REGULATING PHYSICIAN SPEECH*

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Lawmakers have increasingly sought to shape communications between physicians and patients by enacting laws that either mandate or prohibit the provision or solicitation of particular information. Some of these laws can be justified as efforts to protect patients by enforcing accepted standards of medical practice, but others are grounded in medical positions that are the subject of substantial dispute among expert physicians or that even flatly contradict an established consensus within the medical community. The Supreme Court has never articulated a clear legal standard applicable to governmental efforts to control physicians' communications with patients. In the absence of such guidance, lower courts have adopted a hodgepodge of approaches, none of which is entirely satisfactory. The purpose of this Article is to fill this gap by articulating a coherent approach to the judicial review of laws regulating physician-patient communications. This Article rejects the two primary approaches that have been proposed in the literature—applying strict scrutiny to all laws regulating physician-patient communications, on the one hand, or applying varying forms of heightened scrutiny (either strict or intermediate) to limited categories of communications, on the other. Instead, it proposes that courts should apply intermediate scrutiny to all laws interfering with any aspect of physician-patient communications. However, rather than simply looking at any interest asserted by the government and then deciding whether it is "important," courts applying intermediate scrutiny should ask whether laws interfering with physician speech are reasonably related to the specific governmental interest in upholding the quality of professional practice. The assessment of whether a law is consistent with this standard should generally be decided with reference to the views of the professional community; however, contrary to other commentators, this Article argues that lawmakers should not be required to defer to the professional

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community's views in all situations. This Article applies this standard to a variety of laws interfering with physician-patient communications, concluding that some of them can be justified while others cannot.

INTRODUCTION

The practice of medicine, at its heart, is a communicative endeavor. Many medical interventions are purely communicative, ranging from talk therapy for mental illnesses to counseling about dietary and lifestyle changes for patients with coronary heart disease. Even when physicians prescribe drugs or perform medical procedures, they are expected to first engage the patient in a conversation to identify symptoms and risk factors, assess available treatment options, and determine the appropriate course of care in light of the patient's values and goals.[1] A growing body of literature recognizes that the manner in which physicians engage in these conversations has a significant impact on patient outcomes.[2]

Increasingly, lawmakers have sought to shape communications between physicians and patients by enacting laws that either mandate

1. *See infra* text accompanying notes 77–78.
2. *See infra* text accompanying notes 247–50.

or prohibit the provision or solicitation of particular information. For example, statutes in some states require physicians to inform terminally ill patients about the availability of palliative care,[3] disclose specific information to patients undergoing hysterectomies[4] or treatment for breast cancer,[5] and tell women if mammogram results reveal the presence of dense breast tissue.[6] More controversially, several states have enacted mandatory disclosure laws in the context of abortion, some of which require physicians to make highly disputed factual assertions, such as a statement that abortion is linked to an "increased risk of suicide ideation and suicide."[7] At the other end of the spectrum are laws that prohibit physicians from engaging in particular types of communications with patients, including prohibitions on recommending the use of medical marijuana,[8] making routine inquiries about firearm ownership,[9] or engaging in talk therapy designed to change minors' sexual orientation.[10]

Some of these laws can be justified as efforts to protect patients by enforcing accepted standards of medical practice. For example, research shows that efforts to change minors' sexual orientation are not only ineffective but also create a risk of psychological harm.[11]

3. *See* CAL. HEALTH & SAFETY CODE § 442.5 (West 2016); N.Y. PUB. HEALTH LAW § 2997-c (McKinney 2015).

4. *See* N.Y. PUB. HEALTH LAW § 2496 (McKinney 2012).

5. *See* Rachael Andersen-Watts, *The Failure of Breast Cancer Informed Consent Statutes*, 14 MICH. J. GENDER & L. 201, 211 n.65 (2008) (citing twenty-two state statutes requiring physicians to disclose specific breast cancer treatment options).

6. *See* ARE YOU DENSE ADVOCACY, INC., HANDY GUIDE TO STATE DENSITY REPORTING LAWS (2018), https://www.areyoudenseadvocacy.org/application/files/3815/3010/0865/STATE_REPORTING_LAWS_6.26.18FIN.pdf [https://perma.cc/FA6C-W7FM]. Other mandatory disclosure laws require physicians to inform pregnant women of the drugs expected to be delivered during pregnancy and childbirth, N.Y. PUB. HEALTH LAW § 2503 (McKinney 2012), to provide standardized information to patients undergoing procedures involving the use of collagen or silicone, CAL. BUS. & PROF. CODE §§ 2259(a), 2259.5(a) (West 2012), to disclose specific risks to patients considering electroconvulsive treatment, COLO. REV. STAT. § 13-20-401(4)(d) (Lexis through 2018 Legis. Sess.), and to provide specific information to individuals undergoing genetic testing, *see* Kayte Spector-Bagdady et al., *Analysis of State Laws on Informed Consent for Clinical Genetic Testing in the Era of Genomic Sequencing*, 178 AM. J. MED. GENETICS 81, 83–84 (2018) (reviewing state statutes).

7. Planned Parenthood Minn., N.D., S.D. v. Rounds (*Rounds II*), 686 F.3d 889, 894 (8th Cir. 2012) (en banc).

8. *See infra* text accompanying note 79.

9. *See infra* notes 119–20 and accompanying text.

10. *See infra* text accompanying notes 94–102.

11. *See generally* AM. PSYCHOLOGICAL ASS'N, REPORT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION TASK FORCE ON APPROPRIATE THERAPEUTIC RESPONSES TO SEXUAL ORIENTATION (2009), https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf [https://perma.cc/3Q6K-SYEK] (concluding that efforts to

Laws banning this practice are arguably comparable to prohibitions on the use of dangerous and ineffective drugs. Other laws, however, are grounded in medical positions that are the subject of substantial dispute among expert physicians[12] or that even flatly contradict an established consensus within the medical community.[13]

The Supreme Court has never articulated a clear legal standard applicable to governmental efforts to control physicians' communications with patients. In the absence of such guidance, lower courts have adopted a hodgepodge of approaches, none of which is entirely satisfactory. Some courts have suggested that, in light of the government's role in regulating the medical profession, physicians' communications with their patients are entitled to no First Amendment protection.[14] Others have subjected restrictions on physicians' speech to heightened First Amendment scrutiny but with inconsistent rationales and disparate outcomes.[15] Among both courts and commentators, there remains substantial disagreement over not only the standard to apply in these cases but also the types of state interests that legitimately can be taken into account.

The purpose of this Article is to articulate a coherent approach to judicial review of laws regulating physicians' communications with their patients. Part I examines existing case law concerning regulations of physician-patient communications, demonstrating that the Supreme Court's approach to the issue remains unsettled and that lower courts have applied inconsistent theories with irreconcilable results. Part II considers the appropriate standard of review to apply in these cases. It rejects the two primary approaches that have been proposed in the literature—applying strict scrutiny to all laws regulating physician-patient communications, on the one hand, or applying varying forms of heightened scrutiny (either strict or intermediate) to limited categories of communications, on the other. Instead, it proposes that intermediate scrutiny should be applied to all

change sexual orientation are unlikely to be successful and involve some risk of psychological harm).

12. For example, physicians disagree about the appropriateness of recommending marijuana as a therapeutic option. *See, e.g.*, Elin Kondrad & Alfred Reid, *Colorado Family Physicians' Attitudes Toward Medical Marijuana*, 26 J. AM. BOARD FAM. MED. 52, 53–55 (2013).

13. *See infra* note 119 and accompanying text (noting medical professionals' support for routinely asking patients whether they have firearms in their homes).

14. *See, e.g.*, Lowe v. SEC, 472 U.S. 181, 233 (1985) (White, J., concurring); Wollschlaeger v. Governor of Fla., 760 F.3d 1195, 1226 (11th Cir. 2014), *vacated on reh'g*, 797 F.3d 859 (11th Cir. 2015), *vacated on reh'g*, 814 F.3d 1159 (11th Cir. 2015), *aff'd in part and rev'd in part en banc*, 848 F.3d 1293 (11th Cir. 2017).

15. *See infra* Section II.B.

laws interfering with any aspect of physician-patient communications. Part III provides greater detail on how intermediate scrutiny should be applied in physician speech cases. It argues that, rather than simply looking at any interest asserted by the government and then deciding whether it is "important," courts applying intermediate scrutiny should ask whether laws interfering with physician speech are substantially related to the specific governmental interest in upholding the quality of professional practice. It further argues that courts should assess whether a law is consistent with this standard with reference to the views of the professional community. Contrary to other commentators, however, it argues that lawmakers should not be required to defer to the professional community's views in all situations. Part III ends by applying this standard to a variety of laws interfering with physician-patient communications, concluding that some of them can be justified while others cannot.

I. EXISTING CASE LAW

When physicians speak to the public—for example, by giving a speech at a conference or writing a letter to the editor of a newspaper—there is little dispute that they are entitled to the same First Amendment protections afforded any other speaker.[16] Likewise, courts have rejected the argument that professional advertising is exempt from First Amendment scrutiny.[17] Thus, restrictions on advertising by physicians are subject to the same standards applicable to any other regulations of commercial speech.

However, there is far less clarity regarding the appropriate standard to apply to laws regulating communications within the physician-patient relationship. As the following sections demonstrate, some decisions suggest that such speech is exempt from First Amendment scrutiny. Others conclude that it is entitled to First Amendment protection but disagree about the appropriate standard to apply.

16. *See, e.g.*, Bailey v. Huggins Diagnostic & Rehab. Ctr., Inc., 952 P.2d 768, 773 (Colo. App. 1997) (dismissing action for negligent misrepresentation against a dentist who recommended the removal of amalgams in a book and television interview, citing the dentist's First Amendment interest in "[t]he expression of opinions upon matters of public concern").

17. *See, e.g.*, Zauderer v. Office of Disciplinary Counsel, 471 U.S. 626, 656 (1985) (striking down Ohio's ban on the use of illustrations in attorney advertising).

A. Supreme Court Cases

One of the earliest Supreme Court discussions of the First Amendment's application to professional communications appears in Justice White's concurring opinion in *Lowe v. SEC*,[18] which argued that an unregistered investment adviser had a First Amendment right to publish nonpersonalized investment advice in a securities newsletter.[19] In concluding that the adviser's publication was protected speech, Justice White emphasized that the communications were not made in the context of a professional-client relationship.[20] If they had been, he suggested, they would have constituted "the practice of a profession" and would not have been entitled to any First Amendment protection.[21] Arguing that "[t]he power of government to regulate the professions is not lost whenever the practice of a profession entails speech,"[22] he concluded that the First Amendment is inapplicable to communications made within "the personal nexus between the professional and client."[23] "Just as offer and acceptance are communications incidental to the regulable transaction called a contract," Justice White wrote, speech within the context of a professional relationship is incidental to the regulable activity of practicing a profession.[24]

Although some lower courts have cited Justice White's observations with approval,[25] it is important to remember that his opinion did not command a majority of the Court. Moreover, although the opinion speaks broadly of the government's power to

18. 472 U.S. 181 (1985).

19. *See id.* at 211 (White, J., concurring). The majority in *Lowe* did not reach the First Amendment issue because it concluded that the defendant's activities did not fall under the SEC's jurisdiction. *See id.* (majority opinion).

20. *See id.* at 236 (White, J., concurring).

21. *Id.* at 232. As support for this distinction, Justice White cited Justice Jackson's observation in *Thomas v. Collins*, 323 U.S. 516 (1945) (Jackson, J., concurring), that "the state may prohibit the pursuit of medicine as an occupation without its license, but I do not think it could make it a crime publicly or privately to speak urging persons to follow or reject any school of medical thought." *Lowe*, 472 U.S. at 231 (White, J., concurring) (quoting *Thomas*, 323 U.S. at 544 (Jackson, J., concurring)).

22. *Lowe*, 472 U.S. at 228 (White, J., concurring).

23. *Id.* at 232 (arguing that communications are a part of professional practice when one "takes the affairs of a client personally in hand and purports to exercise judgment on behalf of the client in the light of the client's individual needs and circumstances").

24. *Id.*

25. *See, e.g.*, Wollschlaeger v. Governor of Fla., 760 F.3d 1195, 1217–18 (11th Cir. 2014), *vacated on reh'g*, 797 F.3d 859 (11th Cir. 2015), *vacated on reh'g*, 814 F.3d 1159 (11th Cir. 2015), *aff'd in part and rev'd in part en banc*, 848 F.3d 1293 (11th Cir. 2017); Pickup v. Brown, 728 F.3d 1042, 1053 (9th Cir. 2013), *amended on denial of reh'g en banc*, 740 F.3d 1208 (9th Cir. 2014).

regulate the professions, it is clear from the context that Justice White was referring to a specific form of regulation: the power to "restrict entry into professions and vocations through licensing schemes."[26] Specifically, he argued that, in light of the government's power "to ensure that only those who are suitable to fulfill their fiduciary responsibilities may engage in the profession,"[27] the challenged statute was not unconstitutional "[a]s applied to limit entry into the profession of providing investment advice tailored to the individual needs of each client."[28] Nothing in the opinion suggested that the government has the power to regulate the *content* of professional speech without being subject to ordinary First Amendment constraints.

Subsequent Supreme Court decisions support the view that the First Amendment applies to content-based restrictions on professionals' communications. One example is *Gentile v. State Bar of Nevada*,[29] in which the Court found that the First Amendment did not preclude states from disciplining attorneys for making extrajudicial statements that the lawyer knows or reasonably should know will have a substantial likelihood of materially prejudicing an adjudicative proceeding.[30] In reaching this conclusion, the Court observed that "the speech of lawyers representing clients in pending cases may be regulated under a less demanding standard than that established for regulation of the press," but it did not suggest that restrictions on professional speech are entirely exempt from First Amendment scrutiny.[31] Four years later, in *Florida Bar v. Went for It*,[32] the Court cited *Gentile* for the proposition that "[t]here are circumstances in which we will accord speech by attorneys on . . . matters of legal representation the strongest protection our Constitution has to

26. *Lowe*, 472 U.S. at 229 (White, J., concurring).

27. *Id.* at 230.

28. *Id.* at 233. *But see* Paul Sherman, Commentary, *Occupational Speech and the First Amendment*, 128 HARV. L. REV. F. 183, 199 (2015), http://harvardlawreview.org/wp-content/uploads/2015/03/vol128_Sherman.pdf [https://perma.cc/JR5R-DX2G] (arguing that exempting licensing requirements from First Amendment scrutiny "is hard to square with the Supreme Court's long-held view that licensing laws are among the most onerous burdens that can be imposed on speech"); Rodney A. Smolla, *Professional Speech and the First Amendment*, 119 W. VA. L. REV. 67, 106 (2016) ("Even the threshold decision to require a license is not immune from high levels of First Amendment scrutiny.").

29. 501 U.S. 1030 (1991).

30. *Id.* at 1058.

31. *Id.* at 1074.

32. 515 U.S. 618 (1995) (upholding a thirty-day restriction on targeted direct-mail solicitation of accident victims and their relatives as valid regulation of commercial speech).

offer."[33] However, neither of these cases involved efforts to regulate private conversations between professionals and their clients.

Only two Supreme Court cases have directly addressed the constitutionality of laws regulating communications by physicians with their patients. The first, *Rust v. Sullivan*,[34] was a challenge to federal regulations prohibiting physicians in federally funded family planning facilities from counseling patients on abortion. In a 5-4 decision, the Court upheld the regulations on the ground that the government is free to limit the scope of services provided by federally funded programs and to require program participants not to offer services that go beyond that scope.[35] The Court also emphasized that the regulations did not "require[] a doctor to represent as his own any opinion that he does not in fact hold" and that the relationship between physicians and patients in the program was not "sufficiently all encompassing so as to justify an expectation on the part of the patient of comprehensive medical advice."[36] However, while these observations would seem to imply that at least some restrictions on physician-patient communications could be vulnerable to a First Amendment challenge, the Court expressly left that question unresolved.[37] Moreover, because the case involved conditions placed on participants in federally funded programs, it says little about the standard applicable to restrictions on physician speech in private physician-patient relationships.

Of greater relevance is the Supreme Court's 1992 decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[38] That case involved a challenge to a Pennsylvania law that, among other things, required physicians performing abortions to provide specific information about the risks of the procedure, the risks of carrying the fetus to term, the probable gestational age of the fetus, alternatives to abortion, and the fact that the father might be responsible for child support payments.[39] In addition to finding that these requirements did

33. *Id.* at 634.

34. 500 U.S. 173 (1991).

35. *Id.* at 193–94.

36. *Id.* at 200.

37. *Id.* ("It could be argued . . . 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 . . . .").

38. 505 U.S. 833 (1992) (plurality opinion).

39. *Id.* at 881.

not violate the Due Process Clause of the Fourteenth Amendment,[40] a plurality of the Court found that the mandatory disclosures did not violate physicians' First Amendment rights.[41] According to the plurality, even though the disclosure requirements implicated "the physician's First Amendment rights not to speak," they did so "only as part of the practice of medicine, subject to reasonable licensing and regulation by the State."[42]

The *Casey* plurality's terse discussion of the First Amendment leaves a great deal open to interpretation. The two cases it cited as support—*Wooley v. Maynard*[43] and *Whalen v. Roe*[44]—are at best only obliquely related to mandated disclosures by physicians to patients. *Wooley* struck down a New Hampshire law requiring drivers to display the motto "Live Free or Die" on their license plates,[45] and *Whalen* upheld a New York statute requiring physicians to report prescriptions for controlled substances to public health authorities.[46] Neither of these cases involved governmental intrusions into physician-patient discussions. Moreover, as Robert Post has observed, "Exactly how the strict First Amendment standards of *Wooley* are meant to qualify the broad police power discretion of *Whalen* [was] left entirely obscure."[47]

At a minimum, the plurality's reference to "the physician's First Amendment rights not to speak" affirms that physicians' communications with their patients are entitled to at least some First Amendment protection. However, the plurality never articulated the applicable standard of review.[48] On the one hand, its use of the word "reasonable" might mean that such laws are permissible as long as they have a rational basis, given that the word "reasonable" is often used as a synonym for "rational."[49] On the other hand, the plurality

40. The plurality concluded that the requirements did not violate the Due Process Clause because they did not impose an "undue burden" on a woman's ability to determine whether or not to carry a pregnancy to term. *See id.* at 881–83.

41. *Id.* at 884.

42. *Id.*

43. 430 U.S. 705 (1977).

44. 429 U.S. 589 (1977).

45. *Wooley*, 430 U.S. at 713.

46. *Whalen*, 429 U.S. at 603–04.

47. Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 946.

48. *See* Sonia M. Suter, *The First Amendment and Physician Speech in Reproductive Decision Making*, 43 J.L. MED. & ETHICS 22, 24 (2015) (observing that *Casey* "left ambiguous how to evaluate regulations of professional speech in health care").

49. *See* Scott W. Gaylord, *A Matter of Context:* Casey *and the Constitutionality of Compelled Physician Speech*, 43 J.L. MED. & ETHICS 35, 36 (2015) ("[I]n the context of the practice of medicine, compelled disclosures generally do not impose an undue burden

made this statement only after having already determined (in the context of its due process analysis) that the state had a "substantial" interest in requiring the disclosures[50] and noting "the ways in which the speech requirement was narrowly drawn."[51] In light of these findings, the Pennsylvania law would have survived even the higher standard of intermediate scrutiny,[52] making it unnecessary for the plurality to decide which of the two standards it was required to apply. The most that can be said about *Casey* is that the plurality was clearly not applying strict scrutiny in its First Amendment analysis, as it made no effort to determine whether the statute was "narrowly tailored" or based on a "compelling state interest."

The Supreme Court's 2018 decision in *National Institute of Family and Life Advocates v. Becerra* (*NIFLA*),[53] while not directly dealing with communications within a physician-patient relationship, sheds light on the Court's current thinking on the First Amendment's application to professional speech more generally. *NIFLA* involved a challenge to a California statute regulating so-called crisis pregnancy centers ("CPCs"), which are organizations that offer a limited range of pregnancy-related services and exist primarily to "discourage and prevent women from seeking abortions."[54] The California statute required licensed CPCs to notify women that the state provides free and low-cost pregnancy-related services, including abortions, and required unlicensed facilities to notify women that the facilities are not licensed to provide medical services.[55] A group of CPCs challenged the statute under the First Amendment and moved for a

and, consequently, are subject only to 'reasonableness' or rational basis review under *Casey*."); B. Jessie Hill, *Sex, Lies, and Ultrasound*, 89 U. COLO. L. REV. 421, 432 (2018) ("The Court's language of reasonableness, along with its dismissive treatment of the claim, suggest something like rational basis review was applied to the physician's free speech claim.").

50. *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 882 (1992) (plurality opinion).

51. *See* Wollschlaeger v. Governor of Fla., 760 F.3d 1195, 1246 (11th Cir. 2014) (Wilson, J., dissenting) (noting that the Pennsylvania statute at issue in *Casey* "was limited to 'truthful and not misleading' information" and did "'not prevent the physician from exercising his or her medical judgment' not to provide the information in certain situations" (quoting *Casey*, 505 U.S. at 882, 884)), *vacated on reh'g*, 797 F.3d 859 (11th Cir. 2015), *vacated on reh'g*, 814 F.3d 1159 (11th Cir. 2015), *aff'd in part and rev'd in part en banc*, 848 F.3d 1293 (11th Cir. 2017).

52. *See id.* ("This analysis mirrors an intermediate scrutiny analysis and shows that the law in question passes constitutional muster under that standard.").

53. 138 S. Ct. 2361 (2018).

54. *Id.* at 2368.

55. *Id.* at 2368–70.

preliminary injunction to prevent the statute from being enforced.[56] The district court denied the motion, finding that the CPCs could not show a likelihood of success on the merits.[57] The Ninth Circuit affirmed.[58] According to the Ninth Circuit, the notice requirement for licensed facilities satisfied the "lower level of scrutiny" applicable to regulations of "professional speech," while the notice requirement for unlicensed clinics satisfied "any level of scrutiny."[59] In a 5-4 decision, the Supreme Court reversed.

The Court began its analysis by stating that most content-based restrictions on speech are "presumptively unconstitutional" and will be upheld only if they are "narrowly tailored to serve compelling state interests."[60] It criticized the Ninth Circuit's conclusion that content-based regulations of professional speech are subject to a lower level of scrutiny, observing that "this Court has not recognized 'professional speech' as a separate category of speech."[61] At the same time, the Court did "not foreclose the possibility" that professional speech might constitute "a unique category that is exempt from ordinary First Amendment principles,"[62] as it found that the statute would be unconstitutional even if strict scrutiny were not applied. It characterized the notice requirement for licensed facilities as "wildly underinclusive," on the grounds that the state's interest in providing low-income women with information about state-sponsored services applied equally to health centers not covered by the statute.[63] It also found that the state could have achieved its goal of informing women about the availability of state-sponsored services through less-

56. *Id.* at 2370.

57. *Id.*

58. *Id.*

59. *Id.* (quoting Nat'l Inst. of Family & Life Advocates v. Harris, 839 F.3d 823, 835, 837, 839 (9th Cir. 2016), *rev'd sub nom.* Nat'l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361 (2018)).

60. *Id.* at 2371 (quoting Reed v. Town of Gilbert, 135 S. Ct. 2218, 2226 (2015)).

61. *See id.* The Court emphasized that "[s]peech is not unprotected merely because it is uttered by 'professionals.'" *Id.* at 2371–72. This was an odd claim for two reasons. First, the Ninth Circuit had not held that professional speech is "unprotected"; it simply found that such speech is subject to intermediate, rather than strict, scrutiny. *See* Nat'l Inst. of Family & Life Advocates v. Harris, 839 F.3d 823, 839 (9th Cir. 2016), *rev'd sub nom.* Nat'l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361 (2018). Second, proponents of a professional speech doctrine have been clear to emphasize that the doctrine does not apply to all speech "uttered by 'professionals'" but rather to the more limited category of communications within a professional-client relationship. *See, e.g.*, Daniel Halberstam, *Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions*, 147 U. PA. L. REV. 771, 843 (1999) (distinguishing between speech "uttered in the course of professional practice" and speech "uttered by a professional").

62. *NIFLA*, 138 S. Ct. at 2375.

63. *Id.* (quoting Brown v. Entm't Merchs. Ass'n, 564 U.S. 786, 802 (2011)).

restrictive means, such as public information campaigns.[64] The Court expressed the same concerns about underinclusiveness with respect to the notice requirement for unlicensed facilities.[65] In addition, it concluded that the justification for that requirement was "purely hypothetical," as there was no evidence that women did not already know that these clinics were unlicensed.[66]

NIFLA's implications for laws governing physician-patient communications are difficult to determine. In addition to leaving open the possibility that the regulation of professional speech might not be subject to ordinary First Amendment principles, the Court noted that, even if strict scrutiny does apply to professional speech, "[s]tates may regulate professional conduct, even though that conduct incidentally involves speech."[67] The Court cited *Casey* as support for this proposition, implying that informed consent discussions fall into the category of "professional conduct" that has an incidental effect on speech.[68] It further suggested that this exception to strict scrutiny might go beyond informed consent to include other regulations of professional speech "tied to a [medical] procedure."[69] The reason this exception did not apply to the California statute in *NIFLA* was that the law regulated facilities rather than physicians, and it applied "regardless of whether a medical procedure is ever sought, offered, or performed."[70] However, depending on how the Court applies this speech/conduct distinction in future cases, it is possible that, even if most content-based regulations of professional speech are governed by strict scrutiny, laws governing physician-patient communications will remain subject to a more deferential standard of review.

B. Lower Court Cases

The scant Supreme Court case law on point has left lower courts with little guidance in cases involving restrictions on professional communications. The one issue on which there appears to be a consensus is that laws requiring licensing of individuals who engage in speech-related professions do not violate the First Amendment rights

64. *Id.* at 2376.
65. *See id.* at 2378.
66. *Id.* at 2377 (quoting Ibanez v. Fla. Dep't of Bus. & Prof'l Regulation, Bd. of Accountancy, 512 U.S. 136, 146 (1994)).
67. *Id.* at 2372.
68. *Id.*
69. *Id.* at 2373.
70. *Id.*

of nonlicensed persons.[71] For example, circuit courts have rejected First Amendment challenges to laws requiring licensing of psychotherapists,[72] interior designers,[73] fortune tellers,[74] and accountants.[75] None of these cases, however, directly addressed efforts to regulate the content of communications between professionals and their clients.[76] On that question, lower courts have adopted a broad range of approaches, reflecting dramatically different understandings of the First Amendment issues at stake. This section considers those cases, focusing on those specifically related to the medical profession.

1. Physician Speech Recommending Therapeutic Options

A core function of physician speech is to ensure that patients have information about the range of therapeutic options available in their particular circumstances. This responsibility is reflected in the doctrine of informed consent, which requires that physicians not only present the risks and benefits of proposed treatments but also discuss available alternatives that fall within the prevailing standard of care.[77]

71. The D.C. Circuit, however, has held that the lower level of First Amendment protection for licensing requirements is limited to occupations involving individualized professional-client relationships. *See* Edwards v. District of Columbia, 755 F.3d 996, 1000 & n.3 (D.C. Cir. 2014) (applying heightened scrutiny to a regulation requiring tour guides to pass a licensing exam on the ground that tour guides "provide virtually identical information to each customer"). In addition, the Fifth Circuit has held that states may not use their licensing authority to restrict persons from using professional titles outside the context of professional practice. *See* Serafine v. Branaman, 810 F.3d 354, 360 (5th Cir. 2016) (finding that Texas could not prohibit an unlicensed political candidate from describing herself as a psychologist on her campaign website, noting that "[o]utside the fiduciary relationship between client and therapist, speech is granted ordinary First Amendment protection").

72. *See* Nat'l Ass'n for the Advancement of Psychoanalysis v. Cal. Bd. of Psychology, 228 F.3d 1043, 1053 (9th Cir. 2000).

73. *See* Locke v. Shore, 634 F.3d 1185, 1189 (11th Cir. 2011).

74. *See* Moore-King v. County of Chesterfield, 708 F.3d 560, 570 (4th Cir. 2013). To the extent the Supreme Court's 2018 decision in *NIFLA* casts doubt on the idea that professional speech is a distinct First Amendment category, the continued precedential value of the Fourth Circuit's decision in *Moore-King* remains uncertain. *See NIFLA*, 138 S. Ct. at 2375 (questioning whether there is "a persuasive reason for treating professional speech as a unique category that is exempt from ordinary First Amendment principles," but not "foreclos[ing] the possibility that some such reason exists").

75. *See* Accountant's Soc'y of Va. v. Bowman, 860 F.2d 602, 605 (4th Cir. 1988).

76. *See, e.g.*, *Nat'l Ass'n for the Advancement of Psychoanalysis*, 228 F.3d at 1055–56 (noting that the law requiring licenses for psychotherapists did not "dictate the content of what is said in therapy").

77. *See* Nadia N. Sawicki, *Modernizing Informed Consent: Expanding the Boundaries of Materiality*, 2016 U. ILL. L. REV. 821, 829–32 [hereinafter Sawicki, *Modernizing Informed Consent*] (describing the common law foundations of informed consent).

In addition to being a legal duty, presenting patients with alternatives to proposed treatments is considered part of physicians' ethical obligation to respect patients' decision-making autonomy.[78]

Within this context, many physicians strongly objected when, in response to state laws immunizing physicians from prosecution for recommending marijuana for medical purposes, the federal government declared that physicians who made such recommendations would risk losing their federal licenses to prescribe controlled substances.[79] In *Conant v. Walters*,[80] a coalition of physicians and patients brought suit to enjoin enforcement of this policy on First Amendment grounds.[81] A district court found for the plaintiffs, and the government appealed.[82]

In affirming the district court, the Ninth Circuit asserted that the government's threat to revoke the controlled substance registrations of physicians who recommend medical marijuana undermined "core First Amendment interests of doctors and patients."[83] Unlike licensing laws, which are content-neutral standards for judging individuals' qualifications for entry into a profession, penalizing physicians for recommending medical marijuana "seeks to punish physicians on the basis of the content of doctor-patient communications."[84] The court noted that, in a previous case upholding licensing requirements for mental health professionals, it had emphasized that the law did not seek to control the content of therapists' communications with patients or to prevent therapists from relying on particular psychoanalytic techniques.[85] Here, however, the law directly regulated the content of what physicians could say to their patients.

The court was particularly troubled by the fact that the challenged policy intruded on the normal process of professional decision-making. It contrasted the blanket policy against recommending medical marijuana with the Pennsylvania law that had been upheld in *Casey*, which excused physicians from making the required disclosures if they had a reasonable belief that doing so would have a "severely adverse effect on the physical or mental

78. *See id.* at 827–29 (discussing the ethical foundations of informed consent).

79. *See* Administration Response to Arizona Proposition 200 and California Proposition 215, 62 Fed. Reg. 6164, 6164–66 (Feb. 11, 1997).

80. 309 F.3d 629 (9th Cir. 2002).

81. *Id.* at 632.

82. *Id.*

83. *Id.* at 636.

84. *Id.* at 637.

85. *Id.*

health of the patient."[86] In light of this exception, the court observed that the Pennsylvania law "did not 'prevent the physician from exercising his or her medical judgment.'"[87]

The Ninth Circuit also compared the case to *Legal Services Corp. v. Velazquez*,[88] in which the Supreme Court struck down a statute preventing legal service organizations receiving federal funds from challenging welfare laws.[89] "Like the limitation in *Velazquez*," the court found that the prohibition on recommending medical marijuana "'alter[s] the traditional role' of medical professionals by 'prohibit[ing] speech necessary to the proper functioning of those systems.'"[90] The court's reliance on *Velazquez* suggests that the problem with the federal policy was not simply that it interfered with the rights of individual physicians and patients but also that it undermined physicians' ability to conform to the medical profession's own standards and norms.

2. Physician Speech with Therapeutic Purposes

While many medical treatments involve drugs or procedures, in other situations physicians treat patients with nothing more than words. An obvious example is when psychiatrists engage in talk therapy with their patients, a process in which the treatment consists entirely of conversation. Other examples include advising patients on improving cardiac health through diet or exercise,[91] and counseling patients about nonpharmaceutical strategies for dealing with symptoms such as insomnia or pain.[92] As discussed further below, it can sometimes be difficult to differentiate between speech that

86. *Id.* at 638 (quoting Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 883–84 (1992) (plurality opinion)).

87. *Id.* (quoting *Casey*, 505 U.S. at 883–84).

88. 531 U.S. 533 (2001).

89. *Id.* at 536–37.

90. *Conant*, 309 F.3d at 638 (alterations in original) (quoting *Velazquez*, 531 U.S. at 544).

91. *See generally* Nancy T. Artinian et al., *Interventions to Promote Physical Activity and Dietary Lifestyle Changes for Cardiovascular Risk Factor Reduction in Adults*, 122 CIRCULATION 406 (2010) (discussing the role of physician counseling in improving cardiac health).

92. *See generally* John McBeth et al., *Cognitive Behavioral Therapy, Exercise, or Both for Treating Chronic Widespread Pain*, 172 ARCHIVES INTERNAL MED. 48, 48 (2012) (concluding that telephone-delivered cognitive behavioral therapy led to "substantial, statistically significant, and sustained improvements" in patients' global assessments of their health); Amir Qaseem et al., *Management of Chronic Insomnia Disorder in Adults: A Clinical Practice Guideline from the American College of Physicians*, 165 ANNALS INTERNAL MED. 125 (2016) (discussing the importance of behavioral counseling as a first-line treatment for insomnia).

recommends a therapeutic option and speech that constitutes the therapy itself.[93] Nonetheless, the Ninth Circuit in *Pickup v. Brown*[94] found that the distinction between these two types of speech had constitutional significance.

Pickup involved a challenge to a California law prohibiting licensed mental health care providers from performing therapies intended to change minors' sexual orientation (known as "sexual orientation change efforts," or "SOCE").[95] These therapies included techniques such as "assertiveness and affection training with physical and social reinforcement" and attempts "to change gay men's and lesbians' thought patterns by reframing desires, redirecting thoughts, or using hypnosis."[96] Providers who violated the statute could be subject to professional discipline.[97]

In upholding the law, the court distinguished the ban on SOCE from the federal policy against recommending medical marijuana, which the court had previously found unconstitutional in *Conant*.[98] It observed that the policy at issue in *Conant* involved "doctor-patient communications *about* medical treatment,"[99] whereas the ban on SOCE targeted a *type* of medical treatment that just happens to be carried out through the mechanism of speech. According to the court, because the speech was primarily "therapeutic, not symbolic," it did not constitute "an act of communication" triggering First Amendment protection.[100] Instead, when "treatment is performed through speech alone," regulation of that speech constitutes a regulation of conduct, "subject to deferential review just as are other regulations of the practice of medicine."[101] The court emphasized that physicians remained free to discuss SOCE with their patients and to express opinions about its advantages and drawbacks, as long as they did not actually perform the therapy themselves.[102]

The Ninth Circuit's opinion in *Pickup* also clarified—or perhaps narrowed—its previous decision in *Conant* by emphasizing that even

93. *See infra* text accompanying notes 247–50.

94. 740 F.3d 1208 (9th Cir. 2014). As with *Moore-King*, the Supreme Court's 2018 decision in *NIFLA* creates some uncertainty as to the continued precedential value of the Ninth Circuit's decision in *Pickup*. *See supra* note 74.

95. *Pickup*, 740 F.3d at 1222–23.

96. *Id.* at 1222.

97. *Id.* at 1223.

98. *Id.* at 1219–20.

99. *Id.* at 1227.

100. *Id.* at 1230.

101. *Id.* at 1230–31.

102. *Id.* at 1219.

speech about treatment is subject to "somewhat diminished" First Amendment protection.[103] Citing Justice White's concurring opinion in *Lowe*, the court observed that, when speech occurs "within the confines of a professional relationship," the purpose is "to advance the welfare of the clients, rather than to contribute to public debate."[104] It found that a greater degree of regulation is justified under these circumstances in light of the government's interest in protecting clients from harm. Whereas *Conant* was concerned with the possibility that *restrictions* on speech could interfere with physicians' ability to make individualized medical judgments, in *Pickup*, the court emphasized the government's interest in protecting patients *from* speech "that is not consistent with the accepted standard of care."[105] For example, the court observed that the First Amendment would not prohibit a state from revoking the license of a physician who "counsel[s] a patient to rely on quack medicine."[106]

Shortly after the Ninth Circuit's decision in *Pickup*, the Third Circuit confronted a similar challenge to a New Jersey law prohibiting the use of SOCE with minor patients. In its decision in *King v. Governor of New Jersey*,[107] the Third Circuit found that the law was constitutional but rejected the Ninth Circuit's view that the law should be analyzed as a regulation of conduct rather than a limitation on speech.[108] The court relied primarily on the Supreme Court's decision in *Holder v. Humanitarian Law Project*,[109] which rejected the government's effort to characterize a law prohibiting the provision of legal advice to terrorist organizations as a limitation on conduct with only incidental effects on speech.[110] According to the Third Circuit, the decision in *Humanitarian Law Project* "makes clear that verbal or written communications, even those that function as vehicles for

103. *Id.* at 1228.

104. *Id.*

105. *Id.*

106. *Id.*

107. 767 F.3d 216 (3d Cir. 2014). As with *Moore-King* and *Pickup*, the Supreme Court's 2018 decision in *NIFLA* creates some uncertainty as to the continued precedential value of the Third Circuit's decision in *King*. *See supra* note 74.

108. *King*, 767 F.3d at 226–29.

109. 561 U.S. 1 (2010).

110. *See id.* at 35–36. Despite finding that the statute implicated protected speech, the Court upheld it as applied to the kinds of support the plaintiffs sought to provide. *See id.* at 36 (finding that the government had sustained its burden of showing that "it was necessary to prohibit providing material support in the form of training, expert advice, personnel, and services to foreign terrorist groups").

delivering professional services, are 'speech' for purposes of the First Amendment."[111]

Despite its conclusion that the prohibition on SOCE was a regulation of speech and not conduct, the Third Circuit rejected the plaintiffs' First Amendment challenge to the statute.[112] Like the Ninth Circuit, the court found that speech within the confines of a professional relationship is entitled to only "diminished" First Amendment protection.[113] The court emphasized that clients typically have "no choice but to place their trust in . . . professionals," given that professionals have specialized knowledge and training that most clients lack.[114] According to the court, to adequately protect vulnerable clients, states must have sufficient leeway to regulate all aspects of professional practice, even if doing so may sometimes involve placing limits on speech.[115] The court concluded that the appropriate standard of review of restrictions on professional speech was intermediate scrutiny, under which "prohibitions of professional speech are constitutional only if they directly advance the State's interest in protecting its citizens from harmful or ineffective professional practices and are no more extensive than necessary to serve that interest."[116] It found that the prohibition on SOCE satisfied this standard, in light of medical testimony that the practice had the potential to cause serious harm.[117]

3. Physician Speech to Elicit Information from Patients

Physicians communicate with patients not only to convey information or engage in speech-based forms of treatment but also to prompt patients to share information that might be relevant to decisions about their care. Such information might include personal and family medical histories or details about diet, exercise, and other

111. *King*, 767 F.3d at 225–26.
112. *Id.* at 224.
113. *Id.*
114. *Id.* at 232.
115. *Id.*
116. *Id.* at 233. The Third Circuit suggested that this standard was arguably stricter than the plurality's approach in *Casey*, but it distinguished *Casey* on the ground that "the regulation it addressed fell within a special category of laws that compel disclosure of truthful factual information." *Id.* at 235–36 (citing Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 881 (1992) (plurality opinion)). It concluded that *Casey* was inapplicable because the ban on SOCE was "a prohibition of speech, not a compulsion of truthful factual information." *Id.* at 236.
117. *Id.* at 238.

behaviors.[118] In some cases, physicians ask the same questions to everyone because they have important health-related implications for all classes of patients. In other cases, physicians may tailor their questions based on the patient's age, gender, or preexisting diagnoses.

In response to evidence of the health risks associated with firearm ownership, major medical groups have recommended that, along with other routine questions, physicians ask their patients whether they have firearms in their homes so that they can counsel patients about the importance of storing weapons safely.[119] However, following complaints by individuals who perceived these questions as intrusive, Florida enacted a statute prohibiting physicians from inquiring about firearm ownership unless they have made a particularized determination that the information is relevant to the patient's medical care or safety, or to the safety of others.[120]

118. *See* Tosha B. Wetterneck et al., *Development of a Primary Care Physician Task List to Evaluate Clinic Visit Workflow*, 21 BMJ QUALITY & SAFETY 47, 50 (2012) (listing twenty-six categories of information physicians are expected to gather from patients during a patient encounter).

119. *See* Council on Injury, Violence, & Poison Prevention Exec. Comm., Am. Acad. of Pediatrics, *Firearm-Related Injuries Affecting the Pediatric Population*, 130 PEDIATRICS e1416, e1421 (2012) ("The AAP recommends that pediatricians incorporate questions about the presence and availability of firearms into their patient history taking and urge parents who possess guns to prevent access to these guns by children."); *Prevention of Firearm Accidents in Children H-145.990*, AMA, https://policysearch.ama-assn.org/policyfinder/detail/H-145.990?uri=%2FAMADoc%2FHOD.xml-0-547.xml [https://perma.cc/4YH3-ZW3C] (last updated 2018) (calling on AMA members to "inquire as to the presence of household firearms as a part of childproofing the home"); *see also* Steven E. Weinberger et al., *Firearm-Related Injury and Death in the United States: A Call to Action from 8 Health Professional Organizations and the American Bar Association*, 162 ANNALS INTERNAL MED. 513, 514 (2015) ("[P]hysicians must be allowed to speak freely to their patients in a nonjudgmental manner about firearms, provide patients with factual information about firearms relevant to their health and the health of those around them, fully answer their patients' questions, and advise them on the course of behaviors that promote health and safety without fear of liability or penalty.").

120. FLA. STAT. ANN. §§ 381.026, 456.072, 790.338 (West 2017 & West Supp. 2019). Together, these provisions provide that licensed health care providers and facilities may not enter information about a patient's firearm ownership into a patient's medical record "if the practitioner knows that such information is not relevant to the patient's medical care or safety, or the safety of others," FLA. STAT. ANN. § 790.338(1) (West 2017); must refrain from asking whether a patient or his or her family member owns firearms unless the practitioner or facility believes in good faith that the "information is relevant to the patient's medical care or safety, or the safety of others," FLA. STAT. ANN. § 381.026(b) (West Supp. 2019); and must refrain from discriminating against or harassing patients based on firearm ownership, FLA. STAT. ANN. § 790.338(5)–(6) (West 2017). Violation of these provisions constitutes ground for professional discipline, including the potential loss of a physician's medical license. FLA. STAT. ANN. § 456.072(u), (nn) (West Supp. 2019).

In *Wollschlaeger v. Governor of Florida*,[121] a group of physicians and advocacy groups challenged the statute as a violation of the First Amendment.[122] The district court found that the statute was subject to heightened scrutiny because it imposed a content-based restriction on physicians' expression.[123] It concluded that, regardless of whether the statute was analyzed under strict or intermediate scrutiny, the state's interests were insufficient to justify the limitation on speech.[124] In particular, it found that the State's reliance on the Second Amendment was misplaced, as physicians' questions about firearm ownership do not deprive individuals of their right to keep and bear arms,[125] and that there was no evidence that the prohibition was necessary to protect patients from discrimination or harassment.[126] The court also found that the state's interest in protecting patients' privacy was not a sufficient basis for upholding the law, given the existence of federal and state laws protecting the confidentiality of medical records.[127]

Ultimately, the Eleventh Circuit upheld the district court in an en banc decision,[128] but only after a three-judge panel had issued three separate opinions reversing the district court, each of which rested on a different rationale. In its first decision, issued in July 2014,[129] the majority of the three-judge panel found that the law was exempt from First Amendment scrutiny because it regulated conduct rather than expression.[130] This decision relied on a broad interpretation of Justice White's observation in *Lowe* that "[t]he power of government to regulate the professions is not lost whenever

121. 848 F.3d 1293 (11th Cir. 2017) (en banc).

122. *Id.* at 1300–01.

123. Wollschlaeger v. Farmer, 880 F. Supp. 2d 1251, 1261–62 (S.D. Fla. 2012), *aff'd in part and rev'd in part en banc sub nom.* Wollschlaeger v. Governor of Fla., 848 F.3d 1293 (11th Cir. 2017).

124. *Wollschlaeger*, 848 F.3d at 1317.

125. *Wollschlaeger*, 880 F. Supp. 2d at 1264.

126. *Id.* at 1264–65.

127. *Id.* at 1265. In addition to finding that the law interfered with physicians' First Amendment rights, the district court found that it was unconstitutionally vague because it did "not define what constitutes 'relevant to the patient's medical care or safety, or the safety of others,'" and because "what constitutes 'unnecessary harassment' is left to anyone's guess." *Id.* at 1268–69.

128. *Wollschlaeger*, 848 F.3d at 1319.

129. Wollschlaeger v. Governor of Fla., 760 F.3d 1195 (11th Cir. 2014), *vacated on reh'g*, 797 F.3d 859 (11th Cir. 2015), *vacated on reh'g*, 814 F.3d 1159 (11th Cir. 2015), *aff'd in part and rev'd in part en banc*, 848 F.3d 1293 (11th Cir. 2017).

130. *Id.* at 1217.

the practice of a profession entails speech."[131] Rejecting the argument that this statement was limited to licensing requirements, the majority concluded that *any* regulation of a professional's exercise of judgment on behalf of an individual client is entirely exempt from First Amendment scrutiny.[132] The majority acknowledged the Ninth Circuit's distinction in *Pickup* between physician speech "about medical treatment" and speech that "was itself treatment," but it found that "the line between treatment and communication about treatment is not necessarily so clear."[133] For example, it observed that a physician's effort to help a patient stop smoking might begin with asking the patient whether he smokes, followed by a recommendation not to continue.[134] Likewise, it observed that "[a] physician's inquiry about the presence of firearms in a patient's home may be viewed as the opening salvo in an attempt to treat any issues raised by the presence of those firearms."[135] According to the majority, both the initial questions and the follow-up they engender are "part and parcel with the physician's treatment of the patient."[136]

The panel's July 2014 decision provoked a sharp dissent that, among other things, criticized the majority for "creating a new category of speech immune from First Amendment review."[137] Perhaps in response to these comments, the panel took the unusual step of vacating its decision sua sponte and, in July 2015, substituted a new opinion[138] in which it concluded that the law was, in fact, a direct regulation of speech subject to First Amendment scrutiny.[139] However, the majority found that the regulation of speech within the context of professional-client relationships is subject to a "lesser level of scrutiny,"[140] given the state's interest in "regulation of the profession for the protection of the public, and regulation of the

131. *Id.* at 1217–18 (quoting Lowe v. SEC, 472 U.S. 181, 228 (1985) (White, J., concurring)).

132. *Id.* at 1222–23 ("We are not convinced that a licensing requirement is the only form of professional regulation that may validly touch on professional speech.").

133. *Id.* at 1224.

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.* at 1237 (Wilson, J., dissenting).

138. Wollschlaeger v. Governor of Fla., 797 F.3d 859 (11th Cir.), *vacated on reh'g*, 814 F.3d 1159 (11th Cir. 2015), *aff'd in part and rev'd in part en banc*, 848 F.3d 1293 (11th Cir. 2017).

139. *See id*. at 886 ("[W]hile the discrimination provision is a regulation of professional conduct with merely an incidental effect on speech, and thus does not implicate the First Amendment, the record-keeping, inquiry, and harassment provisions *do* regulate a significant amount of protected speech.").

140. *Id.* at 892.

[physician-patient] relationship for the protection of the patient and the benefit of society."[141] It therefore concluded that the appropriate standard of review was intermediate scrutiny.[142]

Citing "simple common sense," the majority found that the state's interests were sufficiently strong to satisfy the intermediate scrutiny standard.[143] The majority emphasized that the statute did not prohibit physicians from inquiring about firearms if they made a good faith judgment that doing so was "medically appropriate in the circumstances of the particular patient's case."[144] Thus, it viewed the statute as limiting only irrelevant medical inquiries and concluded that "[p]roscribing highly intrusive speech that physicians themselves do not believe to be relevant or necessary directly advances the State's interest in protecting its citizens from harmful or ineffective professional practices and safeguarding their privacy."[145]

A few months later, the panel once again vacated its decision sua sponte and substituted yet another opinion.[146] The third decision was prompted by the Supreme Court's 2015 decision in *Reed v. Town of Gilbert*,[147] which struck down a municipal law imposing stricter limits on signs advertising religious services than on signs displaying political or ideological messages.[148] Because Justice Thomas's majority decision in *Reed* suggested that all content-based restrictions on speech must be evaluated under strict scrutiny, the panel chose to reevaluate the Florida statute using strict, rather than intermediate, scrutiny. It concluded that, even if strict scrutiny applied, the Florida statute would still be constitutional, as the state's interest behind the law was "compelling" and the law was "narrowly tailored to advance that interest."[149]

Given the panel's own struggles with the proper resolution of this case, the Eleventh Circuit's decision to reconsider it en banc did not come as a surprise. The en banc court's ruling largely mirrored the district court's earlier analysis. Emphasizing that the legislature's evidence of harms caused by physician firearm inquiries was limited

141. *Id.* at 889.
142. *Id.* at 896.
143. *Id.* at 898.
144. *Id.* at 900.
145. *Id.* at 898.
146. Wollschlaeger v. Governor of Fla., 814 F.3d 1159 (11th Cir. 2015), *aff'd in part and rev'd in part en banc*, 848 F.3d 1293 (11th Cir. 2017).
147. 135 S. Ct. 2218 (2015).
148. *Id.* at 2233.
149. *Wollschlaeger*, 814 F.3d at 1186.

to "six anecdotes and nothing more,"[150] the court found that the state had failed to provide evidence that the statute addressed "harms that are 'real, [and] not merely conjectural.'"[151] In addition, like the district court, the en banc court emphasized that other mechanisms already existed to promote the state's legitimate interest in protecting patient privacy.[152]

The en banc majority expressly declined to decide whether it was necessary to subject the Florida statute to strict scrutiny, as it found that the statute failed even the more lenient standard of intermediate scrutiny.[153] However, Judge Wilson, who had dissented from the original panel decisions upholding the statute, wrote separately "to underscore the importance of applying the most demanding standard of scrutiny to this content-based law."[154] Although he acknowledged that "the Supreme Court has not squarely addressed the appropriate level of protection for professional speech," he argued that "[c]ontent-based restrictions on speech are permitted only when they fall within a few historic and traditional categories, such as obscenity or defamation," and that "[a]bsent from any such category of unprotected speech is truthful speech by physicians."[155] Distinguishing "other professional speech situations in which the state has a valid interest in regulating a specialized profession,"[156] Judge Wilson characterized the Florida statute as a "subversive attempt" to "silence[] doctors who advance a viewpoint about firearms with which the state disagrees."[157]

4. Compelled Physician Speech

In contrast to the cases discussed in the previous sections, which involved limitations on what physicians are permitted to say to their patients, several decisions in the context of abortion involve laws compelling physicians to make specific disclosures. The abortion laws are not the only examples of government-mandated disclosure requirements,[158] but so far they are the only ones that have resulted in

150. Wollschlaeger v. Governor of Fla., 848 F.3d 1293, 1312 (11th Cir. 2017) (en banc).
151. *Id.* (quoting Turner Broad. Sys., Inc. v. FCC, 512 U.S. 622, 664 (1994)).
152. *Id.* at 1314.
153. *Id.* at 1311.
154. *Id.* at 1324 (Wilson, J., concurring).
155. *Id.* at 1325.
156. *Id.* (citing Gentile v. State Bar of Nev., 501 U.S. 1030, 1051–52 (1991) (discussing cases involving "commercial speech by attorneys or restrictions upon release of information that the attorney could gain only by use of the court's discovery process")).
157. *Id.* at 1324.
158. *See supra* text accompanying notes 3–6.

First Amendment litigation. The circuit courts have reached conflicting opinions on the appropriate standard to apply.

In two separate en banc decisions in *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds* (*Rounds I* and *Rounds II*),[159] the Eighth Circuit interpreted *Casey* to mean that a state "can use its regulatory authority to require a physician to provide truthful, non-misleading information relevant to a patient's decision to have an abortion, even if that information might also encourage the patient to choose childbirth over abortion."[160] First, in its 2008 decision (*Rounds I*), the court applied this standard to uphold South Dakota's requirement that physicians inform pregnant women that abortion "will terminate the life of a whole, separate, unique, living human being" with whom the woman "has an existing relationship."[161] Rejecting the argument that the physicians were being forced to transmit the state's "ideological message," it found that the required disclosure was factually accurate under the statute's own definition of the term "human being," which included "an individual living member of the species of Homo sapiens . . . during [its] embryonic [or] fetal age[]."[162] The court concluded that it was "incumbent upon . . . a physician answering a patient's questions" to explain that the term "human being" had a particular statutory meaning.[163]

Four years later, in its decision in *Rounds II*, the court upheld another part of South Dakota's abortion statute, which required

159. *Rounds II*, 686 F.3d 889 (8th Cir. 2012) (en banc); *Rounds I*, 530 F.3d 724 (8th Cir. 2008) (en banc).

160. *Rounds I*, 530 F.3d at 734–35. Although the court did not specify which standard of review it was applying, its focus on whether the compelled disclosures were truthful and not misleading is similar to the Supreme Court's approach in *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985). In that case, the Court held that states may require an attorney to disclose "purely factual and uncontroversial information about the terms under which his services will be available" because doing so is "reasonably related to the State's interest in preventing deception of consumers." *Id.* at 651. The *Zauderer* standard essentially amounts to a form of rational basis review and represents an exception to the standard of intermediate scrutiny that normally applies in commercial speech cases. *See* Note, *Repackaging* Zauderer, 130 HARV. L. REV. 972, 972 (2017).

161. *Rounds I*, 530 F.3d at 726 (quoting S.D. CODIFIED LAWS § 34-23A-10.1 (Westlaw through 2019 Reg. Sess. effective Mar. 27, 2019)).

162. *Id.* at 735–36 (alterations in original) (quoting S.D. CODIFIED LAWS § 34-23A-1 (Westlaw through 2019 Reg. Sess. effective Mar. 27, 2019)).

163. *Id.* at 735–36; *see also* B. Jessie Hill, *The First Amendment and the Politics of Reproductive Health Care*, 50 WASH. U. J.L. & POL'Y 103, 113 (2016) (arguing that the court considered this information relevant only because it had "fram[ed] abortion as predominantly (or at least substantially) a moral decision rather than a medical one," thereby "expand[ing] the concept of 'relevance' beyond its traditional boundaries in the informed-consent context").

physicians to state that "increased risk of suicide ideation and suicide" are "statistically significant risk factors to which the pregnant woman would be subjected."[164] According to the court, this statement was truthful because there was evidence that having an abortion is correlated with suicide or suicide ideation—i.e., that the prevalence of suicidality is greater among women who have had abortions than among women who have not.[165] Although it acknowledged that there was no medical consensus "as to whether abortion plays a causal role in the observed correlation between abortion and suicide," it found that this uncertainty did not make the mandatory disclosure misleading.[166] To establish that the disclosure was "unconstitutionally misleading or irrelevant," the plaintiffs would have had to prove that "abortion has been ruled out, to a degree of scientifically accepted certainty, as a statistically significant causal factor in post-abortion suicides."[167] In other words, even though some women might interpret the disclosure to mean that having an abortion would make it more likely that they would become suicidal, and even though such a causal relationship had not been established, physicians could still be required to make the disclosure because the implied causal connection had not been definitively proven to be false. The court suggested that, to the extent the required disclosure might be confusing, it was the physicians' job to "explain[] [the information] correctly to their patients."[168]

The Fifth Circuit's decision in *Texas Medical Providers Performing Abortion Services v. Lakey*,[169] involving a Texas statute requiring providers to display and discuss the results of a sonogram before performing abortions, relied on a similar approach. According to the Fifth Circuit, the state's authority to regulate the medical profession includes the right to require "truthful, nonmisleading, and relevant" disclosures, and such requirements do not infringe on physicians' First Amendment right not to speak.[170] Like the Eighth Circuit in *Rounds II*, it relied on *Casey* as support for this proposition, describing the plurality's First Amendment analysis in that case as

164. *Rounds II*, 686 F.3d at 894.

165. *Id.* at 899 ("[T]he standard medical practice, as reflected in the record, 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.").

166. *Id.* at 900.

167. *Id.*

168. *Id.* at 904–05.

169. 667 F.3d 570 (5th Cir. 2012).

170. *Id.* at 576.

"the antithesis of strict scrutiny."[171] Characterizing the descriptions of sonogram results as "the epitome of truthful, non-misleading information,"[172] the court suggested that withholding the information from the woman would be "more of an abuse to her ability to decide."[173]

In contrast, in *Stuart v. Camnitz*,[174] the Fourth Circuit took a very different approach to the First Amendment implications of compelled physician disclosures. *Stuart* involved a challenge to North Carolina's abortion disclosure requirements, which compelled physicians to display and describe the results of a sonogram even if the woman was "avert[ing] her eyes from the displayed images" or "refus[ing] to hear the simultaneous explanation and medical description."[175] Finding that *Casey* "did not hold sweepingly that all regulation of speech in the medical context merely receives rational basis review," the court found that the proper standard for analyzing content-based physician disclosure requirements was intermediate scrutiny.[176] It found that the North Carolina law failed that standard because, even assuming a substantial state interest in promoting childbirth, the law did not "directly advance the interest without impeding too greatly on individual liberty interests or competing state concerns."[177]

The court's primary objection to the law was that it was incompatible with "[t]raditional informed consent requirements,"[178] in which the physician's role is "to inform and assist the patient without imposing his or her own personal will and values on the patient."[179] By "[t]ransforming the physician into the mouthpiece of the state," the court argued, the law "undermines the trust that is necessary for facilitating healthy doctor-patient relationships."[180] Unlike the Fifth and Eighth Circuits, the Fourth Circuit did not find it dispositive that all of the required disclosures were truthful: "While it is true that the words the state puts into the doctor's mouth are factual, that does not divorce the speech from its moral or ideological implications."[181]

171. *Id.* at 575.
172. *Id.* at 578.
173. *Id.* at 579.
174. 774 F.3d 238 (4th Cir. 2014).
175. *Id.* at 243.
176. *Id.* at 249.
177. *Id.* at 250.
178. *Id.* at 251.
179. *Id.* at 252.
180. *Id.* at 253.
181. *Id.* at 246.

The Fourth Circuit's decision in *Stuart* is notable for its reliance on professional medical standards. Specifically, it criticized the North Carolina law as being "in direct contravention of medical ethics and the principle of patient autonomy."[182] While the court recognized the state's role in regulating the medical profession, it asserted that "[t]he government's regulatory interest is less potent in the context of a self-regulating profession like medicine."[183] Like the Ninth Circuit in *Conant*, the court also suggested that states have an obligation to respect physicians' "capacity for independent medical judgment that professional status implies."[184]

II. DETERMINING THE APPROPRIATE STANDARD OF REVIEW

Among legal commentators, there is broad consensus that at least some laws regulating physicians' communications with their patients should be subject to heightened First Amendment scrutiny. However, commentators disagree about not only the appropriate level of scrutiny—strict versus intermediate—but also the types of laws to which heightened scrutiny should apply. This part considers the two primary approaches to the issue that appear in the literature. The first calls on courts to apply strict scrutiny to all laws regulating physicians' communications with their clients. The second argues that certain types of laws regulating physician speech should trigger heightened scrutiny—in some cases strict, and in others intermediate—while others should enjoy no First Amendment protection at all. After examining the practical and theoretical problems with both of these approaches, this part concludes by proposing that all laws that interfere with any aspect of physician-patient speech should be subject to a uniform standard of intermediate scrutiny.

A. Strict Scrutiny

Some commentators argue that physicians' communications with their patients implicate core First Amendment values. Accordingly, they argue that laws regulating such communications should be upheld only if they can satisfy strict scrutiny, the highest standard of First Amendment review. This standard requires proof that the laws

182. *Id.* at 255.
183. *Id.* at 248.
184. *Id.* at 253.

are necessary to achieve a "compelling state interest" and that they have been "narrowly tailored" to accomplish that goal.[185]

Paula Berg, for example, argues that physician-patient communications implicate core First Amendment values under both the "marketplace of ideas" and "personal liberty" rationales for protecting freedom of expression.[186] The marketplace of ideas theory posits that the purpose of protecting free speech is to encourage the open competition of ideas, thereby enabling individuals to discover "the truth."[187] Berg argues that physician-patient discourse should be protected under this framework because it contributes to both "the patient's truth" about the best course of medical treatment in her individual circumstances and to "scientific and medical truth" about the best way for physicians to treat similar patients in the future.[188] Under the personal liberty approach, free speech is protected because it safeguards private thoughts and fosters individual autonomy and self-determination.[189] Berg argues that this approach also supports giving a high level of protection to physician-patient communications, as such speech is "essential to maintaining patients' autonomy, self-determination, and dignity in the face of illness" and is necessary to protect the patient's right to bodily integrity.[190]

Other commentators who support the application of strict scrutiny draw on Supreme Court decisions in First Amendment cases not involving professional speech. Martha Swartz, for example, argues that the Court's decision in *Sorrell v. IMS Health*,[191] which struck down a Vermont statute prohibiting pharmacies from selling information to pharmaceutical companies about which drugs particular doctors were prescribing, implies that content- or speaker-based restrictions on speech are always subject to strict scrutiny, even when the restrictions relate only to commercial transactions.[192] If this is true for restrictions on commercial speech, she argues, it must also be true for laws regulating physicians' communications with their

185. Reed v. Town of Gilbert, 135 S. Ct. 2218, 2226 (2015).

186. *See* 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, 235 (1994).

187. *Id.* at 231–32.

188. *Id.* at 235–36.

189. *Id.* at 234.

190. *Id.* at 237.

191. 564 U.S. 522 (2011).

192. Martha Swartz, *Physician-Patient Communication and the First Amendment After* Sorrell, 17 MICH. ST. U. J. MED. & L. 101, 107 (2012).

patients, particularly in light of "the trust-based nature of the physician-patient relationship."[193]

Similarly, Paul Sherman argues that restrictions on professional speech should be subject to strict scrutiny in light of the Supreme Court's decision in *Humanitarian Law Project*,[194] discussed above in connection with the Third Circuit's decision in *King*.[195] Sherman also relies on the Supreme Court's decision in *United States v. Stevens*,[196] which struck down a federal law criminalizing the sale or possession of depictions of animal cruelty.[197] *Stevens* emphasized that courts do not have "freewheeling authority to declare new categories of speech outside the scope of the First Amendment" but instead must ask whether "the given category of speech has been historically treated as unprotected."[198] Because there is no evidence that professional speech was historically exempt from First Amendment scrutiny, Sherman concludes that content-based restrictions on such speech "should be treated just like any other content-defined category of speech."[199]

The problem with these arguments is that they ignore important differences between physician-patient communications and the type of speech that has traditionally enjoyed the highest level of First Amendment protection—speech on "matters of public concern."[200] Allowing the government to interfere with speech on matters of public concern by declaring certain opinions valid and others off limits would be antithetical to the very concept of democratic self-governance.[201] By applying strict scrutiny in these situations, courts can prevent the government from stifling free public debate.

193. *Id.* at 121; *see also* Martha Swartz, *Are Physician-Patient Communications Protected by the First Amendment?*, 2015 CARDOZO L. REV. DE NOVO 92, 103 (2015).

194. Sherman, *supra* note 28, at 190.

195. *See supra* text accompanying notes 109–11 (discussing *Humanitarian Law Project*).

196. 559 U.S. 460 (2010).

197. *See* Sherman, *supra* note 28, at 191–92.

198. *Id.*

199. *Id.* at 192; *see also* Smolla, *supra* note 28, at 112 (arguing that applying strict scrutiny to restrictions on professional speech "serves the valuable purpose . . . of filtering out government regulation that is not, in the classic sense, targeted at preventing criminal, tortious, or palpably unethical professional conduct, but instead an attempt to skew the marketplace of ideas or invade the buffer of confidentiality and autonomy that protects the integrity of the professional-client relationship").

200. *See, e.g.*, Snyder v. Phelps, 562 U.S. 443, 451–52 (2011) ("[S]peech on 'matters of public concern' . . . is 'at the heart of the First Amendment's protection.'" (alteration in original) (quoting Dun & Bradstreet, Inc. v. Greenmoss Builders, Inc., 472 U.S. 749, 758–59 (1985) (opinion of Powell, J.))).

201. *See, e.g.*, James Weinstein, *Participatory Democracy as the Central Value of American Free Speech Doctrine*, 97 VA. L. REV. 491, 506 (2011) (arguing that "we all have a right to formal participation in the political process," which "includes at least the right to

However, this preference for government agnosticism makes little sense when applied to the realm of professional oversight. Professions—particularly the so-called learned professions, such as medicine—are premised on the existence of a specialized body of knowledge, the command of which is a prerequisite for obtaining professional status.[202] Because clients do not typically have access to this knowledge, it can be difficult for them to independently evaluate the quality of professional advice, making them vulnerable to exploitation by incompetent or unscrupulous practitioners. Professional oversight helps overcome this knowledge disparity by providing a mechanism for sanctioning practitioners who do not adhere to the profession's internal standards of quality.[203] While professional standards are typically flexible enough to incorporate a wide range of perspectives,[204] there are certain positions that fall outside the bounds of professional norms. For example, there is a well-established medical consensus that childhood vaccines "do not cause autism."[205] In light of this consensus, physicians have faced disciplinary action for facilitating parents' efforts to avoid complying with medically recommended vaccination schedules.[206]

be free from coercive laws forbidding speakers from expressing some particular view on a matter of public concern and laws that seek to prevent audiences from hearing certain views because the government fears that they will be persuaded to support some unwise policy").

202. *See* Deborah Jones Merritt, *Hippocrates and Socrates: Professional Obligations to Educate the Next Generation*, 51 WAKE FOREST L. REV. 403, 405–06 (2016) ("[P]rofessionals demonstrate at least three characteristics: they apply specialized bodies of knowledge, maintain complex educational systems to convey that knowledge, and impart ethical codes as part of that education.").

203. *See* Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285, 295 (2010) ("As an extension of the state's police power, the medical board's disciplinary authority is aimed at protecting medical consumers from the harms they may incur at the hands of incompetent or dishonest physicians.").

204. *See* Kenneth S. Abraham, *Custom, Noncustomary Practice and Negligence*, 109 COLUM. L. REV. 1784, 1812 (2009) (noting that, "in medical malpractice, evidence of compliance with noncustomary practices, if they reflect a 'respectable minority' school of thought, is not only admissible, but in some states is conclusive").

205. *Education and Public Awareness on Vaccine Safety and Efficacy H-440.830*, AMA, https://policysearch.ama-assn.org/policyfinder/detail/vaccine%20safety?uri=%2FAMADoc%2FHOD.xml-0-3846.xml [perma.cc/NE9N-NFHL] (last updated 2017).

206. *See* Tara Haelle, *Pediatrician Bob Sears Punished for Questionable Vaccine Exemption*, FORBES (July 1, 2018), https://www.forbes.com/sites/tarahaelle/2018/07/01/pediatrician-bob-sears-license-temporarily-revoked-after-questionable-vaccine-exemption/#3a66a668ef60 [https://perma.cc/LL6S-QEZH]. To take an example from the legal profession, the Federal Rules of Civil Procedure require lawyers to bring forward exclusively "nonfrivolous argument[s]," FED. R. CIV. P. 11(b)(2), a standard that presupposes that some legal arguments are objectively incorrect, *see, e.g.*, Ahmed v.

Because effective professional oversight depends on the government's ability to distinguish between right and wrong opinions, many scholars have argued that the usual presumption against content-based speech limitations should not apply to regulations of professional speech. For example, Robert Post argues that, in professional practice, "we insist upon competence, not debate,"[207] which implies that "[t]raditional First Amendment values would seem to carry very little force."[208] Noting that physicians are "routinely held liable for malpractice for speaking or for failing to speak," he concludes that the regulation of physician speech—including "sanction[ing] viewpoints that are false"[209]—is "theoretically and practically inseparable from the regulation of medicine."[210]

Similarly, Claudia Haupt argues that government can legitimately limit professional speech based on its content. According to Haupt, the reason for protecting professional speech is to safeguard the integrity of "knowledge communities," which she defines as "network[s] of individuals who share common knowledge and experience as a result of training and practice."[211] These knowledge communities have "shared notions of validity and a common way of knowing and reasoning," which "limit the range of acceptable opinions found within them."[212] Thus, Haupt argues, advice that is consistent with the knowledge community's views is entitled to "robust First Amendment protection," but advice that is not accepted by the knowledge community should receive no First Amendment protection at all.[213]

Recognizing the legitimacy of imposing content-based limitations on physician-patient communications does not necessarily mean that physician speech should be excluded from the First Amendment entirely. It does suggest, however, that strict scrutiny is not the appropriate standard to apply. Strict scrutiny is designed to make it difficult for the government to restrict speech based on the content of

Gateway Grp. One, No. 12 Civ. 0524 (BMC), 2012 U.S. Dist. LEXIS 79386, at *3–4 (E.D.N.Y. June 7, 2012) (imposing sanctions on an attorney for asserting a legal argument with "no chance of success").

207. Post, *supra* note 47, at 950.

208. *Id.* at 951.

209. *Id.* at 950.

210. *Id.* at 951.

211. Claudia E. Haupt, *Professional Speech*, 125 YALE L.J. 1238, 1249–51 (2016) [hereinafter Haupt, *Professional Speech*].

212. *Id.* at 1251.

213. Claudia E. Haupt, *Unprofessional Advice*, 19 U. PA. J. CONST. L. 671, 675 (2017) [hereinafter Haupt, *Unprofessional Advice*].

the message,[214] but, in the context of professional regulation, we *want* government to distinguish between acceptable and unacceptable opinions and advice. Requiring government to prove that all regulations of physician speech are "narrowly tailored" to achieving a "compelling state interest" would unduly restrict government's ability to carry out this function, as it would prevent regulators from taking action where evidence of harm is persuasive but not necessarily incontrovertible. As Wendy Parmet and Jason Smith point out, this is often true in health cases, where "empirical evidence regarding the impact of regulations is seldom complete and conclusive."[215]

It may be that the Supreme Court's decisions in *Sorrell*, *Reed*, and other cases reflect a growing view among the justices that all content-based restrictions on speech should be analyzed under strict scrutiny, even when those restrictions do not implicate matters of public concern. However, the Court expressly declined to reach this question in its 2018 decision in *NIFLA*,[216] suggesting that a majority of justices might not be willing to support such an approach. Moreover, *NIFLA* suggests that, even if the Court ultimately concludes that content-based restrictions on most professional speech must satisfy strict scrutiny, regulations of treatment-related communications might be subject to a more deferential standard of review.[217] Thus, unless and until the Supreme Court expressly rules otherwise, there is no reason for courts reviewing regulations of physician-patient communications to assume that strict scrutiny necessarily applies.

B. Mixed Levels of Scrutiny

Some commentators argue that certain types of laws regulating physician speech are more problematic than others and that these laws should trigger some form of heightened scrutiny—in some cases strict, and in others intermediate—while others should enjoy no First Amendment protection at all. For example, although Post argues that most content- and viewpoint-based regulations of professional speech do not implicate core First Amendment values, he believes that heightened scrutiny should apply in two situations. The first is when a law seeks to compel physicians to transmit "ideological" messages.[218]

214. *See supra* text accompanying notes 200–01.

215. Wendy E. Parmet & Jason Smith, *Free Speech and Public Health: Unraveling the Commercial-Professional Speech Paradox*, 78 OHIO ST. L.J. 887, 912 (2017).

216. *See supra* text accompanying note 62.

217. *See supra* text accompanying notes 67–70.

218. *See* Post, *supra* note 47, at 939.

He argues that such laws should be subject to "rigorous and almost certainly fatal First Amendment scrutiny."[219] The second is when a law interferes with "communications involving informed consent"[220] by "requir[ing] physicians to communicate information that the medical profession regards as false, or prohibit[ing] physicians from communicating information that the medical profession regards as true."[221] For these laws, Post would apply the standard applicable in commercial speech cases,[222] which is intermediate scrutiny.[223]

Regarding the first category, Post argues that laws requiring physicians to engage in ideological speech cannot be justified as a form of professional regulation, because the transmission of ideological messages is not part of "legitimate medical practice."[224] Other commentators have echoed Post's criticism of ideological speech requirements. David Orentlicher, for example, argues that laws requiring physicians to transmit ideological messages "exploit the trust of patients in their physicians," thereby "corrupt[ing] the fiduciary relationship between patient and physician."[225] Similarly, Janet Dolgin argues that laws regulating physician speech can be justified if they are reasonably connected to patient protection, but not if they are enacted "in service to economic ends and partisan belief systems."[226]

The problem with carving out ideological speech requirements for separate treatment, however, is that the concept of ideological speech is inherently malleable.[227] For example, in *Stuart*, the Fourth

219. *Id.* at 957.

220. *Id.* at 979.

221. *Id.* at 939.

222. *See id.* at 978.

223. *See* Milavetz, Gallop & Milavetz P.A. v. United States, 559 U.S. 229, 249 (2010) ("[R]estrictions on nonmisleading commercial speech regarding lawful activity must withstand intermediate scrutiny . . . .").

224. Post, *supra* note 47, at 954.

225. David Orentlicher, *Abortion and Compelled Physician Speech*, 43 J.L. MED. & ETHICS 9, 13 (2015).

226. Janet L. Dolgin, *Physician Speech and State Control: Furthering Partisan Interests at the Expense of Good Health*, 48 NEW ENG. L. REV. 293, 342 (2014); *see also* Jennifer M. Keighley, *Physician Speech and Mandatory Ultrasound Laws: The First Amendment's Limit on Compelled Ideological Speech*, 34 CARDOZO L. REV. 2347, 2351 (2013) ("[S]tate laws compelling physician speech that spreads the state's ideological and non-medical message should be subject to strict scrutiny."); Nadia N. Sawicki, *Informed Consent as Compelled Professional Speech: Fictions, Facts, and Open Questions*, 50 WASH. U. J.L. & POL'Y 11, 14 (2016) [hereinafter Sawicki, *Informed Consent*] ("Informed consent mandates that require physicians to communicate 'ideological' speech are likely subject to strict scrutiny . . . .").

227. *See* Axson-Flynn v. Johnson, 356 F.3d 1277, 1284 n.4 (10th Cir. 2004) ("[I]t is difficult to imagine a standard by which a court could determine whether non-commercial

Circuit characterized North Carolina's law requiring physicians to display the results of sonograms to women seeking abortions as an ideological requirement because it was designed "to convince women seeking abortions to change their minds or reassess their decisions."[228] But, in *Lakey*, the Fifth Circuit concluded that Texas's virtually identical requirement was not ideological because it involved "the purest conceivable expression of 'factual information.'"[229] It found that any impact the information had on the woman's decision-making process would be the result of "her own 'ideology' . . . not of any 'ideology' inherent in the information she has learned."[230] In other contexts, however, even purely factual disclosure requirements have been described as ideological. For example, in his concurring opinion in *NIFLA*, Justice Kennedy applied the "ideological" label to California's law requiring CPCs to inform women that the state provided free or low-cost pregnancy-related services.[231] The required disclosure was obviously factual, but Justice Kennedy was troubled by the fact that it was designed to "promote the State's own preferred message advertising abortions."[232] Overall, it is hard to discern any consistent test for defining an ideological message. It seems that the label is most often applied after a court has already determined that a speech requirement is substantively inappropriate, rather than as a neutral way for distinguishing between different categories of speech.[233]

Indeed, virtually all speech requirements could be characterized as ideological in one sense or another. Although the concept of ideological speech is often used to describe politically motivated messages, the literal definition of an "ideology" is simply a "body of

speech is or is not ideological."); Sawicki, *Informed Consent*, *supra* note 226, at 14 ("[T]he definition of what counts as 'ideological' speech is widely disputed.").

228. Stuart v. Camnitz, 774 F.3d 238, 246 (4th Cir. 2014).

229. Tex. Med. Providers Performing Abortion Servs. v. Lakey, 667 F.3d 570, 577 n.4 (5th Cir. 2012).

230. *Id.*

231. *NIFLA*, 138 S. Ct. 2361, 2379 (2018) (Kennedy, J., concurring) ("The California Legislature included in its official history the congratulatory statement that the Act was part of California's legacy of 'forward thinking.' . . . But it is not forward thinking to force individuals to 'be an instrument for fostering public adherence to an ideological point of view [they] fin[d] unacceptable.'" (quoting Wooley v. Maynard, 430 U.S. 705, 715 (1977))).

232. *Id.*

233. *Cf.* Ronald H. Silverman, *Weak Law Teaching, Adam Smith and a New Model of Merit Pay*, 9 CORNELL J.L. & PUB. POL'Y 267, 293 (2000) ("[W]e commonly reserve pejorative terms like ideology or propaganda for those value systems that we do not like.").

ideas."[234] The practice of medicine incorporates multiple ideologies, ranging from the foundational principle of "do no harm"[235] to specific maxims like "treat patients with the least invasive therapy first."[236] The entire doctrine of informed consent can be seen as an ideological regulation of the practice of medicine insofar as it is grounded in philosophical views about the centrality of patient autonomy in medical decision-making.[237] Thus, under a broad interpretation of the concept of ideology, heightened scrutiny could potentially apply to virtually all regulations of physician-patient speech.

Post's second category for applying heightened scrutiny encompasses laws that interfere with physician-patient "communications involving informed consent."[238] He argues that, just as commercial speech doctrine protects consumers' right to receive information necessary to make enlightened purchasing decisions, the First Amendment should also protect patients' right to the information necessary to make informed medical choices.[239] Other commentators have also suggested that restrictions on physician speech are most problematic when they interfere with the process of

234. *See* A. Mechele Dickerson, *Regulating Bankruptcy: Public Choice, Ideology, & Beyond*, 84 WASH. U. L. REV. 1861, 1886 (2006) ("[I]deology typically is thought to mean a common and coherent philosophy, outlook, or shared body of ideas or beliefs or a worldview or cultural belief system that helps individuals (or groups) generate and inform their decisionmaking process."); Lewis A. Kornhauser, *The Great Image of Authority*, 36 STAN. L. REV. 349, 372 (1984) ("Generally, ideology refers descriptively to the set of beliefs, norms, attitudes, and concepts held by an individual or widely held within a group of individuals.").

235. *See, e.g.*, Katie Page, *The Four Principles: Can They Be Measured and Do They Predict Ethical Decision Making*, 13 BMC MED. ETHICS 1, 2 (2012) ("The Hippocratic injunction to do no harm has been an axiom central to the education of medical and graduate students."); *cf.* Sahreen Malik Bhanji, *Health Care Ethics*, 4 J. CLINICAL RES. BIOETHICS 1, 1 (2013) (describing "trustworthiness and honesty" as part of the "ideology and core values of nursing").

236. *See, e.g.*, Carl G. Klutke & John J. Klutke, *Interstitial Cystitis/Painful Bladder Syndrome for the Primary Care Physician*, 15 CANADIAN J. UROLOGY (SUPP. 1) 44, 48 (2008) ("Certainly, as with any disease that tends to be of chronic nature and requires continuous or at least intermittent treatment, one main tenet is to apply the least invasive therapy that affords sufficient relief of symptoms.").

237. *See* Sawicki, *Modernizing Informed Consent*, *supra* note 77, at 827–29; *cf.* Ann Kelly, *Research and the Subject: The Practice of Informed Consent*, 26 POLAR 182, 188 (2003) (discussing "the ideology of informed consent" as applied to ethnographic research).

238. *See* Post, *supra* note 47, at 979–80. Post acknowledges that his concerns about inappropriate intrusion into physician-patient communications might sometimes "transcend the narrow confines of informed consent disclosures," but he worries that expanding First Amendment protection more broadly could "threaten[] to restrict the state's ability freely to regulate the provision of medical treatment." *Id.*

239. *Id.* at 978.

informed consent to treatment. Sonia Suter, for example, argues that "professional speech associated with informed consent is high value speech" and that restrictions on such speech "require heightened, if not strict, scrutiny."[240] Emphasizing the importance of informed consent to autonomous decision-making, Suter argues that heightened scrutiny is necessary to ensure that physicians and patients have "sufficient discretion" to engage in an "individualized dialogue."[241] Suter recognizes that states generally have considerable leeway in enacting laws regulating medical treatments, but she argues that laws interfering with the "decision-making process" about treatment should be subjected to a higher standard because of the "self-determination and autonomy goals of protecting speech."[242]

Yet, while informed consent is undoubtedly a central aspect of the physician-patient relationship, the idea that there exists a distinct category of "informed consent discussions," separate and apart from other physician-patient communications, is an artificial construct. As bioethicists have long stressed, informed consent is most appropriately viewed as an ongoing, interactive process, rather than a one-way disclosure of information conducted at a particular moment in time.[243] Virtually any aspect of physician-patient communications can be viewed as part of this process as long as it has the potential to affect patients' decisions about the type of medical treatment they are willing to undergo.

For example, the federal policy at issue in *Conant*, which penalized physicians who recommended medical marijuana to their patients, would not initially appear to involve an informed consent communication; its purpose was to prevent physicians from making a particular treatment recommendation, rather than to force physicians to describe proposed treatments in any particular way. Yet the policy could also be viewed as interfering with patients' ability to provide informed consent to other treatments for which medical marijuana might be considered a reasonable alternative. For example, a patient might be better able to assess the risks and benefits of taking opioids for pain if she knew that marijuana might provide similar benefits

240. Suter, *supra* note 48, at 22.

241. *Id.* at 27.

242. *Id.* at 28.

243. *See, e.g.*, Christine Grady, *Enduring and Emerging Challenges of Informed Consent*, 372 NEW ENG. J. MED. 855, 859 (2015) (noting the "need for ongoing communication processes that allow the incorporation of changing information and changed expectations over time").

with a lower risk of addiction.[244] To the extent the federal policy prevented physicians from discussing this alternative with their patients, it could be seen as a limitation on "communications involving informed consent," even though the policy did not directly address the process of informed consent at all.

It might be possible to overcome this definitional problem by broadening the scope of heightened scrutiny to any laws that prohibit or compel the provision or solicitation of information *about* medical treatment, regardless of whether the information technically falls within the parameters of an informed consent discussion. Such an approach would be similar to the Ninth Circuit's decision in *Pickup*, which distinguished between laws interfering with communications about medical treatment and laws regulating medical treatment carried out through the mechanism of speech.[245] However, as the Third Circuit recognized in *King*, the Supreme Court's decision in *Humanitarian Law Project* casts significant doubt on the constitutional validity of that distinction.[246]

More generally, any effort to distinguish between discussions about treatment from treatment itself ignores how deeply speech and treatment are intertwined in the medical context. A growing body of literature recognizes that the manner in which physicians communicate with patients has a significant impact on medical outcomes, independent of the specific treatments provided. For example, in sixteen of the twenty-one randomized studies reviewed in one article, the manner in which physicians communicated with patients was shown to have a significant influence on outcomes such as pain control, blood pressure and blood sugar levels, and emotional health.[247] Some studies have identified poor provider-patient communication as a key reason why members of minority groups

244. *See* Kevin P. Hill, *Medical Marijuana for Treatment of Chronic Pain and Other Medical and Psychiatric Problems*, 313 JAMA 2474, 2474 (2015) (finding that "use of marijuana for chronic pain, neuropathic pain, and spasticity due to multiple sclerosis is supported by high-quality evidence").

245. *See* Pickup v. Brown, 740 F.3d 1208, 1226–27 (9th Cir. 2014).

246. Holder v. Humanitarian Law Project, 561 U.S. 1, 27–28 (2010).

247. John M. Travaline, Robert Ruchinskas & Gilbert E. D'Alonzo, *Patient-Physician Communication: Why and How*, 105 J. AM. OSTEOPATHIC ASS'N 13, 14 (2005); *see also* Charlotte Blease, *The Principle of Parity: The "Placebo Effect" and Physician Communication*, 38 J. MED. ETHICS 199, 200–01 (2011) (reporting that patients whose physicians adopted a "friendly, tactful and supportive communication style" experienced "substantial improvements" in medical outcomes, including an average two-day reduction in postcoronary surgery hospital stay).

frequently experience fewer benefits from medical interventions than the general population.[248]

Several mechanisms have been suggested to explain how physician-patient communications might influence medical outcomes. One commentator posits that "[t]he physician's style of communication can promote a sense of empowerment among patients by encouraging them to believe that the situation is optimistic and that their actions will promote recovery" and that this attitude can itself engender positive outcomes.[249] Others argue that communication styles affect patients' sense of connection with physicians and that this connection "can ultimately improve their health mediated through participation in their care, adherence to treatment, and patient self-management."[250] Whatever the precise mechanism, the existence of a link between physician communication and medical outcomes suggests that all physician speech is potentially therapeutic. As a result, the effort to create different standards for speech *about* treatment and speech that *is* treatment is unlikely to succeed.

Timothy Zick suggests another basis for carving out particular categories of physician speech for heightened constitutional protection—the distinction between the "application of general standards of professional care, which can indirectly regulate speech,"[251] and regulations of "professional-client communications about, concerning, or relating to the recognition, scope, or exercise of constitutional rights."[252] Examples of the latter sort of regulation include laws targeting physician-patient communications about abortion[253] or the right to bear arms.[254] According to Zick, these types

248. Gregory B. Diette & Cynthia Rand, *The Contributing Role of Health-Care Communication to Health Disparities for Minority Patients with Asthma*, 132 CHEST J. (SUPP.) 802S, 802S–03S (2007).

249. Blease, *supra* note 247, at 200.

250. *Impact of Communication in Healthcare*, INST. FOR HEALTHCARE COMM. (July 2011), http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare [https://perma.cc/UVA6-BYTJ]; *see also* John M. Kelley et al., *The Influence of the Patient-Clinician Relationship on Healthcare Outcomes: A Systematic Review and Meta-Analysis of Randomized Controlled Trials*, 9 PLOS ONE, no. e94207, Apr. 9, 2014, at 1, 1–2 (arguing that "cognitive care"—defined as "information gathering, sharing medical information, patient education, and expectation management"—is "likely to produce richer interpersonal interactions").

251. Timothy Zick, *Professional Rights Speech*, 47 ARIZ. ST. L.J. 1289, 1336 (2015).

252. *Id.* at 1294.

253. *See id.* at 1328–29 ("[L]aws compelling physicians to disclose detailed, content-specific information regarding abortion, or to present ideological messages to patients . . . ought to be treated as suspect under the First Amendment.").

of professional speech regulations "are, and ought generally to be treated as, regulations of political expression based on content" and therefore should be subject to strict scrutiny under the First Amendment.[255]

However, Zick's proposal to apply strict scrutiny to all laws limiting professional speech related to the exercise of constitutional rights would appear to be foreclosed by the Supreme Court's plurality opinion in *Casey*, which upheld mandatory disclosures related to abortion under a lower standard of review.[256] Moreover, even if his approach could somehow be reconciled with *Casey*, it is difficult to see how it would constitute much of a limit in the context of physician-patient speech. Given that competent individuals have a constitutionally protected interest in refusing unwanted bodily invasions,[257] virtually all physician-patient communications can be viewed as speech related to the exercise of a constitutional right, at least to the extent they relate to invasive medical treatments the patient might potentially undergo. Thus, at least in the medical context, Zick's proposal to limit heightened scrutiny to professional speech related to the exercise of constitutional rights might not amount to much of a limitation at all.

Finally, Haupt's approach to physician speech also rejects the uniform application of heightened scrutiny in the context of professional speech regulations. As discussed above, Haupt's view is that the First Amendment protects professional speech only to the extent it falls within the "range of knowledge that is acceptable as good professional advice," as determined by the profession's own internal standards of acceptability.[258] Thus, rather than applying a uniform standard of heightened scrutiny to all legislative restrictions on physician-patient communications, she suggests a sliding scale of

254. *See id.* at 1327 (arguing that the Florida firearms statute challenged in *Wollschlaeger* should have been subjected to strict scrutiny because "what it actually regulates is a conversation relating to the right to bear arms").

255. *Id.* at 1359.

256. *See supra* text accompanying notes 38–52.

257. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990) (first citing Vitek v. Jones, 445 U.S. 480, 494 (1980); then citing Parham v. J.R., 442 U.S. 584, 600 (1979)) (discussing cases that "support the recognition of a general liberty interest in refusing medical treatment"); Washington v. Harper, 494 U.S. 210, 221–22 (1990) (recognizing that prisoners have "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs").

258. Haupt, *Unprofessional Advice*, *supra* note 213, at 675; *see supra* text accompanying note 213.

judicial review, in which "[t]he further state regulation diverges from professional consensus[,] . . . the more skeptical courts ought to be."[259]

However, it is difficult to see how such a sliding scale approach would be workable in practice. Consider a case in which plaintiffs challenge a law regulating physician speech, and the state's response (perhaps supported by explicit legislative findings) is that the law simply codifies an existing consensus within the professional community. Under Haupt's approach, heightened scrutiny will apply only if the court refuses to defer to the state's assertion of professional consensus and instead independently determines that the law is, in fact, inconsistent with prevailing professional opinion. Yet, while there is no mathematically precise relationship between tiers of constitutional scrutiny and courts' willingness to defer to a legislature's factual findings,[260] as a practical matter the two questions tend to be highly interrelated. In particular, courts are more likely to be deferential to legislative factual findings under a rational basis standard[261] and more likely to question legislative findings when applying heightened scrutiny.[262] As a result, Haupt's approach creates a kind of catch-22: to apply heightened scrutiny, courts must be willing to second-guess states' assertions about the state of professional opinion, but this kind of second-guessing is unlikely unless the court has already determined that heightened scrutiny is the appropriate standard to apply.[263]

259. Claudia E. Haupt, *Professional Speech and the Content-Neutrality Trap*, 127 YALE L.J.F. 150, 153, 171 (2017), https://www.yalelawjournal.org/pdf/Haupt_xv7cdx9m.pdf [https://perma.cc/T3T2-PUNK].

260. *See* Caitlin E. Borgmann, *Rethinking Judicial Deference to Legislative Fact-Finding*, 84 IND. L.J. 1, 10 (2009) ("The constitutional tiers of review . . . are neither a reliable predictor of judicial deference to legislative fact-finding nor an acceptable guide to the appropriateness of such deference.").

261. *See* William D. Araiza, *Deference to Congressional Fact-Finding in Rights-Enforcing and Rights-Limiting Legislation*, 88 N.Y.U. L. REV. 878, 921 (2013) ("[W]hen courts apply the rational basis standard, they do not insist on proof that an actual state of affairs exists; rather, they are content to presume the existence of facts necessary to establish the requisite connection to a legitimate government purpose.").

262. *See id.* ("As part of its insistence on the least possible intrusion on the protected value, heightened scrutiny requires that the reviewing court have in front of it the actual facts of the situation—the government's actual interest and the real factual background.").

263. For this reason, Wendy Parmet and Jason Smith suggest that Haupt's proposed approach might be better characterized as a form of heightened scrutiny in disguise. *See* Parmet & Smith, *supra* note 215, at 902 n.131 (arguing that "[a]lthough Haupt criticizes the Eleventh Circuit for concluding that [the Florida statute's] lack of content neutrality required heightened scrutiny," the approach she proposes "can easily be viewed as a form of heightened scrutiny" to the extent that it rejects "the radical deference to the legislature that usually marks rational basis review").

Rather than attempting to carve out specific categories of physician speech for heightened First Amendment protection, a better approach would be to apply a uniform standard of intermediate scrutiny to all regulations interfering with physician-patient speech. By requiring proof that speech restrictions "directly advance the State's interest in protecting its citizens from harmful or ineffective professional practices and are no more extensive than necessary to serve that interest,"[264] intermediate scrutiny adequately protects physicians' and patients' interest in open medical communications. At the same time, unlike strict scrutiny, the standard is not so demanding that it would preclude legitimate regulatory efforts to uphold professional quality. The next part of this Article considers how a uniform standard of intermediate scrutiny can be applied in a manner that promotes both of these goals.

III. APPLYING THE STANDARD

Virtually all of the lower court decisions discussed in Part I were decided under intermediate scrutiny, but the results of those cases were far from consistent. The differences in outcome result from disagreement about the types of state interests that should be counted in the analysis, as well as how the strengths of those interests are appropriately assessed. This part argues that, rather than simply looking at any interest asserted by the government and then deciding whether it is "important," courts applying intermediate scrutiny should ask whether laws interfering with physician speech are substantially related to the specific governmental interest in upholding the quality of professional practice. It further argues that the assessment of whether a law is consistent with this standard should generally be decided with reference to the views of the professional community. Contrary to those proposed by other commentators, however, the standard proposed here would not require lawmakers to defer to the professional community's views in all situations.

A. Defining and Assessing the State's Interests

Some courts have upheld limitations on physician-patient communications under intermediate scrutiny by balancing physicians' First Amendment rights against an excessively broad range of governmental interests. In *Rounds I*, for example, the Eighth Circuit

264. King v. Governor of N.J., 767 F.3d 216, 233 (3d Cir. 2014).

justified South Dakota's requirement that physicians inform pregnant women that abortion "will terminate the life of a whole, separate, unique, living human being" in part by citing the state's authority to promote childbirth over abortion.[265] In one of the vacated panel decisions in *Wollschlaeger*, the Eleventh Circuit justified Florida's prohibition on routine requests about firearm ownership in part by citing the state's interest in "protection of the Second Amendment right to keep and bear arms."[266]

The problem with this approach is that it ignores the underlying justification for applying intermediate—as opposed to strict—scrutiny to governmental regulations of professional speech. As discussed above, the government should be entitled to exercise greater control over professional speech than other types of communications to uphold the profession's internal standards of quality for the benefit of clients who lack the knowledge to independently evaluate the quality of professional advice.[267] Given this justification, upholding a professional speech regulation under intermediate scrutiny should depend on a showing that the law is in fact substantially related to the state's interest in upholding professional quality. If the state seeks to defend a restriction on professional speech by appealing to *other* governmental interests, it should have the burden of meeting the same standard of strict scrutiny applicable to content-based regulations of nonprofessional speech.

The critical question then becomes how courts should determine whether a particular speech restriction in fact promotes professional quality. At one extreme, it might be argued that if a state asserts that a limitation on professional speech is a necessary quality control mechanism courts should generally defer to that judgment—absent, perhaps, evidence that the state's quality claims are pretexts for nefarious purposes, such as restricting politically unpopular ideas. This argument would rest on the fact that the right to practice a profession depends on having a state-issued license, and license holders must agree to adhere to conditions established by the state.[268]

265. *See Rounds I*, 530 F.3d 726, 734 (8th Cir. 2008) (en banc) (noting the Supreme Court's statement that "[t]he government may use its voice and its regulatory authority to show its profound respect for the life within the woman" (alteration in original) (quoting Gonzalez v. Carhart, 550 U.S. 124, 157 (2007))).

266. Wollschlaeger v. Governor of Fla., 814 F.3d 1159, 1192–93 (11th Cir. 2015), *aff'd in part and rev'd in part en banc*, 848 F.3d 1293 (11th Cir. 2017).

267. *See supra* text accompanying notes 202–13.

268. *See* Michael S. Young & Rachel K. Alexander, *Recognizing the Nature of American Medical Practice: An Argument for Adopting Federal Medical Licensure*, 13

Because the state sets the conditions under which professionals may practice, it might be argued, the definition of professional quality is ultimately within the state's control.

This view of professional authority seems to have driven at least one of the panel decisions in *Wollschlaeger*, in which the court gave short shrift to the argument that prohibiting physicians from making routine inquiries about firearm ownership was unconstitutional because it violated professional medical standards. Specifically, although the court acknowledged that "[s]everal medical associations . . . have policies that endorse physicians' practice of asking questions and providing counseling regarding firearms,"[269] it found that these professional statements were irrelevant because "Florida may regulate professional standards of medical care within its borders—regardless of what medical associations may recommend."[270] As support for this conclusion, the panel cited the Supreme Court's 1954 decision in *Barsky v. Board of Regents*,[271] which recognized that "[t]he practice of medicine . . . is lawfully prohibited by the State except upon the conditions it imposes."[272]

The argument that professional standards of care are ultimately subordinate to the government's regulatory authority cannot be dismissed out of hand. When regulating pure conduct, as opposed to speech, the government is generally under no obligation to defer to professional opinion. It seems clear, for example, that a physician who sought to treat patients with an illegal psychedelic drug could not rely on emerging professional support of such therapy[273] as a defense to a

DEPAUL J. HEALTH CARE L. 145, 166–67 (2010) (describing the state-based system of medical licensure).

269. Wollschlaeger v. Governor of Fla., 760 F.3d 1195, 1216 n.11 (11th Cir. 2014), *vacated on reh'g*, 797 F.3d 859 (11th Cir. 2015), *vacated on reh'g*, 814 F.3d 1159 (11th Cir. 2015), *aff'd in part and rev'd in part en banc*, 848 F.3d 1293 (11th Cir. 2017).

270. *Id.* (citing Barsky v. Bd. of Regents, 347 U.S. 442, 449 (1954)).

271. 347 U.S. 442 (1954).

272. *Id.* at 451 (upholding a six-month suspension of a physician's medical license for refusing to produce documents in response to a subpoena issued by the Committee on Un-American Activities of the U.S. House of Representatives).

273. *See, e.g.*, Robin L. Carhart-Harris et al., *Psilocybin with Psychological Support for Treatment-Resistant Depression: An Open-Label Feasibility Study*, 3 LANCET PSYCHIATRY 619, 619 (2016) (finding "preliminary support for the safety and efficacy of psilocybin for treatment-resistant depression"); Alicia L. Danforth et al., *MDMA-Assisted Therapy: A New Treatment Model for Social Anxiety in Autistic Adults*, 64 PROGRESS NEURO-PSYCHOPHARMACOLOGY & BIOLOGICAL PSYCHIATRY 237, 237 (2016) (showing that MDMA-assisted therapy could reduce social anxiety symptoms and increase social adaptability); Ben Sessa & Matthew W. Johnson, *Can Psychedelic Compounds Play a Part in Drug Dependence Therapy?* 206 BRIT. J. PSYCHIATRY 1, 1 (2015) (examining the "revisiting of psychedelic drug therapy throughout psychiatry").

charge of criminal drug distribution. More generally, while the Food and Drug Administration ("FDA") has consistently asserted a policy of noninterference with the practice of medicine,[274] physicians generally cannot treat patients with drugs or devices that have not received FDA approval or clearance for at least one indication,[275] even if their assessment of the risks and benefits to the patient are consistent with prevailing medical norms.[276]

Yet lawmakers do not have unbridled authority to disregard professional medical opinion. In *Whole Woman's Health v. Hellerstedt*,[277] for example, the Court struck down a Texas law requiring abortion providers to meet the same standards as ambulatory surgery centers and to have admitting privileges at a hospital within thirty miles of the facility.[278] Rather than deferring to the State's own assessment of medical necessity,[279] the Court conducted its own analysis of the benefits and burdens of the challenged requirements, drawing heavily on the opinions of relevant professional groups.[280] The regulations at issue in *Whole Woman's Health* can be distinguished from ordinary regulations of medical practice because they affected women's constitutionally protected interest in obtaining an abortion. However, the same can be said for

274. W. Nicholson Price II, *Regulating Black-Box Medicine*, 116 MICH. L. REV. 421, 441 (2017) ("FDA has long taken the position—and others have long understood—that it does not regulate the practice of medicine.").

275. *See* United States v. Caronia, 703 F.3d 149, 152–53 (2d Cir. 2012) (noting that drugs may not be introduced into interstate commerce until the FDA has approved them for a specific use but that, after drugs are approved, physicians may prescribe them for both approved and unapproved uses).

276. Limited exceptions apply to the use of investigational drugs for the treatment of serious or life-threatening diseases or conditions in patients unable to participate in clinical trials, assuming the manufacturers are willing to make the drug available. *See* 21 C.F.R. §§ 312.300–.320 (2018) (governing FDA's expanded access program for patients with serious or immediately life-threatening diseases or conditions); *see also* 21 U.S.C.A. § 360bbb-0a (Westlaw through Pub. L. No. 116-5, 116-8, & 116-12) (authorizing manufacturers to provide investigational drugs to patients with a "life-threatening disease or condition" outside the FDA's expanded access program). However, these exceptions were created by regulation or statute; as a matter of constitutional law, patients do not have a right to be treated with drugs that have not received FDA approval. *See* Abigail All. for Better Access to Developmental Drugs v. Eschenbach, 495 F.3d 695, 697 (D.C. Cir. 2007) (en banc) (rejecting terminally ill patients' assertion of a constitutional right to access unapproved drugs).

277. 136 S. Ct. 2292 (2016).

278. *Id.* at 2300.

279. *See id.* at 2310 (rejecting the court of appeals's conclusion that "legislatures, and not courts, must resolve questions of medical uncertainty").

280. *Id.* at 2312–13, 2315–18 (citing professional associations' amicus briefs).

regulations of professional speech, which directly implicate First Amendment rights.[281]

More generally, even assuming that regulatory authority generally trumps professional standards in the area of medical products or procedures, the logic of such an approach does not apply to regulations affecting speech. Decisions about whether to allow patients to use a new drug or other intervention reflect a balancing of risks and benefits to the overall population,[282] as well as policy considerations like the need to create incentives for manufacturers to invest resources in conducting clinical trials.[283] These assessments implicate broad questions of social policy about which professional medical standards should not be determinative. By contrast, as discussed above, the primary justification for regulating professional speech is to counterbalance the inherent knowledge disparity between professionals and clients, which makes individuals vulnerable to exploitation by incompetent or unscrupulous practitioners.[284] The only way to achieve this goal is if professional regulations are informed by those who have the specialized knowledge and experience that laypersons lack—i.e., members of the professional community itself. In fact, states themselves recognize this need, which is why regulatory bodies charged with overseeing professionals, such as licensing boards, are typically comprised predominantly of members of the regulated profession.[285]

281. *See* Suter, *supra* note 48, at 27 (arguing that regulation of physician speech should be treated "less deferentially than state regulation of medical care" because "regulating speech, as opposed to medical conduct, affects information disclosure, which deserves heightened protection" under the First Amendment).

282. *See, e.g.*, NAT'L ACADS. OF SCIS., ENG'G, & MED., PAIN MANAGEMENT AND THE OPIOID EPIDEMIC: BALANCING SOCIETAL AND INDIVIDUAL BENEFITS AND RISKS OF PRESCRIPTION OPIOID USE 1 (2017) (calling on the FDA to "incorporat[e] individual and societal considerations into its risk-benefit framework for opioid approval and monitoring"); *id.* at 397 (stating that the FDA should consider the "broader societal consequences" of opioid use, including "diversion and the overall impact of addiction on the health and well-being of patients who develop" opioid use disorder in its risk-benefit assessments of opioids).

283. *See* Elizabeth Weeks Leonard, *Right to Experimental Treatment: FDA New Drug Approval, Constitutional Rights, and the Public's Health*, 37 J.L. MED. & ETHICS 269, 274 (2009) (observing that allowing patients to access experimental drugs directly, without enrolling in FDA-overseen clinical trials, "could seriously hamper scientific research and undermine drug innovation").

284. *See supra* text accompanying notes 202–13.

285. *See* John Lunstroth, *Voluntary Self-Regulation of Complementary and Alternative Medicine Practitioners*, 70 ALB. L. REV. 209, 238 (2006) (noting that state licensure laws "delegate authority to regulate the occupation to the profession itself which then functions through a board whose members are drawn from the profession").

Thus, to determine whether a regulation of professional speech is reasonably related to the state's interest in upholding professional quality, courts should consider evidence bearing on the professional community's opinions. Such evidence might include whether the restriction was developed in consultation with members of the profession, as well as testimony from practitioners as to whether the restriction supports or hinders their professional goals.[286] This kind of evidence played a central role in the Third Circuit's decision in *King*, which upheld New Jersey's ban on SOCE in large part because it was enacted with professional support.[287]

In addition to considering the views of members of the professional community, courts should take judicial notice of certain inherent attributes of professional-client relationships that exist independently of the particular subject matter being regulated. For example, in *Velazquez*, the Supreme Court observed that "the traditional role of the attorney" includes "complete analysis of the case, full advice to the client, and proper presentation to the court."[288] In its decision in *Conant*, the Ninth Circuit relied on this observation to conclude that a federal rule prohibiting physicians from recommending medical marijuana violated professional standards because it prevented physicians from conveying accurate and complete information based on an individualized assessment of the

286. Considering the views of the professional community does not necessarily mean deferring to organized professional groups like the AMA. Unlike in some countries, professional organizations in the U.S. are voluntary associations with no formal powers. *See* Katharine Van Tassel, *Hospital Peer Review Standards and Due Process: Moving from Tort Doctrine Toward Contract Principles Based on Clinical Practice Guidelines*, 36 SETON HALL L. REV. 1179, 1182 n.11 (2006) ("[M]embership in professional associations is not required for practice, and nonmembers cannot be disciplined." (quoting John H. Colteaux, Note, *Hospital Staff Privileges: The Need for Legislation*, 17 STAN. L. REV. 900, 901 (1965))). Even the most prominent groups, such as the AMA, typically represent only a minority of practitioners. *See* Ariel R. Schwartz, Note, *Doubtful Duty: Physicians' Legal Obligation to Treat During an Epidemic*, 60 STAN. L. REV. 657, 662 (2007) (noting that the AMA represents only a quarter of physicians currently practicing in the United States). Professional organizations' opinions will therefore not always represent the views of the profession overall. In some cases, the views expressed by particular professional associations may be driven by extraneous factors such as conflicts of interest or political calculations, rather than a genuine application of professional standards and expertise.

287. King v. Governor of N.J., 767 F.3d 216, 238 (3d Cir. 2014).

288. Legal Servs. Corp. v. Velazquez, 531 U.S. 533, 544, 546 (2001). Similarly, in *Rust v. Sullivan*, the Court suggested that, even in the context of government-funded health services, laws that prevent physicians from providing complete medical advice might raise First Amendment problems if the physician-patient relationship is "sufficiently all encompassing so as to justify an expectation on the part of the patient of comprehensive medical advice." Rust v. Sullivan, 500 U.S. 173, 200 (1991).

patient's particular needs.[289] Similarly, in *Stuart*, the Fourth Circuit cited several basic principles of professionalism in striking down North Carolina's requirement for physicians to display and describe the results of a sonogram to women seeking abortions, including the physician's obligation to make an "independent medical judgment"[290] and "to inform and assist the patient without imposing his or her own personal will and values on the patient."[291] Restrictions on speech that do not respect these basic requirements cannot plausibly be justified as efforts to promote the state's interest in upholding professional quality.

Some commentators would go further and require courts to give conclusive weight to professional standards in assessing professional speech regulations, rather than merely requiring consideration of such standards as part of their analysis. For example, Haupt argues that "[t]he First Amendment . . . should provide a shield against the state's requirement that professionals dispense unprofessional advice"[292] and that "the distinction between good and bad advice should be drawn by the knowledge community."[293] As support for this position, she argues that under the law of medical malpractice "it is the profession itself that determines what constitutes reasonable care, and courts have long awarded deference to the profession in such cases."[294]

However, the claim that regulations of professional speech must always be consistent with the norms and standards of the professional community ignores the fact that professional quality is a multifaceted concept that includes both technical and nontechnical dimensions. In the medical context, technical components of quality relate to methods for diagnosing, treating, and preventing diseases and conditions, whereas nontechnical aspects include "the interpersonal (e.g., communication, teamwork), cognitive (e.g., decision-making, situational awareness) and personal resource skills (e.g., coping with stress and fatigue)."[295] While professionals' training and expertise

289. Conant v. Walters, 309 F.3d 629, 631 (9th Cir. 2002) (quoting Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 883–84 (1992) (plurality opinion)); *see also* Jack M. Balkin, *Information Fiduciaries and the First Amendment*, 49 U.C. DAVIS L. REV. 1183, 1218 n.147 (2016) (recognizing "a constitutional interest in the development and faithful application of professional knowledge").

290. Stuart v. Camnitz, 774 F.3d 238, 253 (4th Cir. 2014).

291. *Id.* at 252.

292. Haupt, *Unprofessional Advice*, *supra* note 213, at 728.

293. *Id.* at 705.

294. *Id.* at 708.

295. Riaz A. Agha, Alexander J. Fowler & Nick Sevdalis, *The Role of Non-Technical Skills in Surgery*, 4 ANNALS MED. & SURGERY 422, 424 (2015); *see also* R. Flin & N. Maran, *Identifying and Training Non-Technical Skills for Teams in Acute Medicine*, 13

make them uniquely qualified to evaluate the technical aspects of quality, they do not necessarily make them experts on the nontechnical dimensions. In fact, in *Canterbury v. Spence*,[296] one of the leading cases establishing the modern doctrine of informed consent, the court specifically concluded that judgments about how physicians should communicate with patients (part of the "interpersonal" dimension of quality) are often "non-medical" in nature.[297] As a result, the court found that the standard for assessing the adequacy of physicians' disclosures to patients should be based on whether a "reasonable patient" would find the information "material" to her decision, without regard to the professional community's prevailing practices or views.[298]

Moreover, while courts have traditionally deferred to professional standards in medical malpractice cases, deference to professional judgment is not absolute. As Philip Peters has documented, in several jurisdictions, medical malpractice juries are instructed to make their own judgment about what a "reasonable physician" would have done under the circumstances rather than simply basing their decision on prevailing professional norms.[299] Similarly, courts evaluating restrictions on physician speech should have the option of rejecting professional opinion when they conclude that the professional community's views do not comport with larger societal conceptions of reasonableness.[300] For example, even if a substantial segment of the professional community believed it was appropriate to attempt to change minors' sexual orientation, courts still could legitimately uphold anti-SOCE laws as legitimate efforts to protect the civil rights of sexual minorities.[301]

QUALITY & SAFETY HEALTH CARE (SUPP. 1) i80, i82 (2004) (identifying gathering and exchanging information as key elements of anesthesiologists' nontechnical skills).

296. 464 F.2d 772 (D.C. Cir. 1972).

297. *Id.* at 785 ("The decision to unveil the patient's condition and the chances as to remediation . . . is oftentimes a non-medical judgment.").

298. *See id.* at 786–87.

299. *See* Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 187–88 (2000) ("Modern malpractice law is moving slowly away from a custom-based standard of care and toward a reasonable physician standard.").

300. Similarly, Parmet and Smith argue that "the ultimate question is whether the regulation of health-related speech protects health," not whether it conforms to "the profession's own perspectives and methodologies." Parmet & Smith, *supra* note 215, at 914. As an example, they suggest that "[a] law prohibiting physicians from urging patients to smoke by claiming that smoking was good for their health . . . would pass muster even if the AMA recommended otherwise." *Id.*

301. *See* Ignatius Yordan Nugraha, *The Compatibility of Sexual Orientation Change Efforts with International Human Rights Law*, 35 NETH. Q. HUM. RTS. 176, 192 (2017)

B. Application to Cases

Under the approach proposed above, the appropriate resolution of most of the cases discussed in Part I of this Article should be readily apparent. On the one hand, the prohibitions on SOCE at issue in *Pickup* and *King* would survive intermediate scrutiny because they were substantially related to the state's interest in promoting professional quality, as indicated by their uniform support among professional organizations. On the other hand, the federal ban on recommending medical marijuana in *Conant*, the Florida law prohibiting routine requests about firearm ownership in *Wollschlaeger*, and the compelled abortion disclosures in *Rounds I* and *II*, *Lakey*, and *Stuart* would all be struck down. In addition to conflicting with inherent norms of professional-client relationships, most of these laws were opposed by professional medical associations.[302] Moreover, there were no factors present in these cases that would give courts any reason to depart from the professional community's views. In fact, the defendants in most of those cases did not even attempt to describe the challenged laws as efforts to uphold professional quality. Rather, in *Conant*, the ban on recommending medical marijuana was justified as an effort to enforce the government's policy against the distribution of controlled substances,[303] while the abortion disclosure laws appeared to be primarily intended to discourage abortion.[304]

(concluding that international human rights law "requires States to prohibit SOCE for minors as a whole").

302. In *Conant*, the California Medical Association submitted an amicus brief in support of the plaintiffs' challenge to the federal policy. *See* Conant v. Walters, 309 F.3d 629, 631 (9th Cir. 2002). In *Wollschlaeger*, the Florida chapters of the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians were part of the group of plaintiffs challenging the Florida law. *See* Wollschlaeger v. Farmer, 880 F. Supp. 2d 1251, 1257 (S.D. Fla. 2012), *aff'd in part and rev'd in part en banc sub nom.* Wollschlaeger v. Governor of Fla., 848 F.3d 1293 (11th Cir. 2017). In the abortion disclosure cases, amici supporting the plaintiffs included the American College of Pediatricians, *see Rounds II*, 686 F.3d 889, 889 (8th Cir. 2012) (en banc), and the American College of Obstetricians and Gynecologists, the American Medical Association, and the American Public Health Association, *see* Stuart v. Camnitz, 774 F.3d 238, 238 (4th Cir. 2014).

303. *See Conant*, 309 F.3d at 632–33.

304. *See Stuart*, 774 F.3d at 246 (noting that "the clear and conceded purpose" of North Carolina's mandatory disclosure requirement "is to support the state's pro-life position"); *Rounds II*, 686 F.3d at 906 (suggesting that required disclosures might "encourage the patient to choose childbirth over abortion" (quoting *Rounds I*, 530 F.3d 724, 735 (8th Cir. 2008) (en banc))); Tex. Med. Providers Performing Abortion Servs. v. Lakey, 667 F.3d 570, 576 (5th Cir. 2012) (concluding that the required disclosures "might cause the woman to choose childbirth over abortion" (quoting Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 889 (1992))).

The most challenging case for the proposed standard is the Supreme Court's decision in *Casey*. On the one hand, Pennsylvania's mandatory disclosures were similar to those at issue in *Rounds I* and *II*, *Lakey*, and *Stuart* in that they were primarily designed to discourage abortion. On the other hand, the focus of the required disclosures was the risks and alternatives to abortion, which are standard elements of informed consent.[305] Admittedly, the required disclosures were unbalanced—they emphasized reasons against having an abortion without also disclosing the potential benefits of the procedure[306]—but they at least were limited to factual information that a reasonable patient would arguably want to know. Moreover, as the Ninth Circuit observed in *Conant*, the law did not prevent physicians from exercising independent medical judgment because it allowed for exceptions when the disclosure would have a "severely adverse effect on the physical or mental health of the patient."[307]

Courts can therefore apply *Casey* in a manner that remains deferential to professional standards. For example, consistent with *Casey*, courts can emphasize the importance of limiting mandatory disclosures to the traditional elements of informed consent—i.e., factual information about risks, benefits, and alternatives—as opposed to sensational efforts to provoke an emotional reaction, such as forcing patients to view ultrasound images even when they are averting their eyes.[308] Moreover, courts can insist that, like the Pennsylvania law upheld in *Casey*, other mandatory disclosure laws allow for exceptions in cases where a physician reasonably determines

305. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772, 787–88 (D.C. Cir. 1972) ("The topics importantly demanding a communication of information are the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated.").

306. In fact, prior to *Casey*, the Supreme Court had struck down similar informed consent statutes in the abortion context for precisely this reason. *See* Thornburgh v. Am. Coll. of Obstetricians & Gynecologists, 476 U.S. 747, 762 (1986) (characterizing another compelled disclosure law as "nothing less than an outright attempt to wedge the Commonwealth's message discouraging abortion into the privacy of the informed-consent dialogue between the woman and her physician"); City of Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416, 444 (1983) (striking down a city ordinance requiring specific disclosures to women undergoing abortions on the ground "that much of the information required is designed not to inform the woman's consent but rather to persuade her to withhold it altogether").

307. *See Conant*, 309 F.3d at 638 (quoting Planned Parenthood Se. Pa. v. Casey, 505 U.S. 833, 883–84 (1992)); Haupt, *Professional Speech*, *supra* note 211, at 1260 (observing that the Pennsylvania statute "neither required that the providers communicate this information as their own . . . nor prohibited the providers from expressing their disagreement with the state's policy" and that "there was a provision for physicians to refrain from providing certain information if they deemed it harmful to their patients").

308. *See Stuart*, 774 F.3d at 243.

that the disclosure would have an adverse effect on the patient's physical or mental health.

What are the implications of the standard proposed here for the other mandatory disclosure laws mentioned in the introduction to this Article, which have not been the subject of litigation?[309] Unlike the compelled abortion disclosure laws, most of these laws were enacted at the urging of patient advocates, who were concerned that physicians were not regularly providing patients with important information. For example, laws requiring physicians to inform breast cancer patients about the availability of breast-conserving treatment options were enacted "at the behest of former breast cancer patients," many of whom believed that mastectomies were being overused.[310] Laws requiring physicians to tell women if mammogram results reveal the presence of "dense breast tissue" were enacted based on the urging of advocates "outraged at the thought of women having yearly mammograms without knowing that their dense breast tissue could obscure cancerous tumors."[311] The most recent wave of mandatory disclosure laws, requiring physicians to offer terminally ill patients the option of receiving information and counseling about palliative care and end-of-life decision-making, were the result of advocacy by terminally ill patients and their families.[312]

In contrast to the support for these laws among many patient advocates, mandatory disclosure laws have been met with strong opposition from the medical profession. For example, when Massachusetts's breast cancer treatment disclosure law was enacted, the Massachusetts Medical Society sought to have the statute repealed on the ground that it interfered with the patient-physician relationship.[313] Similarly, state medical societies objected to the passage of laws requiring disclosure of end-of-life alternatives.[314] After New York's Palliative Care Information Act was enacted, an

309. *See supra* text accompanying notes 3–6.

310. Andersen-Watts, *supra* note 5, at 203.

311. Alena Allen, *Dense Women*, 76 OHIO ST. L.J. 847, 855–56 (2015).

312. *See* Jane E. Brody, *Frank Talk About Care at Life's End*, N.Y. TIMES, Aug. 23, 2010, at D1 (noting that New York's Palliative Care Information Act was enacted at the urging of the advocacy group Compassion and Choices of New York).

313. Susan G. Nayfield et al., *Statutory Requirements for Disclosure of Breast Cancer Treatment Alternatives*, 86 NAT'L CANCER INST. J. 1202, 1206 (1994).

314. Jane E. Brody, *Law on End-of-Life Care Rankles Doctors*, N.Y. TIMES, June 7, 2011, at D7 (noting that New York's law was "[v]ehemently opposed by the Medical Society of the State of New York"); *see also* Steven E. Weinberger et al., *Legislative Interference with the Patient-Physician Relationship*, 367 NEW ENG. J. MED. 1557, 1558 (2012) (opposing, on behalf of several medical associations, "[l]aws that specifically dictate or limit what physicians discuss during health care encounters").

oncologist and geriatrician published an editorial in the *New England Journal of Medicine* expressing their sympathy with the law's overall objectives but criticizing its effort "to prescribe legislatively what should be a subtle, intimate conversation between doctor and patient that often happens over time."[315]

Despite the opposition to these laws among members of the professional community, however, it would be difficult to conclude that they are not reasonably related to the state's interest in upholding professional quality. Requiring physicians to disclose the results of medical testing, as in the breast density legislation, or the available treatment alternatives, as in the breast cancer treatment and end-of-life care laws, is well within the parameters of standard informed consent doctrine. Unlike most of the informed consent laws in the context of abortion, these statutes require disclosure of factually accurate, relevant information that reasonable patients might genuinely want to receive.

Some commentators have argued that mandatory disclosure laws actually undermine patients' autonomy because, while they might appear to be factual, they subtly push patients toward certain legislatively preferred decisions. For example, Rachael Andersen-Watts has described breast cancer disclosure laws as "morally coercive tool[s]" that "stem in part from the assumption that individual women were making an 'incorrect' decision when they chose mastectomy instead of lumpectomy."[316] Similarly, Alena Allen has criticized the state-prescribed information in some states' breast density disclosure laws for "direct[ing] women to 'use' the information provided about dense breast tissue to 'ask' [their] doctor if more screening tests might be useful."[317] By "predetermining for women how they should use information about dense breast tissue," she argues, these statutes "substitut[e] the judgment of legislators for the judgment of women."[318] Allen also raises the concern that these statutes could lead to an overuse of supplemental follow-up screenings in contravention of evidence-based medical guidelines.[319]

Even accepting the validity of these criticisms, however, they do not make the statutes unconstitutional under the standard proposed

315. Alan B. Astrow & Beth Popp, *The Palliative Care Information Act in Real Life*, 364 NEW ENG. J. MED. 1885, 1885 (2011).

316. Andersen-Watts, *supra* note 5, at 203–04.

317. Allen, *supra* note 311, at 874–75.

318. *Id.* at 875.

319. *Id.* at 892.

in this Article.[320] While it would be problematic if the statutes required physicians to recommend particular medical options to patients regardless of their own medical judgment, none of the statutes do that. The breast cancer treatment laws simply require physicians to inform patients that breast-conserving treatments are among the available options, without stating that these treatments are necessarily preferable in the patient's situation. While the breast density notification laws do imply that supplemental screening might be appropriate in some situations, they ultimately direct patients to engage in a discussion with their physicians. As part of this discussion, physicians can explain that prevailing medical guidelines do not endorse additional screening for women with dense breast tissue in the absence of other risk factors.[321] Because these statutes do not seek to override the physician's individualized medical judgment, they are consistent with the state's interest in upholding professional quality—even if professional associations do not necessarily agree.

That being said, the fact that these statutes are probably constitutional does not mean that they are wise from a policy perspective. It is understandable that legislators would want to respond to concerns that patients are being asked to make important medical decisions without a full appreciation of the issues, but requiring physicians to provide patients with "an additional page in the hefty pile of papers foisted on patients"[322] is unlikely to be helpful. Research has shown that "even when doctors lavish information on patients, most patients neither understand nor remember it."[323] Moreover, no matter how well the required disclosures are initially drafted, they can easily become outdated as medical knowledge evolves. A better approach would be to encourage the greater use of interactive "patient decision aids," which are tools designed not only to provide information but to help patients sort through the available options in light of their personal values and goals.[324] Rather than

320. To be clear, neither Andersen-Watts nor Allen suggests that the mandatory disclosure laws are unconstitutional; their arguments are grounded in policy concerns, not constitutional law. In fact, Allen concludes that "the constitutionality of the density notification provisions cannot seriously be doubted." *Id.* at 891 ("*Casey* affirmed the state's authority to regulate the content of physician-patient communications under the state's licensing authority.").

321. *See id.* at 892.

322. Astrow & Popp, *supra* note 315, at 1886.

323. Omri Ben-Shahar & Carl E. Schneider, *The Failure of Mandated Disclosure*, 159 U. PA. L. REV. 647, 668 (2011).

324. According to a Cochrane systematic review, decision aids are "interventions designed to help people make specific and deliberate choices among options (including the status quo), by making the decision explicit and by providing (at the minimum)

continuing to enact mandatory disclosure laws, legislatures concerned about promoting more informed patient decision-making should consider measures to support the integration of these decision aids into clinical care.[325]

CONCLUSION

Laws that restrict or compel physician speech pose special challenges for the First Amendment because they implicate two potentially competing considerations. On the one hand, inappropriate government interference in physician-patient communications can distort professional practice by preventing physicians from providing or soliciting information important to patients' medical care. On the other hand, because patients typically lack the knowledge necessary to independently evaluate the quality of professional practice, the public relies on the government to ensure that practitioners uphold professional norms. To fulfill this mission, the government necessarily must make judgments about the opinions and advice that physicians express.

To account for both of these considerations, this Article calls on courts to subject restrictions on physician-patient communications to a uniform standard of intermediate scrutiny, with a specific focus on whether the restrictions directly advance the state's interest in upholding the quality of professional practice. This approach is rigorous enough to protect physicians' and patients' interest in open communication without being so demanding that it precludes legitimate regulatory efforts to uphold professional quality. The proposed uniform standard would bring clarity to an area of law that has been marked by considerable confusion, without introducing the

information on the options and outcomes relevant to a person's health status as well as implicit methods to clarify values." DAWN STACEY ET AL., DECISION AIDS FOR PEOPLE FACING HEALTH TREATMENT OR SCREENING DECISIONS (REVIEW) 8 (Cochrane Consumers & Commc'n Grp. ed., 2017). The review notes that decision aids may include

> information on the disease/condition; costs associated with options; probabilities of outcomes tailored to personal health risk factors; an explicit values clarification exercise; information on others' opinions; a personalized recommendation on the basis of clinical characteristics and expressed preferences; and guidance or coaching in the steps of making and communicating decisions with others.

Id. at 11.

325. *See generally* Thaddeus Mason Pope, *Certified Patient Decision Aids: Solving Persistent Problems with Informed Consent Law*, 45 J.L. MED. & ETHICS 12 (2017) (calling for efforts to incentivize the use of patient decision aids, including the creation of independent certification or credentialing processes).

practical and theoretical problems raised by proposals for variable standards of review.