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Physician-Patient Speech: An Analysis of the State of Patients' First Amendment Rights to Receive Accurate Medical Advice

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— Note —

PHYSICIAN-PATIENT SPEECH:
AN ANALYSIS OF THE STATE OF
PATIENTS’ FIRST AMENDMENT
RIGHTS TO RECEIVE ACCURATE
MEDICAL ADVICE

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INTRODUCTION

Visits to the doctor are, for most Americans, a chore. We go to the doctor not because we want to but because doctors have something that we lack: medical expertise.

When we go to the doctor, we are asking her to transfer a limited amount of knowledge about the human body and all of its potential weaknesses to us. The doctor pokes us, shines light on us to see parts of us that go unseen for several months, directs us to cough or spit or urinate or squat, and asks us questions that we may not want to answer. Then, in between periods of waiting that vary between annoying and absurd, the doctor tells us what is wrong with us and what we can do (or not do) about it.

To say that speech is important to this equation would be like saying speech is important to winning a debate; speech is the very mechanism by which the physician-patient relationship functions. A typical doctor visit is bookended by dialogue between physician and patient. At first, the physician asks, and the patient answers, questions in an attempt to diagnose the patient. At the conclusion, the physician returns to give the patient the diagnosis and the recommended treatment plan.

The First Amendment protects “freedom of speech”—the right of each person to be free from government restrictions on many different kinds of speech.¹ While the First Amendment does not protect all speech, it does cover a vast range of expression. The First Amendment gives a person the freedom to wear a jacket with “Fuck the Draft” printed on the back into a courthouse,² a corporation the right to give money to support a political candidate or cause,³ video game store owners the right to sell violent games to minors,⁴ and, as demonstrated below, a doctor the right to recommend that patients use marijuana to treat the symptoms of an illness.⁵

At the same time, however, states have the authority to regulate certain professions, including the medical profession. To be able to practice medicine in a state, a doctor must obtain a license to practice.⁶ The license is issued by a state board and carries with it certain obligations and responsibilities—most of which are concerned with protecting the vulnerabilities that are an inherent part of being a patient.⁷

Patients are inherently vulnerable in their relationships with physicians because physicians have the expertise—the medical knowledge—that each patient needs. This creates an “imbalance of power” between the physician and patient.⁸ This imbalance can be so great that a patient may come to depend on the physician’s expertise “on matters of life and death.”⁹ Indeed, so vulnerable are patients in some

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1. U.S. CONST. amend. I.
 2. *Cohen v. California*, 403 U.S. 15, 16 (1971).
 3. *Citizens United v. FEC*, 558 U.S. 310, 319 (2010).
 4. *Brown v. Entm’t Merchs. Ass’n*, 131 S. Ct. 2729, 2738 (2011).
 5. *Conant v. Walters*, 309 F.3d 629, 632 (9th Cir. 2002).
 6. *E.g.*, *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992) (plurality opinion) (noting that the practice of medicine is subject to “reasonable licensing and regulation by the state”); *Wollschlaeger v. Governor of Fla.* 760 F.3d 1195, 1218–19 (11th Cir. 2014) (quoting *Casey*, 505 U.S. at 884).
 7. *E.g.*, Katharin McCarthy, Note, *Conant v. Walters: A Misapplication of Free Speech Rights in the Doctor-Patient Relationship*, 56 ME. L. REV. 447, 465 (2004) (“[T]he states retain the power to regulate the professional conduct of physicians, even when speech may be used to carry the conduct out . . .”).
 8. AM. COLL. OF PHYSICIANS, ETHICS MANUAL (Lois Snyder ed., 6th ed. 2012), available at http://www.acponline.org/running_practice/ethics/manual/manual6th.htm#physician-patient [hereinafter ACP ETHICS MANUAL]; *Wollschlaeger*, 760 F.3d, at 1214.
 9. *Wollschlaeger*, 760 F.3d, at 1214.

situations that a patient “may be . . . at the mercy of his or her physician.”¹⁰

Risk of exploitation of these vulnerabilities is perhaps at its highest when the physician is communicating with the patient, because that is precisely how and when the transfer of expertise from physician to patient occurs. When a physician tells a patient that the patient needs to undergo, for example, chemotherapy as treatment for malignant cancer, the patient’s life is altered in an instant. This imbalance is exacerbated by the fact that most patients take doctors at their word; one can easily imagine that a patient diagnosed with malignant cancer and prescribed chemotherapy might try to schedule treatment as soon as possible, immediately putting trust in the physician’s diagnosis and treatment recommendation.

Perhaps the most obvious way to correct the physician-patient imbalance is to regulate physicians in a way that protects patients’ interests.¹¹ As discussed above, states have this power as the licensing bodies for the medical profession.

One common manifestation of state protection against physician conduct is the malpractice suit. Using the cancer patient example above, if the physician were to make a mistake when diagnosing the patient with cancer (and then recommending chemotherapy), the patient would, generally speaking, be able to sue the doctor for malpractice in an attempt to be made whole again. The physician who committed the malpractice could not defend her actions in court by saying her diagnosis and treatment were protected by the First Amendment simply because the diagnosis was made and the treatment prescribed through the medium of speech.¹²

All of this is, more or less, commonly understood. What is not commonly understood, however, is the nature of the relationship between the First Amendment and state regulations of the practice of medicine, including regulations stipulating what doctors can, must, and must not say to their patients. Indeed, the intersection of the First Amendment and physician-patient speech has become so utterly

10. *Id.*

11. *See, e.g., id.* at 1215 (“[W]ithout the protections imposed by professional codes of conduct and the law of malpractice, such a patient would have no recourse if the physician chooses to abuse the physician-patient relationship in some way . . .”).

12. Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 950 (“Without so much as a nod to the First Amendment, doctors are routinely held liable for malpractice for speaking . . .”).

confounding that lower federal courts seem to be issuing conflicting opinions each time a physician-patient speech case arises.¹³

Only in passing has the Supreme Court addressed the conflict between the First Amendment and state regulation of physician speech.¹⁴ This has left lower courts to decide entire cases on the basis of single and isolated statements.¹⁵ Because speech is so critical to the proper functioning of the physician-patient relationship—and because courts cannot agree on a proper legal standard for evaluating First Amendment claims in the context of state regulations of physician speech—it is my position that the Supreme Court should intervene and set a clear standard for lower courts. This standard must take account of states' interests in regulating the medical profession: to protect patients' interests in receiving the best possible medical care.

If a constitutional standard for physician-patient speech fails to take adequate account of patients' rights to receive information under the First Amendment, that standard is insufficient. Moreover, by focusing on physician-patient speech from the standpoint of physicians' rights to deliver information to patients,¹⁶ lower federal courts are failing to protect the constitutional rights of patients as a class. It is the rights of patients to receive information from physicians, much more than the rights of physicians to deliver information to patients, that regulation of physician-patient speech threatens.¹⁷ Thus, it is critical for courts to analyze any regulation of physician-patient speech from the perspective of patients.

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13. See *infra* Parts II, III (examining the holdings of five recent physician-patient speech cases and analyzing those cases for conflicts and similarities).
 14. See, e.g., *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992) (plurality opinion) (dismissing the argument for constitutional protection of physician-patient speech in a paragraph).
 15. See, e.g., *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889, 900 (8th Cir. 2012) (turning on the application of the truthful-and-not-misleading test articulated in *Casey*); *Wollschlaeger v. Farmer*, 880 F. Supp. 2d 1251, 1262 (S.D. Fla. 2012) (attempting to apply the *Casey* test), *rev'd sub nom.* *Wollschlaeger v. Governor of Florida*, 760 F.3d 1195 (11th Cir. 2014); Post, *supra* note 12, at 944 (“Although the Court has decided a number of cases about professional advertising, ‘the Supreme Court and lower courts have rarely addressed the First Amendment contours of a professional’s freedom to speak to a client.’” (quoting Daniel Halberstam, *Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions*, 147 U. PA. L. REV. 771, 834 (1999))).
 16. See *infra* Part III.
 17. See Post, *supra* note 12, at 979 (“First Amendment constraints on the regulation of professional physician speech . . . should focus on the right of the patient to receive information, rather than on the right of the doctor to speak as she wishes.”).

In Part I, this Note uses the guidance of scholars to define the contours of the physician-patient speech doctrine. Specifically, Part I attempts to divide physician-patient speech into two categories: physician speech that is equivalent to “conduct” and physician speech that is mere speech. As will be discussed in Part II, the lower courts purport to use these two categories to distinguish between physician speech that is subject to state regulation and physician speech that receives substantial First Amendment protection.

Part II is divided into three sections, each of which explores recent decisions by lower courts and their significance on the greater physician-speech doctrine. Part II.A explains and analyzes two cases from the Ninth Circuit. In *Conant v. Walters*,¹⁸ the Ninth Circuit struck down a federal policy that threatened to punish any physician who would recommend that a patient use marijuana.¹⁹ Interestingly, the Ninth Circuit was forced to distinguish *Conant* in the next case I will discuss, *Pickup v. Brown*,²⁰ which upheld a California law that prohibits licensed mental health care providers from using certain practices to attempt to persuade juveniles to change their sexual orientation.²¹ Part II.B explains and analyzes the Eleventh Circuit’s majority opinion in *Wollschlaeger v. Governor of Florida*,²² which reversed the trial court in the course of upholding a Florida law that prohibits physicians from asking patients if they own guns.²³ Lastly, Part II.C examines the Eighth Circuit’s decision in *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds*,²⁴ which upheld state-mandated physician speech regarding the likelihood of a patient who has had an abortion to commit suicide or experience suicide ideation.²⁵

Part III ties together the cases discussed in Part II by pointing out the similarities and inconsistencies between them in order to establish something along the lines of a loose-fitting “physician-patient speech doctrine.” At the heart of this “doctrine” is a pattern of examining the First Amendment rights at stake from the standpoint of the physician as the deliverer of medical advice, as opposed to the patient as receiver of medical advice.

18. 309 F.3d 629 (9th Cir. 2002).

19. *Id.* at 632.

20. 740 F.3d 1208 (9th Cir. 2014).

21. *Id.* at 1222.

22. 760 F.3d 1195 (11th Cir. 2014).

23. *Id.* at 1203.

24. 686 F.3d 889 (8th Cir. 2012).

25. *Id.* at 900.

Part IV argues that the current doctrine fails to adequately take account of patients' stakes in the outcomes of the cases, as well as in the policy created by a First Amendment jurisprudence that looks at physician speech cases through the narrow lens of the physician as deliverer of medical information. While physicians are subject to state regulation, the patient is not. Because patients are not subject to state regulation, any law that cuts into a patient's First Amendment rights should receive more than rational-basis scrutiny. Furthermore, because the Supreme Court has, time and time again, affirmed the First Amendment rights of a person to *receive* speech,²⁶ that right should enter into any analysis of a regulation that abridges that right.

I ultimately conclude that in order to create a physician-patient speech doctrine that adequately protects patients' interests in receiving frank and open communication from their physicians, courts must analyze the First Amendment issues from the standpoint of patients as the recipients of information.

I. DEFINING THE CONTOURS OF THE PHYSICIAN-PATIENT SPEECH DOCTRINE

"The right of the doctor to advise his patients according to his best lights seems so obviously within First Amendment rights as to need no extended discussion."

—Justice William O. Douglas²⁷

In order to fully grasp the physician-patient speech doctrine's place in the larger context of First Amendment jurisprudence, it is first necessary to understand why some speech by physicians goes unprotected by the Free Speech Clause. In this section, I explain the conflict between the First Amendment and state regulations on the practice of medicine. I will do this by showing (1) why courts might uphold regulations that clearly abridge physician speech without giving the First Amendment a second thought and (2) why courts would not apply the same logic to all regulations that abridge physician speech.

The physician-patient relationship holds, and has held for a long time, a very important role in society.²⁸ Patients depend on physicians

26. See, e.g., *Stanley v. Georgia*, 394 U.S. 557, 564 (1969) ("It is now well established that the Constitution protects the right to receive information and ideas."); *Lamont v. Postmaster Gen.*, 381 U.S. 301, 305 (1965) (recognizing a First Amendment right to receive political publications via the U.S. Postal Service sent from foreign countries); *Bd. of Educ. v. Pico*, 457 U.S. 853, 867 ("[T]he right to receive ideas follows ineluctably from the *sender's* First Amendment right to send them . . .").

27. *Poe v. Ullman*, 367 U.S. 497, 513 (1961) (Douglas, J., dissenting).

to ask appropriate questions and properly explain medical procedures throughout the treatment process.²⁹

Generally speaking, states act as licensing bodies in professional fields.³⁰ In order to ensure that the general public maintains a level of trust in each particular professional field, states have latitude to define minimum acceptable standards of care.³¹

Because the practice of medicine operates through the medium of speech, defining minimum acceptable standards of care often involves rules that compel or restrict speech.³² In *Planned Parenthood v. Casey*,³³ one of the few Supreme Court cases to address physician-patient speech, the Supreme Court upheld a provision in a Pennsylvania statute that compelled physicians to give patients seeking abortions certain information. A plurality of the Justices concluded that the relevant provision permitted Pennsylvania to prescribe the content of this message as part of regulating the standards by which physicians obtain informed consent from their patients about abortion procedures.³⁴ Planned Parenthood challenged the informed consent provision as an impermissible speech compulsion under the First Amendment.³⁵ With little more than a few sentences—and two citations to cases that still seem only marginally relevant to many First Amendment scholars³⁶—the Court dismissed Planned Parenthood’s free speech claim. The Court reasoned that there is “no constitutional infirmity” in compelling speech as part of the regulation of the practice of medicine.³⁷ Applying the Court’s logic

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28. See *Rust v. Sullivan*, 500 U.S. 173, 200 (calling the patient-physician relationship “traditional”).
 29. ACP ETHICS MANUAL, *supra* note 8, at 78. (“Physicians must strive to create an environment in which honesty can thrive and patients feel that concerns and questions are elicited.”).
 30. McCarthy, *supra* note 7, at 465 (“[T]he states retain the power to regulate the professional conduct of physicians, even when speech may be used to carry the conduct out . . .”).
 31. See *id.*
 32. Post, *supra* note 12, at 950.
 33. 505 U.S. 833 (1992).
 34. *Id.* at 884 (plurality opinion).
 35. *Id.*
 36. *Id.* The Court cites to *Wooley v. Maynard* for the proposition that the First Amendment covers the right not to speak. 430 U.S. 705, 705 (1977). But *Maynard* involved a First Amendment challenge to a New Hampshire law requiring the state’s motto to be on all license plates, and had nothing to do with compelled physician speech. Even more mysterious is the citation to *Whalen v. Roe* because *Whalen* did not involve the First Amendment at all. 429 U.S. 589, 589 (1977).
 37. *Casey*, 505 U.S. at 884.

to a malpractice claim, for example, it becomes clear that the Court is correct insofar as it posits that there are at least some situations in which it would be inappropriate to subject a state regulation on physician speech to exacting First Amendment scrutiny. As the Ninth Circuit has put it, “[a] doctor ‘may not counsel a patient to rely on quack medicine. The First Amendment would not prohibit the doctor’s loss of license for doing so.’”³⁸

The next step in defining the doctrine is to address why it would be just as inappropriate, if not more so, to simply say that *all* physician speech should go unprotected by the First Amendment. The relationship between physician and patient is often a nuanced one. A physician is sometimes a friend of a patient, and at other times the physician might be a mentor or role model for a patient. Speech between the physician and the patient therefore cannot be completely controlled by minimum standards of care and malpractice suits. Surely a physician can engage a patient in friendly banter about the weekend’s football game without that speech being subject to regulation by the state. Another example is that of a statement by a physician in public and on a matter of public concern. The First Amendment would not tolerate a state policy that prohibits physicians from speaking out against a war on a city sidewalk simply because of the physician’s profession.³⁹

Dean Robert Post described the distinction illustrated above as the difference between physician-patient speech and speech by a physician.⁴⁰ “Physician-patient speech” is speech made as part of the practice of medicine, such as a physician telling a patient that she should stay off her feet and ice her ankle twice a day. Described in a

38. *Pickup v. Brown*, 740 F.3d 1208, 1228 (9th Cir. 2014) (quoting *Conant v. McCaffrey*, No. C 97-00139, 2000 WL 1281174, at *13 (N.D. Cal. Sept. 7, 2000)).

39. *Id.* at 1227 (“[A] doctor who publicly advocates a treatment that the medical establishment considers outside the mainstream, or even dangerous, is entitled to robust protection under the First Amendment—just as any person is—even though the state has the power to regulate medicine.”); *Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195, 1218 (11th Cir. 2014) (“[First Amendment] protections are at their apex when a professional speaks to the public on matters of public concern . . .”).

40. Post, *supra* note 12, at 947. Dean Post uses the terms “professional speech” and “speech . . . uttered by a professional.” In order to keep the focus on speech made in the context of the physician-patient relationship and to avoid confusion, this Note uses the term “physician-patient speech” for speech made during the course of the professional relationship (also called “conduct”) and “speech by a physician” for speech that, for one reason or another, falls outside that relationship. It bears emphasis that the physician-patient speech doctrine can really be viewed as a narrow subset of the professional speech doctrine and that rarely will there be any important distinctions between physician-patient speech and professional speech for constitutional purposes.

more general way, physician-patient speech is *conduct* because the speech is inseparable from the act of diagnosing or treating the patient.⁴¹

“Speech by a physician,” on the other hand, describes speech made by a physician that is not a part of the practice of medicine. If, for example, “a physician while examining a patient should stumble, twist his ankle, and spontaneously curse, his exclamations would not constitute [physician-patient] speech.”⁴² While this latter example may offend some patients, it will not directly affect the quality of care that the patient receives and so is not, or, as we shall see below, *should* not be, subject to state regulation.⁴³

Lower courts have attempted to rely upon the distinction between physician-patient speech and speech by a physician by identifying the former as “conduct” and the latter as ordinary “speech.”⁴⁴ Using the language of conduct versus speech allows courts to avoid the messy business of attempting to describe the different kinds of speech, including why each deserves its own distinct category complete with an entirely different level of First Amendment protection. A lower court will define speech as conduct if it occurs in a situation the court sees as an inseparable part of a more general conduct.⁴⁵ For example, when a doctor tells a patient to take two pills a day for a week, she is speaking to the patient, but more generally she is *treating* the patient. Lower courts use the opportunity to define the speech within the general category of treatment because defining it by the more particular act of speech makes it difficult to distinguish from other kinds of speech.

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41. *Pickup*, 740 F.3d at 1229 (noting that where a state regulation on physician conduct has an “incidental effect on speech,” First Amendment concerns are lessened); *Wollschlaeger*, 760 F.3d at 1203 (upholding Florida law as a legitimate regulation on physician conduct with only an incidental effect on speech); see also Christina E. Wells, *Abortion Counseling as Vice Activity: The Free Speech Implications of Rust v. Sullivan and Planned Parenthood v. Casey*, 95 COLUM. L. REV. 1724, 1740 (1995) (“The speech/conduct distinction, a recurring one in First Amendment jurisprudence, is grounded in the idea that, while the First Amendment protects freedom of expression, it does not protect mere action.”).
 42. Post, *supra* note 12, at 952.
 43. *Id.* (noting that physician speech is not subject to state regulation if it is not part of the practice of medicine).
 44. See, e.g., *Pickup*, 740 F.3d at 1227–29 (using a “continuum” model to describe the difference between regulations of “conduct,” which receive little First Amendment protection, and speech *about* conduct, which receives some First Amendment protection).
 45. *Id.* at 1229 (“Most, if not all, medical . . . treatments require speech, but that fact does not give rise to a First Amendment claim when the state bans a particular treatment.”).

Unfortunately, it is not always easy to distinguish between speech as conduct and ordinary speech. At least one court has taken the speech as conduct category past the logical limits of the category by defining all speech that occurs within the confines of the examination room as conduct.⁴⁶ Another court has drawn a line between physician recommendations for how to treat an illness (speech) and the actual treatment of that illness by prescribing medication (conduct).⁴⁷

One specific area in which courts have had difficulty distinguishing between physician conduct and physician speech involves informed consent laws.⁴⁸ Generally speaking, the doctrine of informed consent requires physicians to explain to patients their medical conditions and all appropriate courses of action that are reasonably within the physician's knowledge.⁴⁹ The purpose of informed consent is to give the patient information in terms that are clear enough to enable the patient to make autonomous choices about health.⁵⁰ Some informed consent laws, like the one discussed in *Planned Parenthood v. Casey*, compel doctors to give patients a state-mandated message. The *Casey* Court upheld the law by reasoning that the state was simply prescribing the appropriate course of *conduct* for a physician in a certain situation. But what happens if an informed consent law mandates *speech* that goes outside the field of medicine and into the field of philosophy? Moreover, what if an informed consent law compels a physician to tell patients something that is not accepted as

46. See *Wollschlaeger*, 760 F. 3d at 1219 (using a “personal nexus” test to distinguish between permissible state regulations and state regulations subject to First Amendment scrutiny and concluding that the “personal nexus” between physician and patient is at its highest “within the confines of the physician’s examination room,” and thus the state is most free to regulate physicians within the physical space of the examination room).

47. See *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002).

48. Post, *supra* note 12, at 972 (asserting that informed consent laws are distinct from laws that regulate the practice of medicine because “[r]egulation of informed consent . . . controls the dissemination of knowledge,” whereas laws that regulate the practice of medicine are concerned with “the quality of medical care that physicians are obligated to provide”).

49. *Id.* at 941 (“[Informed consent] requires a physician to explain to a ‘patient in nontechnical terms . . . what is at stake: the therapy alternatives open to him, the goals expectably to be achieved, and the risks that may ensue from particular treatment and no treatment.’” (quoting *Canterbury v. Spence*, 464 F.2d 772, 782 n.27 (D.C. Cir. 1972))).

50. *Id.* at 972 (“Informed consent doctrine mandates the communication of medical knowledge to the end that a lay patient can receive the expert information necessary to make an autonomous, intelligent and accurate selection of what medical treatment to receive.”).

true in the greater medical community? In other words, between doctors and state legislatures, who wins?

One last gray area in the doctrine of physician-patient speech is created when a law restricts speech based on an ideological viewpoint but purports to be a regulation of the practice of medicine. Viewpoint-based speech restrictions are generally subject to strict scrutiny, and are rarely upheld.⁵¹ But whether or not a speech restriction is viewpoint-based is not always an easy question to answer. Even if statements made by the chief proponents of a law clearly manifest an intention to be viewpoint-based, courts will not usually consider the law as such unless it is evident on its face.⁵²

Independent of whether a regulation on physician-patient speech fits neatly into one of these categories, conduct or speech, speech compulsion or restriction, content-based or content-neutral, it is the position of this Note that the most important constitutional interest at stake in physician-patient speech cases is the First Amendment right of the patient to receive frank medical advice from the physician. At least one scholar has made the argument that the Supreme Court in *Casey* failed to recognize the First Amendment rights at issue from the vantage point of the patient.⁵³ This Note argues that recent cases reveal that the lower federal courts have strayed even further from protecting patients' rights. The following section analyzes some notable physician speech cases that have come out of the lower courts since *Casey*. In each of these cases, the courts fail to take account of the First Amendment rights of patients.

II. THE PHYSICIAN-PATIENT DOCTRINE IN ACTION

“*[P]rofessional Speech may be entitled to ‘the strongest protection our Constitution has to offer.’*”⁵⁴

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51. See, e.g., Gayland O. Hethcoat II, *In the Crosshairs: Legislative Restrictions on Patient-Physician Speech About Firearms*, 14 DEPAUL J. HEALTH CARE L. 1, 18 (2011) (“When a regulation goes further than discriminating in content and discriminates in viewpoint . . . the odds of withstanding judicial review become even greater, if not insurmountable.”).
 52. See *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889, 906 (8th Cir. 2012).
 53. Paula Berg, *Toward a First Amendment Theory of Doctor-Patient Discourse and the Right to Receive Unbiased Medical Advice*, 74 B.U. L. REV. 201, 206 (1994) (“[T]his Article strives to succeed where *Rust* and *Casey* failed by developing a First Amendment theory of doctor-patient discourse that appreciates and protects patients’ interests.”).
 54. *Conant v. Walters*, 309 F.3d 629, 637 (9th Cir. 2002) (quoting *Fla. Bar v. Went For It, Inc.*, 515 U.S. 618, 634 (1995)).

“To survive First Amendment scrutiny, the government’s policy [restricting physician-patient communication] must have the requisite ‘narrow specificity.’”⁵⁵

“[T]he Supreme Court ‘has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty’”⁵⁶

Each of the following cases raises different questions about the extent to which the physician-patient speech doctrine protects patients’ First Amendment rights to receive frank medical advice from their physicians. In *Conant v. Walters*, a class of physicians and patients sought to enjoin the enforcement of a statement of policy that the government intended to punish any physician who recommended the use of marijuana as an appropriate mode of treatment.⁵⁷ In *Pickup v. Brown*, a group of state-licensed mental health care providers brought a First Amendment challenge to a California law that prohibits them from providing “sexual orientation change efforts” therapy to juveniles.⁵⁸ In *Wollschlaeger v. Governor of Florida*, a group of physicians brought a First Amendment challenge to a Florida law that prohibits physicians from asking patients if the patients own guns.⁵⁹ Lastly, in *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds*, Planned Parenthood brought a First Amendment challenge to an informed consent law in South Dakota that compels physicians to warn patients of a post-abortion increase in the risk of suicide and suicide ideation.⁶⁰

A. *Conant v. Walters and Pickup v. Brown*

In 1996, the director of the Office of National Drug Control Policy issued a statement addressing California legislation that decriminalized the possession and use of marijuana for certain medical conditions. In the statement, the federal government threatened to revoke or suspend the license to prescribe controlled substances of any practicing physician who recommended the use of marijuana as a legitimate way to treat an illness.⁶¹ Seeking to enjoin the enforcement of the government’s policy as a violation of free speech, a group of

55. *Id.* at 639 (quoting *NAACP v. Button*, 371 U.S. 415, 433 (1963)).

56. *Rounds*, 686 F.3d at 899–900 (quoting *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007)).

57. *Conant*, 309 F.3d at 633.

58. *Pickup v. Brown*, 740 F.3d 1208, 1209 (9th Cir. 2014).

59. *Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195, 1203 (11th Cir. 2014).

60. *Rounds*, 686 F.3d at 892.

61. Administration Response to Arizona Proposition 200 and California Proposition 215, 62 Fed. Reg. 6164 (Feb. 11, 1997).

physicians and a group of patients joined together to file a class action suit.⁶²

The United States District Court for the Northern District of California issued a permanent injunction against the government policy as offensive to the First Amendment.⁶³ On appeal, the Ninth Circuit directly addressed the question of whether the federal government's statement of policy was a permissible regulation of physician-patient speech.⁶⁴ Rejecting the government's argument that under California law a physician's recommendation to use marijuana effectively functioned as a prescription, the court concluded that the recommendation was protected speech.⁶⁵

The Ninth Circuit reasoned that a patient was free to make a number of autonomous legal choices upon receiving a recommendation to use marijuana. For example, a patient "could petition the government to change the law" banning marijuana use for medical purposes.⁶⁶ The patient also remained free to choose to violate federal law by obtaining and using marijuana—or even to reject the physician's recommendation altogether. According to the court, the government's policy statement did not only restrict speech; it compromised the physician-patient relationship by "prevent[ing] the physician from exercising his or her medical judgment."⁶⁷

One particular point of emphasis in the majority opinion was "the core First Amendment values of the doctor-patient relationship."⁶⁸ The court took the position that just because physicians are members of a "regulated profession does not . . . result in a surrender of First Amendment rights."⁶⁹ The court justified this position by pointing to exactly what it was protecting by extending First Amendment rights into the realm of the state-regulated physician-patient relationship: "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."⁷⁰

Having found physician-patient communications worthy of First Amendment protection, the court then turned its attention to the

62. *See Conant*, 309 F.3d at 633.

63. *Conant v. McCaffrey*, 172 F.R.D. 681, 701 (N.D. Cal. 1997).

64. *Conant*, 309 F.3d at 636–39.

65. *Id.* at 639.

66. *Id.* at 634.

67. *Id.* at 638 (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992)).

68. *Id.* at 637.

69. *Id.*

70. *Id.* at 636.

government policy in question. The court held that the policy lacked the “requisite ‘narrow specificity’” for restrictions on physician speech;⁷¹ the government’s inability “to articulate exactly what speech is proscribed” ultimately proved fatal to the government’s defense of its policy.⁷² Because the government policy depended largely on the patient designating the physician’s words as a “recommendation,” the policy could not withstand a First Amendment challenge as it “[le]ft doctors and patients ‘no security for free discussion.’”⁷³

Judge Kozinski’s concurrence deserves a mention at this point, and it bears noting that Kozinski’s views here helped form the theoretical basis upon which this Note is based. Kozinski begins his concurrence as follows:

I write only to explain that for me the fulcrum of this dispute is not the First Amendment right of the doctors. That right certainly exists and its impairment justifies the . . . injunction . . . [But t]hose immediately . . . affected by the federal government’s policy are the patients, who will be denied information crucial to their well-being⁷⁴

Even though *Conant*’s holding ultimately found First Amendment value in physician-patient speech, and even though the majority based its reasoning in part upon the fundamental importance of the physician-patient relationship, Judge Kozinski felt the need to write separately to emphasize his belief that the First Amendment rights at stake belonged to patients, not physicians. The “disparity between [the] benefits and burdens” that the government policy created for physicians made it so that physicians had much to lose and little to gain by either disobeying the policy or challenging it at law.⁷⁵ They could recommend marijuana but would have to do so under the threat of losing their license to prescribe other medicine. Because physicians would have had little reason to challenge the policy outside a sense of professional responsibility, the government policy ultimately harmed patients the most, as patients would lose access to the unfiltered medical advice of their chosen physicians. This disparity between the relative benefits and burdens, Kozinski reasoned, must be considered when courts assign and analyze First Amendment rights.⁷⁶

71. *Id.* at 639. The court pulled the phrase “narrow specificity” from *NAACP v. Button*, 371 U.S. 415, 433 (1963).

72. *Conant*, 309 F.3d at 639.

73. *Id.* (quoting *Thomas v. Collins*, 323 U.S. 516, 535 (1945)).

74. *Id.* at 639–40 (Kozinski, J., concurring).

75. *Id.* at 640.

76. *Id.*

Eleven years after deciding *Conant* in favor of an expansive reading of the First Amendment in the context of physician-patient speech, the Ninth Circuit was put in a position of distinguishing its own precedent. In *Pickup v. Brown*,⁷⁷ the Ninth Circuit upheld Senate Bill 1172 (“SB 1172”), a California law that prohibits state-licensed mental health care providers from using “any practices by mental health care providers . . . that seek to change [a juvenile’s] sexual orientation.”⁷⁸ The court offered the following explanation for its holding: “[SB] 1172 regulates conduct. It bans a form of treatment for minors; it does nothing to prevent licensed therapists from discussing the pros and cons of [sexual orientation change efforts] with their patients.”⁷⁹ Thus, while SB 1172 prohibited speech made in the course of trying to change a juvenile’s sexual orientation, it did not ban speech *about* the prohibited conduct.

To distinguish *Conant*, the court claimed that in that case the federal policy at issue prohibited physicians from *recommending* that patients use marijuana as treatment, as distinct from a law that prohibits speech that is *part and parcel of the treatment process*. In other words, the federal policy in *Conant* prohibited doctors from talking *about* treatment, whereas SB 1172 prohibited the treatment itself, including all spoken words that happened to be a part of the treatment process.⁸⁰ The court reasoned that the following three principles governed its holding:

- (1) [D]octor-patient communications *about* medical treatment receive substantial First Amendment protection, but the government has more leeway to regulate the conduct necessary to administering treatment itself;
- (2) psychotherapists are not entitled to special First Amendment protection merely because the mechanism used to deliver mental health treatment is the spoken word; and
- (3) nevertheless, communication that occurs during psychotherapy does receive some constitutional protection, but it is not immune from regulation.⁸¹

77. 740 F.3d 1208 (9th Cir. 2013).

78. *Id.* at 1222–24.

79. *Id.* at 1229.

80. *Compare id.* at 1226 (“[T]he demarcation between conduct and speech in *Conant* was clear. The policy prohibited doctors from *prescribing* or *distributing* marijuana, and neither we nor the parties disputed the government’s authority to prohibit doctors from *treating* patients with marijuana.”), *with id.* at 1229 (“Here, unlike in *Conant* . . . the law *allows* discussions about treatment, recommendations to obtain treatment, and expressions of opinions about SOCE and homosexuality.”).

81. *Id.* at 1227.

Using these three principles to categorize *Conant* and *Pickup*, the court concluded that *Conant* fit under the first principle as involving speech about treatment, while *Pickup* fit under the second principle because SB 1172 prohibits only physician speech that is an inseparable part of sexual orientation change treatment.⁸²

In the next section, I will explain the Eleventh Circuit's application of the physician-patient speech doctrine to a dispute over a Florida law that prohibits doctors from asking patients certain questions about gun ownership. Note that the court attempted to use the Ninth Circuit decisions as precedent in reaching its conclusion.

B. Wollschlaeger v. Governor of Florida

In July 2010, Dr. Chris Okonkwo, a pediatrician in Ocala, Florida, received a visit from Amber Ullman and her then four-month-old infant. In the course of a medical examination of the infant, Dr. Okonkwo asked Ullman if she kept a gun in her house. Ullman refused to answer the question. Dr. Okonkwo then told Ullman that he had concerns about his ability to be her child's pediatrician and that she would need to find a new pediatrician if she continued to refuse to answer his questions.⁸³ Ullman still refused to answer and even threatened to call a lawyer.⁸⁴

In the aftermath of the "Ocala Incident," Dr. Okonkwo claimed that asking the parents of his patients questions about potential safety hazards—such as swimming pools and cleaning products—was his regular practice and that the practice was encouraged by the American Association for Pediatrics and the American Medical Association.⁸⁵ Ullman claimed that the question was invasive and unrelated to the medical examination of her child.⁸⁶

82. *Id.* at 1229 ("Here, unlike in *Conant* . . . the law allows discussions about treatment, recommendations to obtain treatment, and expressions of opinions about SOCE and homosexuality.").

83. Fred Hiers, *Family and Pediatrician Tangle over Gun Question*, Ocala.com (July 23, 2010), <http://www.ocala.com/article/20100723/news/100729867/1402/news?p=1&tc=pg>. It bears noting that under the American Medical Association Code of Ethics, the physician or the patient is at liberty to terminate a relationship at any time. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION 342–43 (2012–2013 ed.).

84. Hiers, *supra* note 83.

85. *Id.* The American Medical Association does encourage physicians to ask patients about the presence of firearms in the household and to provide parents with information about safe storage of firearms. *H-145.990 Prevention of Firearm Accidents in Children*, AM. MED. ASS'N, <https://ssl3.ama-assn.org/apps/ecommm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fhtml%2fPolicyFinder%2fpolicyfiles%2fHnE%2fHnE%2fH-145.990.HTM> (last visited Sept. 26, 2014).

86. Hiers, *supra* note 83.

Boosted by anecdotal evidence of a problem from the “Ocala Incident” and the efforts of some powerful lobbying organizations,⁸⁷ the Firearm Owners’ Privacy Act (“FOPA”) was enacted by the Florida legislature and signed into law by then-Governor Rick Scott.⁸⁸ Under FOPA, licensed health care practitioners may not do any of the following: (1) keep records about a patient’s gun ownership if such information is not relevant to the patient’s medical care or safety; (2) ask a patient about gun ownership unless the physician believes the question is relevant to the patient’s care or safety; (3) discriminate against a patient because the patient owns a gun; or (4) unnecessarily harass a patient about owning a gun.⁸⁹ The punishment for violating FOPA can be harsh; a practitioner who violates FOPA can lose her license to practice.⁹⁰

In *Wollschlaeger v. Farmer*,⁹¹ a group of medical practitioners succeeded in permanently enjoining FOPA as an unconstitutional restriction on speech. In defense of the law, the State of Florida argued that the law was an ordinary regulation on the medical profession. The United States District Court for the Southern District of Florida disagreed, holding that FOPA impermissibly burdened speech.⁹² The court characterized FOPA as a content-based speech restriction, rejecting Defendant’s argument that the law merely imposed a regulation on the practice of medicine.⁹³

The Eleventh Circuit reversed on appeal, concluding that FOPA merely defines the limits of acceptable *conduct* for a physician during the course of a medical examination.⁹⁴ In *Wollschlaeger v. Governor of Florida*, the Eleventh Circuit took a different perspective than the district court, viewing the law as a reasonable measure to “protect[] a patient’s ability to receive effective medical treatment without

87. Emily Miller, “Docs v. Glocks” Showdown in Florida, WASH. TIMES, Aug. 15, 2013, <http://www.washingtontimes.com/news/2013/aug/5/docs-vs-glocks-showdown-in-florida/> (“The National Rifle Association helped push the law through the Florida Legislature in 2011.”).

88. Privacy of Firearm Owners, CS/CS/HB 155 (Fla. 2011), <http://www.myfloridahouse.gov/Sections/Bills/billsdetail.aspx?BillId=44993&SessionIndex=-1&SessionId=66&BillText=&BillNumber=155&BillSponsorIndex=0&BillListIndex=0&BillStatuteText=&BillTypeIndex=0&BillReferredIndex=0&HouseChamber=H&BillSearchIndex=0> (last visited Sept. 26, 2014).

89. FLA. STAT. § 790.338 (2014).

90. FLA. STAT. § 790.338(8) (2014).

91. 880 F. Supp. 2d 1251 (S.D. Fla. 2012).

92. *Id.* at 1270.

93. *Id.* at 1261.

94. *Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195, 1203 (11th Cir 2014).

compromising the patient's privacy with regard to matters unrelated to healthcare."⁹⁵

In defining FOPA as a regulation of the kind that does not need to be subjected to strict scrutiny, the majority used a "personal nexus" test.⁹⁶ Reasoning that physicians' First Amendment claims are strongest when their speech is made in public on matters of public concern and weakest when made in private on matters of private concern, the court concluded that FOPA "regulates physician speech . . . where the 'personal nexus between professional and client' is perhaps at its most significant; within the confines of the physician's examination room, where the physician exercises his or her judgment to deliver professional treatment and advice to a particular patient, tailored to that patient's personal circumstances, in private."⁹⁷

The court went on to cite *Pickup v. Brown* for the proposition that regulations that define appropriate treatments are not subject to First Amendment scrutiny. The court rejected the plaintiffs' argument that questions about gun ownership are not part of the treatment process. In support of this position, the court pointed out that medical treatment "may begin with an inquiry ('do you smoke?'), followed by a recommendation and . . . counseling ('you should quit because smoking has been shown to cause cancer'). . . . [A] physician would almost certainly characterize an attempt to convince a patient to cease smoking as . . . treatment."⁹⁸ Because inquiries about gun ownership could be characterized as part of the treatment process—and thus could be defined as part and parcel of the physicians' conduct—the state was free to regulate the inquiries.

The next case involves a different kind of First Amendment challenge than the last two cases. Whereas *Conant* and *Wollschlaeger* both dealt with speech restrictions, the next case involves a First Amendment challenge to an informed consent law that compels physicians to deliver a state-mandated message before the treatment stage.

95. *Id.* at 1214.

96. *Id.* at 1218 ("Thus, '[t]he key to distinguishing between occupational regulation and abridgment of [F]irst [A]mendment liberties is in finding a personal nexus between professional and client" (quoting *Accountant's Soc'y of Va. v. Bowman*, 860 F.2d 602, 605 (4th Cir. 1988))).

97. *Id.* at 1219.

98. *Id.*

C. Planned Parenthood Minnesota, North Dakota,
South Dakota v. Rounds

In *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds*,⁹⁹ Planned Parenthood sought to enjoin a provision in a South Dakota informed consent law that requires physicians to provide patients with a written statement before performing an abortion.¹⁰⁰ The provision at issue in the case—the “suicide provision”—ordered that the written statement describe “all known medical risks of the procedure and statistically significant risk factors to which the pregnant woman would be subjected,”¹⁰¹ including “[i]ncreased risk of suicide and suicide ideation.”¹⁰² Planned Parenthood originally challenged the “suicide provision” as both an undue burden on abortion rights and as a violation on “physicians’ First Amendment right to be free from compelled speech.”¹⁰³

The United States Court of Appeals for the Eighth Circuit relied upon a standard articulated by the Supreme Court in *Planned Parenthood v. Casey* to uphold the informed consent law. According to the court, Planned Parenthood failed to show that the “disclosure at issue ‘is either untruthful, misleading, or not relevant to the patient’s decision to have an abortion.’”¹⁰⁴

Planned Parenthood argued that the compelled disclosure was untruthful and misleading because it implied a “causal link between abortion and suicide” that was not established by medical authority.¹⁰⁵ The court disagreed with Planned Parenthood’s assessment of the statutory language, finding that “no language [in the statute] refers to such a causal link.”¹⁰⁶ The majority held that the outcome of the case rested on the appropriate medical definition of the phrase “increased risk.” Because the accepted meaning of the phrase “increased risk” lacked “a requirement for conclusive proof of causation,”¹⁰⁷ the state did not need to establish conclusive proof of causation between abortion and the increased risk of suicide and

99. 686 F.3d 889 (8th Cir. 2012).

100. *Id.* at 893–94.

101. S.D. CODIFIED LAWS § 34-23A-10.1(e) (2011).

102. § 34-23A-10.1(e)(ii).

103. *Rounds*, 686 F.3d at 892.

104. *Id.* at 893 (quoting *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 653 F.3d 662, 735 (8th Cir. 2011)).

105. *Id.* at 894.

106. *Id.*

107. *Id.* at 895.

suicide ideation in order to mandate the disclosure of the “identification [of suicide and suicide ideation as] a medical risk.”¹⁰⁸

The court also rejected Planned Parenthood’s contention that the statute compelled the disclosure of an untruthful message because the increased risk of suicide ideation and suicide ideation “to which the pregnant woman would be subjected” was not a “known medical risk of the procedure.”¹⁰⁹ Citing a “relevant rule of statutory construction,” the court identified the phrase “to which a woman would be subjected” as a “limiting clause” that should be interpreted as modifying only the immediately preceding phrase, “statistically significant risk factors,” and not the phrase before that, “all known medical risks of the procedure.”¹¹⁰

Furthermore, because the “standard medical practice . . . is to recognize a strongly correlated adverse outcome as a ‘risk’ while further studies are conducted to clarify whether various underlying factors play causal roles,”¹¹¹ Planned Parenthood—not the state—was required to present medical evidence establishing “to a degree of scientifically accepted certainty”¹¹² that abortion did not cause an increase in the risk of suicide and suicide ideation. In support of its position, Planned Parenthood presented the court with a ninety-one-page report from the American Psychological Association (“APA”) reviewing the medical literature on the relationship between abortion and the risk of suicide. The APA report found that “the best scientific evidence indicates that the relative risk of mental health problems among adult women who have an unplanned pregnancy is no greater if they have an elective first-trimester abortion than if they deliver that pregnancy.”¹¹³ Nevertheless, the majority found that the APA report merely created medical uncertainty about the connection between abortion and suicide. Because “the Supreme Court ‘has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty,’ including ‘in the abortion context,’”¹¹⁴ the *Rounds* Court held that the South Dakota law was sufficiently truthful, non-misleading, and relevant to meet the standard laid out in *Casey*.¹¹⁵

108. *Id.*

109. *Id.* at 896.

110. *Id.*

111. *Id.* at 899.

112. *Id.* at 900.

113. BRENDA MAJOR ET AL., REPORT OF THE APA TASK FORCE ON MENTAL HEALTH AND ABORTION 90 (2008).

114. *Rounds*, 686 F.3d at 905–06 (quoting *Gonzalez v. Carhart*, 550 U.S. 124, 163–64 (2007)).

115. *Id.* at 906.

III. AN ANALYSIS OF THE PHYSICIAN-PATIENT SPEECH DOCTRINE

This Part analyzes common threads between the five cases discussed in Part II, with the goal of establishing the existence of a loosely connected doctrine. I will start by looking at the most obvious similarities between the cases, such as the fact that all involve doctors and patients and a state regulation. Then, I will move toward less obvious similarities, including similarities that may only be true of some of the cases. In the end, I identify what I believe are the two most important similarities that exist among the cases: (1) that the truly determinative factor in each case is the court's characterization of the purpose of the state regulation and whether that purpose fits within traditional spheres of state regulation; and (2) that each court fails to consider that patients, in addition to physicians, might have First Amendment interests at stake—interests that are *not subject to state regulation*.

Perhaps the most obvious commonality among the five cases is that each involves a state regulation affecting the doctor physician relationship. All of the cases, excepting *Rounds* and *Casey*, involved a regulation that directly prohibited doctors from saying certain things to their patients.¹¹⁶ I will identify these cases as the “Speech Restriction Cases.” In *Rounds* and *Casey*, the regulation compels doctors to deliver a state mandated message, and so I will call these the “Speech Compulsion Cases.”

All of the courts in the Speech Restriction Cases agreed that states could regulate physician conduct, even if a regulation on conduct incidentally swept up some physician speech as a part of the regulation.¹¹⁷ All three of the courts in the Speech Restriction Cases agreed that *physicians* have a First Amendment right and that this right provides varying levels of protection to *physicians* depending on some combination of factors involving (1) the context in which the speech is regulated (does it regulate conduct or speech, and is the “personal nexus” between the physician and patient a close one?), (2) the nature of the state regulation (is it a content-based, or viewpoint-

116. *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002) (federal policy prohibiting physician recommendations of marijuana); *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014) (sexual orientation change efforts law); *Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195 (11th Cir. 2014) (discussing the FOIA).

117. *Conant*, 309 F.3d at 639 (“Our decision is consistent with principles of federalism that have left states as the primary regulators of professional conduct.”); *Pickup*, 740 F.3d at 1229 (finding that the state’s power to regulate professional speech is greatest where the regulation is directed at professional conduct); *Wollschlaeger*, 760 F.3d at 1218 (noting the states’ “long-established authority” to regulate physician conduct).

based, speech restriction?), and (3) the purpose of the regulation (does it do similar things as other state regulations on the practice of medicine, like protect privacy interests?).

Breaking down these factors, each court agreed that content- and viewpoint-based restrictions should receive strict scrutiny.¹¹⁸ There was, however, disagreement between the district court and appellate court in *Wollschlaeger* regarding whether or not the FOPA was a content-based speech restriction. And while the Eleventh Circuit in *Wollschlaeger* was the only court to emphasize the fact that the law at issue only affected physician speech that occurs in the “private confines of the examination room,”¹¹⁹ all of the courts in the Speech Restriction Cases at least mentioned that speech by a physician in public on a matter of public concern would receive full First Amendment protection.¹²⁰ Lastly, and most significantly, all of the cases noted the importance of the *state’s purpose for having the regulation*.¹²¹

In fact, a close examination of each case, including the Speech Compulsion Cases, will show that the court’s characterization of the purpose of the regulation at issue proved to be determinative in the outcome of the case.

For example, in *Conant*, the Ninth Circuit concluded that the only legitimate purpose the federal government could have for prohibiting physicians from recommending marijuana to patients was to prevent physicians from helping patients *obtain* marijuana, a purpose that was already covered by existing criminal laws that prohibited “aiding and abetting” the possession of a controlled substance.¹²² Since controlled substances were already covered by rules

118. *Conant*, 309 F.3d at 637 (“[C]ontent-based restrictions on speech are ‘presumptively invalid.’” (quoting *R.A.V. v. City of St. Paul*, 505 U.S. 377, 382 (1992))); *Pickup*, 740 F.3d at 1231 (“[C]ontent- or viewpoint-based regulation[s] . . . must be closely scrutinized.”); *Wollschlaeger*, 760 F.3d at 1239 (“Content-based statutes . . . are presumptively invalid.” (quoting *R.A.V.*, 505 U.S. at 382)).

119. *Compare Wollschlaeger*, 760 F.3d at 1219 (finding that the need for state regulation of physician conduct is at its highest in “the examination room”), *with Conant*, 309 F.3d 629 (no discussion of the physical location of the regulated conduct), *and Pickup*, 740 F. 3d 1208 (no discussion of physical location).

120. *See supra* note 118.

121. *Conant*, 309 F.3d at 637 (to control drug trafficking); *Pickup*, 740 F.3d at 1223 (to protect juveniles); *Wollschlaeger*, 760 F.3d 1195 (to protect patients’ privacy); *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889, 892 (8th Cir. 2012) (to ensure patients give informed consent to abortion procedure); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 844 (1992) (to protect informed consent).

122. *Conant*, 309 F.3d at 635–36 (“A doctor’s anticipation of patient conduct, however, does not translate into aiding and abetting, or conspir-

outside those directly concerning state regulation of professional conduct, and because recommendations were not equivalent to prescriptions in this regard, the *Conant* Court found that the purpose behind the federal policy could not justify its infringement on physician speech.

In contrast, the Eleventh Circuit concluded in *Wollschlaeger* that the purpose of FOIA was to protect patients' privacy on matters deemed irrelevant to medical care.¹²³ The court conceded that professional rules already protect patients' privacy in a general way but ultimately reasoned that that fact alone would not prevent the state from providing an extra safeguard by defining specific boundaries in regards to the kind of information doctors can ask for and keep.¹²⁴ The court even dismissed the idea that the conduct versus speech distinction could determine the outcome in the case, because "the line between treatment and communication about treatment is not necessarily . . . clear." Thus, the purpose of protecting the privacy interests of patients, more than the application of a fungible conduct-versus-speech test, proved to be the difference between strict constitutional scrutiny and none at all.

Even in *Rounds*, the court framed the issue around the purpose of the statute in regards to regulating the medical profession. The court concluded that the informed consent law passed constitutional scrutiny not only because it found the law to be truthful and not misleading, but also because the law provided very specific directions to physicians concerning an area of medicine that has been subject to state regulation for a long time: the process of obtaining informed consent from patients before performing a certain course of treatment or procedure.¹²⁵

Even though the courts do not directly state it as the constitutional standard for physician-patient speech cases, it is the *purpose of the state regulation*, as determined by the courts, that proves to be the most critical and determinative factor in physician-patient speech cases. If a court finds that a regulation serves the same interests as

acy. A doctor would aid and abet by acting with the specific intent to provide a patient with the means to acquire marijuana.").

123. *Wollschlaeger*, 760 F.3d at 1203 ("The Act seeks to protect patients' privacy by restricting irrelevant inquiry and record-keeping by physicians regarding firearms.").

124. *Id.* at 1215 ("The Act merely reaffirms the boundaries surrounding what constitutes good medical practice by codifying into law this common-sense proposition, and serves the important purpose of protecting the privacy rights of patients who do not wish to answer questions about irrelevant and private matters.").

125. *Rounds*, 686 F.3d at 893 (emphasizing that the South Dakota law at issue only compels physician speech as part of the process of obtaining informed consent from patients).

traditional state regulations, such as regulations that protect privacy or, as in *Pickup*, the unique interests of juveniles, then the court will almost certainly uphold the restriction (as long as it is not a content- or viewpoint-based restriction). On the other hand, if a court cannot find a basis in a traditional area of state regulation of physician speech, then it is more likely to subject the regulation to strict scrutiny.

There is one last similarity between the cases discussed in Part II. All of the courts in those cases, with the possible exception of *Conant*, treated the physician as the “active player” in the case, meaning the person whose First Amendment rights were either violated by the regulation or not. This makes sense on the surface, as all of the regulations at issue are directed at physicians; in each case, it is the physician who is given a choice to either follow the regulation or face reprimand. But that fact alone does not mean that the physician is the only one whose First Amendment rights are implicated.

As discussed in Part IV below, the First Amendment includes the right to receive information. Because patients go to doctors to obtain information, patients have a First Amendment interest in state regulations that affect physician speech. This First Amendment interest in receiving information is almost entirely lost in the physician-patient speech jurisprudence. Moreover, because patients are not licensed by the state, and thus are not subject to special state regulations that may infringe on First Amendment interests, the lower courts are failing to do a large part of the appropriate analysis.

IV. TOWARD A PATIENT-CENTERED UNDERSTANDING OF THE FIRST AMENDMENT

The majority opinions in *Conant*, *Pickup*, *Wollschlaeger*, and *Rounds* (and even the *Casey* plurality) each analyzed the First Amendment issues from the standpoint of physicians’ free speech rights.¹²⁶ It is my position that in contrast to this physician-centered approach to free speech, it was the rights of patients as receivers of medical information that were actually at stake in those cases. By failing to fully consider patients’ First Amendment rights, the courts in all of these cases left out the central constitutional issue: whether the law or order in question infringed on patients’ rights to receive frank and free-flowing medical advice from their physicians. In order to make the case for this patient-based theory of free speech, I will first argue that such an approach to the First Amendment is rooted in precedent.

Indeed, the Supreme Court has recognized that the First Amendment protects the right to receive information to the same

126. See *supra* Part II.

degree as the right to speak it.¹²⁷ The Court has applied this interpretation of free speech in a vast range of factual scenarios, from the right of a wife to receive mail from her incarcerated husband¹²⁸ to the right of consumers to receive the prices of prescription drugs from advertisers.¹²⁹ The right to receive information under the First Amendment commonly comes up in the context of commercial speech. In those cases, the Court has reasoned that the First Amendment serves to protect the “informational function of advertising.”¹³⁰ Exploring the right to receive information from the standpoint of the marketplace theory of the First Amendment, Justice Brennan observed that “[i]t would be a barren marketplace of ideas that had only sellers and no buyers.”¹³¹

In *Wollschlaeger*, the court held that “there is no ‘constitutional infirmity’ where the speech rights of physicians are ‘implicated, but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State.’”¹³² The court did not consider applying a patient-based theory of the First Amendment, which would have recognized the right of patients to receive the full range of information that a physician could give about the potential health risks that are inherent to gun ownership.¹³³ Likewise, in *Rounds*, the court framed its holding from the standpoint of physicians: “the suicide advisory presents neither an undue burden on abortion rights nor a violation of *physicians’* free speech rights.”¹³⁴ In so doing, the court ignored that the suicide advisory effectively prevented patients

127. See, e.g., *Stanley v. Georgia*, 394 U.S. 557, 564 (1969) (“It is now well established that the Constitution protects the right to receive information and ideas.”); *Lamont v. Postmaster Gen.*, 381 U.S. 301 (1965) (recognizing a First Amendment right to receive political publications via the U.S. Postal Service sent from foreign countries); *Bd. of Educ. v. Pico*, 457 U.S. 853, 867 (1982) (“[T]he right to receive ideas follows ineluctably from the sender’s First Amendment right to send them.”).

128. *Procunier v. Martinez*, 416 U.S. 396 (1974).

129. *Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council*, 425 U.S. 748 (1976).

130. *Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm’n of N.Y.*, 447 U.S. 557, 563 (1980); see also *Zauderer v. Office of Disciplinary Counsel of the Supreme Court of Ohio*, 471 U.S. 626, 651 (1985) (“First Amendment protection [of] commercial speech is justified principally by the value to consumers of the information such speech provides . . .”).

131. *Lamont*, 381 U.S. at 308 (Brennan, J., concurring).

132. *Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195, 1219 (11th Cir. 2014) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 834 (1992)).

133. *Id.*

134. *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889, 906 (8th Cir. 2012) (emphasis added).

from receiving additional relevant information on the subject from their physicians. Even the *Conant* majority, while acknowledging the “core First Amendment interests of doctors *and patients*”¹³⁵ and the “‘imperative need for confidence and trust’ inherent in the doctor-patient relationship,”¹³⁶ failed to adequately explain the rationale for protecting the communication from the patient’s side of the relationship.¹³⁷

Only Judge Kozinski’s concurring opinion in *Conant* gives adequate attention to the distinction between protecting the First Amendment rights of patients to receive information and the First Amendment rights of physicians to give it. The issue with framing the competing arguments from the standpoint of the physician’s free speech rights is that “the harm to patients from being denied the right to receive candid medical advice is far greater than the harm to doctors from being unable to deliver such advice.”¹³⁸ Physicians adjust to laws curtailing their free speech rights and have little incentive, outside a sense of professional obligation, to provide patients with the best medical advice or to challenge speech restrictions or compulsions. Physicians have much to lose from defying laws, however, as some speech restrictions—such as the government policy in *Conant* and the speech restriction in *Wollschlaeger*—carry stiff professional consequences, sometimes as harsh as revoking their license to prescribe controlled substances¹³⁹ or even suspending or revoking their license to practice.¹⁴⁰

In contrast to the stake that the physicians had in the outcomes of the cases examined in this Note, patients had relatively little to gain from the speech restrictions and much to lose from being denied accurate and current information. While modern technology allows patients the freedom to research their medical inquiries on their own and decide for themselves about the relative efficacy and morality of medical procedures and treatments, “word-of-mouth and the Internet are poor substitutes for a medical doctor; information obtained from

135. *Conant v. Walters*, 309 F.3d 629, 636 (9th Cir. 2002) (emphasis added).

136. *Id.* (quoting *Trammel v. United States*, 445 U.S. 40, 51 (1980)).

137. *See id.* at 629–39 (discussing, in the majority opinion, only the physician’s First Amendment rights).

138. *Id.* at 643 (Kozinski, J., concurring).

139. The government order at issue in *Conant* carried with it the potential repercussion of the government stripping the physician’s license to prescribe medication. *Id.* at 632 (majority opinion).

140. The Florida law at issue in *Wollschlaeger* carried the threat of the state revoking the license to practice of any physician who failed to comply. *Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195, 1204–05 (11th Cir. 2014).

chat rooms and tabloids cannot make up for the loss of individualized advice from a physician.”¹⁴¹

CONCLUSION

The physician-patient speech doctrine is a dynamic area of First Amendment law that—if the last twelve years are an accurate indicator—is certain to evolve in the coming decade. It is critical to approach speech restrictions and compulsions that affect the physician-patient relationship as “striking at core First Amendment interests of doctors *and patients*.”¹⁴² Open and honest communication between physicians and patients is “an integral component of the practice of medicine,”¹⁴³ and, especially in certain contexts, is worthy of “the strongest protection our Constitution has to offer.”¹⁴⁴

Speech compulsions that order physicians to disclose information that conflicts with the weight of medical authority have the potential to chill physician speech and thus fail to reflect “the imperative need for confidence and trust”¹⁴⁵ between doctors and patients. Insofar as the truthful-non-misleading-and-relevant standard articulated in *Casey* allows government entities to compel physician speech that lacks an established basis in research accepted by the mainstream medical community, that standard inadequately protects patients’ rights to receive any and all uncensored medical advice that their physicians are able and willing to give them.

Ultimately, because physicians are usually the ones who are actively threatened with punishment for disobeying speech compulsions and restrictions—and because the stakes are highest for patients in the debate about the applicability of the First Amendment to laws regulating physician-patient communications—it is critical to view the First Amendment as protecting patients’ rights to receive frank and open medical advice from their physicians. Whatever standard of review courts choose to apply to constitutional disputes over physician-patient speech restrictions must take adequate account of patients’ First Amendment rights to receive free-flowing, honest communication from their physicians, or else we will continue the current trend of inconsistency in the outcomes of cases. Moreover, a patient-based standard of review would bring cases like *Wollschlaeger*, *Rounds*, *Pickup*, and *Conant* into line with the Supreme Court’s First Amendment jurisprudence in other contexts. Such a standard would

141. *Conant*, 309 F.3d at 644 (Kozinski, J., concurring).

142. *Id.* at 636 (majority opinion) (emphasis added).

143. *Id.*

144. *Fla. Bar v. Went For It, Inc.*, 515 U.S. 618, 634 (1995).

145. *Trammel v. United States*, 445 U.S. 40, 51 (1980).

appropriately have a greater likelihood of chilling the laws and policies that strain open communication between physicians and patients, instead of allowing for laws that chill that communication. As the Supreme Court has put it, “[i]f the First Amendment means anything, it means that regulating speech must be a last—not first—resort.”¹⁴⁶

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146. *Thompson v. W. States Med. Ctr.*, 535 U.S. 357, 373 (2002).

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