Assuming Access to Professional Advice

Claudia E. Haupt

Keywords: First Amendment, Professional Speech, Torts, Malpractice, Fiduciary Duties, Professional Licensing

Abstract: Access to reliable health advice can make the difference between life and death. But good advice is hard to come by. Within the confines of the professional-client or doctor-patient relationship, the First Amendment operates in a way that protects good and sanctions bad advice. Outside of this relationship, however, the traditional protections of the First Amendment prohibit content- and viewpoint discrimination. Good and bad advice are treated as equal. A core assumption of First Amendment theory is the autonomy of speakers and listeners. Another assumption, as this Article demonstrates in the health context, is the availability of access to professional advice. This assumption, however, is erroneous because access to health advice in fact is unevenly distributed.

This Article argues that assuming access to professional advice creates indefensible inequality. Lack of access to expert advice puts some listeners at much higher risk than others. Current First Amendment doctrine is largely unproblematic for those who can afford expert advice, and makes expert advice much costlier where health provider access is needed to obtain good advice. Those who lack access must place a higher degree of trust in widely-available information because they have no more reliable alternative. In other words, First Amendment doctrine places a higher burden on those who can least afford expert advice and who are most dependent on experts in public discourse.

Introduction

Access to reliable health advice can make the difference between life and death. But good advice is hard to come by. While this is true in ordinary times, the COVID-19 pandemic has made the need for widely available, scientifically accurate health advice particularly pressing. Within the confines of the doctor-patient relationship, the First Amendment operates in a way that protects good and sanctions bad advice.[1] For example, there is no First Amendment defense to malpractice liability if a doctor dispenses bad advice to

Claudia E. Haupt, J.S.D., Ph.D., *is an Associate Professor of Law and Political Science at Northeastern University in Boston, Massachusetts, USA.*

The Journal of Law, Medicine & Ethics, 49 (2021): 531-541.
DOI: https://doi.org/10.1017/jme.2021.77

a patient that results in harm.[2] Outside of the doctor-patient relationship, however, the traditional protections of the First Amendment generally prohibit content and viewpoint discrimination.[3] As a result, good and bad advice are treated as equal.

A core assumption of First Amendment theory is the autonomy of speakers and listeners. But when expertise is involved, non-expert listeners cannot be assumed to have the knowledge necessary to make truly autonomous decisions. This is why we distinguish between the professional-client relationship, designed to provide necessary expertise as the basis for important life decisions, and public discourse, where ideas are freely debated among speakers, in the first place. Another assumption, as this Article demonstrates in the health context, is the availability of access to expert advice. This assumption, however, is erroneous because access to health advice in fact is unevenly distributed. What if access to the doctor-patient relationship, and thus access to expert medical knowledge, is unattainable?

The stark theoretical and doctrinal contrast between regulated speech within the doctor-patient relationship and largely unregulated speech in public discourse is only justifiable if listeners have equal access to expert advice. Lack of access puts some listeners at much higher risk than others.

This Article argues that assuming access to professional advice creates indefensible inequality. The stark theoretical and doctrinal contrast between regulated speech within the doctor-patient relationship and largely unregulated speech in public discourse is only justifiable if listeners have equal access to expert advice. Lack of access puts some listeners at much higher risk than others. Current First Amendment doctrine is fairly unproblematic for those who can afford expert advice, but it makes expert advice much costlier where health provider access is needed to obtain good advice.[4] Those who lack access must place higher trust in widely-available information, which is unregulated as to its accuracy in public discourse, because they have no more reliable alternative. In other words, First Amendment doctrine places a higher burden on those who can least afford expert advice and who are most reliant on experts in public discourse. Differential access falls largely, though not exclusively, along racial lines;[5] vulnerable populations are less likely to receive reliable health advice routinely.[6]

Scholars have recently begun to highlight the distributive effects of First Amendment jurisprudence. As Nelson Tebbe observed, "[j]udges and other constitutional actors have been interpreting freedoms of speech and religion in a manner that unwinds government programs designed to ameliorate disparities of wealth, income, and other primary goods."[7] This Article is situated in conversation with that emergent line of First Amendment scholarship. As in other areas, "constitutional actors might respond by improving their understanding of how First Amendment rights interact with economic justice."[8] Excavating the mistaken premise of access to professional advice contributes to this larger project. The access problem has many facets that are widely discussed in the health law literature, but the First Amendment issue foregrounded here remains largely implicit. Although an obvious doctrinal distinction exists between the doctor-patient relationship and public discourse, the underlying assumption usually stays unacknowledged. Widely available access to healthcare, to be clear, is an important policy goal independent of First Amendment arguments, and I do not suggest that there is a First Amendment claim to access. Rather, the argument I make here is that without equal access, the assumptions underlying First Amendment doctrine are erroneous, and therefore, the resulting differential treatment of listeners within the doctor-patient relationship and those outside of it is unjustified.

The distinctive treatment of expertise in the doctor-patient relationship is only justifiable if listener autonomy is ensured. Either reliable expert advice must be widely available, as I will argue here, or the balance between speech protection and liability outside of the doctor-patient relationship ought to be recalibrated, with potential implications beyond this context. Focusing on the narrower issue of access to professional advice, this Article offers one way of mitigating the imbalance.

This Article proceeds in three Parts. Part I sketches the current First Amendment framework governing the distinctive doctrinal treatment of professional speech, that is, speech within the professional-client or doctor-patient relationship for the purpose of giving professional advice. Part II exposes the inequalities this First Amendment framework creates and

The Journal of Law, Medicine & Ethics, 49 (2021): 531-541. © 2021 The Author(s)

https://doi.org/10.1017/jme.2021.77 Published online by Cambridge University Press

highlights its consequences, putting free speech theory into conversation with the health law literature concerned with access disparities. Part III offers improving access to advice as one approach to mitigate the disconnect between the underlying theoretical assumption of access and the reality of limited access to the doctor-patient relationship.

Expanding access to expert advice suggests an admittedly highly speech-protective approach which sustains current First Amendment doctrine. It does not alter the balance between speech protection and liability for bad advice in public discourse, outside of the doctor-patient relationship. It also does not address continuing inequity within the doctor-patient relationship that concerns the quality of available advice.[9] Short of rearranging the existing balance between speech protection and liability for bad advice in public discourse, the importance of improving access to reliable advice by broadening access to healthcare services becomes particularly salient in a pandemic where the potential health harms from following bad advice are especially high.

I. The Framework of Unequal Advice

First Amendment doctrine bifurcates the quality of information in public discourse and the doctor-patient relationship.[10] Whereas speech within the doctor-patient relationship is regulated in numerous ways to ensure its accuracy, these constraints are generally absent outside of this relationship. "The distinction between public speech and non-public speech is embedded deeply within the fabric of First Amendment doctrine …,"[11] as is evident in the issues surrounding professional advice. (For purposes of this Article, I will limit the discussion to the doctor-patient relationship, but the claims I make throughout to a large extent also apply to other professional relationships.) As the Ninth Circuit put it, "outside the doctor-patient relationship, doctors are constitutionally equivalent to soapbox orators and pamphleteers, and their speech receives robust protection under the First Amendment."[12] This Part sketches the doctrinal distinction between professional speech and speech in public discourse and their respective normative underpinnings, focusing in particular on autonomy interests of the speaker and listener in addition to other free speech justifications such as the marketplace of ideas and democratic self-government interests.[13]

Importantly, although the Supreme Court declared in its 2018 decision in *NIFLA v. Becerra* that it has never recognized a category of professional speech, it does afford the speech within the doctor-patient relationship special doctrinal treatment.[14] Justice Thomas, writing for the *NIFLA* majority, discussed "[l]ongstanding torts for professional malpractice" and emphasized that informed consent is "firmly entrenched in American tort law."[15] Subsequently, it is still true that "identifying professional speech as distinct merely acknowledges a specific set of doctrinal features that we have traditionally assumed apply to speech between professionals and clients."[16] The bifurcation between speech in the doctor-patient relationship (irrespective of its "professional speech" label which, despite its descriptive accuracy, the Court disfavors) on the one hand, and in public discourse on the other thus still holds after *NIFLA*.[17]

A. Professional Speech

The law constrains what professionals may communicate to their patients within the confines of the doctor-patient relationship for the purpose of giving professional advice. These constraints are designed to ensure that patients receive comprehensive, accurate, and reliable advice. Whereas restrictions based on content and viewpoint are generally considered suspect, these limits — including professional licensing, fiduciary duties, informed consent, and malpractice liability — all place permissible limits on the content of advice.[18] I will map each of these features in turn. They all hinge on the nature of professional advice as different from other forms of speech.

The speech within the doctor-patient relationship is of a specific quality. Unlike other types of speech, its content is tied to professional knowledge, that is, expertise specific to the profession.[19] We might think of the professions as "knowledge communities" which exist to generate and disseminate knowledge.[20] The individual professional functions as a conduit between the knowledge community and the client or patient.[21] This connection to a knowledge community distinguishes the quality of advice communicated within the doctor-patient relationship from speech, including for example health advice, that occurs outside of it for example in traditional media such as television or on social media platforms such as Facebook, YouTube, Twitter, and the like. Conceptualizing the professions as knowledge communities for speech purposes also parallels the mechanics of malpractice liability where "the knowledge community's standard of care determines the benchmark against which the individual professional's liability is assessed."[22]

Importantly, professional knowledge is neither monolithic nor static. There is a range of opinions that count for good professional advice (as also recognized in tort law through the "two schools of thought" or "respectable minority" doctrine),[23] and profes-

The Journal of Law, Medicine & Ethics, 49 (2021): 531-541. © 2021 The Author(s)

sional knowledge can change over time.[24] Indeed, "[w]hat once was accepted in the field may soon be outdated."[25] However, the shared notions of validity to which knowledge communities subscribe limit the range of what counts as acceptable expertise.[26] Change within the knowledge community's discourse occurs by reference to these shared notions of validity.[27] Thus, "[d]ifferent assessments of shared knowledge, if valid under the agreed upon methodology, may produce good professional advice, even if it departs from the mainstream."[28] Emergent knowledge can work its way into the mainstream, as illustrated for example by the case of medical marijuana.[29]

During the COVID-19 pandemic, this process of updating advice according to new scientific insights was in unusually plain view, at times confusing the public.[30] This confusion in significant part is due to the fact that the process of expanding and updating knowledge ordinarily occurs internally. By the time professional advice reaches the public in ordinary times, it likely will have gone through deliberations within the knowledge community. The academic literature, conferences, and personal interactions can serve as sites of professional knowledge formation.[31] Though mostly through internal mechanics, knowledge communities update their advice, and they typically do so on the basis of a shared professional standard, reflected in common ways of knowing and reasoning and, in the case of scientific insights, the scientific method.[32] This also means that certain opinions can be excluded from the body of professional knowledge — or at least made extremely costly by imposing potential liability if harm results from expressing those opinions as advice — something that is impermissible in public discourse. In this respect, as Robert Post put it, "[e]xpert knowledge requires exactly what normal First Amendment doctrine prohibits."[33]

The doctor-patient relationship is characterized by an asymmetry of knowledge, where the patient seeks the doctor's advice to obtain knowledge the patient otherwise lacks.[34] At the same time, patient autonomy demands that the ultimate decision to act on professional advice rests with the patient.[35] This most fundamentally means the patient is able to make important life decisions for herself. Being able to do so, however, first requires "accessing the knowledge community's knowledge through the individual professional."[36] Of course, access is just a necessary, but not necessarily sufficient, first step; the patient also must understand the advice. The professional, in turn, must "communicate all information necessary to make an informed decision to the client."[37] In the classic formulation of *Canterbury v. Spence*, the patient needs professional advice to gain "enlightenment with which to reach an intelligent decision."[38] The interest thus protected is the patient's decisional autonomy, the ability to "chart his own course."[39]

Among the guardrails securing reliable advice within the doctor-patient relationship are features that would otherwise run afoul of the First Amendment. Before giving advice, professionals must be licensed. As far back as 1889, the Supreme Court has linked licensing and professional qualification. In upholding a licensing requirement to practice medicine, in *Dent v. West Virginia*, the Court noted: "No one has a right to practice medicine without having the necessary qualifications of learning and skill; and the statute only requires that whoever assumes, by offering to the community his services as a physician, that he possesses such learning and skill, shall present evidence of it by a certificate or license from a body designated by the State as competent to judge of his qualifications."[40] Professional licensing, though often criticized as an economic obstacle to limit entry to the profession, also serves to ensure health and safety of the patient by establishing minimum standards to practice.[41]

As I have explained in more detail elsewhere,

> "[t]he most salient justification for professional licensing is ensuring the professional's competence; thus, the object of licensing is the professional's knowledge. Licensing so understood ties the individual professional to the knowledge community by requiring a link between the ability to speak as a professional and the communication of knowledge as defined by the profession."[42]

In an ordinary First Amendment context, by contrast, licensing requirements might be understood as prior restraints on speech.[43] But whereas government permission to speak speech is troublesome in public discourse, and serves as a justification to prohibit prior restraints, and licensing functions as an ex-ante requirement to dispense advice, "suppression of incompetent advice is normatively desirable in the professional context."[44] The goal is "preserving the reliability of expert knowledge by guarding professionals' competence, and protecting the dissemination of reliable professional advice to the client."[45] Moreover, licensed professionals are subject to professional discipline where members of the profession "evaluate whether their peers meet the community's professional standard."[46]

Professional licensing has long been debated for several reasons, mostly concerned with improper tai-

The Journal of Law, Medicine & Ethics, 49 (2021): 531-541. © 2021 The Author(s)

loring of licensing regimes.[47] And "[t]he mere fact that someone is licensed to practice medicine does not guarantee that they are scientifically competent."[48] As currently implemented, professional licensing frequently is only a rough indicator of knowledge, and professional discipline is often focused on factors outside of professional knowledge and practice. For example, Nadia Sawicki noted that medical boards "often focus on character-related misconduct, including criminal misconduct, that bears only a tangential relation to clinical quality and patient care."[49] The current regimes of licensing and discipline should be improved to better serve their goal of ensuring competent advice from licensed professionals. But as a theoretical and doctrinal matter, properly calibrated licensing and discipline serve an important function in the dissemination of expert advice to listeners, and their purpose aligns with the interest of protecting the integrity of professional advice.[50] This is also why novel First Amendment challenges to professional licensing ought to fail.[51]

In addition, fiduciary duties attach within the doctor-patient relationship that create duties of loyalty and care to mitigate the knowledge asymmetry.[52] When the patient entrusts their doctor with providing guidance on important health decisions, the doctor must act in the patient's best interest. This also means the doctor has to act according to the insights of the profession.[53] A fiduciary relationship between speakers and listeners, however, is incompatible with the idea of speaker and listener autonomy in public discourse.[54] In analyzing fiduciary obligations, one could focus primarily on the type of relationship, as some scholars do, or the content of information conveyed within the relationship. The professional's obligation is to convey the insights of the knowledge community in an accurate and comprehensive manner.[55] But whereas fiduciary duties provide normative support for a patient's trust in their doctor, it is also important to note that disparities exist in the level of trust between patient and provider. The trust between provider and patient may be influenced by a range of factors, including for example cultural, religious, political, or socio-economic differences. In short, access to the doctor-patient relationship by itself does not necessarily provide equal access to relationships of trust. I will return to this point later in Part III.

Likewise, informed consent requirements, which enforce the interest in full disclosure of relevant information in the medical context, address the knowledge asymmetry and aim to ensure patient autonomy.[56] Of course, on the eve of *Canterbury*'s fiftieth anniversary, critiques of the way consent is obtained in practice abound, but the goal of meaningful consent and understanding of risks, benefits, and alternatives remains at the core of ensuring patient autonomy.[57]

Finally, malpractice liability can be understood to protect the integrity of advice a patient receives from their doctor. Although the fiduciary duty of care includes the duty to act as a competent professional, it is not necessarily duplicative of the malpractice regime. The category of harm is betrayal of trust in the former and professional incompetence in the latter regime.[58] The two regimes are complementary in that the patient's interests include both the accuracy of advice and the ability to rely on that advice.[59] Professional knowledge in both instances provides the benchmark against which individual professionals are assessed; thus, the knowledge community sets the standard of care and the individual professional is compared to that standard.[60] Put into a free speech perspective, "only good professional advice, as measured by the standards of the relevant knowledge community is protected."[61] Thus, "[b]ad professional advice is subject to tort liability, and the First Amendment provides no defense."[62]

Shifting to the perspective of underlying speech interests, we can see that the constraints imposed on the doctor-patient relationship are designed to govern speech in the listener's interest. Consequently, the professional's interest as a speaker within the doctor-patient relationship is unlike the speaker interest outside of it. Whereas the speaker's autonomy interest in public discourse typically is understood as the speaker's interest to speak their own mind, "the autonomy interest to freely express one's personal opinions," the speaker interest at stake within the doctor-patient relationship is the professional autonomy interest "to express one's professional opinion as a member of the knowledge community."[63] This speaker interest interacts with the listener's decisional autonomy interest in that it provides the knowledge necessary for the listener's decision.[64] Post notes that "[b]ecause the practices that produce expert knowledge regulate the autonomy of individual speakers to communicate, because they transpire in venues quite distant from the sites where democratic public opinion is forged, they seem estranged from most contemporary theories of the First Amendment."[65] I will next turn to the First Amendment landscape outside of the doctor-patient relationship to highlight the differences, focusing on the role of expertise and professional advice.

B. Speech Outside of the Professional Relationship

The constraints imposed on speech in the doctor-patient relationship to ensure its accuracy, as measured by the standards of the knowledge community, are typically absent outside of the relationship. In pub-

The Journal of Law, Medicine & Ethics, 49 (2021): 531-541. © 2021 The Author(s)

lic discourse, there is no distinction between expertise and quackery.[66] Advice that departs from the insights of the knowledge community can be sanctioned in the professional-client relationship, but "false ideas" do not exist in public discourse.[67] Whereas malpractice liability may be imposed for bad advice in the doctor-patient realtionship that results in harm, First Amendment doctrine outside of that relationship protects lies just as much as disciplinary expertise.[68] Content-and viewpoint-based regulations, uniformly accepted for professional speech in the form of informed consent and malpractice as just discussed,[69] are presumptively unconstitutional outside of the professional-client or doctor-patient relationship.[70] Just as informed consent requirements have no place in the public discourse, so too are fiduciary duties incompatible with speech in that context.[71] Where there is no "personal nexus between professional and client …, and a speaker does not purport to be exercising judgment on behalf of any particular individual with whose circumstances he is directly acquainted,"[72] the duties owed within the professional relationship do not exist. In public discourse, in short, each speaker and listener is on their own.

Importantly, the identity of the speaker in public discourse is irrelevant for First Amendment purposes. Thus, a professional's private speech in public discourse receives the same protection as anyone else's.[73] Of course, it is possible that a professional's private speech will be perceived as more likely to convey accurate information.[74] Based on their training and licensing, doctors in public discourse, for example, might be considered trustworthy, and their statements on medical matters might be deemed more reliable than those of laypeople. But unlike in the doctor-patient relationship, there are no legal guardrails — such as malpractice liability for bad advice — to ensure that this is actually the case: "When a physician speaks to the public, his opinions cannot be censored and suppressed, even if they are at odds with preponderant opinion within the medical establishment."[75] Outside of the professional relationship, individual professionals are not bound by the knowledge community's insights.[76]

Moreover, professionals may challenge the professional knowledge community's most fundamental insights in public discourse, something they are not free to do while dispensing professional advice within the professional relationship.[77] Imagine, for example, that a trained and licensed physician hosts a television program in which he gives advice. No matter how inaccurate the advice may be, such a professional "cannot under the First Amendment be held to the standard of medical malpractice that would censor him within the professional-client relationship. In short, a professional may give bad advice to millions of viewers — but not to one client."[78]

The reason for this difference is that under existing doctrine as currently understood, "[w]ithin public discourse, traditional First Amendment doctrine systematically transmutes claims of expert knowledge into assertions of opinion."[79] Moreover, the speaker's perspective tends to be the central concern in public discourse.[80] Normatively, the constraints that limit speech in the professional-client relationship are absent in public discourse, because speakers are considered to be equals.[81] As I have explained, a "traditionally strong notion of equality continues to pervade our understanding of the First Amendment. The justification is based in democratic theory: a fundamental belief in equality of speakers and opinions in public discourse is necessary for equal participation, which in turn forms the basis of democracy."[82]

By contrast, in the professional setting, one could consider the lack of equality among speakers — and, characteristically for that relationship, the lack of equality between speakers and listeners — with respect to expert knowledge "undemocratic." Professional knowledge, and expertise more generally, breaks the assumption of equality among speakers and opinions. But it still serves an important function, because "it informs public discourse in a manner that can lead to more informed decisions of citizens without expert knowledge by providing expertise that would not otherwise exist. Thus, precisely by virtue of its undemocratic nature, professional knowledge has the potential to advance democratic public discourse. On this view, the presence of expert knowledge is better for public discourse than its absence."[83]

In addition to the justification for speaker equality based in democracy and autonomy among speakers in public discourse generally, the marketplace of ideas rationale may supply good reasons to let professionals challenge their knowledge community's consensus outside of the professional relationship. Whereas an "epistemic marketplace" exists within the profession where new insights are generated through arguments based on agreed-upon methods, it might further innovation to challenge the orthodoxy from the outside. Airing unorthodox ideas outside of the doctor-patient relationship could provide an avenue to push knowledge in unexpected directions. In addition, it helps to educate the public about cutting-edge research that might advance professional knowledge. On this reasoning, the "professional ahead of the curve" is a potentially valuable voice that should not be silenced because they depart from the current state of professional knowledge. Airing unorthodox ideas outside of the doctor-patient relationship could provide an ave-

The Journal of Law, Medicine & Ethics, 49 (2021): 531-541. © 2021 The Author(s)

nue to push knowledge in unexpected directions. In addition, it helps to educate the public about cutting-edge research that might advance professional knowledge. But this trade-off to favor innovation also can result in serious harm. In the context of health advice, emergent and untested ideas might have adverse effects that have not yet been discovered or sufficiently studied. While this potential for harm is to be avoided within the doctor-patient relationship, it is generally accepted in public discourse.

The COVID-19 pandemic provides a cautionary tale. Whereas updating knowledge within the discourse of the profession is based on shared ways of knowing and reasoning, challenges in public discourse are not necessarily based on a shared methodology. Thus, in the spirit of equality among speakers, any challenge is permissible. During the pandemic, we have seen such challenges from both experts and non-experts. While challenges to expertise from government speakers, such as for example former White House advisor Dr. Scott Atlas,[84] may be particularly problematic especially if they are couched in the form of advice or commands, and the normative basis might be challenged for considering them equals in public discourse, other speakers, including other professionals, are free to challenge even the most fundamental professional insights.[85] This has led to harmful outcomes such as the widely-reported death of a man and hospitalization of his wife after ingesting chloroquine to prevent coronavirus, reportedly relying on President Trump's erroneous assertions about its benefits.[86] As currently understood, however, the balance between speech protection and liability for harm in public discourse cuts decisively in favor of protecting speech.

II. Unequal Access to Advice and Its Consequences

In discussing the racial inequities in the context of the public health response to COVID-19 in the United States, Aziza Ahmed and Jason Jackson point out that "[t]he legal system has … contributed to the production of the background conditions that lead to extreme health disparities and lay the foundation for poor health outcomes among vulnerable populations, particularly racial minorities."[87] The legal system also both governs who has access to healthcare and sets the legal parameters for speech protection. The interaction of First Amendment doctrine with its underlying assumption of access and the reality of limited access come together to exacerbate such disparity. The immediate consequence of unequal access to health advice is that some individuals must rely on information publicly available to make health decisions.

Access to medical care in the United States is limited, and vulnerable populations — including racial minorities — suffer from the resulting inequities.[88] To be sure, the First Amendment perspective highlights a narrow conception of access, that is, it focuses only on the individual's ability to enter into a doctor-patient relationship. But it is important to note that the access to healthcare problem is much larger, encompassing both "(1) dearth of actual services and (2) racism in healthcare settings that impedes access."[89] During the COVID-19 pandemic, the problem of unequal access intensified, but the pandemic has only exacerbated a problem that has existed all along.[90]

To reiterate, the lack of access to health advice results in inequality in many ways, including with respect to the First Amendment. Improving access to healthcare is an essential policy goal independent of First Amendment concerns. But from a First Amendment perspective, it is meaningful to acknowledge that without equal access, the assumptions underlying current doctrine are erroneous, and the resulting differential treatment of listeners is unjustified. A necessary prerequisite for listener autonomy in public discourse is equal access to relevant information. Information may come from any number of sources, including traditional media outlets, social media and the like. But information in public discourse is not the same as expert knowledge. Even in public discourse, it makes a difference for an individual's autonomy interest whether information is supported by scientific standards or based on junk science. In the health context, however, equal access to information means equal access to a specific kind of information, namely expert knowledge. As I have explained, "[t]he listener's perspective reveals the qualitative difference between them. A client or patient today may have access to virtually unlimited amounts of information through multiple channels. Yet, none of this information amounts to expert knowledge. To be flip, Dr. Google is not *really* your doctor."[91] This significantly limits decisional autonomy, which requires comprehensive, accurate (as measured by the standards of the relevant knowledge community), and reliable information personally tailored to the patient.[92]

Again, the COVID-19 example usefully illustrates the pitfalls of relying soley on public discourse. Perhaps most prominently, celebrity "TV doctors" have been dispensing advice to large audiences that is inconsistent with professional expertise.[93] On the one hand, there are known personalities with large pre-pandemic followings, maybe best exemplified by Dr. Oz, whose penchant for unorthodox views may have already been known by many viewers.[94] On the other hand, less prominent professionals emerged

The Journal of Law, Medicine & Ethics, 49 (2021): 531-541. © 2021 The Author(s)

who may "sincerely and authentically hold false scientific beliefs."[95] Take the example of Dr. Stella Immanuel who appeared in a video widely shared on social media.[96] As Post recounts, she promoted — apparently based on her sincere conviction — hydroxychloroquine as a cure for COVID-19. However, had she advised a patient in the same way and subsequently been sued for malpractice, Post argues that a First Amendment defense would likely be unsuccessful in this scenario, because doctors cannot demand that their patients gamble with their health to follow doctors' unorthodox views.[97]

This is not to suggest that there is no reliable health advice available outside of the doctor-patient relationship. Throughout the pandemic, for example, good medical advice was also dispensed by "the doctor-journalists who usually play a supporting role in network and cable newscasts and have now become the leading performers."[98] But while the American Medical Association provides guidelines for physicians' media interactions,[99] the quality of advice is not secured by the same legal guardrails as advice within the doctor-patient relationship.

III. One Approach: Improving Access

The bottleneck for First Amendment purposes between generally available but unchecked health information and reliable expert knowledge is access to the doctor-patient relationship. Improving access to advice is the least doctrinally disruptive and thus most speech-protective solution to the First Amendment problem. It may not ultimately be the one that is normatively most desirable, but in terms of immediate payoff, it seems worth examining. From a First Amendment perspective, a wide range of approaches could lead to the desired result. Whether Medicare for all, a robust ACA expansion, or more targeted programs to improve access for vulnerable populations is the most suitable approach from a health policy perspective would not meaningfully change the First Amendment calculus. As long as equality among listeners as recipients of health advice is ensured, First Amendment theory is largely agnostic as to the specifics of expanding advice. Another, less speech-protective alternative might realign the balance between speech protection and liability for advice that results in harm.[100] But, as Tebbe convincingly argues, "it must be accepted that a turnabout in First Amendment interpretation is not likely anytime soon."[101] Though unquestionably a massive policy challenge, improving access would not require a change in First Amendment interpretation. And, as already indicated, improving the availability of access is only a first step which must be followed by ensuring the high quality of personally tailored advice within professional relationships of trust for all patients.

An even narrower proposal not centered on access to the doctor-patient relationship itself might be a "public option" for supplying expertise in public discourse, particularly in times of public health crises. One possibility could be an aggressive public rollout of expertise, for example by the CDC. But such a strategy may be only of limited success. First, it depends on political willingness to take on the role of providing expertise, something that was notably absent in the early days of the pandemic during the Trump administration. And even assuming that a competent agency was able to disseminate advice, it may be unsatisfactory. One central problem to such an approach is the position of government experts in the marketplace of ideas more broadly. In an age of viral memes, and widespread mis-and disinformation, which I will return to, the government's message may be lost in the cacophony of messages. Indeed, to combat this challenge, the administration is now seeking to enlist influencers on social media to amplify its public health message.[102]

Another issue is related to the individualized nature of public health measures. To illustrate, Ahmed and Jackson explain that the CDC's COVID-19 response displayed features of the "neoliberal" turn in public health that "emphasizes individual actions over structural responses."[103] Thus, in the early stages of the pandemic, individual actions such as washing hands — "what might have seemed like an easy individual behavior change exercise"[104] — were stressed, largely disregarding the social determinants of health.[105] They further note that this is not a new approach, but rather continues a trend "that has transformed virtually all arenas of public policy since the 1970s. It haunts the response to public health crises in the United States including epidemics that preceded COVID-19."[106] In this approach, racial inequities are perpetuated.[107] Although "race was formally absent in the policies that promoted individual responsibility, it was fundamental to the underlying political logic that fueled the rise of the neoliberal approach."[108] Thus, there are structural inequities that may be packaged into a public rollout of medical information that are based in the government's overall contemporary approach to public health.

In short, attempting to replace the doctor-patient relationship with such a "public option" for obtaining expertise, perhaps even limited to a particular public health crisis, is a fraught alternative. Ultimately, short of shifting the balance between speech protection and liability, expanding access to the doctor-patient relationship is the most speech-protective way to justify

The Journal of Law, Medicine & Ethics, 49 (2021): 531-541. © 2021 The Author(s)

the bifurcation between advice within the doctor-patient relationship and public discourse.

Finally, two caveats to the partial solution of expanding access. First, expertise has been eroded even when there is access. This is part of the larger story of the "democratization" of expertise.[109] Even equalized access to healthcare still does not solve the problem of educational disparities and a fragmented information landscape. Not everyone will get information from reliable sources, and access does not guard against dis-or misinformation. To illustrate, there is evidence of large-scale mis- and disinformation about a wide range of aspects related to the COVID-19 pandemic,[110] including an intensified problem of vaccine misinformation.[111] Distinct from the role of experts in public discourse, non-experts also have rendered advice. In the current pandemic, influencers have had a large role in disseminating bad advice.[112] It helps to have access to the doctor-patient relationship, but it's not the solution to the plague of health mis-and disinformation.[113] Individuals can still fall prey to bad advice from these sources and suffer significant harm, even if they have access to premium care. And, as we have seen in connection with mask mandates and COVID-19 vaccine efforts, there can be political resistance of individuals that has nothing to do with lack of access to expertise.[114]

Second, the argument here solves a First Amendment theory problem with a policy problem, that is, improving access to healthcare. A critic might suggest that rather than thinking about how to best fix First Amendment doctrine, we ought to focus on policy strategies to end the distributive inequities. The social determinants of health suggest a sprawling problem that goes well beyond access to the doctor-patient relationship. Vulnerable "populations disproportionately suffer from health conditions, including higher rates of asthma, diabetes, cancer, and heart disease."[115] This is due to a variety of "structural and environmental issues, such as poor housing conditions; living in food deserts and food swamps; contaminated water; air pollution; and persistent stress due to employment and financial insecurity, poverty, and racial discrimination."[116] The underlying problem is the unequal distribution of resources and opportunities in addition to access to healthcare, not First Amendment doctrine or access to information. As Ahmed and Jackson argue, "the literature on the social determinants of health focuses on structural constraints to good health, including the mechanisms through which the upstream legal regime produces poor health outcomes. This approach emphasizes the point that the idea of risk is not about a rational individual making a calculated choice, nor is it about access to information. Instead, people's poor health outcomes are often the result of structural factors well outside of their control."[117] And, relatedly, even access to healthcare or (equal) health information would not necessarily and without more lead to equitable health outcomes.[118] Merely creating better access thus is not by itself sufficient for the larger problem of health disparities. Nonetheless, it is worth exposing the assumption of access as a central flaw in First Amendment doctrine. And one way to remedy this mistaken assumption is through improved access.

IV. Conclusion

Angela Harris and Aysha Pamukcu note that "[w]e live in a time of increasingly steep inequalities, not only in income and wealth, but also in access to basic public goods like healthy food, clean water, and adequate housing."[119] Current First Amendment doctrine exacerbates these inequalities. As Tebbe diagnoses with respect to current interpretations of freedom of speech (and religion), "the regressive impact of actions grounded in these constitutional freedoms is particularly noticeable against the backdrop of historic levels of economic inequality. Paradoxically, these constitutional rights, which are commonly associated with democracy, are working to undermine the material conditions for a cooperative society."[120] The lack of access to expert advice and the idea of a largely unregulated free trade in ideas in public discourse places an indefensible burden on some listeners that undermines the equality justification for speech protection and content-and viewpoint neutrality. This Article exposed a central flaw in First Amendment doctrine, the assumption of access to advice, and suggests as one plausible remedy the expansion of access to the doctor-patient relationship.

Acknowledgements

Many thanks to Caroline Corbin, Hiba Hafiz, Jonathan Kahn, Chip Lupu, Kristin Madison, Wendy Parmet, Catherine Ross, Blaine Saito, and Sonia Suter as well as participants in the GW Law Symposium "First Amendment Values in Health Care," the Northeastern University School of Law Faculty Colloquium, and the Boston Area Junior Faculty Roundtable for helpful comments and conversations. Thanks also to Kemelly Fortunati and Erin Gannon for excellent research assistance.

Note

The author has no conflicts to disclose.

References

1. *See* C. E. Haupt, "Professional Speech," *Yale Law Journal* 125, no. 5 (2016): 1238-1303.

The Journal of Law, Medicine & Ethics, 49 (2021): 531-541. © 2021 The Author(s)

2. *See* C. E. Haupt, "Unprofessional Advice," *University of Pennsylvania Journal of Constitutional Law* 19, no. 3 (2017): 671-729.
3. *See Reed v. Town of Gilbert*, 135 S.Ct. 2218 (2015); *National Institute of Family & Life Advocates v. Becerra* [NIFLA], 138 S.Ct. 2361 (2018).
4. *See* C.E. Haupt, "When Health Advice is Hard to Come by, BIPOC Suffer the Consequences," Bill of Health, *available at* <https://blog.petrieflom.law.harvard.edu/2020/10/06/health-advice-first-amendment-bipoc/> (last visited September 27, 2021).
5. *See, e.g.*, R. Yearby, "Sick and Tired of Being Sick and Tired: Putting an End to Separate and Unequal Health Care in the United States 50 Years After the Civil Rights Act," *Health Matrix* 25 (2015): 1-32 ("The largest disparity in accessing quality health care and health status in the United States is between African Americans and Caucasians."). For current data, *see, e.g.,* N. Ndugga and S. Artiga, *Disparities in Health and Health Care: 5 Key Questions and Answers*, KFF (May 11, 2021), *available at* <https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers> (last visited Sept.27, 2021).
6. A. P. Harris and A. Pamukcu, "The Civil Rights of Health: A New Approach to Challenging Structural Inequality," *UCLA Law Review* 67 (2020): 758-832.
7. *See, e.g.,* N. Tebbe, "A Democratic Political Economy for the First Amendment," *Cornell Law Review* 105, no. 3 (2020): 959-1022.
8. *Id.* at 963.
9. *See, e.g.*, Yearby, *supra* note 5, at 2; A. Ahmed and J. Jackson, "Race, Risk, and Personal Responsibility in the Response to COVID-19," *Columbia Law Review Forum* 121, no. 3 (2021).
10. *See* C. E. Haupt, "Licensing Knowledge," *Vanderbilt Law Review* 72, no. 2 (2019): 501-559 (discussing the distinction between information and knowledge).
11. R.C. Post, *Democracy, Expertise, Academic Freedom: A First Amendment Jurisprudence for the Modern State* (New Haven: Yale University Press, 2012): at 23.
12. *Pickup v. Brown*, 728 F.3d 1042, 1054 (9th Cir. 2014).
13. *See* Haupt, *supra* note 1, at 1243.
14. *NIFLA v. Becerra*, 138 S.Ct. at 2373 ("This Court's precedents do not recognize such a tradition for a category called 'professional speech.'").
15. *Id.*
16. C.E. Haupt, "The Limits of Professional Speech," *Yale Law Journal Forum* 128 (2018): 185-200.
17. *Id.* at 188.
18. *Id.* at 192.
19. Haupt, *supra* note 1, at 1242.
20. *Id.* at 1241.
21. *Id.* at 1254.
22. *Id.* at 1242.
23. Haupt, *supra* note 2, at 708.
24. *Id.* at 677.
25. *Id.*
26. *Id.* at 680.
27. *Id.*
28. *Id.* at 704.
29. *Id.* at 721.
30. *See, e.g.,* C. Farr, "Why Scientists are Changing their Minds and Disagreeing During the Coronavirus Pandemic," CNBC, *available at* <https://www.cnbc.com/2020/05/23/why-scientists-change-their-mind-and-disagree.html> (last visited September 27, 2021).
31. Haupt, *supra* note 1, at 1252.
32. *Id.* at 1253.
33. Post, *supra* note 11, at 9.
34. Haupt, *supra* note 2, at 680.
35. Haupt, *supra* note 1, at 1243.
36. Haupt, *supra* note 2, at 680.
37. *Id.* at 1271.
38. 464 F.2d 772, 780 (D.C. Cir. 1972).
39. *Id.* at 781 ("To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential.")
40. 129 U.S. 114, 123 (1889).
41. *See* Haupt, *supra* note 10, at 509-531; Haupt, *supra* note 2, at 679 ("In licensing, the administrative function of granting access to the profession and the substantive evaluation of the knowledge community's ability to impart its professional knowledge come together.").
42. Haupt, *supra* note 10, at 530.
43. *Id.* at 554-55 (noting disagreement among courts and scholars on the question whether professional licensing requirements constitute a prior restraint).
44. *Id.* at 555.
45. *Id.* at 504.
46. Haupt, *supra* note 16, at 190.
47. Haupt, *supra* note 10, at 523-524.
48. R. Post, "NIFLA and the Construction of Compelled Speech Doctrine," *Indiana Law Journal* at *17 n.67, *available at* <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3798562> (forthcoming, last revised April 16, 2021).
49. N. Sawicki, "Character, Competence, and the Principles of Medical Discipline," *Journal of Health Care Law and Politics* 13, no. 2 (2010).
50. Haupt, *supra* note 10, at 523-24.
51. *Id.* at 559.
52. *See, e.g.,* M. J. Mehlman, "Why Physicians are Fiduciaries for Their Patients," *Indiana Health Law Review* 12, no. 1 (2015): 1-63.
53. Haupt, *supra* note 16, at 191.
54. Haupt, *supra* note 10, at 544.
55. *Id.* at 545.
56. *See* Haupt, *supra* note 1, at 1287-1289.
57. See, e.g., S.C. Grant, "Informed Consent- We Can and Should Do Better," *JAMA Network*, April 28, 2021, *available at* <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2779253> (last visited September 27, 2021).
58. Haupt, *supra* note 10, at 548.
59. *Id.*
60. Haupt, *supra* note 1, at 1286-1287.
61. Haupt, *supra* note 17, at 191.
62. *Id.*
63. Haupt, *supra* note 1, at 1243.
64. *Id.* at 1271-72.
65. Post, *supra* note 11, at xii.
66. *See, e.g.*, J.R. Bambauer, "Snake Oil Speech," *Washington Law Review* 93, no. 1 (2018): 73-143.
67. Haupt, *supra* note 16, at 191.
68. *See United States v. Alvarez*, 567 U.S. 709 (2012).
69. C.E. Haupt, "Professional Speech and the Content-Neutrality Trap," *Yale Law Journal Forum* 127 (2017): 185-200.
70. *See Reed v. Town of Gilbert*, 135 S.Ct. 2218, 2226 (2015).
71. Haupt, *supra* note 10, at 544.
72. *Lowe v. SEC*, 472 U.S. 181, 232 (1985)(White, J., concurring).
73. Haupt, *supra* note 1, at 1254-57.
74. Haupt, *supra* note 2, at 681.
75. R. Post, "Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech," *University of Illinois Law Review* 2007, no. 3 (2007): 939-990.
76. *Id.*
77. Haupt, *supra* note 2, at 681.
78. *Id. See also* J. Baron, "Social Media is a Good Source of Bad Medicine," *Forbes*, *available at* <https://www.forbes.com/sites/jessicabaron/2018/11/30/social-media-bad-medicine/?sh=4643213e62e1> (last visited Sept. 27, 2021).
79. Post, *supra* note 11, at 44.
80. *See, e.g., id.* at xi.
81. Haupt, *supra* note 2, at 682.
82. Haupt, supra note 10, at 540.
83. *Id.* at 541.
84. N. Weiland, S.G. Stolberg, M.D. Shear, and J. Tankersley, "A New Coronavirus Advisor Roils the White House with Unorth-

The Journal of Law, Medicine & Ethics, 49 (2021): 531-541. © 2021 The Author(s)

odox Ideas," *New York Times*, September 9, 2020 *available at* <https://www.nytimes.com/2020/09/02/us/politics/trump-scott-atlas-coronavirus.html> (last visited Sept. 27, 2021).
85. *See, e.g.*, C.E. Haupt and W. E. Parmet, "Government Speech, Distorted Science, and the First Amendment," *University of Illinois Law Review* (forthcoming, 2022) (examining the parallel between government speech as a form of expert advice and professional speech and its potential implication for liability), *available at* <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3954547> (last visited November 16, 2021).
86. N. Vigdor, "Man Fatally Poisons Himself While Self-Medicating for Coronavirus, Doctor Says," *New York Times*, *available at* <https://www.nytimes.com/2020/03/24/us/chloroquine-poisoning-coronavirus.html?smid=url-share> (last visited September 27, 2021).
87. Ahmed and Jackson, *supra* note 9, at 49.
88. *See*, e.g., B. A. Noah, "A Prescription for Racial Equality in Medicine," *Connecticut Law Review* 40, no. 3 (2008): 675-721; E. A. Benfer, "Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice," *American University Law Review* 65, no. 2 (2015): 275-351; R. Yearby, "Sick and Tired of Being Sick and Tired: Putting an End to Separate and Unequal Health Care in the United States 50 years After the Civil Rights Act of 1964," *Health Matrix* 25, no. 1 (2015): 1-32; R. Yearby, "Racial Inequities in Mortality and Access to Health Care: The Untold Peril of Rationing Health Care in the United States," *Journal of Legal Medicine* 32 (2011): 77-91; R. Yearby, "Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause," *Journal of Law Medicine & Ethics* 48, no. 3 (2020): 518-526.
89. Ahmed and Jackson, *supra* note 9, at 64 n.85.
90. *Id.* at 49-51. See also W.A.I. Frederick, "What Happens When People Stop Going to the Doctor? We're About to Find Out," *New York Times*, *available at* <https://www.nytimes.com/2021/02/22/opinion/medical-care-coronavirus.html?smid=url-share> (last visited Sept. 27, 2021) (discussing the impact of the COVID-19 pandemic on racial minorities).
91. Haupt, *supra* note 10, at 532.
92. Haupt, *supra* note 1, at 1271.
93. J. Hibberd, "TV Doctors like Dr. Phil, Dr. Oz Keep Blowing it When Talking Coronavirus," *Entertainment Weekly*, *available at* <https://ew.com/tv/dr-phil-oz-drew-coronavirus-fail/> (last visited September 27, 2021).
94. *See, e.g.*, T. McCoy, "Half of Dr. Oz's Medical Advice is Baseless or Wrong, Study Says," *Washington Post*, *available at* <https://www.washingtonpost.com/news/morning-mix/wp/2014/12/19/half-of-dr-ozs-medical-advice-is-baseless-or-wrong-study-says/> (last visited September 27, 2021).
95. Post, *supra* note 47, at *17.
96. S. Frenkel and D. Alba, "Misleading Virus Video, Pushed by the Trumps, Spreads Online," *New York Times*, *available at* <https://www.nytimes.com/2020/07/28/technology/virus-video-trump.html?smid=url-share> (last visited September 27, 2021).
97. Post, *supra* note 47, at *17.
98. See, e.g., J. Kluger, "In a Time of Pandemic, TV Doctors Wield Growing Influence. Is That A Good Thing?" *Time*, *available at* <https://time.com/5828108/tv-doctors-coronavirus/> (last visited September 27, 2021).
99. AMA, "Physicians in the Media: Responsibilities to the Public and the Profession," American Medical Association, *available at* <https://www.ama-assn.org/delivering-care/ethics/physicians-media-responsibilities-public-and-profession> (last visited September 27, 2021).
100. Haupt, *supra* note 4.
101. Tebbe, *supra* note 7, at 964.
102. T. Lorenz, "To Fight Vaccine Lies, Authorities Recruit an 'Influencer Army,'" *New York Times*, August 1, 2021, *available at* <https://www.nytimes.com/2021/08/01/technology/vaccine-lies-influencer-army.html> (last visited Sept. 27, 2021).
103. Ahmed and Jackson, *supra* note 9, at 52.
104. *Id.* at 47-48.
105. *Id.* at 49.
106. *Id.* at 53.
107. *Id.* at 54-55.
108. *Id.* at 55.
109. *See* Haupt, *supra* note 10, at 533.
110. *See, e.g.*, D. C. Nunziato, "Misinformation Mayhem: Social Media Platforms' Efforts to Combat Medical and Political Misinformation," *First Amendment Law Review* 19 (2020); J. Donovan, "Social-media Companies Must Flatten the Curve of Misinformation," *Nature*, *available at* <https://www.nature.com/articles/d41586-020-01107-z> (last visited Sept. 27, 2021).
111. *See, e.g.*, A. S. Rutschman, "Facebook's Latest Attempt to Address Vaccine Misinformation — And Why It's Not Enough," *Health Affairs*, *available at* <https://www.healthaffairs.org/do/10.1377/hblog20201029.23107/full/> (last visited Sept. 27, 2021).
112. J. Waterson, "Influencers Among 'Key Distributors' of Coronavirus Misinformation," *The Guardian*, *available at* <https://www.theguardian.com/media/2020/apr/08/influencers-being-key-distributors-of-coronavirus-fake-news> (last visited September 27, 2021).
113. *See* W. E. Parmet and J. Paul, "COVID-19: The First Post-truth Pandemic," *American Journal of Public Health* 110, no. 7 (2020): 945–946.
114. *See, e.g.*, R. Rojas, "Masks Become a Flash Point in the Virus Culture Wars,'" *New York Times*, *available at* <https://www.nytimes.com/2020/05/03/us/coronavirus-masks-protests.html?smid=url-share> (last visited September 27, 2021); D. Ivory, L. Leatherby, and R. Gebeloff, "Least Vaccinated U.S. Counties Have Something in Common: Trump Voters," *New York Times*, *available at* <https://www.nytimes.com/interactive/2021/04/17/us/vaccine-hesitancy-politics.html?smid=url-share> (last visited September 27, 2021) ("The disparity in vaccination rates has so far mainly broken down along political lines.").
115. Ahmed and Jackson, *supra* note 9, at 67.
116. *Id.*
117. *Id.* at 62
118. *See, e.g.*, Yearby, *supra* note 5, at 5; D. B. Matthew, "Toward a Structural Theory of Implicit Racial and Ethnic Bias in Health Care," *Health Matrix* 25 (2015): 61-86.
119. Harris and Pamukcu, *supra* note 6, at 762.
120. Tebbe, *supra* note 7, at 959-960.

The Journal of Law, Medicine & Ethics, 49 (2021): 531-541. © 2021 The Author(s)