, that licensing boards could provide empirical evidence to support this concern. Moreover, even if some members of the public might misunderstand the extent to which the physician's views deviate from professional consensus, those misconceptions could be corrected by disseminating accurate information—i.e., through the mechanism of counterspeech—rather than by forcing physicians to issue disclaimers whenever they speak.[154]

CONCLUSION

The foregoing analysis suggests that disciplinary actions are unlikely to play a major role in responding to physicians who disseminate medical misinformation. Unless a licensing board can establish that a physician disseminated objectively false information with knowledge of its falsity or with reckless disregard of whether it was true, professional sanctions for statements made outside the physician-patient relationship are unlikely to survive a constitutional challenge. It is also unlikely that courts would allow boards to impose disclaimer requirements whenever physicians express views that conflict with professional norms.

Because malpractice lawsuits are also not a viable option in these situations,[155] the limited availability of disciplinary actions means that physicians who disseminate medical information may face no legal repercussions. Efforts to control the dissemination of medical misinformation by physicians will therefore

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[154] *See supra* note 87.

[155] In most cases, malpractice actions require proof of a physician-patient relationship. *See, e.g.*, Ande v. Rock, 647 N.W.2d 265 (Wis. Ct. App. 2002). Although some courts have authorized malpractice lawsuits in the absence of a formal physician-patient relationship, those cases generally involve physicians making individualized determinations related to the treatment of specific individuals; *see, e.g.*, Warren v. Dinter, 926 N.W.2d 370 (Minn. 2019) (allowing medical malpractice action against a hospitalist who recommended against admitting the plaintiff for in-patient care).

depend on imposing other types of consequences. For example, while licensing boards may be limited in their ability to impose disciplinary penalties, they are free to exercise their own First Amendment rights by issuing statements calling out medical falsehoods and disseminating the truth. Similarly, when physicians who disseminate misinformation are affiliated with universities or other institutions, those institutions can issue public statements condemning the physician's views and explaining why they are wrong.[156] In addition, private entities, which are not bound by the First Amendment, have broad discretion to rely on speech-related criteria in determining eligibility for benefits. For example, medical specialty boards, which certify physicians in fields like internal medicine or surgery,[157] might consider revoking the certification of physicians who spread medical misinformation.[158] Hospitals and other private health care organizations could revoke such physicians' staff privileges or terminate their employment.[159] Under some circumstances even government employers could fire or discipline physician employees based on the content of their speech.[160]

However, while disciplinary action may not be the primary solution, it can play an important role in particularly egregious situations. When physicians make statements that contradict well-established medical facts and lack any evidentiary basis, licensing boards can make a strong argument that the physician knew the statements were false or at least entertained serious

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[156] *See* Pizzo et al., *supra* note 41, at 724 (calling on universities to "publicly state that the university does not endorse the physician's claims and finds them contrary to the weight of scientific evidence").

[157] *See Member Boards*, AM. BD. OF MED. SPECIALTIES, https://www.abms.org/member-boards/ (last visited Nov. 10, 2021).

[158] *See* Rita Rubin, *When Physicians Spread Unscientific Information about COVID-19*, 327 JAMA 904, 906 (2022) (reporting the American Board of Emergency Medicine's position that "making public statements that are directly contrary to prevailing medical evidence can constitute unprofessional conduct and may be subject to review by ABEM").

[159] *See* Andrea Salcedo, *Hospital Revokes Houston Doctor's Privileges for "Spreading Dangerous Misinformation" about Covid on Twitter*, WASH. POST (Nov. 5, 2021), https://www.washingtonpost.com/nation/2021/11/15/houston-doctor-suspended-hospital-misinformation-covid/ (reporting that Houston Methodist Hospital suspended the privileges of a physician who had used her personal Twitter account to promote the drug ivermectin as a treatment for COVID-19).

[160] Pickering v. Bd. of Educ., 391 U.S. 563, 568 (1968) (holding that public employees' right to speak on matters of public concern must be balanced against "the interest of the State, as an employer, in promoting the efficiency of the public services it performs through its employees"); *see* Garcetti v. Ceballos, 547 U.S. 410 (2006) (finding that the First Amendment does not protect government employees' speech if the speech relates to the employee's official job duties).

doubts as to whether the statements were true. Assuming a board can make such a showing, the First Amendment should not prevent boards from holding physicians accountable for the harm that they cause.