

# If it ducks like a quack: balancing physician freedom of expression and the public interest

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## ABSTRACT

Physicians expressing opinions on medical matters that run contrary to the consensus of experts pose a challenge to licensing bodies and regulatory authorities. While the right to express contrarian views feeds a robust marketplace of ideas that is essential for scientific progress, physicians advocating ineffective or dangerous cures, or actively opposing public health measures, pose a grave threat to societal welfare. Increasingly, a distinction has been made between professional speech that occurs during the physician-patient encounter and public speech that transpires beyond the clinical setting, with physicians being afforded wide latitude to voice empirically false claims outside the context of patient care. This paper argues that such a bifurcated model does not sufficiently address the challenges of an age when mass communications and social media allow dissenting physicians to offer misleading medical advice to the general public on a mass scale. Instead, a three-tiered model that distinguishes between citizen speech, physician speech and clinical speech would best serve authorities when regulating physician expression.

Conflict over the right of the state and professional bodies to regulate the speech of physicians whose views defy societal norms or consensus standards of care dates back centuries to controversies surrounding complementary remedies, patent medicines and contraceptives.<sup>1-4</sup> Since the World War II, the US Food and Drug Administration has targeted purveyors of ineffective treatments, such as orgone and laetrile, while the authorities have largely turned a blind eye to those physicians who advocate against public health measures such as vaccination.<sup>5, 6</sup> American law has carved out a wide berth for dissenting views, a safe harbour known as the respectable minority doctrine.<sup>7</sup> Until recently, it was unheard of for a provider to be disciplined for setting a poor example for patients through personal lifestyle choices, such as by smoking cigarettes in front of a hospital.<sup>8</sup> While leading ethicists including Arthur Caplan have called for the revocation of the licenses of physicians who oppose childhood vaccination, in the highest profile American case to date, that of prominent vaccine sceptic Jack Wolfson, the Arizona Board of Osteopathic Examiners in Medicine and Surgery refused to take action on the grounds that the controversial cardiologist had a right to ‘express his opinion’.<sup>9, 10</sup> However, the COVID-19 pandemic has drawn renewed attention to the rights of physicians to express views and engage in conduct that runs

contrary to the expertise of the medical establishment. For example, the Oregon Medical Board suspended the license of physician Steven LaTulippe for refusing to wear a mask and warning his patients that doing so was ‘very dangerous’, while an oncology nurse in that state, Ashley Grames, was placed on administrative leave, and later consented to stop practising nursing entirely, for not physically distancing or wearing a mask outside of work.<sup>11, 12</sup> Yet physicians touting debunked cures for COVID-19 (eg, hydroxychloroquine) or claiming that the pandemic is a ‘manufactured crisis’ continue to speak out in the USA without sanction—although with increasing professional and public backlash.<sup>13</sup> Meanwhile in Italy, the Rome Doctors Guild announced that it had warned or suspended 10 physicians ‘accused of unwarranted criticism of vaccinations’.<sup>14, 15</sup> The challenging issue of physician dissent has become only more fraught in the high-stakes context of a global pandemic that has already claimed millions of lives.

Law and ethics surrounding the freedom of expression of dissenting physicians has evolved piecemeal as contentious cases have arisen. Opinion 8.12 of the American Medical Association’s Code of Ethics imposes on physicians an obligation to ensure that all of the information they provide to the public is ‘accurate’ and ‘based on valid scientific evidence and insight gained from professional experience’, while many state regulations remain unclear on the subject.<sup>16</sup> Nevertheless, authorities have increasingly turned to a bifurcated model of regulation that distinguishes between speech that occurs in the clinical context and that which occurs outside the medical setting. The ‘professional speech doctrine’ takes the approach that while physicians deserve the same right to expression as other individuals outside their clinical work—such as when writing pamphlets or speaking in the public square—their speech may be curtailed substantially during encounters with patients.<sup>17, 18</sup> This doctrine essentially classifies direct patient counselling as a form of professional *conduct* as distinguished from traditionally protected categories of speech. American courts of appeals have used that distinction in addressing state bans on gay conversion therapy, Florida’s restriction on physician inquiries related to firearms and California’s requirement that anti-abortion crisis pregnancy centres postwarnings that ‘free or low-cost’ abortions are available elsewhere.<sup>19-21</sup> Unfortunately, the approach affords no middle ground. Yet the COVID-19 pandemic has shed light on a swath of speech that is not directed at individual patients in the examination room or surgery, yet nonetheless offers specific medical



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advice to the public that differs substantially from merely expressing general ideas on healthcare, medicine and policy. This paper briefly reviews the competing values at stake with regard to physician expression and then proposes a three-tiered approach for analysing and regulating such expression.

### THE DEBATE OVER RESTRICTING PHYSICIAN SPEECH

Broad protections for the free speech rights of physicians can be justified on numerous public policy grounds. Free expression increases the likelihood that providers will contribute to the marketplace of ideas, and today's dissenting views may prove tomorrow's innovations and future generations' orthodoxies. From Mendel and Semmelweis to the work of Barry Marshall and Robin Warren linking *Helicobacter pylori* to peptic ulcers, scientific breakthroughs have often been met with scepticism and hostility. Of course, many wrong ideas will have to be permitted in the proverbial marketplace if the best ideas are to gain traction. Prohibiting physician dissent runs the risk of suppressing such ideas and driving potential innovators from the field entirely. A sceptic of the medical consensus might choose a career in academic science or industry, fearing regulation of his/her ideas by overzealous medical boards. Moreover, the blades of censorship and censure, once unsheathed, can be used to slice haphazardly through public discourse: advocating for racial equality, female suffrage, gay rights, family planning, sex education, drug legalisation and aid-in-dying have all proven anathema to some medical critics in the past—and once speech can be limited, history shows that authorities will use that ability to challenge views they oppose. Beyond the policy considerations, physicians may also assert a fundamental right to expression. Why should one give up one's right to voice one's opinions after receiving a medical degree any more than when becoming licensed as a barber or a plumber?

Yet some fundamental differences distinguish restrictions on the speech of medical professionals from those of ordinary citizens. In most Western nations, physicians in essence operate as part of a guild: their numbers are fixed by the government or professional bodies in order to regulate quality and increase reimbursement.<sup>22</sup> In the USA, for instance, anyone with the skill and training can pay a fee to become a barber. In contrast, residency positions are limited like taxicab medallions or liquor licenses or radio frequencies, and—with rare exceptions—such training is required for licensure.<sup>23</sup> Many European nations are even more restrictive in their access to opportunities to practice medicine.<sup>24</sup> As such, once an individual accepts the privilege of becoming a physician, it does not seem unreasonable to ask that individual to accept additional responsibilities. One of these burdens might arguably be limits on speech and conduct that significantly compromises the public's health. State regulations and professional standards already impose such duties in other areas through 'role morality':<sup>25</sup> barbers are welcome to have romantic relationships with their clients, but physicians who have sex with patients are usually subject to discipline. In many nations, certain other professionals are already limited in their right to express themselves based on the nature of their work. For example, in many jurisdictions, judges are prohibited from making statements that might call the impartiality of the courts into question. In the USA, the Hatch Act prevents many government employees from engaging in a range of political endeavours that implicate free speech.<sup>26</sup> In addition, the training and expertise that physicians receive increases the likelihood that laypersons will rely on their statements. As a result, one might argue, they have a higher burden to maintain the accuracy of

their statements than do private citizens. Similarly, in practising medicine, physicians inevitably become role models in matters of health and safety. Needless to say, a clear conflict exists here between this responsibility and private liberty; for instance, it is hard to imagine a state medical board requiring doctors to eat healthily or forgo tobacco. The question remains whether certain conduct exists that is legal yet so extreme as to justify official sanction.<sup>27</sup>

The American courts have historically distinguished speech from conduct, protecting the former far more extensively than the latter.<sup>28</sup> This distinction proves reasonably effective when applied to altercations in bars, or distinguishing between academics discussing the hypothetical overthrow of the government from militants attempting revolution. In the medical context, this division proves much less useful. The regulation of certain forms of conduct, such as the wearing of masks, is certainly reasonable. However, both telling patients not to wear masks and lobbying the legislature against mask mandates are both speech, yet forms of speech fundamentally different in kind. An approach that transcends the traditional speech-conduct distinction is necessary.

### A THREE-TIERED FRAMEWORK

This paper proposes a three-tiered framework for assessing and regulating the expression of physicians. Speech/Conduct in the first tier ('citizen speech'), which relates broadly to matters of healthcare and public policy, deserves the greatest level of protection. Speech/Conduct in the second tier ('physician speech') involves situations in which a physician, acting on the authority of his/her position, offers specific medical guidance to the public; this speech, as discussed below, should be subject to a greater degree of regulation. Finally, speech/conduct in the third tier ('clinical speech'), which is closely related to the concept of 'professional speech', should be subject to significant regulation with regard to the standards of care of the profession. Each of these three tiers of speech is discussed in more detail below.

#### Tier 1: citizen speech

The justification for regulating physician speech is at its weakest when the physician is speaking as an ordinary citizen. Such speech might be on a political or social topic entirely unrelated to medicine, or it might be on a medically related matter in which the physician is speaking as an advocate for policy change. Whether the physician agrees with the consensus opinion of the medical establishment or not is irrelevant. Such an approach would protect those physicians who support expanding access to healthcare and those who oppose doing so, providers who want antiracism measures imposed and those who do not consider antiracism a priority, those who support lockdowns to control the coronavirus pandemic and even those who oppose such measures. These ideas, whether wise or foolish, are best contested in the marketplace, not before professional regulators. Permitting such debate increases the likelihood of innovation and progress, and suppressing such debate runs the risk of tarnishing the credibility of the profession, especially if one of these suppressed ideas proves true. In fact, citizen speech of this sort likely requires *more* protection in the medical profession than currently exists. The structure of academic medicine in the USA, for instance, sees most clinical faculty holding joint appointments at both medical schools and hospitals. The latter provide a large percentage of their financial support. Even with assurances of academic freedom and tenure from their medical schools, these faculty are constrained in their ability to speak on

matters of public policy by fear of termination by their hospitals. Physicians have allegedly faced discipline for criticising their home institutions on a wide range of issues from diversity to pandemic preparedness.<sup>29 30</sup> Political pressure from social activists on both the political right and left (so-called ‘cancel culture’), augmented by the rise of social media, also suppresses citizen speech by physicians. Sometimes universities and medical schools are complicit in this suppression. For example, the University of Pennsylvania’s Perelman School of Medicine issued a statement disavowing former associate dean of curriculum Stanley Goldfarb’s controversial *Wall Street Journal* column opposing the rise of social justice-related curricula in medical education.<sup>31</sup> Whatever the merits of Goldfarb’s arguments—and this author does not happen to agree with them—danger lies in universities distancing themselves publicly from the controversial ideas of their own faculty. In public discourse, the right to be wrong without fear of reprisal is essential for intellectual progress.

### Tier 2: physician speech

In some circumstances, doctors will address the general public on specific medical matters that implicate care choices. While no individual doctor-patient relationship exists under the circumstances, this situation is fundamentally different from that of a physician speaking broadly on a matter of public concern. Laypeople are likely to rely on such statements and to act accordingly, often at the expense of their own health. That is not to say that *all* opinions offered to the public by physicians should be more heavily regulated merely because members of the public might rely on them. Rather, citizen speech only becomes physician speech when it is presented as factual. So a physician is well within his/her rights as a citizen to discourage the public from accepting the measles, mumps and rubella (MMR)-II vaccine because it was originally derived from fetal tissue and he views its use as morally objectionable.<sup>32</sup> The public can recognise that the physician is offering an opinion based on his/her own personal values and can weigh the recommendation through their own ethical lens. In contrast, the state should be permitted to regulate more strictly a physician who urges the public not to accept the MMR-II vaccine because it causes autism, which numerous studies have shown to be empirically false, or because it does not work.<sup>33</sup>

An analogy might be drawn to a civil engineer commenting on bridge safety. If the engineer declares on television that suspension bridges are safe, and a particular bridge fails, that is analogous to citizen speech and does not merit sanction. In contrast, most people would agree that if an engineer meets a driver on a road during a storm and declares that the bridge up ahead is not washed out, while in fact he knows that it is, his conduct clearly merits punishment. Physician speech is analogous to the engineer going on television and announcing the bridge is not washed out—when, in fact, it is. Merely because the advice is offered collectively, rather than individually, does not absolve the speaker from responsibility. Similarly, offering generally commentary on social media stands well within the rights of physicians. However, offering specific false information on these media—such as stating that the MMR-II vaccine causes autism on a public Facebook post or Twitter feed—is just as dangerous as the engineer deceiving drivers about the washed-out bridge and should be just as open to regulation. Needless to say, challenges will arise regarding blended or mixed speech that contains both statements of value and false statements of fact. For example, a physician might criticise a particular intervention as both ‘immoral and ineffective’. While some difficulty may arise

in parsing out these distinctions, it does not mean that regulators should not attempt to do so.

The standard for evaluating physician speech should be the malpractice standard. In other words, if the advice given collectively or publicly were offered to an individual patient in a clinical setting, and he or she acted on it, would that speech justify a malpractice claim? Such an approach protects recommendations that may not reflect the majority consensus, but nonetheless have enough expert support to qualify for immunity under the respected minority doctrine. While the malpractice standard should apply, civil liability—rather than state regulation—is a poor mechanism for regulating such speech. Potential plaintiffs may receive false medical information from many sources and injured parties will have incentive to falsely attribute their own poor choices to dissenting physicians after the fact. At the opposite extreme, followers of dissenting physicians may refuse to take action even after suffering injuries, thereby allowing deleterious physician speech to continue unchecked.

While it is clear that the state or licensing bodies should be the regulators of physician speech, how to regulate such speech is a more challenging question. While the state or medical board might be justified in prohibiting certain statements, especially during a public health crisis such as the COVID-19 pandemic, that intervention is not the only available step. At a minimum, the medical authorities might require anyone advancing such misleading physician speech to issue a concrete disclaimer stating they are not offering clinical advice. Regulators might go one step further and require such physicians to make clear to audiences the absence of medical authority or empirical evidence to justify their position—or even to explain to the public the actual standard of care. (This approach actually remedies one of the issues that arises with blended speech, as such an approach may force speakers to distinguish value-based and fact-based statement by appending disclaimers to the latter.) Regulators might also choose to prevent those advocating actionable physician speech from profiting from such speech: sharing false information with the public is one matter, growing rich off the proceeds of such false information is another matter entirely. Whatever specific regulatory steps they take, regulators should consider the dangers posed by such physician speech when acting, rather than deferring to the speaker as though the speech were no different than ordinary citizen speech.

### Tier 3: clinical speech

State licensing boards and courts have a long history of regulating speech and expression in the context of the physician-patient relationship. Arguably, one of the key purposes of medical licensure and of tort liability is to ensure that certain clinical standards are met during these encounters. Needless to say, physicians are generally afforded considerable flexibility in offering clinical advice and management. Extensive debate exists surrounding whether the state should be able to regulate clinicians’ speech in these encounters on a wide range of political and moral issues including abortion, aid-in-dying, conversion therapy, and gun safety. Those debates are beyond the scope of this paper. Also, the exact boundary between physician speech and clinical speech can prove murky on occasion, such as when potential patients at the office of Florida physician Jack Cassell were greeted with a sign in 2010 that read “If you voted for Obama ... seek urologic care elsewhere”.<sup>34</sup> However, states are clearly within their authority to penalise or revoke the licenses of providers who provide medical information to patients during clinical encounters that is false and dangerous, such as discouraging vaccination on safety or efficacy grounds. Applying this principle becomes somewhat more challenging in the setting of

social media: Is a Facebook account or Twitter feed with numerous followers offering a general opinion or offering medical advice to each of them? Does it matter if some of these followers are also patients of the provider (which also raises other questions regarding professional boundaries that lie beyond the scope of this paper)? In other words, when does physician speech on social media become clinical speech? The key question appears to be whether the recipient of the information might reasonably interpret that guidance to be offered as part of a clinical encounter or ongoing physician-patient relationship. If so, it can be regulated like any other direct clinical communication between doctors and their patients.

### BY WHOSE AUTHORITY?

One question that is bound to arise related to the proposed three-tiered model is what mechanism should be used to operationalise and enforce these rules. The two leading possibilities are professional organisations—such as the American Medical Association, the American College of Physicians, etc—or, as suggested above, state licensing authorities. Solid arguments can be advanced for each of these positions. The benefit of regulation by professional organisations is that such an approach allows physicians, who have both insight into the norms of their profession and incentives to protect its reputation and interests, to govern themselves. However, recent history has demonstrated that such an approach often lacks teeth. Even after medical organisations proscribe member participation in such morally fraught endeavours as force feeding prisoners, capital punishment and so-called enhanced interrogation, non-member physicians continue to engage in such practices with impunity. The most striking example of this may be the inability of the American Psychiatric Association (APA) to enforce a rule preventing the diagnosis of public figures, as psychiatrists opposed to the ‘Goldwater rule’ merely resign their APA membership and continue to engage in the APA-proscribed practice. States licensing authorities, in contrast, have the power to act decisively against *all* licensees, regardless of their standing with professional organisations. Since many dissenting physicians are already outliers alienated from traditional professional organisations and their norms, the regulation of their speech is likely better left to state authorities.

### CONCLUSION

The goal of this paper is not to persuade regulators to suppress any particular set of ideas nor to penalise doctors who hold any specific viewpoints. Rather, the aim is to reframe the debate surrounding physician expression. The current distinction between speech that occurs in the clinical setting and speech that occurs in the marketplace ignores a crucial third category of statements (‘physician speech’) that are expressions of clinical guidance offered outside the individual physician-patient relationship. In the era prior to the rise of mass media and the internet, the ability of dissenting physicians to offer empirically questionable advice to the public was relatively circumscribed, so the bifurcated dichotomy of citizen speech and professional or clinical speech proved workable. In contrast, the current international health crisis has emphasised how inadequate such an approach is for the regulation of dissident medical providers during a pandemic. In no other field are experts permitted to offer life-threatening advice under the colour of professional authority and to avoid regulation solely because they offer false information collectively rather than to individual clients or patients. Freedom of expression will suffer little if regulators separate ‘physician speech’ from more traditional forms of

citizen speech and then monitor and regulate such utterances more closely.

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