Limitations of Medical Licensing: The Role of State Boards of Medicine in Regulating Medical Misinformation

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Introduction

Throughout the COVID-19 pandemic, public health officials warned the public to be wary of medical misinformation[1] and disinformation.[2] The World Health Organization declared that the deluge of misinformation was an "infodemic."[3] This infodemic was so pervasive that President Biden decried social media for "killing people" by allowing medical misinformation to circulate.[4] Many public health officials struggled to ensure that the public was receiving accurate information as new data would come to light.[5] State and federal elected officials clashed over even basic facts as they debated whether to adopt quarantines, vaccine mandates, and other measures to combat the pandemic.[6] These disputes have eroded trust in public health initiatives

1 Off. of the U.S. Surgeon Gen., Confronting Health Misinformation: The U.S. Surgeon General's Advisory on Building a Healthy Information Environment 4–7 (2021), https://www.hhs.gov/sites/default/files/surgeon-general-misinformation-advisory.pdf (defining misinformation as "false, inaccurate, or misleading according to the best available evidence at the time").

2 *Id.* at 4 (defining disinformation as a subset of misinformation but "can sometimes be spread intentionally to serve a malicious purpose").

3 *Infodemic*, World Health Org., https://www.who.int/health-topics/infodemic (last visited Dec. 1, 2023) (defining an infodemic as "too much information including false or misleading information in digital and physical environments" that "causes confusion and risk-taking behaviours that can harm health," "leads to mistrust in health authorities[,] and undermines the public health response").

4 Barbara Ortutay, *Biden: Social Media Platforms 'Killing People' with Misinfo*, AP News (July 16, 2021), https://apnews.com/article/joe-biden-business-health-media-social-media-73ca875f1d1c04bc69108607d8499e3c. A federal court subsequently enjoined the Biden administration from contacting social media companies to suppress disfavored viewpoints, including medical claims related to COVID-19. Missouri v. Biden, No. 3:22-cv-01213, 2023 WL 4335270 (W.D. La. July 4, 2023). While this case is beyond the scope of this current article, it is worth noting for future exploration.

5 Lauren Sausser, *With Public Health on the Line, Here's How Local Health Departments are Fighting Misinformation*, CNN Health (Jan. 9, 2023), https://www.cnn.com/2023/01/09/health/public-health-departments-misinformation-khn-partner/index.html (noting that "covid-related language" was "complex" and "difficult to understand," leading a public health expert to recognize "that our communication missteps created the environment where disinformation flourished").

6 Wendy E. Parmet, *Fights Between U.S. States and the National Government Are Endangering Public Health*, Sci. Am. (Oct. 19, 2022), https://www.scientificamerican.com/article/fights-between-u-s-states-and-the-national-government-are-endangering-public-health/ (arguing that "[t]he divergent approaches by different state governments in 2020 and 2021 also muddied the public health message" and made it difficult to determine if certain strategies such as masking

and led the public health community to rethink how to best communicate with the public.[7]

Of particular concern is when duly licensed physicians lend credence to unproven claims by virtue of their professional qualifications.[8] Critics question how they can circulate misinformation and even disinformation while retaining their licenses.[9] Shouldn't physicians face consequences for disseminating misinformation capable of harming their patients and the general public? Shouldn't those whom society trusts to hold a license to practice medicine be held to high standards?

State medical boards, which are responsible for regulating physicians and other practitioners, recognized during the pandemic that they would need to evaluate physicians' conduct under "[s]tandards of care [that] may evolve as novel scientific discoveries occur and as new evidence becomes available."[10] Advocates have urged state medical boards to discipline physicians who promote medical misinformation and disinformation,[11] and the public and the medical community widely support disciplining measures to combat disinformation.[12] But as this Article demonstrates, state medical boards face legal and policy

were beneficial).

7 Sausser, *supra* note 5 (noting that "data suggests that the skepticism and misinformation surrounding covid vaccines now threatens other public health priorities" such as routine childhood immunizations and flu vaccinations).

8 Carl H. Coleman, *Physicians Who Disseminate Medical Misinformation: Testing the Constitutional Limits on Professional Disciplinary Action*, 20 First Amend. L. Rev. 113, 115 (2022) (discussing instances of licensed physicians presenting misinformation on vaccines and medical products).

9 Kristina Fiore, *Worst COVID Liars Still Have Their Licenses*, Medpage Today (Dec. 28, 2021), https://www.medpagetoday.com/special-reports/exclusives/96408.

10 Fed'n of State Med. Bds., Professional Expectations Regarding Medical Misinformation and Disinformation 2–6 (2022), https://www.fsmb.org/siteassets/advocacy/policies/ethics-committee-report-misinformation-april-2022-final.pdf (providing guidance to state medical boards and physicians on the balancing standards of care in "emergent or urgent circumstances").

11 de Beaumont Foundation, Disinformation Doctors: Licensed to Mislead i (2021), https://debeaumont.org/wp-content/uploads/2021/12/dBF-NLFD-Disinformation-Doctors-report-vf.pdf (arguing that "state medical boards have a duty to act in the public's best interest"); Y. Tony Yang & Sarah Schaffer DeRoo, *Disciplining Physicians Who Spread Medical Misinformation*, 28 J. Pub. Health & Mgmt. Prac. 595, 595 (2022) (noting "increasing calls in the medical community... to revoke the licenses and board certifications of physicians who promulgate medical misinformation").

12 de Beaumont Foundation, *supra* note 11, at i (noting a poll finding that "a majority of American adults – nine in 10 – believe that doctors who intentionally spread misinformation about COVID-19 should be held accountable").

obstacles to take such actions.

This Article consists of three parts. Part I provides an overview of the role and function of state medical boards. Part II will discuss the role of public policy in how physicians convey medical information. Finally, Part III will explain the limits of boards and licensing as a means of reducing the spread of misinformation. This Article notes that the same limits that protect physicians who spread misinformation may shield other physicians who provide their patients with counsel on health issues that are politically disfavored. While the COVID-19 pandemic provides a starting point for this analysis, examples of physicians making dubious, and even malicious, claims are not confined to the pandemic.[13] This is especially true as states take diverging positions on how a physician may legally practice in other clinical areas such as reproductive health.[14]

I. Overview of State Medical Boards

State medical boards have long held the ability to license physicians and other health professionals.[15] While some critics have argued that the state-by-state licensing process is too time-consuming and bureaucratic in an increasingly transient world,[16] federal policymakers have shown little appetite for usurping medical licensing from the states.[17] This Part will discuss the history, current role, and prevailing criticisms of state medical boards.

A. History of State Medical Boards

Since the mid-nineteenth century, states have maintained regulatory processes for the licensure of health professionals within

13 Fed'n of State Med. Bds., *supra* note 10, at 1 (noting that "misinformation and disinformation have existed for centuries").

14 Selena Simmons-Duffin, *Doctors Who Would Like to Defy Abortion Laws Say It's Too Risky*, NPR (Nov. 22, 2022), https://www.npr.org/2022/11/22/1138558392/doctors-who-would-like-to-defy-abortion-laws-say-its-too-risky.

15 Dent v. West Virginia, 129 U.S. 114, 122–23 (1889) ("[I]t has been the practice of different States, from time immemorial, to exact in many pursuits a certain degree of skill and learning upon which the community may confidently rely . . .").

16 U.S. Dep't of Health & Hum. Servs. et al. , Reforming America's Healthcare System Through Choice and Competition 36–37 (2018), https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf.

17 George J. Annas, *Congress, Controlled Substances, and Physician-Assisted Suicide: Elephants in Mouseholes*, 354 New Eng. J. Med. 1079, 1083 (2006) (noting that "Congress historically has been loath to legislate medical practice").

their borders.[18] The authority to license professionals is derived from the Tenth Amendment's reservation of states' "police power" to protect their residents' health and safety.[19] The Supreme Court upheld this use of the states' police power in *Dent v. West Virginia*.[20] Here, a person convicted of practicing medicine without a license challenged the constitutionality of the West Virginia statute which prohibited the unauthorized practice of medicine.[21] The state statute authorized the West Virginia health board to grant a license to practice medicine to an applicant who met certain eligibility requirements: the applicant must have a degree from a reputable medical school and pass an examination approved by the state board or another state's board or have practiced continuously for at least ten years in West Virginia before the state statute took effect.[22] Practicing without complying with the West Virginia requirements could subject an unlicensed practitioner to a misdemeanor.[23] The defendant argued that West Virginia was depriving him of his liberty to practice medicine.[24] The Court, however, held that the state's conditions on the practice of medicine were not unconstitutional.[25] A state may "prescribe all such regulations as, in its judgment, will secure or tend to secure [its people] against the consequences of ignorance and incapacity as well as of deception and fraud" in the practice of medicine.[26] The Court reasoned that a license provides consumers with some assurance of competency in a complex field involving study and preparation.[27]

Today, more than seventy state and territorial medical boards exist in the United States.[28] As of 2020, there were over one million

18 Jacqueline Landess, *State Medical Boards, Licensure, and Discipline in the United States*, 17 Focus 337, 338 (2019).

19 *Id.* at 337–38.

20 *Dent*, 129 U.S. at 122, 128.

21 *Id.* at 117–18, 121.

22 *Id.* at 115–17.

23 *Id.* at 117.

24 *Id.* at 118–20 (noting that the defendant had not practiced medicine for the required ten years).

25 *Id.* at 128.

26 *Id.* at 122. The Court noted that a state could require regulations that are "appropriate to the calling or profession, and attainable by reasonable study or application" without these regulations being deemed a deprivation of a "right to pursue a lawful vocation." *Id.*

27 *Id.* at 122–23.

28 Fed'n of State Med. Bds., Guidelines for the Structure and Function of a State Medical and Osteopathic Board 1 (2021), https://www.fsmb.org/siteassets/advocacy/policies/guidelines-for-the-structure-and-function-of-a-state-medical-and-osteopathic-board.pdf. This figure includes boards in both states and territories as well as jurisdictions that maintain separate boards for regulating

licensed physicians in the United States, 20 percent more than in 2010,[29] and a quarter of all licensed physicians held licenses in multiple states,[30] which also marked an increase since the prior 2018 census.[31] The percentage of physicians holding multiple licenses will likely grow because of post-pandemic interest in telehealth, which allows physicians to practice virtually but requires them to be licensed in every state where their patients are located.[32]

B. How State Medical Boards Regulate Physicians

State medical boards use two principal ways of regulating physician practice: restricting who can obtain a license and disciplining those who hold licenses.[33] These methods serve several important policy goals. By restricting who can obtain a license, state medical boards signal to patients that a licensed physician has met a minimum threshold deemed necessary by state policymakers for the safe practice of medicine; those who do not have a license are unauthorized to practice medicine.[34] Once physicians obtain their licenses, they must maintain a basic level of competency, demonstrated through continuing medical education, to qualify for renewals.[35] If they fail to maintain a minimum level of competency, state medical boards can subject them to a disciplinary proceeding.[36] Disciplinary proceedings can remove incompetent physicians from practice while encouraging others to maintain minimum standards to avoid discipline.[37]

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allopathic and osteopathic doctors. *Id.* at 8.

29 Aaron Young et al., *FSMB Census of Licensed Physicians in the United States, 2020*, J. Med. Regul., July 2021, at 57, 58.

30 *Id.* (noting that nearly a quarter of licensed physicians hold "two or more active licenses," or over 1.4 million licenses for a million physicians).

31 Aaron Young et al., *FSMB Census of Licensed Physicians in the United States, 2018*, J. Med. Regul., July 2019, at 7, 17.

32 *See* Julie Appleby, *Telehealth Took Off During the Pandemic. Now, Battles Over State Lines and Licensing Threaten Patients' Options*, Time (Aug. 26, 2021), https://time.com/6092635/telehealth-state-lines-licensing/ (noting that continued interest in telehealth and "growing interest by investors" is increasing interest in interstate licensing).

33 U.S. Dep't of Health & Hum. Servs., State Discipline of Physicians: Assessing State Medical Boards Through Case Studies 8–9 (2006), https://aspe.hhs.gov/sites/default/files/private/pdf/74616/stdiscp.pdf.

34 Lawrence Gostin, Public Health Law 254 (1st ed. 2000).

35 U.S. Dep't of Health & Hum. Servs., *supra* note 33, at 8.

36 *Id.* at 8 (noting that "[p]hysicians can be disciplined for numerous misbehaviors, from business offenses to problems in the quality of care").

37 *Id.* at 9.

Medical discipline is a relatively modern administrative process. From the outset of medical licensing in the mid-nineteenth century, state boards focused more on preventing the unauthorized practice of medicine than enforcing requirements for safe practice.[38] But many groups, including the American Medical Association, a membership-based organization that represents physicians, criticized this focus spanning from the mid- to late twentieth century.[39] Assessments of state medical boards at that time revealed that many boards lacked both funding and a formal infrastructure through which to conduct investigations and hear disciplinary cases.[40] In 1956, the Federation of State Medical Boards ("FSMB")[41] developed model state laws and administrative best practices to help state medical boards conduct disciplinary hearings.[42] In the 1960s, state medical boards began creating disciplinary processes to ensure greater accountability for public safety.[43]

The FSMB's most recently revised guidelines in 2021 contain an extensive, but not exclusive, list of fifty-eight different grounds for discipline.[44] Many of these recommended grounds relate to fraud, misrepresentation, and dishonesty: they range from specific acts such as cheating on a licensing exam to more general grounds such as "[a]ny conduct that may be harmful to the patient or public" or that is "likely to deceive, defraud, or harm the public."[45] These latter grounds

38 Landess, *supra* note 18, at 338.

39 *Id.* (noting an "an increased push for public accountability" over physician competency in the 1960s and 1970s); David Johnson & Humayun J. Chaudhry, *The History of the Federation of State Medical Boards: Part Four – The Rise of Medical Discipline*, 1960s and 1970s, J. Med. Regul., March 2012, at 8, 8.

40 Johnson & Chaudhry, *supra* note 39, at 9; *see also* Landess, *supra* note 18, at 337 (noting that while "some medical boards were functioning by the early 1900s, these institutions did not have the power, organization, or oversight that they have today to regulate medical practice").

41 The FSMB is the association representing state medical boards in the United States. Fed'n of State Med. Bds., *Membership Information*, https://www.fsmb.org/about-fsmb/fsmb-member-medical-boards/ (last visited Dec. 15, 2023). For background on the FSMB, which was founded in 1912, see *History*, Fed'n Of State Med. Bds., https://www.fsmb.org/about-fsmb/history/ (last visited Dec. 15, 2023).

42 Fed'n of State Med. Bds., *supra* note 28; Johnson & Chaudhry, *supra* note 39, at 12.

43 Johnson & Chaudhry, *supra* note 39, at 12; *see also* Fed'n of State Med. Bds., *supra* note 28.

44 Fed'n of State Med. Bds., *supra* note 28, at 34–38. Lillvis and McGrath have found that state medical boards in more liberal political environments tend to be more active in disciplining physicians. Denise F. Lillvis & Robert J. McGrath, *Directing Discipline: State Medical Board Responsiveness to State Legislatures*, 42 J. Health Pols., Pol'y & L. 123, 123, 134 (2017).

45 Fed'n of State Med. Bds., *supra* note 28, at 34. Relevant to medical misinformation

for discipline may provide state medical boards with a catch-all clause, but disciplinary actions based on catch-all language must align with the requirement in *Dent* that a nexus exists between the practice of medicine and the alleged harm.[46]

To assist consumers in making healthcare choices, state medical boards make information on licensees and disciplinary actions publicly available.[47] The FSMB recommends that state medical boards compile a publicly accessible profile for each of their licensees; maintain processes for reviewing licensees' competency, including for behavioral health issues that could interfere with work; and create a reporting system that licensees may use to highlight other licensees' failures to comply with standards of professionalism and competency.[48]

State medical boards share the results of disciplinary actions across jurisdictions to prevent incompetent or unprofessional physicians from regaining their ability to practice medicine in a fresh jurisdiction.[49] The FSMB also launched "a repository for disciplinary actions taken by state medical boards" in 1962; by 1981, "all state medical boards [were] report[ing] to the data bank."[50] The FSMB maintains DocInfo, a searchable public database that includes information on licensed physicians from state medical boards.[51] DocInfo compiles from all state medical boards' data and thus has information on every licensed physician.[52] However, despite the FSMB guidelines,[53] state medical

and disinformation, the FSMB recommends that states include misrepresenting that an "incurable condition, sickness, disease, or injury can be cured" as a grounds for discipline. *Id.* at 34–35.

46 Dent v. West Virginia, 129 U.S. 114, 123 (1889); *see also* Nadia N. Sawicki, *Character, Competence, and The Principles of Medical Discipline*, 13 J. Health Care L. & Pol'y 285, 294 (2010).

47 Johnson & Chaudhry, *supra* note 39, at 13 (discussing trends in the sophistication of state disciplinary proceedings beginning in the 1960s, including a "trend toward transparency and public accountability").

48 *Id.* at 11–14.

49 Fed'n of State Med. Bds., *supra* note 41 (noting that the FSMB launched "a repository for disciplinary actions taken by state medical boards" in 1962 with "all state medical boards report to the data bank" by 1981); *see also* Johnson & Chaudhry, *supra* note 39, at 11 (discussing the development of a FSMB disciplinary reporting system).

50 *Id.*; *see also* Johnson & Chaudhry, *supra* note 39, at 11 (discussing the development of a FSMB disciplinary reporting system).

51 *See generally Docinfo*, Docinfo, https://www.docinfo.org/ (last visited Dec. 15, 2023).

52 *See* Docinfo, *Frequently Asked Questions*, https://www.docinfo.org/faq/ (last visited Dec. 15, 2023).

53 Fed'n of State Med. Bds., *supra* note 28, at 1 (noting that a goal of the guidelines

boards' reports "are not necessarily consistent in how they categorize the grounds for professional discipline," so DocInfo may vary across states.[54] Thus, transparency efforts like DocInfo may be of limited value to consumers seeking a robust tool to compare physicians.[55]

C. Criticism of State Medical Boards

Despite efforts to keep the state-by-state licensing system current,[56] state-level licensing has been criticized as offering inefficient and ineffective protections to consumers.[57] For example, some critics argue that the state-level licensing process fails to provide consumers with meaningful metrics of physician competency.[58] They suggest that competing, market-based credentialing systems would provide consumers with a superior means of determining physician quality.[59] This line of criticism argues that because state medical boards are comprised almost entirely of health professionals, they are monopolistic,[60] prone to cronyism,[61] and allow the regulated to regulate themselves.[62] This criticism acknowledges that a well-functioning licensing system may improve quality, but counters that too often, licensing can raise costs

is to "encourage the development and use of consistent standards, language, definitions, and tools").

54 Sawicki, *supra* note 46, at 303.

55 *See* U.S. Dep't of Health & Hum. Servs., *supra* note 33, at v; *see also* Landess, *supra* note 18, at 339–40.

56 Johnson & Chaudhry, *supra* note 39, at 8–9.

57 U.S. Dep't of Health & Hum. Servs. et al., *supra* note 16, at 31–32 (arguing that "even well-intentioned regulations may impose unnecessary restrictions on provider supply and, therefore, competition"); Randall G. Holcombe, *Does Licensing of Health Care Professionals Improve Health Care?*, 93 J. Med. Licensure & Discipline, Summer 2007, at 13, 17–18.

58 Holcombe, *supra* note 57, at 17–18 ("Regulation takes away some of the incentive for patients to discriminate based on quality, because all practitioners meet the government's standards, and it takes away some of the ability for patients to discriminate based on quality, because there is only one standard under the regulatory regime.").

59 Holcombe, *supra* note 57, at 18.

60 *See* U.S. Dep't of Health & Hum. Servs, *supra* note 33, at 11; Paul Starr, *The Consolidation of Professional Authority, 1850-1930*, *in* The Social Transformation of American Medicine 79, 102–03 (1982).

61 Gostin, *supra* note 34, at 255 ("Licensing can be unfair because it parcels out a privilege based upon the discretion of officials.").

62 Sawicki, *supra* note 46, at 295–96; *see also* Johnson & Chaudhry, *supra* note 39, at 11 (noting a 1961 presentation on problems with the disciplinary process included a criticism that "physicians [were] reluctant to offer testimony or provide a deposition against a colleague accused of misconduct").

by limiting the availability of medical services and creating barriers to entry for competing disciplines.[63] These concerns are not unfounded: the Supreme Court found in *North Carolina Board of Dental Examiners v. Federal Trade Commission* that, under certain circumstances, the Federal Trade Commission can investigate licensing restrictions in the dental context as anticompetitive behavior.[64]

Other critics suggest that state-level approaches to healthcare issues can hamper our ability to find uniform national solutions.[65] For example, these critics argue that state-level licensing has frustrated providers' ability to deliver care through telehealth because, as stated earlier, a physician needs to maintain a license in each state where the patient is located for these virtual visits.[66] A single, national license, rather than one in each state, would be simpler for a physician to obtain and encourage physicians to practice virtually in medically underserved areas.[67] In response to such efforts to "federalize" licensing,[68] many states

63 U.S. Dep't of Health & Hum. Servs. et al., *supra* note 16, at 9; Conor Norris & Edward Timmons, *Biden Licensing Report Is A Step Backward*, The Hill (Apr. 5, 2022), https://thehill.com/opinion/finance/3259255-biden-licensing-report-is-a-step-backward/ ("But often, less-stringent forms of regulation can protect consumers from harm without posing the same barriers to entry that can be so costly.").

64 N.C. State Bd. Dental Exam'rs v. Fed. Trade Comm'n, 574 U.S. 494, 502, 510, 516 (2015) (finding that a state board of dentistry, comprised solely of dentists selected by that state's dentists, was not immune from federal antitrust laws when it promulgated regulation limiting non-dentists' ability to deliver competing services).

65 Parmet, *supra* note 6 (noting that "the federal government's involvement with health [has] expanded" as our economy has become more nationalized and less localized and "health threats [are] increasingly recognized as nationwide in scope").

66 See Avery Schumacher, *Telehealth: Current Barriers, Potential Progress*, 76 Ohio St. L.J. 409, 411–12 n.7 (2015).

67 *See* Schumacher, *supra* note 66; Ateev Mehrotra et al., *Telemedicine and Medical Licensure – Potential Paths for Reform*, 384 New Eng. J. Med. 687, 687 (2021) (noting that "physicians must be licensed in the state where the patient is located," which "creates substantial administrative and financial hurdles for physicians hoping to use telemedicine to treat out-of-state patients").

68 Anita Slomski, *Telehealth Success Spurs a Call for Greater Post-COVID-19 License Portability*, 324 JAMA 1–8 (2020); *Members of Congress Introduce Legislation to Address Health Professional License Portability During a Public Health Emergency*, Nat'l Council of State Bds. of Nursing [NCSBN] (Aug. 21, 2020), https://www.ncsbn.org/news/members-of-congress-introduce-legislation-to-address-health-professional-license-portability-during-a-public-health-emergency (highlighting federal legislation introduced in response to the COVID-19 pandemic to address interstate licensing during a public health emergency). Notably, the Veterans Administration promulgated a regulation to clarify a long-standing policy that

are pursuing new regulatory mechanisms such as interstate compacts[69] to allow some level of reciprocity so that health professionals can practice across state lines.[70] Such efforts to create a national physician license would seem to conflict with *Dent v. West Virginia*'s holding that medical licensing is squarely within the states' police powers.[71] But some scholars argue that in light of modern Commerce Clause jurisprudence, "there is no longer any serious question that Congress has the authority under the Commerce Clause to regulate the practice of medicine."[72]

Still others have criticized boards' disciplinary processes as an ineffective tool "to have a significant impact on professional quality."[73] The majority of cases that appear before state medical boards are the result of complaints from patients or peer health professionals or referrals from other agencies.[74] Reliance on complaints rather than other investigative techniques[75] makes the review process inherently reactive.[76] Moreover, scholarly research into disciplinary action by state medical boards suggests that only a minority of cases actually involve evaluating

its practice guidelines preempted state scope of practice. U.S. Dep't of Veterans Affs., *VA Confirms Authority for Its Health Care Professionals to Practice Across State Lines* (Nov. 13, 2020), https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5566.

69 *About the Compact, A Faster Pathway to Physician Licensure*, Interstate Med. Licensure Compact, https://www.imlcc.org/a-faster-pathway-to-physician-licensure/ (last visited Dec. 15, 2023).

70 Mehrotra et al., *supra* note 67, at 688–89. For example, such efforts help metropolitan communities that border or cross multiple jurisdictions. *E.g.*, Letter Announcing New Reciprocity Agreement for Physician Licensure with the Md. And Va. State Bds. Of Physicians, D.C. Bd. of Med. (Mar. 15, 2023), https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/BOM%20DMV%20Reciprocity%20Notification%203.15.2023.pdf.

71 Dent v. West Virginia, 129 U.S. 114, 128, 122 (1889).

72 Annas, *supra* note 17, at 1083; *see also* Timothy Bonis, *Is a Federal Medical License Constitutional?*, Harv. Bill of Health (Jan. 3, 2023), https://blog.petrieflom.law.harvard.edu/2023/01/03/is-a-federal-medical-license-constitutional/ (summarizing different theories for a constitutional basis for a federal medical license); Mehrotra et al., *supra* note 67, at 688; Parmet, *supra* note 6 (noting that Congress has used the Commerce Clause as well as its ability to tax and spend to regulate health matters).

73 Sawicki, *supra* note 46, at 287.

74 *Id.* at 292–93 (noting that the "medical disciplinary process is generally reactive, rather than proactive"); U.S. Dep't of Health & Hum. Servs., *supra* note 33, at 21 (finding in a case study of five states that the "public share of complaints ranged from about 60% to 90%" and the "next most common sources are other public agencies and hospitals").

75 *Id.* at 292.

76 *Id.*

clinical competence.[77] Such research suggests that state medical boards might be failing to prioritize investigating and disciplining physicians on their ability to practice safely and competently, which is ostensibly the primary purpose of medical boards today.[78] Thus, critics such as the watchdog group Public Citizen argue that state medical boards should widen their oversight capabilities over physicians in the interest of patient safety and become even more involved in overseeing medical practice.[79]

Understanding such criticism is informative in understanding how state medical boards can improve, but state medical boards do not fall short completely. While DocInfo and state medical boards' databases do not contain all the information that consumers may want in evaluating a physician, such as a disciplinary history,[80] they do present a starting point for consumer vetting and provide a platform

77 *Id.* at 303 (noting that reviews of disciplinary actions found that anywhere from less than 15% and up to 18.8% of cases related to competence). Sawicki found that the majority of disciplinary actions pertain to "unspecified 'unprofessional conduct'" as well as criminal conduct, "misconduct not directly linked to medicine or patient care," or behavioral health issues. *Id.* at 303–05. State medical boards may not report settlements. *Id.* at 303 n.111.

78 *Id.* at 307–14 (arguing that boards attempt to tie cases under various theories to competency without a sufficient nexus); *see also* Dent v. West Virginia, 129 U.S. 114, 123 (1889) (noting that boards are deemed "an authority competent to judge" whether an individual is qualified to hold a medical license "for the protection of society").

79 Alan Levine et al., State Medical Boards Fail to Discipline Doctors With Hospital Actions Against Them (Mar. 2011), https://www.citizen.org/article/state-medical-boards-fail-to-discipline-doctors-with-hospital-actions-against-them/. Public Citizen, for example, has argued that state medical boards should use additional data such as malpractice claims and private disciplinary actions by hospitals to be more aware of physicians' conduct. *Id.* at 6 (noting that state medical boards had failed to act even when private organizations reported sanctions "that would seem to warrant medical board action"). Some of these criticisms parallel earlier federal reviews of state disciplinary processes. *E.g.*, Dep't of Health & Hum. Servs. Off. of Inspector Gen., Federal Initiatives to Improve State Medical Boards' Performance (1993), https://oig.hhs.gov/oei/reports/oei-01-93-00020.pdf.

80 *Supra* notes 72–79.

for consumer concerns.[81] A market-driven process[82] could leave behind consumers who lack the resources or capacity to judge competing credentialing systems.[83] Disciplinary investigations are labor-intensive and often require medical experts' opinions to augment a state medical board's professional staff.[84] The capacity to engage in such work can be limited by state budgets and workforce shortages.[85] These challenges also provide context for the difficulties that state medical boards face in disciplining physicians who spread misinformation and disinformation.

II. How Physicians and Public Policy Influence Medical Information

Medical licensing provides consumers with a minimal level of assurance that licensed physicians will be able to provide accurate information,[86] but how consumers receive medical information is changing. A physician may be competing with other sources of information—such as direct-to-consumer advertising, medical websites, and other healthcare professionals—as consumers seek out alternate opinions.[87] Moreover, several states have enacted legislation limiting the availability of certain medical procedures, making physicians in these states concerned about discipline for even communicating to consumers about such politically disfavored medical procedures.[88]

81 *Supra* notes 46–51 (discussing public databases). One scholar notes that the difference between public and private evaluations of physicians is that public standards are a minimal floor for entry and thus to serve the public whereas private ones may focus more on quality as part of a competitive marketplace. Sawicki, *supra* note 46, at 296–97. For information on other sources for evaluating physicians. *See* Fabia Rothenfluh & Peter J. Schulz, *Physician Rating Websites: What Aspects Are Important to Identify a Good Doctor, and Are Patients Capable of Assessing Them? A Mixed-Methods Approach Including Physicians' and Health Care Consumers' Perspectives*, J. Med. Internet Rsch., May 2017, at e127.

82 Holcombe, *supra* note 57, at 17–18.

83 Claudia E. Haupt, *Assuming Access to Professional Advice*, 49 J.L., Med., & Ethics 531, 537 (2021).

84 Sawicki, *supra* note 46, at 296.

85 Landess, *supra* note 18, at 340 (noting that state medical boards' "funding and resources are [often] scarce and subject to legislative control and constraints").

86 *See supra* Sections I.A–B.

87 Todd Shryock, *Medical Misinformation is Making it Harder to Treat Patients*, Med. Econs. (Apr. 3, 2023), https://www.medicaleconomics.com/view/medical-misinformation-is-making-it-harder-to-treat-patients.

88 *Supra* notes 43–45; Sawicki, *supra* note 46, at 295.

A. Physicians' Role in the Dissemination of Medical Information

Physicians play a key role for many consumers in making decisions regarding their care as physicians provide counsel about—and can be a gatekeeper to—healthcare services.[89] But in a global marketplace, physicians are competing with other healthcare messengers for the attention of their patients.[90] These competing messages may not be misinformation as defined above;[91] instead, the sources of competing messages are often commercially motivated and not focused on individual patients, and therefore the message may be of inferior value to the physician's advice.[92] For instance, many physicians believe that direct-to-consumer prescription drug advertising encourages patients to ask their physicians for the promoted products even though these products may be less effective than older medicines.[93] Physicians performing individualized assessments should be in a superior position to reflect on an individual patient's needs, but broadly disseminated advertisements might contain useful advice that a physician would not provide about recent innovations or changing practice patterns.[94]

The pandemic offered insight into how competing messages affect physicians' ability to communicate with their patients.[95] A survey of physicians' experiences during the pandemic found that two in five

89 Canterbury v. Spence, 464 F.2d 772, 782 (D.C. Cir. 1972) (discussing the trust that a patient places on the physician); Gostin, *supra* note 34, at 254–56 (discussing how government uses licensing to limit the provisions of services like healthcare only to licensees).

90 Lauren Campbell et al., *Social Media Use by Physicians: A Qualitative Study of the New Frontier of Medicine*, BMC Med. Informatics & Decision Making, July 15, 2016, at 1 (noting that a "significant number" of internet users indicated that they are influenced by online advice for medical decisions).

91 *See supra* notes 1–3.

92 *See* Andrew R. Robinson et al., *Direct-to-Consumer Pharmaceutical Advertising*, 164 Archives of Internal Med. 427, 428 (2004) (discussing how prescription drug advertising persuades some consumers to request that their physician prescribe the advertised drug).

93 Robinson et al., *supra* note 92, at 429–30 (discussing physicians' and patients' views on whether advertising contains sufficient information on an advertised drug's costs and other treatment options).

94 Oliver Kim, *A Response to Meyerson's Defence of the American Right to Try*, 16 J. Bioethical Inquiry 463, 465 (2019) (noting the substantial lag time before new innovations become part of the standard of care).

95 Tiffany Hsu, *As Covid-19 Continues to Spread, So Does Misinformation About It*, N.Y. Times (Dec. 28, 2022), https://www.nytimes.com/2022/12/28/technology/covid-misinformation-online.html (highlighting physicians' experiences with patients who receive inaccurate information about COVID-19 from social media).

physicians heard patients offer inaccurate information related to the coronavirus.[96] Physicians had higher confidence than the public in the safety and effectiveness of COVID-19 vaccines.[97] The survey further found that more than 70 percent of physicians believed that COVID-19 misinformation was negatively affecting their patients and making the delivery of care more difficult.[98]

While most physicians trusted public health evidence during the pandemic like the safety and effectiveness of vaccines, a minority of physicians disseminated misinformation.[99] These physicians received attention from individuals skeptical and resistant to COVID-19 vaccines and precautions.[100] Notably, some physicians even obtained public platforms that helped spread misinformation, including as witnesses at

96 de Beaumont Foundation, *Physician Poll: Medical Misinformation Is Harming Patients*, de Beaumont Foundation (Mar. 29, 2023), https://debeaumont.org/news/2023/physician-poll-medical-misinformation-is-harming-patients/.

97 de Beaumont Foundation, *U.S. Physicians: Medical Misinformation Is Harming Patients' Health* 1, de Beaumont Foundation (2022), https://debeaumont.org/resources/u-s-physicians-medical-misinformation-is-harming-patients-health/ (finding that over 90% of physicians believed that COVID-19 vaccines were safe and effective compared to 65% of the public).

98 de Beaumont Foundation, *supra* note 97.

99 *Id.*; Coleman, *supra* note 8, at 117–22 (identifying several high-profile cases of physicians speaking out against vaccinations and public health measures aimed at reducing the spread of COVID-19). The often-vocal physicians disseminating disinformation may be motivated by financial incentives or an increased public profile in conservative media outlets. 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; Olga Khazan, *When 'Talk to Your Doctor' Goes So, So Wrong*, The Atlantic (Sept. 10, 2021), https://www.theatlantic.com/politics/archive/2021/09/doctors-tell-patients-not-vaccinated-covid-19/620024/; Brandon Hawk, *Stella Immanuel's Theories About the Relationship Between Demons, Illness and Sex Have a Long History*, The Conversation (July 29, 2020), https://theconversation.com/stella-immanuels-theories-about-the-relationship-between-demons-illness-and-sex-have-a-long-history-143587 (discussing how one physician's religious beliefs might explain her views that illness may be the result of "supernatural evil").

100 Brumfiel, *supra* note 99.

legislative hearings[101] and even as appointees to government positions.[102]

Consistent with growing concerns regarding the public health effects of misinformation originating from physicians, the FSMB released a statement and ethical guidance on professional expectations for physicians related to medical misinformation and disinformation.[103] Notably, the FSMB reported that a majority of state medical boards had experienced "an increase in complaints about [physicians] disseminating false or misleading information since the onset of the COVID-19 pandemic."[104] The FSMB underscored that professional ethics requires "physicians [to] base the care they provide on the best scientific evidence available at the time, while being truthful and transparent about the sources of their recommendations to foster trust in delivering ethical medical care."[105] Further, the FSMB noted that while physicians often prescribe medicines for off-label use,[106] a physician cannot invoke the

101 *E.g.*, Alexandra Ellerbeck, *Some Doctors Spreading Coronavirus Misinformation Are Being Punished*, Wash. Post (Dec. 6, 2021), https://www.washingtonpost.com/politics/2021/12/06/some-doctors-spreading-coronavirus-misinformation-are-being-punished/ (noting that "an Ohio-based licensed osteopathic physician" testified before the Ohio House of Representatives that "the coronavirus vaccines could leave people 'magnetized'"); Jason Lemon, *Republicans Spar Over Ron Johnson Inviting COVID Vaccine Skeptic to Senate Hearing*, Newsweek (Dec. 8, 2020), https://www.newsweek.com/republicans-spar-over-ron-johnson-inviting-covid-vaccine-skeptic-senate-hearing-1553282 (discussing a disagreement in the U.S. Senate Homeland Security and Governmental Affairs Committee over an invitation for testimony extended to a physician who "touted the controversial anti-malaria drug hydroxychloroquine as a treatment for the novel coronavirus—despite scientific evidence showing the drug is ineffective").

102 *E.g.*, Arek Sarkissian, *Florida Surgeon General Altered Key Findings in Study on Covid-19 Vaccine Safety*, Politico (Apr. 24, 2023), https://www.politico.com/news/2023/04/24/florida-surgeon-general-covid-vaccine-00093510 (noting that the Florida official, "a well-known Covid-19 vaccine skeptic," mischaracterized the health risk that COVID-19 posed to young men in a state-sponsored study); Rita Rubin, *When Physicians Spread Unscientific Information About COVID-19*, 327 JAMA 904, 904 (2022) (noting a physician complaint filed against the Florida surgeon general for spreading misinformation about COVID-19 vaccines and safety measures while promoting "unproven and possibly dangerous medications to treat COVID-19").

103 Fed'n of State Med. Bds., *supra* note 28.

104 *Id.* at 7.

105 *Id.* at 5.

106 As part of the FDA's approval of a product, the FDA will approve an actual label to be used with that product, and the label contains information including "approved indications for product use, as well as the approved dosage, method of administration, and patient population." Rebecca Dresser & Joel Frader, *Off-Label Prescribing: A Call for Heightened Professional and Government Oversight*, 37 J.L., Med. & Ethics 476, 477 (2009). However, many products are used successfully "off

doctrine of off-label use as "an appropriate defense or cover for rogue practices occurring without accompanying rationale or justification based in science."[107]

B. Public Policy's Role in Defining and Creating Misinformation

In addition to the competing messages of physicians and other private actors, policymakers are weighing into the debate on what is appropriate medical information. Significant disagreements have arisen between liberal and conservative states over what advice may be considered misinformation and thus could constitute grounds to discipline a physician.

For example, states have responded differently to the COVID-19 public health emergency, with some debating legislation to curb perceived governmental overreach while others consider legislation that would expand public health authority.[108] Some policymakers have pushed for legislation to shield physicians who promote and prescribe the drug ivermectin to treat COVID-19.[109] Florida passed a package of bills in May 2023 as part of a "medical freedom" initiative.[110] These statutes provide health professionals with a right to refuse to provide services based on a moral or religious objection[111] and protect whistleblowers who report organizations for failing to accommodate these refusals.[112] The legislation prohibits licensing boards from disciplining healthcare professionals "because the individual has spoken or written publicly

label," or for indications that are not included on the FDA's approved label. *Id.* at 477–81 (discussing the evidentiary and ethical considerations that physicians and other stakeholders may use to evaluate off-label prescribing).

107 Fed'n of State Med. Bds., *supra* note 10, at 6.

108 Elizabeth Platt et al., *Trends in US State Public Health Emergency Laws, 2021-2022*, 113 Am. J. Pub. Health 288 (2023).

109 Rebecca Fotsch, *Who to Believe? Consequences for Physicians and Nurses Who Spread Misinformation*, 13 J. Nursing Regul. 70, 70–71 (2022) (noting legislation in Indiana and Wisconsin that would shield health professionals from disciplinary action for prescribing or dispensing ivermectin for COVID-19).

110 Off. of Gov. Ron DeSantis, *Governor Ron DeSantis Signs the Strongest Legislation in the Nation for Medical Freedom* (May 11, 2023), https://www.flgov.com/2023/05/11/governor-ron-desantis-signs-the-strongest-legislation-in-the-nation-for-medical-freedom/; Megan Messerly et al., *DeSantis is Championing Medical Freedom. GOP State Lawmakers Like What They See*, Politico (Mar. 1, 2023), https://www.politico.com/news/2023/03/01/desantis-medical-freedom-gop-florida-00084842 (noting that the Florida legislation may be replicated in other states).

111 S.B. 1580, § 2, 2023 Sess. (Fla. 2023) (modifying Fla. Stat. § 381.00321(1)(2)).

112 S.B. 1580, § 2, 2023 Sess. (Fla. 2023) (modifying Fla. Stat. § 381.00321(3)).

about a health care service or public policy."[113] Further, the statutes give the Florida health department the ability to bar specialty boards from participation in the licensing process if they engage in prohibited disciplinary actions.[114]

On the other hand, California passed legislation[115] attempting to strengthen the state medical board's authority to police COVID-19 misinformation.[116] Whereas the Florida law potentially applies to a broad range of content,[117] the California law only considers "misinformation or disinformation related to COVID-19, including false or misleading information regarding the nature and risks of the virus, its prevention and treatment; and the development, safety, and effectiveness of COVID-19 vaccines."[118] The law only applies to information in direct patient care for either "treatment or advice."[119] California Governor Gavin Newsom underscored in his signing statement that the legislation was "narrowly tailored to apply only to those egregious instances in which a licensee is acting with malicious intent or clearly deviating from the required standard of care."[120] The governor, however, expressed concern about the potential "chilling effect" that the law could have on discussions between patients and their physicians given the ongoing development of COVID-19 treatments.[121] The California law's constitutionality was challenged on First Amendment grounds in multiple lawsuits, and an appeal is pending before the Ninth Circuit as of the time of this article.[122]

113 Fla. Stat. § 456.61(1) (2023).

114 *Id.* § 456.61(2).

115 A.B. 2098, 2021-2022 Sess. (Cal. 2022).

116 Steven Lee Myers, *California Approves Bill to Punish Doctors Who Spread False Information*, N.Y. Times (Aug. 29, 2022), https://www.nytimes.com/2022/08/29/technology/california-doctors-covid-misinformation.html.

117 *Supra* notes 68–69.

118 A.B. 2098 § 22270(a), 2021-2022 Sess. (Cal. 2022).

119 *Id.* § 2270(b)(3).

120 Gavin Newsom, Letter from Gov. Gavin Newsom to the California State Assembly (Sept. 30, 2022), https://www.gov.ca.gov/wp-content/uploads/2022/09/AB2098-signing-message.pdf.

121 *Id.*

122 Corinne Purtill, *Law Aimed at Doctors Who Spread COVID-19 Misinformation is Put on Hold by Judge*, L.A. Times (Jan. 26, 2023), https://www.latimes.com/science/story/2023-01-26/law-aimed-at-doctors-who-spread-covid-19-misinformation-is-put-on-hold-by-judge. The appeal before the Ninth Circuit, *McDonald v. Lawson*, Nos. 22-56220, 23-55069 (9th Cir. Jan. 24, 2023), arises from whether the Central District (No. 8:22-cv-1805) and Southern District (No. 3:22-cv-1922) of California erred by not granting a preliminary injunction. At least four cases have been brought in federal district courts in California. Brief of the New Civil Liberties Alliance As Amicus Curiae in Support Of Plaintiffs-Appellants And Reversal,

States' approaches to regulating other areas of medical practice such as reproductive health mirror the stark contrast between Florida's and California's COVID-19 laws.[123] For instance, since the Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision overturned the constitutional right to an abortion, several states have enacted legislation to restrict or ban abortion.[124] Even prior to *Dobbs*, Texas had enacted legislation that created a private right of action against those who had "aided or abetted an abortion."[125] States have also banned gender-affirming care, particularly for children and adolescents,[126] despite clinical support for it.[127] In some cases, physicians can be disciplined and face civil penalties for providing such care.[128]

State restrictions on clinical practice are creating information gaps and potentially leading to misinformation for patients seeking banned care in these states.[129] Physicians in these states are concerned about facing penalties, including the loss of a license, for discussing information that is clinically accurate but legally and politically disfavored.[130] Not only do restrictions on legitimate discussions hurt

McDonald v. Lawson, Nos. 22-56220, 23-55069 (9th Cir. Jan. 24, 2023).

123 Simmons-Duffin, *supra* note 14 (discussing the penalties that physicians face for violating state abortion bans).

124 Kelly Baden & Jennifer Driver, *The State Abortion Policy Landscape One Year Post-Roe*, Guttmacher Inst. (June 15, 2023), https://www.guttmacher.org/2023/06/state-abortion-policy-landscape-one-year-post-roe.

125 Texas Heartbeat Act, S. 87-8, 2021 Sess. (Tex. 2021).

126 Sophie Putka et al., *These States Have Banned Youth Gender-Affirming Care*, MedPage Today (May 10, 2023), https://www.medpagetoday.com/special-reports/exclusives/104425; *Map: Attacks on Gender Affirming Care by State*, Hum. Rts. Campaign, (May 8, 2023), https://www.hrc.org/resources/attacks-on-gender-affirming-care-by-state-map (noting that some states "have considered banning care for transgender people up to 26 years of age").

127 US Dep't of Health & Hum. Servs., Off. Population Affs., Gender-Affirming Care and Young People (2022), https://opa.hhs.gov/sites/default/files/2023-08/gender-affirming-care-young-people.pdf ("Medical and psychosocial gender affirming healthcare practices have been demonstrated to yield lower rates of adverse mental health outcomes, build self-esteem, and improve overall quality of life for transgender and gender diverse youth.").

128 Putka et al., *supra* note 126. While outside the scope of this current article, it is worth noting that federal courts have enjoined states from enforcing a ban on gender-affirming care, in part due to First Amendment concerns. *See, e.g.*, Brandt v. Rutledge, 551 F. Supp. 3d 882 (E.D. Ark. 2021).

129 Sherry L. Pagoto et al., *The Next Infodemic: Abortion Misinformation*, 25 J. Med. Internet Rsch., 2023 no. 1, at 1, 2–3.

130 Selena Simmons-Duffin, *3 Abortion Bans in Texas Leave Doctors 'Talking in Code' to Pregnant Patients*, NPR (Mar. 1, 2023), https://www.npr.org/sections/health-shots/2023/03/01/1158364163/3-abortion-bans-in-texas-leave-doctors-talking-

patients' ability to understand their care options, but patients also may seek out alternate opinions from other sources and risk exposure to misinformation when physicians feel unable to provide them with complete information.[131] A public health advocate thus might be outraged that a medical board might not be able to discipline a physician who advocates against public health measures on COVID-19[132] but could discipline a physician who aids a patient seeking an abortion.[133]

III. Challenges of Regulating Medical Misinformation from a Board's Perspective

With this context on the role and function of state medical boards and physicians' relationship to medical misinformation, this Part further considers the political and legal limitations that boards face in addressing physicians who disseminate medical misinformation.

A. Political Oversight of Medical Boards

As part of state government,[134] state medical boards are part of a political entity, and thus elected officials may scrutinize a board's administrative decisions.[135] For example, during the pandemic, some state legislators questioned whether boards were unfairly targeting physicians who were recommending hydroxychloroquine or other

in-code-to-pregnant-patients; Simmons-Duffin, *supra* note 14. Note that the Ninth Circuit's decision in *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002) (cert denied, 540 U.S. 946 (2003)), may be instructive in the limits of sanctioning physicians for providing advice that may conflict with the law. At issue was whether a California physician could recommend medical marijuana, which had been legalized under state law, without being disciplined by the federal Drug Enforcement Administration for violating the federal Controlled Substances Act. *Id.* at 632–33. The Ninth Circuit held that federal enforcement against a physician's recommendation of medical marijuana would "punish physicians on the basis of the content of doctor-patient communications." *Id.* at 637. The discussion between a patient and a physician did not necessarily lead to a violation of federal law but could lead to other options. *Id.* at 634.

131 John Yang, *Tracking and Combating the Rise of False Online Information About Abortion*, PBS (Apr. 22, 2023), https://www.pbs.org/newshour/show/tracking-and-combating-the-rise-of-false-online-information-about-abortion.

132 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; Fiore, *supra* note 9.

133 Simmons-Duffin, *supra* note 130.

134 Dent v. West Virginia, 129 U.S. 114, 117–18 (1889).

135 Lillvis & McGrath, *supra* note 44, at 134–37, 149.

"alternative" treatments for COVID-19.[136] As in Florida, conservative legislators in other states who disapprove of COVID-19 public health measures have introduced legislation to limit their state medical board's ability to conduct investigations or disciplinary proceedings for recommending such alternatives.[137]

Further, medical boards can face funding constraints to fulfill their missions due to limited state budgets.[138] Disciplining a physician can be expensive due to the expert-intensive review process for competency and the need to hold an evidentiary hearing.[139] Limited disciplinary actions also may reflect diminished staff capacity as boards compete with other agencies for talent.[140] Moreover, state medical boards like other state agencies "respond to budgetary signals" and may change their behavior in response to legislative threats.[141]

B. Legal Protections of the Physician-Patient Relationship

As a threshold matter, state medical boards may also be limited in their oversight capabilities due to the extent of authorizing laws.[142]

136 Blake Farmer, *Medical Boards Pressured to Let it Slide When Doctors Spread COVID-19 Misinformation*, Med. Econs. (Feb. 17, 2022), https://www.medicaleconomics.com/view/medical-boards-pressured-to-let-it-slide-when-doctors-spread-covid-19-misinformation (discussing an inquiry from a Tennessee state representative to the state medical board about its misinformation policy); Hayden Sparks, *After Criticizing Hydroxychloroquine Use, Texas Medical Board Says Doctors Free to Use Drug*, The Texan (Aug. 19, 2020), https://thetexan.news/after-criticizing-hydroxychloroquine-use-texas-medical-board-says-doctors-free-to-use-drug/ (noting that a Texas state senator had "decried the [Texas medical board] for trying to intimidate doctors who use treatments like hydroxychloroquine to treat coronavirus patients").

137 Farmer, *supra* note 136 (noting that the Tennessee legislature passed legislation "making it more difficult for the [state medical board] to investigate complaints about physicians' advice on covid vaccines or treatments"); Tahir, *supra* note 132 (noting that at least a dozen states had introduced or passed legislation that "restricted state medical boards' powers").

138 De Beaumont Foundation, *supra* note 11, at 6; Landess, *supra* note 18, at 3 (noting that for state medical boards, "funding and resources are [often] scarce and subject to legislative control and constraints").

139 U.S. Dep't of Health & Hum. Servs., *supra* note 33, at 39–41; Sawicki, *supra* note 46, at 296.

140 U.S. Dep't of Health & Hum. Servs., s*upra* note 33, at 42 (finding that boards face "recruitment and retention problems" due to salary, lack of advancement, and "high work load").

141 Lillvis & McGrath, *supra* note 44, at 6.

142 Tahir, *supra* note 132 (referring to a statement by FSMB CEO Humayun Chaudhry that "[l]egal structures developed for the 20th century are, in many states, not

Some states' medical practice statutes do not permit those states' boards to investigate infractions that occur beyond the physician-patient relationship.[143] A physician-patient relationship[144] establishes certain fiduciary duties that a physician owes the patient.[145] When a physician speaks at a forum (regardless of whether the physician is advocating a policy position), the physician does not create a professional relationship with the audience for purposes of most boards' disciplinary review.[146] Some boards might be able to discipline physicians who knowingly or recklessly present medical misinformation because such an act could be seen as a public harm.[147]

One disciplinary tool that state medical boards possess within the context of the physician-patient relationship is the doctrine of informed consent.[148] Boards may be able to discipline a physician for failing to obtain informed consent upon performing care on a patient after sharing misinformation.[149] For instance, the Texas medical board disciplined a physician for prescribing hydroxychloroquine off-label

suited to discipline doctors who broadcast misinformation on social media because the physicians are not directly treating patients").

143 Fed'n of State Med. Bds., *supra* note 10, at 2.

144 Valarie Blake, *When is a Patient-Physician Relationship Established?*, 14 Am. Med. Ass'n. J. Ethics 403, 403 (2012) (noting that "[t]he legal definition of a patient and the corresponding duties of the physician" vary from state to state); Am. Med. Ass'n, *Patient-Physician Relationships, AMA Code of Ethics*, https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-physician-relationships (last visited Dec. 15, 2023) (defining the relationship as starting "when a physician serves a patient's medical needs" and "entered into by mutual consent between physician and patient (or surrogate)," with limited exceptions).

145 Haupt, *supra* note 83, at 535.

146 Coleman, *supra* note 8, at 141 (noting that "when physicians make public statements about medical matters, they are not speaking to an individual who has entrusted them with providing individually tailored medical guidance"); Haupt, *supra* note 83, at 536 (noting that a physician speaking outside a professional relationship with a patient must be allowed to express themselves for there to be opportunity for "equal participation").

147 Coleman, *supra* note 8, at 131 (arguing that eroding the public's trust in the medical community could be a rationale for disciplining a physician). *See also* Fed'n of State Med. Bds., *supra* note 28, at 37 (recommending that states include conduct that "bring[s] the medical profession into disrepute" as grounds for discipline; *supra* notes 43–45 (discussing FSMB's recommendations for disciplinary grounds); Coleman, *supra* note 8, at 134–36 (discussing the burden that a state medical board would need to meet to prove actual malice).

148 Haupt, *supra* note 83, at 533, 535 (explaining that the duty to obtain informed consent is an imperfect tool for combatting medical misinformation because it is a duty between a physician and a patient before the physician provides a service, not a warning that a physician would need to offer before speaking generally)

149 See Fed'n of State Med. Bds., *supra* note 28, at 37; Haupt, *supra* note 83, at 535.

as a COVID-19 treatment without providing adequate information on health risks.[150] The doctrine of informed consent assures that patients receive critical information about the risks of a treatment or product and can make fully educated decisions.[151] Obtaining informed consent is critically important, particularly in areas where the science is evolving, so that patients can understand the risks of a treatment or product and thus make a fully educated decision.[152] Without knowing a treatment's potential risks and alternatives, the patient cannot truly consent to a procedure.[153]

C. First Amendment Constraints on Discipline

Courts traditionally have allowed states to regulate licensed professionals, including physicians, in ways that can constrain their First Amendment rights.[154] The presumption for regulating "professional speech" is that some of a licensed professional's speech is "merely incidental to practicing a profession."[155] The degree of protection can depend on the context of the speech: for example, if a physician has a financial stake in an unsafe medical product but promotes it, free speech protections are not as extensive against a liability claim.[156]

State medical boards need to review physicians' "professional speech" as part of disciplinary investigations: such reviews include whether the physician presented clear and accurate information to

150 Josephine Harvey, *"Demon Sperm" Doctor Fined $500, Given Light Penalty By Texas Medical Board*, Huffington Post (Nov. 2, 2021), https://www.huffpost.com/entry/stella-immanuel-texas-medical-board-hydroxychloroquine-coronavirus_n_618086dae4b0ec286d30bde6; *see also* Hawk, *supra* note 99 (providing additional context on this physician's seemingly conflicting beliefs on science and religion).

151 Am. Med. Ass'n, Opinion 2.1.1., AMA Code of Ethics, https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent (last visited Jan. 23, 2024).

152 Coleman, *supra* note 8, at 134–35; Kim, *supra* note 94, at 465.

153 Canterbury v. Spence, 464 F.2d 772, 780 (D.D.C. Cir. 1972).

154 Cassandra Burke Robertson & Sharona Hoffman, *Professional Speech at Scale*, 55 U.C. Davis L. Rev. 2063, 2071–74 (2022) (discussing the evolution of First Amendment caselaw on states' ability to regulate licensed professionals). As a state actor, state licensing agencies are subject to First Amendment limitations. *See* Sawicki, *supra* note 46, at 293–94 (noting that state medical boards are state actors and must follow "traditional constitutional constraints").

155 Robertson & Hoffman, *supra* note 154, at 2071–72 (discussing how a "professional speech" doctrine originated from a concurrence in *Lowe v. SEC*, 472 U.S. 181, 232 (1985) (White, J., concurring)).

156 Coleman, *supra* note 8, at 122.

patients to warn them of the consequences of a procedure.[157] Indeed, the Court held that a state could compel physicians to deliver a specific message as part of obtaining informed consent.[158] In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, a challenge to Pennsylvania's abortion restrictions, the Supreme Court considered whether a physician could assert a First Amendment right against compelled speech.[159] At issue was Pennsylvania's requirement that, to obtain informed consent to perform an abortion, a physician must inform a patient about "the health risks of the abortion and of childbirth" and provide state-published printed materials about alternatives to abortion.[160] So long as the required information was "truthful and not misleading," the Court reasoned that such a requirement is permissible.[161] Likening the compelled speech here to any other informed-consent requirement "about any medical procedure," the Court dismissed the First Amendment concern as "only . . . part of the practice of medicine, subject to reasonable licensing and regulation by the State."[162] There was no First Amendment violation even though "the physician's First Amendment rights not to speak are implicated."[163]

Similarly, some scholars argue that licensing boards should be able to compel physicians to provide a warning that their public advocacy does not constitute medical advice.[164] One might see a distinction between a physician saying, "This policy would negatively impact my patients' health," versus, "This policy would negatively impact my patients' health, and I recommend that patients do not comply."[165] The former statement is advocating a political viewpoint, but

157 Fed'n of State Med. Bds., *supra* note 10 (outlining FSMB recommendations for disciplining physicians including for misstatements and fraudulent claims).

158 Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 882–84 (1992).

159 *Id.* at 884 (discussing the existence of "an asserted First Amendment right of a physician not to provide information about the risks of abortion, and childbirth, in a manner mandated by the State").

160 *Id.* at 881.

161 *Id.* at 882. Notably, *Casey* states that this requirement for compelled speech is not an undue burden on obtaining an abortion. This is no longer applicable under *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022).

162 *Id.* at 884.

163 *Casey*, 505 U.S. at 884.

164 Coleman, *supra* note 8, at 141–42 (noting that *Casey* held that a state could compel a physician to provide certain information to a patient before providing care such as an abortion).

165 Coleman, *supra* note 8, at 123–25 (discussing viewpoints about physicians' speech on policy issues versus medical advice in a public forum).

without a disclaimer, an audience could interpret the latter as medical advice or a directive.[166] Without a professional-speech exception to the First Amendment, particularly for speech advising the public on health matters, the government cannot reasonably draw a distinction between political opinions and medical recommendations that physicians share with the public.[167] To counter disfavored public speech—whether that is a physician recommending gender-affirming care or recommending patients avoid COVID-19 vaccines—the government is left to regulatory alternatives that do not consider speech itself.[168]

The Supreme Court, however, has held that a speaker does not lose free-speech rights simply for being a licensed professional.[169] In *National Institute of Family and Life Advocates v. Becerra* ("*NIFLA*"),[170] the Court rejected a "professional speech" exemption from First Amendment protections.[171] After all, licensed professionals may need to advocate on policy matters affecting their profession.[172] Physicians have played prominent roles in advocating for and against public policy initiatives that could impact how they deliver care to their patients.[173]

166 Coleman, *supra* note 8, at 125.

167 Nat'l Inst. of Fam. & Life Advocs. v. Becerra ("NIFLA"), 138 S. Ct. 2361, 2375–77 (2018).

168 *Id.* at 2373–74 (reasoning that truthful ideas will prevail in the proverbial marketplace of ideas). This ignores that in some areas of science and medicine that are rapidly evolving, information is more often uncertain and thus may not be demonstrably true or false. Coleman, *supra* note 8, at 134–36. Finding speakers to provide a countervailing narrative can also be challenging: while some physicians seemingly have been able to present misinformation on COVID-19 without disciplinary action, other physicians have worried about legal challenges, Purtill, *supra* note 122, or were overwhelmed by the increased patient volume that increased in part by lack of progress on countering misinformation, Brumfiel, *supra* note 99 (reporting on unlicensed physicians that increase the spread of COVID-19 misinformation).

169 *Id.* at 2375.

170 *Id.*

171 *Id.* (reasoning that a state cannot "reduce a group's First Amendment rights by simply imposing a licensing requirement"); Haupt, *supra* note 83, at 534; Coleman, *supra* note 8, at 139–40.

172 NIFLA, 138 S. Ct. at 2375 ("Professionals might have a host of good-faith disagreements, both with each other and with the government, on many topics in their respective fields. Doctors and nurses might disagree about the ethics of assisted suicide or the benefits of medical marijuana . . .").

173 *E.g.*, Alan Braid, *Why I Violated Texas's Extreme Abortion Ban*, Wash. Post (Sept. 18, 2021), https://www.washingtonpost.com/opinions/2021/09/18/texas-abortion-provider-alan-braid/ (speaking out against a Texas state law that established a civil penalty for performing or assisting a patient in obtaining an abortion after six weeks as well as admitting that he violated the law as "a personal

For example, physicians in California and Florida may wish to speak out against how each state is regulating their ability to communicate to their patients about COVID-19.[174] The First Amendment would treat the physicians' advocacy as protected political speech regardless of how each state is attempting to define misinformation.[175]

At issue in *NIFLA* was a California law compelling both licensed and unlicensed facilities that provide "pregnancy-related services" to give a notice to patients about California's public programs for family planning, including abortion.[176] This law was a response to lawmakers' concern that certain clinics were providing misinformation to women seeking abortion services.[177] A coalition of licensed and unlicensed facilities challenged the notice requirement as a violation of the First Amendment because they were opposed to abortion but felt that California was compelling them to speak in support of state-supported abortion services.[178] For licensed facilities, the Ninth Circuit found that California could compel such speech without violating the First Amendment because medical licensees must be willing to accept some regulatory requirements as a condition of being licensed professionals, including limitations on free speech.[179] The Supreme Court declined to recognize such "professional speech" as a "new categor[y] of speech for diminished constitutional protection."[180] Instead, the Court noted that states "regulate professional conduct, even though that conduct incidentally involves speech," citing *Casey*.[181] For example, a state might require transparency as part of commercial advertising for a professional's services, but here, California was asking the facilities

risk"). Braid was subsequently sued under the state law that he was protesting. Jordan Freiman, *Texas Doctor Who Wrote Op-ed About Intentionally Violating State's Abortion Ban Sued Under New Law*, CBS News (Sept. 21, 2021), https://www.cbsnews.com/news/texas-abortion-law-alan-braid-doctor-sued/.

174 *Supra* notes 115–122 (discussing physicians' asserting a First Amendment right against California's regulation of COVID-19 information).

175 *See NIFLA*, 138 S. Ct. at 2374–75 (2018); Haupt, *supra* note 83, at 536–37.

176 *NIFLA*, 138 S. Ct. at 2368–71.

177 *See* Molly Redden, *One State Finally Cracked Down on Deceptive Anti-Abortion Pregnancy Centers*, Mother Jones (Oct. 12, 2015), https://www.motherjones.com/politics/2015/10/state-just-became-first-crack-down-deceptive-anti-abortion-pregnancy-centers/.

178 NIFLA, 138 S. Ct. at 2371.

179 Nat'l Inst. of Fam. & Life Advocs. v. Harris, 839 F.3d 823, 840–41 (9th Cir. 2016).

180 NIFLA, 138 S. Ct. at 2372 (quoting Denver Area Educ. Telecommc'ns. Consortium, Inc. v. FCC, 518 U.S. 727, 804 (1996) (Kennedy, J., concurring in part, concurring in judgment in part, and dissenting in part)).

181 *Id.* at 2372.

to advertise services that they did not offer but that the state was subsidizing.[182] While not "foreclos[ing] the possibility" of distinguishing "professional speech" in the future, the Court found that the California law violated the First Amendment. [183]

By declining to recognize "professional speech,"[184] the *NIFLA* ruling constrains states' ability to regulate physicians and other licensed professionals.[185] *Casey* allowed Pennsylvania to compel physicians to provide information before performing a specific procedure.[186] Such a requirement is a reasonable standard of practice within a state's interest in protecting the public's health.[187] The *NIFLA* Court distinguished California's requirement because the requirement in *Casey* was part of obtaining informed consent to perform a procedure (the abortion) and therefore regulating conduct (the provision of that medical service).[188] In contrast, the California requirement was not tied to informed consent for a medical procedure but rather applied "to all interactions between a covered facility and its clients, regardless of whether a medical procedure is ever sought, offered, or performed."[189] *NIFLA* might protect physicians who provide advice about services that are clinically appropriate but politically disfavored[190] but will make regulating misinformation more difficult because in both cases physicians can argue they are merely offering advice, not actual conduct.[191] Without a "professional speech" exception to the First Amendment, the state must link a regulation to the physician's conduct, not the physician's speech.[192]

182 *Id.*

183 *Id.* at 2375. Further, the Court reasoned that even if it adopted intermediate scrutiny for a professional speech to review the California notice requirement, the requirement still would violate the licensees' First Amendment rights. *Id.*

184 *Id.*

185 *See* Robertson & Hoffman, *supra* note 154, at 2068–69.

186 Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 884 (1992) ("[A] requirement that a doctor give a woman certain information as part of obtaining her consent to an abortion is, for constitutional purposes, no different from a requirement that a doctor give certain specific information about any medical procedure.").

187 *See* Dent v. West Virginia, 129 U.S. 114, 122–23 (1889).

188 NIFLA, 138 S. Ct. at 2373–74 .

189 *Id.* at 2374.

190 *See supra* notes 128–33.

191 *See* Sonia M. Suter, *Reproductive Technologies and Free Speech*, 49 J.L., Med. & Ethics 514, 521–24 (2021) (overviewing critiques of the two cases and presenting the view that the distinction is an attempt to engage in "constitutional gerrymandering against abortion rights").

192 NIFLA, 38 S. Ct. at 2373–74 (noting that California could not apply its regulation "to all interactions . . . regardless of whether a medical procedure is ever sought, offered, or performed").

The long-term effect of *NIFLA* on state medical boards remains to be seen, but the decision does raise significant concerns for implementation because its holding is so far from a bright-line rule.[193] In at least two legal cases, the lack of a "professional speech" doctrine was relevant in state licensing boards' unsuccessful attempts to prohibit individuals from engaging in what they considered unauthorized practice. In the first case, decided before *NIFLA* but following similar reasoning, a federal district court in Kentucky held that the Kentucky Board of Examiners of Psychology could not sanction an advice columnist who described himself as a family psychologist but was not licensed in the state.[194] The columnist was licensed in North Carolina as a "psychological associate"[195] and wrote a nationally syndicated column on parental advice.[196] The Kentucky board argued that, by issuing a cease-and-desist order not to hold himself out as a psychologist in Kentucky, the state was barring conduct, not the columnist's speech, and any infringement on his speech should be viewed under intermediate scrutiny as "professional speech."[197] But the court noted that the board's invocation of professional speech was not supported by a clear doctrine[198] and then concluded that any protections of professional speech would not apply in this case because the columnist had no professional relationship with his readers.[199]

In another case, decided shortly after *NIFLA*, the Georgia Board of Nursing reached a consent judgment with a woman holding herself out as a "Certified Professional Midwife" despite being unlicensed to provide midwifery services.[200] The consent judgment provided that the board would "not pursue cease and desist actions against unlicensed individuals using the term 'midwife,['] 'certified professional midwife,' and/or 'CPM' . . . where it is clear that the purpose . . . is not to advertise that such person can legally provide midwifery services."[201]

193 *See* Coleman, *supra* note 8, at 138 (noting *NIFLA* "provides little guidance on the kinds of speech that can be regulated as an aspect of professional practice").

194 Rosemond v. Markham, 135 F. Supp. 3d 574, 589–90 (E.D. Ky. 2015).

195 *Id.* at 578.

196 *Advice Columnist Not "Practicing Without a License"* Pro. Licensing Rep. (Feb. 11, 2016), https://professionallicensingreport.org/advice-columnist-not-practicing-without-a-license/.

197 *Rosemond*, 135 F. Supp. 3d at 580.

198 *See id.* at 582–85.

199 *Id.* at 584 (noting that a personal nexus must exist between a professional and a client for the state to be able to regulate the conduct between the two).

200 Pulley v. Thompson, No. 1:19-cv-05574-AT (N.D. Ga. 2020) (consent order and final judgment).

201 *Id.* at ¶ 6. Note that as part of the settlement, the plaintiff Deborah Ann Pulley

These decisions suggest that the offending speech did not violate the First Amendment because neither individual was providing a service but rather merely representing to the public that they had a credential that was not recognized by the state.[202] Unlike the criminal defendant in *Dent*,[203] these individuals argued that they did not actively practice in the state that took action against them.[204] One may read these cases to suggest that no harm resulted from the speech because ultimately no healthcare service resulted from the offending speech.[205] But such a view[206] ignores that merely saying one has a credential—particularly one similar in name to a license approved by the state—does impact whether consumers may accept the speaker's healthcare advice.[207] Instead, *NIFLA* narrowed states' options for controlling misinformation[208] while forcing consumers to parse out the Court's distinction between conduct and speech.[209]

agreed to include a disclaimer "that she is not licensed in Georgia nor practicing midwifery in Georgia" as well as not advertising that she could provide such services. *Id.* at ¶ 7. Prior to the lawsuit, a 2015 change in state law limited the type of professional that could provide midwifery services, thereby prohibiting Pulley from continuing to practice because she did not meet the new eligibility thresholds. Caleb Trotter, *Georgia Midwives Won't Be Fined Anymore for Calling Themselves Midwives*, Pac. Legal Found. (July 9, 2020), https://pacificlegal.org/georgia-midwives-victory/.

202 *Supra* notes 171, 176.

203 *See* Dent v. West Virginia, 129 U.S. 114, 117–18 (1889).

204 *Supra* notes 195–202.

205 In particular, the *Rosemond* court stressed that there was no evidence of any harm as it was unclear if the intended recipient even took the columnist's advice. *See* Rosemond v. Markham, 135 F. Supp. 3d 574, 587–588 (E.D. Ky. 2015).

206 Such a view parallels critics who advocate for a more market-driven approach, *supra* notes 57–63, toward state-based licensing: consumers could make their healthcare decisions after hearing from different speakers with competing private credentials.

207 *See supra* notes 87–93 (discussing how a speaker's medical credentials gave greater resonance to medical misinformation).

208 Inst. of Fam. & Life Advocs. v. Becerra ("NIFLA"), 138 S. Ct. 2361, 2376–78 (2018) (explaining why California could not require even unlicensed facilities to provide a notice on alternative services). While *NIFLA* might be distinguished as compelling speech on a topic that the speaker opposed, Suter, *supra* note 191, at 523, the *Rosemond* court found even compelling the advice columnist to merely disclose his lack of an in-state medical license was subject to strict scrutiny, *Rosemond*, 135 F. Supp. at 585–86.

209 Haupt, *supra* note 83, at 537.

Conclusion

The task before state medical boards is to ensure that patients and consumers receive accurate, comprehensive medical advice from physicians so that they can make educated healthcare decisions. Efforts to discipline physicians who spread misinformation and even disinformation demonstrate that boards face structural challenges—both the legal and policy limits aforementioned—that limit their capacity to discipline physicians in these contexts. State medical boards may lose any legal foundation that they have to discipline physicians who spread misinformation as the Supreme Court moves toward a more libertarian view of the First Amendment.[210] Further, as states' diverging laws around certain areas of clinical practice continue to create information gaps, state medical boards may prove not to be the best means for reining in misinformation.

210 *See supra* notes 57–63 (discussing criticisms of state-based licensing that support a more market-driven approach).