Article

Physicians Spreading Medical Misinformation: The Uneasy Case for Regulation

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Physicians have played a surprisingly prominent role in the current "infodemic" of false and misleading medical claims. Yet, state medical boards, the governmental agencies responsible for professional licensure and oversight, have sanctioned remarkably few physicians. Pushing back against the widespread criticism of medical boards for insufficient action, this Article questions the overall suitability of licensure regulation to police medical misinformation. First, uncertainty exists about medical boards' jurisdiction and legal authority. Many misinformation claims have involved physicians communicating publicly, not while treating patients. Given the primarily patient-centered legal and ethical frameworks governing the practice of medicine, serious challenges arise in making legally cognizable the wrongs arising from physicians, acting outside a doctor-patient relationship, spreading medical falsehoods to the community.

First Amendment barriers to restricting physician speech add further complications. To date, most scholarly commentary has focused on whether medical boards can navigate around constitutional concerns. The implicit assumption of much of this work is that, but for the First Amendment, the case for medical board intervention remains very strong. Taking a different approach, this Article delves deeper into additional limitations

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that, regardless of the First Amendment, cast considerable doubt on the prospects for optimal licensure regulation. Medical boards remain poorly designed for combatting physician-spread misinformation, suffering from professional bias in their composition, starved resources, time-consuming and reactive procedures, opacity, and insufficient institutional resilience and independence. Moreover, because of the difficulty in defining medical misinformation with precision, wide discretion is inevitably left to medical boards in targeting certain claims and particular physicians. This introduces serious risks that medical boards will inevitably overreach and conflate unorthodox, yet potentially innovative medical claims, with misinformation or exercise disciplinary powers for anti-competitive reasons.

Further advancing the literature, this Article also synthesizes data on disciplinary proceedings in the three largest states—California, Texas, and Florida—to provide a more comprehensive accounting of how medical boards are responding to physicians spreading COVID-19 misinformation.

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INTRODUCTION

Infectious disease was not the only contagion of the COVID-19 pandemic. False and misleading medical information also spread rapidly, with devastating impact. Characterized as an "infodemic" by the World Health Organization (WHO),[1] this deluge of medical misinformation has been linked to adoption of ineffective and dangerous treatments, rejection of mitigation measures such as masking, and other serious harms.[2] Dismayingly, physicians have played a surprisingly prominent role in the infodemic, originating misinformation or amplifying it further.[3] Physicians pose special dangers when disseminating falsehoods because they can leverage the public trust by "weaponizing their white coats."[4]

As a result, there have been increasing calls for legal action against physicians who spread medical misinformation. Most efforts have focused on state medical boards, the governmental agencies responsible for licensure, discipline, and general oversight of physicians in each jurisdiction.[5] Yet, to date, medical

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1. Press Release, Managing the COVID-19 Infodemic: Promoting Healthy Behaviours and Mitigating the Harm from Misinformation and Disinformation, WHO (Sept. 23, 2020) [hereinafter Managing the COVID-19 Infodemic], 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 [https://perma.cc/AE63-PF5Z] (calling for action to be taken to reduce harms caused by medical misinformation during the COVID-19 pandemic).

2. *See infra* Part I.C (detailing the harms caused by spreading false misinformation).

3. *See* Victoria Knight, *Will 'Dr. Disinformation' Ever Face the Music?*, KFF HEALTH NEWS (Sept. 22, 2021), https://kffhealthnews.org/news/article/disinformation-dozen-doctors-covid-misinformation-social-media [https://perma.cc/L2PM-SHZP] (reporting on a physician's contributions to medical misinformation and detailing the broader landscape of medical misinformation on social media); *see also infra* Part I.B (providing examples and discussion of how physicians contributed to the infodemic).

4. Brian Castrucci & Nick Sawyer, *Covid Vaccine and Treatment Misinformation Is Medical Malpractice. It Should Be Punished*, NBC NEWS (Jan. 8, 2022), https://www.nbcnews.com/think/opinion/covid-vaccine-treatment-misinformation-medical-malpractice-it-should-be-punished-ncna1287180 [https://perma.cc/2AZK-49YK] (advocating for reprimanding physicians who spread medical misinformation due to the power they hold to influence the public).

5. *See* Davey Alba & Sheera Frenkel, *Calls Grow to Discipline Doctors Spreading Virus Misinformation*, N.Y. TIMES (Aug. 27, 2021), https://www

boards have initiated remarkably few disciplinary actions, while even renewing the licenses of physicians actively spreading misinformation.[6] The seemingly anemic, flatfooted response has engendered widespread criticism, with medical boards lambasted for not protecting the community and for "failing to hold these doctors accountable."[7]

A significantly complicating issue, however, is that many instances of physician-spread misinformation have involved general statements to the public, rather than in the course of treatment of a particular patient. For example, certain physicians, through community meetings, media interviews, or social media posts, promoted the anti-malaria drug hydroxychloroquine for treating COVID-19, the same medication used and encouraged by former President Trump but discredited as generally ineffective and potentially dangerous for combatting the virus.[8] When

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.nytimes.com/2021/08/27/technology/doctors-virus-misinformation.html [https://perma.cc/AJW2-89K2] (reporting on the government agencies that have been contacted regarding doctor misconduct).

6. *See infra* Parts II.A and II.B (reviewing how medical boards have responded to physicians spreading medical misinformation); Geoff Brumfiel, *A Doctor Spread COVID Misinformation and Renewed Her License with a Mouse Click*, NPR (Nov. 4, 2021), https://www.npr.org/sections/health-shots/2021/11/04/1051873608/a-doctor-spread-covid-misinformation-and-renewed-her-license-with-a-mouse-click [https://perma.cc/BU8T-QRY8].

7. Castrucci & Sawyer, *supra* note 4. For additional critiques of the lack of response to physician-spread medical misinformation, see Richard A. Friedman, *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 [https://perma.cc/G7EV-38TQ]; Victoria Knight, *Will Doctors Who Are Spreading COVID-19 Misinformation Ever Face Penalty?*, TIME (Sept. 20, 2021), https://time.com/6099700/covid-doctors-misinformation [https://perma.cc/FQW7-9XP8]; Harris Meyer, *Shouldn't Docs Who Spread False COVID-19 Info Lose Their Licenses?*, MEDSCAPE (Aug. 18, 2021), https://www.medscape.com/viewarticle/956796 [https://perma.cc/6VBZ-XVVT]; Avery G. Wilks, *SC's Doctor Discipline Board Silent as COVID-19 Misinformation Debate Rages*, POST & COURIER (Feb. 26, 2022), https://www.postandcourier.com/health/covid19/scs-doctor-discipline-board-silent-as-covid-19-misinformation-debate-rages/article_fb828894-90d6-11ec-9a3b-97fa1a547a5c.html [https://perma.cc/5ZVP-SPSB].

8. *See* Geoff Brumfiel, *This Doctor Spread False Information About COVID. She Still Kept Her Medical License*, NPR (Sept. 14, 2021), https://www.npr.org/sections/health-shots/2021/09/14/1035915598/doctors-covid-misinformation-medical-license [https://perma.cc/KT7Z-HNG8] (reporting on a physician who promoted hydroxychloroquine); Aaron Blake, *Fox News and Trump Are Still Pushing Hydroxychloroquine. Here's What the Data Actually*

a physician provides medical advice that fails to conform to the customary standard of care, the injured patient can bring a negligence action.[9] In addition, a medical board can discipline the physician for following unprofessional methods of care in rendering treatment.[10] But when the physician communicates to the public at large, no relationship with an individual patient clearly exists. Absent an express duty of care breached to a patient, the grounds for medical board sanction become much more contested. Indeed, physician-spread misinformation presents vexing problems as a matter of regulation because, as this Article explores, considerable confusion exists about the societal role private physicians undertake when communicating to the general public, and how this implicates medical professionalism and fitness for practice.[11]

The First Amendment adds an additional layer of complication, restricting how medical boards can discipline physicians for their speech. To date, most scholarly commentary has focused on the First Amendment obstacles and whether medical boards can navigate around constitutional concerns.[12] The implicit assumption of much of this work is that, but for the First Amendment,

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Shows, WASH. POST (June 21, 2021), https://www.washingtonpost.com/politics/2021/06/21/hydroxycholoroquine-coronavirus-treatment-trump-allies-cant-quit [https://perma.cc/SH73-FNYW] (discrediting hydroxychloroquine's effectiveness in combatting COVID-19).

9. *See, e.g.*, Seifert v. Balink, 888 N.W.2d 816, 822 (Wis. 2017) ("This medical malpractice case is based on the claim that the defendant doctor was negligent . . . .").

10. *See, e.g.*, MINN. STAT. § 147.091(k) (2023) ("The board may refuse to grant a license . . . or may impose disciplinary action . . . against any physician. The following conduct is prohibited and is grounds for disciplinary action: . . . [c]onduct that departs from or fails to conform to the minimal standards of acceptable and prevailing medical practice . . . .").

11. Claudia Haupt refers to these hard-to-categorize communications as "pseudo-professional advice." Claudia E. Haupt, *Pseudo-Professional Advice*, 103 B.U. L. REV. (forthcoming 2023) (manuscript at 3). In these situations, the physician, or other licensed professional, provides expert advice in public discourse and therefore outside a traditional professional-client relationship where the dispensing of advice is more easily constrained as a legal matter. *Id.*

12. *See, e.g.*, Haupt, *supra* note 11, at 6–20; Carl H. Coleman, *Physicians Who Disseminate Medical Misinformation: Testing the Constitutional Limits on Professional Disciplinary Action*, 20 FIRST AMEND. L. REV. 113, 128–41 (2022); William M. Sage & Y. Tony Yang, *Reducing "COVID-19 Misinformation" While Preserving Free Speech*, 327 JAMA 1443 (2022); Michelle M. Mello, *Vaccine Misinformation and the First Amendment—The Price of Free Speech*, 3 JAMA HEALTH F. e220732 (2022).

the case for medical board intervention remains very strong. This Article, however, takes a very different approach. Breaking new ground, it delves deeper into the many nuanced considerations, implicating not solely the First Amendment but also other important issues of law, medical ethics, and health policy, calling into question the overall suitability of licensure regulation to combat medical misinformation. Further advancing the literature, this Article also synthesizes data on disciplinary proceedings in the three largest states—California, Texas, and Florida—to provide a more comprehensive accounting of how medical boards are responding to the threat of physicians spreading COVID-19 misinformation.

The prospects for optimal medical board oversight in this contested space seem very dim. While narrow pathways may exist for medical boards to sanction physicians without impermissibly infringing on free speech rights, as some commentators contend,[13] fundamental problems remain. A central challenge is that law and medical ethics primarily view a physician's obligations relationally to individual patients. Physicians' special responsibilities for the health of non-patients and the general public remain much more ambiguous and elusive.[14] Because "it's not clear that . . . physicians who are not government officials have any legal obligation . . . to the government or the public to promote public health,"[15] it becomes difficult to characterize and make legally cognizable the wrongs arising from physicians disseminating medical falsehoods to the community. Acknowledging the serious harms resulting from physicians who spread misinformation publicly, this Article nonetheless questions the legal and ethical basis, effectiveness, and prudence of expanded licensure regulation. Demanding that medical boards crack down on physicians spreading falsehoods has undeniable rhetorical appeal. But exhorting medical boards to do more work in this area is unlikely to have the desired effects, absent more radical changes to the regulatory system for medical licensure and the

13. *See infra* Part II.A (exploring how medical boards can sanction physicians).

14. *See generally* Richard S. Saver, *Physicians' Elusive Public Health Duties*, 99 N.C. L. REV. 923, 930–41 (2021) (analyzing factors that make physicians' duties to protect public health difficult to identify and weak in application).

15. Meyer, *supra* note 7 (paraphrasing University of Pennsylvania Professor Jonathan Moreno to illustrate the lack of clarity on how physicians can be sanctioned for spreading misinformation to non-patients).

patient-centered legal and ethical frameworks governing the practice of medicine.

Even if the legal authority and operations of medical boards were significantly overhauled, however daunting the task, the payoff still may not be worth it. Expanded licensure regulation introduces confounding downsides alongside any benefits, including serious risks that medical boards will conflate unorthodox yet potentially innovative medical claims with misinformation or use their disciplinary powers for anti-competitive reasons.[16] Moreover, some harms from medical misinformation may need to be tolerated in order to ensure vigorous physician debate about health issues affecting the community. This information generation expands the marketplace of ideas concerning medical topics of public importance and supports the scientific method's constant push for the reevaluation of existing interpretations and hypotheses.[17]

This Article proceeds in four parts. Part I provides necessary background, reviewing differing definitions of medical misinformation, the prevalence of physicians spreading misinformation during the COVID-19 pandemic, and the associated harms. Part II explores the limited action by medical boards, including synthesizing data on disciplinary proceedings in the three largest states. Part III explains why this tepid response is predictable and understandable, analyzing the unclear legal authority, mixed and under-theorized ethics guidance, institutional design limitations, and policy concerns about overreach that complicate effective medical board action. Part IV concludes with a brief discussion of alternative regulatory approaches that bypass problematic reliance on medical board oversight.

I. BACKGROUND

A. DEFINITIONAL ISSUES

A threshold regulatory challenge is the lack of a generally accepted definition of "medical misinformation." One leading interpretation views medical misinformation as factual claims that are "false based on current scientific consensus."[18] A

16. *See infra* Part III.C.

17. *See infra* Part III.C.

18. Wen-Ying Sylvia Chou et al., *Where We Go from Here: Health Misinformation on Social Media*, 110 AM. J. PUB. HEALTH S273, S273 (2020).

recently enacted California law which authorized professional discipline of physicians for spreading COVID-19 misinformation, followed this look-to-consensus approach, considering misinformation as "false information that is contradicted by contemporary scientific consensus contrary to the standard of care."[19] But definitions relying on scientific or professional consensus may be too narrow in assuming that, for the applicable medical topic, clear scientific consensus exists. In certain situations, such as newly emerging disease threats, scientific views can be in flux and consensus unsettled. Even in a no-clear-consensus environment, some factual claims can still be very misleading and damaging.[20] Accordingly, the WHO and the U.S. Surgeon General have endorsed a second, broader interpretation of medical misinformation, considering it a communication viewed as false according to the "best available evidence at the time."[21]

Both definitional approaches suffer from imprecision. Indeed, a federal district court recently enjoined enforcement of the new California law, finding the statutory definition of misinformation—contradicted by "contemporary scientific consensus"—unconstitutionally vague under the Due Process Clause of the Fourteenth Amendment.[22] The judge reasoned that

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19. CAL. BUS. & PROF. CODE § 2270(b)(4) (West 2023). Even more recently, the California legislature passed new legislation, signed by the Governor, repealing the same statutory provisions regarding COVID-19 misinformation and physician discipline. S.B. 815, 2023–24 Leg., Reg. Sess. (Cal. 2023); John Woolfolk, *Gov. Newsom Signs Bill Repealing Doctor-Muzzling COVID Misinformation Law He Signed a Year Ago,* MERCURY NEWS (Oct. 10, 2023), https://www.mercurynews.com/2023/10/06/gov-newsom-signs-bill-repealing-doctor-muzzling-covid-misinformation-law-he-signed-a-year-ago [https://perma.cc/3BGS-CGBG]. *See also infra* notes 176–77 (discussing the California statute further).

20. Managing the COVID-19 Infodemic, *supra* note 1 (emphasizing the damage caused by spreading contradictory or unclear information in an emergency).

21. *Confronting Health Misinformation: The U.S. Surgeon General's Advisory on Building a Healthy Information Environment*, U.S. SURGEON GEN. 4 (2021) [hereinafter U.S. SURGEON GEN.], https://www.hhs.gov/sites/default/files/surgeon-general-misinformation-advisory.pdf [https://perma.cc/6QLH-9PGX].

22. Høeg v. Newsom, No. 2:22-cv-01980, 2023 WL 414258, at *10 (E.D. Cal. Jan. 25, 2023). The temporary injunction only enjoins enforcement of the law against the plaintiffs in the lawsuit, not enforcement of the law generally. *Id.* at *12. Meanwhile, a different federal district court reached a contrary result

consensus in this context could mean, among other interpretations, informal, general opinions of physicians, published guidelines after more formal deliberation by expert medical groups, or pronouncements of public health officials, each of which could lead to different conclusions.[23]

One particularly challenging question is how to assess whether a claim is sufficiently false or inaccurate to make it misinformation. Whether applying the narrower "scientific consensus" or potentially broader "best available evidence" standards, what fairly comprises the evidence base is not always clear, especially because there is no single customary standard of care in medicine. Rather, physicians routinely follow a spectrum of approaches.[24] Misinformation usually must be measured, somewhat subjectively, along hard-to-discern yardsticks. These include (1) consensus views held by a sufficient *quantity* of health professionals; (2) consensus views of health professionals, even

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and denied a motion for a temporary injunction against the new California law. McDonald v. Lawson, No. 8:22-cv-01805, 2022 WL 18145254, at *14 (C.D. Cal. Dec. 28, 2022). In the latter *McDonald* case, the court rejected similar constitutional challenges to the new law. The *McDonald* court found vagueness concerns overstated because, among other reasons, when consensus was unclear the new statute would not impose liability as "there is nothing to contradict" and the law only applies to physician-patient treatment and advice, not public advocacy about current scientific consensus, thus introducing little risk of chilling otherwise legitimate speech. *Id*. at *6–9. Plaintiffs' appeal of the denial of a temporary injunction is pending before the U.S. Court of Appeals for the Ninth Circuit. But California declined to appeal the temporary injunction issued by the *Høeg* court, with speculation that the state prefers for the appellate court to rule first on the *McDonald* decision, which allows enforcement of the new law. *See* Bernard J. Wolfson, *California's COVID Misinformation Law Is Entangled in Lawsuits, Conflicting Rulings*, L.A. TIMES (Mar. 17, 2023), https://www.latimes.com/science/story/2023-03-17/californias-covid-misinformation-law-is-entangled-in-lawsuits-conflicting-rulings [https://perma.cc/X4UV-CJNZ] (reporting on lawsuits surrounding California's COVID-19 misinformation laws). It is not clear yet whether the lawsuits and pending appeal will be declared moot with the very recent repeal of the California medical misinformation law. *See supra* note 19.

23. *Høeg*, 2023 WL 414258, at *7–10.

24. *See, e.g.*, CONG. BUDGET OFF., PUB. NO. 2975, RESEARCH ON THE COMPARATIVE EFFECTIVENESS OF MEDICAL TREATMENTS: ISSUES AND OPTIONS FOR AN EXPANDED FEDERAL ROLE 12 (2007) ("[T]he apparent variation in [treatment] norms indicates that there is not sufficient evidence to determine which approach is most appropriate."). *See also infra* notes 293–95 and accompanying text (documenting how physicians often consider a range of non-evidence-based factors in deciding on the best treatment and that many common treatments are not backed by solid evidence).

if limited in number, of sufficient *quality* in their background training and relevant expertise; or (3) evidence that has been gathered through best available methods, which may or may not mean the "gold standard" of randomized controlled clinical trials because in some contexts such trials are not feasible or sufficiently determinative. This subjectivity in determining the appropriate evidence base proved problematic for California's new medical misinformation law. For example, the federal judge, in declaring the law unconstitutionally vague, found quite unclear whether "scientific consensus" meant a plurality or majority of physician opinions and whether peer-reviewed articles or less rigorous sources should also be consulted to determine consensus at a given time.[25]

More generally, a considerably large "epistemological grey area" likely exists consisting of medical claims that may deviate from the two leading misinformation standards—"current scientific consensus" or the "best available evidence"—but are still not clearly false.[26] These claims, while ultimately accurate, initially may be considered too unorthodox to merit consensus. Or, the claims may be theoretically and medically plausible, and even ultimately accurate, but lack preliminary supporting evidence.

In any event, medical misinformation can occur without any intent to harm and the source may actually believe that it is good information. A subset of misinformation, however, is disseminated with negative purposes. The U.S. Surgeon General refers to this as medical "disinformation," a false communication counter to the best available evidence at the time, but when the source created it with intent to profit or cause harm.[27] Compared to misinformation, disinformation may trigger different legal analyses and consideration of additional regulatory tools, as it more likely rises to the level of common law fraud and related offenses that require proof of harmful purpose and sufficient scienter.[28]

This Article uses the term "medical misinformation" in a broad, inclusive manner, covering both misleading and false communications, measured against either scientific consensus

25. *Høeg*, 2023 WL 414258, at *8–10.

26. Coleman, *supra* note 12, at 134.

27. U.S. SURGEON GEN., *supra* note 21.

28. *See infra* Part IV.B (discussing remedies to medical misinformation through tort and statutory law).

or the best available evidence. Misinformation is also intended to encompass the distinct subset of disinformation when the physician knows the claim is false and acts with purpose to cause harm or profit from it.

B. PERVASIVENESS AND EXAMPLES OF PHYSICIAN-SPREAD MISINFORMATION

The prevalence of physicians spreading medical misinformation has been hard to measure, in part because of the confidentiality of many medical board proceedings, and because no single governmental entity or private clearinghouse tracks such information.[29] However, indirect evidence suggests that physicians have played a surprisingly prominent role in the COVID-19 infodemic. The Federation of State Medical Boards (FSMB), the umbrella organization for all the state medical boards, surveyed its members and reported in December 2021 that about two-thirds of medical boards had seen an increase in complaints of physicians spreading COVID-19 misinformation.[30]

Other research suggests that physicians have acted as misinformation "superspreaders." The Center for Countering Digital Hate analyzed anti-COVID-19 vaccine content on social media platforms, focusing on twelve persons who played large roles in spreading incorrect or misleading claims.[31] This "disinformation dozen" accounted for 65% of all anti-vaccine content on the social media platforms studied during the measurement period in 2021.[32] Among the disinformation dozen were at least

29. *See, e.g.*, *Enforcement*, IOWA BD. OF MED., https://medicalboard.iowa.gov/physicians/enforcement [https://perma.cc/NRR4-EXV2] ("An investigation is confidential. It cannot be shared with the public, the complainant, or the licensee involved. The public may know only when the board files charges against a licensee.").

30. *Two-Thirds of State Medical Boards See Increase in COVID-19 Disinformation Complaints*, FED'N OF STATE MED. BDS. (Dec. 9, 2021) [hereinafter *State Medical Boards*], https://www.fsmb.org/advocacy/news-releases/two-thirds-of-state-medical-boards-see-increase-in-covid-19-disinformation-complaints [https://perma.cc/WC3W-RRN5].

31. *The Disinformation Dozen*, CTR. FOR COUNTERING DIGIT. HATE (Mar. 24, 2021), https://counterhate.com/wp-content/uploads/2022/05/210324-The-Disinformation-Dozen.pdf [https://perma.cc/6E2S-TH8G]. The twelve individuals were selected based on numbers of followers, high volumes of content, and rapid growth of their social media accounts. *Id.* at 5.

32. *Id.* at 6.

four physicians, three licensed and one retired.[33] They included Dr. Sherri Jane Tenpenny, who testified before the Ohio legislature that the COVID-19 vaccine could cause people to become magnetized and tweeted that masking can suppress the immune system.[34] The group also included Dr. Joseph Mercola, a Florida osteopath physician with a long history of peddling natural cures and opposing vaccination, who posted statements on Facebook that hydrogen peroxide can successfully treat coronavirus.[35]

Only one of these "superspreader" physicians was directly disciplined by medical boards.[36] The Medical Board of Ohio reached out to Dr. Tenpenny a few weeks after her controversial testimony before the Ohio legislature.[37] In her Report and Recommendation, the Medical Board Hearing Examiner found that Dr. Tenpenny refused to meet with Board investigators and failed to answer interrogatories from the Board or attend investigatory depositions and conferences.[38] In light of these findings, the Board followed the Examiner's Recommendation and

33. *Id.* at 18, 24, 33; Sheera Frenkel, *The Most Influential Spreader of Coronavirus Misinformation Online*, N.Y. TIMES (July 24, 2021), https://www.nytimes.com/2021/07/24/technology/joseph-mercola-coronavirus-misinformation-online.html [https://perma.cc/DD2X-XWRN].

34. *The Disinformation Dozen*, *supra* note 31, at 19; Morgan Trau, *Cleveland Doctor, Who Said COVID-19 Vax Makes People Magnetic, Under State Investigation*, ABC NEWS 5 CLEVELAND (Oct. 28, 2022), https://www.news5cleveland.com/news/politics/ohio-politics/cleveland-doctor-who-said-covid-19-vax-makes-people-magnetic-under-state-investigation [https://perma.cc/LGY8-WE7T].

35. *The Disinformation Dozen*, *supra* note 31, at 13; Frenkel, *supra* note 33.

36. *Licensee Information*, N.C. MED. BD., https://portal.ncmedboard.org/Verification/viewer.aspx?ID=155456 [https://perma.cc/289H-9JKC] (documenting unrelated disciplinary actions against Rashid Buttar, now deceased, in North Carolina through October 2023); *License Details*, ILL. DEP'T OF FIN. AND PRO. REGUL., https://online-dfpr.micropact.com/lookup/licenselookup.aspx [https://perma.cc/QK5Q-QJ5H] (listing no disciplinary actions taken against Dr. Mercola in Illinois through October 2023); *Joseph Michael Mercola*, FLA. DEP'T OF HEALTH, https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthcareProviders/LicenseVerification?LicInd=19667&Procde=1901&org=%20 [https://perma.cc/BN8V-HHBC] (listing no disciplinary actions taken against Dr. Mercola in Florida through October 2023); *infra* notes 37–39 (documenting the State Medical Board of Ohio's decision to indefinitely suspend Sherri Tenpenny's medical license).

37. Trau, *supra* note 34.

38. Sherri J. Tenpenny, D.O., No. 22-CRF-0168, at 10–11 (State Med. Bd. of Ohio July 14, 2023), https://elicense.ohio.gov/oh_verifylicensedetails?pid=a0Rt000000084mlEAA [https://perma.cc/54BE-2SEV] (Report and Recommendation).

indefinitely suspended Dr. Tenpenny's medical license for her failure to cooperate with the investigation.[39] Meanwhile, the Food and Drug Administration has sent Dr. Mercola a warning letter because his company's website referenced unapproved, misbranded products as established COVID-19 treatments.[40]

Organized physician groups have also amplified medical misinformation. Members of America's Frontline Doctors (AFD) appeared on the steps of the U.S. Supreme Court dressed in white coats to make unsubstantiated claims that masks did not slow the spread of COVID-19 and that hydroxychloroquine effectively treated the virus.[41] AFD's website has been used to sell prescriptions for the anti-parasitic drug ivermectin to treat COVID-19,[42] a discredited and unapproved use of the drug, and the website received over 6.8 million visits in 2021.[43] AFD's founder, Dr. Simone Gold, promoted hydroxychloroquine for treating COVID-19 in other public settings.[44] Dr. Gold also participated in the U.S. Capitol riot on January 6, 2020, eventually pleading guilty to a federal misdemeanor.[45] When she was sentenced to prison, the California Medical Board placed her license

39. Sherri J. Tenpenny, D.O., No. 22-CRF-0168 (State Med. Bd. of Ohio Aug. 9, 2023), https://elicense.ohio.gov/oh_verifylicensedetails?pid=a0Rt000000084mlEAA [https://perma.cc/54BE-2SEV] (Entry of Order).

40. Letter from William A. Correll, Dir., U.S. Food & Drug Admin. Ctr. for Food Safety & Applied Nutrition Off. of Compliance, to Joseph M. Mercola, Mercola.com (Feb. 18, 2021), https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/mercolacom-llc-607133-02182021 [https://perma.cc/9S9H-XMCY].

41. Sheera Frenkel & Davey Alba, *Misleading Virus Video, Pushed by the Trumps, Spreads Online*, N.Y. TIMES (July 28, 2020), https://www.nytimes.com/2020/07/28/technology/virus-video-trump.html [https://perma.cc/8QPC-QX9X].

42. *See* Vera Bergengruen, *How 'America's Frontline Doctors' Sold Access to Bogus COVID-19 Treatments—and Left Patients in the Lurch*, TIME (Aug. 26, 2021), https://time.com/6092368/americas-frontline-doctors-covid-19-misinformation [https://perma.cc/S9S8-9UXP] (reporting on AFD).

43. *Disinformation Doctors: Licensed to Mislead*, DE BEAUMONT 5 (Dec. 2021), https://test-de-beaumont-foundation.pantheonsite.io/wp-content/uploads/2021/12/dBF-NLFD-Disinformation-Doctors-report-vf.pdf [https://perma.cc/4HJE-9N6P].

44. Brumfiel, *supra* note 8.

45. Stephanie Mencimer, *Insurrectionist Tells Judge Her Elite Credentials Should Keep Her out of Prison*, MOTHER JONES (June 15, 2022), https://www.motherjones.com/politics/2022/06/simone-gold-insurrectionist-tells-judge-her-elite-credentials-should-keep-her-out-of-prison [https://perma.cc/WT6B-TD5Q].

on inactive status.[46] This change, automatically triggered under the state licensing law whenever a physician is incarcerated for a misdemeanor, was still not considered a form of disciplinary action by the medical board itself.[47] In other words, it was only Gold's Capitol riot conduct that led to any licensure restrictions, despite her long, very public work in spreading medical misinformation.[48]

Other noteworthy examples include Dr. Thomas Cowan, a California internist who claimed in a widely circulated YouTube video that 5G networks caused COVID-19.[49] Similarly, Dr. Daniel Stock, an Indiana physician, generated viral clips from his remarks at a local school board meeting that vaccines were ineffective and masks did not help curb the spread of the virus.[50]

Because of such viral videos and postings, various commentators assert that physician-spread misinformation is more prevalent in the social media era, as false claims can transmit further and more rapidly than physician communications in the past.[51]

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46. Cheryl Clark, *Simone Gold, of America's Frontline Doctors, Reports to Federal Prison*, MEDPAGE TODAY (July 29, 2022), https://www.medpagetoday.com/special-reports/exclusives/99978 [https://perma.cc/Y7AW-BR6X].

47. *Id.*

48. Another highly visible physician-source of COVID-19 misinformation was Dr. Scott Atlas, advisor to the Trump Administration's Coronavirus Task Force. Dr. Atlas made numerous questionable claims, including that young people could not transmit the virus and that allowing the disease to transmit naturally would lead to less deaths than trying to mitigate its spread. Philip A. Pizzo et al., *When Physicians Engage in Practices That Threaten the Nation's Health,* 325 JAMA 723, 723 (2021). The Dr. Atlas episode, however, is more of an outlier. His governmental position was much more public-facing than the typical private physician, including responsibilities for communicating to the public about Task Force deliberations and recommendations concerning COVID-19. *Id.* As such, public statements outside of clinical care were part of his expected professional role. *Id.*

49. Barbara Feder Ostrov, *Conspiracy Theory Doctor Surrenders Medical License*, CALMATTERS (Feb. 5, 2021), https://calmatters.org/health/2021/02/conspiracy-theory-doctor-surrenders-medical-license [https://perma.cc/94RB-28DP].

50. Abram Brown, *Meet the Indiana Doctor Behind the New Ultra-Viral Coronavirus Misinformation Video*, FORBES (Aug. 12, 2021), https://www.forbes.com/sites/abrambrown/2021/08/12/daniel-stock-indiana-doctor-video-mt-vernon-school-board-coronavirus-covid/?sh=6c390e36731b [https://perma.cc/Y8KE-WCLB].

51. *See, e.g.*, Rita Rubin, *When Physicians Spread Unscientific Information About COVID-19*, 327 JAMA 904, 905 (2022) ("[B]efore the advent of social

Social media likely exacerbates the dangers, as it allows for the amplification of the views of even a small number of physicians making false claims.[52] Further, the public engages with misinformation differently when online, more likely to disseminate false claims onward, adding to a large volume of inaccurate information in circulation.[53] On the other hand, one must be wary of overstating the impact of social media. Misinformation online, while generating attention in the moment, may impact the views of only a small minority of users already predisposed to certain opinions.[54] Also, there are many other societal factors at play that drive increased polarization and distrust of traditional authorities.[55]

Even more important, physician-spread misinformation is hardly a new phenomenon, and it is highly debatable whether things were any better in the past. The famous Flexner Report, published in 1910, is often viewed as the key dividing point in the history of American medicine.[56] The implementation of its recommendations on biomedical education and strict admissions requirements for medical schools transformed physician training and renewed a sense of professionalism in medicine.[57] The

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media, physicians espousing false information usually did so without attracting much attention . . . ." (paraphrasing FSMB President Dr. Humayun Chaudhry)).

52. *Id.*

53. Christina Pazzanese, *Battling the 'Pandemic of Misinformation,'* HARV. GAZETTE (May 8, 2020), https://news.harvard.edu/gazette/story/2020/05/social-media-used-to-spread-create-covid-19-falsehoods [perma.cc/7GYL-SUCQ].

54. *See* Gideon Lewis-Kraus, *How Harmful Is Social Media?*, NEW YORKER (June 3, 2022), https://www.newyorker.com/culture/annals-of-inquiry/we-know-less-about-social-media-than-we-think [perma.cc/4YFS-NT6N] (interviewing a researcher who said that the small number of Twitter users who are consistently exposed are unlikely to change their opinions after exposure to fake news because they likely agreed with the information already).

55. *Id.* (presenting research showing that "political realignment and nationalization" beginning in the 1960s, manifesting in talk radio, contributed to polarization).

56. *See* Ross Pomeroy, *1910: The Year American Medicine Changed Forever*, REALCLEARSCIENCE (Nov. 8, 2018), https://www.realclearscience.com/blog/2018/11/08/1910_the_year_american_medicine_changed_forever.html [https://perma.cc/5PSK-N7KJ].

57. *See, e.g.*, Thomas P. Duffy, *The Flexner Report—100 Years Later*, 84 YALE J. BIOLOGY & MED. 269, 274–75 (2011) (crediting the Flexner Report for the restoration of American medical professionalism); *The Flexner Report and Medical Education*, NPR, at 2:59 (Jan. 18, 2010), https://www.npr.org/templates/story/story.php?storyId=122702668 [https://perma.cc/7YVE-JQH8]

Flexner Report also spurred efforts to strengthen licensure regulation and medical board oversight of physicians.[58] The era before the Flexner Report featured many unregulated, unskilled practitioners, including physicians who broadly peddled elixirs and promoted other false medical treatments to the public.[59] The period after the Flexner Report supposedly saw medicine become much more evidence-based, with "[t]reatments not rooted in science . . . rooted out."[60]

Nonetheless, physician-spread misinformation continued as a regular, albeit disturbing, feature of American medicine even decades after the Flexner Report and yet still well before the COVID-19 pandemic. And the physicians involved made quite effective use of old-fashioned media and traditional marketing methods, such as newspaper advertising and community fairs, to ensure that their messages reached broad segments of the public. For example, in the 1930s, physicians promoted "radium tonics" for the treatment of gout, high blood pressure, and other ailments, despite the serious dangers of ingesting radium internally.[61] In the 1940s and 1950s, prominent physicians publicly endorsed ineffective cancer treatments like lipid therapy, special

(acknowledging that Flexner helped consolidate a movement to strengthen medical licensing laws).

58. *See* Duffy, *supra* note 57, at 272 ("Medical education at the turn of the century was a for-profit enterprise that was producing a surplus of poorly trained physicians. The enactment of state licensing laws put teeth into the indictments of the report. Flexner sounded the death knell for the for-profit proprietary medical schools in America."); *The Flexner Report and Medical Education*, *supra* note 57; David A. Johnson, *Finding Historical Context in Medical Regulation: A Bibliographical Guide*, 105 J. MED. REGUL. 17, 21 ("For regulators, the starting point should be Chapter 11 of Flexner's report that spoke directly to the statutory role of state medical boards as the 'instrument' cementing the reforms of progressive medical schools as the basis for minimum qualifications for physician licensure.").

59. *See, e.g.*, Dawn Mitchell, *The Cure for What Ails You: Elixirs, Tonics and Snake Oil*, INDYSTAR (Jan. 3, 2019), https://www.indystar.com/story/news/history/retroindy/2019/01/03/cure-what-ails-you-elixirs-tonics-and-snake-oil/2288353002 [https://perma.cc/UD8B-4J2W] ("When looking through the Indianapolis newspaper archives, especially during the late 19th and early 20th centuries, one can't help but be amazed by the tonics, tinctures and elixirs, known as patent medicines, that promised cures and relief.").

60. Pomeroy, *supra* note 56.

61. *See Medicine: Radium Drinks*, TIME (Apr. 11, 1932), https://content.time.com/time/subscriber/article/0,33009,743525,00.html [https://perma.cc/PD52-J9FE] (recounting the death of a man treated with radium water and exploring controversy around doctor-prescribed radium drinks).

diets, and coffee enemas.[62] During the Jim Crow era, many Southern physicians promoted false views that African Americans were biologically predisposed to become more seriously ill from tuberculosis and other diseases, pointing to racial factors as the reasons for high black mortality rates.[63] These arguments were relied upon to resist broader environmental and public health remediation measures.[64] And in the 1970s, physicians promoted laetrile for combatting various cancers, a medication with no demonstrated effectiveness, making anecdotal and other unsupported, misleading claims of success and broadly encouraging freedom of choice of treatment, leading to thousands of patients rejecting more proven, conventional therapies.[65]

C. HARMS ASSOCIATED WITH PHYSICIANS SPREADING MISINFORMATION

The wide transmission of medical misinformation has generated a public health crisis.[66] Misinformation has likely caused individuals to reject important mitigation measures, such as vaccination, masking, and social distancing, that protect the larger community from disease exposure.[67] Misinformation can also encourage pursuit of ineffective or dangerous treatments, as seen with inaccurate claims about the usefulness of ivermectin and hydroxychloroquine for combatting COVID-19.[68] This can

62. *See* Morris Fishbein, *History of Cancer Quackery*, 8 PERSPS. BIOLOGY & MED. 139, 150–51 (1965).

63. *See* SAMUEL KELTON ROBERTS JR., INFECTIOUS FEAR: POLITICS, DISEASE, AND THE HEALTH EFFECTS OF SEGREGATION 44–47, 49 (2009).

64. *See id.* at 46–47, 60–61, 251 n.70; Andrea Patterson, *Germs and Jim Crow: The Impact of Microbiology on Public Health Policies in Progressive Era American South*, 42 J. HIST. BIOLOGY 529, 529–34, 554–55 (2009).

65. *See* David M. Greenberg, *The Case Against Laetrile: The Fraudulent Cancer Remedy*, 45 CANCER 799, 804–06 (1980).

66. *See, e.g.*, U.S. SURGEON GEN., *supra* note 21, at 2 ("Health misinformation is a serious threat to public health.").

67. *See, e.g.*, Francesco Pierri et al., *Online Misinformation Is Linked to Early COVID-19 Vaccination Hesitancy and Refusal*, 12 SCI. REPS., 1, 3–5 2022 (finding a negative correlation between levels of online misinformation and vaccine uptake rates); U.S. SURGEON GEN., *supra* note 21 ("Misinformation has caused confusion and led people to decline COVID-19 vaccines, reject public health measures such as masking and physical distancing, and use unproven treatments.").

68. U.S. SURGEON GEN., *supra* note 21 (stating that medical misinformation has led people to use unproven treatments); *see also supra* notes 41–44

cause direct medical harm as well as the squandering of limited healthcare resources. As ivermectin became more prominently promoted, poison centers reported increased numbers of calls related to complications from taking the drug.[69] Meanwhile, researchers estimate that health insurers spent approximately $2.5 million for ivermectin prescriptions in a single week in 2021, despite a lack of evidence of the medication's effectiveness in treating the virus.[70]

Misinformation also generates wider harms, undermining the basic operations of the medical and public health systems. It produces risks for healthcare staff, airline and transit employees, and other frontline personnel who must communicate and enforce public health measures on the ground. As a result of misinformation, these workers have been attacked, subjected to online harassment, death threats, and vandalism.[71] In addition, misinformation seeds general distrust in medical, public health, and governmental authorities. It can, for example, confuse members of the public into thinking that all conflicting medical views have equally relative weight and that the basis for expert recommendations is unstable, when in practice a reliable core of knowledge commands considerable consensus within the medical profession.[72]

(documenting the promotion of hydroxychloroquine as a COVID-19 treatment by physicians).

69. Darius Tahir, *Medical Boards Get Pushback as They Try to Punish Doctors for Covid Misinformation*, POLITICO (Feb. 1, 2022), https://www.politico.com/news/2022/02/01/covid-misinfo-docs-vaccines-00003383 [https://perma.cc/KC6X-U3EZ].

70. Kao-Ping Chua et al., *US Insurer Spending on Ivermectin Prescriptions for COVID-19*, 327 JAMA 584, 586 (2022).

71. *See, e.g.*, Michelle M. Mello et al., *Attacks on Public Health Officials During COVID-19*, 324 JAMA 741, 741 (2020) ("Across the US, health officers have been subject to doxing . . . , angry and armed protesters at their personal residences, vandalism, and harassing telephone calls and social media posts, some threatening bodily harm and necessitating private security details.").

72. Minimally acceptable standards of care, reflecting professional consensus, are widely recognized and play a central role within medical practice. These care standards range from performance to decision-making to appropriateness of clinical services. *See, e.g.*, Eleanor D. Kinney, *The Origins and Promise of Medical Standards of Care*, 6 VIRTUAL MENTOR 574, 575 (2004) ("The American health care sector has indeed moved from a paradigm of autonomous professional decision making to a paradigm of collective decision making based on empirically derived standards of care.").

Physician-spread misinformation has more potency than other forms of medical misinformation. Because physicians command significant status as learned professionals, the public will highly credit their views as based on specialized knowledge and training.[73] Individuals are more likely to heed physician advice, even when false. Physicians have an inherent, powerful platform in the community, with tremendous capacity to influence public attitudes and decision-making in ways that magnify misinformation's overall risks.

Psychologically challenging times, such as a pandemic, provide fertile conditions for medical misinformation to thrive. Medical misinformation is often framed in sensationalist or emotional ways to align with cognitive biases, appeal to an individual's anxiety, or reaffirm the audience's political and cultural values.[74] Science has become more politicized in the current era of intense polarization.[75] Thus, medical "truths" as understood by the lay community may dangerously turn more on how many other persons in an individual's network share or like information than traditional scientific analysis and evidence.[76] Against this backdrop, network sharing of physician-generated misinformation, combined with the white coat weaponization effect, can have a pernicious impact.

II. RESPONSE OF THE MEDICAL BOARDS

A. MEDICAL BOARDS GENERALLY AND FSMB RESPONSE

The primary means of regulating physician quality and conduct is through the state-level system of professional licensing boards, or medical boards. As governmental agencies, medical boards derive their authority from enabling statutes, usually

73. *See* Castrucci & Sawyer, *supra* note 4 and accompanying text.

74. *See* U.S. SURGEON GEN., *supra* note 21, at 5 (identifying three reasons for why misinformation spreads quickly on social media sites, including the sensationalist framing of misinformation posts, the liking and sharing features, and algorithms that "prioritize content based on popularity and similarity to previously seen content").

75. *See* Richard J. Baron & Yul D. Ejnes, *Physicians Spreading Misinformation on Social Media—Do Right and Wrong Answers Still Exist in Medicine?*, 387 NEW ENG. J. MED. 1, 1 (2022) (labelling the current era as one of "heavily politicized science").

76. *Id.* ("In the era of social media and heavily politicized science, 'truth' is increasingly crowdsourced: if enough people like, share, or choose to believe something, others will accept it as true.").

called Medical Practice Acts.[77] In granting a license, medical boards confer legal authority on individuals to practice medicine.[78] They also review patient complaints, monitor physician conduct, and administer professional discipline, including mandated education, fines, and licensure suspension or revocation.[79] Typically, medical board decision-making operates through a governing board or committee. The members include physicians and laypersons, although physicians comprise a large majority of a typical medical board's membership.[80] Individuals serving on medical boards are usually appointed by the governor, with recommendations made by state medical societies, but some enabling statutes give appointment powers to the legislature or follow other selection procedures.[81]

Medical boards have primarily responded to physicians spreading COVID-19 misinformation through general warnings and guidance statements. The Federation of State Medical Boards (FSMB), the umbrella organization for the different state medical boards, issued a statement in July 2021 advising that physicians disseminating COVID-19 vaccine misinformation risked disciplinary action, including loss of medical license.[82]

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77. *See, e.g.*, CAL. BUS. & PROF. CODE §§ 2000–2027 (West 2023) (California's Medical Practice Act).

78. *See, e.g.*, *About Physician Licensure*, FED'N OF STATE MED. BDS., https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/about-physician-licensure [https://perma.cc/FQ38-3HXL] (stating that the practice of medicine is a licensed profession and explaining the requirements to obtain a medical license).

79. Nadia N. Sawicki, *Complaints to Professional and Regulatory Bodies, in* THE OXFORD HANDBOOK OF U.S. HEALTH LAW 465, 467–70 (I. Glenn Cohen et al. eds., 2015).

80. David A. Johnson et al., *The Role and Value of Public Members in Health Care Regulatory Governance,* 94 ACAD. MED. 182, 183 (2019) (discussing study results showing that physicians represented 85% of board membership, while public members represented between 9% and 15% depending on how organizations defined "public member"); Elizabeth Chiarello*, Barriers to Medical Board Discipline: Cultural and Organizational Constraints*, 15 ST. LOUIS U. J. HEALTH L. & POL'Y 55, 74 (2021) ("[T]he vast majority of board members are physicians themselves.").

81. *See* Elizabeth Pendo et al., *Protecting Patients from Physicians Who Inflict Harm: New Legal Resources for State Medical Boards*, 15 ST. LOUIS U. J. HEALTH L. & POL'Y 7, 19 (2021).

82. Press Release, Fed'n of State Med. Bds., FSMB: Spreading COVID-19 Vaccine Misinformation May Put Medical License at Risk (July 29, 2021), https://www.fsmb.org/advocacy/news-releases/fsmb-spreading-covid-19-vaccine-misinformation-may-put-medical-license-at-risk [perma.cc/7PF9-4QNJ].

FSMB's general justification was that physicians spreading misinformation put all patients in danger and breached their professional responsibility to share factual, consensus-based information.[83]

Imposing actual discipline, of course, falls within the jurisdiction of individual state medical boards, not FSMB. Several state medical boards largely adopted or signaled support for the FSMB guidance.[84] Beyond such warning guidance, however, discipline to date has been quite limited. While FSMB reported from its 2021 annual survey that about two-thirds of state medical boards had seen an increase in complaints about physicians spreading COVID-19 misinformation, only twenty-one percent of the boards indicated that they had already imposed some form of sanction.[85] *Politico*, relying on FSMB summary data, reported that from January 2021 to February 2022 only eight physicians nationwide had been disciplined in some form for spreading COVID-19 misinformation.[86]

B. DATA FROM CALIFORNIA, FLORIDA, AND TEXAS

Medical board actions in California, the nation's largest jurisdiction, follow a similar pattern. Analysis of publicly available disciplinary proceedings reveals that, for the period from January 1, 2020, to March 30, 2022, there were approximately 927 disciplinary actions against licensed physicians.[87] During this same time frame, however, *zero physicians* received a formal sanction directly relating to spreading COVID-19 misinformation.[88] One physician linked to COVID-19 misinformation, based on public news accounts, faced threatened discipline by the medical board in this period, but for other conduct, likely

83. *Id.*

84. *See, e.g.*, *COVID-19 Misinformation*, WASH. MED. COMM'N (Sept. 22, 2021), https://wmc.wa.gov/sites/default/files/public/COVID-19/COVID-19%20Misinformation%20Position%20Statement.pdf [perma.cc/RYC2-K762] ("The WMC supports the position taken by the Federation of s (FSMB) regarding COVID-19 vaccine misinformation.").

85. *State Medical Boards*, *supra* note 30.

86. Tahir, *supra* note 69.

87. This is based on analysis of data from disciplinary actions reported on the Medical Board of California website. *See* Appendix 1.

88. *See id.* During this same time period, Dr. Thomas Cowan voluntarily surrendered his license rather than face possible disciplinary action. Ostrov, *supra* note 49*; see also infra* notes 98–101 and accompanying text.

reflecting how non-misinformation-related offenses are generally easier for medical boards to prosecute.[89]

Likewise, consider Texas, the second largest state. For the same period (January 1, 2020, to March 30, 2022) analysis of the publicly available disciplinary proceedings reveals that the state medical board undertook approximately 773 disciplinary actions against licensed physicians.[90] Among this group, only three physicians received sanctions for spreading COVID-19 misinformation to patients (0.4% of actions) and the medical board disciplined an additional two physicians for spreading COVID-19 misinformation to non-patients and the general public (0.3% of actions).[91] The latter group included Jerel Biggers, D.O. The Texas Medical Board alleged that Dr. Biggers, in connection with a nurse under his supervision, issued false and misleading advertising to the general public promoting stem cell therapies and intravenous (IV) treatments for COVID-19 prevention.[92] The Board argued that this violated various provisions of the Texas Medical Practice Act, including prohibitions against false or deceptive advertising and engaging in unprofessional conduct likely to defraud the public.[93] The Board eventually reached a settlement with Dr. Biggers, allowing him to retain his license contingent on completing continuing medical education

89. The medical board filed complaints against Dr. John Humiston in 2022, relating to negligent treatment of various patients (but not for COVID-19 related care), failure to maintain adequate records, and for granting child vaccine exemptions (not involving the COVID-19 vaccine) for unsupported reasons. *See* Physician's and Surgeon's Certification No. A 83402, No. 800-2018-048053, at 3, 45–49 (Med. Bd. Cal. Dep't of Consumer Affs., Feb. 6, 2023), https://www2.mbc.ca.gov/PDL/document.aspx?path=%5cDIDOCS%5c20230206%5cDMRAAAJD6%5c&did=AAAJD230206182647412.DID&licenseType=A&licenseNumber=83402%20#page=1 [https://perma.cc/QJK2-JT6X]. But Dr. Humiston's promotion of alternative medicines such as Colloidal Silver 500 with Vitamin C as treatment for COVID-19, which apparently led some former patients to decline getting the COVID-19 vaccine, was not acted on by the medical board in this same period. *See Vaccine Skeptic Gets Two Jabs at Her Critic,* SAN DIEGO READER (Sept. 15, 2021), https://www.sandiegoreader.com/news/2021/sep/15/letters-needle-sticks [perma.cc/7PNZ-BXRF].

90. This is based on analysis of data from disciplinary actions reported on Texas Medical Board website. *See* Appendix 2.

91. *Id.*

92. The License of Jerel Raymond Biggers, D.O., No. G2646, at 4 (Tex. Med. Bd. Mar. 5, 2021), https://profile.tmb.state.tx.us/Search.aspx?d3726faf-fba8-40bb-b87f-1fe14f10fa8e [https://perma.cc/D9LR-XM9B].

93. *Id.* at 4–5.

requirements, passing certain new exams, and submitting supervision agreements for further review.[94]

Medical board data from Florida, the nation's third most populous state, tracks very similarly. Review of publicly available disciplinary records indicates that for the same time frame (January 1, 2020, to March 30, 2022), there were 126 disciplinary actions against licensed physicians.[95] However, *zero physicians* received sanction related to spreading COVID-19 misinformation, whether to patients or to the public.[96] This lack of discipline occurred despite Dr. Joseph Mercola, considered one of the nation's superspreaders of COVID-19 misinformation, headquartering his natural health business operations in Florida.[97]

Of course, publicly reported instances of discipline do not tell the full story of medical board oversight. Preliminary medical board actions, such as opening an investigation in response to a complaint or reaching out to a physician for information, are often confidential. These behind-the-scenes "nudges" may leverage the threat of sanction to prod changes in physician conduct, but leave limited public record.[98] Relatedly, some physicians may have resigned their licenses rather than contest medical board discipline. California physician Dr. Thomas Cowan, who, as noted previously, publicly claimed that 5G networks caused COVID-19,[99] voluntarily surrendered his license in 2021.[100] But he ominously suggested on his website that he would continue

94. *Id.* at 5–8.

95. This is based on analysis of data from disciplinary actions reported on Florida Department of Health website. *See* Appendix 3.

96. *Id.*

97. *See supra* notes 35–40 and accompanying text.

98. *See Should Physicians Face Disciplinary Actions for Misinformation?*, WEBMD (Jan. 19, 2021), https://www.webmd.com/coronavirus-in-context/video/hank-chaudhry [https://perma.cc/KJ4B-QJLJ] (video transcript of interview with FSMB president Hank Chaudhry discussing the efficacy of medical board "nudge[s]" in encouraging physicians to change their behavior).

99. Ostrov, *supra* note 49.

100. *See* Physician's and Surgeon's Certificate No. G 86923, No. 800-2015-016334, at 3 (Med. Bd. Cal. Dep't of Consumer Affairs, Jan. 29, 2021), https://www2.mbc.ca.gov/BreezePDL/document.aspx?path=%5cDIDOCS%5c20210128%5cDMRAAAHL7%5c&did=AAAHL210129202932167.DID [https://perma.cc/3GN7-XZAA]; Ostrov, *supra* note 49 and accompanying text. It is not clear if the Medical Board of California was pursuing active discipline for the COVID-19 claims, as he had already been placed on probation in 2017 for prescribing unapproved medications for treating a patient with breast cancer. *Id.*

to spread misinformation, under the radar of medical board oversight. Cowan stated that moving forward he planned to work as an "unlicensed health coach" and take on a "new way of interacting with [his] friends, previously known as patients."[101]

C. RARE DISCIPLINARY ACTIONS

Discipline has occurred in isolated instances, but usually linked to problematic conduct involving direct patient interactions, as opposed to spreading misinformation to the general public. The sanctions have also been relatively light. For example, Texas physician Dr. Stella Immanuel, a member of AFD, made many public claims about hydroxychloroquine as an effective COVID-19 treatment, along with earlier statements in her career spreading conspiracy theories that medical treatments used alien DNA.[102] She was subject to a remedial plan by the Texas Medical Board, involving Board review of her informed consent documents, and fined only $500 per year so long as the remedial plan continued.[103] But the corrective plan was terminated within a few months.[104] The aggravating conduct relied upon was failing to inform her patients of the risks of using hydroxychloroquine as an off-label treatment, as opposed to her many public, inaccurate claims about the drug.[105]

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101. Ostrov, *supra* note 49.

102. Dickens Olewe, *Stella Immanuel—The Doctor Behind Unproven Coronavirus Cure Claim*, BBC NEWS (July 29, 2020), https://www.bbc.com/news/world-africa-53579773 [https://perma.cc/G6MG-3VLW].

103. *See* Remedial Plan, Stella G. Immanuel, M.D., License No. S3994, at 2 (Tex. Med. Bd. Oct. 15, 2021), https://texasscorecard.com/wp-content/uploads/2022/10/remedial-plan-immanuel-md.pdf [https://perma.cc/2SKK-5ZXY].

104. Amanda D'Ambrosio, *Stella Immanuel Highest U.S. Prescriber of Ivermectin and HCQ,* MEDPAGE TODAY (Mar. 2, 2023), https://www.medpagetoday.com/special-reports/exclusives/103353 [https://perma.cc/7DTP-KNAF] ("[O]n Jan. 4, 2022, the remedial plan was terminated 'due to completion of all requirements,' according to the website of the Texas Medical Board.").

105. *See* Remedial Plan, *supra* note 103, at 1 (finding that Dr. Immanuel "failed to give adequate informed consent to one patient for the prescription of hydroxychloroquine for treatment of COVID-19"); Blake Farmer, *Medical Boards Pressured to Let It Slide When Doctors Spread Covid Misinformation*, KFF HEALTH NEWS (Feb. 15, 2022), https://kffhealthnews.org/news/article/medical-boards-pressured-to-let-it-slide-when-doctors-spread-covid-misinformation [https://perma.cc/63NK-GCJ3] ("The Texas Medical Board fined Immanuel $500 for not informing a patient of the risks associated with using hydroxychloroquine as an off-label covid treatment."). In 2021 and 2022, Dr. Immanuel ordered more prescriptions than any other physician in the entire

The case of Oregon family physician Steven LaTulippe stands out as one noteworthy exception to this overall pattern of inaction by medical boards. According to the Oregon Medical Board, Dr. LaTulippe and his staff did not follow public health guidelines concerning masking, social distancing, and pre-visit COVID-19 screening of patients.[106] Dr. LaTulippe also allegedly told patients that masks did not limit the spread of COVID-19.[107] But the problematic conduct extended beyond interactions with clinic patients. Dr. LaTulippe also posted on Twitter and other social media platforms false vaccine information and inaccurate claims about COVID-19 being linked to population control.[108]

The Oregon Medical Board first suspended LaTulippe's license in December 2020 and then revoked it in September 2021.[109] The medical board found that the physician's actions presented risks to patients.[110] But importantly the medical board did not perceive its authority as limited to combatting patient-focused harm. It further concluded that LaTullipe's negative advice about masking "actively promote[d] transmission of the virus *within the extended community*."[111] This threatened to "undermine acceptability among [his] patients *and the general populace* of one of the primary measures known to significantly diminish viral transmission."[112] The medical board concluded that spreading this misinformation constituted unprofessional or dishonorable conduct under the state Medical Practice Act,

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United States for both hydroxychloroquine and ivermectin. D'Ambrosio, *supra* note 104.

106. *See* Steven Arthur LaTulippe, MD, License No. MD22341, at 6 (Or. Med. Bd. Dec. 4, 2020) [hereinafter LaTulippe Suspension], https://omb.oregon.gov/Clients/ORMB/OrderDocuments/ff970292-5807-41ba-9c1e-c2b81de89cd1.pdf [https://perma.cc/S484-APRT]; Kelly Jones, *Medical Misinformation Can Be Deadly. So Why Do So Many Doctors Get Away with It?* VERIFY (Apr. 20, 2022), https://www.verifythis.com/article/news/verify/health-verify/medical-misinformation-doctors-covid-disinformation-health-impact-consequences/536-b3a599cc-dd11-4d54-9ca0-70044111a86e [https://perma.cc/X5DM-HADW].

107. LaTulippe Suspension, *supra* note 106, at 5.

108. Jones, *supra* note 106.

109. *Id.* The Board's emergency suspension was upheld in a final order issued in May 2021. Steven Arthur LaTulippe, MD, License No. MD22341 (Or. Med. Bd. May 6, 2021) (final order), https://omb.oregon.gov/Clients/ORMB/OrderDocuments/6f460081-4771-441c-a5e7-2a4c3c203523.pdf [https://perma.cc/LTD4-XVNV].

110. LaTulippe Suspension, *supra* note 106, at 6–7.

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

112. *Id.*

specifically as conduct "contrary to medical ethics" and "a danger to the health or safety of the public."[113]

III. MEDICAL BOARD LIMITATIONS

The generally feeble response of medical boards reflects the considerable challenges of relying upon licensure regulation to police the medical misinformation problem. Serious barriers include unclear legal authority, structural problems in the institutional design and operations of medical boards, and policy concerns about overreach. Admittedly, several of these same obstacles also arise with oversight of physicians generally, such as the difficulties medical boards face in sufficiently addressing impaired physicians or sexual exploitation of patients.[114] But these factors all combine, and prove especially troubling and formidable, in the context of medical misinformation. Relying on licensure regulation to address physicians publicly spreading falsehoods implicates challenging, unresolved questions about physicians' responsibilities and professional role boundaries beyond direct patient care, as well as the value of robust physician communications to the general public, even if sometimes false.

A. UNCLEAR AUTHORITY

1. First Amendment Constraints

As governmental bodies, medical boards remain subject to the First Amendment. An important distinction is regulation of speech versus regulation of conduct. Medical boards cannot unconstitutionally infringe on the free speech rights of licensed physicians and the First Amendment can protect even untruthful speech.[115] However, medical boards can restrict physician conduct that somewhat touches on speech as part of regulating

113. *Id.*, at 5. *See also* OR. REV. STAT. ANN. § 677.188(4)(a) (defining "unprofessional or dishonorable" conduct as including actions that might endanger the public).

114. *See, e.g.*, Kunal K. Sindhu et al., *Honoring the Public Trust: Curbing the Bane of Physician Sexual Misconduct*, 9 J.L. & BIOSCIENCES 1, 1 (2022) (explaining that physician sexual misconduct is prevalent and underreported).

115. United States v. Alvarez, 567 U.S. 709, 722 (2012) (rejecting "the notion that false speech should be in a general category that is presumptively unprotected" by the First Amendment).

the general practice of medicine.[116] For example, medical boards can sanction physicians for recommending unapproved products to patients, because the treatment fails to conform to professional standards of care.[117]

The Supreme Court has forcefully moved away from earlier cases suggesting that "professional speech" might be viewed as a different category of speech, subject to a more deferential standard of review, and therefore more easily restricted.[118] Instead, recent U.S. Supreme Court cases like *National Institute of Family and Life Advocates v. Becerra* (*NIFLA*) indicate that strict scrutiny, which involves the lowest level of deference, generally applies to the restriction of professional speech.[119] Even *NIFLA*, however, recognized that a more deferential review standard might still apply when regulation of conduct "incidentally involves" speech, such as requiring physicians to provide certain information about a procedure as part of obtaining informed consent.[120] Hence, the ongoing importance of the speech versus conduct characterization in determining how much latitude medical boards have to act.

Impliedly relying upon the regulation-of-conduct rationale, some commentators contend that, at least in some contexts, medical boards can discipline physicians for spreading

116. *See, e.g.*, Nat'l Inst. of Fam. & Life Advocs. v. Becerra [hereinafter *NIFLA*], 138 S.Ct. 2361, 2373 (2018) ("[T]his Court has upheld regulations of professional conduct that incidentally burden speech.").

117. Sage & Yang, *supra* note 12, at 1444 (explaining that the government can sanction "recommendations by professionals that patients take illegal medications or controlled substances without following legally required procedures").

118. *See NIFLA*, 138 S.Ct. at 2361 (2018) ("[P]rofessional speech is not a separate category of speech . . . .").

119. *Id.* at 2368–71 (rejecting the view that professional speech is not subject to strict scrutiny in deciding the constitutionality of a California law requiring crisis pregnancy centers to notify patients that the State of California provides family planning services, including abortion, and requiring unlicensed clinics to notify patients that they are not licensed). While demonstrating skepticism about treating professional speech as a distinct category of speech, the Court did not, however, entirely rule out the prospect in some future case and in discrete contexts. "In sum, neither California nor the Ninth Circuit has identified a persuasive reason for treating professional speech as a unique category of speech that is exempt from ordinary First Amendment principles. We do not foreclose the possibility that some such reason exists." *Id.* at 2375.

120. *Id.* at 2372.

misinformation because it constitutes unprofessional conduct.[121] Yet sanctioning physician communications to the general public, not in the course of regular patient care, seems more likely to trigger strict scrutiny review as speech restrictions based on content, speaker, or viewpoint. Characterizing communications to the public as professional conduct, not speech, seems very debatable when public statements seem so disconnected to core, commonly understood private physician functions, like advising particular patients about medical treatment.[122]

Further complicating the analysis, however, is that despite the U.S. Supreme Court's highly free-speech-protective stance, healthcare licensing cases only infrequently reach the Court. Lower courts adjudicating the vast majority of these disputes have tended to be less categorical and, at times, more deferential to medical board actions that infringe on physician speech.[123]

Assuming strict scrutiny review did apply, a medical board seeking to justify action against a physician for her communications must show that a "compelling state interest" exists and that the limitations are "narrowly tailored," or the least restrictive means available.[124] Medical boards can likely show that

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121. Mello, *supra* note 12 ("There is also latitude for regulating professional speech: state medical licensing boards can suspend the licenses of physicians whose statements constitute unprofessional conduct."). Likewise, in McDonald v. Lawson, No. 8:22-cv-01805-FWS-ADS, 2022 WL 18145254 (C.D. Cal. Dec. 28, 2022), the federal district court refused to enjoin California's new medical misinformation law based on First Amendment challenges, finding that the law was a proper regulation of professional conduct that incidentally burdened speech as part of monitoring medical care. *Id.* at *11. Key to the court's treatment of the new law as principally about regulating professional conduct was that the statute only applies to physician-patient communications, not public statements. *Id.* at *10–11. *See also infra* notes 176–77 and accompanying text.

122. *See* Carl Coleman, *License Revocation as a Response to Physician Misinformation: Proceed with Caution*, HEALTH AFFS. (Jan. 5, 2022), https://www.healthaffairs.org/do/10.1377/forefront.20211227.966736 [https://perma.cc/D54Y-FB84] ("[B]oards are likely to have considerable discretion when disciplining physicians for statements made in connection with medical procedures, as such actions would constitute the regulation of professional conduct. On the other hand, because physicians' public statements are unconnected with any medical procedure, disciplinary actions based on those statements would be subject to normal First Amendment standards.").

123. *See* Cassandra Burke Robertson & Sharona Hoffman, *Professional Speech at Scale,* 55 UC DAVIS L. REV. 2063, 2085 (2022) (providing examples of lower courts finding for both sides).

124. *NIFLA*, 138 S. Ct. 2361, 2371 (2018) (quoting Reed v. Town of Gilbert, 576 U.S. 155, 163 (2015)).

combatting physician-spread medical misinformation is a compelling state interest. As previously noted, devastating consequences can arise for individuals and overall public health from physician-spread misinformation.[125] Much more difficult, though, is whether sanctioning physicians for their communications is the least restrictive means available. The typical, more constitutionally sound remedy for false speech is counterspeech.[126] In other words, the government could provide accurate medical information to the public in order to mitigate the harm from particular physicians' false claims.

Accordingly, some commentators conclude that medical boards can likely only sanction a narrow range of physician misinformation: when the speaker knows it is false or acts with reckless disregard as to its falsity.[127] Under this view, the ordinary remedy of counterspeech will not suffice because the harms involved from speech that a physician knows to be false, or acts in reckless disregard of its falsity, extend beyond individuals experiencing risks from following unsound medical information. The additional dangers include a critical loss of trust in the medical profession generally when the public sees physicians as reckless or intentionally misleading regarding accurate healthcare information.[128] This loss of confidence can jeopardize future healing relationships as well as public acceptance of sound public health guidance. Counterspeech alone, the argument goes, does very little to restore critically needed trust in the medical profession.

However, while seemingly persuasive, even the loss-of-trust rationale for restricting physician speech remains subject to question. Broad governmental assertions that restrictions of speech are necessary to protect public confidence and professional integrity will not be sufficient for satisfying First

125. *See supra* Part I.C.

126. Some scholars question whether counterspeech should be properly considered a least restrictive remedy in these contexts when it is likely insufficient to address the broader harms of physician-disseminated misinformation. *See* Haupt, *supra* note 11, at 50 ("Counterspeech, as explained, is an insufficient remedy and so doctrinal insistence on its availability as a less restrictive means is normatively beside the point."); Mello, *supra* note 12 (arguing counterspeech is an ineffectual policy because "false beliefs arising from vaccine misinformation are extremely difficult to dislodge").

127. Coleman, *supra* note 12, at 116.

128. *Id.*

Amendment scrutiny.[129] In fact, it is not at all clear that medical board discipline of physicians publicly spreading misinformation remains the only way to secure patient trust in medicine and the integrity of the medical profession. Which particular actions erode or enhance trust can be hard to discern because trust remains a fickle resource, often operating in unpredictable ways in healthcare settings.[130] Actions to enhance patient trust can sometimes have the opposite, intended effect. For example, behavioral research suggests that regulations requiring physicians to disclose their financial conflicts, rather than making patients more vigilant about ascertaining their physician's loyalty, may instead lead to more adherence to the physician's advice.[131] Patients may end up trusting the physician more because of the act of disclosure. Or the disclosure may create new pressures to follow the physician's advice lest the patient appear to be questioning the physician as dishonest, a position likely uncomfortable for the patient.[132]

Moreover, trust in physicians may be far more resilient than portrayed by commentators worrying about the impact of medical misinformation. As previously discussed, physician-spread

129. *Cf.* United States v. Alvarez, 567 U.S. 709, 725–28 (2001). In *Alvarez*, the Court held that the Stolen Valor Act, which made it a crime to falsely claim receipt of military medals, violated the First Amendment. *Id.* at 711. Among other reasons, the Court stated that "[t]he link between the Government's interest in protecting the integrity of the military honors system and the [Stolen Valor] Act's restrictions on the false claims of liars . . . has not been shown." *Id.* at 725. The Court concluded that the Government had fallen short in demonstrating that "unchallenged claims [of military medals] undermine the public's perception of the military and the integrity of its awards system." *Id.* at 728. Thus, the Court would likewise strongly question across-the-board assertions that false medical claims undermine the integrity of the medical profession and public confidence in doctors.

130. *See generally* Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 509 (2002) (explaining how efforts designed to enhance patient trust in the medical system "can also, paradoxically, weaken trust").

131. *See* Steven D. Pearson et al., *A Trial of Disclosing Physicians' Financial Incentives to Patients,* 166 ARCHIVES INTERNAL MED. 623, 623 (2006) (finding disclosure of physician financial incentives enhanced patient loyalty to their physician groups and that more patients reported trusting their doctors more because of the disclosure than those who reported trusting their doctors less).

132. *See* George Loewenstein et al., *The Unintended Consequences of Conflict of Interest Disclosure,* 307 JAMA 669, 669–70 (2012) (explaining how "insinuation anxiety" can result from disclosure of financial interests, which can decrease patient trust but increase a patient's willingness to follow their physician's advice).

misinformation has recurred, and often reached broad segments of the public, throughout the history of American medicine.[133] And yet physicians as a group have continually enjoyed high social status, commanding significant public trust compared to other professions.[134] Patients develop stickiness in their current treatment relationships and, even if concerned about a physician's reliability, likely find it difficult to contemplate withdrawing from their physician.[135] Patients also place trust in their personal physicians from starting conditions of vulnerability, in order to activate the process of healing. This intrinsic basis for patient trust may be more powerful and stable across different settings than information that might erode trust.[136] Further, patients may quite comfortably distinguish their negative views of individual physicians spreading misinformation from their views about medicine generally, as "trust in the system of medicine can survive even when individual professionals violate that trust."[137]

Thus, the loss-of-trust rationale likely over-generalizes. It appears to assume, without sufficient behavioral evidence, that physicians spreading misinformation publicly will automatically threaten trust in physicians and medicine across the board. Yet, it is more likely that physician-spread misinformation will impact patient trust with varying severity across different misinformation contexts. For example, patients might continue to have significant trust in medicine even when learning that some physicians misrepresent experimental products as approved, believing physicians are simply zealous in trying to deliver cutting-

133. *See supra* notes 61–65 and accompanying text.

134. *See* Megan Brenan, *Nurses Retain Top Ethics Rating in U.S., but Below 2020 High*, GALLUP (Jan. 10, 2023), https://news.gallup.com/poll/467804/nurses-retain-top-ethics-rating-below-2020-high.aspx [https://perma.cc/GU6E-ZSVB] (indicating that 62 percent of persons surveyed viewed physicians as having very high/high honesty and ethical standards, ranking only behind nurses among all professions, a relative ranking result consistent with earlier Gallup polls over the years).

135. *See* Genevieve Pham-Kanter, *Act II of the Sunshine Act,* 11 PLOS MED. e1001753, e1001754 (2014) (noting the "time and effort costs involved in switching [physicians] may be too large" even if patients would prefer to switch).

136. Hall, *supra* note 130, at 507–08.

137. *Id.* at 508.

edge treatments for their patients.[138] Whereas patients might develop far more negative views of medicine when some physicians falsely promote ineffective treatments, as this calls into question the value of medical knowledge.

Other commentators see a pathway for medical board sanction, without running afoul of the First Amendment, when physicians provide false or misleading medical information to the public for direct financial or personal benefit.[139] This could include physicians who promote unproven "natural" products for treating COVID-19, to drum up sales orders from which they will profit, or try to achieve public notoriety to attract new patients. Medical board sanction in this context might similarly be justified as the only available remedy to mitigate the harm of undermining trust in the medical profession, lest the public ends up believing physicians spread misinformation for economic self-interest.[140] Medical board action would also help complement and vindicate possible fraud claims governing such deceptive conduct under statutory and common law.[141] Indeed, separate civil judgments against a physician for fraud provide strong grounds for licensure discipline, as Medical Practice Acts often make it an actionable offense to obtain practice business or anything of value through false representations.[142] Finally, some commentators still see room for medical board regulation of physician speech, even with strict scrutiny applied, when a strong evidentiary record shows how this avoids harm to patients. Such evidence may be more easily identified by medical boards than in

138. Because of the widespread occurrence of "therapeutic misconception," in which "patient-subjects," researchers, and clinicians have a "mistaken belief that decisions about [the patients'] personal medical care are being made solely for [their] benefit while [they are] a participant in a research study," many patients conflate experimental interventions with ordinary clinical care and may have overly optimistic views about access to experimental services. Jennifer B. McCormick, *How Should a Research Ethicist Combat False Beliefs and Therapeutic Misconception Risk in Biomedical Research?*, 20 AMA J. ETHICS 1100, 1100–02 (2018).

139. *See* Sage & Yang, *supra* note 12, at 1444 (noting licensing boards can probably sanction a physician for false communications "offered to obtain a financial or personal benefit").

140. *See id.*

141. *See infra* Part IV.B.

142. *See, e.g.*, N.C. GEN. STAT. § 90-14(a)(8) (authorizing the medical board to discipline a physician who "[b]y false representations has obtained or attempted to obtain practice, money or anything of value").

other professional contexts because the consequences of poor decision-making tend to be so grave in healthcare.[143] This may make lower courts more wary of overturning medical board regulation even when speech-restrictive.

In sum, medical board sanctions on physicians' public communications, not in the course of treating a patient, are more susceptible to First Amendment challenges and may have difficulty passing strict scrutiny. Nonetheless, a pathway may exist for surviving strict scrutiny review in particular contexts. This includes when licensure sanction, not counterspeech, seems the only effective remedy as well as when medical board action complements corresponding common law and statutory fraud claims arising from false physician statements.

2. Medical Practice Acts

Medical Practice Acts, the enabling statutes for medical boards, provide unclear authority for disciplining physicians who spread misinformation publicly. As previously noted, the sanction against Oregon physician Dr. LaTulippe for disseminating false claims is an outlier.[144] Oregon's Medical Practice Act broadly allows for discipline of "[u]nprofessional or dishonorable conduct," defined to include actions "detrimental to the *best interests of the public*."[145] This extends to "*any* conduct or practice which does or might constitute a danger to the health or safety of a patient *or the public*."[146]

Other Medical Practice Acts are seemingly narrower in application. First, most statutes focus on regulation of the "practice of medicine," usually defined as general "holding out" to the

143. Robertson & Hoffman, *supra* note 123, at 2095 ("Bad advice on medical matters is far more likely to lead to physical injury or even death, and these consequences cannot be undone by financial compensation. This may explain, in part, lower courts' efforts to uphold speech-restrictive regulations related to health care." (footnote omitted)). Relatedly, Claudia Haupt has argued for a more robust understanding of harm in professional free speech cases. Haupt, *supra* note 11, at 49–50. Haupt contends that tailored discipline of physicians providing "pseudo-professional advice" to the public can be justified under First Amendment principles because it aligns with the broader conceived harm-avoidance function of (1) ensuring professionals render competent advice generally and (2) facilitating the critically needed ability of professional communities to maintain expertise knowledge standards. *Id.* at 47–51.

144. *See supra* notes 105–12 and accompanying text.

145. OR. REV. STAT. § 677.188(4) (2023) (emphasis added).

146. *Id.* § 677.188(4)(a) (emphasis added).

public as authorized to provide medical services, "offering or undertaking to prevent or to diagnose, correct, and/or treat . . . by any means . . . any . . . infirmity," prescribing medical products, or offering surgical procedures.[147] Such broad language could cover communications to the public likely to be perceived and acted on by the audience as medical advice. Nonetheless, it remains debatable whether communications directed to the general public should fairly fall under these statutory definitions of "practice of medicine."[148] The "holding out" concept is ordinarily meant to police unlicensed practitioners from posing as physicians.[149] Considering every public communication of an already licensed physician as the "practice of medicine" would have problematically broad application, sweeping in comments that are intrinsically distinct from patient-directed claims and heavily burdening physicians to take on demanding professional responsibilities in all sorts of contexts. When a physician makes public statements, she is not communicating with a patient within a healing relationship where patient trust has been specially reposed in the physician. Nor is there a reasonable expectation that the physician will provide individually tailored medical consultation after patient examination or review of a medical history or record.[150] Yes, there is still a risk that non-patients may interpret a physician's public claims as medical advice. But individuals regularly come across conflicting medical views and multiple sources of health information expressed in public communications, some of which they will heed and some of which they will ignore.[151] This is qualitatively different than the strong deference a patient can be expected to give her personal physician.

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147. *See, e.g.*, *Essentials of a State Medical and Osteopathic Practice Act*, FED'N OF STATE MED. BDS. 5 (Apr. 2015) [hereinafter *FSMB Model Act*], https://www.fsmb.org/siteassets/advocacy/policies/essentials-of-a-state-medical-and-osteopathic-practice-act.pdf [https://perma.cc/8PLV-RGCN].

148. *See* Baron & Ejnes, *supra* note 75 (noting the lack of clarity whether physicians' posts on social media constitutes medical practice).

149. *See, e.g.*, Minn. Stat. § 147.081 subdiv.3(1) (defining the practice of medicine, in part, as "hold[ing] out to the public . . . that the person is authorized to practice medicine" in Minnesota's criminal statute detailing the crime of practicing medicine without a license).

150. Coleman, *supra* note 12, at 141 ("[W]hen physicians make public statements about medical matters, they are not speaking to an individual who has entrusted them with providing individually tailored medical guidance.").

151. *Id.*

Second, even if purely public communications can be considered "the practice of medicine," Medical Practice Acts authorize discipline for only statutorily enumerated conduct that occurs during the practice of medicine. Most disciplinary offenses concern a physician's activities with a patient, such as prescribing medications without a medical purpose.[152] Very few statutes impose obligations on a physician to protect the health of non-patients and the general public, except for disease reporting obligations, which tend to be minimally enforced.[153] The patient-centered focus of Medical Practice Acts is consistent with the common law. Courts typically hold that physicians owe duties first and foremost to their patients, with other obligations necessarily inferior.[154]

Several Medical Practice Acts contain open-ended "harm to the public" language as potential grounds for physician discipline, similar to the provisions in the Oregon statute relied upon to sanction Dr. Steven LaTulippe.[155] However, in the fair number of other states with narrower statutes, "boards may be limited to only considering those infractions that occur within the context of a physician-patient relationship or only during the provision of medical care to patients."[156]

Even in states with Medical Practice Acts that have broad "harm-to the public" language, it seems that medical boards do not regularly enforce such a standard on the ground. The overwhelming majority of serious medical board disciplinary actions involve complaints of physicians impaired by drugs and alcohol, engaged in sexual relations with patients, and other patient care

152. *See, e.g.*, MINN. STAT. § 147.091(s) (2023).

153. *See* Saver, *supra* note 14, at 939–40 ("There is a noteworthy dearth of professional licensure actions for conduct involving harm to non-patients and the health of the community.").

154. *See infra* notes 180–82 and accompanying text.

155. *See supra* notes 145–46 and accompanying text. For example, Illinois' statute provides for sanction for "unprofessional conduct of a character likely to deceive, defraud, or harm the public." 225 ILL. COMP. STAT. 60/22(A)(5) (2023). Likewise, the FSMB's model Medical Practice Act authorizes discipline for "conduct likely to deceive, defraud, or harm the public," or "any conduct that may be harmful to the patient or the public." *FSMB Model Act*, *supra* note 147, § IX(D)(4), (52), (54).

156. *Professional Expectations Regarding Medical Misinformation and Disinformation*, FED'N OF STATE MED. BDS. 8 (Apr. 2022) [hereinafter *FSMB Ethics Report*], https://www.fsmb.org/siteassets/advocacy/policies/ethics-committee-report-misinformation-april-2022-final.pdf [https://perma.cc/Y6DJ-QXUK].

concerns.[157] There is simply a dearth of professional disciplinary actions for physician conduct involving harm to non-patients and the health of the public generally. This is against a backdrop of limited medical board discipline for *any* reason.[158]

In the rare cases when conduct outside the doctor-patient relationship is relied upon as grounds for discipline, it has been for offenses like tax fraud, criminal conviction, shoplifting, and possession of marijuana for personal use.[159] For these limited instances, catch-all "unprofessional conduct" language in many Medical Practice Acts can be used to justify sanctioning physicians for activities beyond treating patients.[160] The general rationale is that questionable, untrustworthy conduct reflects negatively on the physician's fitness, character, or competence to practice medicine.[161] However, it seems fairly arbitrary why certain actions, like tax fraud, are deemed sufficiently probative of the physician's professionalism and suitability for practicing medicine. Dishonest conduct in non-patient-care contexts may be objectionable and disappointing, but this does not mean that the physician similarly engages in deception in the clinic or lacks expert medical skills. The few cases to address somewhat

157. James M. DuBois et al., *Serious Ethical Violations in Medicine: A Statistical and Ethical Analysis of 280 Cases in the United States from 2008–2016*, 19 AM. J. BIOETHICS 16, 16 (2019) ("Nearly all [physician ethical misconduct] cases involved repeated instances (97%) of intentional wrongdoing (99%), by males (95%) in nonacademic medical settings (95%), with oversight problems (89%) and a selfish motive such as financial gain or sex (90%). More than half of cases involved a wrongdoer with a suspected personality disorder or substance use disorder (51%)."). *See also* Linda M. Richmond, *4 Common Reasons Doctors Get Disciplined by State Medical Boards*, MDLINX (Apr. 23, 2021) https://www.mdlinx.com/article/most-common-reasons-doctors-get-disciplined-by-state-medical-boards/5p7yNlCEzZbBUBMw0cAUEK [https://perma.cc/8FJ9-H7L8] (noting that the most common reasons for medical board censure include sexual harassment/abuse of patients, physician impairment by drugs and alcohol, and general negligence/incompetence).

158. *See infra* notes 242–48 and accompanying text.

159. *See* Coleman, *supra* note 12, at 125; *In re* Revocation of the License to Practice Medicine and Surgery of Jean D. Kindschi, 319 P.2d 824, 827 (Wash. 1958) (affirming suspension of physician who pled guilty to filing false tax returns); Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline,* 13 J. HEALTH CARE L. & POL'Y 285, 305–06 (2010) (identifying common reasons for medical license suspension).

160. *See, e.g.*, OR. REV. STAT. § 677.190(1)(a) (2023) (authorizing the medical board to discipline licensed physicians for "[u]nprofessional or dishonorable conduct").

161. Coleman, *supra* note 12, at 138–39.

extraneous, deceptive activities as constituting unprofessional conduct are not very persuasive in their reasoning.[162] Instead, they tend to equate, in broad, conclusory fashion, any conduct indicating untrustworthiness, however unrelated to healthcare, with a physician's unfitness to practice medicine.[163] Several of these cases also assume that any deceitful activity by a physician will diminish public trust in the profession, resulting in patients less likely to follow medical advice.[164] However, as discussed previously, it is all too easy to over-generalize the loss-of-trust rationale.[165] Further, such heavy reliance on loss of public trust as a rationale for discipline problematically shifts the inquiry about a physician's licensure status away from the physician's intrinsic abilities for medical practice to the mysterious, often nonclinical, and highly subjective reasons why individuals have faith in their personal doctors.[166]

A seemingly more persuasive argument supporting discipline, even operating under a Medical Practice Act that

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162. *See* Sawicki, *supra* note 159, at 317 ("[M]ost courts attempting to define fitness to practice or explain how a particular category of professional misconduct relates to professional fitness are able to offer little more than circular reasoning in support of their conclusions.").

163. For example, in *In re Kindschi*, the Supreme Court of Washington upheld the medical board's temporary suspension of Dr. Kindschi's medical license following his guilty plea of tax fraud. 319 P.2d at 827. The Medical Practice Act at the time defined "unprofessional conduct" to include conviction of "any offense involving moral turpitude." OR. REV. STAT. ANN. § 18.72.030(1) (West 1955) (repealed 1986). After reasoning that tax fraud should be understood as a crime of moral turpitude, the court could have simply applied the Medical Practice Act provisions, which seemed to then automatically require the licensure suspension. Nonetheless, in very broad language that would seemingly make any dishonest conduct in any sphere of a physician's life as grounds for professional discipline, the court further opined that "[t]he public has a right to expect the highest degree of trustworthiness of the members of the medical profession. We believe there is a rational connection between income tax fraud and one's fitness of character or trustworthiness to practice medicine . . . ." *In re* Kindschi, 319 P.2d at 826.

164. *See* Haley v. Med. Disciplinary Bd., 818 P.2d 1062, 1069 (Wash. 1991) ("Being convicted of tax fraud does not indicate any lack of competence in the technical skills needed to be a physician. Rather, it indicates a lack of the high degree of trustworthiness the public is entitled to expect from a physician. . . . [A]nd it diminishes the profession's standing in the public eye. Trust is essential to ensure treatment will be accepted and advice followed.").

165. *See supra* notes 129–37 and accompanying text.

166. *See* Sawicki, *supra* note 159, at 311–12 (criticizing the loss-of-trust rationale on these grounds).

authorizes sanction for only primarily patient-directed conduct, is that a physician's public spread of misinformation suggests a high likelihood that the physician is also communicating the same false claims as medical advice while treating actual patients.[167] This would, in turn, support following patient-centered grounds for discipline expressly authorized under Medical Practice Acts, such as failure to follow acceptable medical standards of care in treating patients.[168] A physician's false public claims might also call into question the physician's medical knowledge, triggering competence grounds for discipline under various Medical Practice Acts related to the inability to practice medicine with a reasonable degree of skill and safety for patients.[169]

However, bootstrapping acts of public misinformation to treatment conduct with patients also raises certain problems in terms of the government's burden of proof. Indirect evidence, at best, of a physician's patient activities or competence in the clinic, inferred from public comments, may not be sufficient to satisfy the preponderance of the evidence standard applicable to the majority of state medical boards.[170] Such indirect evidence is even less likely to meet the higher standards applicable to other boards.[171] It is not uncommon for individuals to comment publicly in ways that they may not act privately, and the same holds true for physicians. While adhering to customary professional standards in their patient interactions and rendering medical services with sufficient skill, physicians may be intentionally provocative with their public statements to foster general debate or further inquiry about certain topics. Physicians may also choose to be more careful and practice between the lines in their patient, but not public, activities, because of malpractice liability

167. *See FSMB Ethics Report*, *supra* note 156, at 9 (recommending state medical boards consider whether the disinformation "indicate[s] high likelihood that same disinformation is being provided to patients," among other factors).

168. *See, e.g.*, N.C. GEN. STAT. § 90-14(a)(6) (2023) (defining "[u]nprofessional conduct" as including "departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice").

169. *See, e.g.*, *id.* § 90-14(a)(11) (2023) (authorizing medical board discipline for "[l]ack of professional competence to practice medicine with a reasonable degree of skill and safety for patients").

170. *See* Pendo et al., *supra* note 81, at 36–37 (finding that thirty-five states use a preponderance of the evidence standard in medical board proceedings and explaining that standard's requirements).

171. *See id.* (discussing state courts requiring the higher clear and convincing standard in state medical board disciplinary cases).

concerns. Also, as a matter of fairness and policy, given the severe consequences of licensure restriction, if medical boards want to discipline physicians for their patient-directed conduct, the case should be made more directly. Evidence of substandard care with patients is not hard to come by.[172] A medical board can investigate and obtain medical records, prescription orders, and other information to identify more tangible indications of substandard patient care before imposing discipline.

Some Medical Practice Acts authorize sanctioning physicians for false or misleading statements to the public, which would seemingly cover many instances of medical misinformation. But this is usually limited to advertising or solicitations, as an attempt to protect potential patients who may follow up with the physician for services or products, as opposed to regulating more general public statements.[173] Meanwhile, other Medical Practice Acts offer seemingly broad discretion for medical boards to impose discipline for general deceitful conduct, not necessarily only advertising, such as the Alaska statute that allows sanction for "deceit, fraud, or intentional misrepresentation."[174] However, a limiting consideration is that the Alaska law, similar to other Medical Practice Acts, contemplates that the deceitful conduct occurs "*while providing professional services or engaging in professional activities*."[175] Thus, there is a cart-before-the-horse problem. If making statements to the public is not considered a professional medical activity for a typical private physician, or not even recognized as the "practice of medicine" per the earlier discussion of that term, then general communications to the public, even if deceitful, should not trigger these statutory reasons for discipline.

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172. *See, e.g.*, Washington v. Cranmer, 20 N.E.3d 613, 617–19 (Mass. App. Ct. 2014) (finding a patient's submission of medical records and an expert opinion letter from a board-certified neurologist sufficient evidence of malpractice to preclude dismissal).

173. *See, e.g.*, CAL. BUS. & PROF. CODE § 651(a) (2023) ("It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to include . . . the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed.").

174. ALASKA STAT. § 08.64.326(a)(2) (2023).

175. *Id.* (emphasis added).

To truly resolve the unclear statutory authority problem, Medical Practice Acts in many states may need amending to expressly identify spreading medical misinformation as a disciplinary offense. Illustrating the concerns about unclear statutory authority, California legislators recently enacted a law amending the state Medical Practice Act to expressly provide that it was "unprofessional conduct" for a physician to "disseminate misinformation or disinformation related to COVID-19."[176] While the law helpfully clarified that spreading misinformation was both unprofessional and a licensure offense, it also remained fairly limited in scope. It applied only to physician communications "to a patient under the [physician's] care in the form of treatment or advice" and did not extend to physician statements to the general public.[177] The California legislation exemplifies the difficulty in empowering medical boards to sanction physician conduct outside the doctor-patient relationship.

3. The Flawed Malpractice Analogy

Many commentators, in advocating for licensure discipline, have characterized physicians publicly spreading medical misinformation as engaging in "malpractice." For example, Dr. Richard Friedman, writing in *The New York Times*, opined that "[w]hen doctors use the language and authority of their profession to promote false medical information . . . . they have crossed the line from free speech to medical practice—or, in this case, something akin to malpractice."[178] While powerfully dramatic, the malpractice analogy does not have firm legal support.

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176. CAL. BUS. & PROF. CODE § 2270(a) (West 2023). As previously noted, a federal judge had temporarily enjoined enforcement of the new California law, finding it unconstitutionally vague. *See supra* notes 22–23 and accompanying text. Even more recently, the California legislature repealed the medical misinformation law. *See supra* note 19.

177. CAL. BUS. & PROF. CODE § 2270(b)(3) (West 2023); *see also* Corinne Purtill, *Doctors Fear California Law Aimed at COVID-19 Misinformation Could Do More Harm Than Good,* L.A. TIMES (Oct. 6, 2022), https://www.latimes.com/science/story/2022-10-06/spreading-lies-about-covid-19-could-get-doctors-disciplined-in-california [https://perma.cc/CM8M-LL2T] (reporting that the new law would only apply to communications between physicians and patients about the patient's care and not physicians' COVID-19-related posts on social media).

178. Friedman, *supra* note 7. Similarly, bioethicist Arthur Caplan, in contending free speech concerns should not impede medical board action, analogized spreading misinformation to providing negligent medical treatment and actionable malpractice. *See* Rubin, *supra* note 51, at 906.

First, "malpractice" actions generally arise under state tort law and are initiated by patients alleging harm, not medical boards.[179] Second, even if a malpractice action involved a non-patient as the plaintiff, it would have to clear many hurdles, including most importantly the absence of a doctor-patient relationship. Physicians' traditional legal obligations actionable in a malpractice action, including the duties of care, confidentiality, and non-abandonment, generally arise only from the formation of a treatment relationship with a specific patient.[180]

Indeed, physicians generally do not have open-ended duties to attend to the health of non-patients and the wider public. The unwillingness to impose community health obligations reflects courts' concerns with infeasible liability pressures, too many potential plaintiffs, unworkable standards, and maintaining patient-centeredness to reinforce physicians' ethical and quasi-fiduciary obligations to put their patients' interests first.[181] Courts have allowed actions by non-patients against physicians in only narrow situations, such as protecting an identifiable third party who may be at risk of contracting an infectious disease because of close contact with the physician's patient.[182]

Even if a duty could be established between a non-patient and the physician, difficult issues arise in establishing causation. A member of the public is likely exposed to a wide variety

179. *See, e.g.*, MINN. STAT. § 541.076(b) (2023) ("An action by a patient or former patient against a health care provider alleging malpractice, error, mistake, or failure to cure . . . must be commenced within four years from the date the cause of action accrued.").

180. *See, e.g.*, LaFleur v. Jetzer, No. 4:14-CV-04175-KES, 2015 WL 6157745, at *5 (D.S.D. Oct. 20, 2015) (noting that most courts do not recognize medical malpractice claims arising out of independent medical evaluations for benefits claims because a doctor-patient relationship has not been formed).

181. *See, e.g.*, Ellis v. Peter, 627 N.Y.S.2d 707, 709 (N.Y. App. Div. 1995) ("'[A] physician's duty of care is ordinarily one owed to his or her patient' and does not extend to the 'community at large.'") (quoting Purdy v. Pub. Adm'r of Cnty. of Westchester, 72 N.Y.2d 1, 9 (N.Y. 1988); Eiseman v. State, 70 N.Y.2d 175, 188 (N.Y. 1987)); *see also* Saver, *supra* note 14, at 932–36 (noting that while courts have on occasion found physicians to have duties to patients' spouses and other third parties closely connected to patients, these duties are narrow and generally do not apply to the general public).

182. *See* Doe v. Cochran, 210 A.3d 469, 472 (Conn. 2019) ("[A] physician who mistakenly informs a patient that he does not have a sexually transmitted disease (STD) may be held liable in ordinary negligence to the patient's exclusive sexual partner for her resulting injuries when the physician knows that the patient sought testing and treatment for the express benefit of that partner.").

of medical information and misinformation, generated from multiple sources. In addition, she might experience significant intervening events, including a change in medical condition or receiving treatment with another healthcare professional, between seeing a physician's false public claims and acting on the claims, as well as between acting on the claims and eventually developing injury. It would become daunting to show, consistent with the preponderance of the evidence standard required for a tort action, that a particular physician's public statements were the "but for" factual cause of the non-patient's harm.[183]

Admittedly, commentators using the "malpractice" term might intend it, in a less technical legal sense, to mean catch-all unprofessional conduct falling below agreed-upon standards, rather than a traditional tort claim. This comes much closer to what medical boards traditionally regulate. But this still begs the question: what clearly defined standard is not being met when physicians spread misinformation outside of a doctor-patient relationship? As discussed previously, many Medical Practice Acts do not expressly provide that spreading misinformation publicly is grounds for discipline, and it is at least debatable whether public communications even constitute professional medical conduct.

Even construing "malpractice" in its broader sense leads to another difficult question: malpractice with regard to whom? Dr. Richard Friedman argued that medical boards should undertake discipline "especially when the 'patient' in question is the nation" as the harm done in these situations is far greater than what may occur with a single patient encounter.[184] But this would mean conceiving of the public as a private physician's patient, or at least a focal point of the physician's legal obligations. This extends far beyond how physicians' legal duties have traditionally been recognized. It may indeed be beneficial and socially optimal to reconceptualize physicians' responsibilities to account more expressly for securing the health of the community. Under

183. *See, e.g.*, Alex Stein, *Toward a Theory of Medical Malpractice*, 97 IOWA L. REV. 1201, 1217 (2012) (observing that because providers can point to the patient's "preexisting medical condition and other circumstances for which they are not responsible[,] . . . . causation in a medical malpractice case [presents] an extremely complex issue").

184. Friedman, *supra* note 7.

current law, however, physicians' duties to protect the public's health are very elusive and rest on unsteady legal ground.[185]

4. Mixed and Under-Theorized Ethics Guidance

The catch-all "unprofessional conduct" provision as a disciplinary offense in many Medical Practice Acts can be interpreted as ensuring that physicians follow medicine's commonly understood ethical standards.[186] Other Medical Practice Acts expressly provide for sanction of physicians for violating the American Medical Association's Code of Medical Ethics (AMA Code) or similar guidance.[187] Thus, it is important to account for professional ethical perspectives when considering the legal basis for medical board discipline.

Some commentators look back as far as the famous guidance from Hippocrates, and the oft-repeated maxim that physicians should "first, do no harm,"[188] as demonstrating why it is unethical for physicians to spread misinformation publicly. Under this view, the do-no-harm obligation "transcends individual patient-physician encounters to situations in which physicians make medical recommendations for populations."[189] However, this interpretation may be more aspirational than clear-cut. It reads the do-no-harm obligation very broadly as applying to conduct with non-patients. Traditional medical ethics instruction, however, has generally equated the do-no-harm approach with the bioethical principle of nonmaleficence, which is seen as patient-focused, reflecting "a fundamental commitment on the part of

185. *See* Saver, *supra* note 14, at 939–40 (discussing state statutes that could be read expansively to impose on physicians a responsibility to the public but are instead enforced narrowly).

186. Pizzo et al., s*upra* note 48, at 723–24.

187. *See, e.g.*, OHIO REV. CODE ANN. § 4731.22(B)(18) (West 2023) (authorizing medical board disciplinary action against physicians who violate "any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations that the board specifies by rule").

188. *See* Robert H. Shmerling, *First, Do No Harm,* HARV. HEALTH PUBL'G: HARV. HEALTH BLOG (June 22, 2020) https://www.health.harvard.edu/blog/first-do-no-harm-201510138421 [https://perma.cc/7TSP-B8TB] (describing the "do no harm" principle).

189. Pizzo et al., *supra* note 48.

health care professionals to protect *their patients* from harm."[190] Likewise, most medical school graduates take formal pledges, often based on the Hippocratic Oath, in which they promise to put the patient's welfare first.[191] But these pledges mention public-directed obligations far less frequently, if at all.[192]

The more common source of ethics instruction, the AMA Code, has limited guidance on point. Principle V of the AMA Code states that a physician "shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, *make relevant information available to patients, colleagues, and the public*, obtain consultation, and use the talents of other health professionals when indicated."[193] Meanwhile, Principle VII provides that a physician "shall recognize a responsibility to *participate in activities contributing to the improvement of the community and the betterment of public health*."[194] Some commentators read the two provisions together, particularly the emphasized language, to mean that a physician has an ethical obligation to share truthful medical information with the public, in order to improve community health.[195] This interpretation has been extended even further to contend that a physician also has an ethical responsibility to correct medical misinformation reaching the public, even if the physician did not originate or spread the claim.[196]

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190. Thomas R. McCormick, *Principles of Bioethics*, UNIV. OF WASH. SCH. OF MED. DEP'T OF BIOETHICS & HUMANS., https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/articles/principles-bioethics [https://perma.cc/3XWS-TNWK] (emphasis added).

191. *See* Audiey C. Kao & Kayhan P. Parsi, *Content Analyses of Oaths Administered at U.S. Medical Schools in 2000*, 79 ACAD. MED. 882, 88 (2004) (finding that 81.6 percent of oaths studied included a promise to put the "health and life of [the] patient" first).

192. *Id.* (finding that only 19.1 percent of oaths studied included a promise to "aid[] in the general welfare of the community").

193. *AMA Principles of Medical Ethics*, AMA CODE OF MED. ETHICS [hereinafter *AMA Principles of Medical Ethics*] (emphasis added), https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics [https://perma.cc/6EP2-J6C4].

194. *Id.* (emphasis added).

195. *See, e.g.*, Joel T. Wu & Jennifer B. McCormick, *Why Health Professionals Should Speak out Against False Beliefs on the Internet,* 20 AMA J. ETHICS 1052, 1055 (2018) ("Taken together, these principles articulate an ethical obligation to make relevant information available to the public to improve community and public health.").

196. *Id.*

Additional provisions of the AMA Code touch indirectly on false communications to the public. Principle II provides that a physician "shall uphold the standards of professionalism [and] *be honest in all professional interactions*."[197] Relatedly, AMA Code of Medical Ethics Opinion 2.3.2, addressing physicians' use of social media, reminds physicians to ensure that "professional information on their own sites . . . is *accurate and appropriate*."[198] And, likewise, AMA Code of Medical Ethics Opinion 8.12 advises physicians communicating with the media to be mindful of their obligations not just to patients but also "the public[] and the medical profession" and to ensure that the information they provide is "accurate" and "based on valid scientific evidence and insight gained from professional experience."[199]

Thus, a plausible interpretation of the AMA Code and relevant ethical opinions, read in combination, is that physicians have an ethical responsibility to disseminate only accurate medical information when communicating publicly. But the strength and degree of this obligation remain questionable. For example, Principle II applies only to "professional interactions" and, as previously discussed, it is not always clear that when a physician communicates to the public, not in the course of patient care, she engages in a professional interaction.[200] Meanwhile, the heavy reliance on Principles V and VII regarding a physician's commitment to educate the public and improve community health glosses over the fact that any public health role envisioned by the AMA Code for private physicians is necessarily secondary and inferior to the clearer command that physicians act for the benefit of the patients that they actually treat. This is reflected in Principle VIII's instruction that a physician "shall, while caring for a patient, *regard responsibility to the patient as paramount*."[201] Because of the strong patient-centered framework of the AMA Code, even commentators arguing that physicians have such a public ethical responsibility concede that "[t]he

197. *AMA Principles of Medical Ethics*, *supra* note 193 (emphasis added).

198. *Opinion 2.3.2: Professionalism in the Use of Social Media*, AMA CODE OF MED. ETHICS, https://www.ama-assn.org/delivering-care/ethics/professionalism-use-social-media [https://perma.cc/V73B-L3Z5].

199. *Opinion 8.12: Ethical Physician Conduct in the Media*, AMA CODE OF MED. ETHICS, https://www.ama-assn.org/delivering-care/ethics/ethical-physician-conduct-media [https://perma.cc/PT5D-VD32].

200. *AMA Principles of Medical Ethics*, *supra* note 193.

201. *Id.* (emphasis added).

professional obligation to confront false health beliefs and information is more straightforward *within a clinical setting*."[202] If a physician's public spread of misinformation, beyond the clinical setting, violates clearly understood ethical standards, why does the AMA Code lack stronger recognition of a physician's overall responsibilities for the health of non-patients?

Commentators often justify physicians' ethical responsibilities to confront medical misinformation with their well-positioned ability to do so.[203] However, their special skills and capabilities to prevent harm do not inevitably mean that physicians' ethical responsibilities extend into all sorts of non-clinical settings, as this could become quite a slippery slope. After all, the AMA Code also provides that physicians generally have ethical discretion to decline to treat individuals in non-emergency situations in the absence of an established doctor-patient relationship.[204] This ethical latitude exists even though a physician's failure to use her special skills and capabilities may lead to the non-patient's therapeutic decline. It is not clear, therefore, why a strong ethical responsibility to combat public misinformation should be imposed when a physician can ethically decline to treat non-patients; failure to treat can have a more direct and foreseeable negative impact than the spread of misinformation.[205]

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202. Wu & McCormick, *supra* note 195 (emphasis added).

203. *See, e.g.*, Jack Resneck Jr., *Turning the Tide Against Medical Disinformation Will Take All of Us*, AM. MED. ASS'N (Oct. 5, 2022), https://www.ama-assn.org/about/leadership/turning-tide-against-medical-disinformation-will-take-all-us [https://perma.cc/2W97-GNWM] (calling on physicians to combat the spread of medical disinformation, which "should alarm all [physicians] who have taken an oath to protect . . . patients from harm").

204. *Opinion 1.1.2: Prospective Patients*, AMA CODE OF MED. ETHICS, https://code-medical-ethics.ama-assn.org/ethics-opinions/prospective-patients [https://perma.cc/P6AS-W9X2].

205. Yes, the two situations might be distinguished because one is an act of misfeasance (spreading misinformation) and the other an act of nonfeasance (failure to treat), perhaps justifying different ethical approaches. But conduct characterized as nonfeasance can frequently be recharacterized as misfeasance, while the bioethical principle of nonmaleficence and avoiding harm to patients usually incorporates active wrongdoing (commission) and passive inaction. *See, e.g.*, John M. Adler, *Relying upon the Reasonableness of Strangers: Some Observations About the Current State of Common Law Affirmative Duties to Aid or Protect Others*, 1991 WIS. L. REV. 867, 878–84 (1991) (arguing that the distinction between misfeasance and nonfeasance is difficult to identify and apply consistently); McCormick, *supra* note 190 ("The principle of nonmaleficence

It may very well be preferable to impose stronger ethical responsibilities on physicians to protect community health precisely because they have special capabilities to do so and are uniquely positioned to prevent public health harms.[206] But it should be acknowledged, at a minimum, that assigning special altruistic responsibilities to physicians, outside the context of patient care, aligns awkwardly with the patient-centered focus of traditional medical ethics and creates difficult problems in determining proper boundaries for such non-patient obligations.

One other consideration is whether the current "infodemic" represents an exigent circumstance, akin to a disease pandemic, justifying broader ethical obligations on physicians to act for the community. However, even during pandemics the physician's ethical obligation to care for non-patients is not considered absolute. Other considerations can still outweigh any duty to treat. Current AMA guidance provides latitude to physicians to decline to treat prospective patients during disasters in order to ensure physician availability to provide care in the future, a recognition of the need to avoid overburdening physicians with unbounded obligations to the public generally.[207]

Other interpretations connect physicians' professional obligations concerning misinformation to the importance for the healthcare system to maintain public confidence in medicine. The FSMB's Ethics and Professionalism Committee warned that doctors disseminating falsehoods can dangerously "erod[e] trust in physicians and undermin[e] confidence in the integrity of the

requires of us that we not intentionally create a harm or injury to the patient, either through acts of commission or omission."). This calls into question why failure to treat should be addressed more leniently than spreading misinformation.

206. Saver, *supra* note 14, at 970 ("With physicians in particular, there are strong policy reasons to treat them, even outside the doctor-patient relationship, as different from ordinary individuals. Their actions and inactions with regard to public health risks have more significant, wide-ranging consequences for the community because of their role indispensability to safeguarding the health of the populace.").

207. *See Opinion 8.3: Physicians' Responsibilities in Disaster Response & Preparedness*, AMA CODE OF MED. ETHICS, https://www.ama-assn.org/delivering-care/ethics/physicians-responsibilities-disaster-response-preparedness [https://perma.cc/7JRU-G2V7]; *see also* David Orentlicher, *The Physician's Duty to Treat During Pandemics*, 108 AM. J. PUB. HEALTH 1459, 1460 (2018) ("[P]hysicians could easily use the exceptions in the AMA code to swallow up the rule, especially because the code does not explain how to weigh the needs of current patients against those of future patients.").

medical profession."[208] This ultimately seems the strongest ethical reason for sanctioning physicians: the damaging way misinformation can subvert medicine's ability to command public respect by calling into question physicians' integrity and trustworthiness. However, as previously noted in the discussion of First Amendment considerations, trust operates in healthcare settings in unpredictable ways, and the public's trust in medicine may actually be quite resilient, notwithstanding numerous historical instances of physician-spread misinformation.[209]

Moreover, the "eroding trust" rationale for identifying physician conduct as unethical is awfully broad. For example, physicians who participate in cost containment programs—limiting orders for costly and only marginally effective services—could be accused of acting unethically because this appears as rationing, something highly likely to undermine public trust in medicine. Yet, conserving limited medical resources prudently is considered an ethical, vitally important activity for physicians and endorsed by the AMA Code.[210] Thus, it becomes difficult to discern why possible trust erosion makes publicly spreading medical misinformation so ethically problematic, yet it seemingly matters far less in evaluating other physician activity.[211]

5. Analogy to Ethical Rules for Lawyers Spreading Misinformation

Ethical standards governing the practice of law and medicine are very similar because of the shared emphasis on professional integrity, relational obligations, and the professional's strong loyalty to the client/patient. Thus, it is worth considering

208. *FSMB Ethics Report*, *supra* note 156, at 2.

209. *See supra* notes 129–37 and accompanying text.

210. *Opinion 11.1.2*: *Physician Stewardship of Health Care Resources*, AMA CODE OF MED. ETHICS, https://www.ama-assn.org/delivering-care/ethics/physician-stewardship-health-care-resources [https://perma.cc/S9UT-5C5U].

211. One possible distinction is that it becomes more visible to the community when physicians espouse misinformation publicly compared to when physicians participate in cost containment, making it more likely that physician-spread misinformation impacts public trust negatively. But this distinction may be overbroad as certain forms of physician cost-containment can be salient nonetheless and the public likely has heightened concerns about rationing of medical care. *See, e.g.*, Alan B. Cohen, *The Debate over Health Care Rationing: Déjà Vu All over Again?*, 49 INQUIRY 90, 91 (2012) ("Whatever their source of discomfort, Americans respond negatively to the slightest mention of the word [rationing].").

how legal ethics address the analogous problem of lawyers spreading misinformation, particularly to non-clients and outside of legal proceedings. Attorneys owe a duty of candor to a court and other tribunals in which they appear, reflected in Rule 3.3 of the American Bar Association Model Rules of Professional Conduct (ABA Model Rules).[212] Several professional responsibility rules require lawyers to be truthful even outside the courtroom. ABA Model Rule 4.1, concerning "[t]ruthfulness in statements to others," instructs that a lawyer shall not knowingly "make a false statement of material fact or law to a third person."[213] However, Rule 4.1 only applies to statements a lawyer makes "[i]n the course of representing a client."[214]

More analogous to the situation of a physician spreading misinformation to non-patients is ABA Model Rule 8.4, which addresses maintaining the integrity of the legal profession.[215] Rule 8.4(c) considers it "professional misconduct" for a lawyer to "engage in conduct involving dishonesty, fraud, deceit or misrepresentation."[216] This rule seemingly applies broadly, as it is not expressly limited to attorney conduct within a judicial proceeding, before a tribunal, or in the course of client representation.

However, Rule 8.4(c) has usually been implemented in a narrower fashion. Some commentators suggest that it is typically enforced only when additional corresponding violations of other professional ethical rules also occur, rather than sanctioning stand-alone false public claims.[217] The rule expressly has no knowledge or mental state elements. Yet several jurisdictions interpret the rule as requiring, before sanctions can be applied, evidence that the attorney knew her statements were false, analogous to the tort of intentional misrepresentation or some degree of attorney culpability beyond mere negligence.[218] Further, some scholars have interpreted the official commentary to Rule 8.4 as suggesting that lawyers should not be sanctioned under the rule

212. MODEL RULES OF PRO. CONDUCT r. 3.3 (AM. BAR ASS'N 2023).

213. MODEL RULES OF PRO. CONDUCT r. 4.1 (AM. BAR ASS'N 2023).

214. *Id.*

215. MODEL RULES OF PRO. CONDUCT r. 8.4 (AM. BAR ASS'N 2023).

216. *Id.* r. 8.4(c).

217. *See, e.g.*, Renee Knake Jefferson, *Lawyer Lies and Political Speech*, 131 YALE L. J. F. 114, 130 (2021) ("[Rule 8.4(c)] is typically enforced only in connection with additional ethics rule violations.").

218. *See* Noelle N. Wyman & Sam Heavenrich, *Vaccine Hesitancy and Legal Ethics*, 35 GEO. J. LEGAL ETHICS 1, 15 (2022).

for dishonest conduct unless the conduct is also otherwise unlawful.[219]

Questions about lawyers' unprofessional conduct in publicly spreading misinformation surfaced dramatically following the 2020 presidential election. Attorneys for former President Trump, including Sidney Powell and Rudy Giuliani, promoted false conspiracies of election fraud, inviting calls for their professional discipline.[220] The New York Bar filed a high-profile ethics complaint against Giuliani, relying upon the New York equivalent standards to ABA Model Rules 4.1 and 8.4(c).[221] A state court upheld the New York Bar's suspension of Giuliani's license to practice law.[222] The court concluded discipline was justified because of Giuliani's "demonstrably false and misleading statements to courts, lawmakers and *the public at large*."[223] The court warned that the misinformation disseminated by Giuliani risked damaging public confidence in government generally.[224] Further, the court emphasized that an attorney spreading false statements tarnishes the integrity of the legal profession by calling into question "its mandate to act as a trusted and essential part of the machinery of justice" and undermining an attorney's important role "as a crucial source of reliable information."[225]

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219. Andrew M. Perlman, *The Legal Ethics of Lying About American Democracy*, *in* BEYOND IMAGINATION? THE JANUARY 6 INSURRECTION 13 (West Academic Publishing) (forthcoming 2022) (arguing that the discussion concerning the need to discipline attorneys for illegal conduct in Comment 2 of Rule 8.4(c) "strongly impl[ies] that lawful conduct should not be a basis for discipline"); MODEL RULES OF PRO. CONDUCT r. 8.4(C) cmt. 2 ("Many kinds of illegal conduct reflect adversely on fitness to practice law, such as offenses involving fraud and the offense of willful failure to file an income tax return. However, some kinds of offenses carry no such implication.").

220. Heidi Przybyla, *Despite Rebukes, Trump's Legal Brigade Is Thriving*, POLITICO (July 5, 2022), https://www.politico.com/news/2022/07/05/trump-maga-lawyers-00043917 [https://perma.cc/WJ4A-HFV9] (reporting on groups and individuals advocating for professional discipline against attorneys who brought frivolous suits alleging claims of widespread voter fraud in the wake of the 2020 election).

221. *In re* Giuliani, 146 N.Y.S.3d 266, 268 (N.Y. App. Div. 2021).

222. *Id.*

223. *Id.* (emphasis added).

224. *Id.* at 283.

225. *Id.*

Giuliani faces a similar ethics complaint filed by the D.C. Bar, and that disciplinary action is still ongoing.[226]

On the one hand, the Giuliani example offers strong support for the idea that a professional should receive sanction for spreading false information to the public on matters within her professional expertise. The rationales offered by the New York court mirror justifications previously discussed for sanctioning physician-spread misinformation: maintaining the integrity of the profession and securing public confidence in the class of professionals generally.[227]

On the other hand, this example does not address the legitimate questions about whether public trust in physicians may be more resilient than assumed and whether sanctioning physician-spread misinformation is trust-enhancing across the board, given the difficulty of tracking how trust operates in healthcare settings.[228] Further, one must be wary of over-generalizing from legal ethics to medical ethics. The physician's role in sustaining the integrity of medicine and the healthcare delivery system is less clear and, in any event, qualitatively different than the lawyer's obligation to preserve the integrity and fairness of legal institutions and the adjudicative process. Lawyers usually take on narrowly defined roles as advocates within a dispute resolution system. Physicians' functions are far more-open ended than performing as zealous (yet truthful) advocates, such as making decisions about allocating limited healthcare resources.[229] Which actions threaten professional integrity, as well as the individual practitioner's responsibility for the trustworthiness of system operations, may play out quite differently in medicine compared to law.

Moreover, the Giuliani case is still not the best analogy to physicians spreading misinformation publicly in the course of

226. A panel of the D.C. Bar's Board of Professional Responsibility has recommended disbarment. *In re* Giuliani, Disciplinary Docket No. 2020-D253, at 38 (D.C.C.A. Bd. of Pro. Resp. July 7, 2023), https://assets.bwbx.io/documents/users/iqjWHBFdfxIU/rvt7KS1jA1U4/v0 [https://perma.cc/B2XK-6PFT].

227. *See supra* text accompanying notes 127–28.

228. *See supra* text accompanying notes 129–37.

229. William M. Sage, *Physicians as Advocates*, 35 HOUS. L. REV. 1529, 1531–32 (1999) (arguing that while both lawyers and doctors are "advocates," the role of a doctor as an advocate is much broader than the narrow focus of a lawyer given that doctors serve in many roles and balance competing considerations in making healthcare decisions).

general communications. First, the New York court understood the disciplinary proceeding to apply to Giuliani's false statements "*in connection with his representation of a client* [former President Trump]."[230] This contrasts with physicians making public claims, such as through social media posts, outside an ordinary doctor-patient relationship. When the professional's communications are one step removed from client representation/patient care, she acts outside her ordinarily understood professional role, where specialized care and diligence are expected, and the misinformation may be far less probative of her overall suitability for professional practice.[231] Second, in the New York proceeding, there were alternative grounds for disciplining Giuliani under the rule expecting duty of candor before a tribunal, because of his misrepresentations to various courts and during legislative proceedings, without having to address the spread of misinformation to the general public.[232]

A more apt example than the Giuliani episode concerns Kellyanne Conway, political advisor to former President Trump. Ms. Conway, an attorney licensed in the District of Columbia, served as political counselor to the President, but not officially acting as an attorney. A group of law professors filed an ethics complaint with the D.C. Bar, arguing that Conway should be sanctioned under the jurisdiction's equivalent to ABA Model Rule 8.4(c), which, as previously discussed, considers it "professional misconduct" for a lawyer to "engage in conduct involving dishonesty, fraud, deceit or misrepresentation."[233] The ethics complaint cited several false public statements by Conway,

230. *In re* Giuliani, 146 N.Y.S.3d at 270 (emphasis added).

231. When legal conduct is not connected to representation of a client, the grounds for professional discipline become much more difficult. In these contexts, attorneys are seemingly acting outside the scope of their ordinarily understood professional roles and non-representation actions may have limited bearing on attorneys' character and capacity to engage in legal practice. *See* Perlman, *supra* note 219, at 10 (explaining that the rules of professional conduct primarily address conduct related to representation of a client "by design" and that "[t]here is usually no reason to apply those rules to lawyers when they are acting outside of their professional roles").

232. *In re* Giuliani, 146 N.Y.S.3d at 268.

233. Letter from Abbe Smith et al., Law Professors, to the Off. of Disciplinary Couns., Bd. on Pro. Resp., D.C. Cir. (Feb. 20, 2017) [hereinafter Law Professors' Letter], https://legalectric.org/f/2017/02/MisconductComplaint_KellyanneConway.pdf [https://perma.cc/TSG4-QZZS]; MODEL RULES OF PRO. CONDUCT r. 8.4(c) (AM. BAR ASS'N 2023).

including incorrectly stating that President Obama had banned Iraqi refugees from coming to the United States following a non-existent "Bowling Green Massacre" and putting forth "alternative facts" to dispute media reports of the crowd size at President Trump's inauguration.[234] However, the law professors' ethics complaint conceded that not every act of public misrepresentation should be actionable under the rule, thinking it appropriate only when the public falsehoods call into serious question the lawyer's fitness or character for the practice of law.[235]

Nonetheless, it remains debatable how far to extend professional sanction under Rule 8.4(c) for purely public comments, however false, when unconnected to legal representation of a client. After all, any falsehood can easily be framed as calling into serious question the lawyer's character, fitness, and capacity for professional practice. This would transform all public comments by a lawyer, even when not practicing law, into a dangerous minefield. Indeed, some commentators worried that imposing sanction on Conway would lead to a round of complaints against public officials who also are licensed attorneys, for mere hyperbole, when the better remedy for such false public claims would be more speech.[236]

Thus, the Kellyanne Conway episode serves as a warning to medical boards about automatically turning public falsehoods, one step removed from rendering of professional services to a client/patient, into serious questions about an individual's character, fitness, and capacity for professional practice. The D.C. Bar apparently did not act on the law professors' complaint.[237] And it drew very mixed responses from commentators, with concerns

234. Law Professors' Letter, *supra* note 233.

235. *Id.*

236. *See, e.g.*, Steven Lubet, *In Defense of Kellyanne Conway*, SLATE (Feb. 27, 2017), https://slate.com/news-and-politics/2017/02/the-misconduct-complaint-against-kellyanne-conway-is-dangerously-misguided.html [https://perma.cc/NG2Z-5FWU] ("Imposing discipline on Conway—even the mildest slap on the wrist—would inevitably lead to a slew of new complaints against attorneys involved in public debate.").

237. There is no public record of ultimate licensure sanction against Conway and the D.C. Bar's disciplinary counsel remarked to the media that his office receives far more complaints than it actually investigates. Sari Horwitz, *Law Professors File Misconduct Complaint Against Kellyanne Conway*, WASH. POST (Feb. 23, 2017), https://www.washingtonpost.com/politics/law-professors-file-misconduct-complaint-against-kellyanne-conway/2017/02/23/442b02c8-f9e3-11e6-bf01-d47f8cf9b643_story.html [https://perma.cc/EAJ4-U7LD].

voiced about overreach.[238] A similar complaint filed against Conway in New Jersey, where she is also licensed to practice law, was unsuccessful.[239] The Office of Attorney Ethics for New Jersey issued a short letter saying that the allegations, even if true, would not make a showing of unethical conduct or incapacity to practice law.[240]

In short, the view from legal ethics is a bit muddled. The professional responsibility rules have at times been used to impose sanctions on lawyers for spreading misinformation, but only the most egregious actions are acted upon.[241] Concerns arise about public misrepresentations undermining the integrity and trustworthiness of the profession, similar to the medical ethics approach. But the law and medicine ethics comparison remains somewhat inexact, given the different roles lawyers and physicians perform within their respective delivery systems. Meanwhile, considerable uncertainty remains about how far professional responsibility rules should extend in sanctioning a lawyer's false communications to the public when in a non-representation role.

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238. *See, e.g.*, Lubet, *supr*a note 236; Joan C. Rogers, *Ethics Complaint Against Kellyanne Conway—'Political Stunt'?*, BLOOMBERG L. NEWS (Mar. 9, 2017), https://www.bloomberglaw.com/product/blaw/document/X9UE0PHK000000 [https://perma.cc/L4FJ-72TA] ("[O]ther law professors told Bloomberg BNA that the complaint against Conway raises broader issues about applying ethics rules to lawyers' statements to the media in the political arena. The views expressed by these scholars suggest the complaint may not have much chance of success—and that may be a good thing."); Kevin C. Shelly, *Drexel Dean to Seek Disbarment of Kellyanne Conway in N.J.*, PHILLY VOICE (Feb. 24, 2017), https://www.phillyvoice.com/drexel-dean-seeks-sanctions-against-kellyanne-conway [https://perma.cc/923Y-8AYT] (quoting law professor John F. Banzhaf III as criticizing attempts to discipline Conway as "seek[ing] a remedy which appears to be unconstitutional because it would chill the freedom of speech of any political figure simply because he or she was a member of the bar, and create an untenable double standard in which a tiny group of unelected officials could wreck someone's livelihood").

239. *See* Brian Sheppard, *The Ethics Resistance*, 32 GEO. J. LEGAL ETHICS 235, 248 (2019).

240. *Id.*

241. Wyman & Heavenrich, *supra* note 218, at 19 ("When bar counsels do bring ethics charges under Rule 8.4(c) for out-of-court statements, they tend to target lawyers who impugn the legitimacy of the court or the legal system itself . . . .").

B. INSTITUTIONAL INFEASIBILITY

1. Inadequate Procedures and Institutional Design

Absent more radical changes to their overall procedures and institutional design, medical boards simply will not be up to the task of monitoring physicians publicly spreading misinformation. To start, medical boards have traditionally faced criticism for weak oversight of physicians generally, even on matters unrelated to medical misinformation.[242] Based on FSMB data, medical boards nationwide disciplined approximately 3,000 physicians in 2022,[243] representing just 0.3 percent of physicians in the country.[244] This is consistent with an earlier analysis of 2017 data indicating that medical boards imposed discipline on just over 0.4 percent of the approximately 970,000 physicians with active medical licenses.[245] Other researchers estimate physician sanction for any licensure violation remains quite rare, affecting only 5 in 1,000 physicians per year.[246] This low level of physician discipline has remained fairly constant over multiple years, even as the number of physicians nationwide has increased.[247] And when imposed, most sanctions are mild, such as fines or required

242. *See, e.g.*, John Fauber & Matt Wynn, *7 Takeaways From Our Year-Long Investigation into the Country's Broken Medical License System*, USA TODAY (Nov. 30, 2018), https://www.usatoday.com/story/news/2018/11/30/medical-board-license-discipline-failures-7-takeaways-investigation/2092321002 [https://perma.cc/D6YA-M5RA] ("A year-long investigation by the *Milwaukee Journal Sentinel*, *USA Today* and *MedPage Today* has revealed that failures in the country's medical license system are widespread and leaves hundreds of potentially dangerous doctors practicing with clean records in some states despite documented disciplinary problems in other states.").

243. *Physician Discipline in 2022*, FED'N OF STATE MED. BOARDS (2023), https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/u.s.-medical-licensing-and-disciplinary-data/physician-discipline [https://perma.cc/ZT96-WSN2].

244. This is based on approximately 3,000 physicians disciplined in 2022, per the FSMB data, compared to a physician census of approximately 1,018,000 licensed physicians in the United States in 2020. *See* Aaron Young et al., *FSMB Census of Licensed Physicians in the United States, 2020*, 107 J. MED. REGUL. 57, 58 (2021).

245. Christopher G. Roy, *Patient Safety Functions of State Medical Boards in the United States*, 94 YALE J. BIOLOGY & MED. 165, 170 (2021).

246. James M. DuBois et al., *Preventing Egregious Ethical Violations in Medical Practice: Evidence-Informed Recommendations from a Multidisciplinary Working Group*, 104 J. MED. REGUL. 23, 24 (2018).

247. Roy, *supra* note 245, at 170–71.

additional training, as medical boards rarely remove a physician from practice, even temporarily.[248]

Low discipline rates and overall mild sanctions likely reflect the self-protective dynamics of the medical licensure system. While they are state administrative bodies, medical boards operate principally as a form of professional self-regulation. Although their composition varies across states, a large majority of individuals appointed to serve on the governing boards/committees of medical boards are themselves licensed physicians.[249] Thus, a recurring concern has been whether medical boards are prone to regulatory capture and professional bias, with physicians serving on medical boards reluctant to take action against their medical peers.[250]

Next, many medical boards do not have adequate resources for their basic missions, suffering from chronic underfunding.[251] Investigations require that a medical board incur significant costs and time as well as deploy sufficient personnel and, in some instances, engage expert consultants. After the investigation stage, proving licensure violations can be resource-intensive. Consistent with the due process standards reflected in most Medical Practice Acts, medical boards must conduct a hearing and show by a preponderance of the evidence that a physician has violated a licensure standard to justify disciplinary action.[252] As a result, medical boards prioritize discipline for easily provable offenses, such as physicians with parallel criminal convictions or who have tested positive for substance abuse.[253] Medical

248. Pendo et al., *supra* note 81, at 13.

249. *See Board Membership Composition*, FED'N OF STATE MED. BOARDS (2023), https://www.fsmb.org/siteassets/advocacy/regulatory/board-structure/board-membership-composition.pdf [https://perma.cc/95W7-PV4M].

250. Sawicki, *supra* note 79, at 471 ("Like many administrative agencies, medical boards are faulted for being subject to professional capture—a phenomenon whereby an industry protects itself rather than the consumer community at large.").

251. Isaac D. Buck, *Regulation of Professionals and Facilities in the United States*, *in* THE OXFORD HANDBOOK OF COMPARATIVE HEALTH LAW 293, 298 (David Orentlicher & Tamara K. Hervey eds., 2020) ("It is also the case that boards are often underfunded, which can severely constrain their ability to investigate and sanction poorly performing professionals.").

252. *See, e.g.*, N.C. GEN. STAT. § 90-14.6(e) (2023).

253. Sawicki, *supra* note 79, at 472 ("More recent evidence suggests that less than a third of disciplinary actions are taken on the basis of quality-of-care concerns, with the majority of actions being taken for reasons related to conduct

boards tend to bootstrap general unprofessional conduct concerns onto these narrower, objective violations and are less likely to take up more imprecise, and costlier to investigate, unprofessional conduct allegations.[254]

This is especially pertinent to how medical boards likely view initiating action against physicians publicly spreading misinformation. Unless their budgets are significantly expanded, medical boards will likely continue to concentrate their firepower on narrower, more objective offenses, not medical misinformation. As bioethicist Arthur Caplan has explained, medical boards "have their hands full with doctors who have committed felonies, doctors who are molesting their patients. Keeping an eye on misinformation is somewhat down on the priority list."[255]

Another significant problem arises from how medical boards take on cases. Most investigations are complaint-driven, in response to accusations made by patients, health professionals, and other stakeholders, with the majority of complaints coming from patients and their families.[256] In other words, medical boards do not perform very well in proactively monitoring, no doubt tied to their resource constraints. They seem particularly unprepared to surveil social media posts and public claims by physicians in small public forums, such as town meetings. As a result, medical boards will not necessarily learn of many problematic instances of physician-spread misinformation unless directly complained about. This puts much of the burden on patients and other layperson observers to protest to medical boards. Yet, these individuals, because of their lack of expert knowledge, are in the seemingly worst position to know when to challenge medical misinformation. Other institutions, such as a local medical society or health system, might report problematic physician conduct to medical boards. Unfortunately, these entities are subject to non-standard reporting requirements across different states, leading to missed opportunities for enforcement.[257] Medical boards' unreliable, inconsistent uptake

outside the sphere of direct clinical practice—such as substance abuse, criminal activity, and behavioral problems.").

254. *Id.* at 473.

255. Knight, *supra* note 3.

256. Pendo et al., *supra* note 81, at 20.

257. *See Disinformation Doctors: Licensed to Mislead*, *supra* note 43, at 10 ("In recent years, many state medical boards have reduced the number of

processes to identify physician-spread misinformation means, inevitably, less physician accountability.

In addition, significant transparency problems exist. The best remedy for misinformation is, seemingly, sunlight, as holding up the inaccuracy of certain medical claims to public scrutiny can expose falsehoods and potentially change the discourse around contested topics.[258] But complaints under investigation are usually not a matter of public record and, likewise, complaints that post-investigation resulted in no formal action may also remain confidential.[259] No dependable system exists for tracking the volume and nature of complaints about medical misinformation to medical boards nationwide, data critical to the development of evidence-based policies. Dr. Humayun Chaudhry, president of the FSMB, has conceded that it has been "impossible to know how many states ha[ve] opened investigations into doctors spreading misinformation."[260] Further, there is even more limited transparency concerning the informal "nudging" that some medical boards, as described earlier, may try with individual physicians in lieu of pursuing formal investigations and sanctions.[261] Such informal actions, when non-public, have limited deterrence value in terms of alerting other physicians to such misinformation conduct as problematic. This also ensures that the public remains unaware of misinformation concerns raised about certain physicians.[262]

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metrics they report on annually, removing visibility to the number of complaints filed as well as more granular views on what happens to complaints that are referred for investigation. These metrics need to be standard requirements that state medical boards report to the public and the state.").

258. For more on the value of transparency in agency regulation generally, see Jennifer Nash & Daniel E. Walters, *Public Engagement and Transparency in Regulation: A Field Guide to Regulatory Excellence*, PENN PROGRAM ON REGUL. (June 2015), https://www.law.upenn.edu/live/files/4709-nashwalters-ppr-researchpaper062015.pdf [https://perma.cc/YN7B-ZRY5].

259. *See, e.g.*, *Enforcement*, *supra* note 29 ("An investigation is confidential. It cannot be shared with the public, the complainant, or the licensee involved. The public may know only when the board files charges against a licensee.").

260. Alba & Frenkel, *supra* note 5.

261. *See supra* note 98 and accompanying text.

262. *See Disinformation Doctors: Licensed to Mislead*, *supra* note 43, at 6 ("Because complaints that are under investigation are confidential and complaints that are closed without action are not public records, most state medical boards have no public accountability for the number or validity of decisions around complaints that they close without taking action.").

Finally, licensure actions proceed slowly, reflecting the fact-intensive nature of investigations and disciplinary hearings and, again, medical boards' chronic underfunding. The time between referral of a complaint to full opening of an investigation to completion of a possible disciplinary hearing can take many months and sometimes years.[263] This is simply too sluggish a timeframe to respond properly to physicians publicly spreading false claims and to mitigate the damage as "medical misinformation . . . directly impact[s] public health in a matter of days. Complaint review processes that takes months or years are completely insufficient."[264] Further, because of the confidentiality of most ongoing medical board proceedings, physicians, while under review, can continue to spread misinformation, amplifying previous false claims.

2. Institutional Resilience and Independence

Related to these problems of structural design and procedure is the concern that medical boards lack sufficient institutional resilience and independence to take on curbing medical misinformation in a volatile, polarized environment. During the COVID-19 pandemic, debates about the underlying evidence and veracity of many medical claims have become conflated with sharp political disagreements over the balancing of individual liberties with governmental police powers. In this heated climate, medical boards have triggered forceful political pushback for trying to curb physicians spreading misinformation.

The most notorious episode of political interference in medical board action occurred in Tennessee. In 2021, the Tennessee Board of Medical Examiners adopted a statement, modeled on the FSMB's guidance, that physicians spreading COVID-19 misinformation could jeopardize their licenses or otherwise face sanction.[265] An influential Republican state senator sent a series of letters demanding that the statement be deleted from the Medical Board's website and threatening to dismantle the

263. *Id.* at 9.

264. *Id.*

265. *Medical Misinformation or Disinformation Regarding COVID-19*, TENN. BD. OF MED. EXAM'RS (Sept. 21, 2021), https://www.tn.gov/content/dam/tn/health/healthprofboards/medicalexaminers/Covid19.pdf [https://perma.cc/27CN-KN46].

Board.[266] He contended that the policy statement was not clear about what constituted misinformation and that it infringed on private doctor-patient relationships.[267] In response, the Medical Board voted to remove the misinformation statement from its website, but then, several weeks later, reconfirmed the policy but did not repost it on the agency website.[268] Further, despite the readoption of the policy, and likely reflecting the political pressure applied, the Medical Board did not sanction a single Tennessee physician for spreading COVID-19 misinformation.[269] Meanwhile, Tennessee lawmakers introduced several legislative bills that would have restricted the Medical Board's authority to take action against a physician's license based solely on the physician's recommended COVID-19 treatments for a patient.[270] One sponsor said the proposed bills, although not enacted into law, sent the medical board a clear message that the legislature was "willing to step in and rein them in."[271]

North Dakota legislators similarly moved against the state's medical board. A law enacted in 2021, although not specifically addressing spread of misinformation, blocked the state medical board from taking disciplinary actions against physicians who prescribe the anti-parasitic drug ivermectin for treatment or

266. Blake Farmer, *As State Medical Boards Try to Stamp Out COVID Misinformation, Some in GOP Push Back*, NPR (Feb. 14, 2022), https://www.npr.org/sections/health-shots/2022/02/14/1077689734/as-state-medical-boards-try-to-stamp-out-covid-misinformation-some-in-gop-push-b [https://perma.cc/5RFK-L73N].

267. *Id.*

268. *Id.*

269. *Id.* No physician disciplinary actions for spreading COVID-19 misinformation have been reported on the state medical board website through Nov. 1, 2022. *See Health Professionals Boards Disciplinary Actions*, TENN. DEP'T OF HEALTH, https://www.tn.gov/health/health-professionals/health-professionals-boards-disciplinary-actions.html [https://perma.cc/E8BN-RN9M].

270. *See, e.g.*, H.R. 1870 section 1(a), 112th Gen. Assemb. (Tenn. 2022) ("A licensing board or disciplinary subcommittee shall not revoke, fail to renew, suspend, or take an action against a physician's license issued under this chapter based solely on the physician's recommendations to a patient regarding treatment for COVID-19, so long as the physician exercised independent medical judgment and believes that the medical treatment is in the best interest of the patient.").

271. Michael Ollove, *States Weigh Shielding Doctors' COVID Misinformation, Unproven Remedies*, STATELINE (Apr. 6, 2022), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/04/06/states-weigh-shielding-doctors-covid-misinformation-unproven-remedies [https://perma.cc/GJ2L-MFZH].

prevention of COVID-19.[272] The medication has been promoted by conservative commentators and politicians, including Fox News host Laura Ingraham and Senator Ron Johnson.[273] This legislative shield for prescribing ivermectin applies in North Dakota despite a double-blind, randomized controlled trial published in the *New England Journal of Medicine*, regarded as the most definitive analysis to date, which concluded that early treatment with the medication did not provide any clinical benefit.[274] Meanwhile, the FDA has issued a warning that taking ivermectin to treat COVID-19 can be dangerous, with complications including overdoses, seizures, ataxia, comas, and even death.[275]

In about half the states, lawmakers have introduced bills that would block medical boards from disciplining physicians for disseminating COVID-19 misinformation,[276] an approach heavily championed by Florida Governor Ron DeSantis.[277] The sheer number of bills proposed, even if not enacted into law, is an ominous sign about medical boards' ability to avoid crippling political entanglements in dealing with medical misinformation. As Richard Baron, president of the American Board of Internal Medicine, has observed, the flood of medical misinformation and

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272. H.R. 1514, 67th Leg. Assemb., Spec. Sess. (N.D. 2021) (enacted).

273. Aaron Blake, *How Those Ivermectin Conspiracy Theories Convinced People to Buy Horse Dewormer*, WASH. POST (Aug. 24, 2021), https://www.washingtonpost.com/politics/2021/08/24/how-rights-ivermectin-conspiracy-theories-led-people-buying-horse-dewormer [https://perma.cc/WFM2-CZLD].

274. G. Reis et al., *Effect of Early Treatment with Ivermectin Among Patients with Covid-19*, 386 NEW ENG. J. MED. 1721, 1721 (2022) ("Treatment with ivermectin did not result in a lower incidence of medical admission to a hospital due to progression of Covid-19 or of prolonged emergency department observation among outpatients with an early diagnosis of Covid-19.").

275. *Why You Should Not Use Ivermectin to Treat or Prevent COVID-19*, U.S. FOOD & DRUG ADMIN. (Dec. 10, 2021) [hereinafter *FDA Ivermectin Advisory*], https://www.fda.gov/consumers/consumer-updates/why-you-should-not-use-ivermectin-treat-or-prevent-covid-19 [https://perma.cc/93LB-NLVA].

276. Ollove, *supra* note 271.

277. Mary Ellen Klas, *DeSantis Wants Ban on COVID Mask and Vaccine Mandates to Be Permanent*, TAMPA BAY TIMES (Jan. 17, 2023), https://www.tampabay.com/news/florida-politics/2023/01/17/desantis-wants-ban-covid-mask-vaccine-mandates-be-permanent [https://perma.cc/C6P7-KYHZ] (documenting Governor DeSantis's support of legislative proposals which would limit regulatory board sanction of physicians for expressing their views only if it led to "direct physical harm." The proposal was introduced after California passed legislation that would authorize regulators to discipline physicians for spreading misinformation about COVID-19).

the divisive political environment have combined such that regulatory apparatus underlying medical board oversight is "unraveling."[278]

Individual medical board members have also faced threats of violence for tackling misinformation. Kristina Lawson, president of the Medical Board of California, reported that when the Board took up the issue of physicians spreading false COVID-19 claims, anti-vaccination protesters accosted her in a dark parking garage.[279] The men allegedly identified themselves as members of AFD, the physician organization associated with spreading numerous false medical claims.[280] Lawson also said that a drone surveilled her home and that she ended up having to hire private security.[281]

External interference in medical board operations subverts one of the supposed advantages of the physician licensure system: the clinical expertise of medical boards. In heavily utilizing the specialized training and experience of their physician members, medical boards can reportedly reach better decisions and obtain buy-in from regulated medical professionals.[282] However, it should not surprise that political pressures would influence the decision-making of supposedly apolitical medical boards. Chronically underfunded, they often rely on annual budget allocations from state legislatures, and their members are usually appointed by, and subject to removal by, the governor/legislature.[283] This authority to determine the structure and resource levels of medical boards can, among other levers, become powerful mechanisms for institutional control. One health policy study reviewed rates of physician discipline by medical boards along with changes in the political makeup of their corresponding state legislatures. The researchers concluded that as state

278. Tahir, *supra* note 69.

279. Aaron McDade, *Head of California Medical Board Kristina Lawson Says Anti-Vaxxers Followed Her to Work*, NEWSWEEK (Dec. 9, 2021), https://www.newsweek.com/head-california-medical-board-kristina-lawson-says-anti-vaxxers-followed-her-work-1658046 [https://perma.cc/5432-WB4B].

280. *Id.*; *see also supra* notes 41–44 and accompanying text.

281. Tahir, *supra* note 69.

282. Buck, *supra* note 251, at 297.

283. *See id.* at 298; Denise F. Lillvis & Robert J. McGrath, *Directing Discipline: State Medical Board Responsiveness to State Legislatures*, 42 J. HEALTH POL., POL'Y & L. 123, 133 (2017) ("As another mechanism of control, political actors often share the prerogative to appoint and confirm agency leaders/board members (and chairs).").

legislatures became more conservative, physician discipline by the medical boards decreased.[284] Possible reforms for making medical boards more resilient include designing them as truly independent agencies, with fixed budgets, professional staff with employment protections, and members appointed to multi-year terms with limited possibility for removal.[285] However, any such reforms would need to be careful not to insulate medical boards completely from external sources of control and legislative oversight. Otherwise, the professional self-regulation system could end up only furthering the aims of organized medicine and remain unresponsive to the larger public interest.[286]

C. OVERREACH: CURBING MISINFORMATION VS. INNOVATIVE/UNORTHODOX PRACTICE

A beefed-up role for medical boards in policing medical misinformation also raises serious policy concerns about overreach. As noted previously, defining "medical misinformation" with sufficient precision remains very difficult.[287] This problematically leaves wide discretion for medical boards to discipline physicians. A danger inherent in the self-regulation licensure system is that medical boards can use their disciplinary powers for anticompetitive reasons.[288] Physician members, usually drawn from traditional professional networks and organizations, can push

284. Lillvis & McGrath, *supra* note 283, at 149.

285. For more on the structural features and other factors that support agency independence, and several examples, see Kirti Datla & Richard L. Revesz, *Deconstructing Independent Agencies (and Executive Agencies)*, 98 CORNELL L. REV. 769, 784–808 (2013).

286. *See, e.g.*, Sidney Wolfe & Robert E. Oshel, *Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2017–2019*, PUB. CITIZEN 14 (Mar. 31, 2021), https://www.citizen.org/wp-content/uploads/2574.pdf [https://perma.cc/2B9R-TM6Q] (advocating for regulatory board independence from state medical societies, recognizing that regulatory oversight should not be "unduly influenced by special interest groups such as state and national medical societies").

287. *See supra* Part I.A.

288. *See* Eli Y. Adashi et al., *The New State Medical Board: Life in the Antitrust Shadow*, HEALTH AFFS. (Jan. 6, 2020), https://www.healthaffairs.org/do/10.1377/forefront.20191226.86148/full [https://perma.cc/A43H-KCTL] (noting "[d]ecades of legal battles over alleged anticompetitive practices" by state medical boards); *see also* Roger D. Blair & Christine Piette Durrance, *Licensing Health Care Professionals, State Action and Antitrust Policy*, 100 IOWA L. REV. 1943, 1946 (2015) (describing the "vested economic interest" advanced by board members).

medical boards to move against rival practitioners, often less established, who offer alternative services that appeal to patients' unmet needs.[289] For example, certain medical boards have been accused of establishing needless standards, such as face-to-face examination, for physicians to prescribe medications in connection with telehealth services.[290] These requirements impede rivals from offering innovative alternatives to costlier, less accessible in-person care. Apart from anticompetitive concerns, lack of clear standards about what constitutes medical misinformation can lead to uneven, arbitrary enforcement as "one professional's clinically innovative treatment that may constitute a breakthrough is another professional's example of dangerously unproven and substandard care."[291]

To be clear, physician-spread medical misinformation has included patently outrageous falsehoods and conspiracy theories. For example, AFD's Dr. Stella Immanuel, who disturbingly promoted hydroxychloroquine for treating COVID-19, also publicly stated that medical treatments make use of alien DNA.[292] But other claims that might be labeled "misinformation" are instead unconventional, even innovative, but still have some merit or a colorable scientific basis.[293]

Part of the difficulty in separating the wheat from the chaff arises from the complex nature of medical practice. Medicine's scientific underpinnings can create the false impression that rigorous evidence supports most medical interventions and that physicians choose between clearly right and clearly wrong

289. *See* Buck, *supra* note 251, at 298–99 (identifying the danger of anticompetitive behavior carried out through medical boards).

290. *See* Teladoc, Inc. v. Tex. Med. Bd., No. 1:15-CV-343-RP, 2016 WL 4362208, at *1 (W.D. Tex. Aug. 15, 2016). The Texas Medical Board defended its actions, among other reasons, as protected by the state action immunity doctrine. *Id.* But the Texas Medical Board voluntarily terminated its defense when new state legislation eliminated the disputed requirements imposed by the medical board. *See* Adashi et al., *supra* note 288; *see also* William M. Sage & David A. Hyman, *Antitrust as Disruptive Innovation in Health Care: Can Limiting State Action Immunity Help Save a Trillion Dollars?*, 48 LOY. U. CHI. L.J. 723, 737–39 (2017) (documenting the Teladoc antitrust litigation).

291. Buck, *supra* note 251.

292. Olewe, *supra* note 102.

293. *See* U.S. SURGEON GEN., *supra* note 21, at 17 ("[I]t is important to be careful and avoid conflating controversial or unorthodox claims with misinformation. Transparency, humility, and a commitment to open scientific inquiry are critical.").

treatments for most conditions. Instead, many medical treatments diffuse into practice and become adopted without thorough evaluation, such as completing randomized controlled clinical trials. Researchers estimate about fifty percent of common medical treatments lack a solid evidence base demonstrating effectiveness.[294]

As a result, non-evidence-based factors can hold large sway over physician adoption of treatments, ranging from anecdotal impressions to reimbursement considerations to marketing by drug companies to where physicians trained to what they perceive their professional peers are doing.[295] Meanwhile, the complexities of human biology, genetic differences, and patient heterogeneity mean that for certain illnesses, many possible care pathways exist and the same intervention can present different benefits and harms for similarly situated patients. Accordingly, medical custom is not monolithic, reflected in medical malpractice law's recognition of a variable standard of care. Many jurisdictions allow a physician to claim that she still practiced within the protective standard of medical custom if a "respectable minority" or competing "school of thought" supported her treatment decision, even if not in accord with the dominant medical custom.[296]

Given the considerable variability of medical custom, and the limited evidence underlying many existing treatments, certain instances of alleged physician-spread misinformation might instead constitute legitimate medical claims or views that present useful challenges to the status quo. In other words, some controversial medical claims might be unorthodox, but still accord with respected minority views, while others might be

294. Austin Frakt, *Why Doctors Still Offer Treatments That May Not Help,* N.Y. TIMES (Aug. 26, 2019), https://www.nytimes.com/2019/08/26/upshot/why-doctors-still-offer-treatments-that-may-not-help.html [https://perma.cc/M6CQ-SE5V]; *see also* J. Michael McGinnis et al., *The Nation's Need for Evidence on Comparative Effectiveness in Health Care: Learning What Works Best*, *in* LEARNING WHAT WORKS: INFRASTRUCTURE REQUIRED FOR COMPARATIVE EFFECTIVENESS RESEARCH 60, 60–62 (2011) (identifying the need for more evidence demonstrating the efficacy of the growing number of drugs and treatments so that healthcare choices are easier to make).

295. Lars Noah, *Medicine's Epistemology: Mapping the Haphazard Diffusion of Knowledge in the Biomedical Community*, 44 ARIZ. L. REV. 373, 377–78 (2002).

296. *See* Tim Cramm et al., *Ascertaining Customary Care in Malpractice Cases: Asking Those Who Know*, 37 WAKE FOREST L. REV. 699, 703–05 (2002).

innovative and call for an important reevaluation of outmoded medical consensus. Thus, serious concerns arise about over-deterring the expression of alternative medical views under the guise of policing medical misinformation.

The policy concerns about overreach resonate with many of the underlying rationales for the First Amendment's protection of free expression. As First Amendment cases have observed, even false information has value. Some false statements are unavoidable and necessary for truly robust, uninhibited communications to occur.[297] Further, as the concurring justices in *United States v. Alvarez* noted, false statements prove useful even in scientific work, as they may help to challenge the status quo, and careful examination of false information "can promote a form of thought that ultimately helps realize the truth."[298] Thus, public communication of non-consensus medical information ensures a robust exchange of views, adds to the community discourse around important healthcare topics, and prods investigators to refine research directions. Indeed, the scientific method that underlies many medical advances critically depends on continual doubt, by relentlessly questioning and reevaluating existing hypotheses.[299]

To be clear, the scientific method should not be equated with the "marketplace of ideas" theory advanced by various courts and scholars in exploring the meaning and rationale behind the First Amendment.[300] Scientific questions are ordinarily not resolved by airing out multiple competing views, completely unrestricted and all appearing equally valid to start, and assuming rational citizens will speak in favor of and adopt more persuasive claims and reject those that are false. Instead, medical information derived from the scientific method arises from constant hypothesis testing, experimentation, repeated observations,

297. *See* United States v. Alvarez, 567 U.S. 709, 718 (2012) ("[S]ome false statements are inevitable if there is to be an open and vigorous expression of views in public and private conversation, expression the First Amendment seeks to guarantee.").

298. *Id.* at 733 (Breyer, J., concurring).

299. *See* Liv Grjebine, *Why Doubt Is Essential to Science*, SCI. AM. (Oct. 9, 2020), https://www.scientificamerican.com/article/why-doubt-is-essential-to-science [https://perma.cc/L65A-NEXJ].

300. *See generally* Daniel E. Ho & Frederick Schauer, *Testing the Marketplace of Ideas*, 90 N.Y.U. L. REV. 1160, 1165–75 (2015) (exploring the normative, epistemic, and empirical justifications for the "marketplace of ideas" theory).

failure, and then reevaluation of existing hypotheses. This may involve a robust exchange of differing views. But it is more than just winning a debate or attracting more adherents in the community by compelling arguments. Following the scientific method, a new interpretation or paradigm commands attention because it has better explanatory power over prior interpretations in the face of new testing data or observations.[301] Thus, protecting a marketplace of ideas, dependent on free expression, is clearly not the same as directly ensuring medical progress through scientific inquiry and research. Nonetheless, allowing for robust exchange of competing medical claims helps at least establish important predicate conditions necessary for the scientific method to do its work. In particular, this supports and reinforces the unwillingness to treat commonly understood medical views as fixed, as going forward new experimentation may still prove them false.

Further, because useful ideas central to the scientific method arise from "the freedom to venture without the confines of traditional thinking,"[302] it remains important to ensure that challenging medical questions arise in the public domain from all possible corners. It is tempting, but wrong, to assume that physicians who will have to defend allegations of spreading medical misinformation will be cut from the same cloth: politically conservative, unscientific, and anti-vaccination. Instead, too heavy a hand in sanctioning medical misinformation can ensnare all types, including politically liberal physicians and those with very scientific orientations. For example, in earlier decades, certain physicians in good faith expressed disagreements about organized medicine's stance on marijuana, believing it overstated the dangers and dismissed the potential medical benefits.[303] Their claims could have, at the time, been considered

301. *See* Peter Ellerton, *What Exactly Is the Scientific Method and Why Do So Many People Get It Wrong?*, CONVERSATION (Sept. 14, 2016), https://theconversation.com/what-exactly-is-the-scientific-method-and-why-do-so-many-people-get-it-wrong-65117 [https://perma.cc/HR74-95K5].

302. Abraham Loeb, *Where Do Ideas Come from?*, SCI. AM. (July 23, 2018), https://blogs.scientificamerican.com/observations/where-do-ideas-come-from [https://perma.cc/P2RL-5CFV].

303. *See e.g.*, Shira Schoenberg, *Pro-Marijuana Doctors Explain Their Support for Legalization*, MASS LIVE (Nov. 4, 2016), https://www.masslive.com/politics/2016/11/pro-marijuana_doctors_explain_support_for_legalization_in_massachusetts.html [https://perma.cc/7TL4-MFXL] (documenting physicians

medical misinformation, exposing them to potential licensure discipline.[304]

Similarly, as of several years ago, few physicians recommended gender reassignment treatments for transgender pediatric patients. The physicians who moved the needle were able to speak frankly about possible new standards for organized medicine to consider.[305] More recently, demonstrating the dangers of over-regulation through licensure, the Florida Medical Board adopted a new standard of care that prohibits physicians from prescribing puberty blockers and hormones, or performing surgical procedures, as part of gender-affirming care for minor patients.[306] The action has been widely criticized as driven by

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voicing their support for marijuana legalization, with some arguing that it has therapeutic benefits, while official health-related organizations like the Massachusetts Medical Society opposed legalization due to perceived addiction risks and harm to adolescents); David L. Nathan et al., *The Physicians' Case for Marijuana Legalization*, 107 AM. J. PUB. HEALTH 1746 (2017) (arguing for marijuana legalization because legalization would facilitate comprehensive regulation that would protect the public health, especially for minors).

304. *See supra* note 303; *C.f.* Conant v. Walters, 309 F.3d 629, 632 (9th Cir. 2002) (striking down, as infringing on physicians' First Amendment rights, a federal enforcement policy in which physicians could face revocation of registration to prescribe controlled substances if they recommended medical marijuana to a patient).

305. Members of the World Professional Association for Transgender Health publicized new treatment standards that attracted the attention of major medical groups and insurers. *See* Emily Bazelon, *The Battle over Gender Therapy*, N.Y. TIMES (June 15, 2022), https://www.nytimes.com/2022/06/15/magazine/gender-therapy.html [https://perma.cc/S52S-HSUK].

306. FLA. ADMIN. CODE ANN. r. 64B8-9.019 (2023); *see also* Azeen Ghorayshi, *Florida Restricts Doctors from Prescribing Gender Treatments to Minors*, N.Y. TIMES (Nov. 4, 2022), https://www.nytimes.com/2022/11/04/health/florida-gender-care-minors-medical-board.html [https://perma.cc/638Q-2CD4]. The Florida legislature codified the medical board's action in later legislation. FLA. STAT. § 456.001(9)(a) (2023). A federal district court has granted a preliminary injunction in favor of several families protesting the new Board rules and legislation. Doe v. Ladapo, No. 4:23cv114-RH-MAF, 2023 WL 3833848, at *17 (N.D. Fla. June 6, 2023). Among other reasons, the court found that the plaintiffs had valid constitutional law claims that the Board rules and statute likely violated the Equal Protection Clause (applying intermediate scrutiny to classifications based on sex) and Due Process Clause (through infringement on parental rights over medical decision-making). *Id.* at *7–11. The injunction applies only to the three children whose parents brought the action and it addresses only the prohibition on puberty blockers, not the provisions restricting surgical treatment. *Id.* at *17.

politics and not medical science.[307] Yet, physicians who publicly question the clinical rationale behind the new care standard now run the risk of facing licensure sanction for spreading misinformation contrary to the supposedly expert, consensus-driven conclusions of the Florida Board of Medicine.

In short, medical history and current examples show that controversial claims by physicians raise important questions for reconsidering prevailing clinical knowledge. Even if some claims are amiss, ensuring the free exchange of views may eventually lead to more accurate medical understandings. Thus, there is significant societal value in allowing dissident physicians to make questionable, and even false, public claims. The criticisms in the long run help fuel the scientific method's relentless push for reevaluation and new testing that, for medical progress to occur, necessarily disturb current consensus.

Because of the large spectrum of legitimate physician opinions, the American Board of Internal Medicine (ABIM), the largest specialty professional medical organization in the country, has proposed limiting physician discipline for spreading misinformation to "wrong answers," and "false information" determined by experts consulting the relevant (often peer-reviewed) literature—statements such as "children can't spread Covid."[308] While appropriately respectful of not turning every professional disagreement into charges of spreading misinformation, the ABIM's position also is so narrow that it will likely disappoint advocates urging more of a medical board crackdown on physicians peddling falsehoods. The ABIM approach would leave untouched many contested medical claims. Even the ABIM concedes that "[a] whole range of statements with which many—or even most—physicians might disagree would therefore not trigger" its recommended disciplinary process.[309] For example, dubious claims about particular new mutations of the coronavirus would still have a hard time meeting the ABIM's standard of false "determined by experts consulting the literature" when

307. *See* Ghorayshi, *supra* note 306 ("Major medical groups in the United States, including the American Academy of Pediatrics, have condemned state bans and insurance restrictions of such care as dangerous political intrusions into standard medical practice."); *Ladapo*, 2023 WL 3833848, at *13 ("The statute and rules were an exercise in politics, not good medicine.").

308. Baron & Ejnes, *supra* note 75, at 3.

309. *Id.*

relevant publications, especially peer-reviewed, have not yet been generated on these still developing topics.[310]

Indeed, because medical facts on the ground can change so rapidly, serious questions arise about medical boards' ability to timely define, investigate, and sanction problematic misinformation without overdeterrence. The COVID-19 pandemic's constantly shifting information landscape has required constant reevaluation of prior medical assumptions. Early in the pandemic, it was unclear whether the virus transmitted through airborne droplets and aerosol particles. Some researchers, worried about the potential for large air-borne virus spread, warned that early governmental guidance to the public to stand at least six feet apart would not be sufficient to prevent infection.[311] This initial outlier view now commands considerable consensus, but in the early months of the pandemic, sufficient testing and published literature on the issue did not exist to resolve the question. Arguably, physicians expressing public concerns about insufficient distancing guidelines could have been sanctioned for spreading medical misinformation undermining public health.[312]

Other claims by medical authorities early in the COVID-19 pandemic also proved, over time, inaccurate. The Centers for Disease Control and Prevention (CDC), along with other influential public health organizations, did not initially appreciate the risk of asymptomatic spread and did not even suggest tracking it.[313] Meanwhile, the U.S. Surgeon General initially advised that the general public not buy masks, implying they would not

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310. *Id.*

311. *See* Pien Huang, *Coronavirus FAQs: Why Can't the CDC Make Up Its Mind About Airborne Transmission?*, NPR (Sept. 25, 2020), https://www.npr.org/sections/goatsandsoda/2020/09/25/916624967/coronavirus-faqs-why-cant-the-cdc-make-up-its-mind-about-airborne-transmission [https://perma.cc/VVJ2-R637].

312. Allysia Finley, *California's Medical 'Misinformation' Crusade Could Cost Lives*, WALL ST. J. (Apr. 20, 2022), https://www.wsj.com/articles/california-medical-misinformation-disinformation-bill-cost-lives-deaths-covid-19-ivermectin-oxygen-ventilator-hospitalization-vaccine-side-effect-pandemic-first-amendment-censorship-11650462870 [https://perma.cc/EWH2-CH23].

313. Evan Anderson & Scott Burris, *Imagining a Better Public Health (Law) Response to COVID*-19, 56 U. RICH. L. REV. 955, 998 (2022) (documenting the CDC's early belief that tracking asymptomatic spread of COVID-19 was not important and discussing the consequences ensuing from their resulting reluctance to track it).

be effective in preventing infection (although the real reason may have been to preserve the limited supply of masks for front-line healthcare providers at heightened risk of contracting the virus).[314] Early dissenter physicians who publicly expressed skepticism that testing for symptoms like fever was sufficient to tell if someone was infectious, or who advised the public to wear masks, provided critical viewpoints for fair public debate.[315] It remains important to ensure sufficient room for physicians to air discordant views without fear of professional discipline for spreading claims that, without clearer definitional standards, can be characterized as misinformation.

IV. ALTERNATIVES TO MEDICAL BOARD REGULATION

If looking to medical boards will likely disappoint, what else can be done to combat physician-spread misinformation? A full examination of possible alternatives is beyond this Article's intended scope, which instead responds to the widespread demands for expanded medical board action. This Part, however, briefly reviews some alternatives that bypass problematic reliance on medical board oversight. Admittedly, each is incomplete and, even if pursued in combination, may still prove sub-optimal. At bottom, it comes down to a pragmatic choice of selecting the least bad regulatory approaches. These alternatives, while not magic bullets, offer partial benefits without raising the full range of thorny problems associated with enhanced medical board oversight. Moreover, even if these alternatives cannot fully mitigate the harms of physician-spread misinformation, it may be better to under-regulate than over-control.

As previously discussed, this trade-off favors the greater good of generating robust exchange of physician views about medical topics of public importance, buttressing the marketplace of ideas, and supporting the scientific method's critical reexamination of current interpretations and hypotheses.[316]

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314. *Id.* at 999.

315. *See, e.g.*, Audrey McNamara, *CDC Criticized for Guidance Saying People Exposed to Coronavirus May Not Need Testing*, CBS NEWS (Aug. 28, 2020), https://www.cbsnews.com/news/coronavirus-testing-exposed-centers-for-disease-control [https://perma.cc/DVV8-ZZN8] (discussing various physicians' public criticisms that CDC guidance did not sufficiently account for risk of transmission by asymptomatic individuals).

316. *See supra* notes 296–306 and accompanying text.

A. COUNTERSPEECH

The more constitutionally sound remedy for combatting false information is counterspeech.[317] Medical boards, or other governmental bodies like state health agencies, the CDC, or the U.S. Surgeon General's Office, can issue advisories, undertake health education campaigns, and generate other public communications to correct errors from physician-spread misinformation, altering the informational environment. For example, the FDA has issued straightforward guidance advising the public not to use ivermectin to treat COVID-19, warning "[t]here's a lot of misinformation around, and you may have heard that it's okay to take large doses of ivermectin. It is not okay."[318]

Private entities can also help. To combat false medical claims circulating through social media, host technology platforms can deploy several mitigation measures. Putting aside the more contentious battles over outright blocking false communications and certain speakers, platforms can increase users' familiarity with generally accepted medical claims through embedded accuracy nudges, prompts for reliable news outlets, and related actions. Such exposure is thought to increase the downstream uptake of reliable medical information.[319] Meanwhile, professional medical societies like the AMA can add their own communications to the public discourse, countering potentially distracting misinformation claims. Regional medical associations may be particularly well-positioned to tailor messaging to the needs and conditions of local communities, such as providing their physician members with scripts to address the misinformation most likely seen by their patients.[320] Importantly, educational efforts should focus not just on correcting false medical claims already circulating, but instructing individuals how to be smarter consumers of health information going forward,

317. *See supra* notes 125–27 and accompanying text.

318. *FDA Ivermectin Advisory*, *supra* note 275. The guidance notes that the medication has not been approved for treating COVID-19, can be dangerous to health when taken in large quantities, and that current evidence does not show it is effective for addressing the virus. *Id.*

319. *See* Anna Harvey, *Combatting Health Misinformation and Disinformation: Building an Evidence Base*, HEALTH AFFS. (Nov. 23, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20211118.932213 [https://perma.cc/9X8M-XXSY].

320. Sydney B. Blankenship et al., *Physicians' Role in the COVID-19 Infodemic: A Reflection*, 114 S. MED. J., 812, 813 (2021).

including providing tools to assess the general reliability of medical claims and the sources of information.[321]

Unfortunately, counterspeech will not compensate victims, deter future conduct, provide corrective justice, or restore public trust in the medical profession—ends seemingly better achieved through a tort action or medical board discipline. Moreover, counterspeech is likely insufficient to combat all forms of medical misinformation, as some studies suggest education can prove disappointingly ineffective against certain medical falsehoods. This is especially true when addressing claims, such as anti-vaccination information, that appeal to individuals who embrace alternative models of health, remain suspicious of expertise or governmental authority, and otherwise reject biomedical "facts" in favor of other modes of interpretation.[322] Educational "debunking" communications have a hard time addressing the emotional and often enigmatic reasons why individuals engage with medical misinformation.[323] Additionally, the sheer quantity of medical misinformation in circulation, the way it spreads rapidly through trusted networks, and individuals' psychological predispositions that make them receptive to false medical claims "undercut the notion that the solution to false speech is more speech."[324]

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321. *See* Julia Belluz & John Lavis, *Joe Rogan Is a Drop in the Ocean of Medical Misinformation*, N.Y. TIMES (Feb. 8, 2022), https://www.nytimes.com/2022/02/08/opinion/joe-rogan-health-misinformation-solutions.html [https://perma.cc/SV7D-NYVN] (identifying public education on how to assess health treatment claims as potentially the best strategy to combatting the mass appeal of medical misinformation).

322. *See* Anna Kata, *A Postmodern Pandora's Box: Anti-Vaccination Misinformation on the Internet*, 28 VACCINE 1709, 1711–13 (2010) (studying common themes and messages found on anti-vaccination websites).

323. Heidi J. Larson & David A. Broniatowski, *Why Debunking Misinformation Is Not Enough to Change People's Minds About Vaccines*, 111 AM. J. PUB. HEALTH 1058, 1060 (2021) ("A decontextualized debunking strategy does not engage with the substance of the listener's concern, the debunker's job is to educate or otherwise fill an information gap. A more effective response to misinformation is more compassionate; it starts from the premise that the misinformed individual has legitimate concerns and feelings.").

324. Mello, *supra* note 12, at e220732.

B. TORT MISREPRESENTATION ACTIONS/STATUTORY ACTIONS FOR DECEPTIVE TRADE PRACTICES

As previously noted, aggrieved individuals bringing malpractice actions against physicians publicly spreading misinformation will have difficulty succeeding unless they can also establish that a doctor-patient relationship existed and, even then, difficult proof issues regarding causation may still jeopardize the claims.[325] Absent a doctor-patient relationship, tort law would likely treat a physician spreading misinformation like any layperson spreading falsehoods. Liability can arise under the common law tort of intentional misrepresentation, otherwise known as fraud.[326] In theory, successful intentional misrepresentation actions impose deterrence pressures, provide compensation to injured parties, and, through tort law's expressive function, elucidate the consequential social wrong of trusted physicians misleading the public.

However, the intentional misrepresentation tort has limited reach and will likely not cover many inaccurate claims by physicians. Intentional misrepresentation causes of action must meet high standards of proof regarding the defendant's state of mind: first, proving scienter in terms of the defendant's knowing the information was false or recklessly disregarding its falsehood and, second, proving the defendant's intent to induce reliance on the misinformation.[327] Also, many jurisdictions impose heightened pleading requirements, requiring that the circumstances of the fraud be stated with particularity,[328] while some jurisdictions further require that the allegations be proven by clear and convincing evidence, rather than the ordinary preponderance of the evidence standard.[329]

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325. *See supra* notes 178–84 and accompanying text.

326. To succeed in an intentional misrepresentation claim, the plaintiff generally must show (1) material misrepresentation of fact, opinion, or law; (2) sufficient scienter by defendant about the misrepresentation's falsehood; (3) defendant's purpose to induce plaintiff to act; (4) justifiable reliance on the misrepresentation by plaintiff; and (5) resulting economic loss. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR ECON. HARM §§ 9, 10 (AM. L. INST. 2020).

327. *Id.*

328. *See, e.g.*, N.Y. C.P.L.R. 3016(b) (MCKINNEY 2023) ("Where a cause of action or defense is based upon misrepresentation, fraud, mistake, wilful [sic] default, breach of trust or undue influence, the circumstances constituting the wrong shall be stated in detail.").

329. *See, e.g.*, *In re* Marriage of Cutler, 588 N.W.2d 425, 430 (Iowa 1999) (stating Iowa's clear and convincing fraud standard).

Therefore, physicians spreading misinformation could potentially escape liability by calling into question their knowledge or reckless disregard of the falsity of their claims. Some positions, while highly unorthodox, may not be clearly falsifiable in periods of medical uncertainty and ever-shifting information, like the COVID-19 pandemic. Likewise, physicians could minimize liability by arguing a lack of intent to induce reliance by particular members of the public. They could instead claim the provocative communications were meant to contribute to the public discourse on contested issues, not be taken as medical advice. Even more important, the intentional misrepresentation tort has traditionally been limited to situations of commercial dealings between parties where one suffers economic loss.[330] The tort is thus an awkward fit for many misinformation situations, where an aggrieved plaintiff would primarily allege physical harm.

As opposed to intentional misrepresentation claims, negligent misrepresentation actions can be brought simply by alleging the defendant acted carelessly in communicating false information, rather than having to show knowledge or reckless disregard of the falsehood.[331] Negligent misrepresentation actions, therefore, would seemingly apply to a wider range of misinformation conduct. However, many courts limit the duty of care in negligent misrepresentation cases to parties in professional or fiduciary relationships, because of concerns of open-ended liability in communicating information.[332] It is not clear that this tort can be used to address communications between physicians and non-patient members of the public, which generally involve arms-length relationships. Moreover, the tort usually requires that the defendant have a pecuniary interest in the subject matter, to avoid imposing liability for gratuitous

330. *See, e.g.*, Neurosurgery & Spine Surgery, S.C. v. Goldman, 790 N.E.2d 925, 931–33 (Ill. App. Ct. 2003); Doe v. Dilling, 888 N.E.2d 24, 36–40 (Ill. 2008).

331. *See, e.g.*, RESTATEMENT (THIRD) OF TORTS: LIAB. FOR ECON. HARM § 5 (AM. L. INST. 2020).

332. *See, e.g.*, Williams v. Smith, 820 N.W.2d 807, 818–19 (Minn. 2012) (refusing to recognize a duty of care that protects a prospective government employee from the negligence of a government representative because the parties' relationship was not of a fiduciary nature, the parties were both sophisticated business people, and there were no public policy reasons to impose a duty of care under these circumstances).

communications.[333] In some instances of misinformation dissemination, the physicians have no direct economic interest and are not transacting with members of the public; instead, they are making provocative claims and statements for general circulation.

Related to, and potentially supplementing, common law tort misrepresentation claims are statutory claims for deceptive trade practices. Most states have statutes that sanction defendants who, in the course of their business or professional occupation, engage in deceptive practices for commercial benefit. Unlike intentional misrepresentation claims, proof of the physician's bad intent or state of mind may not be required, making the statutory claims potentially more viable.[334] Under such statutes, deceptive practices include representing services or goods as having beneficial qualities that they actually lack or other conduct creating "confusion or misunderstanding."[335] These laws could be relied upon, for example, to sanction physicians promoting the sale of unproven, unapproved "natural" COVID-19 treatments from which they profit. Several state deceptive trade practice statutes allow for injured parties to bring private actions in addition to enforcement by the State Attorney General.[336]

However, the reach of statutory deceptive trade practice claims remains limited, similar to common law misrepresentation claims. These actions will primarily apply to instances of economic harm, not physical injury, experienced by individuals acting on a physician's false communications to the public.[337] Additionally, several state deceptive trade practice statutes exempt

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333. *See, e.g.*, RESTATEMENT (THIRD) OF TORTS: LIAB. FOR ECON. HARM § 5 (AM. L. INST. 2020).

334. Dee Pridgen, *The Dynamic Duo of Consumer Protection: State and Private Enforcement of Unfair and Deceptive Trade Practice Laws*, 81 ANTITRUST L.J. 911, 918 (2017) ("The FTC Act, and its state UDAP statute offspring, eliminated the need to prove intent to deceive . . . .").

335. *See* Uniform Deceptive Trade Practices Act, 815 ILL. COMP. STAT. 510/2(a)(12) (2023).

336. *See, e.g.*, N.C. GEN. STAT. § 75-16 (2023) ("If any person shall be injured . . . by reason of any act or thing done by any other person, firm or corporation in violation of the provisions of this Chapter, such person . . . shall have a right of action . . . .").

337. *See* Pridgen, *supra* note 334, at 941 ("[I]n many if not most states, a cause of action based on physical rather than economic injury is not covered under the state UDAP statute.").

from regulation "professional services" involving advice, opinion, or similar professional skills, such as traditional services by architects and doctors.[338] In these states, problems with substandard professional services are meant to be addressed by other laws, such as malpractice claims, not deceptive trade practice statutes. Thus, a difficult interpretation issue arises whether a physician making false medical claims to the general public, not individual patients, is rendering "professional services." If this is understood as essentially providing professional advice or opinion, the falsehoods might be exempt from regulation by the various state deceptive trade practice statutes with professional services exceptions. Further, as a matter of pragmatic implementation, these statutes are unlikely to address situations where physicians make provocative, false claims to stir up public opinion, but unrelated to their direct economic benefit. Deceptive trade practice statutes are more typically enforced against parties transacting with the community for goods or services related to false claims.[339]

C. DECERTIFICATION/DECREDENTIALING

Private professional medical organizations, sometimes known as specialty boards, exercise significant influence in the healthcare sector, providing additional quality control to supplement governmental regulation and the deterrence pressures of tort law. Groups such as the American Academy of Pediatrics develop practice guidelines and provide continuing professional education.[340] Physicians can also voluntarily seek to be certified by these specialty boards. Certification and full membership are reserved for physicians who demonstrate sufficient knowledge and clinical skills in the respective medical specialty, usually assessed by administering detailed examinations to applicants. In contrast to licenses granted by state medical boards, which are required for physicians to practice medicine legally in each jurisdiction, certification by a private professional medical

338. *See, e.g.*, TEX. BUS. & COM. CODE ANN. § 17.49 (West 2023).

339. *See, e.g.*, State v. Minn. Sch. of Bus., Inc., 935 N.W.2d 124, 124 (Minn. 2019) (involving an action under state deceptive trade practices statute alleging that schools misled enrolling students into believing criminal justice programs would be a pathway to working as police and probation officers).

340. *See* Joseph T. Flynn et al., *Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents*, 140 PEDIATRICS e20171904 (2017).

organization is not a legal precondition to practice.[341] That said, certification is prestigious, signaling a practitioner's special training and skills. Certification also has direct economic value, as certain payors and healthcare institutions contractually require that their participating physicians have some form of specialty board certification.[342]

Thus, private medical organizations can wield significant leverage by withholding certification or decertifying already approved physicians. Along these lines, the American Board of Medical Specialties (ABMS), the umbrella group for most of the nation's private professional medical organizations, issued guidance in September 2021 sounding the alarm about physician-spread misinformation.[343] ABMS advised that physicians spreading misinformation risked losing certification by one of ABMS's member organizations.[344]

Enhanced oversight by private professional medical organizations offers certain advantages over relying on licensure discipline by medical boards. As private entities, private professional medical organizations are not subject to the same First Amendment limitations and statutory authority concerns, as public medical boards, affording them greater flexibility. They also are further insulated from outside political interference as, unlike medical boards, they are not subject to state legislative control or dependent on public funding. Yet, concerns still arise about the difficulty in defining medical misinformation. Also, there remains the risk that physicians in organization leadership positions can wield the decertification authority in anticompetitive ways to threaten economic rivals or to stifle legitimate physician dissent on certain medical topics. On the other hand, the consequences of decertification are not as severe as revocation of license by a medical board because certification is not a legal

341. Sandra Johnson, *Structure of Governmental Oversight of Quality in Healthcare*, *in* THE OXFORD HANDBOOK OF U.S. HEALTH LAW 489, 491 (I. Glenn Cohen et al. eds., 2015).

342. *Id.*

343. Press Release, Am. Bd. of Med. Specialties, ABMS Issues Statement Supporting Role of Medical Professionals in Preventing COVID-19 Misinformation (Sept. 13, 2021), https://www.abms.org/newsroom/abms-issues-statement-supporting-role-of-medical-professionals-in-preventing-covid-19-misinformation [https://perma.cc/Z92C-LN26].

344. *Id.*

requirement for providing physician services.[345] Thus, some risk of error may be more easily tolerated in decertification actions, to support the larger goal of reputable physician groups combatting false medical claims.

Similarly, private hospitals and other private healthcare entities may join the fight by restricting the medical staff privileges of physicians who spread medical misinformation. Known as "decredentialing," a restriction of staff privileges that means the physician lacks the authority to provide services at the institution. For example, in 2021, Methodist Hospital in Houston suspended staff privileges of physician Mary Bowden because she was spreading COVID-19 misinformation, including using social media to question the COVID-19 vaccine's effectiveness and advocating the use of the anti-parasitic drug ivermectin.[346] Rather than continue to fight the decredentialing action, Bowden resigned from the hospital.[347]

As with private professional medical organizations, private healthcare institutions have greater flexibility in sanctioning physicians for spreading misinformation because, as non-governmental entities, they are not subject to the same First Amendment limitations, and direct legislative control, that complicate medical board oversight. However, this advantage should not be overstated. Decredentialing or otherwise "firing" physicians from private healthcare systems is not always an easy option. At many institutions, the medical staff bylaws that govern hospital-staff relations may not clearly define spreading

345. *See* Johnson, *supra* note 341, at 491; Brendan Murphy, *Licensing and Board Certification: What Residents Need to Know*, AM. MED. ASS'N. (May 22, 2019), https://www.ama-assn.org/medical-residents/transition-resident-attending/licensing-and-board-certification-what-residents [https://perma.cc/K3WE-PMLH] ("While every physician must be licensed to practice medicine, board certification is a voluntary process.").

346. Amanda Watts & Alaa Elassar, *Texas Doctor Suspended for Spreading 'Misinformation' About Covid-19 Submits Resignation Letter*, CNN (Nov. 13, 2021), https://www.cnn.com/2021/11/13/us/houston-doctor-suspended-covid-19/index.html [https://perma.cc/K6WL-U9TZ]; Lucio Vasquez, *Houston Doctor Suspended for Vaccine Misinformation Files $25 Million Defamation Lawsuit Against Methodist Hospital*, HOUS. PUB. MEDIA (July 25, 2022), https://www.houstonpublicmedia.org/articles/news/health-science/2022/07/25/429010/houston-doctor-suspended-for-vaccine-misinformation-files-25-million-defamation-lawsuit-against-methodist-hospital [https://perma.cc/3R3S-HVP8].

347. Rubin, *supra* note 51.

misinformation as an actionable offense for restricting staff privileges.[348] Further, it can be time-consuming and expensive to restrict privileges when a physician challenges the decision and exercises full appeal rights under the medical staff bylaws. And, in some situations, institutional action may invite additional legal challenges. In the case of Dr. Bowden, while she did not initially appeal the restriction of her privileges, she later filed a $25 million defamation lawsuit against the hospital, accusing the institution of tarnishing her reputation in the dust-up over combatting her controversial medical claims.[349] A trial judge recently dismissed the defamation lawsuit, but Dr. Bowden stated that she plans to appeal.[350]

In sum, alternatives exist that avoid the numerous difficulties of relying on medical boards to police medical misinformation. Unfortunately, these different approaches likely fall short in adequately regulating physicians disseminating falsehoods. But they offer benefits nonetheless in partially mitigating some of the resulting harms of physician-spread misinformation.

CONCLUSION

Physician-spread misinformation poses a clear problem still in search of a clear solution. Considerable confusion exists about the societal role private physicians undertake when communicating to the general public and how this implicates, if at all, professional conduct and fitness for practice. Even if public communications fall within the ambit of a private physician's professional activities, it remains unsettled what obligations legally, as well as optimally, attach to such behavior. Licensure regulation seems particularly ill-suited to police the spread of misinformation. Because of the patient-centered focus underlying law and medical ethics, it becomes difficult to make legally cognizable the wrongs arising from physicians spreading falsehoods to the community when acting outside their clinical interactions with patients. First Amendment obstacles to sanctioning

348. *See, e.g.*, *Medical Staff Bylaws and Rules and Regulations of Stanford Health Care*, https://stanfordhealthcare.org/health-care-professionals/medical-staff/governing-documents.html [https://perma.cc/53AT-X9DU] (making no direct mention of misinformation).

349. Vasquez, *supra* note 346.

350. Michael DePeau-Wilson, *Bowden's Defamation Suit Against Houston Methodist Tossed*, MEDPAGE TODAY (Feb. 2, 2023), https://www.medpagetoday.com/special-reports/features/102937 [https://perma.cc/4DLC-R85G].

physician speech, along with structural problems in institutional design and operations, further complicate the effectiveness of medical board oversight.

Enhanced licensure regulation also may not be worth the accompanying downsides along with any marginal benefits. Because of the challenges in defining medical misinformation with precision, wide discretion is inevitably left to medical boards in determining which physicians and which claims to sanction. This raises legitimate concerns that medical boards will conflate unorthodox, yet innovative, medical claims with misinformation, as well as use their disciplinary powers for anti-competitive reasons. Risk of overreach threatens to limit robust public discourse by physicians on health issues of community interest. Even false physician communications have value, consistent with the marketplace of ideas rationale underlying the First Amendment, as well as for ensuring favorable conditions for the scientific method to do its work. Alternatives to licensure regulation, such as counterspeech and decertification, can partially mitigate risks, but, regrettably, some harms from physician-spread misinformation may simply need to be tolerated.

APPENDIX 1: CALIFORNIA SUMMARY

Analysis based on disciplinary actions publicly available on the California Medical Board website, at https://www.mbc.ca.gov/License-Verification/default.aspx.

California Summary							
Year	**Total Number of Complaints Received**	**Total Number of Disciplinary Actions Taken Against Physicians**	**Total Number of COVID-19 Misinformation Spreaders Disciplined for Unrelated Reasons**	**Total Number of Physicians Disciplined for Physician-Patient Interactions Related to COVID-19 [not misinformation]**	**Total Number of Physicians Disciplined for Spreading COVID-19 Misinformation to Patients**	**Total Number of Physicians Disciplined for Spreading COVID-19 Misinformation to the Public**	**Total Number of Disciplinary Actions Related to COVID-19**
Jan 1., 2020 – Dec. 31, 2020	10,868	338	0	0	0	0	0
Jan 1, 2021 – Dec. 31, 2021	10,103	469	1*	1*	0	1*	1
Jan 1, 2022 – March 30, 2022	***	120	0	1**	0	0	1
TOTALS	**n/a**	**927**	**1**	**2**	**0**	**1**	**2**

Category	Name	Date	License Number	Description of Discipline
Physicians Disciplined for Physician-Patient Interactions Related to COVID-19 [not misinformation]	Dr. Hongsheng Wei	2022	A 85829	Dr. Wei failed to wear a mask or other facial covering during a clinic visit with a patient. The California State Medical Board issued a public letter of reprimand.
Physicians Disciplined for Spreading COVID-19 Misinformation to Patients				
Physicians Disciplined for Spreading COVID-19 Misinformation to the Public	Dr. Thomas Cowan	2021	G 86923	Dr. Cowan posted a YouTube video theorizing that 5G networks cause COVID-19. Dr. Cowan voluntarily surrendered his California medical license and no further action was taken by the California State Medical Board.

Notes
* *Dr. Thomas Cowan voluntarily surrendered his license rather than face discipline*
** *This action was taken against Dr. Hongsheng Wei*
*** *Total number of complaints are unavailable until the annual report is finalized*

APPENDIX 2: TEXAS SUMMARY

Analysis based on disciplinary actions publicly available on Texas Medical Board website, at https://www.tmb.state.tx.us/page/look-up-a-license.

Texas Summary							
Year	**Total Number of Complaints Received**	**Total Number of Disciplinary Actions Taken Against Physicians**	**Total Number of COVID-19 Misinformation Spreaders Disciplined for Unrelated Reasons**	**Total Number of Physicians Disciplined for Physicain-Patient Interactions Related to COVID-19 [not misinformation]**	**Total Number of Physicians Disciplined for Spreading COVID-19 Misinformation to Patients**	**Total Number of Physicians Disciplined for Spreading COVID-19 Misinformation to the Public**	**Total Number of Disciplinary Actions Related to COVID-19**
Jan 1., 2020 – Dec. 31, 2020	n/a	349	2*	3	0	0	5
Jan 1, 2021 – Dec. 31, 2021	n/a	366	3*	4	3**	2***	12
Jan 1, 2022 – March 30, 2022	n/a	58	0	0	0	0	0
TOTALS	**n/a**	**773**	**5**	**7**	**3**	**2**	**17**

Category	Name	Date	License Number	Description of Discipline
Physicians Disciplined for Physician-Patient Interactions Related to COVID-19 [not misinformation]	Peter Shedden	10/16/2020	J1040	Dr. Shedden was disciplined for continuing to perform surgeries in violation of an executive order related to COVID-19.
	Ernest Layton	10/16/2020	J1106	Dr. Layton was disciplined for continuing to perform surgeries in violation of an executive order related to COVID-19.
	Gregory Eads	10/16/2020	M4048	Dr. Eads was disciplined for continuing to perform surgeries in violation of an executive order related to COVID-19.
	Bernice Gonzalez	03/05/2021	J6466	Dr. Gonzalez was disciplined for performing non-essential hormone replacement procedures on 10 patients using PPE that could have been used in the COVID-19 response (violating Governor's executive order GA-09).
	Damon Hill	06/11/2021	F6744	Dr. Hill was disciplined for failing to return phone calls regarding one patient's positive COVID-19 test results, resulting in delayed care.
	Gregory Colon	08/20/2021	J5731	Dr. Colon was disciplined for failing to personally evaluate (via telephone or telemedicine) one patient's COVID-19 symptoms before prescribing asthma medication.
	Eric Hensen	10/15/2021	R0868	Dr. Hensen was disciplined for refusing to wear a facemask in violation of an executive order and emergency board order related to COVID-19.
Physicians Disciplined for Spreading COVID-19 Misinformation to Patients	Stella Immanuel	10/15/2021	S3994	The Board and Dr. Immanuel entered into a non-disciplinary remedial plan to address her failure to give adequate informed consent to a patient for the prescription of hydroxychloroquine for treatment of COVID-19.
	Ray Rollins	12/10/2021	G5552	The Board and Dr. Rollins entered into a non-disciplinary remedial plan in response to his failure to meet the standard of care in the treatment and care of a patient. Dr. Rollins provided the patient with unproven information about

				COVID-19 prevention and a cure that is also unproven.
	Ivette Lozano	12/20/2021	J4310	The Board and Dr. Lozano entered into a mediated order in response to Dr. Lozano's failure to meet treatment requirements for two patients she treated for COVID-19 with complementary and alternative medicine.
Physicians Disciplined for Spreading COVID-19 Misinformation to the Public	Jerel Biggers	03/05/2021	G2646	The Board and Dr. Biggers entered into an agreed order in response to Dr. Biggers failure to adequately supervise his midlevel provider. As a result of this inadequate supervision, Dr. Biggers' delegate issued false and misleading advertising for stem cell therapies and IV treatments for COVID-19 prevention.
	Lindsey Jackson	6/11/2021	N0125	The Board and Dr. Jackson entered into a non-disciplinary remedial plan in response to her improper advertisement of COVID-19 treatments. The Board found that Dr. Jackson invited patients to her practice by advertising supplements and vitamin injections approved by the Galveston County Health District to protect them against COVID-19 by enhancing their immune system.

Notes
* *Unlicensed individuals*
** *These actions were taken against Drs. Immanuel, Rollins, and Lozano*
*** *These actions were taken against Drs. Biggers and Jackson*

APPENDIX 3: FLORIDA SUMMARY

Analysis based on disciplinary actions publicly available on Florida's Department of Health website, at https://mqa-internet.doh.state.fl.us/MQASearchServices/EnforcementActionsPractitioner.

Florida Summary							
Year	**Total Number of Complaints Received**	**Total Number of Disciplinary Actions Taken Against Physicians**	**Total Number of COVID-19 Misinformation Spreaders Disciplined for Unrelated Reasons**	**Total Number of Physicians Disciplined for Physician-Patient Interactions Related to COVID-19 [not misinformation]**	**Total Number of Physicians Disciplined for Spreading COVID-19 Misinformation to Patients**	**Total Number of Physicians Disciplined for Spreading COVID-19 Misinformation to the Public**	**Total Number of Disciplinary Actions Related to COVID-19**
Jan 1., 2020 – Dec. 31, 2020	114	44	0	0	0	0	0
Jan 1, 2021 – Dec. 31, 2021	120	68	0	0	0	0	0
Jan 1, 2022 – March 30, 2022	39	14	0	0	0	0	0
TOTALS	**273**	**126**	**0**	**0**	**0**	**0**	**0**

Category	Name	Date	License Number	Description of Discipline
Physicians Disciplined for Physician-Patient Interactions Related to COVID-19 [not misinformation]	N/A			
Physicians Disciplined for Spreading COVID-19 Misinformation to Patients	N/A			
Physicians Disciplined for Spreading COVID-19 Misinformation to the Public	N/A			