UNPROFESSIONAL ADVICE

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ABSTRACT

Professional speech should receive robust First Amendment protection. It should be shielded from state interference that seeks to prescribe or alter the content of professional advice. But how should we decide what advice falls within the scope of defensible professional knowledge? Where, in other words, does First Amendment protection for professional speech end and tort liability for professional malpractice begin? This Article provides a theoretical foundation to distinguish professional from unprofessional advice.

The professions are best conceptualized as knowledge communities whose main reason for existence is the generation and dissemination of knowledge. But knowledge communities are not monolithic; there is a range of knowledge that is acceptable as good professional advice. Advice falling within this range should receive robust First Amendment protection. Conversely, bad advice is subject to professional malpractice liability, and the First Amendment provides no defense. Protecting good professional advice and sanctioning bad advice requires a normative and doctrinal defense for excluding outliers from First Amendment protection. In providing such a defense, this Article puts the First Amendment into conversation with the tort law of professional malpractice and the law of evidence governing the admissibility of expert testimony. Conceptualizing professionals as members of knowledge communities, this Article provides a theory to identify the range of valid professional knowledge for First Amendment purposes.

TABLE OF CONTENTS

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INTRODUCTION

When you go to your doctor, lawyer, therapist, or pharmacist, you do so because you want to access a useful body of knowledge these professionals possess. In order to solve your individual problem, you rely on the professional's competent, accurate, and comprehensive advice. But what if your advice-giving professional departs from, or refuses to deploy, the full range of professional knowledge? Imagine she has a political, philosophical, or religious disagreement with her profession: your lawyer objects to same-sex marriage and refuses to draft marriage-related documents for you and your same-sex spouse;[1] your therapist believes homosexual behavior is sinful and homosexuality ought to be remedied by conversion therapy;[2] your

1 *Cf.* Elizabeth Sepper, *Doctoring Discrimination in the Same-Sex Marriage Debates*, 89 IND. L.J. 703, 707–08 (2014) ("Lawyers could refuse to prepare prenuptial agreements [for same-sex couples].").

2 *See* Pickup v. Brown, 740 F.3d 1208, 1222 (9th Cir. 2014), (upholding the California conversion therapy law against a Free Speech challenge); King v. Governor of N.J., 767 F.3d 216, 240–41 (3d Cir. 2014) (upholding the New Jersey conversion therapy law against a Free Speech and Free Exercise challenge); Doe v. Christie, 33 F. Supp. 3d 518, 520 (D.N.J. 2014) *aff'd sub nom.* Doe v. Governor of N.J., 783 F.3d 150 (3d Cir. 2015).

pharmacist considers abortion to be a grave moral wrong, believes some forms of birth control to be abortifacients, and refuses to advise on the availability of such drugs.[3] Or your advice-giving professional has a scientific disagreement with her profession: your doctor thinks marijuana is medically beneficial;[4] perhaps she finds mammograms useless.[5]

Professional speech should receive robust First Amendment protection. In particular, it should be shielded from state interference that seeks to prescribe or alter the content of professional advice.[6] While new forms of aggressive state intervention into professional advice-giving have made the need for such protection particularly salient,[7] the federal appellate courts are in marked disagreement on the proper treatment of these issues.[8] Highlighting the profound difficulties courts face in analyzing the underlying theoretical and doctrinal questions, a panel of the Eleventh Circuit alone

3 *Cf.* Stormans v. Wiesman, 794 F.3d 1064, 1071 (9th Cir. 2015) (upholding Washington's requirement that pharmacies dispense all available prescription medications), *cert. denied*, 136 S. Ct. 2433 (2016).

4 *Cf.* Conant v. Walters, 309 F.3d 629, 633 (9th Cir. 2002) (physicians treating patients with serious illnesses recommended medical marijuana despite contrary government policy).

5 *Cf.* Denise Grady, *American Cancer Society, in a Shift, Recommends Fewer Mammograms*, N.Y. TIMES (Oct. 20, 2015), http://nyti.ms/1kmsLFE (reporting on Kevin C. Oeffinger et al., *Breast Cancer Screening for Women at Average Risk: 2015 Guideline Update From the American Cancer Society*, 314 J. AM. MED. ASS'N 1599 (2015); Evan R. Myers et al., *Benefits and Harms of Breast Cancer Screening: A Systematic Review*, 314 J. AM. MED. ASS'N 1615 (2015); Nancy L. Keating & Lydia E. Pace, Editorial, *New Guidelines for Breast Cancer Screening in US Women*, 314 J. AM. MED. ASS'N 1569 (2015)); Gina Kolata, *Vast Study Casts Doubts on Value of Mammograms*, N.Y. TIMES (Feb. 12, 2014), http://nyti.ms/1eSbFcm (reporting on Mette Kalager et al., Editorial, *Too Much Mammography*, BRIT. MED. J. (2014) and Anthony Miller et al., *Twenty Five Year Follow-up for Breast Cancer Incidence and Mortality of the Canadian National Breast Screening Study: Randomised Screening Trial*, BRIT. MED. J. (2014)).

6 *See generally* Claudia E. Haupt, *Professional Speech*, 125 YALE L.J. 1238 (2016) (developing a theory of First Amendment protection for professional speech based on an understanding of the professions as knowledge communities).

7 *See, e.g.*, Rick Rojas, *Arizona Orders Doctors to Say Abortions with Drugs May Be Reversible*, N.Y. TIMES (Mar. 31, 2015), http://nyti.ms/1DpDo0Q ("Arizona . . . became the first state to pass a law requiring doctors who perform drug-induced abortions to tell women that the procedure may be reversible, an assertion that most doctors say is wrong."); *see also* Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds, 686 F.3d 889, 906 (8th Cir. 2012) (upholding a state law requiring doctors to inform patients seeking an abortion of an increased risk of suicide to obtain informed consent).

8 *Compare* Pickup v. Brown, 728 F.3d 1042 (9th Cir. 2013) (upholding California conversion therapy law as permissible regulation of conduct), *aff'd in part, rev'd in part, and remanded*, 740 F.3d 1208 (9th Cir. 2014) (denying rehearing en banc) *with* King v. Christie, 981 F. Supp. 2d 296, 320 (D.N.J. 2013) (upholding New Jersey conversion therapy law as permissible regulation of speech), *aff'd*, 767 F.3d 216 (3d Cir. 2014); *see also* Stuart v. Camnitz, 774 F.3d 238, 248 (4th Cir. 2014) (rejecting the Fifth and Eighth Circuits' interpretation of constitutionality of abortion regulations under the First Amendment).

issued three consecutive conflicting opinions in the same case[9] before the court's en banc decision offered yet another analysis.[10]

Existing accounts of professional speech pay insufficient attention to theorizing about the scope of defensible professional advice.[11] If the First Amendment protects good professional advice, how should we decide what advice falls within the scope of defensible professional knowledge? Where, in other words, does First Amendment protection for professional speech end and tort liability for professional malpractice begin? Answering these questions requires a firm theoretical foundation to distinguish professional from unprofessional advice. The larger jurisprudential endeavor in this Article, then, is to chart the boundaries between the First Amendment and tort law.

This Article provides a theory of the scope of First Amendment protection for professional advice, and explains and justifies corollaries in other areas of law. The professions, as I have argued before, are best conceptual-

9 Wollschlaeger v. Governor of Fla. (*Wollschlaeger I*), 760 F.3d 1195, 1203 (11th Cir. 2014) (upholding a Florida law prohibiting doctors from inquiring about gun ownership as "a legitimate regulation of professional conduct"), vacated and superseded on reh'g (*Wollschlaeger II*), 797 F.3d 859, 868-69 (11th Cir. 2015) (upholding the Florida law as "a permissible restriction on physician speech"). The court reached its decision applying "a lesser form of scrutiny" commonly applied in commercial speech cases. *Wollschlaeger II* at 892-94, vacated and superseded on reh'g (*Wollschlaeger III*), 814 F.3d 1159, 1168 (11th Cir. 2015) (upholding the Florida law as "a permissible restriction on physician speech"). This time, the court held the statute survives strict scrutiny (however, it did so without determining what level of scrutiny should apply). *Wollschlaeger III* at 1186, vacated by granting en banc reh'g, 649 F. App'x 647 (11th Cir. 2016).

10 Wollschlaeger v. Governor of Fla. (*Wollschlaeger IV*), 848 F.3d 1293, 1318 (11th Cir. 2017) (holding unconstitutional as violating the First Amendment the record-keeping, inquiry, and anti-harassment provisions and holding constitutional the anti-discrimination provision of the Florida Firearms Owners' Privacy Act).

11 There is renewed academic interest in the topic of professional speech, but the focus of inquiry tends to be primarily on the question of its constitutional protection rather than the scope of what constitutes good professional advice. *See, e.g.*, Martha Swartz, *Are Physician-Patient Communications Protected by the First Amendment?*, 2015 CARDOZO L. REV. DE NOVO 92, 93 (2015); Harrison Blythe, Note, *Physician-Patient Speech: An Analysis of the State of Patients' First Amendment Rights to Receive Accurate Medical Advice*, 65 CASE W. RES. L. REV. 795, 798 (2015); Rodney A. Smolla, *Professional Speech and the First Amendment*, 119 W. VA. L. REV. 67 (2016); Patrick Bannon, Note, *Intermediate Scrutiny vs. the "Labeling Game" Approach:* King v. Governor of New Jersey *& the Benefits of Applying Heightened Scrutiny to Professional Speech*, 23 J.L. & POL'Y 649 (2015); Erika Schutzman, Note, *We Need Professional Help: Advocating for a Consistent Standard of Review When Regulations of Professional Speech Implicate the First Amendment*, 56 B.C. L. REV. 2019 (2015); Ryan T. Weiss, Note, *Removing the "Silencer": Coverage & Protection of Physician Speech Under the First Amendment*, 65 DUKE L.J. 801 (2016); Shannon Zabel, Note, Docs v. Glocks*: The Need for First Amendment Protection in Preventative Care*, 24 TEMPLE POL. & CIV. RTS L. REV. 483 (2015); Kayla M. Bennett, Comment, *Professional Speech Targeted by the Florida Gun Privacy Law: The Impact of* Wollschlaeger *on Physician and Attorney Speech*, 54 WASHBURN L.J. 725 (2015); Kathryn E. Mayer, Note, *Taking Physicians Out of the Straightjacket: Defending Physician Free Speech Rights by Defining the "Truthful and Nonmisleading" Standard*, 104 KY. L.J. 353 (2016).

ized as knowledge communities whose main reason for existence is the generation and dissemination of knowledge.[12] But knowledge communities are not monolithic: there is a range of knowledge that is acceptable as good professional advice. Advice falling within this range should receive robust First Amendment protection. Conversely, bad advice—that is, advice falling outside of the acceptable range—is subject to professional malpractice liability, and the First Amendment provides no defense.[13] Conceptualizing the professions as knowledge communities provides a theoretical basis for this doctrinal truism.

Protecting good professional advice and sanctioning bad advice—or, interchangeably, "unprofessional advice"—requires a normative and doctrinal defense for excluding outliers from First Amendment protection when their professional advice diverges too much from the profession's consensus.[14] But how much is too much—and who decides? As a matter of free speech theory, excluding outliers runs headlong into an otherwise axiomatic First Amendment principle: the prohibition of content discrimination.[15] Robert Post has identified a tension between expert knowledge and the un-

12 Haupt, *supra* note 6, at 1241.

13 It is well established in the literature that the First Amendment provides no defense against malpractice claims. *See* Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 950–51 (2007) ("Without so much as a nod to the First Amendment, doctors are routinely held liable for malpractice for speaking or failing to speak . . . . First Amendment values would seem to carry very little force in the context of professional speech."); *cf.* Eugene Volokh, *Speech as Conduct: Generally Applicable Laws, Illegal Courses of Conduct, "Situation Altering Utterances," and the Uncharted Zones*, 90 CORNELL L. REV. 1277, 1344, 1347 (2005) (noting some speech may be inherently harmful and thus ripe for regulation). Nonetheless, some courts continue to struggle with this. Stated in an oversimplified way, the argument is that the state may regulate the professions and the permissibility of regulation is incompatible with the First Amendment. *See, e.g.*, King v. Christie, 981 F. Supp. 2d 296, 319 (D.N.J. 2013) ("[T]here is a more fundamental problem with [the argument that professional counseling is speech], because taken to its logical end, it would mean that *any* regulation of professional counseling necessarily implicates fundamental First Amendment free speech rights, and therefore would need to withstand heightened scrutiny to be permissible. Such a result runs counter to the longstanding principle that a state generally may enact laws rationally regulating professionals, including those providing medicine and mental health services.") (emphasis in original).

14 I use the term "consensus" not in the sense of "truth," but rather agreement relative to the relevant knowledge community. *See, e.g.*, Sheila Jasanoff, *Serviceable Truths: Science for Action in Law and Policy*, 93 TEX. L. REV. 1723, 1741 (2015) ("[T]he argument is not that science has been able to access unvarnished truth, but rather that relevant scientific communities have been able to set aside all theoretical and methodological disagreements to come together on a shared position. If most or all members of the relevant thought collective are in agreement, then that collective judgment surely demands a high degree of respect from society in general and the law more particularly.").

15 *But see Wollschlaeger IV*, 848 F.3d 1293 (applying content neutrality to professional speech). I would reject the application of the content-neutrality requirement in the area of professional speech, *see* Claudia E. Haupt, *Professional Speech and the Content-Neutrality Trap*, 127 YALE L.J. F. __ (forthcoming 2017) draft available at https://ssrn.com/abstract=2945062.

derlying assumptions of First Amendment doctrine, concluding that "[e]xpert knowledge requires exactly what normal First Amendment doctrine prohibits."[16] Reconsidering the role of experts—in this case, professionals—and their relationship with knowledge communities, however, provides a new perspective. Viewed from this vantage point, this Article argues, First Amendment interests can be reconciled with the "truth"-seeking, preserving, and communicating nature of professional speech. Conceptualizing professionals as members of knowledge communities guides the task of identifying the range of valid professional knowledge for First Amendment purposes.

This Article distinguishes between two kinds of professionals who depart from the consensus of their knowledge community: *internal* outliers and *external* outliers. I define as internal outliers professionals within knowledge communities whose disagreement results from alternative assessments based on the profession's shared ways of knowing and reasoning, that is, alternative assessments based on a shared methodology. These professionals are part of the knowledge community. By contrast, I define as external outliers those professionals who premise their disagreement on refusing to follow the shared ways of knowing and reasoning due to exogenous beliefs. These professionals place themselves outside the knowledge community.

I suggest that to the extent that a professional's internal outlier status is based upon disagreement with the knowledge community's insights based on shared notions of validity, departure from the professional standard ought to be permissible. Indeed, dynamic development and refinement of professional insights will often depend on such divergent assessments.[17] Internal outliers, however, can also produce bad advice by misusing the agreed-upon methodologies and bases for reasoning within the discourse of the profession.[18] Yet, even these professionals ostensibly base their findings on the same knowledge foundation. Conversely, external outliers' reliance on exogenous reasons undermines the status of the professional as a member of the knowledge community. An external outlier by definition does not place her professional advice on shared notions of validity and common ways of knowing and reasoning.[19]

This analysis plays out against a larger jurisprudential (and political) backdrop. The role of external outliers is connected to questions surrounding individual exemptions from generally applicable laws. In the wake of

16 ROBERT C. POST, DEMOCRACY, EXPERTISE, AND ACADEMIC FREEDOM: A FIRST AMENDMENT JURISPRUDENCE FOR THE MODERN STATE 9 (2012).

17 *Infra* Part IV.B.

18 *Infra* Part IV.A.

19 *Infra* Part II.A.

Burwell v. Hobby Lobby Stores, Inc.[20] and the recent spate of state religious freedom legislation—first in anticipation of, and then in reaction to, marriage equality nationwide[21]—these issues have come to the forefront of legal and political debate.[22] Though the focus in this area tends to be on commercial services,[23] the provision of professional services may be even more fraught.[24] Internal outliers, likewise, may find themselves in the minority due to shifting understandings of the underlying knowledge basis. What once was accepted in the field may soon be outdated. Scientific, le-

20 134 S. Ct. 2751 (2014).

21 *See* Obergefell v. Hodges, 135 S. Ct. 2584, 2608 (2015) (recognizing a constitutional right of same-sex marriage).

22 *See generally* Douglas NeJaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L.J. 2516 (2015) (discussing, in light of *Hobby Lobby*, claims of religious exemptions from generally applicable laws). It is entirely possible that the *Hobby Lobby* decision will have more political than legal force going forward. *See, e.g.*, Ira C. Lupu, *Moving Targets: Religious Freedom,* Hobby Lobby*, & the Future of LGBT Rights*, 7 ALABAMA CIV. RTS & CIV. LIB. L. REV. 1 (2015) ("[T]he political impact of *Hobby Lobby* may be much greater than its legal impact."). Either way, the decision and its aftermath inform the background of this discussion. *See also* Stormans, Inc. v. Wiesman, 136 S. Ct. 2433 (2016) (Alito, J., dissenting from denial of certiorari) ("This case is an ominous sign. At issue are Washington State regulations that are likely to make a pharmacist unemployable if he or she objects on religious grounds to dispensing certain prescription medications . . . . If this is a sign of how religious liberty claims will be treated in the years ahead, those who value religious freedom have cause for great concern.").

23 One of the paradigmatic cases in this area is Elane Photography, LLC v. Willock, 309 P.3d 53, 62–63, 72 (N.M. 2013), *cert. denied*, 134 S. Ct. 1787 (2014) (upholding the New Mexico Human Rights Act against free speech and free exercise challenges and finding a company refusing to photograph a same-sex commitment ceremony violated the Act by discriminating on the basis of sexual orientation). *See* Samuel R. Bagenstos, *The Unrelenting Libertarian Challenge to Public Accommodations Law*, 66 STAN. L. REV. 1205, 1233–37 (2014) ("Although the New Mexico Supreme Court rejected *Elane Photography*'s First Amendment free speech claim, that claim deserves close analysis, for businesses subject to public accommodations laws will surely raise similar arguments in the future."); *see also* Washington v. Arlene's Flowers, Inc., 187 Wash.2d 804, 823 (Wash. 2017) (holding a flower shop owner liable under a Washington anti-discrimination law for refusing to sell flowers to same-sex couple and finding the law does not violate the First Amendment); Craig v. Masterpiece Cakeshop, Inc., 370 P.3d 272, 283 (Colo. App. 2015) (holding that a bakery "violated Colorado's public accommodations law by refusing to create a wedding cake for Craig's and Mullins' same-sex wedding celebration"), *petition for cert. filed*, No. 16-111 (U.S. Jul. 22, 2016); Lupu, *supra* note 22, at 33–35 (providing an overview of current litigation in this area).

24 *See, e.g.*, Abby Phillip, *Pediatrician Refuses to Treat Baby with Lesbian Parents and There's Nothing Illegal About It*, WASH. POST, (Feb. 19, 2015), http://www.washingtonpost.com/news/morning-mix/wp/2015/02/19/pediatrician-refuses-to-treat-baby-with-lesbian-parents-and-theres-nothing-illegal-about-it/ ("A Michigan pediatrician declined to treat the infant daughter of a lesbian couple in yet another example of the growing tensions between advocates for LGBT rights and those who want greater religious expression protections."); Emma Green, *When Doctors Refuse to Treat LGBT Patients*, THE ATLANTIC, (Apr. 19, 2016), http://www.theatlantic.com/health/archive/2016/04/medical-religious-exemptions-doctors-therapists-mississippi-tennessee/478797/ (discussing Mississippi law extending conscience objections to treating LGBT patients).

gal, and political forces may interact in a way that sometimes aligns with the insights of the knowledge community, but sometimes contradicts them.

This Article proceeds in four Parts. Part I introduces the concept of knowledge communities, and focuses the analysis on knowledge communities as providers of professional services. It considers how knowledge is formed within these communities, public expectations toward these communities, and state regulation of them. Complicating the picture, it takes into account different institutional settings in which professionals operate.

Part II takes a normative view of professionals' duties and justifications for departure from professional consensus. This Part assesses the role of outliers within and outside of professional knowledge communities and the fundamental expectations of the public served by these professionals. It investigates what constitutes an appropriate basis for justifying a professional's outlier status. The point of departure is the concept of the professions as knowledge communities, and especially the notion of a shared knowledge basis. For all valid claims, I argue, reference to the shared knowledge basis and common ways of knowing and reasoning is necessary. Scientific disagreement within the knowledge community must be based on individual professionals' divergent interpretations of the shared knowledge. The advice-giving function of the individual professional is thus tied back to the range of defensible opinions within the knowledge community. If, however, the advice is based on an assessment of the knowledge rooted in exogenous reasons, the professional places himself outside of the knowledge community. Here, the distinction between internal and external outliers is key. Both internal and external outliers can produce unprofessional advice. But the difference is that internal outliers will base their reasoning on shared knowledge while external outliers will base theirs on exogenous factors. The law should protect the exogenous beliefs of external outliers as a matter of personal belief of the individual. But it should not, as a general matter, accommodate them as justifying departure from professional knowledge.

Part III turns to the treatment of outliers in tort law on professional malpractice and the law of evidence governing the admissibility of expert testimony, bringing these areas of law into conversation with the First Amendment. The treatment of outliers in these areas provides the normative corollary of basing good professional advice on a shared methodology and shared ways of knowing and reasoning. The distinction between good and bad advice should be drawn along these lines. It thus supports the division of professionals into internal and external outliers. Whether the substantive content of advice *internal* outliers give—advice that is based on a shared methodology and common ways of knowing and reasoning—clears the bar of good advice, moreover, is also for the knowledge community to decide. Both tort law and evidence already operate on this basis; and both

have resolved the overarching "who decides" questions largely in favor of the knowledge community. Thus, in addition to providing normative support, these areas inform the workability of this approach in litigation practice.

Part IV demonstrates how this theory of the scope of First Amendment protection for professional advice works when applied to the controversies referenced at the outset. These examples illustrate problems associated with identifying the range of valid professional advice. Applying the theory of distinguishing professional from unprofessional advice proposed in this Article provides guidance in resolving these disputes.

I. THE PROFESSIONS AS KNOWLEDGE COMMUNITIES

The learned professions are best conceptualized as knowledge communities.[25] Taking this view as the starting point has significant implications for the role of the individual professional, both in relation to her client and in relation to her profession. The state regulates the professions in multiple and varied ways, including through licensing requirements and the imposition of professional malpractice liability. When state regulation aligns with professional insights, it is usually unproblematic. But when state regulation is incompatible with professional insights, significant problems arise.

State involvement in determining training requirements to obtain professional licensing in particular can lead to considerable tensions. 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. It is appropriate for the state to enforce formal educational standards without implicating professional speech.[26] But the substantive content of the educational programs directly affects the content of professional advice. State involvement, accordingly, should be tailored with deference to the knowledge community.

A. Professionals as Members of Knowledge Communities

The definition of "profession" and the processes of professionalization are contested. But the key defining feature—and one generally shared across the manifold definitions—is the professions' knowledge-based character.[27] Thus, "[t]he connection to a knowledge community circumscribes

25 Haupt, *supra* note 6, at 1241; *see also* Timothy Zick, *Professional Rights Speech*, 47 ARIZ. ST. L.J. 1289, 1294 (2015) (adopting the characterization of the professions as "knowledge communities").

26 Haupt, *supra* note 6, at 1282–83.

27 *Id.* at 1249.

the type of communication rendered as professional advice."[28] The centrality of knowledge is reflected in the asymmetrical relationship between the professional and the client. The very reason the professional's advice is valuable to the client is that the professional has knowledge that the client lacks. In order to make important life decisions, the client depends on accessing the knowledge community's knowledge through the individual professional.

> [K]nowledge communities . . . describe a network of individuals who share common knowledge and experience as a result of training and practice. They are engaged in solving similar problems by drawing on a shared reservoir of knowledge which, at the same time, they help define and to which they contribute. Their common understandings allow for the generation and exchange of insights within the [knowledge] community. Consequently, members of knowledge communities have shared notions of validity and a common way of knowing and reasoning.[29]

Despite possible disagreement on individual issues, professionals continue to subscribe to a shared body of knowledge.[30] Yet, it is important to emphasize that "this is not to say that knowledge communities are monolithic. But their shared notions of validity limit the range of acceptable opinions found within them."[31] It is the challenge of defining this range of valid professional opinions that the remainder of this Article addresses.

1. Individual Professionals

Professional speech is speech by a professional, within a professional-client relationship, communicating the insights of the knowledge community for the purpose of providing professional advice.[32] Conceptualizing the individual professional in this manner as the conduit between the knowledge community and the client requires distinguishing the professional's personal opinion from his professional advice. It is worth reiterating that distinction.[33] The key to determining what is professional advice is whether the advice is rendered within the confines of a professional-client relationship: "Where the personal nexus between professional and client does not exist, and a speaker does not purport to be exercising judgment on behalf of any particular individual with whose circumstances he is directly acquainted"[34] the speaker is not engaged in professional speech. Thus,

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28 *Id.* at 1248.
29 *Id.* at 1250–51.
30 *Id.* at 1250.
31 *Id.* at 1251.
32 *Id.* at 1247.
33 *See id.* at 1254–57 (providing a more detailed discussion of distinguishing private speech).
34 Lowe v. SEC, 472 U.S. 181, 232 (1985) (White, J., concurring).

speech by a professional[35] outside of the professional-client relationship is not professional speech.[36]

Speaking as a participant in public discourse, a professional's private speech receives ordinary First Amendment protection. It is likely that the speaker's professional training will influence the listeners' perception of the message, in particular its accuracy.[37] But as long as the speaker is not acting within the confines of the professional-client relationship, it is important to recognize that he is not bound by the knowledge community's insights. Indeed, speaking in public discourse, the speaker is free to challenge even the most axiomatic insights of the knowledge community.[38]

Consider a professional—a trained physician, for instance—hosting a television program in which he dispenses advice.[39] Even if the physician disagrees with the profession, he cannot under the First Amendment be held to the standard of medical malpractice that would censor him within the professional-client relationship.[40] In short, a professional may give bad advice to millions of viewers—but not to one client. At the intersection of professional speech and academic speech, the protection of private speech in public discourse plays out in the same way. Imagine the physician on television also holds a medical faculty appointment, and the insights propagated to viewers do not hold up to scientific standards.[41] Here, too, the

35 *See* Daniel Halberstam, *Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions*, 147 U. PA. L. REV. 771, 843 (1999) (explaining that enforcement of professional norms extends to speech used in the course of professional practice, not simply speech uttered by a professional); Post, *supra* note 13, at 947 (quoting *id.*).

36 *See* Halberstam, *supra* note 35, at 851 ("Publication of advice for indiscriminate distribution generally will defeat a conclusion that the advice was rendered within the professional-client relationship . . . ."); *see also* Pickup v. Brown, 728 F.3d 1042, 1054 (9th Cir. 2014) ("Thus, outside the doctor-patient relationship, doctors are constitutionally equivalent to soapbox orators and pamphleteers, and their speech receives robust protection under the First Amendment.").

37 Haupt, *supra* note 6, at 1255–56.

38 *See, e.g.*, Halberstam, *supra* note 35, at 848 (noting that the First Amendment protects the practice of the profession, not the listener's subjective desire for information); *see also* Post, *supra* note 13, at 947 (discussing the disciplining of doctors and dentists who told patients that amalgams were toxic despite the weight of scientific evidence suggesting otherwise); POST, *supra* note 16, at 12–13 (recounting the controversy over the safety of dental amalgams).

39 For a recent highly publicized controversy that played out along these lines, *see, e.g.*, Bill Gifford, *Dr. Oz is No Wizard, but No Quack, Either*, N.Y TIMES, Apr. 26, 2015, at SR 3 (recapping the controversy surrounding Dr. Oz's program).

40 Post, *supra* note 13, at 949 ("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."); POST, *supra* note 16, at 43 ("If an expert chooses to participate in public discourse by speaking about matters within her expertise, her speech will characteristically be classified as fully protected opinion.").

41 *See, e.g.*, Verena Dobnik, *Physicians Want Dr. Oz Gone from Columbia Medical Faculty*, WASH. TIMES (Apr. 16, 2015), http://www.washingtontimes.com/news/2015/apr/16/doctors-want-mehmet-oz-gone-from-columbia-faculty/ (discussing the demand made by a group of doctors to remove Dr. Oz from the Columbia faculty due to his televised promotion of treatments and cures

First Amendment provides protection of private speech in public discourse where academic standards are not fulfilled. As Robert Post puts it:

> Biologists can with impunity write editorials in the *New York Times* that are such poor science that they would constitute grounds for denying tenure within a university. Members of the general public can rely on expert pronouncements within public discourse only at their peril. Such pronouncements are ultimately subject to political rather than legal accountability.[42]

The underlying justification is that the First Amendment should treat speakers in public discourse as equals. Consequently, there is no such thing as the notion of a "false idea" in public discourse.[43] By contrast, while there is a range of valid professional opinions that members of the knowledge community may disagree on, there is also a universe of advice that is plainly wrong as a matter of expert knowledge. What constitutes valid professional knowledge, however, is for the profession to decide. Expert knowledge thus is not treated as equal to other opinions. And we affirmatively do not want it to be: this notion is clearly reflected in the imposition of tort liability for professional malpractice. The tort regime directly, and appropriately, sanctions unprofessional advice.

A critic of distinguishing the role of the professional in public discourse might object that the very notion of "public discourse" is indeterminate. But whatever the controversies at the margins concerning the concept of public discourse might be, the professional-client relationship is not part of it. The law already attaches certain distinct features to this particular relationship between speaker and listener, including evidentiary privileges, a fiduciary duty and a duty of confidentiality. In doing so, it singles out the professional-client relationship as distinct.

2. Institutional Settings

Many professionals are not solo-practitioners, but rather work within various institutional settings; this complicates the picture significantly. Their obligations to their profession may clash with their obligations to their institutional employer. The entities in which professionals are embedded can be governmental or private, religious or secular. Depending on

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that are allegedly unsupported by scientific evidence); Terrence McCoy, *Half of Dr. Oz's Medical Advice is Baseless or Wrong, Study Says*, WASH. POST (Dec. 19, 2014), https://www.washingtonpost.com/news/morning-mix/wp/2014/12/19/half-of-dr-ozs-medical-advice-is-baseless-or-wrong-study-says/?utm_term=.a72528168ae0 (illustrating the debate surrounding Dr. Oz's promotion of treatments that have been unsupported or contradicted by scientific studies).

42 POST, *supra* note 16, at 44.

43 Post, *supra* note 13, at 949 (internal citations omitted); *see* United States v. Alvarez, 132 S. Ct. 2537 (2012) (explaining how false ideas are not categorically unprotected by the First Amendment).

these variables, professionals will be pulled in different directions regarding the content of their advice. But the First Amendment should protect professionals who resist those forces to guard their professional advice against outside interference. Professionals' primary allegiance ought to be to their knowledge community on the one hand, and their clients on the other. If professionals are hired to provide professional services, the content of their advice should not be determined by who pays them, but rather, by the knowledge community's understanding of what constitutes defensible professional advice. This is also the underlying assumption of the tort regime.[44]

With respect to governmental settings, the Supreme Court addressed government-funded professional services perhaps most prominently in *Rust v. Sullivan*,[45] concerning abortion counseling, and *Legal Services Corporation v. Velazquez*,[46] concerning legal advice. While the Court held the limits on abortion counseling in *Rust* to be compatible with the First Amendment, it held unconstitutional the restrictions imposed on legal advice in *Velazquez*.[47]

In *Rust*, recipients of federal funding for "family-planning services" were prohibited from disseminating advice on abortion.[48] Moreover, providers were barred from "referral for abortion as a method of family planning."[49] These limits on professional advice applied "even upon specific request."[50] However, providers were given a "permissible response to such an inquiry": "[T]he project does not consider abortion an appropriate method of family planning and therefore does not counsel or refer for abortion."[51] The Court upheld the funding scheme against the First Amendment challenge, pointing out that the professionals "remain free to say whatever they wish about abortion outside the [government-funded] project."[52] By framing the case as one about selectively funding some activities but not others, Chief Justice William Rehnquist obscured the point that professional speech was at the heart of the matter.[53] The opinion expressly left unanswered the question about First Amendment protection of government-

44 *Infra* Part III.A.

45 500 U.S. 173, 178 (1991).

46 531 U.S. 533, 536–37 (2001).

47 *See also* Haupt, *supra* note 6, at 1259–62 (discussing the relevance of these cases for professional speech doctrine).

48 *Rust*, 500 U.S. at 178–79.

49 *Id.* at 179 (internal quotations omitted).

50 *Id.* at 180.

51 *Id.* (internal quotations omitted).

52 *Id.* at 183 (internal quotations omitted).

53 *See id.* at 193 (asserting that the government "has merely chosen to fund one activity to the exclusion of another.").

funded professional speech.[54] Under the knowledge community-focused theory of professional speech, however, this question will likely be answered as follows: if a professional is paid to give professional advice, the professional's primary allegiance is to the knowledge community and the client. The First Amendment, therefore, should shield against government interference even when the government funds the professional's advice. Indeed, this is the result—even if not the reasoning—the Court reached in *Velazquez*.

In *Velazquez*, government-funded Legal Services Corporation ("LSC") attorneys were prohibited from challenging existing welfare law on behalf of their indigent clients.[55] Justice Anthony Kennedy distinguished *Rust* as a government speech case; by contrast, he asserted that the speech in *Velazquez* is private speech.[56] This distinction introduces slippage in the concepts of government, private, and professional speech. As discussed in the previous section, professional speech is distinct from private speech of a professional.[57] Despite this analytical ambiguity, Justice Kennedy focused on the professional role of the lawyer, concluding that "[t]he advice from the attorney to the client and the advocacy by the attorney to the courts cannot be classified as governmental speech even under a generous understanding of the concept. In this vital respect this suit is distinguishable from *Rust*."[58] The government-funded lawyer, in other words, has to fulfill the same professional role as any lawyer who is not funded by the government, including "complete analysis of the case, full advice to the client, and proper presentation to the court."[59]

In terms of the institutional context, it is difficult to distinguish *Rust* and *Velazquez*, as Justice Antonin Scalia suggested in his *Velazquez* dissent.[60] The government funds these professional services precisely because they are rendered by professionals. As Justice Harry Blackmun pointed out in his *Rust* dissent, the physicians who are part of the federally funded program are expected to give clients comprehensive advice regarding family planning. The project "[seeks] to provide them with the full range of in-

54 *Id.* at 200 ("It could be argued by analogy that traditional relationships such as that between doctor and patient should enjoy protection under the First Amendment from Government regulation, even when subsidized by the Government. We need not resolve that question here . . . .").

55 Legal Services Corporation v. Velazquez, 531 U.S. 533, 536–37 (2001).

56 *Id.* at 540–42 (stating that "the LSC program was designed to facilitate private speech, not to promote a governmental message.").

57 *See supra* Part I.A.1.

58 *Velazquez*, 531 U.S. at 542–43.

59 *Id.* at 546.

60 *Id.* at 553–59 (Scalia, J., dissenting) ("[T]he majority's contention that the subsidized speech in these cases is not government speech because the lawyers have a professional obligation to represent the interests of their clients founders on the reality that the doctors in *Rust* had a professional obligation to serve the interests of their patients.").

formation and options regarding their health and reproductive freedom."[61] In other words, the government-funded professionals in this case, too, are expected to act like professionals. And, as Justice Blackmun emphasized, "the legitimate expectations of the patient and the ethical responsibilities of the medical profession demand no less."[62] The government funded, as Justice Scalia put it, "the normal work of doctors" and "the normal work of lawyers" in these cases.[63]

Of course, the outcome under the knowledge community-focused theory of professional speech is exactly the opposite from that of the Scalia dissent in *Velazquez*: both the doctors in *Rust* and the lawyers in *Velazquez* ought to be able to invoke First Amendment protection of their professional speech against outside interference if the government funds them to act as "normal" professionals.

When professionals are directly employed by the government, they are likewise held to the standards of the profession. Government entities can also contract with private parties for the provision of professional services to government employees. In one set of cases, professionals were contracted by the government to provide counseling services to government employees.[64] A company providing counseling services to several police departments, including in Minneapolis, Minnesota, and Springfield, Illinois, for example, sued the respective municipalities over ending the psychological counseling contract due to anti-gay views expressed by the professionals.[65] When their views are expressed outside the professional-client relationship, they are private speech. Within this relationship, they are professional speech. And if they are contrary to the professional consensus, they are unprofessional advice.

Religious organizations have built a large professional services infrastructure in which professionals are embedded. The religious tenets, transferred onto the institutions employing these professionals, may contradict their employees' professional insights. Elizabeth Sepper has carefully examined such countervailing forces in the health care context where hospital policies may prohibit doctors from employing the full range of their profes-

61 Rust v. Sullivan, 500 U.S. 173, 213 (1991) (Blackmun, J., dissenting).

62 *Id.* at 213–14.

63 *Velazquez*, 531 U.S. at 562 (Scalia, J., dissenting).

64 *See, e.g.*, Campion, Barrow & Assocs. of Ill., Inc. v. City of Minneapolis, 652 F. Supp. 2d 986 (D. Minn. 2009) (concerning providers of psychological services to police department); Campion, Barrow & Assocs., Inc. v. City of Springfield, 559 F.3d 765 (2009) (concerning the same); Walden v. Centers for Disease Control and Prevention, 669 F.3d 1277 (11th Cir. 2012) (concerning health and wellness services for CDC employees).

65 *Campion, Barrow & Assocs. of Ill.*, 652 F. Supp. 2d at 990–91; *Campion, Barrow & Assocs., Inc.*, 559 F.3d at 767.

sional knowledge.[66] As the largest nonprofit provider, Catholic healthcare is perhaps the most prominent example.[67] The United States Conference of Catholic Bishops issues the Ethical and Religious Directives for Catholic Health Care Services.[68] Several provisions contained in the Directives "contradict accepted professional ethical imperatives that require doctors and nurses to place patient welfare above self-interest, respect patient autonomy, guarantee continuity of care, and ensure patients receive adequate information."[69] Most important for purposes of this discussion is the fact that "[t]he directives limit the information doctors may provide to 'morally legitimate alternatives,' with wide-ranging repercussions for physician practice and patient care."[70] To name only one such limit, "Catholic clinics have refused to instruct HIV-positive patients as to the importance of condoms."[71] The range of advice that may be rendered in these settings is markedly limited as compared to the full range of available professional knowledge.

In the healthcare context, however, it is worth noting that "many healthcare institutions that assert an objection to legal, medically necessary care are not affiliated with any religion."[72] Moreover, the problem is compounded by mergers in the healthcare market. On the one hand, non-Catholic hospitals may merge with Catholic healthcare providers. On the other hand, formerly Catholic hospitals may be required to adhere to the Directives even after they have been acquired by another entity.[73] Sepper calls the result "Zombie religious institutions."[74] The continued adherence

66 *See* Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501 (2012).

67 *Id.* at 1519–20.

68 U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (Nov. 17, 2009), http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.

69 Sepper, *supra* note 66, at 1520.

70 *Id.* at 1521.

71 *Id*.

72 *Id.* at 1518. As Sepper explains:

> Only when an institution refuses to deliver legal, necessary care does the law recognize a concept of "institutional conscience." Under most provisions, an entire hospital, healthcare system, clinic, or practice group may refuse contested treatments. The legislation typically does not differentiate between religious and secular, public and private, and for-profit and not-for-profit institutions. In several jurisdictions, broad conscience clauses allow *any* corporation or entity associated with healthcare—including insurance companies—to decline to participate in, refer for, or give information about *any healthcare service* for reasons of conscience. Employees and medical staff of all faiths, beliefs, and backgrounds must then abide by the institutional policy of refusal.

Id. at 1514.

73 *Id.* at 1523–24; *see also* Elizabeth Sepper, *Contracting Religion*, *in* LAW, RELIGION, AND HEALTH IN THE UNITED STATES (Holly Fernandez Lynch, I. Glenn Cohen & Elizabeth Sepper eds., forthcoming 2017), draft available at http://ssrn.com/abstract=2783518.

74 *See* Elizabeth Sepper, *Zombie Religious Institutions*, 112 NW. U. L. REV._ (forthcoming 2018) draft available at https://ssrn.com/abstract=2932235.

to the directives by formerly Catholic hospitals that are not readily identifiable as such calls into question one possible remedy, namely disclosure.[75] Consequently, as Sepper notes, "providers will be caught between moral restrictions and medical ethics."[76] Professionals whose professional obligation is to render comprehensive advice will find themselves constrained from communicating the insights of the knowledge community.

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The bottom line is this: professionals may operate in a variety of institutional settings. But if professionals are hired primarily to render professional advice, no matter the institutional setting, they are members of the profession first. As such, they are bound together by the knowledge community and its shared ways of knowing and reasoning, serving as the conduit between the knowledge community and the client. Irrespective of the institutional setting, the First Amendment should therefore protect defensible professional advice.

B. Knowledge Communities, Outliers, and the State

If shared knowledge is the defining feature, shared education is one of the fundamental aspects that bind the members of knowledge communities together. In this context, significant tensions can arise among knowledge communities, outliers, and the state. Consider an example: recently, the North Carolina state legislature considered a bill that would have put at risk the accreditation of the University of North Carolina ("UNC") medical school.[77] The measure "would prevent employees at the state's two public medical schools—UNC and East Carolina University's Brody School of Medicine—from performing or supervising abortion procedures."[78] However, "[t]he national accrediting body for medical schools requires OB/GYN residents to be educated in performing abortion procedures."[79] State regulation in this instance would have altered the content of what the knowledge community has determined to be necessary professional knowledge.

Another illustrative example involves the conflict between the American Psychological Association's ("APA") Committee on Accreditation and the Department of Education over accreditation standards for psychology

75 *See infra* Part II.A.3.

76 Sepper, *supra* note 66, at 1525.

77 Sarah Brown, *Abortion Bill Targets UNC School of Medicine*, THE DAILY TAR HEEL (Apr. 2, 2015), http://www.dailytarheel.com/article/2015/04/abortion-bill-targets-unc-medical-school.

78 *Id*.

79 *Id*.

programs. The APA delisted homosexuality as a mental disorder in 1973.[80] The APA Ethics Code prohibits discrimination on the basis of sexual orientation.[81] Yet, the accreditation standards in Footnote 4 permitted preferential hiring and enrollment of coreligionists in psychology programs.[82] This was seen as undermining the professional norms of psychologists, and the APA was poised to remove the footnote. But in the end, there were concerns over the APA's status as licensing body.[83] The Department of Education, in a letter dated September 6, 2001, urged the APA to retain Footnote 4.[84]

The affair reveals the confluence of substantive concerns over the integrity of the professional knowledge communicated in the programs, and subsequently by professionals who graduate from them, and the seemingly merely administrative question of which programs' graduates are eligible to be licensed psychologists. Voices in the psychology literature have articulated this concern as follows: "The ethical codes of the helping professions, which are fundamental to the profession and the education and training of professionals, have been set against the U.S. Constitution and the personal freedoms it protects (i.e., freedom of religion and freedom of speech)."[85] Persuading (or pressuring, as some suggest[86]) the profession to maintain an exemption for religious programs thus amounts to state interference endorsing the outlier status of certain professionals against the rest of the profession. The state thus enforces a substantive change in the knowledge com-

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80 Maryka Biaggio, Sue Orchard, Jane Larson, Kelly Petrino, & Roberta Mihara, *Guidelines for Gay/Lesbian/Bixesual-Affirmative Educational Practices in Graduate Psychology Programs*, 34 PROFESSIONAL PSYCHOLOGY: RESEARCH AND PRACTICE 548 (2003).

81 *Ethical Principles of Psychologists and Code of Conduct*, AM. PSYCHOLOGICAL ASS'N, http://www.apa.org/ethics/code/ (last updated Jan. 1, 2017).

82 For a brief history of Footnote 4, *see* Clark D. Campbell, *Religion in Education and Training*, *in* THE OXFORD HANDBOOK OF EDUCATION AND TRAINING IN PROFESSIONAL PSYCHOLOGY 472, 478 (W. Brad Johnson & Nadine J. Kaslow eds., 2014).

83 *See* D. Smith, *Accreditation Committee Decides to Keep Religious Exemption*, 33 MONITOR ON PSYCHOLOGY 16 (2002).

> Also affecting the committee's decision was the U.S. Department of Education (DOE), which suggested that, if the footnote was removed, it would be forced to consider revoking APA's recognition as an accrediting body. Since APA is the only organization approved by the DOE to accredit professional psychology programs, that would have left all psychology students in a lurch—ineligible for some types of federal funding and, in some cases, unable to gain licensure.

Id.

84 Letter from William D. Hansen to Susan Zlotlow, Director, Off. of Program Consultation and Accreditation, American Psychological Ass'n, https://www2.ed.gov/policy/highered/guid/secletter/010906.html.

85 Kristin A. Hancock, *Student Beliefs, Multiculturalism, and Client Welfare*, 1 PSYCHOLOGY OF SEXUAL ORIENTATION AND GENDER DIVERSITY 4 (2014).

86 Maryka Biaggio, *Do Some APA-Accredited Programs Undermine Training to Serve Clients of Diverse Sexual Orientation?*, 1 PSYCHOLOGY OF SEXUAL ORIENTATION AND GENDER DIVERSITY 93, 94 (2014) (speaking of "significant external pressure").

munity's shared training, demanding the permissibility of certain outlier positions against the knowledge community itself.

Accommodating student claims for exemption from certain training requirements against their educational institutions has the same effect.[87] Future professionals may be trained in secular or religious schools, and the formation of the knowledge basis of each individual professional is influenced accordingly. Upon endorsing the American Psychiatric Association's elimination of homosexuality from its list of mental disorders, the APA set as a goal of psychology training "that psychologists work to remove the stigma that had been attached to homosexuality."[88] The internal discourse of the profession concerning accreditation of psychology programs focused on access of LGBT students to psychology programs as well as the substantive training all psychology students receive on LGBT issues.[89]

The particular challenges of religious professional education are well recognized in the psychology literature: "As may be expected, any time minority programs deviate from accepted paradigms for professional preparations, there are issues with which to reckon."[90] According to estimates, there are less than a dozen APA-accredited Christian psychology programs.[91] One comparative study of evangelical protestant psychologists trained in secular and those trained in religiously affiliated programs—counterintuitively—found that "[r]eligious psychologists trained at secular programs were comparatively more conservative and more likely to use and value religious techniques in psychotherapy with religious or nonreligious clients than were religious psychologists trained at religiously affili-

87 *See, e.g.*, Keeton v. Anderson-Wiley, 664 F.3d 865, 872 (11th Cir. 2011) (expelling a student for hypothetical statements that she would reference LBGTQ clients to conversion therapy was not a violation of student's first amendment rights); Ward v. Polite, 667 F.3d 727, 730 (6th Cir. 2012) (holding that expelling a student for referral of an LGBTQ client to other students against school's policy was a violation of First Amendment rights). In the psychology literature it has been emphasized that the programs in these cases are not APA-accredited psychology programs. *See* Campbell, *supra* note 78, at 484 ("There have been several stories over the last few years about trainees who have refused to work with a gay student or trainees who insisted upon using reparative therapies . . . . However, in reviewing these cases, the students are usually not psychology graduate students from APA-accredited programs."). While this is certainly relevant for the internal discourse within the psychology profession, it does not affect the larger point: the state is endorsing students' outlier status against the consensus of the profession regarding appropriate education standards.

88 Biaggio et al., *supra* note 80, at 548.

89 *Id.* at 549.

90 Campbell, *supra* note 82, at 481 ("Specifically, religious distinctive programs have to repeatedly address issues of academic freedom and diversity, particularly as they relate to sexual orientation and the provisions of Footnote 4 in the G&P . . . .").

91 *Id.* at 478 (pointing out further that to date, "all religious distinctive programs are founded on the Christian faith tradition.").

ated programs."[92] In response, some suggest that "training provided in religious distinctive programs prepares students for more judicious use of such interventions."[93] Voices in the psychology literature lament the lack of data in questions surrounding the relationship between religious programs and professional expertise imparted regarding LGBT issues.[94] In any event, it should be the profession that makes this determination internally.

To be sure, the medical and mental health fields are not the only providers of professional training to face such concerns. There is a considerable body of scholarship on religious law schools, for instance.[95] Nor are these issues solely domestic.[96] But the two fields highlighted here concern today's most politically and socially contested areas. In the end, the important takeaway is that professional outlier status may be created in different ways, including the institutional context in which the professional operates and education in which professional knowledge is imparted. The reference point, however, is the knowledge basis of the profession and its shared ways of knowing and reasoning.

II. JUSTIFICATIONS FOR PROFESSIONAL OUTLIER STATUS

This Part investigates what constitutes an appropriate basis for justifying a professional's outlier status. It considers the interests of professionals and of knowledge communities, and client expectations toward them. To the extent that a professional's outlier status is grounded in disagreement based on shared notions of validity, departure from the knowledge community's insights must be permissible. Indeed, dynamic development and refinement of professional insights will often depend on such divergent assessments. However, outlier status based on exogenous reasons undermines the status of the professional as a member of the knowledge community founded in shared notions of validity and common ways of knowing and reasoning. This explains the initial distinction between internal and external outliers.

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92 Randall Lehmann Sorenson & Shawn Hales, *Comparing Evangelical Protestant Psychologists Trained at Secular Versus Religiously Affiliated Programs*, 39 PSYCHOTHERAPY: THEORY/RESEARCH/PRACTICE/TRAINING 163 (2002).

93 Campbell, *supra* note 82, at 481.

94 *Id.* at 483.

95 *See, e.g.*, Russell G. Pearce, *Symposium Foreword: The Religious Lawyering Movement: An Emerging Force in Legal Ethics and Professionalism*, 66 FORDHAM L. REV. 1075 (1998).

96 *See, e.g.*, Trinity W. Univ. v. British Columbia Coll. of Teachers, 2001 S.C.C. 31 (2001) (concerning the accreditation of a teacher training program); Trinity W. Univ. v. Law Soc'y of Upper Canada, 2015 ONSC 4250 (July 2, 2015) (accreditation of a law school); Trinity W. Univ. v. Nova Scotia Barristers' Soc'y, 2015 NSSC 25 (Jan. 28, 2015) (concerning recognition of law degrees from religious law school by provincial licensing bodies).

It will be the reasonable expectation of the knowledge community that the individual professional fully and accurately communicates the profession's knowledge to the client.[97] Correspondingly, the client seeking professional advice reasonably may expect that she receives competent and comprehensive professional advice in accordance with the profession's insights. In other words, the client expects that she will access the *entire* body of knowledge relevant to her problem that constitutes the state of the art in the field. The normative corollary can be found in the law of professional malpractice where the standard of care against which the professional's advice is measured is determined by the profession itself: exercise of the profession according to the degree and skill of a well-qualified professional. The knowledge community thus determines the benchmark against which the individual professional's liability is assessed.[98] This does not only mean what the professional says must be correct, it also means that it must be comprehensive.

The distinction between internal and external outliers is a distinction in kind—namely, a different kind of justification for departure from professional knowledge. While internal outliers justify their alternative assessments by relying on the shared knowledge basis of the profession, external outliers justify their departure by reliance on exogenous factors. Their disagreement is premised on rejecting the shared way of knowing and reasoning due to exogenous beliefs. By doing so, they place themselves outside of the knowledge community. The remainder of this Part will defend the exclusion of external outliers from the knowledge community.

The distinction between internal outliers giving good advice and internal outliers giving bad advice, by contrast, is a distinction in degree. Whether their advice clears the bar of "good advice" is for the knowledge community to decide. Internal outliers may misuse the shared methodology, resulting in bad advice. But it is up to the knowledge community to decide what the bar of good advice is, and what degree of departure is permissible. I will return to this issue in Parts III and IV below.

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97 There is another dimension that I subsume under the knowledge community's expectations of the individual professional, but that others have identified separately as the expectation of the professional: "Reasonable belief about what a job entails is one measure of whether refusals of conscience should be protected." Kent Greenawalt, *Refusals of Conscience: What Are They and When Should They Be Accommodated?*, 9 AVE MARIA L. REV. 47, 55 (2010). Greenawalt points out that nurses trained at a time when abortion was illegal would not reasonably expect to be called upon to assist in such a procedure. *Id.* That is certainly true. Under my theory of the professions as knowledge communities, however, the job of the individual professional entails whatever the knowledge community defines it to be, even if its scope changes over time.

98 *See infra* Part III.A.

A. External Outliers

Taking account of the expectations toward professionals, this subpart explains why external outliers should be considered to have placed themselves outside of the knowledge community. Through a lens of public reason, the knowledge community's expectations toward the professional and the client's expectations toward the professional demand that any departure be based upon the shared knowledge basis. But the defining feature of external outliers' justifications for departure is that they are based on exogenous reasons.

One recent example involves pharmacists who refuse to advise clients on the availability of drugs they consider to be abortifacients.[99] Other examples of restricting the range of available advice may include professional advice on assisted reproductive technology ("ART") for same-sex couples.[100] Yet another example involves crisis pregnancy centers, at least to the extent that they hold themselves out as providing professional advice.

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99 *Cf. Stormans*, 794 F.3d at 1064 (9th Cir. 2015) (upholding the Washington requirement that pharmacies dispense all prescription medications); *see also* Dennis Rambaud, *Prescription Contraceptives and the Pharmacist's Right to Refuse: Examining the Efficacy of Conscience Laws*, 4 CARDOZO PUB. LAW., POL. & ETHICS J. 195 (2006) (recounting instances of conscientious refusal by pharmacists and analyzing related laws); Jane W. Walker, Comment, *The Bush Administration's Midnight Provider Refusal Rule: Upsetting the Emerging Balance in State Pharmacist Refusal Laws*, 46 HOUSTON L. REV. 939 (2009) (recounting instances of conscientious refusal by pharmacists and analyzing midnight provider rule); Heather A. Weisser, *Abolishing the Pharmacist's Veto: An Argument in Support of a Wrongful Conception Cause of Action Against Pharmacists Who Refuse to Provide Emergency Contraception*, 80 SO. CAL. L. REV. 865 (2007) (arguing against pharmacist choice in providing contraceptives); Lora Cicconi, *Pharmacist Refusals and Third-Party Interests: A Proposed Judicial Approach to Pharmacist Conscience Clauses*, 54 UCLA L. REV. 709 (2007) (discussing pharmacist refusals); Matthew White, *Conscience Clauses for Pharmacists: The Struggle to Balance Conscience Rights With the Rights of Patients and Institutions*, 2005 WISC. L. REV. 1611 (2005) (discussing pharmacist refusals); Charu A. Chandrasekhar, *RX for Drugstore Discrimination: Challenging Pharmacy Refusals to Dispense Prescription Contraceptives Under State Public Accommodations Laws*, 70 ALB. L. REV. 55 (2006) (discussing pharmacist refusals); Sarah J. Vokes, *Just Fill the Prescription: Why Illinois' Emergency Rule Appropriately Resolves the Tension Between Religion and Contraception in the Pharmacy Context*, 24 L. & INEQ. 399 (2006) (discussing pharmacist refusals); Melissa Duvall, *Pharmacy Conscience Clause Statutes: Constitutional Religious "Accommodations" or Unconstitutional "Substantial Burdens" on Women?*, 55 AM. U. L. REV. 1485 (2006) (discussing conscience clause statutes); Amy Bergquist, Note, *Pharmacist Refusals: Dispensing (With) Religious Accommodation Under Title VII*, 90 MINN. L. REV. 1073 (2006) (discussing pharmacist refusals); Brittany L. Grimes, Note, *The Plan B for Plan B: The New Dual Over-the-Counter and Prescription Status of Plan B and Its Impact Upon Pharmacists, Consumers, and Conscience Clauses*, 41 GA. L. REV. 1395 (2007) (evaluating the impact of Plan B's over-the-counter status).

100 *Cf.* Douglas NeJaime, Griswold*'s Progeny: Assisted Reproduction, Procreative Liberty, and Sexual Orientation Equality*, 124 YALE L.J. F. 340, 340–41 (2015) ("As same-sex couples have gained access to marriage, some who opposed same-sex marriage have shifted their views, expressing support for same-sex equality while attempting to limit its impact. In particular, some now accept same-sex marriage while maintaining their commitment to biological, gender-differentiated parenting."). However, it is doubtful that such restrictions specifically targeted at

The following discussion first distinguishes between motivations and justifications, animated by the idea of public reason. In short, public justifications should be based on reasons that individuals of divergent backgrounds—moral, religious, and political—can accept as valid in a pluralist society.[101] Translated to the professional realm, the shared acceptance of advice follows when it is based on justifications internal to the knowledge community. The shared ways of knowing and reasoning are accepted as valid among members of the knowledge community irrespective of their personal commitments. Likewise, clients seeking a professional's advice will accept professional advice justified by the knowledge community's shared ways of knowing and reasoning as such, whether or not their priors otherwise align with the advice-giving professional's. Acceptance of professional advice follows from its nature as expert knowledge, not based on individual exogenous commitments. Applied to the context of professional advice, when the justifications are exogenous, the dissenting professional typically does not serve the expectations of the knowledge community or individual clients.

The two final subparts interrogate whether mitigating these expectations is possible by providing disclosures of professionals' exogenous commitments to their clients, or whether departure from the professional consensus due to exogenous—and here, primarily religious—reasons is generally justifiable under an exemptions regime.

1. Motivations and Justifications

External outliers base their divergence from professional consensus on exogenous reasons; often, their disagreement will be religiously motivated and therefore exogenous to the ways of knowing and reasoning of the knowledge community. Take the pro-life pharmacist as an example. Here, motivation and justification for refusing to provide comprehensive advice align: the motivating reason the pharmacist refuses to advise on certain drugs is his religious, political, or philosophical opposition to abortion. The justification is the same. It does not matter whether scientifically the drugs act in a certain way, as long as the pharmacist believes that they do.

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gay parents are tenable: "State laws on assisted reproductive technology may still be based on an exclusive model of different sex couples, but that model will not survive." Lupu, *supra* note 22, at 7 n.21. *But see* Christian Medical & Dental Associations, Assisted Reproductive Technology Ethics Statement (Jan. 22, 2017), http://cmda.org/resources/publication/assisted-reproductive-technology-ethics-statement (emphasizing the heterosexual, married two-parent family).

101 *See generally* JOHN RAWLS, POLITICAL LIBERALISM (1996) (suggesting in large part that pluralistic societies need to have reasonable rules for debate and discussion to bridge the gap between fundamentally opposed positions).

But motivation and justification do not necessarily align. Outliers who justify their departure from the professional consensus in terms exogenous to professional discourse—such as religious outliers—must be distinguished from outliers who may have a religious disagreement with the profession, but who nonetheless purport to share the knowledge basis of the profession to support their views.

For example, the National Association for Research and Therapy of Homosexuality ("NARTH")—one of the last remaining professional organizations that supports conversion therapy[102]—portrays itself as an alternative to the American Psychiatric Association. A founding member of NARTH asserts that "NARTH came into existence in response to threats to take away the right of patients to choose therapy to eliminate or lessen same-sex attraction."[103] The group claims to "defend[] the right of therapists to provide such treatment and provides a forum for the dissemination of research on homosexuality."[104] Importantly, the group explicitly invokes the knowledge basis and methodology of the profession:

> Concerned that professional organizations and publications in the mental health field have fallen under the control of those who would use them to forward social constructionist theories, political agendas, and advocacy research, NARTH has fought for a return to *established theoretical approaches, solid research*, therapy that puts the patient first, and freedom to discuss, debate, and disagree.[105]

The motivating factor for believing that homosexuality is wrong and must be remedied by therapy may be religious,[106] but the organization explicitly claims to place itself within the discourse of the knowledge community. Thus, despite the perhaps religious motivation, the justification is framed in terms of scientific discourse of the profession.

So what should we make of motivations and justifications for outlier status? When motivation and justification align, and both are based on exogenous reasoning—as in the pro-life pharmacist example—the professional is an *external* outlier placing himself outside of the knowledge community. The justification for departure at its core is a rejection of the

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102 On the role of NARTH in the JONAH litigation and exclusion of conversion therapy expert witnesses, *see infra* notes 217, 242–265 and accompanying text.

103 Benjamin Kaufman, *Why NARTH? The American Psychiatric Association's Destructive and Blind Pursuit of Political Correctness*, 14 REGENT U. L. REV. 423 (2002).

104 *Id*.

105 *Id.* (emphasis added).

106 *Id.* ("When people are discriminated against on the basis of their religious beliefs or denied help that they believe is in their best interests, they need an advocate to defend their rights."); *id.* at 440 ("If this trend persists, persons with strongly held religious beliefs may be unwilling to seek help from professional therapists. Religious groups may be forced to act as alternative professional organizations, and the demand for the entire mental health profession will be substantially reduced.").

knowledge community's shared ways of knowing and reasoning. But as long as the justification is framed in terms of the discourse of the knowledge community, I am inclined to consider the outliers as *internal* outliers. Their justification (at least ostensibly) respects the shared ways of knowing and reasoning. Does this invite dishonesty? This invokes a general problem in the theory of public reason.[107] But as long as a professional justification is possible, I am inclined to disregard the potential dishonesty as to motives. On a functional level, it will be virtually impossible for courts to make judgments about subjectivity in this area. It will generally be possible, however, to presume honesty as to motive and judge the justification in relation to the knowledge community's standards. Indeed, this is analogous to the tort regime where professional advice is measured against the profession's standard.

True external outliers will base their justifications on exogenous factors. Here, another useful illustration is provided by professional associations that explicitly frame their mission in religious terms. Individual professionals may understand their professional duty as part and parcel of their religious duty.[108] The Christian Medical & Dental Associations ("CMDA"), for instance, with nearly 18,000 members strong, represents such professionals.[109] CMDA's Ethics and Scientific Statements "are based on scientific, moral and biblical principles."[110] The Homosexuality Ethics Statement, for example, sets forth a framework for viewing homosexuality in biblical, social, and medical context [111] The medical factors, however, largely depart from scientific consensus.[112] Notably, CMDA em-

107 *See, e.g.*, Micah Schwartzman, *The Sincerity of Public Reason*, 19 J. POL. PHILOSOPHY 375 (2011) (discussing the impact of background moral values on political debate, particularly on the sincerity of politically "reasonable" justifications for moral positions).

108 *See, e.g.*, Christian Medical & Dental Associations, *Christian Physician's Oath Ethics Statement* (June 10, 2005), http://cmda.org/resources/publication/christian-physicians-oath-ethics-statement ("With gratitude to God, faith in Christ Jesus, and dependence on the Holy Spirit, I publicly profess my intent to practice medicine for the glory of God.").

109 Christian Medical & Dental Associations, *About Our Organization*, https://cmda.org/about/ ("Founded in 1931, CMDA provides programs and services supporting its mission to "change hearts in healthcare" with a current membership of nearly 18,000.").

110 Christian Medical & Dental Associations, *CMDA's Ethics and Scientific Statements*, http://cmda.org/issues/page/cmdas-ethics-statements.

111 Christian Medical & Dental Associations, *Homosexuality Ethics Statement*, (Apr. 21, 2016), http://cmda.org/resources/publication/homosexuality-ethics-statement.

112 *Id.* They are:

1. Among individuals who engage in homosexual acts, there is an increased incidence of drug or alcohol dependence, compulsive sexual behavior, anxiety, depression, and suicide. These consequences are harmful to the health of same-sex patients and are associated with increased medical costs to society.
2. Some homosexual acts are physically harmful because they disregard normal human anatomy and function. These acts are associated with increased risks of tissue injury and transmission of infectious diseases.

braces conversion therapy and in doing so cites NARTH or NARTH-affiliated individuals.[113]

The religious justification is more clearly articulated in the CMDA statement on ART, in which it sorts available reproductive technologies into "consistent with God's design for reproduction," "morally problematic," and "inconsistent with God's design for the family."[114] The family is defined as a married, heterosexual couple, resting on explicitly religious terms where "marriage and the family are the basic social units designed by God. Marriage is a man and a woman making an exclusive commitment for love, companionship, intimacy, spiritual union, and, in most cases, procreation."[115] Providing professional advice concerning ART consistent with the ethics statement will necessarily limit the range of options otherwise available. And the justification for limiting professional advice will rest purely on exogenous considerations.

Perhaps, then, those professionals whose justifications are based on exogenous factors constitute their own knowledge community, one that should not be held to conform to the standards of the profession. Instead, perhaps they should be held to the standard of the "Christian doctor" or "Christian lawyer," or the standard of a coreligionist in the same profession. But here, the self-understanding of the group is relevant. The CMDA, for instance, addresses this issue in its Professionalism Ethics Statement in which they define themselves as medical professionals.[116] Moreover, the CMDA Malpractice Ethics Statement explicitly references the standard of care applicable in ordinary physician malpractice.[117] By these metrics, the CMDA sees itself as part of the knowledge community, not a particular sub-group or separate community. To the extent that professionals claim to be part of the knowledge community, however, they ought to be bound to its knowledge basis and methodology.

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3. Homosexual behavior can be changed, even when desire persists. There is valid evidence that many individuals who chose to abstain from homosexual acts have been able to do so.

Id.

113 *See* Christian Medical & Dental Associations, *Homosexuality*, https://cmda.org/library/doclib/homosexuality-ethics-statement-with-references-final-2016.pdf.

114 *See* Christian Medical & Dental Associations, *Assisted Reproductive Technology Statement* (Apr. 29, 2010), http://cmda.org/resources/publication/assisted-reproductive-technology-ethics-statement.

115 *Id*.

116 *See, e.g.*, Christian Medical & Dental Associations, *History of Our Ministry*, https://cmda.org/library/doclib/history-of-cmda.pdf.

117 *See, e.g.*, Christian Medical & Dental Associations, *Malpractice Ethics Statement* (May, 2000), http://cmda.org/resources/publication/malpractice-ethics-statement ("The 'standard of care' refers to those acts which a reasonable physician of like training or skill would do in the same or similar situation.").

As the CMDA examples illustrate, it may not always be easy to classify the justification as exogenous. Moreover, the justification may differ from issue to issue. With respect to immunization, for example, the CMDA "supports the current scientific literature that validates the general practice of immunization as a safe, effective, and recommended procedure."[118] Generalizations, in short, are difficult in this area. But the conceptual line to be drawn along a shared knowledge basis and methodology is theoretically consistent. And typically, courts will be able to conduct the necessary fact-specific inquiry, as they already do so in other areas such as tort law and evidence.

2. Expectations

The expectations of the knowledge community and of clients toward professionals provide another reason why external outliers should generally be considered to place themselves outside of the knowledge community. With respect to the professional's advice-giving function, the knowledge community's interest lies in having individual professionals render accurate, comprehensive advice. This does not occur when the individual professional disseminates advice based on a knowledge basis exogenous to that of the knowledge community. Correspondingly, the individual professional has an autonomy interest in communicating the message according to the standards of the profession to which she belongs.[119] It is this bond that is destroyed when professionals place themselves outside the knowledge community for exogenous reasons. In reciprocal fashion, the individual professional's interest lies in preserving the integrity of the knowledge community's insights just as the knowledge community's interests lie in having the individual professional communicate its insights correctly.

A critic might object that this understanding places the membership in a profession above other constitutive aspects of a professional's identity. I do not mean to suggest that all other aspects of a professional's identity are secondary, and this is particularly true for the professional's religious beliefs. But the focus here is on the function of knowledge communities and the role of the advice-giving individual professional within the professional-client relationship. In his position as conduit between the knowledge community and the client, the defining feature in that particular relationship

118 Christian Medical & Dental Associations, *Immunization Ethics Statement*, https://www.cmda.org/resources/publication/immunization-ethics-statement (Jan. 31, 2017).

119 Haupt, *supra* note 6, at 1272–73 (arguing that this interest goes to the identity of the professional as a member of the profession).

is the professional role. In the professional-client relationship, the individual rendering professional advice is a professional first.

The professional-client relationship is typically characterized by an asymmetry of knowledge; the client seeks the professional's advice precisely because of this asymmetry. The very reason the professional's advice is valuable to the client is thus predicated on the knowledge the professional possesses and the client lacks.[120] The client's interests are only served if the professional communicates information that is accurate (under the knowledge community's current assessment), reliable, and personally tailored to the specific situation of the listener. To bridge the knowledge gap, and to ensure the protection of the client's decisional autonomy interests, the professional has to communicate all information necessary to make an informed decision to the client.[121] Viewed through a lens of public reason from the perspective of the client, the client's expectation is that the professional will not operate based on justifications that are not shared by the profession.

If the client does not receive full information, she may not know what is being withheld, or even that any information is being withheld.[122] Furthermore, the client does not know what is contested professional knowledge and what is not. A patient, for example, may encounter a doctor who for religious reasons will not provide advice on certain treatment options or medications. But the justification for these omissions will not be based on professional knowledge. In the spirit of public reason, the client must reasonably be able to expect that professional advice will be based upon reasons internal to the knowledge community rather than individual, exogenous justifications for departure.

3. Disclosure

Could this information deficit be cured by disclosure? The advice-giving professional could tell the client that the advice she dispenses is limited. The state might even require that any professional whose advice departs from the knowledge community's insights due to exogenous justifications provide such a disclosure. The previous discussion already addressed

120 *See, e.g.,* King v. Governor of the State of New Jersey, 767 F.3d 216, 232 (3d Cir. 2014) ("Licensed professionals, through their education and training, have access to a corpus of specialized knowledge that their clients usually do not. Indeed, the value of the professional's services stems largely from her ability to apply this specialized knowledge to a client's individual circumstances.").

121 Haupt, *supra* note 6, at 1271.

122 *See, e.g.*, Jill Morrison & Micole Allekotte, *Duty First: Towards Patient-Centered Care and Limitations on the Right to Refuse for Moral, Religious or Ethical Reasons*, 9 AVE MARIA L. REV. 141, 148–49 (2010).

some potential problems of disclosure in the healthcare infrastructure.[123] A prominent current example of litigation over disclosure requirements involves crisis pregnancy centers.[124] Often linked to a religious organization, the mission of these centers is to dissuade women from terminating their pregnancy.[125] This mission, however, is sometimes obscured from the advice-seeking client.[126]

With respect to the counseling provided at these facilities, the threshold question is whether crisis pregnancy centers engage in commercial, professional, or some other kind of speech. Courts have been ambiguous at best in classifying the advice dispensed at the centers.[127] Nonetheless, some commentators have been quick to analyze the speech as commercial.[128] But doing so may rest on a misconception.[129] Other scholars have called this classification as commercial speech into question. As Jessie Hill notes, "[t]he counseling transaction itself looks like the kind of one-on-one, fidu-

123 *See supra* Part I.A.2.

124 *See generally*, Evergreen Ass'n Inc. v. City of New York (*Evergreen I*), 801 F. Supp. 2d 197 (S.D.N.Y. 2011) (enjoining New York disclosure law), *aff'd in part and vacated in part*, (*Evergreen II*), 740 F.3d 233 (2d Cir. 2014) (remanding for further proceedings) *cert. denied* 135 S. Ct. 435 (2014); Centro Tepeyac v. Montgomery County (*Centro Tepeyac I*), 779 F. Supp. 2d 456 (D. Md. 2011) (enjoining Maryland disclosure law), *aff'd*, (*Centro Tepeyac II*), 722 F.3d 184 (4th Cir. 2013); Greater Balt. Ctr. for Pregnancy Concerns v. Mayor and City Council of Baltimore, 721 F.3d 264 (4th Cir. 2013) (vacating injunction for failure to adhere to summary judgment standards); Caroline Mala Corbin, *Compelled Disclosures*, 65 ALA. L. REV. 1277, 1340–51 (2014); B. Jessie Hill, Casey *Meets the Crisis Pregnancy Centers*, 43 J. L. MED. & ETHICS 59 (2015); Kathryn E. Gilbert, Note, *Commercial Speech in Crisis: Crisis Pregnancy Center Regulations and Definitions of Commercial Speech*, 111 MICH. L. REV. 591 (2013); Molly Duane, Note, *The Disclaimer Dichotomy: A First Amendment Analysis of Compelled Speech in Disclosure Ordinances Governing Crisis Pregnancy Centers and Laws Mandating Biased Physician Counseling*, 35 CARDOZO L. REV. 349 (2013); Megan Burrows, Note, *The Cubbyhole Conundrum: First Amendment Doctrine in the Face of Deceptive Crisis Pregnancy Center Speech*, 45 COLUM. HUM. RTS. L. REV. 896 (2014); Alice X. Chen, *Crisis Pregnancy Centers: Impeding the Right to Informed Decision Making*, 19 CARDOZO J.L. & GENDER 933 (2013); Kristen Gallacher, *Protecting Women from Deception: The Constitutionality of Disclosure Requirements in Pregnancy Centers*, 33 WOMEN'S RTS. L. REP. 113 (2011).

125 Corbin, *supra* note 124, at 1339–40.

126 *Id.* at 1340.

127 In *Evergreen II*, the Second Circuit left open which standard it applied ("[W]e need not decide the issue, because our conclusions are the same under either intermediate scrutiny . . . or strict scrutiny . . . ."). 740 F.3d at 245. The District Court in *Centro Tepeyac I* found the speech was neither "commercial, professional, [n]or any other form of speech calling for a lower level of scrutiny." *Centro Tepeyac I*, 779 F. Supp. 2d at 468. The Fourth Circuit, upon review, "commend[ed] the court for its careful and restrained analysis." *Centro Tepeyac II*, 722 F.3d at 192.

128 *See, e.g.*, Gilbert, *supra* note 124, at 613–14 (arguing that, while some speech by the facilities may be entitled to strict scrutiny, advertisements and billboards by the facilities are commercial speech). *But see* Corbin, *supra* note 124, at 1343 ("The courts usually found that the speech was not commercial speech . . . .").

129 *Cf.* Haupt, *supra* note 6, at 1264–68 (discussing and rejecting the analogy of commercial and professional speech).

ciary relationship that . . . appears to be the hallmark of professional speech."[130]

Given the stated mission of the centers, it seems clear that the advice rendered would generally not qualify as comprehensive and accurate professional advice.[131] At the same time, at least in some instances employees at these facilities may be holding themselves out as professionals, leading clients to expect professional advice.[132] Assuming, then, that at least some crisis pregnancy centers should be considered to provide professional advice, the advice rendered must measure up to professional standards.[133] Thus, from a professional speech perspective, regulation of such speech is entirely unproblematic—because it is unprofessional advice to begin with.

What about the disclosure requirements imposed by the state?[134] In principle, such disclosure mechanisms will inform the client of the limited scope of professional advice.[135] Similarly, doctor-patient matching, at least theoretically, might provide an attractive solution.[136] In choosing their doc-

130 Hill, *supra* note 124, at 66 ("Unlike other false or unsubstantiated health claims that may be made in various fora, the CPC speech occurs within a counseling relationship in which the listener puts trust in the presumed professional and assumes that the professional will act in her best interests, thus invoking the state's particularly strong interest in protecting the listener.").

131 Corbin, *supra* note 124, at 1342 ("Counseling varies, but most versions would violate medical ethics, as the goal is not to fully and accurately inform women of their medical options but to convince them to forgo abortion by any means necessary."); *see also* Aziza Ahmed, *Informed Decision Making and Abortion: Crisis Pregnancy Centers, Informed Consent, and the First Amendment*, 43 J.L., MED. & ETHICS 51, 52 (2015) (noting that misinformation "includes telling women that there is a link between abortion and breast cancer, that they will experience psychological distress following abortion, and that there is the possibility for future infertility following an abortion."); Erwin Chemerinsky, Opinion, *In California, Free Speech Meets Abortion*, L.A. TIMES (Oct. 16, 2015), http://www.latimes.com/opinion/op-ed/la-oe-1016-chemerinsky-reproductive-fact-act-20151016-story.html ("Crisis pregnancy centers have been known to spread false medical information and use scare tactics to dissuade their clients from seeking abortions.").

132 *See* Corbin, *supra* note 124, at 1350 ("Women who respond to 'Pregnant? Need Help? You have options' advertisements and are administered pregnancy tests by people in white lab coats are led to believe that medical professionals will give them accurate and impartial medical advice. Instead, they are tricked into hearing false information and an ideological message.").

133 There may be other forms of recourse. Certain activities could qualify as consumer fraud, for example, for the speech that falls into this category.

134 *See* Reproductive FACT Act, CAL. HEALTH & SAFETY CODE §§ 123470–123473 (West 2016) (requiring facilities to inform patients of alternative care).

135 Under the California Reproductive FACT Act, licensed healthcare facilities must display the following notice: "California has public programs that provide immediate free or low-cost access to comprehensive family planning services (including all FDA-approved methods of contraception), prenatal care, and abortion for eligible women. To determine whether you qualify, contact the county social services office at [insert the telephone number]." *Id.* § 123472(a)(1). Unlicensed facilities must display the following: "This facility is not licensed as a medical facility by the State of California and has no licensed medical provider who provides or directly supervises the provision of services." *Id.* §123472(b)(1).

136 *See, e.g.*, HOLLY FERNANDEZ LYNCH, CONFLICTS OF CONSCIENCE IN HEALTH CARE 79–97 (2008) (describing doctor-patient matching, which allows a doctor to conscientiously object to

tors, "patients may consider not only the physician's expertise, but also whether they have shared beliefs or points of view."[137] However, in practice, there is a significant filtering problem that may lead to inadequate communication of knowledge from doctor to patient. Imagine a doctor informing a patient that, due to his faith, he will dispense only advice that is consistent with his faith. Even if the patient is of the same faith, it is at least questionable whether it will be obvious to her which advice is left out as inconsistent with the professional's faith. Just as professional knowledge communities are not monolithic, faith communities are not monolithic. What is acceptable in light of religious doctrine for one member of a particular religion may be unacceptable for a coreligionist.[138] But even if disclosure puts the client on notice, the dissenting professional is still not communicating the full range of professional knowledge. And it would reintroduce an element of paternalism—physicians alone deciding on behalf of the patient what information the patient needed to know. On the tort side, this is exactly the situation to be remedied by the doctrine of informed consent.[139] The American Medical Association puts it this way: "The patient's right to self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice."[140] Thus, a disclosure regime only partially cures the problems outlined in the prior discussion.

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performing a procedure if an alternative physician is available, and requiring the objecting doctor to perform if no other physician can reasonably be found).

137 Sonia M. Suter, *The First Amendment and Physician Speech in Reproductive Decision Making*, 43 J.L., MED. & ETHICS 22, 27 (2015).

138 And even in hierarchically organized religions, individual members may depart from official doctrine in large numbers. *See, e.g.*, Michael Lipka, *Majority of U.S. Catholics' Opinions Run Counter to Church on Contraception, Homosexuality*, PEW RES. CTR. (Sept. 19, 2013), http://www.pewresearch.org/fact-tank/2013/09/19/majority-of-u-s-catholics-opinions-run-counter-to-church-on-contraception-homosexuality/ (finding that U.S. Catholics disagree with Catholic doctrine on birth control and same sex marriage).

139 Suter, *supra* note 137, at 27.

140 Ahmed, *supra* note 131, at 52 (quoting American Medical Association, *Opinion 8.08—Informed Consent*). *But see* Cameron O'Brien Flynn & Robin Fretwell Wilson, *When States Regulate Emergency Contraceptives Like Abortion, What Should Guide Disclosure?*, 43 J.L., MED. & ETHICS 72, 78 (2015) (arguing that "following professional norms may not yield disclosures consistent with what most women say they want to know."). In the context of informed consent, Flynn and Wilson concede that "[g]enerally, the risks of a given health care procedure are scientifically resolvable, and therefore patients can benefit from the measured judgment of health care professionals as a group." *Id.* However, they argue that abortion is different: "But unlike ordinary medical procedures, what constitutes life or when life begins are subjects that are not scientifically resolvable. A physician armed with medical knowledge cannot provide an answer to women that women themselves cannot supply to these questions. Moreover, despite the allure of professional norms, sometimes deciding what counts as the professional view is not so easy . . . ." *Id.* at 79–80. The solution, however, is more information rather than less. And disagreements within the profession should be worked out within the knowledge community rather than decided via state regulation.

4. Exemptions

To what extent is the departure from expectations justified by exemptions? Writing more than a decade ago in the context of medical care, health law scholar Alta Charo posed the following set of questions:

> What does it mean to be a professional in the United States? Does professionalism include the rather old-fashioned notion of putting others before oneself? Should professionals avoid exploiting their positions to pursue an agenda separate from that of their profession? And perhaps most crucial, to what extent do professionals have a collective duty to ensure that their profession provides nondiscriminatory access to all professional services?[141]

Today, these questions remain largely unanswered—and since then, leading up to the Supreme Court's decision in *Obergefell v. Hodges*,[142] and certainly in its aftermath, new sites of contestation have emerged.[143] Contemporaneously, conscience exemptions have been at the forefront of legal and political debate for some time now, culminating most recently in the *Hobby Lobby* case.[144] One reaction to the expansion of marriage equality has been to call for exemptions from generally applicable antidiscrimination laws. These would include providers of professional services.[145] The CMDA Same-Sex "Marriage" [sic] Public Policy Statement, for instance, strongly supports such measures.[146] An expansive body of scholarship addresses the plethora of questions surrounding exemptions.

My point here is narrow and conceptual, and concerns only the site of negotiation for potential exemptions granted to professionals refusing to provide comprehensive professional advice. Exemptions for professionals should be negotiated within the knowledge community. Indeed, historically, this has been the case in the health context: "In medicine, until recently, legislative protection has focused on those objections grounded in professional ethical obligations."[147] Objections to marriage equality, however, are unlikely to be rooted in professional norms: "Whereas doctors cite their obligation to preserve life to refuse assisted suicide, those who decline to

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141 R. Alta Charo, *The Celestial Fire of Conscience—Refusing to Deliver Medical Care*, 352 N. ENG. J. MED. 2471, 2473 (2005).

142 135 S. Ct. 2584 (2015).

143 *See generally* Robin Fretwell Wilson, *The Calculus of Accommodation: Contraception, Abortion, Same-Sex Marriage, and Other Clashes Between Religion and the State*, 53 B.C. L. REV. 1417 (2012).

144 134 S. Ct. 2751 (2014).

145 Sepper, *supra* note 1, at 724 ("Religious organizations, small businesses, and professionals would be relieved of certain obligations of nondiscrimination and would avoid legal liability."); *id.* at 743 ("[S]ome objectors could belong to professions characterized by moral complexity and shared ethics (including medicine).").

146 *Same-Sex "Marriage" Public Policy Statement*, CHRISTIAN MED. & DENTAL ASS'NS (Jan. 23, 2016), https://cmda.org/resources/publication/same-sex-marriage-public-policy-statement.

147 Sepper, *supra* note 1, at 726.

perform IVF for lesbian couples cannot anchor their refusal in professional ethics . . . . Indeed, medical ethics prohibit such acts as impermissible discrimination."[148] The same is true outside of the medical context. As Elizabeth Sepper notes, "if a tax or family law attorney objected to serving gay married couples, he or she would be hard pressed to identify the ethical norm supporting the objection."[149]

A critic might object that the professions do not necessarily have a track record that makes them particularly trustworthy. Consider the following examples: the American Medical Association supported the criminalization of abortion;[150] homosexuality was considered a mental illness by professional groups until the 1970s;[151] members of the American Psychological Association allegedly supported the C.I.A. torture program during the Bush administration;[152] Office of Legal Counsel lawyers provided bad advice in the torture memos.[153] How, then, can we trust professionals to properly negotiate conscience exemptions? Perhaps the best answer is that among the finite number of potential decision makers, the professions are the least bad option. State legislatures, as the examples throughout this Article show, are increasingly emboldened to explicitly contradict professional knowledge. Courts may lack the expertise to evaluate the full effects of granting certain exemptions on the ability of professionals to provide services. In other words, deference to the professions on negotiating exemptions may be a second-best, but still preferable option. And the professions are capable of correcting course.[154] Moreover, by giving the professions

148 *Id.* at 743.

149 *Id.*

150 *See* Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991, 1000–02 (noting that American Medical Association advocated for the criminalization of abortion and contraception); *see also* Reva B. Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 280–300 (1992).

151 *See supra* note 82 and accompanying text.

152 *See* James Risen, *American Psychological Association Bolstered C.I.A. Torture Program, Report Says*, N.Y. TIMES (Apr. 30, 2015), https://www.nytimes.com/2015/05/01/us/report-says-american-psychological-association-collaborated-on-torture-justification.html?smid=pl-share&_r=0 ("The American Psychological Association secretly collaborated with the administration of President George W. Bush to bolster a legal and ethical justification for the torture of prisoners . . . ."); *see also* James Risen, *Outside Psychologists Shielded U.S. Torture Program, Report Finds*, N.Y. TIMES (July 10, 2015), https://www.nytimes.com/2015/07/11/us/psychologists-shielded-us-torture-program-report-finds.html (describing the report that establishes a connection between American psychologists and the C.I.A. torture programs).

153 Eric Lichtblau & Scott Shane, *Report Faults 2 Authors of Bush Terror Memos*, N.Y. TIMES (Feb. 19, 2010), http://www.nytimes.com/2010/02/20/us/politics/20justice.html?_r=0.

154 *See, e.g.*, James Risen, *Psychologists Approve Ban on Role in National Security Interrogations*, N.Y. TIMES (Aug. 7, 2015), https://www.nytimes.com/2015/08/08/us/politics/psychologists-approve-ban-on-role-in-national-security-interrogations.html (describing the American Psycho-

the authority to self-regulate, and by decisions made in other areas of the law—most prominently, in the tort law governing professional malpractice—the question has been resolved in favor of the professions despite such concerns beyond the narrow context of conscience exemptions. The idea of symmetry between tort liability and First Amendment protection, then, normatively supports this deference.

B. Internal Outliers

Internal outliers share the knowledge community's notions of validity, methodology, and intersubjective understanding. Their results deviate from the "mainstream;" yet, their outlier status is based on the application of the agreed-upon methods to the same data, only to reach divergent results. Ultimately, internal outlier status is thus grounded in the same set of professional insights. This is the key to understanding that knowledge communities are not monolithic. The same data may be interpreted in several ways. As a matter of tort liability, the resulting professional advice, consequently, is "good" professional advice falling within the range of defensible professional knowledge.[155] Different assessments of shared knowledge, if valid under the agreed upon methodology, may produce good professional advice, even if it departs from the mainstream.

But internal outliers can also produce bad professional advice. If the assessment of the shared knowledge is faulty or based on methodological errors, it will not result in defensible professional advice. One example, discussed in more detail in Part IV, is the study linking certain childhood vaccines to autism.[156]

The more difficult case is that in which outliers assert to be relying on the same knowledge basis without outright falsified or otherwise erroneous use of data. Again, NARTH provides a useful example. Under that group's account, NARTH and the American Psychiatric Association operate based on different paradigms.[157] The claim that the American Psychiatric Association and other professional organizations in the mental health field have been hijacked by "gay activists" and research contrary to their goals has been silenced and scientists oppressed illustrates that NARTH rejects the same methods of reasoning while also asserting its competence in

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logical Association's ban on any psychologist's involvement in interrogation conducted by the United States).

155 Haupt, *supra* note 6, at 1284–87.

156 *See infra* Part IV.A.1.

157 Kaufman, *supra* note 103, at 425 ("The paradigm of the gay activists holds that psychological theories and practice are social constructs and, therefore, are subject to political negotiation. The paradigm of NARTH holds that treatment provided by therapists should be guided by cumulative clinical experience and valid research carried out by responsible professionals.").

the same field. Indeed, they portray the debate as one "within mental health professional organizations."[158] Thus, they do not purport to be part of a different knowledge community. The argument, rather, is that political pressure led to the delisting of homosexuality as a mental disorder from the DSM in 1973: "A review of the history . . . reveals . . . that the decision was not based on science but was the response of an organization under siege by gay activists."[159] In other words, NARTH accuses the mainstream of having attained outlier status. These competing claims can only be overcome by the knowledge community itself.

Thus, for internal outliers we must decide whose advice clears the bar of good professional advice and whose advice does not. The remainder of this Article is concerned only with internal outliers.

III. DEFINING THE SCOPE OF DEFENSIBLE KNOWLEDGE: OUTLIERS IN TORT LAW AND EVIDENCE

In order to determine the range of acceptable advice within the knowledge community, it is helpful to interrogate two areas of the law that have dealt with similar issues: the tort law of professional malpractice and the law of evidence on expert testimony. What is the scope of good advice for First Amendment purposes? To answer this question, this Part brings these two areas of law into the conversation that have traditionally asked similar questions, and that therefore may provide guidance on how to draw the line between professional and unprofessional advice.

Both tort law and the law of evidence governing the admissibility of expert testimony have long acknowledged that knowledge communities are not monolithic.[160] Both provide normative support to the position that the distinction between good and bad advice should be drawn by the knowledge community along the lines of a shared methodology and shared ways of knowing and reasoning. Whether advice based on a shared methodology and common ways of knowing and reasoning clears the bar of good advice on the substance, moreover, is also up to the knowledge community. Additionally, from an institutional competence and workability standpoint, both tort law and the law of evidence governing the admissibil-

158 *Id.*

159 *Id.* at 433.

160 The two interact in a significant way. *See, e.g.*, Edward K. Cheng & Albert H. Yoon, *Does* Frye *or* Daubert *Matter? A Study of Scientific Admissibility Standards*, 91 VA. L. REV. 471, 472–73 (2005) ("In federal courts, where the decision is legally binding, *Daubert* has become a potent weapon of tort reform by causing judges to scrutinize scientific evidence more closely. Tort reform efforts often focus on medical malpractice, products liability, and toxic torts—all cases in which scientific evidence is likely to play a decisive or at least highly influential role.") (footnote omitted).

ity of expert testimony illustrate that courts are able to accommodate the fact that a range of knowledge may constitute good advice.

This Part first turns to the treatment of outliers in tort law, which has traditionally accounted for the fact that a range of opinions may be valid for purposes of defending against claims of professional malpractice liability. In particular the "respectable minority" or "two schools of thought" doctrines, which are available as defenses against malpractice claims in many jurisdictions, serve this function. Ultimately, it is up to the knowledge community to determine what constitutes good advice—for malpractice liability and for First Amendment purposes alike. First Amendment protection of professional speech thus constitutes the flip side of imposing malpractice liability. Conceptually, they are "two sides of the same coin."[161]

This Part then turns to the law of evidence. Robert Post pointed out the parallels between the formation of expert knowledge and the law of evidence: "We rely on expert 'knowledge' precisely because it has been vetted and reviewed by those whose judgment we have reason to trust . . . . This is explicitly the perspective adopted by federal courts when they determine whether to admit expert testimony . . . under Federal Rule of Evidence 702."[162] Professionals, importantly, are experts recognized under FED. R. EVID. 702, though the category of experts under that rule is much larger.[163] Whether expert testimony is admissible and subject only to cross-examination and counter-experts, or whether it is to be excluded provides a micro-scale study of the functioning of expert opinions outside the courtroom setting. In the modern litigation setting, "the twentieth-century trial judge turned into an active gatekeeper, charged with the responsibility of

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161 Haupt, *supra* note 6, at 1285.

162 POST, *supra* note 16, at 8. At the same time, Post juxtaposes this understanding of expert knowledge with underlying First Amendment interests: "The continuous discipline of peer judgment, which virtually defines expert knowledge, is quite incompatible with deep and fundamental First Amendment doctrines that impose a 'requirement of viewpoint neutrality' on regulations of speech and that apply 'the most exacting scrutiny to regulations that suppress, disadvantage, or impose differential burdens upon speech because of its content.'" *Id.* at 9 (citations omitted). The Eleventh Circuit en banc decision in *Wollschlaeger IV* notably disregarded this incompatibility of expert knowledge and viewpoint neutrality. Haupt, *supra* note 14 (criticizing the Court's decision in Wollschlaeger v. Governor of Fla., 848 F.3d 1293 (11th Cir. 2017)).

163 FED. R. EVID. 702 states that:

> A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if:
> (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;
> (b) the testimony is based on sufficient facts or data;
> (c) the testimony is the product of reliable principles and methods; and
> (d) the expert has reliably applied the principles and methods to the facts of the case.

Id.

screening unreliable scientific evidence away from the jury."[164] The underlying interests—ascertaining the reliability of opinions—are the same. Thus, both tort law and the law of evidence offer important insights that can guide theorizing the boundaries of First Amendment protection for professional speech.

A. Tort Law

Tort law sanctions unprofessional advice as professional malpractice or, in the medical context, as medical malpractice. Processes of professionalization are mirrored in the emergence of tort causes of action for professional malpractice. Take the mental health field as an example. Mental health providers find themselves increasingly exposed to malpractice claims as the field becomes increasingly science-based and standards of care become entrenched.[165] The irony is not lost on commentators who point out that the very fact that treatments have improved creates the opportunity for recipients of such care "to pursue tort claims challenging the adequacy of the care they received."[166] A variety of mental healthcare providers may be the target of such claims: physicians such as psychiatrists, as well as psychologists, social workers, and counselors.[167] Conceptually, it is important to remember that the profession sets the standard of care in these cases.[168] While there has been a shift from the customary practice standard, which provided "safety in numbers," to the reasonably prudent physician standard, which relies more on an evidence-based approach than customary

164 Tal Golan, *Revisiting the History of Scientific Expert Testimony*, 73 BROOK. L. REV. 879, 880 (2008).

165 *See* Thomas L. Hafemeister, Leah G. McLaughlin & Jessica Smith, *Parity at a Price: The Emerging Professional Liability of Mental Health Providers*, 50 SAN DIEGO L. REV. 29, 31–32 (2013) (arguing, for example, that higher damages are awarded because science has provided a better understanding of psychological harm); *see also* Steven R. Smith, *Mental Health Malpractice in the 1990s*, 28 HOUS. L. REV. 209, 210–11 (1991) (describing an "avalanche of claims" against physicians for medical malpractice) (quoting J. ROBERTSON, PSYCHIATRIC MALPRACTICE: LIABILITY OF MENTAL HEALTH PROFESSIONALS 5 (1988)). The same was true in medical malpractice in the nineteenth century. *See, e.g.*, Catherine T. Struve, *Doctors, the Adversary System, and Procedural Reform in Medical Liability Litigation*, 72 FORDHAM L. REV. 943, 950 (2004) (noting that "progress in medical knowledge also led to malpractice suits.").

166 Hafemeister, McLaughlin & Smith, *supra* note 165, at 33; *see also* Struve, *supra* note 165, at 948 ("Improvements in medical knowledge and technology have heightened consumer expectations, and have led to lawsuits over imperfect results where previously—under less sophisticated treatment—no suit would have been possible.").

167 *See* Hafemeister, McLaughlin & Smith, *supra* note 165, at 36 ("Suits targeting nonphysicians are typically referred to as professional liability claims, while suits aimed at physicians are categorized as medical malpractice claims. Their basic nature is similar, although the terminology may differ somewhat.") (footnote omitted).

168 *Id.* at 38.

practices,[169] it is the profession itself that determines what constitutes reasonable care, and courts have long awarded deference to the profession in such cases.[170] Expert testimony typically establishes what qualifies as the applicable standard of care.[171]

The development of the standard of care results from contestation within the knowledge community. Scholars acknowledge that, given the "lack of consensus regarding the diagnosis of mental disorders and the appropriate course of treatment for a given diagnosis," it is difficult to establish the standard of care.[172] In the mental health field, "the defining question in these cases is often whether the mental health provider, practicing in a field rife with uncertainty but in which substantial empirical progress is being made, made an error that should incur liability."[173] The tort law of professional malpractice, in other words, takes into account the changing nature of the profession.

Doctrinally, tort law manifests its acknowledgement that a range of opinions may exist in any given field in the "respectable minority" or "two schools of thought" doctrine, which is a defense against malpractice claims in many jurisdictions.[174] It states that "[w]here two or more schools of thought exist among competent members of the medical profession concerning proper medical treatment for a given ailment, each of which is supported by responsible medical authority, it is not malpractice to be among the minority . . . who follow one of the accepted schools."[175] This doctrine explicitly accommodates the range of professional opinions. The benchmark for liability will be established by reference to that particular school of thought: "The 'school of thought' to which mental health providers belong can have considerable significance in a professional liability suit, as their actions will typically be judged against what a reasonable practitioner of that school of thought would have done under similar circumstances."[176]

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169 *See, e.g.*, Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 173 (2000) (discussing the rise of the reasonable physician standard in determining medical malpractice in American jurisprudence).

170 Hafemeister, McLaughlin & Smith, *supra* note 165, at 38–40 (citing Pike v. Honsinger, 49 N.E. 760 (N.Y. 1898)) (expanding on the reasonable physician standard and the deference courts provide to professional judgment).

171 *Id.* at 43; Struve, *supra* note 165, at 945 ("In many malpractice cases, each element of the claim—standard of care, breach, causation, and damages—requires medical expert testimony. Party-retained experts are the standard source of such expertise in the United States.") (footnote omitted).

172 Hafemeister, McLaughlin & Smith, *supra* note 165, at 43.

173 *Id.* at 40 (footnote omitted).

174 *Id.*

175 *Id.* at 41 (quoting Chumbler v. McClure, 505 F.2d 489, 492 (6th Cir. 1974)).

176 Hafemeister, McLaughlin & Smith, *supra* note 165, at 52.

Ambiguity persists both in terms of quantity and quality as courts are hesitant to give numerical guidance on how large the minority must be or what counts as recognized and respected knowledge.[177] Especially with respect to new developments, courts have noted that a publication requirement would be problematic.[178] Notwithstanding these ambiguities, the conceptually significant point is that the doctrine accommodates the fact that there may not be a single correct answer when it comes to professional knowledge. Institutionally, moreover, it does not force courts to function as the referee choosing among contested expert knowledge.

Critics suggest that the doctrine permits unproven or ineffective treatment, which is particularly relevant in a field such as mental healthcare, "where studies of the efficacy of various treatment alternatives are often lacking or highly contentious."[179] Moreover, the doctrine is important "when traditional treatments are called into question by emerging approaches."[180] Especially in a divided field such as mental health, where pharmacotherapy and psychoanalysis arguably embody divergent approaches, "if [one] orientation falls out of style or is deemed inappropriate to address a client's condition, its practitioners may be subject to liability."[181] If the law were to privilege pharmacotherapy, for instance, it "would enhance the risk of liability for practitioners who primarily use traditional, psychoanalytic methods of treatment or other nonpharmaceutical approaches. However, it also suggests physicians may face liability for failing to refer to a nonmedical mental health practitioner a patient who might be better served by receiving a treatment modality that is not focused on pharmaceutical agents."[182] As available treatment options multiply and treatment outcomes improve,[183] individual providers must therefore be aware of the alternatives.

How substantial the disagreement within the profession is, moreover, may itself be contested. In the mental healthcare context, some see psychotherapy and psychopharmacology not as antithetical but rather as complementary.[184] The courts cannot (and should not) be the arbiters of such dis-

177 Tim Cramm, Arthur J. Hartz & Michael D. Green, *Ascertaining Customary Care in Malpractice Cases: Asking Those Who Know*, 37 WAKE FOREST L. REV. 699, 705 (2002) (citing Jones v. Chidester, 610 A.2d 964, 969 (Pa. 1992)).

178 *See id.* at 969 n.21 (citing Gala v. Hamilton, 715 A.2d 1108, 1111 (Pa. 1998)).

179 Hafemeister, McLaughlin & Smith, *supra* note 165, at 41.

180 *Id.*

181 *Id.* at 42.

182 *Id.* (footnotes omitted).

183 *See id.* at 48–52 (providing an overview of the developments in the mental health area since the mid-twentieth century, resulting in the rise of psychopharmacology and psychotherapy).

184 *See, e.g.*, Richard A. Friedman, *Psychiatry's Identity Crisis*, N.Y. TIMES, July 17, 2015, https://www.nytimes.com/2015/07/19/opinion/psychiatrys-identity-crisis.html (arguing for increased psychotherapy research alongside pharmacological research).

agreement. Rather, this state of internal contestation "suggests that mental health practitioners, regardless of their preferred treatment approach, need to remain aware of and be conversant regarding the potential benefits—and risks—of alternative treatment courses and refer their clients to other practitioners when these alternatives better meet their needs."[185] Ultimately, this calls for greater engagement with the range of professional knowledge available. Thus, "to avoid liability when there are several courses of treatment available and the most appropriate choice is not clear, mental health providers should obtain a consultation from someone with expertise regarding these alternatives."[186] And, on the liability side, "failure to obtain a needed referral or consult when treating a client can constitute a breach of the standard of care and result in liability for the provider."[187] Here, again, conversion therapy provides a useful example, as

> different orientations have grown and faded in popularity over the years, with some discredited and associated professionals found liable when their clients experienced harm. For example, "conversion therapy," a school of thought that had a significant number of adherents at one time, subsequently fell out of favor, and its practitioners became the target of numerous professional liability claims.[188]

These examples from contested areas of mental health illustrate how existing tort doctrines deal with the range of professional advice, and how emergent and refuted knowledge are treated with respect to professional malpractice claims. The First Amendment can learn from this area in its explicit acknowledgement of a range of good advice. By conceptualizing First Amendment protection as the flip side of malpractice liability, deference to the knowledge community on the substance of advice follows. The takeaway can be boiled down to two simple, but critical, insights: first, there may not be a single right answer but rather a range of valid opinions that constitute good professional advice; second, the knowledge community—rather than the courts or legislatures—determines what clears the bar of good advice.

B. Evidence

Looking at the treatment of expert witnesses in the law of evidence is particularly instructive because the considerations underlying admissibility of expert testimony in the microcosm of the courtroom essentially mirror considerations underlying the role of the First Amendment. Can the adver-

185 Hafemeister, McLaughlin & Smith, *supra* note 165, at 53–54 (suggesting that physicians should utilize more than one school of thought to best treat patients).

186 *Id.*

187 *Id.* at 54.

188 *Id.* at 52.

sary system provide tools, such as cross-examination or counter-evidence, to weed out "bad" expert opinions? These tools mirror the marketplace idea and the notion of speech and counter-speech. Or does proper administration of the system instead require the exclusion of "bad" experts?[189] Doing so would parallel the exclusion of outliers from First Amendment protection. What can First Amendment theory learn from the treatment of experts in the law of evidence?[190]

The common law largely trusted procedural tools to ensure reliability of expert witnesses' testimony.[191] Since judges were deemed to have inadequate knowledge of the substantive areas of testimony, the common law did not provide the judge tools to substantively evaluate expert testimony. Instead, the adversary system's tools of cross-examination and counter-experts were entrusted to procure reliable testimony. With respect to scientific evidence, however, the standard articulated in *Frye v. United States* demanded "general acceptance in the particular field" governed.[192] In an attempt to reconcile heightened concerns about reliability with persisting

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189 *See, e.g.*, CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, EVIDENCE 664 (5th ed. 2012) ("*Daubert* came amidst increasing concern over 'junk science' . . . ."); Frederick Schauer & Barbara A. Spellman, *Is Expert Evidence Really Different?*, 89 NOTRE DAME L. REV. 1, 1–2 (2013) (describing *Daubert* as "setting out a list of factors designed principally to keep so-called junk science out of the courtroom") (footnote omitted); Cheng & Yoon, *supra* note 160, at 474 ("Under this view, the real contribution of the *Daubert* decision was not in creating a new doctrinal test, but rather in raising the overall awareness of judges—in all jurisdictions—to the problem of unreliable or 'junk' science."). On "junk science," see generally PETER W. HUBER, GALILEO'S REVENGE: JUNK SCIENCE IN THE COURTROOM (1991).

190 This analogy is based on an oversimplification, of course. Even under *Daubert*, the judge as gatekeeper is not intended

> to decide that the testimony is right or wrong or to displace the adversary system. That system depends on cross-examination and allowing the other side to offer its own counter-proof, and these mechanisms put before the trier of fact the necessary information to make a considered judgment, to decide which side should carry the day.

MUELLER & KIRKPATRICK, *supra* note 189, at 651 (footnote omitted). However, "*Daubert* expects judges to decide the question whether the theories, techniques, and data as applied can be trusted." *Id.* Therefore, the analogy still stands. First Amendment protection of professional speech does not eliminate the mechanisms of speech and counter speech. Second opinions, in other words, remain permissible and relevant. First Amendment protection of professional speech, and corresponding lack of protection for "unprofessional" speech, only limits the range of acceptable advice to that based on the knowledge community's range of acceptable insights.

191 *See generally* TAL GOLAN, LAWS OF MEN AND LAWS OF NATURE: THE HISTORY OF SCIENTIFIC EXPERT TESTIMONY IN ENGLAND AND AMERICA (2004); Golan, *supra* note 164; Learned Hand, *Historical and Practical Considerations Regarding Expert Testimony*, 15 HARV. L. REV. 40 (1901) (providing a historical perspective).

192 293 F. 1013, 1014 (D.C. Cir. 1923) ("Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle must be recognized, and while courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained *general acceptance* in the particular field in which it belongs.") (emphasis added).

skepticism about the judge's role to substantively evaluate scientific evidence, at the most basic level, the *Frye* test "deferred to prevailing thinking and practices in the scientific field."[193]

The Supreme Court in *Daubert v. Merrell Dow Pharmaceuticals, Inc.* addressed the standard set forth in the Federal Rules of Evidence, which superseded *Frye*.[194] *Frye* still governs in a number of states though not in the federal courts and a majority of states where instead the *Daubert* test is followed.[195] Moreover, *Kumho Tire Co. v. Carmichael* extended *Daubert* beyond scientific testimony to all expert testimony.[196] Under *Daubert*, "general acceptance" is still one of the factors, though unlike in *Frye*, it is not the only one.[197] Other factors include testing, peer review, and error rates.[198] Both *Frye* and *Daubert* are designed to determine the reliability of the science offered.[199]

Daubert makes the judge the gatekeeper of scientific and other expert evidence.[200] Where "the law deferred to the scientific community on the question whether answers that scientists provide are sufficiently grounded in theory and practice to be trusted and acted upon by courts" before, *Daubert* asks judges "independently to appraise what science has to offer, in effect screening out evidence offered as science if it is invalid or unreliable."[201] But the shift of decision-making power from the scientific com-

193 PAUL F. ROTHSTEIN, MYRNA S. RAEDER & DAVID CRUMP, EVIDENCE IN A NUTSHELL 315 (5th ed. 2007).

194 509 U.S. 579, 589 (1993) ("[T]he *Frye* test was displaced by the Rules of Evidence . . . .").

195 Cheng & Yoon, *supra* note 156, at 472–73.

196 526 U.S. 137, 141 (1999) ("We conclude that *Daubert*'s general holding—setting forth the trial judge's general 'gatekeeping' obligation—applies not only to testimony based on 'scientific' knowledge, but also to testimony based on 'technical' and 'other specialized' knowledge.").

197 *Daubert*, 509 U.S. at 589 ("Frye made 'general acceptance' the exclusive test for admitting expert scientific testimony. That austere standard, absent from, and incompatible with, the Federal Rules of Evidence, should not be applied in federal trials."); *see also Kumho*, 526 U.S. at 156 (referencing "general acceptance" in expanding *Daubert*-style judicial gatekeeper function to non-scientific experts); MUELLER & KIRKPATRICK, *supra* note 189, at 650 (noting how "general acceptance" was "all-important" in *Frye* but only a relevant consideration in *Daubert*); Christopher B. Mueller, *Daubert Asks the Right Questions: Now Appellate Courts Should Help Find the Right Answers*, 33 SETON HALL L. REV. 987, 989 (2003) (noting that "*Daubert* . . . asks directly the question that *Frye* put only indirectly").

198 *Daubert*, 509 U.S. at 593–94.

199 Mueller, *supra* note 197, at 989; MUELLER & KIRKPATRICK, *supra* note 189, at 654 ("*Daubert* said the trial judge is to decide whether the evidence is 'reliable' enough to be considered.").

200 *Daubert*, 509 U.S. at 589 ("[U]nder the Rules the trial judge must ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable."); *see also* MUELLER & KIRKPATRICK, *supra* note 189, at 649–50 (explaining how the "crux of it [*Daubert*] is that courts act as gatekeepers when it comes to scientific (and now technical) evidence").

201 Mueller, *supra* note 197, at 987; *see also* MUELLER & KIRKPATRICK, *supra* note 189, at 654 ("*Daubert* said the trial judge is to decide whether the evidence is 'reliable' enough to be considered. In performing this function, *Daubert* did *not* want the judge to take either the word of the expert or the representations of the proponent as definitive.").

munity to the judiciary[202] may have little practical effect. In practice, it is likely that judges under both regimes essentially make the same inquiry, focusing on general acceptance. Indeed, scholars point out that while *Daubert* makes it "the job of courts to appraise science, and courts are not simply to defer to the scientific community on the question whether evidence presented as science is valid and reliable," they still are charged "to judge science *by the standards that scientists deploy* in judging science."[203] And in doing so, "Rule 706 allows the court at its discretion to procure the assistance of an expert of its own choosing."[204]

Studies suggest that "while the *Daubert* decision itself may have raised judicial scrutiny of scientific evidence across the board, courts in practice engage in essentially the same analysis regardless of whether their jurisdiction is formally *Frye* or *Daubert*."[205] Scholars thus note "that the power of the Supreme Court's *Daubert* decision was not so much in its formal doctrinal test, but rather in its ability to create greater awareness of the problems of junk science. This suggests that courts apply some generalized level of scrutiny when considering the reliability of scientific evidence, regardless of the governing standard."[206] Both ask the same fundamental questions regarding general acceptance in terms of quality and quantity: who (or how many) has to accept what?[207] Over time, however, "the range of reasonable difference" will be determined.[208] In *Kumho*, for instance, the expert's testimony "fell outside the range where experts might reasonably differ."[209]

The focus on methodology in *Daubert*[210] means that "sharply conflicting expert opinions can all pass muster" and "[a]ccepting the expertise of one witness does not entail rejecting the expertise of another witness who has come to the opposite conclusion."[211] With respect to the range of acceptable knowledge, "*Daubert* means that proponents may sometimes present new conclusions based on old data that have led others to contrary conclusions."[212] Yet, the underlying concept of the law of evidence does privilege existing knowledge and, at a very basic level, causes a problem

202 Cheng & Yoon, *supra* note 160, at 471–72.
203 Mueller, *supra* note 197, at 1007 (emphasis added).
204 *Daubert*, 509 U.S. at 595.
205 Cheng & Yoon, *supra* note 160, at 478.
206 *Id.* at 503.
207 ROTHSTEIN, RAEDER & CRUMP, *supra* note 193, at 339–40.
208 *Id.* at 356.
209 Kumho Tire Co. v. Carmichael, 526 U.S. 137, 153 (1999).
210 Daubert v. Merrell Dow Pharm., 509 U.S. 579, 595 (1993) ("The focus, of course, must be solely on principles and methodology, not on the conclusions they generate.").
211 MUELLER & KIRKPATRICK, *supra* note 189, at 651.
212 *Id.* at 650.

for those ahead of the curve.[213] Indeed, the *Daubert* court itself was cognizant of this issue.[214]

Daubert places significant weight on "the scientific method." This mirrors the knowledge community's shared notions of validity and common ways of knowing and reasoning.[215] The judge does not decide on the substantive accuracy of the expert's testimony; likewise, the substantive content of good advice is up to the knowledge community. Both conceptually and from an institutional perspective, then, the law of evidence can inform the treatment of professional advice as a First Amendment matter.

IV. PROFESSIONAL AND UNPROFESSIONAL ADVICE IN PRACTICE

Only good advice should be protected as professional speech. Bad advice is subject to professional malpractice liability, and the First Amendment provides no defense. Applying the theory of First Amendment protection for professional speech based on an understanding of the professions as knowledge communities to a range of controversial cases, this Part illustrates how professional and unprofessional advice can be distinguished. All of the instances discussed in this Part concern *internal* outliers. Characteristically, these professionals' advice may depart from the "mainstream" of the knowledge community, but it is nonetheless based on the same data, using shared methods of knowing and reasoning and a shared methodology in evaluating the data.

A. Tested and Refuted Knowledge

The discussion of tested and refuted knowledge provides examples of the outright misuse of data, as in the MMR vaccine study, as well as the migration of once-accepted advice from the center to the periphery and eventually outside of the realm of shared knowing and reasoning or, in the language of *Kumho*, "outside the range where experts might reasonably differ."[216] Proponents of conversion therapy, as will be shown, are in the pro-

213 *See* ROTHSTEIN, RAEDER & CRUMP, *supra* note 193, at 351 ("Many post-*Daubert* civil cases have been similarly cautious about admitting scientific evidence.").

214 *Daubert*, 509 U.S. at 597 ("We recognize that, in practice, a gatekeeping role for the judge, no matter how flexible, inevitably on occasion will prevent the jury from learning of authentic insights and innovations.").

215 *Cf.* Jennifer E. Laurin, *Criminal Law's Science Lag: How Criminal Justice Meets Changed Scientific Understanding*, 93 TEX. L. REV. 1751, 1758 (2015) ("[I]t is not too idealized a view of expert testimony to acknowledge that scientific experts are commonly accountable to a broader professional community that provides greater accountability and indicia of reliability than many fact witnesses.").

216 Kumho Tire Co., Ltd. v. Carmichael, 526 U.S. 137, 153 (1999); *see also supra* note 209 and accompanying text.

cess of shifting from internal to external outliers. The treatment of expert witnesses in recent conversion therapy litigation reflects this shift.

One way in which formerly good professional advice can become unprofessional advice is through advances in the field. Hypotheses are subject to falsification, and when insights are tested and refuted, the result is that knowledge based on this data is rejected by the field. One court summed up this situation as follows: "[T]he theory that homosexuality is a disorder is not novel but – like the notion that the earth is flat and the sun revolves around it – instead is outdated and refuted."[217] Putting aside whether this characterization is exactly on point, the notion underlying this statement is what matters: something that once was believed to be axiomatic has been rejected by the knowledge community.[218]

1. MMR Vaccine

In early 2015, reports of a measles outbreak originating at Disneyland in California brought renewed focus to communities refusing to vaccinate children.[219] Aside from medical reasons that make vaccination impossible,[220] parents cited either religious or "lifestyle" objections. In some instances, those parents relied on a discredited, and subsequently retracted, study that linked childhood mumps, measles and rubella ("MMR") vaccinations to autism.[221] As Erwin Chemerinsky and Michele Goodwin discuss, there was a noticeable increase in parents refusing to vaccinate their

217 Opinion Relating to Plaintiff's Motion to Bar JONAH's Experts at *24, Ferguson v. JONAH, No. HUD-L-5473-12, 2015 WL 609436, at *9 (N.J. Super. Ct. Law Div. Feb. 5, 2015) (granting plaintiffs' motion to bar five of JONAH's experts and partially granting their motion to bar the sixth).

218 *See also* Marie-Amélie George, *Expressive Ends: Understanding Conversion Therapy Bans*, 68 ALA. L. REV. 793 (2017) (tracing the history of the move of conversion therapy out of the medical mainstream).

219 *See, e.g.*, Editorial, *Reckless Rejection of the Measles Vaccine*, N.Y. TIMES (Feb. 3, 2015), https://www.nytimes.com/2015/02/03/opinion/reckless-rejection-of-the-measles-vaccine.html.

220 Tamar Lewin, *Sick Child's Father Seeks Vaccination Requirement in California*, N.Y. TIMES (Jan. 29, 2015), http://www.nytimes.com/2015/01/29/us/father-of-boy-with-leukemia-asks-california-school-officials-to-bar-unvaccinated-students.html.

221 Michael Specter, *A Death from Measles*, THE NEW YORKER (July 3, 2015), http://www.newyorker.com/news/news-desk/a-death-from-measles; Clyde Haberman, *A Discredited Vaccine Study's Continuing Impact on Public Health*, N.Y. TIMES (Feb. 1, 2015), https://www.nytimes.com/2015/02/02/us/a-discredited-vaccine-studys-continuing-impact-on-public-health.html (both discussing AJ Wakefield et al., *Ileal-lymphoid-nodular Hyperplasia, Non-specific Colitis, and Pervasive Developmental Disorder in Children*, 351 THE LANCET 637 (1998) (Retracted)); s*ee also* The Editors of The Lancet, *Retraction—Ileal-lymphoid-nodular Hyperplasia, Non-specific Colitis, and Pervasive Developmental Disorder in Children*, 375 THE LANCET 445 (2010).

children based on a "medically unsupported theory that inoculation could lead to autism among children."[222]

While the question of objections to vaccinations primarily concerns claims of parental rights and religious exemptions,[223] not professional advice, the discredited autism link illustrates an instance of "tested and refuted" knowledge. The autism link ostensibly was established by interpreting the knowledge community's shared body of knowledge, using scientific methodology. But the study was flawed,[224] and the knowledge community refuted its assertions.[225] In short, the study failed to survive the knowledge community's test of falsification. In addition, the author of the study was stripped of his medical license.[226] This, in a sense, represents the easy case of tested and refuted knowledge.

2. Conversion Therapy

One particularly rich and currently unfolding example of how previously accepted advice becomes bad advice involves the now-discredited practice of conversion therapy or "sexual orientation change efforts" ("SOCE"). Most recently, Connecticut passed legislation prohibiting licensed mental health providers from offering conversion therapy for minors.[227] Such laws are also in effect in California,[228] New Jersey,[229] Oregon,[230] Illinois,[231] and the District of Columbia.[232] Similar legislation is pending in a number of other states,[233] and federal legislation was introduced in the House in May 2015.[234] The Governor of New York implemented measures aimed at end-

222 Erwin Chemerinsky & Michele Goodwin, *Compulsory Vaccination Laws Are Constitutional*, 110 NW. U. L. REV. 589, 591–92 (2016) (discussing the effects of the discredited Wakefield study).

223 *See id.* at 604–11 (explaining "why neither the claimed right of religious freedom nor the asserted right of parents to control the upbringing of their children justifies a constitutional exemption from compulsory vaccination requirements").

224 *Id.* at 591.

225 *Id.* at 592 (noting that "subsequent research disproved Wakefield's findings").

226 Nicholas Kristof, *The Dangers of Vaccine Denial*, N.Y. TIMES (Feb. 7, 2015), http://www.nytimes.com/2015/02/08/opinion/sunday/nicholas-kristof-the-dangers-of-vaccine-denial.html.

227 Christine Stuart, *Connecticut Gov. Malloy immediately signs conversion therapy bill*, NEW HAVEN REGISTER (May 10, 2017), http://www.nhregister.com/government-and-politics/20170510/connecticut-gov-malloy-immediately-signs-conversion-therapy-bill.

228 CAL. BUS. & PROF. §§ 865–865.2 Code D. 2, Ch. 1, Art. 15 (West 20135).

229 N.J. REV. STAT. ANN. Title 45 § § 45:1-554 (West 20134).

230 OR. REV. STAT. § 675.850 et seq. (2015).

231 Youth Mental Health Protection Act, 405 ILL. COMP. STAT. 48/1-30Public Act 099-0411 (2016).

232 D.C. CODE § 7-1231.14a01 et seq. (2015).

233 *See #BornPerfect: Laws & Legislation by State*, NAT'L CTR. FOR LESBIAN RIGHTS, http://www.nclrights.org/bornperfect-laws-legislation-by-state/ (last visited Mar. 18, 2017).

234 H.R. 2450, 114th Cong. (2015). Moreover, pending resolutions H.R. Con. Res. 36, 114th Cong. (2015) ("Expressing the sense of Congress that conversion therapy, including efforts by mental

ing conversion therapy by executive action.[235] During the Obama administration, the White House[236]—and most importantly for present purposes, the Surgeon General[237]—came out against conversion therapy. Federal appellate courts upheld the California and New Jersey legislation, respectively, but took diametrically opposed approaches in doing so.[238] In addition to constitutional challenges under the Free Speech Clause of the First Amendment, the legislation has been upheld against Free Exercise and Establishment Clause challenges.[239]

From the perspective of mental health professionals, advising minors to subject themselves to conversion therapy has become unprofessional advice.[240] In response to an Oklahoma bill to protect conversion therapy,

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health practitioners to change an individual's sexual orientation, gender identity, or gender expression, is dangerous and harmful and should be prohibited from being practiced on minors.") and S. Res. 184, 114th Cong. (2015) ("Expressing the sense of the Senate that conversion therapy, including efforts by mental health practitioners to change the sexual orientation, gender identity or gender expression of an individual, is dangerous and harmful and should be prohibited from being practiced on minors.").

235 Jesse McKinley, *Cuomo Moves Against Therapy That Claims to Make Gay Children Straight*, N.Y. TIMES (Feb. 6, 2016), https://www.nytimes.com/2016/02/07/nyregion/cuomo-moves-against-therapy-that-claims-to-make-gay-children-straight.html.

236 Valerie Jarrett, *Petition Response: On Conversion Therapy*, OBAMA WHITE HOUSE (Apr. 8, 2015, 8:42 PM), https://obamawhitehouse.archives.gov/blog/2015/04/08/petition-response-conversion-therapy.

237 Sunnivie Brydum, *U.S. Surgeon General Opposes Conversion Therapy*, THE ADVOCATE (Apr. 10, 2015, 4:58 PM), http://www.advocate.com/ex-gay-therapy/2015/04/10/watch-us-surgeon-general-opposes-conversion-therapy.

238 *Compare* Pickup v. Brown, 728 F.3d 1042, 1048 (9th Cir. 2013) (upholding California conversion therapy law as permissible regulation of *conduct*), *with* King v. Governor of N.J., 767 F.3d 216, 246 (3d Cir. 2014) (upholding New Jersey conversion therapy law as permissible regulation of *speech*). Despite the circuit split on this issue, the Supreme Court denied certiorari in King v. Christie, 135 S. Ct. 2048 (2015).

239 *See* Welch v. Brown, 58 F. Supp. 3d 1079, 1092 (E.D. Cal. 2014) (upholding California conversion therapy law against Free Exercise and Establishment Clause challenges), *aff'd* 834 F.3d 1041 (9th Cir. 2016).

240 *See, e.g.*, Brief for Am. Ass'n for Marriage & Family Therapy-N.J. Div. et al. as Amici Curiae Supporting Defendants-Appellants, King v. Governor of N.J., 767 U.S. 216 , (2014) (No. 13-4429), 2014 WL 991477, at 4 (stating that the New Jersey conversion therapy law "reflects a broad consensus of responsible medical and mental health experts that efforts to change a child's sexual orientation may cause harm to the child, and that the use of Sexual Orientation Change Efforts ('SOCE') provides no benefits that derive from SOCE itself and that could not be achieved through competent professional counseling that does not attempt to change sexual orientation . . . . [T]he statute is based on the current scientific understanding that homosexuality is not a mental disorder that can or should be 'cured.'"). The amicus brief concludes:

> As the medical and mental health communities have made clear for the last forty years, homosexuality is not a mental disorder in need of a "cure." The medical and mental health communities have advised against practices that attempt to change an individual's sexual orientation because such attempts can cause long-term harm, particularly in the case of minors.

Id. at 23.

members of the profession articulated their opposition based on professional insights.[241]

In *Ferguson et al. v. JONAH*, Jews Offering New Alternatives for Healing ("JONAH," f/k/a Jews Offering New Alternatives to Homosexuality), a New Jersey court after jury trial found conversion therapy providers to be engaged in consumer fraud.[242] This case is particularly instructive precisely for its treatment of expert testimony and the limits set to the scope of valid professional knowledge. In the course of that litigation, experts called to testify on the benefits of conversion therapy were excluded,[243] illustrating how a once-accepted practice has been eliminated from the canon of professional knowledge—from being offered by internal outliers to being offered by external outliers. While the pretrial ruling has no formal precedential effect, it did make the national news as a noteworthy development in conversion therapy litigation.[244]

Plaintiffs in the case argued that the expert testimony should be excluded because, first, "it is a scientific fact that homosexuality is not a disorder, but rather it is a normal variation of human sexuality, and thus any expert opinion concluding that homosexuality is a disorder is inadmissible."[245] They based this assertion on the American Psychiatric Association's 1973 removal of homosexuality as a mental disorder from the Diagnostic and Statistical Manual of Mental Disorders ("DSM"), which was followed by professional organizations domestically and worldwide.[246] Second, plaintiffs argued, "because the belief that homosexuality is a mental disorder is false and lacks any basis in science, any expert opinion that is derived from

241 William S. Meyer, *Duke Psychiatry Professor: Sally Kern's Conversion Therapy Bill Would Do Irreparable Harm to Oklahoma Children*, TULSA WORLD (Mar. 8, 2015, 12:15 AM), http://www.tulsaworld.com/opinion/othervoices/duke-psychiatry-profes . . . herapy-bill-would/article_c97265a5-3cd9-508d-918b-0f81036bba59.html.

242 Erik Eckholm, *In a First, New Jersey Jury Says Group Selling Gay Cure Committed Fraud*, N.Y. TIMES (June 25, 2015), https://www.nytimes.com/2015/06/26/nyregion/new-jersey-jury-says-group-selling-gay-cure-committed-fraud.html.

243 Opinion Relating to Plaintiff's Motion to Bar JONAH's Experts at 26, Ferguson v. JONAH, No. HUD-L-5473-12, 2015 WL 609436, at *9 (N.J. Super. Ct. Law Div. Feb. 5, 2015) (granting plaintiffs' motion to bar five of JONAH's experts and partially granting their motion to bar the sixth).

244 *See, e.g.*, Jason Grant, *Selling Cure for Being Gay Found Illegal in New Jersey*, N.Y. TIMES (Feb. 13, 2015), https://www.nytimes.com/2015/02/14/nyregion/selling-cure-for-being-gay-found-illegal-in-new-jersey.html; Olga Khazan, *Can Sexuality Be Changed?*, THE ATLANTIC (June 3, 2015), http://www.theatlantic.com/health/archive/2015/06/can-sexuality-be-changed/394490/; Olga Khazan, *When the Therapist Is A Quack*, THE ATLANTIC (June 4, 2015), http://www.theatlantic.com/health/archive/2015/06/when-your-therapist-is-a-quack/394886/; Olga Khazan, *The End of Gay Conversion Therapy*, THE ATLANTIC (June 26, 2015), http://www.theatlantic.com/health/archive/2015/06/the-end-of-gay-conversion-therapy/396953/.

245 Opinion Relating to Plaintiff's Motion to Bar JONAH's Experts at 12, Ferguson v. JONAH, No. HUD-L-5473-12, 2015 WL 609436, at *4 (N.J. Super. Ct. Law Div. Feb. 5, 2015).

246 *Id.*

that false initial premise is unreliable and should be excluded."[247] Moreover, they noted that "because their belief that homosexuality is a disorder conflicts with the understanding held by every legitimate professional association, these experts have banded together under NARTH's umbrella."[248] JONAH, by contrast, claimed that "reliance on the DSM is misplaced because the removal of homosexuality was a political, rather than scientific, decision."[249] Moreover, defendants insisted on "their experts' clinical experience in SOCE" and the soundness of their methods.[250]

In excluding the expert witnesses, the judge stated: "The overwhelming weight of scientific authority concludes that homosexuality is not a disorder or abnormal. The universal acceptance of that scientific conclusion—save for outliers such as JONAH—requires that any expert opinions to the contrary must be barred."[251] Turning to the question of reliability, since the litigation occurred in New Jersey state court, the *Frye* standard governed.[252] Applying the general acceptance standard, the court noted that "the DSM is unquestionably authoritative in the mental health field," citing several instances in which other courts have found so.[253] With respect to the allegation that the decision to remove homosexuality from the DSM was political rather than scientific, the court stated that "a trial court should not substitute its judgment for that of the relevant scientific community."[254] Nonetheless, the court did note in a footnote that "the APA does, in fact, provide a scientific reason for its decision to remove homosexuality as a disorder."[255] Whether the APA's decision to "generally accept that homosexuality is not a disorder" was correct, however, "is not a proper inquiry for a court."[256]

Expanding on the meaning of "general acceptance," the court noted that it "is not an end in itself. Nevertheless, general acceptance constitutes strong—some might say conclusive—indicia of whether a sufficient level

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247 *Id.*

248 *Id.*; *see also supra* notes 102–105 and accompanying text (discussing the formation of NARTH in opposition to the American Psychiatric Association's stance on homosexuality).

249 Opinion Relating to Plaintiff's Motion to Bar JONAH's Experts at 15, *JONAH*, 2015 WL 609436, at *5.

250 *Id.*

251 *Id.* at *6.

252 *Id.* at *7 (citing Frye v. United States, 293 F. 1013, 1014 (D.C. Cir. 1923)); *id.* at *9 ("The correct legal standard here is Frye's general acceptance standard.").

253 *Id.* at *7.

254 *Id.* at *8 (citation and internal quotation marks omitted).

255 *Id.* at *8 n.3.

256 *Id.* at *8 ("It is not a proper inquiry for a court to determine the correctness of the APA's decision to generally accept that homosexuality is not a disorder, and no proper basis has been advanced on which a court may reassess the scientific accuracy of the psychiatric categorization of homosexuality.").

of reliability has been achieved."[257] Indeed, "[c]ountless organizations have followed the APA's lead in removing homosexuality from its listings of mental disorders."[258] Although JONAH argued that a more flexible standard governing "a new technique or theory" should apply,[259] the court noted that this case presented the exact opposite situation: while homosexuality was listed in the DSM in the past, it has been removed.[260] And "JONAH has not identified any case that provides a standard for the admission of obsolete and discredited scientific theories. By definition, such theories are unreliable and can offer no assistance to the jury, but rather present only confusion and prejudice."[261]

Moreover, the court addressed the question of unanimity with respect to the general acceptance standard, concluding that "JONAH also cannot point to the existence of NARTH to counter the general acceptance standard. This argument, which assumes that general acceptance requires unanimity, is incorrect."[262] Thus, "general acceptance does not depend on unanimous or universal agreement within the scientific community."[263]

> The existence of a minority of conversion therapy proponents does not and cannot negate the fact that the DSM and its exclusion of homosexuality are generally accepted in the mental health field. Furthermore, a group of a few closely associated experts cannot incestuously validate one another as a means of establishing the reliability of their shared theories.[264]

Finally, the court did take up the methodology question:

> Although not necessary to this decision, one cannot fail but notice that several of the JONAH experts' reports are riddled with methodological errors that also render their opinions inadmissible; these include the refusal to consider studies that do not support their views, and the plagiarism of another JONAH expert's prior work without independent research or analysis.[265]

In the end, the court rightly deferred to the knowledge community's insights. In excluding the expert witnesses, it mirrored the current state of the profession's standard of good professional advice.

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257 *Id.* (citation omitted).

258 *Id.* (further noting that "JONAH hardly can argue that *all* of these organizations—including a federal appellate court—were the victims of manipulation by 'gay lobbying' groups. Regardless, it is not up to this court to decide that question.").

259 *Id.*

260 *Id.* at *9.

261 *Id.*

262 *Id*.

263 *Id*. (quoting State v. Tate, 505 A.2d 941, 950 (N.J. 1986)).

264 *Id.*

265 *Id.* at n.4.

B. Emergent Knowledge

The discussion of emergent knowledge that follows illustrates a shift in the opposite direction: using medical marijuana as an example, outliers' advice can become more widely accepted in the field. The medical marijuana cases illustrate the shift from the fringe of the knowledge community toward the center—when the mainstream of the profession subsequently catches up with the "guy ahead of the curve." As already mentioned, as a matter of evidence law, the *Daubert* court recognized that an approach that privileges existing knowledge harbors the risk of stifling innovation. Here, the perfect congruence of First Amendment protection and tort liability is challenged.

State regulation of off-label drug use provides an example of innovative or generally accepted advice within the knowledge community that conflicts with a state-imposed regulatory scheme restricting professional advice. The off-label drug use example illustrates how state regulation and professional insights collide when the state seeks to restrict professional advice. Here, the need for a dynamic system of deference to the knowledge community becomes clear.

1. Medical Marijuana

In contrast to tested and refuted knowledge, emergent knowledge by definition is generally untested. The medical marijuana cases provide an example of how emergent and untested knowledge can gain traction within the knowledge community and advance to an accepted position. One key question in this context is whether marijuana has medical use, and who determines whether it does or does not.[266] The federal government continues to adhere to the view "that marijuana has no currently accepted medical use in treatment in the United States."[267] The D.C. Circuit affirmed the government's determination.[268] But the medical community's views on medi-

266 The Controlled Substances Act, 21 U.S.C. §§ 801–889 (2012), classifies drugs in five Schedules. Schedule I controlled substances have "no currently accepted medical use in treatment in the United States." *See, e.g.*, Conant v. McCaffrey, No. C 97-00139 WHA, 2000 WL 1281174, at *1 (N.D. Cal. Sept. 7, 2000) (quoting 21 U.S.C. § 812(b)(1)) (discussing the classification of drugs in the medical marijuana context).

267 Editorial, *A Sensible Bill on Medical Marijuana*, N.Y. TIMES (Mar. 11, 2015, at A24); *see also* Conant v. McCaffrey, 172 F.R.D. 681, 701 (N.D. Cal. 1997) (issuing preliminary injunction limiting government's ability to prosecute physicians who recommend use of medical marijuana).

268 *See* All. For Cannabis Therapeutics v. Drug Enf't Admin., 15 F.3d 1131, 1133 (D.C. Cir. 1994) (rejecting Alliance for Cannabis Therapeutics' claim to reclassify marijuana from Schedule I to Schedule II under the Controlled Substances Act).

cal marijuana have shifted over time.[269] The First Amendment question, then, is whether doctors' advice regarding the benefits of medical marijuana is protected professional speech, or whether the government's determination makes it unprofessional advice.

A California initiative, the Compassionate Use Act, took effect in 1996, providing a "right to obtain and use marijuana for medical purposes."[270] The recommendation for use had to be made "by a physician who has determined that the person's health would benefit from the use of marijuana."[271] In the California cases, the district court and the Ninth Circuit alike noted that what is at stake is doctors' ability "on an individualized basis, to give advice and recommendations."[272] Pursuant to federal policy, "the government confirmed that it would prosecute physicians, revoke their prescription licenses, and deny them participation in Medicare and Medicaid for recommending medical marijuana."[273] With respect to the doctors' First Amendment claim, plaintiffs asserted that the policy prevents them from "offer[ing] patients their best medical judgment regarding the use of marijuana to treat disease."[274] The government clarified its position, stating that it "does not prohibit physicians from discussing the risks and benefits of marijuana" and that it did not seek to "prevent physicians from communicating their professional judgments regarding the risks and benefits of any course of treatment."[275] Nonetheless, physicians are not allowed to "provide their patients with oral or written statements in order to enable them to obtain controlled substances in violation of federal law."[276]

Granting a preliminary injunction, the district court noted that "physicians contend they have censored their medical advice to patients," and "patients allege that as a result of the government's policy, they no longer

269 Philip M. Boffey, Editorial, *What Science Says About Marijuana*, N.Y. TIMES (July 30, 2014), https://www.nytimes.com/2014/07/31/opinion/what-science-says-about-marijuana.html; Aaron E. Carroll, *How 'Medical' Is Marijuana?* N.Y. TIMES (July 20, 2015), https://www.nytimes.com/2015/07/21/upshot/is-there-anything-actually-medical-about-medical-marijuana.html; *see also* Deepak Cyril D'Souza & Mohini Ranganathan, Editorial, *Medical Marijuana: Is the Cart Before the Horse?*, 313 J. AM. MED. ASS'N 2431 (2015) (emphasizing factors that support the argument against the need for the use of medical marijuana).

270 *Conant*, 172 F.R.D. at 685–86.

271 *Id.* at 686.

272 *Id.*; *see also* Conant v. Walters, 309 F.3d 629, 644 (9th Cir. 2002) ("[I]nformation obtained from chat rooms and tabloids cannot make up for the loss of individualized advice from a physician with many years of training and experience.").

273 *Conant*, 172 F.R.D. at 686. The federal policy was upheld in *Pearson v. McCaffrey*. 139 F. Supp. 2d 113, 125 (D.D.C. 2001).

274 *Conant*, 172 F.R.D. at 686.

275 *Id.* at 688.

276 *Id.*

trust in their physicians' advice."[277] Finding the speech to be protected by the First Amendment, the court concluded that the government may only prosecute California physicians if "it has probable cause to charge under the federal aiding and abetting and/or conspiracy statutes."[278] The court thus protected the scope of professional advice consistent with the knowledge community's emergent knowledge, despite ongoing scientific debate. The Ninth Circuit subsequently agreed with the district court's assessment on the First Amendment issue, noting that "[t]he government policy does . . . strike at core First Amendment interests of doctors and patients."[279]

In these cases, the characterization of medical knowledge on the benefits of marijuana reveals the changing nature of the profession's insights. In 1997, the district court stated that "a majority of Californians, and many physicians, apparently believe that medical marijuana may be a safe and effective treatment."[280] By the time the controversy reached the Ninth Circuit, Judge Alex Kozinski characteristically made the point very clear:

> To those unfamiliar with the issue, it may seem faddish or foolish for a doctor to recommend a drug that the federal government finds has "no currently accepted medical use in treatment in the United States." But the record in this case, as well as the public record, reflect *a legitimate and growing division of informed opinion* on this issue. A surprising number of health care professionals and organizations have concluded that the use of marijuana may be appropriate for a small class of patients who do not respond well to, or do not tolerate, available prescription drugs.[281]

Summarizing professional findings on the matter,[282] he concluded that "there is a genuine difference of expert opinion on the subject, with significant scientific and anecdotal evidence supporting both points of view."[283] For patients, "obtaining candid and reliable information about a possible avenue of relief is of vital importance."[284] On a matter of emergent

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277 *Id.* at 690. The opinion further notes one of the results is that "physicians . . . are unable to advise patients about safe use of marijuana or guide proper use of marijuana for treatment." *Id.* at 691.

278 *Id.* at 701; Conant v. McCaffrey, No. C 97-00139 WHA, 2000 WL 1281174, at *16 (N.D. Cal. Sept. 7, 2000) (granting in part and denying in part cross-motions for summary judgment; dissolving preliminary injunction; entering permanent injunction); *see also* Haupt, *supra* note 6, at 1300–01 (discussing the question of First Amendment protection of doctors' speech in these cases).

279 Conant v. Walters, 309 F.3d 629, 636 (9th Cir. 2002) ("An integral component of the practice of medicine is the communication between a doctor and a patient. Physicians must be able to speak frankly and openly to patients.").

280 *Conant*, 172 F.R.D. at 686.

281 *Conant*, 309 F.3d at 640–41 (Kozinski, J., concurring) (emphasis added) (citation omitted).

282 *Id.* at 641–42.

283 *Id.* at 643.

284 *Id.*

knowledge, then, the First Amendment rightly protects differing opinions as good professional advice.

Beyond the First Amendment context, the shift from the periphery to the core of professional knowledge is also reflected to a certain extent in the treatment of expert testimony in *United States v. Oakland Cannabis Buyers' Cooperative* ("*OCBC"*)[285] and *Gonzales v. Raich*.[286] OCBC argued that "a drug may not yet have achieved general acceptance as a medical treatment but may nonetheless have medical benefits to a particular patient or class of patients."[287] Justice Thomas, writing for the Court, however, "decline[d] to parse the statute in this manner."[288] As Jessie Hill noted, "despite the fact that the patients in *OCBC* presented evidence, unrefuted by the Government, that marijuana may have legitimate medical uses and may be the only appropriate treatment for some patients, the Court refused to consider that evidence, finding itself to be powerless to override a conclusory and controversial congressional finding."[289]

Four years later, in *Gonzales v. Raich*, a Commerce Clause case, Justice Stevens noted that "[t]he case is made difficult by respondents' strong arguments that they will suffer irreparable harm because, despite a congressional finding to the contrary, marijuana does have valid therapeutic purposes."[290] Justice Thomas in dissent further pointed out that "the Medical Board of California has issued guidelines for physicians' cannabis recommendations, and it sanctions physicians who do not comply with the guidelines."[291] These cases did not hinge on the knowledge community's professional knowledge, but they demonstrate how courts do or do not deal with changing professional insights when emergent knowledge is at issue.

2. Off-Label Use

In order to gain approval by the Food and Drug Administration ("FDA"), prescription drugs must pass rigorous clinical trials. Upon approval of the medication, the FDA approves labeling that includes the chemical composition, the mechanism of action, and the regimen upon which approval is based. But once the FDA has approved the drug, physi-

285 532 U.S. 483, 486 (2001) (holding that no implied medical necessity exception exists for the Controlled Substances Act).

286 545 U.S. 1, 9 (2005) (holding that application of the Controlled Substances Act to intrastate growers and users of medical marijuana does not violate the Commerce Clause).

287 *OCBC*, 532 U.S. at 493.

288 *Id.*

289 B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277, 294 (2007).

290 *Gonzales*, 545 U.S. at 9.

291 *Id.* at 62 (Thomas, J., dissenting).

cians are free to prescribe it to treat illnesses and patients beyond those in the trials.[292] This is known as "off-label" or "evidence-based" use; as of 2008, over one-fifth of prescriptions in the United States fell into this category.[293]

Off-label use raises numerous First Amendment questions. In addition to free speech questions related to the marketing of drugs,[294] there is a First Amendment issue directly at the heart of professional advice. Scholars have noted that "if FDA were to proscribe off-label uses of drugs, it would interfere with physicians' judgments about how to treat their patients, which is forbidden by the [Food, Drug, and Cosmetics Act]."[295] But doctors' freedom to prescribe drugs off-label came into direct conflict with state regulation to limit this ability in the abortion context. Several states, including Texas,[296] Ohio,[297] and Oklahoma,[298] passed legislation requiring doctors to follow FDA protocol for medication abortions. Yet, the Oklahoma Supreme Court noted that off-label use is "common, permissible, and can be required by good medical practice."[299] This type of legislation represents an instance of the legislature determining against the insights of the profession what should be considered good professional advice. In effect, the legislature in these cases codifies previously good advice that has attained internal outlier status by subsequent innovation and advances in the

292 *See* 21 U.S.C. § 396 (2012) ("Nothing in this chapter shall be construed to limit or interfere with the authority of a health care practitioner to prescribe or administer any legally marketed device to a patient for any condition or disease within a legitimate health care practitioner-patient relationship.").

293 Jacob Rogers, *Freedom of Speech and the FDA's Regulation of Off-Label Drug Uses*, 76 GEO. WASH. L. REV. 1429, 1429 (2008).

294 Generally, off-label uses may not be used for promotion of prescription drugs which raises First Amendment questions. *See, e.g.*, Christopher Robertson, *When Truth Cannot Be Presumed: The Regulation of Drug Promotion under an Expanding First Amendment*, 94 B.U. L. REV. 545, 551 (2014); Steven R. Salbu, *Off-Label Use, Prescription and Marketing of FDA-Approved Drugs: An Assessment of Legislative and Regulatory Policy*, 51 FLA. L. REV. 181, 199–200 (1999); Gina Shaw, *Is Off-Label Marketing a First Amendment Right?*, 9 NEUROLOGY TODAY 20, 20 (2009); Rodney A. Smolla, *Off-Label Drug Advertising and the First Amendment*, 50 WAKE FOREST L. REV. 81, 81 (2015); Dina McKenney, Note, *Off-Label Drug Promotion and the Use of Disclaimers*, 92 TEX. L. REV. 231, 238 (2013).

295 Robertson, *supra* note 294, at 548.

296 *See* Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott, 748 F.3d 583, 600–05 (5th Cir. 2014) (upholding Texas law requiring physicians to follow FDA protocol).

297 *See* Planned Parenthood Sw. Ohio Region v. DeWine, 696 F.3d 490, 504–06 (6th Cir. 2012) (upholding Ohio law requiring adherence to the FDA protocol).

298 *See* Okla. Coal. for Reprod. Justice v. Cline, 292 P.3d 27, 27 (Okla. 2012) (holding Oklahoma statute facially unconstitutional), *cert. granted*, 133 S. Ct. 2887 (2013), *certified question answered,* 313 P.3d 253 (Okla. 2013), *cert. dismissed as improvidently granted*, 134 S. Ct. 550 (2013).

299 Cline v. Okla. Coal. for Reprod. Justice, 313 P.3d 253, 258 (Okla. 2013).

field. Professional advice based on this emergent knowledge has become good advice.

The FDA approved mifepristone ("RU-486") in 2000. In doing so, it "approved a specific regimen for administering mifepristone, but soon thereafter abortion providers began to change the protocol."[300] After the drug was approved, "additional clinical trials led to the development of new protocols for administering" it.[301] Under the new regimen, the dosage of mifepristone was reduced to one-third of the original dosage. Moreover, women could self-administer a second drug at home. The length of time during which the drugs could be administered was extended under the new regimen.[302] The second drug, "[m]isoprostol[,] has not been approved by the FDA for use in abortions but has been approved by the FDA to treat ulcers."[303] An alternative evidence-based regimen "involve[s] the use of methotrexate," a drug whose "FDA-approved label . . . is silent on abortion-related uses."[304] The Oklahoma and Ohio legislatures passed legislation requiring that doctors follow the FDA protocol.[305]

In requiring doctors to prescribe drugs contrary to professional practice, the legislation seeks to bind doctors to the uses indicated on the label. In short, the legislature determines against the knowledge community's insights what constitutes good professional advice. Stated another way, the state requires doctors to dispense unprofessional advice. In these cases, the courts did not consider the First Amendment implications of limiting professional advice. Given the newly fractured landscape among federal appellate courts regarding the proper interpretation of the First Amendment implications of *Planned Parenthood v. Casey*,[306] this area of the law ap-

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300 Caitlin E. Borgmann, *Abortion Exceptionalism and Undue Burden Preemption*, 71 WASH. & LEE L. REV. 1047, 1056 (2014).

301 *Cline*, 313 P.3d at 258.

302 *Id.*

303 *Id.*

304 *Id.*

305 The FDA changed the mifepristone guidelines in Spring 2016. *Mifeprex (mifepristone) Information*, FDA.GOV, http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111323.htm (last updated Mar. 30, 2016); *see also* Sabrina Travernise, *New F.D.A. Guidelines Ease Access to Abortion Pill*, N.Y. TIMES (Mar. 30, 2016), https://www.nytimes.com/2016/03/31/health/abortion-pill-mifeprex-ru-486-fda.html.

306 505 U.S. 833 (1992). The somewhat cryptic passage in *Casey* dealing with the First Amendment states:

> All that is left of petitioners' argument is 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. To be sure, the physician's First Amendment rights not to speak are implicated, see *Wooley v. Maynard*, 430 U.S. 705 (1977), but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State, cf. *Whalen v. Roe*, 429 U.S. 589, 603 (1977). We see no constitutional infirmity in the requirement that the physician provide the information mandated by the State here.

Id. at 884.

pears to be in flux.[307] The Fourth Circuit fundamentally challenged the Fifth and Eighth Circuits' positions on professional speech in the abortion context. Judge J. Harvie Wilkinson noted that "[t]he single paragraph in *Casey* does not assert that physicians forfeit their First Amendment rights in the procedures surrounding abortions . . . ."[308] With respect to the relationship between the undue burden standard and the First Amendment, he further pointed out: "The fact that a regulation does not impose an undue burden on a woman under the due process clause does not answer the question of whether it imposes an impermissible burden on the physician under the First Amendment."[309] In short, First Amendment protection of professional speech in the abortion context is unresolved by *Casey* and newly disputed among the circuits.

The theory of professional speech focused on the professions as knowledge communities resolves the issue in favor of First Amendment protection of professionals' advice from state interference. The FDA as licensing body, moreover, should not determine the limits of professional advice.[310] In fact, this is what the Food, Drug and Cosmetics Act explicitly states: "Nothing in this chapter shall be construed to limit or interfere with the authority of a healthcare practitioner to prescribe or administer any legally marketed device to a patient for any condition or disease within a legitimate healthcare practitioner-patient relationship."[311]

Citing this provision, the Oklahoma Supreme Court noted the departure in the abortion context from the usual deference awarded to physicians' professional judgment.[312] Permitting off-label use acknowledges the fact that professional knowledge is not static: "Researchers continue to perform clinical trials, doctors continue to gain experience, and widespread use of a particular treatment allows the medical community to collect data about

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307 *See* Stuart v. Camnitz, 774 F.3d 238, 248 (4th Cir. 2014) (rejecting the Fifth and Eighth Circuits' interpretation of constitutionality of abortion regulations under the First Amendment) *cert. denied sub nom.* Walker-McGill v. Stuart, 135 S. Ct. 2838 (2015); *see also* Scott W. Gaylord, Casey *and the First Amendment: Revisiting an Old Case to Resolve a New Compelled Speech Controversy*, 66 S.C. L. REV. 951, 951–53 (2015) (highlighting states' varying approaches to compelling doctors' speech and uncertainty concerning the constitutionality of those approaches).

308 *Stuart*, 774 F.3d at 249.

309 *Id.*

310 The divergence was eliminated in the 2016 updated guidelines. Travernise, *supra* note 305 ("The American Congress of Obstetricians and Gynecologists said in a statement that it was 'pleased that the updated F.D.A.-approved regimen for mifepristone reflects the current available scientific evidence and best practices.'").

311 21 U.S.C. § 396 (2012).

312 Cline v. Okla. Coal. for Reprod. Justice, 313 P.3d 253, 262 (Okla. 2013) (noting that this is "[i]n contrast to the deference physicians receive regarding treatment decisions in almost all other areas of medicine").

side effects, alternative doses, and potential new uses for treatments."[313] Leading professional organizations have endorsed the type of off-label use prohibited by the Oklahoma legislation.[314] The court cited the FDA's statement that "[g]ood medical practice and the best interests of the patient require that physicians use legally available drugs, biologics and devices according to their best knowledge and judgment."[315] This is true in all other areas of the law, and it is, in fact, "unprofessional conduct" to prescribe, dispense, or administer "drugs in excess of the amount considered good medical practice . . . ."[316] In conclusion, the Oklahoma Supreme Court emphasized the role of the physician's "knowledge and experience."[317] It agreed with the district court that the legislature's restrictions are "completely at odds with the standard that governs the practice of medicine . . . ."[318] The First Amendment, consequently, should provide a shield against the state's requirement that professionals dispense unprofessional advice. Ultimately, the theory of professional speech and advice-giving offered here supports the Oklahoma Supreme Court's position on off-label drug use and rejects the opposite outcome in the decisions of the Fifth and Sixth Circuit.

CONCLUSION

The First Amendment should provide robust protection for professional speech. The scope of protection has to take into account that a range of professional knowledge may count as good advice. Individual professionals may differ in their individual judgments, but being a professional still implies that they subscribe to a shared body of knowledge. And the shared notions of validity limit the range of professional opinions that may be found valid within the profession.

To the extent that the knowledge community decides that outlier status is encompassed by the range of defensible professional knowledge, state regulation should mirror this. Advice that is given in accordance with this range is good professional advice; what falls outside the scope is unprofessional advice. The client seeks good professional advice, that is, defensible

313 *Id.* at 260.

314 *Id.* at 261 ("Both the American College of Obstetricians and Gynecologists and the World Health Organization have endorsed these alternate regimens as safer and more effective than the now-outdated regimen provided for in mifepristone's FDA-approved label.").

315 *Id.*

316 *Id.* (quoting OKLA. STAT. tit. 59 § 509(16) (2012)).

317 *Cline*, 313 P.3d at 262 ("The role of the physician is to heal the sick and the injured, and physicians are required to undergo rigorous training to develop the required knowledge and experience to perform that role well.").

318 *Id.*

professional knowledge. The First Amendment should provide robust protection for this type of advice, but it does not protect unprofessional advice.