REMOVING THE "SILENCER": COVERAGE AND PROTECTION OF PHYSICIAN SPEECH UNDER THE FIRST AMENDMENT

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ABSTRACT

The physician–patient relationship rests on a bedrock of trust. Without trust, patients—and for that matter, physicians—are less willing to divulge information critical to providing accurate medical diagnoses and treatments. The state of Florida seemingly ignored this when its legislature, with support from the National Rifle Association and other pro-gun advocates, enacted the Firearm Owners Privacy Act (FOPA), a statute that restricts physicians from questioning their patients about firearm ownership. In Wollschlaeger v. Governor of Florida*, the United States Court of Appeals for the Eleventh Circuit held that FOPA did not regulate physician speech but, instead, regulated physician conduct. As such, the law was exempted from First Amendment scrutiny. But almost one year to the day after publishing its first* Wollschlaeger *opinion, the Eleventh Circuit* sua sponte *vacated its original opinion and substituted in its place a brand new opinion—one holding that FOPA was subject to First Amendment scrutiny, but nonetheless passed constitutional muster.*

This Note uses the diverging Wollschlaeger *opinions as a vehicle to analyze the First Amendment's coverage and protection of physician speech. Specifically, it argues that an uninhibited line of communication is required to protect the trust necessary for an effective physician–patient relationship. This logical underpinning leads to the conclusion that the First Amendment presumptively covers physician speech and, furthermore, that physician speech should be subject to intermediate scrutiny—a level of scrutiny that FOPA cannot meet.*

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> *The right of the doctor to advise his patients according to his best lights seems so obviously within First Amendment rights as to need no extended discussion.*
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> – U.S. Supreme Court Associate Justice William O. Douglas, *Poe v. Ullman*[1]

INTRODUCTION

The First Amendment serves as a shield against government suppression of speech[2] and does not cease to defend a physician-speaker when he or she speaks in a professional capacity.[3] In fact, the Supreme Court has explicitly recognized that professional speech in many contexts enjoys the *strongest* protection the Constitution provides.[4] But this concept—protected professional speech—contrasts sharply with the common understanding that states "have broad power to establish standards for licensing practitioners and regulating the practice of professions."[5] Thus, no constitutional issue arises when physicians' speech rights are "implicated but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State."[6] These seemingly irreconcilable concepts have led to great confusion regarding the regulation of speech in a professional relationship. Because this dichotomy has gone largely unaddressed by

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

2. *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, 232 (1994) (recognizing that the First Amendment "safeguards individuals' thought processes and expression against government suppression").

3. *See* Planned Parenthood Fed'n of Am. v. Bowen, 680 F. Supp. 1465, 1473 (D. Colo. 1988) (identifying a "physician's First Amendment right to disseminate necessary medical information to patients").

4. *See* Fla. Bar v. Went For It, Inc., 515 U.S. 618, 634 (1995) (asserting that in certain situations, attorney speech receives the "strongest protection our Constitution has to offer"). The First Amendment's protective shield is not limited to professional speech—it also extends to speech utilized to engage in economic activity. *See* Thomas v. Collins, 323 U.S. 516, 531 (1945) (asserting that the safeguards of the First Amendment are still applicable when the speech involves business or economic transactions); *see also* Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, 425 U.S. 748, 770–73 (1976) (stating that commercial speech receives First Amendment protection).

5. Goldfarb v. Va. State Bar, 421 U.S. 773, 792 (1975).

6. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 884 (1992) (plurality opinion) (citations omitted).

the Supreme Court,[7] the relationship between physician speech and the First Amendment remains nascent and unclear.[8]

The Eleventh Circuit Court of Appeals recently addressed this doctrinal confusion. In *Wollschlaeger v. Governor of Florida*,[9] the Eleventh Circuit considered the constitutionality of a Florida statute that restricts healthcare practitioners and facilities from inquiring into a patient's ownership or possession of firearms and ammunition.[10] Specifically, Florida's Firearm Owners Privacy Act (FOPA) prohibits physicians from inquiring about patients' possession of firearms and ammunition,[11] keeping records regarding patients' possession of firearms and ammunition,[12] and harassing[13] or discriminating against[14] patients on the basis of firearm and ammunition possession. Plaintiffs[15] alleged that FOPA openly discriminates based on the viewpoint of physicians' speech[16] and thus violated the First Amendment.[17] Originally, the Eleventh Circuit held that FOPA was not subject to any level of heightened scrutiny because it regulated conduct instead of speech.[18] But, in a surprising turn of events, the Eleventh Circuit *sua sponte* vacated its original opinion and held

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7. *See* Daniel Halberstam, *Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions*, 147 U. PA. L. REV. 771, 834 (1999) ("[T]he Supreme Court and lower courts have rarely addressed the First Amendment contours of a professional's freedom to speak to a client.").

8. *See* Moore-King v. Cty. of Chesterfield, 708 F.3d 560, 570 (4th Cir. 2013) (deciding not to outline specific margins of the professional speech doctrine); *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, 2368 (2013) ("The relationship between the First Amendment and physicians' professional speech unfortunately remains undeveloped and unclear."); Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 944 (referencing the "obscure and controversial" relationship between the First Amendment and regulating professional physician speech).

9. Wollschlaeger v. Governor of Fla., 797 F.3d 859 (11th Cir. 2015).

10. *Id.* at 869; *see also* FLA. STAT. § 790.338 (2014) (codifying Florida's Firearm Owners Privacy Act).

11. FLA. STAT. § 790.338(2).

12. *Id.* § 790.338(1).

13. *Id.* § 790.338(6).

14. *Id.* § 790.338(5).

15. Plaintiffs included various Florida physicians and interest groups. *Wollschlaeger*, 797 F.3d at 868.

16. *Id.* at 871.

17. Plaintiffs also challenged that FOPA was unconstitutionally vague. *Id.* at 878–83. Although these claims may have been meritorious, they are not discussed in this Note.

18. Wollschlaeger v. Governor of Fla., 760 F.3d 1195, 1225 (11th Cir. 2014).

instead that FOPA regulated speech.[19] As a result, answering a second question became necessary: Did FOPA pass heightened scrutiny?[20] After emphasizing the state's strong interest in regulating physician speech "for the protection of the public,"[21] the Eleventh Circuit held that FOPA passed constitutional muster.[22] This interpretation, however, was not unanimous—Judge Charles R. Wilson penned a fiery dissent, claiming that FOPA "significantly infringes upon [the First Amendment] right . . . and cannot pass constitutional muster."[23]

This Note uses the *Wollschlaeger* decision as a lens through which to examine the coverage and protection of physician speech under the First Amendment. It argues that physician speech presumptively falls within the First Amendment's boundaries because an uninhibited line of communication is necessary to a physician–patient relationship founded on trust. Furthermore, as restricting physician speech on discrete topics is necessarily content based, these regulatory schemes must receive at least intermediate scrutiny.

This Note proceeds in three Parts. Part I sets the stage by providing a brief history of FOPA, the First Amendment, and governmental regulation of physicians. Part II argues that physician speech is "covered" by the First Amendment and that the Eleventh Circuit's decision to analyze FOPA under heightened scrutiny was correct—but for the wrong reasons. Having shown that the First Amendment cannot be avoided, Part III explains why and when regulations that restrict physician speech should be subjected to intermediate scrutiny. In doing so, Part III posits that FOPA violates the First Amendment.

I. A BRIEF HISTORY

Grasping the concept of physician speech through the lens of *Wollschlaeger* requires reviewing certain background principles. Part A chronicles both FOPA's infancy and the *Wollschlaeger* case. Part B expatiates on freedom of speech and provides a broad overview of

19. *Wollschlaeger*, 797 F.3d at 886. During final revisions to this Note, the Eleventh Circuit *sua sponte* vacated and replaced its July 2015 opinion as well. Wollschlaeger v. Governor of Fla., No. 12-14009, 2015 WL 8639875 (11th Cir. Dec. 14, 2015). Due to publication deadlines, this Note does not take that opinion into account.

20. *See Wollschlaeger*, 797 F.3d at 886 (proceeding to the scrutiny question only after holding that FOPA implicates speech).

21. *Id.* at 889.

22. *Id.* at 900.

23. *Id.* at 902 (Wilson, J., dissenting).

the First Amendment. Finally, Part C describes the government's ability to regulate the medical field.

A. FOPA's Impetus and Infancy

1. "*A miffed mother, a perturbed pediatrician, a fervent gun-rights organization, and a responsive lawmaker . . . .*"[24] In July 2010, Amber Ullman, a twenty-six-year-old mother from Summerfield, Florida, took her four-month-old daughter to the family's pediatrician, Dr. Chris Okonkwo.[25] Dr. Okonkwo, "a board-certified pediatrician specializing in comprehensive pediatric care,"[26] began asking Mrs. Ullman a variety of questions.[27] Included among those questions was one that pediatricians commonly ask,[28] and the American Association of Pediatrics explicitly recommends:[29] Were firearms kept in the Ullman household?[30]

Surprised and insulted, Mrs. Ullman refused to answer Dr. Okonkwo's question.[31] Mrs. Ullman did not grasp why Dr. Okonkwo's inquiry into firearm possession, which she regarded as privacy invasive, was necessary or relevant to her child's medical care

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24. Clay Calvert, Daniel Axelrod, Justin B. Hayes & Minch Minchin, *Physicians, Firearms & Free Expression: Reconciling First Amendment Theory with Doctrinal Analysis Regarding the Right to Pose Questions to Patients*, 12 FIRST AMEND. L. REV. 1, 11 (2013) (footnotes omitted).

25. Melinda Carstensen, *Scott Signs Doctor-Gun Measure*, THE GAINESVILLE SUN (June 3, 2011), http://www.gainesville.com/article/20110603/ARTICLES/110609797 [http://perma.cc/H8AM-Q36K].

26. Calvert et al., *supra* note 24, at 11.

27. Fred Hiers, *Family and Pediatrician Tangle Over Gun Question*, OCALA STAR-BANNER (July 24, 2010), http://www.ocala.com/article/20100724/ARTICLES/7241001 [http://perma.cc/H8S4-X2YT].

28. *See* Gayland O. Hethcoat II, *In the Crosshairs: Legislative Restrictions on Patient-Physician Speech About Firearms*, 14 DEPAUL J. HEALTH CARE L. 1, 5 (2012) (classifying Dr. Okonkwo's question regarding firearms in the home as a "typical query").

29. *See* American Academy of Pediatrics, *Policy Statement: Firearm-Related Injuries Affecting the Pediatric Population*, 130 PEDIATRICS 1416, 1421 (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."); *see also* AM. MED. ASS'N, HEALTH AND ETHICS POLICIES OF THE AMA HOUSE OF DELEGATES 138 (2015), http://www.ama-assn.org/ad-com/polfind/Hlth-Ethics.pdf [http://perma.cc/NBM6-NGDW] (recommending that physicians "inquire as to the presence of household firearms as a part of childproofing the home" to help prevent accidental firearm deaths in children).

30. Stacey Singer, *Pediatricians Say Gun Privacy Bill Would Muzzle Them*, PALM BEACH POST (Apr. 23, 2011, 1:59 PM), http://www.palmbeachpost.com/news/news/state-regional/pediatricians-say-gun-privacy-bill-would-muzzle-th/nLrqP [http://perma.cc/Y7V2-4QVV].

31. *See* Hiers, *supra* note 27 (classifying Mrs. Ullman's deflective actions as "defensive").

or safety.[32] Dr. Okonkwo, on the other hand, believed that the question was critical to his ability to provide full and complete medical care.[33] To him, the inquiry was analogous to "ask[ing] parents whether they have pools at their homes so he can advise them about water safety."[34] Dr. Okonkwo attempted to assuage Mrs. Ullman's concerns by explaining his rationale for asking these introductory questions,[35] but his attempt was futile. Mrs. Ullman refused to answer, responding, "Didn't you hear what I said? None of your damn business!"[36] Dr. Okonkwo clarified for Mrs. Ullman that her refusal to answer the question "demonstrated a lack of trust—the cornerstone of the patient–physician relationship."[37] Consequently, Dr. Okonkwo terminated the physician–patient relationship and informed Mrs. Ullman that she had thirty days to find a new pediatrician.[38]

This episode in Summerfield however, was not an isolated occurrence. Throughout Florida, constituents reported to their lawmakers that physicians were inquiring into their private possession of firearms. One legislator, for example, expressed concern after a constituent informed him that "a doctor had refused care upon a nine year old . . . because they wanted to know if they had a firearm in their home."[39] Another state legislator faced this situation personally when asked about gun ownership during a visit with his daughter to the family's pediatrician.[40] After the pediatrician asked that he remove any firearms from his family's home, the legislator felt that his Second Amendment rights were under attack.[41]

These narratives served as a springboard for a newly elected state representative to propose House Bill 155 in January 2011.[42] As

32. *See* Singer, *supra* note 30 (stating that Mrs. Ullman explained that whether she owns a gun "has nothing to do with the health of [her] child").

33. Hiers, *supra* note 27.

34. *Id.*

35. *Id.*

36. Helena Rho, *The Pediatricians vs. the NRA*, SLATE (Feb. 1, 2013, 2:53 PM), http://www.slate.com/articles/health_and_science/medical_examiner/2013/02/pediatricians_and_nra_physician_gag_rules_and_the_cdc_aca_and_states.html [http://perma.cc/64B5-JYPY].

37. Hethcoat II, *supra* note 28, at 6.

38. *Id.* at 6–7.

39. Brief for Appellants at 3, Wollschlaeger v. Governor of Fla., 760 F.3d 1195 (11th Cir. 2014) (No. 1:11-cv-22026-MGC), http://op.bna.com/hl.nsf/id/mapi92vmu9/$File/woll%20state's%20brief.pdf [http://perma.cc/8Q6A-LDYW].

40. *Id.* at 3.

41. *Id.*

42. Calvert et al., *supra* note 24, at 13.

introduced, House Bill 155 proffered that verbal or written inquiries "concerning the ownership of a firearm by a patient or the family of a patient" by physicians or their staff "violate[] the privacy of the patient or the patient's family members, respectively."[43] Additionally, the original version contained draconian punishments—violating the statute was a third-degree felony and exposed physicians to fines of up to $5 million dollars.[44] After four months and several amendments,[45] FOPA was codified in its current form.[46]

FOPA imposes on healthcare practitioners[47] four obligations relevant to the discussion here. First, the inquiry provision mandates that healthcare practitioners may not "mak[e] a written inquiry or ask[] questions concerning the ownership of a firearm or ammunition by the patient or by a family member of that patient,"[48] unless that practitioner believes, in good faith, that the information is relevant.[49] Second, unless relevant to the patient's medical care or safety, healthcare practitioners "may not intentionally enter any disclosed information concerning firearm ownership into the patient's medical record."[50] As with the inquiry provision, however, physicians may keep records regarding firearm ownership if deemed relevant.[51] Third, the harassment provision directs healthcare practitioners not to harass patients regarding firearm ownership or possession during an examination.[52] Fourth, the discrimination provision provides that healthcare practitioners must "not discriminate against a patient based solely upon the patient's exercise of the constitutional right to

43. H.B. 155, 113th Legis., Reg. Sess. (Fla. 2011).

44. *Id.* As codified, FOPA significantly reduced the disciplinary measures. *See* FLA. STAT. § 456.072(2) (2014) (codifying the disciplinary actions).

45. *Compare* H.B. 155, 113th Legis., Reg. Sess. (Fla. 2011) (prohibiting "inquiries by physicians or other medical personnel concerning the [patient's or family member's] ownership of a firearm"), *with* FLA. STAT. § 790.388 (adding, *inter alia*, provisions addressing inquiries made in good faith that the information is relevant, inquiries by emergency medical professionals, and insurers' use of information relating to firearm ownership).

46. *See* FLA. STAT. § 790.338 (codifying FOPA).

47. *See* FLA. STAT. § 456.001(4) (defining "[h]ealth care practitioner" as an individual licensed to give medical care under the Florida Statutes, including physicians).

48. FLA. STAT. § 790.338(2); *see also* FLA. STAT. § 381.026(4)(b)(8) (codifying this provision in the Florida Patient's Bill of Rights and Responsibilities).

49. FLA. STAT. § 790.338(2).

50. *Id.* § 790.338(1).

51. *Id.*

52. *Id.* § 790.338(6); *see also id*. § 381.026(4)(b)(11) (codifying this provision in the Florida Patient's Bill of Rights and Responsibilities).

own and possess firearms or ammunition."[53] Violating any of these provisions exposes the physician to a wide variety of punishments, including fines, reduction of practice,[54] return of fees, probation, and revocation or suspension of the physician's medical license.[55]

2. *The* Wollschlaeger *Case and Subsequent Litigation*. FOPA incited significant debate and condemnation.[56] Supporters of the statute, including the National Rifle Association (NRA),[57] argued that firearm possession is a private matter and is protected as a fundamental right by the Second Amendment.[58] Additionally, supporters perceived the firearm inquiries as an expression of an "anti-gun political agenda," not medical advice.[59] FOPA's opponents, on the other hand, claimed that instead of protecting privacy, FOPA intrudes upon the trust necessary to the patient–physician relationship.[60] Furthermore, opponents countered, firearms do, in fact, present significant medical health risks.[61] Thus, doctors ask these

53. *Id.* § 790.338(5); *see also id*. § 380.026(4)(b)(10) (codifying this provision in the Florida Patient's Bill of Rights and Responsibilities).

54. Reduction of practice encompasses a wide variety of restrictions, including limitations on the following: the setting a physician can practice in, the type of services a physician can provide, the number of hours a physician can work, or "any other restriction found to be necessary for the protection of the public health, safety, and welfare." *Id*. § 456.072(2)(c).

55. *See id.* § 456.072(2) (codifying the disciplinary actions).

56. *See* Jay Weaver, *Miami Federal Judge Sides With 'Docs' Over 'Glocks' in Fla. Gun Rights Case*, MIAMI HERALD (July 2, 2012), http://www.miamiherald.com/news/politics-government/article1940987.html [http://perma.cc/N37N-NBDY] (classifying the ensuing debate as "an ideological battle between advocates of free speech and the right to bear arms").

57. *See* Frank Cerabino, Opinion, *Talk to Me, Doc; Just Don't Ask About My Guns*, PALM BEACH POST (Feb. 24, 2011, 1:43 PM), http://m.palmbeachpost.com/news/news/cerabino-talk-to-me-doc-just-dont-ask-about-my-gun/nLqL5 [http://perma.cc/5BRQ-3HRE] (claiming that the NRA lobbied the Florida Legislature "to criminalize the practice of responsible patient care").

58. Hethcoat II, *supra* note 28, at 8. Florida Governor Rick Scott, for example, supported FOPA as a defender of Second Amendment rights. *See Fla. Lawsuit: Can Doctors Ask Patients About Guns?*, FOX NEWS (July 13, 2011), http://www.foxnews.com/us/2011/07/13/fla-lawsuit-can-doctors-ask-patients-about-guns [http://perma.cc/M3ZQ-G63Y] ("I believe in the Second Amendment. I believe the citizens have a right to bear arms."). Ironically, Governor Scott seemingly overlooked FOPA's First Amendment implications. *See id.* (explaining Governor Scott's assertion that citizens "should be able to lead . . . lives without people intruding on them").

59. Greg Allen, *Florida Bill Could Muzzle Doctors on Gun Safety*, NPR (May 7, 2011, 7:31 AM), http://www.npr.org/2011/05/07/136063523/florida-bill-could-muzzle-doctors-on-gun-safety [http://perma.cc/T7W4-8KJM].

60. Hethcoat II, *supra* note 28, at 9.

61. Kathleen Haughney, *State Appeals 'Docs v. Glocks' Ruling*, SUN-SENTINEL (July 31, 2012), http://articles.sun-sentinel.com/2012-07-31/news/fl-state-appeals-docs-glocks-ruling-20120731_1_glocks-state-appeals-state-associations [http://perma.cc/Z8F5-MBJ2].

questions not to further their own political agenda, but rather to convey medical advice that helps prevent accidental injuries.[62] Finally, opponents claimed that any politicizing of FOPA was a result of the NRA's lobbying efforts.[63]

Four days after FOPA was passed, a group of physicians and physician interest groups filed suit in the Southern District of Florida against various State officials,[64] alleging that FOPA violates the First and Fourteenth Amendments of the United States Constitution.[65] As a threshold matter, the Southern District of Florida rejected the State's argument that FOPA dodged First Amendment scrutiny as a regulation of conduct, not speech.[66] Had the Southern District classified FOPA as a regulation of conduct, FOPA would "not [be] subject to First Amendment scrutiny at all."[67] And while the court did not explicitly decide what level of scrutiny to apply, the court undoubtedly applied *some* level of heightened scrutiny.[68] Any decisional avoidance as to the appropriate level of scrutiny was solely because FOPA failed under either intermediate or strict scrutiny.[69] Consequently, the district court permanently enjoined enforcement of FOPA.[70]

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62. *See* Allen, *supra* note 59 (diffusing opponents' fears by explaining that asking preliminary questions is a form of "anticipatory guidance").

63. *See, e.g.*, Steve Bousquet, *Guns and Florida: A Brief History*, TAMPA BAY TIMES (Jan. 7, 2013, 5:39 PM), http://www.tampabay.com/news/politics/stateroundup/guns-and-florida-a-brief-historybr-br-/1269376 [http://perma.cc/MA66-L2A5] (identifying Marion Hammer as the Florida lobbyist for the NRA); Fredereka Schouten, *Little-Known Laws Shed Light on NRA Influence*, USA TODAY (Jan. 15, 2013, 10:36 AM), http://www.usatoday.com/story/news/politics/2013/01/15/nra-gun-friendly-laws/1833733 [http://perma.cc/MZK8-UGX8] (noting that "a Florida gun rights lobbyist and former NRA president" supported the law through the Florida legislature); Tom Watkins, *How the NRA Wields Its Influence*, CNN (Jan. 10, 2013, 7:35 AM), http://www.cnn.com/2013/01/09/us/nra-gun-research [http://perma.cc/HB5F-WRDB] ("Gun-rights advocates, including the NRA, have raised concerns about tracking [firearm ownership] data, including the possibility that acknowledging legal gun ownership could bring higher insurance premiums.").

64. Wollschlaeger v. Farmer, 880 F. Supp. 2d 1251, 1257 (S.D. Fla. 2012).

65. *Id.*

66. *See id.* at 1262 (referencing the court's preliminary injunction, in which the court determined that FOPA "did not constitute a permissible regulation of professional speech or occupational conduct that imposed a mere incidental burden on speech").

67. Barnes v. Glen Theatre, Inc., 501 U.S. 560, 572 (1991) (Scalia, J., concurring).

68. *Farmer*, 880 F. Supp. 2d at 1263.

69. *See id.* (uncovering no reason to decide which standard applies); *see also* Calvert et al., *supra* note 24, at 31–35 (summarizing both the intermediate and strict scrutiny analyses conducted by the district court).

70. *Farmer*, 880 F. Supp. 2d at 1270.

The defendants appealed to the Eleventh Circuit.[71] After the majority hurdled procedural obstacles,[72] it held that FOPA regulated "professional conduct," not speech.[73] Thus, FOPA did not burden speech protected by the First Amendment.[74] Because the First Amendment was not triggered, FOPA was not subject to *any* level of heightened constitutional scrutiny.[75] As a result, the Eleventh Circuit reversed the district court's decision and vacated the injunction against FOPA's enforcement.[76] The Eleventh Circuit's decision, however, was not unanimous. Judge Wilson authored a lengthy dissent, which claimed that the majority's opinion was "unprecedented."[77] According to Judge Wilson, "physician[s] must know all that a patient can articulate" to give a full diagnosis and treatment,[78] and limiting that discussion does not "prevent irrelevant speech from harming the doctor-patient relationship."[79] It only "make[s] healthcare worse."[80]

Almost one year to the day after the original *Wollschlaeger* opinion was published,[81] the Eleventh Circuit, shockingly, *sua sponte* substituted the original opinion with a revised opinion.[82] Instead of holding that FOPA fell wholly outside the scope of First Amendment coverage as a regulation of conduct, as it did initially, in the revised opinion the court concluded that "the record-keeping, inquiry, and harassment provisions *do* regulate a significant amount of protected

71. Notice of Appeal at 1, Wollschlaeger v. Governor of Fla., 760 F.3d 1195 (11th Cir. 2014) (No. 12-14009).

72. *See Wollschlaeger*, 760 F.3d at 1209–13 (concluding that the plaintiffs have standing, and that their claims are ripe).

73. *Id.* at 1217.

74. *See id.* (construing FOPA as having merely "an incidental effect on physicians' speech").

75. *See id.* at 1225 n.17 (reasoning that because FOPA regulates conduct and not speech, "the First Amendment generally does not provide the physician with a shield"); *see also id.* at 1219 (rationalizing that when a law does not burden a substantial amount of protected speech "it does not implicate constitutionally protected activity under the First Amendment" (quoting Locke v. Shore, 634 F.3d 1185, 1191–92 (11th Cir. 2011))).

76. *Id.* at 1203.

77. *Id.* at 1231 (Wilson, J., dissenting).

78. *Id.* at 1237 (quoting Trammel v. United States, 445 U.S. 40, 51 (1980)).

79. *Id.* at 1270–71.

80. *Id.* at 1271.

81. The original opinion was published on July 25, 2014, *id.*, while the revised opinion was published on July 28, 2015. Wollschlaeger v. Governor of Fla., 797 F.3d 859, 859 (11th Cir. 2015).

82. *Wollschlaeger*, 797 F.3d at 868.

speech."[83] As a result, the majority had two supplemental issues to decide: (1) the "level of scrutiny the First Amendment demands of these provisions,"[84] and (2) whether FOPA passed constitutional muster under the applicable level of scrutiny.[85] After establishing that FOPA was subject to intermediate scrutiny,[86] the Eleventh Circuit held that FOPA survived constitutional scrutiny "as a permissible restriction of professional speech."[87]

Although Judge Wilson applauded the majority for finally "subject[ing] [FOPA] to First Amendment scrutiny," he again dissented.[88] Per Judge Wilson's reading, rather than definitively holding that intermediate scrutiny applied to physician speech, the majority left "open the possibility of a more deferential approach to restrictions of speech within the boundaries of a professional relationship."[89] But even assuming for the sake of argument that intermediate scrutiny applied, Judge Wilson argued that FOPA not only "cause[s] doctors to know *less*, not *more*, about their patients' firearm ownership status,"[90] but also fails to protect patients' privacy[91] or their Second Amendment rights.[92] In fact, per Judge Wilson's reading, protecting firearm owners from uneasy "questioning or counseling on firearm safety does not implicate Second Amendment concerns."[93] Thus, he would have held that FOPA is an unconstitutional restriction on physicians' First Amendment rights.[94]

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83. *Id.* at 886. To be sure, the majority opinion concluded that FOPA's discrimination provision "is a regulation of professional conduct with merely an incidental effect on speech, and thus does not implicate the First Amendment." *Id.*

84. *Id.* (citing Lowe v. SEC, 472 U.S. 181, 230 (1985) (White, J., concurring)).

85. *See id.* at 896 (proceeding to consider whether FOPA passes the requisite level of scrutiny).

86. *Id.* ("Accordingly, we will proceed under the rubric of intermediate scrutiny.").

87. *Id.* at 900.

88. *Id.* at 901 (Wilson, J., dissenting).

89. *Id.* at 909.

90. *Id.* at 923.

91. *See id.* at 925 ("[FOPA] plainly is more extensive than necessary to serve patients' interest in keeping the information from their doctors and fails under . . . intermediate scrutiny.").

92. *See id.* at 927 (acknowledging that Florida's asserted Second Amendment interest "belies the State's desire simply to silence a message with which it disagrees").

93. *Id.*

94. *Id.* at 909 (asserting that FOPA "is unconstitutional under either" strict or intermediate scrutiny).

B. A Brief Overview of the First Amendment

The First Amendment, which has been construed to guarantee speech and association rights,[95] mandates that "Congress shall make no law . . . abridging the freedom of speech."[96] But freedom of speech is not an absolute right.[97] Rather, the First Amendment provides tiered levels of protection, which are determined by "the nature of the speech or association, the nature of the regulation, and the location where it occurs."[98] Thus, while certain types of speech receive the strongest protection the Constitution has to offer,[99] others receive no protection at all.[100]

There are two primary categories of restrictions on speech: content-based and content-neutral.[101] When a regulation restricts speech because of its "subject matter[] or its content,"[102] it is generally considered a content-based restriction.[103] Because the First Amendment commands that the "government has no power to restrict expression because of its message [or] its ideas,"[104] these content-based restrictions are "presumptively invalid" and subject to strict scrutiny.[105] On the other hand, a regulation that applies to all speech regardless of content is generally considered content-

95. *See* Cty. Sec. Agency v. Ohio Dep't of Commerce, 296 F.3d 477, 486 (6th Cir. 2002) (referencing the "strong protection" afforded by the First Amendment); Robert A. Sedler, *An Essay on Freedom of Speech: The United States Versus the Rest of the World*, 2006 MICH. ST. L. REV. 377, 379 ("The Supreme Court has interpreted the First Amendment's guarantee of freedom of speech very expansively, and the constitutional protection afforded to freedom of speech is perhaps the strongest protection afforded to any individual right under the Constitution.").

96. U.S. CONST. amend. I.

97. *See* ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 961 (4th ed. 2011) (acknowledging that "there are some categories of speech that are unprotected or less protected by the First Amendment").

98. Kelly P. Welch, Note, *Graffiti and the Constitution: A First Amendment Analysis of the Los Angeles Tagging Crew Injunction*, 85 S. CAL. L. REV. 205, 214 (2011).

99. *See* Boos v. Barry, 485 U.S. 312, 321 (1988) (recognizing that content-based restrictions on political speech in a public forum are "subjected to the most exacting scrutiny").

100. *See* Chaplinsky v. New Hampshire, 315 U.S. 568, 571–72 (1942) (noting that "'fighting' words" receive no First Amendment Protection).

101. *See* Geoffrey R. Stone, *Content-Neutral Restrictions*, 54 U. CHI. L. REV. 46, 58 (1987) (referencing both content-based and content-neutral regulations).

102. Police Dep't of Chi. v. Mosley, 408 U.S. 92, 95–96 (1972).

103. *See* CHEMERINSKY, *supra* note 97, at 960 ("The Supreme Court frequently has declared that the very core of the First Amendment is that the government cannot regulate speech based on its content.").

104. *Mosley*, 408 U.S. at 95.

105. R.A.V. v. City of St. Paul, 505 U.S. 377, 382 (1992).

neutral.[106] These types of restrictions are less objectionable because they do not single out specific content. Accordingly, they receive only intermediate scrutiny.[107]

Content-based and content-neutral regulations are not the only speech restrictions addressed by the First Amendment. For instance, certain types of speech receive a lower species of constitutional protection.[108] This category includes commercial speech,[109] professional speech,[110] and low value sexual speech.[111] Furthermore, some speech falls completely outside of the First Amendment's coverage and fails to trigger any Constitutional protection.[112] Any restrictions on these types of speech are thus upheld as constitutionally permissible.

C. Regulating Healthcare Under the State's Police Power

The most common use of the states' police power to restrict physician speech is through licensure.[113] As early as 1889,[114] the Supreme Court recognized that the government may limit physician speech to only those citizens that possess a license. In *Dent v. West Virginia*,[115] the Supreme Court addressed the constitutionality[116] of a regulation that required physicians to possess a "certificate from the

106. *See* Members of the City Council of L.A. v. Taxpayers for Vincent, 466 U.S. 789, 804 (1984) (explaining the content-neutrality of the law at issue). These regulations must be both viewpoint neutral and subject-matter neutral. CHEMERINSKY, *supra* note 97, at 961.

107. Turner Broad. Sys., Inc. v. FCC, 512 U.S. 622, 662 (1994).

108. *See* Frederick Schauer, *The Boundaries of the First Amendment: A Preliminary Exploration of Constitutional Salience*, 117 HARV. L. REV. 1765, 1769 (2004) (noting that the First Amendment applies different levels of protection to certain types of speech).

109. For a discussion of the First Amendment's protection of commercial speech, see *infra* notes 262–66 and accompanying text.

110. For an argument that professional speech deserves intermediate scrutiny, see *infra* Part III.A.

111. *See* City of Renton v. Playtime Theaters, Inc., 475 U.S. 41, 50 (1986) (applying intermediate scrutiny to a restriction on nonobscene sexual speech).

112. *See, e.g.*, Chaplinsky v. New Hampshire, 315 U.S. 568, 572 (1942) (explaining that the "lewd and obscene, the profane, the libelous, and the insulting or 'fighting' words" do not enjoy the First Amendment's coverage).

113. *See* Shawn L. Fultz, Comment, *If It Quacks Like a Duck: Reviewing Health Care Providers' Speech Restrictions Under the First Prong of* Central Hudson, 63 AM. U. L. REV. 567, 571 (2013) (noting that states often use their police power to regulate professions through the issuance of licenses).

114. *See* Dent v. West Virginia, 129 U.S. 114, 122 (1889) (recognizing the state's inherent licensing ability).

115. Dent v. West Virginia, 129 U.S. 114 (1889).

116. The constitutional claim in *Dent* was a due-process claim. *Id.* at 121.

State Board of Health" to practice medicine.[117] The Supreme Court affirmed that "[t]he power of the State to provide for the general welfare of its people authorizes it to prescribe all such regulations as, in its judgment, will secure or tend to secure them against the consequences of ignorance and incapacity."[118] The Court emphasized the importance of this power as applied to the medical field.[119] Because the regulation promoted proficiency in the practice of medicine, the license requirement was upheld as a proper use of West Virginia's police powers.[120]

In *Watson v. Maryland*,[121] the Supreme Court again recognized the states' legitimate interest in restricting physician speech through regulating the medical field. Maryland, pursuant to its police powers, made it a crime to practice medicine without applying for and obtaining a license.[122] The licensure requirement was predicated on the fact that "[d]ealing . . . with the lives and health of the people" requires a particular level of skill and education.[123] Those that lacked the requisite skill and education were unable to speak as physicians. Since licensure regulations are "within the legislative capacity of the State in the exercise of its police power,"[124] the regulation was held constitutionally permissible.[125]

Moreover, the states' authority to restrict speech through licensure is not limited in scope; it encompasses a wide swath of healthcare professions. For instance, in *Williamson v. Lee Optical of Oklahoma Inc.*,[126] the Supreme Court considered a statute that restricted opticians from fitting eyeglasses without a prescription to

117. *Id.* at 115.

118. *Id.* at 122.

119. *See id.* ("Few professions require more careful preparation by one who seeks to enter it than that of medicine.").

120. *Id.* at 128.

121. Watson v. Maryland, 218 U.S. 173 (1910).

122. *Id.* at 174. As in *Dent*, the primary constitutional claim was a due-process claim. *Id.* at 175.

123. *Id.* at 176. By the time of the *Watson* decision, it was well recognized and widely accepted that states possessed the ability to execute licensure requirements. *See id.* ("To this end many of the States of the Union have enacted statutes which require the practitioner of medicine to submit to an examination . . . and to receive duly authenticated certificates showing that they are deemed to possess the necessary qualifications of learning, skill and character essential to their calling.").

124. *Id.* at 178.

125. *Id.* at 180.

126. Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483 (1955).

do so from an ophthalmologist or optometrist.[127] Because the opticians engaged in medical practices,[128] they could be subject to professional regulations—notably, the licensure restriction.[129] Similarly, in *National Association for the Advancement of Psychoanalysis v. California Board of Psychology*,[130] the Ninth Circuit addressed the constitutionality of a licensure requirement for psychoanalysts.[131] Since the court recognized that California could regulate the licensing of a physician,[132] the regulation on psychoanalysts was properly upheld.[133]

Beyond simple licensure requirements, states commonly implement other restrictions via their police power to protect "the welfare and safety of society."[134] One such regulatory avenue restricts specified conduct within the medical profession. In *Semler v. Oregon State Board of Dental Examiners*,[135] the Supreme Court addressed the constitutionality of a statute that sanctioned dentists from advertising their professional services.[136] At the outset, the Court tersely affirmed that "the protective power of the State"[137] conclusively encompasses the ability to regulate the dental profession.[138] Because the advertising restriction fell within the State's police powers, the sanctions against dentist advertising were upheld as permissible.[139]

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127. *Id.* at 485 n.1.

128. *Williamson* implies that anything pertaining to the body's health is considered medical care. *See id.* at 490 (explaining that opticians "enter the field of health" because eyeglass frames, coupled with corrective lenses, pertain to the human eye).

129. *See id.* at 491 (upholding the license requirement on fitting eyeglasses).

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

131. *Id.* at 1047.

132. *See id.* at 1050 ("[M]ost federal courts have held that a patient does not have a constitutional right to obtain a particular type of treatment or to obtain the treatment from a particular provider if the government has reasonably prohibited that type of treatment or provider." (quoting Mitchell v. Clayton, 955 F.2d 772, 775 (7th Cir. 1993))).

133. *Id.* at 1054. Notably, the court also held that the licensure scheme did not violate any First Amendment rights. *See id.* at 1053 ("[E]ven if a speech interest is implicated, California's licensing scheme passes First Amendment scrutiny.").

134. Fultz, *supra* note 113, at 572.

135. Semler v. Or. State Bd. of Dental Exam'rs, 294 U.S. 608 (1935).

136. *Id.* at 609.

137. *Id.* at 610.

138. *See id.* at 611 (noting that states' capacity to regulate the practice of dentistry is "not open to dispute").

139. *Id.*

Further, states may employ their police powers to protect citizens from incompetent professionals by delineating professional standards.[140] This power is intimately tied with, yet not identical to, a state's licensing authority.[141] When a professional violates a state's professional standards, that state may impose sanctions to promote and shelter public safety.[142] Sanctions may include monetary fines[143] and license suspension or revocation.[144] Although these sanctions cannot undo the harm already incurred by patients or clients, they assist in preventing any future harm.[145]

II. PHYSICIAN SPEECH AS FREE SPEECH

A fog of confusion surrounds the professional speech doctrine as applied to physician speech.[146] Much of this perplexity stems from Justice Douglas's aforementioned statement that "[t]he right of the doctor to advise his patients according to his best lights seems so

140. *See* Thomas v. Collins, 323 U.S. 516, 545 (1945) (Jackson, J., concurring) ("[T]he state may have an interest in shielding the public against the untrustworthy, the incompetent, or the irresponsible . . . ."); *see also* Nat'l Ass'n for the Advancement of Psychoanalysis v. Cal. Bd. of Psychology, 228 F.3d 1043, 1054 (9th Cir. 2000) (citing Justice Jackson's concurrence in *Thomas* to emphasize the compelling state interest in regulating the medical profession through licensing).

141. *See Semler*, 294 U.S. at 611 (recognizing that states "may require licenses and establish supervision by an administrative board").

142. *See* Lap v. Axelrod, 467 N.Y.S.2d 920, 922 (N.Y. App. Div. 1983) (upholding a revocation of a license as a discipline to protect clients from individuals that commit crimes intimately tied with the industry that they are licensed to participate in).

143. *See* Trisha's One Stop, Inc. v. Office of Fin. Regulation, 130 So.3d 285, 288 (Fla. Dist. Ct. App. 2014) (fining an operator of a check-cashing business under the state's professional regulatory authority).

144. Arthur v. D.C. Nurses' Examining Bd., 459 A.2d 141, 147 (D.C. 1983) (citing Proctor v. Hackers' Bd., 268 A.2d 267, 269 (D.C. 1970)).

145. Fultz, *supra* note 113, at 573.

146. *See, e.g.*, Calvert et al., *supra* note 24, at 44 (referencing the "gray area" regarding the standard that courts apply to restrictions imposed on physician speech); Renee Newman Knake, *Attorney Advice and the First Amendment*, 68 WASH. & LEE L. REV. 639, 645 (2011) (explaining that the level of protection afforded to attorney advice is not clear); David T. Moldenhauer, *Circular 230 Opinion Standards, Legal Ethics and First Amendment Limitations on the Regulation of Professional Speech by Lawyers*, 29 SEATTLE U. L. REV. 843, 843 (2006) ("The regulation of professional speech is one of the least developed areas of First Amendment doctrine."); W. Bradley Wendel, *Free Speech for Lawyers*, 28 HASTINGS CONST. L.Q. 305, 305 (2001) (noting that the manner in which the First Amendment should apply to attorneys is "[o]ne of the most important unanswered questions in legal ethics"); Jacob M. Victor, Note, *Regulating Sexual Orientation Change Efforts: The California Approach, Its Limitations, and Potential Alternatives*, 123 YALE L.J. 1532, 1578 (2014) (classifying the question as to how much First Amendment protection extends to professional speech as "complicated").

obviously within First Amendment rights as to need no extended discussion."[147] Ever since Justice Douglas's comments, however, the Supreme Court has offered little guidance into the rights of physicians to speak to their patients.[148] Although it is beyond the scope of this Note to fully expound upon the boundaries of the professional speech doctrine, this Part argues that physician speech should at least be covered by the First Amendment's protective shield. Section A outlines the origins of the professional speech doctrine. Section B discusses the coverage of the First Amendment, and summarizes the majority's divergent approaches in his *Wollschlaeger* opinions. Section C offers a different justification than the *Wollschlaeger* majority's for First Amendment coverage of physician speech and proposes an alternative test to determine when physician speech is covered.

A. The Professional Speech Doctrine

Professional speech is generally defined as "personalized communication given in the context of a fiduciary-like relationship between a person who adheres to a shared body of professional knowledge and values and that person's client."[149] Although different from political[150] or commercial speech,[151] professional speech nonetheless deserves First Amendment protection.[152]

Justice White's concurrence in *Lowe v. SEC*[153] is often credited with establishing the contours of the professional speech doctrine.[154] In *Lowe*, the Supreme Court addressed whether the Securities

147. Poe v. Ullman, 367 U.S. 497, 513 (1961) (Douglas, J., dissenting). For an example of a court struggling with the diverging interests in protecting physician speech, see *Stuart v. Camnitz*, 774 F.3d 238 (4th Cir. 2014) (addressing North Carolina's Woman's Right to Know Act).

148. *See* Calvert et al., *supra* note 24, at 44 (stating that "[t]he Court has offered only cursory comments" discussing physicians' First Amendment rights).

149. Moldenhauer, *supra* note 146, at 892.

150. *See* R.A.V. v. City of St. Paul, 505 U.S. 377, 382 (1992) (explaining that "[c]ontent-based regulations are presumptively invalid" under the First Amendment).

151. For a discussion of the First Amendment's coverage of commercial speech, see *infra* notes 293–301 and accompanying text.

152. *See, e.g.*, King v. Governor of N.J., 767 F.3d 216, 235 (3d Cir. 2014) (concluding that professional speech deserves First Amendment protection).

153. Lowe v. SEC, 472 U.S. 181, 211–36 (1985) (White, J., concurring).

154. *See, e.g.*, Halberstam, *supra* note 7, at 842–43 (using Justice White's concurrence in *Lowe* to outline the professional-speech doctrine's foundational contours); *see also* Keighley, *supra* note 8, at 2368 (employing Justice White's concurrence to establish the contours of the professional speech doctrine).

Exchange Commission could forbid unlicensed "investment advisers" from publishing general investment advice and commentary in various securities newsletters.[155] The unlicensed advisors "contend[ed] that such an injunction str[uck] at the very foundation of the freedom of the press by subjecting it to license and censorship."[156] The majority opinion, however, avoided the constitutional question by concluding that the petitioners were not "investment adviser[s]" as statutorily defined.[157] Thus, the regulation was inapplicable and the SEC could not restrict the petitioners from publicizing their newsletters.[158]

Justice White, however, concluded that the petitioners were "investment adviser[s]."[159] And so, he could not dodge the constitutional question at issue: whether the SEC violated the First Amendment by preventing unlicensed investment advisers from publishing general investment advice.[160] Justice White recognized the diverging interests at issue. On one hand, the First Amendment guarantees the freedom of speech for American citizens.[161] On the other, the government has the power to license and regulate those who desire to pursue a specific profession or vocation.[162] Although the latter interest is undoubtedly legitimate, certain regulatory measures leap past the line of permissibility and become speech restrictions.[163] As applied to *Lowe*, that is exactly what the SEC did—it implemented a "direct restraint on freedom of speech and of the press."[164] Justice White therefore concurred with the majority in result, but would have struck down the SEC's regulation as unconstitutional.[165]

Justice White's opinion gave significant guidance to later courts on how to distinguish between permissible regulations of professional

155. *Lowe*, 472 U.S. at 183.

156. *Id.* at 189 (citing Lovell v. City of Griffin, 303 U.S. 444, 451 (1938)).

157. *Id.* at 211 (White, J., concurring).

158. *Id.*

159. *Id.*

160. *Id.*

161. *Id.* at 228.

162. *Id.*

163. *See id.* at 230 ("At some point, a measure is no longer a regulation of a profession but a regulation of speech or of the press; beyond that point, the statute must survive the level of scrutiny demanded by the First Amendment.").

164. *Id.* at 233.

165. *Id.* at 236.

conduct and impermissible infringements of freedom of speech.[166] For example, governments may "enact[] generally applicable *licensing provisions* limiting the class of persons who may practice the profession."[167] Professionals are categorized as those "who take[] the affairs of a client personally in hand and purport[] to exercise judgment on behalf of the client in the light of the client's individual needs and circumstances."[168] It is irrelevant that licensing provisions may implicate speech concerns—any burden is merely "incidental to the conduct of the profession."[169] Conversely, where no personal nexus exists between professional and client,[170] government restrictions stop operating as proper regulations of professional practice that only incidentally impact speech.[171] Simply put, there is no profession being regulated. Instead, they serve as a direct regulation of speech subject to heightened scrutiny under the First Amendment.[172] Justice White did not address, however, the level of First Amendment protection dedicated to speech regulated within the professional-client nexus.

166. *Id.* at 231–33. Markedly, Justice White cited Justice Jackson's concurrence positively when he asserted that "the state may prohibit the pursuit of medicine as an occupation without its license," but could not "make it a crime publicly or privately to speak urging persons to follow or reject any school of medical thought." *Id.* at 231 (quoting Thomas v. Collins, 323 U.S. 516, 544–48 (1945)).

167. *Id.* (emphasis added).

168. *Id.* at 232.

169. *Id.*

170. Suppose a physician spoke at a political rally for or against abortion regulation. In this hypothetical circumstance, there would be no personal nexus between the professional and client; the physician is speaking on his or her own accord. On the other hand, consider a statute that restricts the practice of unlicensed certified public accountants. *See* Accountant's Soc. of Va. v. Bowman, 860 F.2d 602, 603 (4th Cir. 1988) (discussing a similar statutory scheme). The statute would implicate speech falling within the personal nexus between professional and client, as the implicated speech would be flowing from a professional to a client. *Id.* at 605.

171. *Lowe*, 472 U.S. at 232 (White, J., concurring).

172. *See id.* at 232 & n.11 (citing Near v. Minnesota *ex rel.* Olson, 283 U.S. 697, 720 (1931)) (stating that regulating where no professional relationship exists "becomes [a] regulation of speaking . . . subject to the First Amendment[]"); *see also* Robert Kry, *The "Watchman for Truth": Professional Licensing and the First Amendment*, 23 SEATTLE U. L. REV. 885, 953 (2000) (explaining that in Justice White's test, the personal nexus serves as the "distinction between fully protected publishing activities and professional practice"); Moldenhauer, *supra* note 146, at 885 (opining that the distinction between the state's power to enact restrictions on professions turns on whether a "personal nexus" exists between a professional and their client).

B. First Amendment Coverage of Physician Speech

The first question in any First Amendment analysis is whether First Amendment protection is triggered.[173] As Professor Frederick Schauer explains, this is primarily a question of coverage.[174] Certain acts, words, or behaviors simply do not enjoy any First Amendment protection whatsoever.[175] Because the speech is not covered, it "does not present a First Amendment issue at all."[176] Put differently, "[t]he First Amendment just does not show up."[177]

1. *The First Attempt—Conditioning the First Amendment on a Categorization of Conduct*. Judge Tjoflat, in writing the original majority's opinion, began by recognizing that professional speech is not *wholly* removed from First Amendment coverage.[178] Instead, professional speech is subject to a spectrum of constitutional protection.[179] At one extreme, professionals "engaged in a public dialogue"[180] receive the greatest amount of First Amendment protection and are thus presumptively covered by the First Amendment. At the midpoint of the spectrum lies speech that requires professionals to communicate specific information to their

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173. *See* Charles W. "Rocky" Rhodes, *The First Amendment Structure for Speakers and Speech*, 44 SETON HALL L. REV. 395, 397 (2014) (illuminating that the preliminary question is whether the First Amendment covers the expression); *see also* Frederick Schauer, *Categories and the First Amendment: A Play in Three Acts*, 34 VAND. L. REV. 265, 268 (1981) (explaining that the First Amendment is implicated when speech at issue "is set off by the [F]irst [A]mendment for special protection"). This "coverage" requirement is not unique to the First Amendment—it is pertinent to other constitutional rights. *See, e.g.*, United States v. Marzzarella, 614 F.3d 85, 89 (3d Cir. 2010) (holding that the threshold inquiry in Second Amendment challenges is "whether the challenged law imposes a burden on conduct falling within the scope of the Second Amendment's guarantee").

174. Schauer, *supra* note 108, at 1769.

175. *See id.* ("The acts, behaviors, and restrictions not encompassed by the First Amendment at all—the events that remain wholly untouched by the First Amendment—are . . . consequently measured against no First Amendment standard whatsoever.").

176. *Id.*

177. *Id.*

178. *See* Wollschlaeger v. Governor of Fla., 760 F.3d 1195, 1218 (11th Cir. 2014) (stating that First Amendment protections reach their pinnacle when a professional speaks publicly on a matter of public concern, but reach "a nadir" when a professional "speaks privately, in the course of exercising his or her professional judgment, to a person receiving the professional's services").

179. *See id.* at 1219 (referencing the "spectrum" of professional speech).

180. *Id.* at 1223 (quoting Pickup v. Brown, 740 F.3d 1208, 1227 (9th Cir. 2014)). This type of speech receives strict scrutiny. *See* Turner Broad. Sys., Inc. v. FCC, 512 U.S. 622, 642 (1994) (recognizing that regulations that target speech because of its content receive "the most exacting" constitutional scrutiny).

clients.[181] At the other extreme is the "regulation of professional *conduct*, where the state's power is great, even though such regulation may have an incidental effect on speech."[182] In this scenario, any implicated speech is simply incidental to the permissible regulation and thus is not covered by the First Amendment.[183]

Using this conduct-regulation theory of the professional speech doctrine's coverage, the majority upheld each challenged provision of FOPA without applying heightened scrutiny.[184] The inquiry provision[185] applied to speech in the physician's examination room, where the "personal nexus between professional and client" is most acute.[186] Further, it merely informed physicians that, according to Florida, inquiring into firearm ownership was not a practice of good medicine.[187] Thus, the court categorized the provision as a "regulation of professional conduct" that fell outside of the First Amendment's coverage.[188] Likewise, the record-keeping provision[189] regulated professional conduct, and any burden on speech was merely incidental to FOPA's regulation of the medical field.[190] Although the discrimination[191] and harassment provisions[192] may not have regulated speech at all,[193] if they did, any burden was considered incidental to the regulation of professional conduct.[194] Consequently, the majority

181. *Wollschlaeger*, 760 F.3d at 1223 (citing *Pickup*, 740 F.3d at 1228). This Note argues that this speech receives intermediate scrutiny. *See infra* Part III.A.

182. *Wollschlaeger*, 760 F.3d at 1223 (quoting *Pickup*, 740 F.3d at 1229). Although not discussed in the majority's original opinion, the First Amendment *does* apply to certain types of conduct. *See Pickup*, 740 F.3d at 1230 (quoting Rumsfeld v. Forum for Acad. & Institutional Rights, Inc. (*FAIR II*), 547 U.S. 47, 66 (2006)) (explaining that First Amendment protection only extends to conduct that is "inherently expressive").

183. *See Wollschlaeger*, 760 F.3d at 1217 (finding that FOPA only incidentally affects physician speech, and thus, fell outside of the First Amendment's coverage).

184. *See id.* at 1226 (holding that FOPA does not trigger First Amendment protection).

185. FLA. STAT. § 790.338(2) (2014).

186. *Wollschlaeger*, 760 F.3d at 1219 (quoting Lowe v. SEC, 472 U.S. 181, 232 (1985) (White, J., concurring)).

187. *Id.* at 1219–20.

188. *Id.* at 1220 (citing Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 884 (1992) (plurality opinion)).

189. FLA. STAT. § 790.338(1).

190. *Wollschlaeger*, 760 F.3d at 1221.

191. FLA. STAT. § 790.338(5).

192. *Id.* § 790.338(6).

193. *See Wollschlaeger*, 760 F.3d at 1221 (asserting that the discrimination provision validly regulates professional conduct and "only incidentally—if at all—affects physician speech"); *see also id.* (claiming that harassment *can* involve speech).

194. *Id.*

held that FOPA fell outside First Amendment coverage, and therefore did not facially violate the Constitution.[195]

2. *Taking a Second Shot—The Majority's Two-Dimensional Test.* After *sua sponte* vacating its original opinion, the Eleventh Circuit's revised *Wollschlaeger* opinion disregarded the conduct–speech distinction originally employed and instead focused on "the landscape of professional speech."[196] The majority began by observing that "[t]here is a difference, for First Amendment purposes, between . . . professionals' speech to the public at large versus their direct personalized speech with clients."[197] Speech voiced by a professional in support of "his or her profession and within the confines of a professional-client relationship," for instance, is properly considered professional speech.[198] On the other hand, "speech uttered by a professional that is irrelative to the practice of his or her profession and outside a particular professional-client relationship likely falls beyond the purview of professional speech."[199]

To help distinguish between professional speech deserving of protection and undeserving nonprofessional speech, the majority proposed a two-dimensional test that turns on "the professional effectivity of the speech—whether the physician is speaking in furtherance of the practice of medicine or not, and the relational context of the speech—whether the physician is speaking within a fiduciary relationship or not."[200] When considered in tandem, these two factors divide speech uttered by physicians into four categories: (1) speech uttered by a physician "to the public, in furtherance of the practice of medicine"; (2) speech uttered by a physician "to a client, in furtherance of the practice of medicine"; (3) speech uttered by a physician "to a client, on a matter irrelative to the practice of medicine"; and (4) speech uttered by a physician "to the public, on a matter irrelative to the practice of medicine."[201] At issue in *Wollschlaeger* was the second category—speech uttered by a

195. *Id.* at 1226.
196. Wollschlaeger v. Governor of Fla., 797 F.3d 859, 886 (11th Cir. 2015).
197. *Id.* at 887 (quoting Locke v. Shore, 634 F.3d 1185, 1191 (11th Cir. 2011)).
198. *Id.* (citing King v. Governor of N.J., 767 F.3d 216, 232 (3d Cir. 2014)).
199. *Id.* (citing Lowe v. SEC, 472 U.S. 181, 232 (1985) (White, J., concurring)).
200. *Id.* at 888.
201. *Id.*

professional "to a client, in furtherance of the practice of medicine."[202] Rather than focusing primarily on whether FOPA targeted conduct or speech, however, the majority conceded that FOPA implicated the First Amendment and proceeded to subject the speech to heightened scrutiny.[203]

The majority framed its analysis around the government's interest in regulating physician speech. With regards to the "professional effectivity of the speech," the majority stated that "the government's interest in regulating the profession for the protection of the public . . . is strongest when a professional speaks in furtherance of his profession."[204] By contrast, the professional's interest in speaking freely is "strongest when he speaks on matters unrelated to his profession and weakest when he speaks in furtherance of his profession."[205] As for the relational context of speech, the majority opined that "the government has a strong interest in policing the boundaries of the relationship to protect the weaker party from exploitation."[206] When "[o]utside the confines of such relationships, the government's interest in protecting the listener wanes, and instead the interest of the physician's audience in obtaining information reaches its zenith."[207] Ultimately, the court held that FOPA passed constitutional muster under intermediate scrutiny.[208]

3. *The Coverage of Physician Speech*. Presumably, the majority vacated its original opinion and substituted in its place a revised opinion because the former ignored certain intricacies of First Amendment coverage. As explained by Judge Wilson in his original dissent, regulations must be subjected to "heightened scrutiny *whenever* the government restricts speech because of disagreement with the message it conveys."[209] Certainly, the state may implement

202. *Id.*; *see also id.* at 869 (discussing that FOPA regulates physicians' inquiries into whether a patient owns a firearm for the purpose of medical care).

203. *See id.* at 891 ("[W]e conclude that [FOPA] is a regulation of professional speech.").

204. *Id.* at 889.

205. *Id.*

206. *Id.*

207. *Id*.

208. *Id.* at 900.

209. Wollschlaeger v. Governor of Fla., 760 F.3d 1195, 1236 (11th Cir. 2014) (Wilson, J., dissenting) (quoting Sorrell v. IMS Health Inc., 131 S. Ct. 2653, 2664 (2011)). Judge Wilson chided the original majority opinion for creating an improper exception to First Amendment

licensing and regulatory schemes to restrict certain professional speech,[210] but physicians do not "simply abandon their First Amendment rights when they commence practicing a profession."[211] Rather, "speech is speech, and it must be analyzed as such for purposes of the First Amendment."[212] And speech stemming from the physician–patient relationship is presumptively encompassed within the First Amendment's protective sphere.[213]

Further, courts cannot simply play a "labeling game"[214] by designating speech as conduct to dodge First Amendment scrutiny. Even when certain laws regulate conduct, they are nonetheless subject to First Amendment scrutiny when "the conduct triggering coverage under the statute consists of communicating a message."[215] To determine whether a regulation targets speech or conduct, courts generally focus on the "transmission of ideas."[216] Thus, the state's ability to regulate speech turns on whether that speech is "communicative."[217] Regulations targeting conduct concern speech's "noncommunicative component," whereas regulations targeting speech concern speech's "communicative component."[218] And

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coverage. *See id.* ("The word 'whenever' does not invite exceptions, but the Majority creates one anyway.").

210. For a discussion of the state's ability to regulate the classes of individuals able to speak as a professional, see *supra* Part II.C. *See also* Stuart v. Camnitz, 774 F.3d 238, 247 (4th Cir. 2014) (referencing *King v. Governor of New Jersey*, 767 F.3d 216, 232 (3d Cir. 2014), to explain that licensing provides confidence to clients that their lives are in safe hands).

211. *Camnitz*, 774 F.3d at 247.

212. *King*, 767 F.3d at 229.

213. *See* Rust v. Sullivan, 500 U.S. 173, 200 (1991) (dictum) ("[T]raditional relationships such as that between doctor and patient should enjoy protection under the First Amendment from Government regulation, even when subsidized by the Government."). Although this statement is dictum, it nonetheless hints that physician speech is within First Amendment coverage.

214. Pickup v. Brown, 740 F.3d 1208, 1218 (9th Cir. 2013) (O'Scannlain, J., dissenting).

215. Holder v. Humanitarian Law Project, 561 U.S. 1, 28 (2010).

216. Joseph Blocher, *Nonsense and the Freedom of Speech: What Meaning Means for the First Amendment*, 63 DUKE L.J. 1423, 1475 (2014).

217. *See* LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 580 (1978) (explaining that First Amendment protections are aimed at those governmental actions focused on "communicative impact"); Eugene Volokh, *Speech as Conduct: Generally Applicable Laws, Illegal Courses of Conduct, "Situation-Altering Utterances," and the Uncharted Zones*, 90 CORNELL L. REV. 1277, 1314 (2005) (collecting cases). *But see* Schauer, *supra* note 173, at 279 ("[Communicative impact] theory is incomplete, however, unless it provides some guidance, derived again from the deep theory of the principle of free speech, in determining what species of communicative impact are covered and what species of communicative impact are not.").

218. Volokh, *supra* note 217, at 1314.

communicative speech, even if uttered by a professional to his client, must be subject to heightened scrutiny.[219]

For example, in *King v. Governor of the State of New Jersey*[220] the Third Circuit addressed the constitutionality of a New Jersey statute that restricted licensed counselors from partaking in "sexual orientation change efforts" with patients younger than eighteen years of age.[221] The plaintiffs challenged this statutory scheme, alleging that it violated the First Amendment by restricting the physician's right to speak.[222] The court held that New Jersey's statutory scheme regulated physician *speech*—not simply conduct[223]—because New Jersey prohibited a professional practice that is carried out by way of verbal communication.[224] Accordingly, the Third Circuit held that the First Amendment *does* cover physician speech and, as such, required the application of the appropriate level of heightened scrutiny.[225]

Similarly, in *Stuart v. Camnitz*[226] the Fourth Circuit addressed the constitutionality of North Carolina's Woman's Right to Know Act.[227] The Act required physicians to perform an ultrasound, display the image, and describe the fetus before an abortion "even if the woman actively 'averts her eyes' and 'refuses to hear.'"[228] A group of physicians filed suit, arguing that the compelled speech violated the First Amendment.[229] The Fourth Circuit acknowledged that the statute regulated conduct, "insofar as it directs doctors to do certain things in the context of treating a patient."[230] But that was not the end of the matter—the statute required doctors to communicate the descriptions mandated verbally.[231] Thus, both professional conduct

219. *Cf. Pickup*, 740 F.3d at 1220 (O'Scannlain, J., dissenting) (suggesting that regulations of professional communication are subject to "*some* degree of scrutiny").

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

221. *Id.* at 221 (citing N.J. STAT. ANN. § 45:1–55 (West 2013)).

222. *Id.* at 222.

223. *See id.* at 233 ("While the function of this speech does not render it 'conduct' that is wholly outside the scope of the First Amendment, it does place it within a recognized category of speech that is not entitled to the full protection of the First Amendment.").

224. *See id.* (holding that professional speech receives some diminished protection under the First Amendment).

225. *See id.* (holding that classifying the regulation at issue as professional speech "does not end [the constitutional] inquiry," and thus, moving on to determine the level of scrutiny).

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

227. *Id.* at 242.

228. *Id.* (citing N.C. GEN. STAT. § 90–21.85(b) (2011)).

229. *Id.* at 243.

230. *Id.* at 248.

231. *Id.* at 245.

and professional speech were implicated.[232] Consequently, the Fourth Circuit held that the Act burdened physician speech and thus triggered First Amendment coverage.[233]

Three characteristics of the speech at issue in both *King* and *Camnitz* are integral when considering First Amendment coverage of physician speech. First, the speech at issue occurred in a professional relationship—the physician–patient relationship. Second, the speech in both scenarios, whether compelled or prohibited, was communicative.[234] If the "speech" at issue were noncommunicative, the regulations would not enjoy First Amendment coverage.[235] Finally, the regulations in both cases were content based. Were the regulations content neutral, they may have avoided First Amendment coverage.[236] All three of these characteristics are necessary for physician speech to receive First Amendment protection.

C. Finding the Target: Rationalizing the Coverage and Boundaries of Physician Speech

The discussion up to this point has served as a backdrop to the conflicting *Wollschlaeger* opinions. This Part may add to that confusion by arguing that the second *Wollschlaeger* opinion, which concluded that FOPA implicated the First Amendment, was correct in part—albeit for the wrong reasons. First, this Part argues that the "government's interest in regulating the profession for the protection of the public"[237] does not justify First Amendment coverage of

232. *See id.* at 248 ("[The statute] requires doctors to 'say' as well as 'do.'").

233. *See id.* at 251 (citing Lowe v. SEC, 472 U.S. 181, 229–30 (1985) (White, J., concurring)) (holding that regulations restricting the free speech rights of professionals must pass constitutional scrutiny and adding that "[t]hough physicians and other professionals may be subject to regulations by the state that restrict their First Amendment freedoms when acting in the course of their professions, professionals do not leave their speech rights at the office door" (citation omitted)).

234. *See id.* at 245 (explaining that "the display of the sonogram is plainly an expressive act," and thus, is sufficiently communicative to engender First Amendment protection); King v. Governor of N.J., 767 F.3d 216, 224 (3d Cir. 2014) (holding "that the verbal communication" at issue is communicative, and thus, enjoys First Amendment protection).

235. *See* United States v. O'Brien, 391 U.S. 367, 382 (1968) (citing NLRB v. Fruit & Vegetable Packers Union, 377 U.S. 58, 79 (1964) (Black, J., concurring)) (recognizing that if the restricted speech was noncommunicative, it could properly be regulated as conduct); *see also supra* notes 214–33 and accompanying text (distinguishing between speech and conduct).

236. *See* Wollschlaeger v. Governor of Fla., 760 F.3d 1195, 1241 (11th Cir. 2014) (Wilson, J., dissenting) (asserting that *Lowe v. SEC* implies a requirement of content neutrality to qualify as a permissible regulation of professional conduct).

237. Wollschlaeger v. Governor of Fla., 797 F.3d 859, 889 (11th Cir. 2015).

physician speech. Rather, the centrality of trust in all physician–patient relationships justifies First Amendment protection. Second, this Part rationalizes when the First Amendment should cover physician speech. Particularly, it outlines an alternative test for when physician speech should enjoy First Amendment coverage.

1. *Why The First Amendment Should Cover Physician Speech*. First, regulations that restrict physician speech substantially undermine the foundation of the physician–patient relationship—trust.[238] Trust in the medical context is defined as a psychological state on the part of both patients and physicians that entails an "optimistic attitude towards one's vulnerability."[239] Trust is not simply desirable in the physician–patient relationship; it serves as "the 'glue' that holds the relationship together and makes it possible."[240] Trust is "essential and unavoidable."[241] And although not unique to medicine, trust is more important in the physician–patient relationship than many relationships.[242] In fact, one of the very reasons patients seek medical treatment is to obtain medical care and uninhibited medicinal information.[243] But without trust, patients would not possess enough faith in "their care-givers . . . to lay themselves bare, both physically and emotionally, so the true causes of illness can be understood."[244]

Patients trust physicians because they believe they are receiving their physicians' expert opinion.[245] When regulations prohibit physicians from inquiring about a certain topic, however, that trust is diminished.[246] Diminishing trust and reducing disclosure is significant. It misleads patients' medical decisionmaking because they "have no

238. *See* Post, *supra* note 8, at 977 (explaining that trust is embedded in the physician–patient relationship).

239. Mark Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 474 (2002).

240. *Id.* at 470.

241. *Id.*

242. *Id.* at 471 (explaining that medicinal trust "is paralleled only in fraternal, family, or love relationships").

243. *Cf.* King v. Governor of N.J., 767 F.3d 216, 233 (3d Cir. 2014) (justifying First Amendment coverage of information that "facilitates the 'free flow of commercial information,' in which . . . the intended recipients . . . have a strong interest" (quoting Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc., 425 U.S. 748, 763–64 (1976))).

244. Frances H. Miller, *Trusting Doctors: Tricky Business When It Comes to Clinical Research*, 81 B.U. L. REV. 423, 426 (2001).

245. *See* Post, *supra* note 8, at 978 ("[Patients] wish to receive knowledge that our doctors can uniquely provide . . . .").

246. *See id.* at 977–78 (noting that physicians assume a fiduciary obligation to communicate knowledge that the patient can rely on to decide what their medical care ought to be).

comparable alternative means of acquiring medical information."[247] Further, restricting physician speech undermines the patient's expectations because the physician is unable to supply the care that the patient seeks.[248] But it is not just patients who rely on trust in a medical examining room—physicians trust that "patient[s] will candidly disclose information necessary for the best treatment."[249] Therefore, regulations that breach the examination room walls by restricting physician speech vitiate the physician–patient relationship and impose a net-negative result.

The second *Wollschlaeger* majority opinion, however, argues that patients are relatively powerless in a physician's examination room and that states bolster physician–patient trust by "regulat[ing] the practice of professions to 'shield the public against the untrustworthy, the incompetent, or the irresponsible.'"[250] Thus, the government's interest in regulating physician speech is strongest "[w]hen a physician speaks to a patient in furtherance of the practice of medicine."[251] But this argument is unavailing. First, the allusion to "shield[ing] the public against the untrustworthy, the incompetent, or the irresponsible" is inapposite because that statement was in reference to a licensing regime;[252] indubitably, states have the authority to protect patients from the incompetent through a licensing scheme.[253] Second, allowing the state to regulate speech through conscripted physicians, as FOPA does, destroys patient trust by increasing risk of *governmental* coercion.[254] By replacing physicians' medical judgment with state-mandated silence, FOPA

247. Berg, *supra* note 2, at 247.

248. Stuart v. Camnitz, 774 F.3d 238, 253–54 (4th Cir. 2014).

249. Hethcoat II, *supra* note 28, at 33.

250. Wollschlaeger v. Governor of Fla., 797 F.3d 859, 892 (11th Cir. 2015) (quoting Thomas v. Collins, 323 U.S. 516, 545 (1945) (Jackson, J., concurring)); *see also* Halberstam, *supra* note 7, at 845 (referencing the imbalance of authority in the physician–patient relationship).

251. *Wollschlaeger*, 797 F.3d at 889; *see also Camnitz*, 774 F.3d at 247 (justifying the potential state regulatory authority over physician speech on the State's "regulation . . . [that] 'provide[s] clients with the confidence they require to put their health or their livelihood in the hands'" of a physician (quoting King v. Governor of N.J., 767 F.3d 216, 232 (3d Cir. 2014))).

252. *Wollschlaeger*, 797 F.3d at 892 (quoting *Thomas*, 323 U.S. at 545 (Jackson, J., concurring)).

253. *Thomas*, 323 U.S. at 544 (Jackson, J., concurring). In fact, Justice Jackson would likely reject the majority's assertion that the government possesses a strong interest in regulating physician speech. *See id.* ("Likewise, 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." (emphasis added)).

254. Berg, *supra* note 2, at 230–31.

undermines the trust of the physician–patient relationship. In fact, this damage is "magnified when the physician is compelled to deliver the state's preferred message in his or her own voice."[255] Patients do not know whether their physician is speaking, or the state.[256] Likewise, when states prohibit physician speech, patients do not know whether their physicians' *silence* is based on medical conclusions or the state's mandated preferences. This information imbalance empowers the state to endorse partisan views by restraining the availability of targeted information and deceiving the patient's decisionmaking process.[257]

Distinguishing between *compelled* physician speech and *prohibited* physician speech only serves to highlight the flaws in the majority's rationale. When the state compels speech, the flow of information is uninhibited. Nonetheless, as in *Camnitz*, the patient has the ability to ignore any communication.[258] Conversely, when the state prohibits certain speech, patients have no sufficiently reliable alternative avenue to obtain that information. They cannot simply ignore the undesired speech. It "is never open to contemplation, investigation, or to being discounted or rejected."[259] This is exponentially more disconcerting for medical patients—potentially critical information is off the table for consideration, and patients are restrained from choosing what is in their best interest.[260] Allowing the

255. *Camnitz*, 774 F.3d at 253.

256. Consider again the North Carolina Woman's Right to Know Act, which compels physicians to provide specific information and take certain steps before conducting an abortion. N.C. GEN. STAT. § 90–21.85(a) (2011); *see also supra* notes 226–34 (describing the Act's requirements in greater detail). Patients are left in the dark as to the source of this information, particularly, whether the state prescribed it, or whether their physician did.

257. Berg, *supra* note 2, at 231.

258. *See Camnitz*, 774 F.3d at 252 (discussing implications in North Carolina for implementing a statute that requires women to forcefully ignore physician communication). In fact, North Carolina explicitly recognized this point while codifying the Woman's Right to Know Act. *See* N.C. GEN. STAT. § 90–21.85(b) ("Nothing in this section shall be construed to prevent a pregnant woman from averting her eyes from the displayed images or from refusing to hear the simultaneous explanation and medical description.").

259. Janet L. Dolgin, *Physician Speech and State Control: Furthering Partisan Interests at the Expense of Good Health*, 48 NEW ENG. L. REV. 293, 338 (2014); *cf.* FCC v. Pacifica Found., 438 U.S. 726, 775 (1978) (Brennan, J., dissenting) (recognizing the inherent fears when "[b]oth those desiring to receive [a] message . . . and those wishing to send it to them are prevented from doing so"). In fact, the *Wollschlaeger* majority acknowledged "society's interest in the free flow of information." Wollschlaeger v. Governor of Fla., 797 F.3d 859, 890 (11th Cir. 2015) (quoting Va. State Board of Pharmacy v. Va. Citizens Consumer Council, Inc., 425 U.S. 748, 764 (1975)).

260. *Cf.* Robert Post, *Participatory Democracy and Free Speech*, 97 VA. L. REV. 477, 478–79 (2011) (discussing the marketplace of ideas as a rationale for First Amendment protection). It is

state to restrict physician speech under the guise of protecting patients undermines any trust in their physician, and thus, only serves to harm patients more.[261]

Second, even commercial speech has enjoyed First Amendment coverage for roughly forty years.[262] This coverage is rationalized by the desire to shelter "the free flow of commercial communication in the marketplace."[263] Thus, the First Amendment weighs the government's interest in regulating the commercial speaker against the recipient's need or desire for the information.[264] The First Amendment covers commercial speech when the speech is not false, misleading, or does not involve unlawful activity.[265] This is because misleading speech subverts the rationale for protecting commercial speech under the First Amendment—"the informational function of advertising."[266]

Physician speech deserves First Amendment coverage for many of the same reasons that commercial speech enjoys such coverage. Placing commercial speech behind the First Amendment's protective shield implicates the widely accepted argument that citizens possess a right to accrue "knowledge and thereby retain control over one's own thought processes."[267] Regulatory schemes that restrict physicians'

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true that states may attempt to censor harmful information by restricting physician speech. The First Amendment, however, should still cover this type of restriction; the distinguishing analysis would occur in protection. For a discussion of First Amendment protection, see *infra* notes 287–303 and accompanying text.

261. *See* Martha Swartz, *Physician-Patient Communication and the First Amendment After* Sorrell, 17 MICH. ST. U. J. MED. & L. 101, 114 (2012) (describing the harm that stems from depriving patients of necessary medical information).

262. *Compare* Valentine v. Chrestensen, 316 U.S. 52, 54 (1942) ("We are equally clear that the Constitution imposes no such restraint on government as respects purely commercial advertising."), *overruled by* Payne v. Tennessee 501 U.S. 808 (1991), *with Va. State Bd. of Pharmacy*, 425 U.S. at 770 (protecting commercial speech so that the state may not "keep[] the public in ignorance of the entirely lawful terms that competing pharmacists are offering").

263. Alison L. Stohr, Comment, *Valor for Sale: Applying the Commercial Speech Exception to Self-Promoting Individuals*, 85 TEMP. L. REV. 455, 465 (2013).

264. *See id.* at 463 (justifying protection of commercial speech by analyzing the expression's nature in accordance with the governmental interest served in regulating that expression); *see also* ROBERT C. POST, DEMOCRACY, EXPERTISE, AND ACADEMIC FREEDOM: A FIRST AMENDMENT JURISPRUDENCE FOR THE MODERN STATE 42–43 (2012) (explaining that the Constitution generally protects the speaker's expression, but lower levels of protection for commercial speech are rationalized by the decision to concentrate on safeguarding the listener).

265. Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of N.Y., 447 U.S. 557, 566 (1980).

266. *Id.* at 563 (citing First Nat'l Bank of Bos. v. Bellotti, 435 U.S. 765, 783 (1978)).

267. Berg, *supra* note 2, at 245 (citations omitted); *see* Griswold v. Connecticut, 381 U.S. 479, 482 (1965) ("[T]he State may not, consistently with the spirit of the First Amendment,

ability to speak with their patients, even under the guise of protecting patients, inhibit this right. Patients are constricted in their ability to amass critical medical information. Additionally, commercial speech by its very nature is motivated by pecuniary gain and may not be in the recipient's best interest. But physicians are not primarily motivated by their own financial gain. Their duty[268] is to provide the medical care that is in their patients' best interest. The result is a quasi-regulated profession that mandates only certain speech as appropriate. If self-interested, fiscally driven speech receives First Amendment coverage, patient-interested physician speech should as well.[269]

2. *Building a Test—When Physician Speech Should be Covered by the First Amendment*. Physician speech should receive First Amendment coverage when (1) the speech is rendered within the scope of the doctor–patient relationship, and (2) the information given or requested is truthful and nonmisleading. First, physician speech should only enjoy First Amendment coverage when the trust of the physician–patient relationship is intact. Without trust, the foundation of the physician–patient relationship is absent.[270] As no "personal nexus"[271] exists between physician and patient, the state lacks the supervisory capability to regulate the medical field.[272]

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contract the spectrum of available knowledge."); Kreimer v. Bureau of Police, 958 F.2d 1242, 1255 (3d Cir. 1992) ("Our review of the Supreme Court's decisions confirms that the First Amendment does not merely prohibit the government from enacting laws that censor information, but additionally encompasses the positive right of public access to information and ideas."); Thomas I. Emerson, *Legal Foundations of the Right to Know*, 1976 WASH. U. L.Q. 1, 2 (asserting that the "right to know" should be considered as integral to the freedom of speech and expression under the First Amendment).

268. For a discussion of the physician's duties to the patient, see *infra* notes 275–78 and accompanying text.

269. This is even more so the case when the speech is accurate and nonmisleading. *See* Amarin Pharm., Inc. v. FDA, No. 15-cv-3588 (PAE), 2015 WL 4720039, at *32 (S.D.N.Y. Aug. 7, 2015) (choosing to rule "in favor of giving doctors more, not less, information" in a commercial speech setting).

270. *See* Robert Gatter, *Unnecessary Adversaries at the End of Life: Mediating End-of-Life Treatment Disputes to Prevent Erosion of Physician-Patient Relationships*, 79 B.U. L. REV. 1091, 1100 (1999) ("[T]rust is essential to the way medical treatment decisions are made . . . . [It] is essential to the ethical foundation of the physician-patient relationship."). For a discussion of the importance of trust in the physician–patient relationship, see *supra* notes 238–61 and accompanying text.

271. Lowe v. SEC, 472 U.S. 181, 232 (1985) (White, J., concurring).

272. *See* Pickup v. Brown, 740 F.3d 1208, 1227–28 (9th Cir. 2013) ("[O]utside the doctor-patient relationship, doctors are constitutionally equivalent to soapbox orators and pamphleteers, and their speech receives robust protection under the First Amendment.").

Without a trustful physician–patient relationship, the physician's speech transforms to "speech by a physician."[273] Consequently, the physician-speech doctrine would be inapplicable.[274]

A strong gauge for testing whether the trust of the physician–patient relationship is established is analyzing whether the physician has a duty of faith, trust, and confidence to the patient.[275] Numerous courts agree that "physicians owe a fiduciary obligation to their patients, stemming from the intrinsic nature of the physician-patient relationship."[276] Because the physician is obligated to act in the patient's best interests,[277] the state need not implement regulatory schemes to police improper medical practices. When physician speech is *not* in furtherance of their physician duties,[278] however, it does not fall within the scope of the physician–patient relationship. Consequently, the trust inherent in the physician–patient relationship is absent, and the speech cannot be considered physician speech for First Amendment coverage purposes.

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273. To clarify this analysis, it is helpful to make a nuanced distinction—the difference between "physician speech" and "speech by a physician." On one hand, physician speech is generally understood as speech "uttered in the course of professional practice." Halberstam, *supra* note 7, at 843. On the other hand, speech by a physician is precisely that: "speech . . . uttered by a professional." *Id.* This distinction is critical; the state has no authority to restrict speech solely because a physician uttered the statement. Suppose a physician asks a long-time patient how his or her family's recent vacation was. Or whether his or her child is engaged yet. The state is unable to restrict this kind of speech; it is the archetypal "speech by a physician."

274. *See* Post, *supra* note 8, at 952 (explaining that not all speech during the practice of medicine qualifies as "professional speech"). One example given by Professor Robert Post is if a physician trips while examining a patient. *Id.* Any shouts of pain, even those occurring whilst examining a patient, are not "professional speech." *Id.*

275. *Cf. Fiduciary Duty*, BLACK'S LAW DICTIONARY (10th ed. 2014) (defining a fiduciary duty as "[a] duty of utmost good faith, trust, confidence, and candor owed by a fiduciary . . . to the beneficiary . . . ; a duty to act with the highest degree of honesty and loyalty toward another person and in the best interests of the other person").

276. Thomas L. Hafemeister & Richard M. Gulbrandsen, Jr., *The Fiduciary Obligation of Physicians to "Just Say No" if an "Informed" Patient Demands Services That Are Not Medically Indicated*, 39 SETON HALL L. REV. 335, 369 (2009) (listing cases that recognize the fiduciary nature of the physician–patient relationship).

277. *See* Ison v. McFall, 400 S.W.2d 243, 258 (Tenn. Ct. App. 1964) (holding that physicians owe a fiduciary relationship to their patients, and, as such, must advise their patients if they plan to use any medical treatment that will not be beneficial).

278. In the medical field, the duty owed is to act in the patient's best interests. For a discussion of "the physician's fiduciary duty to act in the patient's best interest," see Swartz, *supra* note 261, at 122.

Suppose that a patient is a personal friend of his physician.[279] During the course of the examination, the physician asks whether his friend would like to go hunting or skeet shooting with him. This inquiry is undoubtedly irrelevant to the patient's medical interests, and thus beyond the scope of the fiduciary obligations of the physician–patient relationship. No "personal nexus" exists in which the physician "purport[s] to be exercising judgment on behalf" of the patient.[280] The physician is speaking as an ordinary citizen.[281] As such, this speech would not be covered as *physician* speech for First Amendment purposes.[282]

Second, as in commercial speech, physician speech should only receive First Amendment coverage when the information conveyed is truthful and nonmisleading. As previously discussed, commercial speech receives First Amendment coverage to ensure the necessary free flow of communication.[283] In order to guarantee the circulation of *accurate information*,[284] that speech must be truthful and nonmisleading.[285] Likewise, as trust is the physician–patient relationship's central component,[286] then physician speech should only be protected when the conveyed information is accurate. Without requiring that the information conveyed be truthful and nonmisleading, any trust between the physician and the patient would

279. This example is adopted from one given by Judge Wilson. *See* Wollschlaeger v. Governor of Fla., 760 F.3d 1195, 1250 (11th Cir. 2014) (Wilson, J., dissenting).

280. Lowe v. SEC, 472 U.S. 181, 232 (1985) (White, J., concurring).

281. *See supra* note 273 (distinguishing between physician speech and speech by a physician). The *Wollschlaeger* majority considers this speech "to a client, on a matter irrelative to the practice of medicine." Wollschlaeger v. Governor of Florida, 797 F.3d 859, 888 (11th Cir. 2015).

282. This speech may be covered, however, as "citizen speech." *See* Lane v. Franks, 134 S. Ct. 2369, 2378 (2014) (citing Garcetti v. Ceballos, 547 U.S. 410, 421 (2006)) (recognizing that citizen speech triggers First Amendment protection); *see also supra* note 273 (drawing a distinction between physician speech and speech by a physician).

283. For a discussion of the First Amendment's protection of commercial speech, see *supra* notes 262–64 and accompanying text. In fact, misleading information is generally understood to fall beyond the ambit of First Amendment protection. *See* Schauer, *supra* note 108, at 1802 (noting that regulation of misleading information "is generally (and silently) understood not to raise First Amendment issues").

284. *See* Post, *supra* note 8, at 978 (justifying the protection of commercial speech due to the accuracy of information).

285. *See* Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of N.Y., 447 U.S. 557, 566 (1980) (identifying whether speech concerns lawful activity or misleading information as the first step in a four-part commercial speech analysis).

286. *See supra* notes 238–61, 270, 276–78 and accompanying text (discussing the importance of trust).

be significantly damaged. The patient would have no assurance that the physician's treatment was potentially effective. Consequently, the physician–patient relationship would be ineffective and patients would be far less willing to disclose sensitive information.

III. THE PERMISSIBLE REGULATION OF FREE PHYSICIAN SPEECH

Not all speech is treated equally—certain speech does not receive any First Amendment coverage.[287] But the First Amendment also distinguishes between various categories of covered speech.[288] Thus, once the First Amendment's protective facilities are triggered, a second question must be answered: How much security does the speech at issue receive?[289] This concept is framed as an inquiry into "protection."[290] Certain speech is more deserving of protection, and thus more elusive of governmental restraint.[291] Having shown that the First Amendment cannot be avoided, Section A demonstrates why intermediate scrutiny should be the appropriate standard for physician speech. Section B explains why FOPA does not pass constitutional muster.

287. For a discussion of the First Amendment's coverage, see *supra* Part II.

288. *See* Schauer, *supra* note 108, at 1770 ("[T]he First Amendment makes a difference in the categories that it covers even when the particular speech that is a member of some covered category winds up unprotected.").

289. *See id.* at 1769 ("When the First Amendment does show up, the full arsenal of First Amendment rules, principles, standards, distinctions, presumptions, tools, factors, and three-part tests becomes available to determine whether the particular speech will actually wind up being protected.").

290. *Id.*

291. *Compare* Turner Broad. Sys., Inc. v. FCC, 512 U.S. 622, 635 (1994) (deciding that intermediate scrutiny is the proper standard for content-neutral regulations), *with* City of L.A. v. Alameda Books, Inc., 535 U.S. 425, 434 (2002) (citing Simon & Schuster, Inc. v. Members of N.Y. State Crime Victims Bd., 502 U.S. 105, 115 (1991); Ark. Writers' Project, Inc. v. Ragland, 481 U.S. 221, 230–31 (1987)) (observing that content-based regulations are analyzed under strict scrutiny).

A. Choosing The Level of Protection—Intermediate Scrutiny[292]

As a template for physician-speech protection, it is helpful to consider the level of protection provided to similar types of speech. Commercial speech is a compelling analogue. Although commercial speech receives less protection than noncommercial speech,[293] it does not lack protection altogether.[294] This is due to the "'commonsense distinction' between speech proposing a commercial transaction, which occurs in an area traditionally subject to government regulation, and other varieties of speech."[295] Commercial speech that receives First Amendment protection[296] is generally subject to intermediate scrutiny.[297]

Commercial speech and physician speech share significant characteristics justifying their comparison. First, both physician speech and commercial speech are beneficial to listeners due to the "informational function"[298] served.[299] Physicians impart specialized knowledge that laypersons have little or no familiarity with. Although the relevant information may be exposed in alternative manners, it will often be disclosed only through a licensed physician. Second,

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292. Although the revised *Wollschlaeger* majority opinion subjected FOPA to intermediate scrutiny, its two-dimensional approach left open the possibility that physician speech may be subject to a lesser level of scrutiny. In deciding what level of scrutiny to apply, the majority recognized that "when a professional speaks to the public in a nonprofessional capacity, courts apply the most exacting scrutiny." Wollschlaeger v. Governor of Fla., 797 F.3d 859, 892 (11th Cir. 2015). But the majority conceived of physician speech as "a context in which the State's interest in regulating for the protection of the public is more deeply rooted." *Id.* Consequently, although the majority left "the question open, it declare[d] that [physician speech] may actually be subject to a level of scrutiny more deferential than intermediate scrutiny." *Id.* at 909 (Wilson, J., dissenting).

293. *See* Sorrell v. IMS Health, Inc., 131 S. Ct. 2653, 2674 (2011) (explaining that courts apply "a less than strict, 'intermediate' First Amendment test when the government directly restricts commercial speech").

294. *See* Thompson v. W. States Med. Ctr., 535 U.S. 357, 374 (2002) (clarifying that the commercial speech test is "significantly stricter than the rational basis test").

295. Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of N.Y., 447 U.S. 557, 562 (1980) (quoting Ohralik v. Ohio State Bar Ass'n, 436 U.S. 447, 455–56 (1978)).

296. For a discussion of First Amendment coverage of commercial speech, see *supra* notes 262–66 and accompanying text.

297. *See* Ass'n of Nat'l Advertisers, Inc. v. Lungren, 44 F.3d 726, 731 (9th Cir. 1994) (concluding that intermediate scrutiny is the appropriate test for commercial speech).

298. *Cent. Hudson*, 447 U.S. at 563 (citing First Nat'l Bank of Bos. v. Bellotti, 435 U.S. 765, 783 (1978)).

299. *See* Post, *supra* note 8, at 979 (referencing "the right of the patient to receive information"); *see also supra* note 263 and accompanying text (mentioning the informative value of commercial speech).

both types of speech occur in areas that are traditionally exposed to government regulation.[300] States have long regulated physicians to protect prospective patients and increase the overall quality of healthcare.[301]

Given these salient similarities, physician speech should receive the same degree of First Amendment protection[302] as commercial speech—intermediate scrutiny.[303] Thus, the government must first establish a "substantial" interest in regulating the physician speech in question.[304] Second, the government must demonstrate that the regulation "directly advances the [asserted] governmental interest."[305] Finally, the government must show that the regulation "is not more extensive than . . . necessary to serve that interest."[306]

B. FOPA's Constitutional Pitfalls

The Eleventh Circuit's holding—based on the unfounded conclusion that restricting physician speech will protect patient privacy and health[307]—reduced physician advice to second-class

300. *See Cent. Hudson*, 447 U.S. at 562 (explaining that commercial speech "occurs in an area traditionally subject to government regulation" (quoting Ohralik v. Ohio State Bar Ass'n, 436 U.S. 447, 455–56 (1978))); *see also supra* Part I.C (documenting the history of medical field regulations through licensing schemes and protective measures).

301. *See* Stuart v. Camnitz, 774 F.3d 238, 247 (4th Cir. 2014) (citing Dent v. West Virginia, 129 U.S. 114, 122 (1889)) (noting the extensive history surrounding medical regulations).

302. To be sure, traditional First Amendment doctrines apply to physician speech, and should continue to do so. For example, content-based and viewpoint-based restrictions on speech receive strict scrutiny. *See* Pickup v. Brown, 740 F.3d 1208, 1231 (9th Cir. 2013) ("[C]ontent- or viewpoint-based regulation[s] . . . must be closely scrutinized." (emphasis omitted)); Conant v. Walters, 309 F.3d 629, 637 (9th Cir. 2002) ("Indeed, even content-based restrictions on speech are 'presumptively invalid.'" (quoting R.A.V. v. St. Paul, 505 U.S. 377, 382 (1992))).

303. Some scholars argue against a lower level of protection for commercial speech. *See, e.g.*, Alex Kozinski & Stuart Banner, *Who's Afraid of Commercial Speech?*, 76 VA. L. REV. 627, 652–53 (1990) (arguing that commercial speech may be equally as important as noncommercial speech, and thus, deserves more protection that currently provided). This Note does not argue that physician speech definitively deserves intermediate scrutiny. Rather, it posits a symmetry argument: physician speech should enjoy *whatever* protection commercial speech enjoys (which, as of this Note's completion, is intermediate scrutiny). Thus, if the Supreme Court later holds that commercial speech deserves strict scrutiny, physician speech should as well.

304. *See Cent. Hudson*, 447 U.S. at 566 (applying the intermediate scrutiny test in a commercial speech case).

305. *Id.*

306. *Id.*

307. Wollschlaeger v. Governor of Fla., 797 F.3d 859, 883 (11th Cir. 2015) (rationalizing that FOPA merely explains what is "within the boundaries of good medical practice").

speech.[308] Instead of protecting patients, restricting physician speech cements a significant barrier to complete medical care and ignores recommendations by established medical organizations.[309] Physicians must engage in a full discussion with their patients to give precise medical advice. Additionally, patients must receive complete information to reach an informed and autonomous choice in their medical care. Restricting such important speech imposes "an undesired and uncomfortable straitjacket"[310] on physicians and their patients.

Under intermediate scrutiny, FOPA must directly advance the government's interest in protecting patient privacy.[311] It is doubtful, however, that any legislative action is necessary to further that interest.[312] To the extent that privacy reinforces the permissibility of any *state* regulation restricting physician speech, current federal regulations alleviate that need. One such regulation, the Patient Protection and Affordable Care Act (PPACA),[313] unambiguously ensures a patient's privacy regarding firearm usage. PPACA prohibits healthcare practitioners from divulging any information concerning "the lawful ownership or possession of a firearm or ammunition,"[314] or "the lawful use, possession, or storage of a firearm or ammunition."[315] Likewise, the federal Health Insurance Portability and Accountability Act (HIPAA),[316] safeguards the privacy of information that patients

308. *See id.* at 909 (Wilson, J., dissenting) (recognizing that even commercial speech is subject to intermediate scrutiny).

309. *See supra* note 29 (documenting the recommendations of the American Academy of Pediatrics and the American Medical Association).

310. Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 67 n.8 (1976).

311. Normally, the preliminary question is whether the government interest qualifies as "substantial." However, Florida concededly has a substantial interest in "promoting the health, safety, and welfare of its citizens." Rubin v. Coors Brewing Co., 514 U.S. 476, 485 (1995) (citing Posadas de P.R. Assocs. v. Tourism Co. of P.R., 478 U.S. 328, 341 (1986)).

312. Florida asserted that FOPA protects the government's interest in safeguarding patients' privacy. *See* Brief for Appellants at 32, Wollschlaeger v. Governor of Fla., 760 F.3d 1195 (11th Cir. 2014) (No. 12-14009) ("[FOPA] serves a number of substantial governmental interests, including . . . the protection of privacy rights . . . .").

313. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 42 U.S.C.).

314. 42 U.S.C. § 300gg-17(c)(5)(A) (2012).

315. *Id.* § 300gg-17(c)(5)(B).

316. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (2012) (codified as amended in scattered sections of 18, 26, 29, and 42 U.S.C.).

disclose to physicians.[317] HIPAA also regulates to what extent healthcare practitioners may disclose their patients' personal "health information."[318] Florida's analogue, for example, dictates that healthcare practitioners may not provide a patient's medical record to a third party without that patient's permission.[319] Thus, FOPA burdens more speech than is necessary; HIPAA "already prohibits and penalizes"[320] improper plunges into patients' private matters.[321]

FOPA's proponents may argue that the privacy interest at stake is not the divulging of firearm ownership information, but the inquiry into firearm ownership itself. Thus, so the argument goes, the only way to safeguard a patient's privacy is by restricting the inquiry in the first place.[322] But this argument is flawed in three regards. First, information related to firearm ownership is not venerated.[323] In fact, federal and state statutes *require* that certain firearm-ownership information be divulged.[324] Second, there is no evidence that patient privacy is in danger, and therefore, that any protection is unnecessary.[325] Third, the asserted privacy interests "are a mere

317. In some jurisdictions privacy exceptions can diminish HIPAA's ability to shelter certain information. *See generally* Stephanie E. Pearl, Note, *HIPAA: Caught in the Cross Fire*, 64 DUKE L.J. 559 (2014) (discussing the HIPAA Privacy Rule).

318. "Health Information" is defined as "any information . . . that: (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual." 45 C.F.R. § 160.103 (2014).

319. *See* FLA. STAT. § 456.057(7)(a) (2014) (mandating that physicians may not furnish or discuss a patient's medical records with "any person other than the patient or the patient's legal representative or other health care practitioners and providers involved in the care or treatment of the patient, except upon written authorization of the patient").

320. STAFF OF H.R. CRIMINAL JUSTICE SUBCOMM., 113TH SESS., BILL ANALYSIS AND FISCAL STATEMENT FOR H.R. 155, at 5 (Comm. Print. 2011).

321. *Cf.* Alex L. Bednar, *HIPAA Implications for Attorney-Client Privilege*, 35 ST. MARY'S L.J. 871, 875 (2004) (emphasizing that HIPAA "serves to enhance trust between patients and health care providers").

322. The *Wollschlaeger* majority agreed with this argument, noting that "[t]he principal harm targeted by [FOPA] is the collection of information regarding . . . firearm ownership." Wollschlaeger v. Governor of Fla., 797 F.3d 859, 898–99 (11th Cir. 2015).

323. *Cf.* Cal. Democratic Party v. Jones, 530 U.S. 567, 585 (2000) (holding that an alleged government interest in protecting voter affiliation was not compelling and noting that the information is not venerated).

324. *See, e.g.*, 18 U.S.C. § 923 (2012) (requiring certain information to be provided when a firearm transfers ownership); FLA. STAT. § 790 (regulating the possession of firearms).

325. *See* Wollschlaeger v. Farmer, 880 F. Supp. 2d 1251, 1266 (S.D. Fla. 2012) (explaining that Florida could not "show that any real [privacy] barriers actually exist or are widespread and

pretext for the State's suppression of speech with which it disagrees."[326] Consequently, any reliance on the patient's privacy interest is misplaced.

Moreover, under intermediate scrutiny a statute may not regulate more extensively than necessary to serve its asserted interest. But FOPA drastically burdens and undermines legislative policy choices. Florida, like many states, maintains child access prevention statutes.[327] These statutes "impose criminal liability on adults who negligently or recklessly leave firearms accessible to minors or otherwise allow minors access to firearms."[328] Statistics help to explain the legislative rationale underlying this type of law—firearms in the home are forty-three times more likely to kill a family member than an intruder.[329] Additionally, deaths by firearms in the home are commonly the result of an accident,[330] homicide,[331] or suicide.[332] These statistical findings support the conclusion that physicians should be encouraged—not restricted—to exercise broad discretion to inquire into their patients' ownership, use, and possession of firearms. Allowing physicians to discuss firearm ownership, use, and possession with their patients would thus help reinforce Florida's chosen policy through the provision of information to those at whom the policy is aimed. Instead, FOPA precludes an opportunity for physicians to help effectuate this policy.

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pervasive"). In fact, nothing would stop a physician from inquiring into other private matters—for example, whether a patient is sexually active or uses contraceptive devices.

326. Calvert et al., *supra* note 24, at 43; *see also* Eugene Volokh, *Court Upholds Florida Law Restricting Doctor-Patient Speech About Guns*, WASH. POST (July 29, 2015), https://www.washingtonpost.com/news/volokh-conspiracy/wp/2015/07/29/court-upholds-restriction-on-doctor-patient-speech-about-guns [http://www.perma.cc/RC9M-CKXC] (explaining that FOPA is "about preventing doctors from spreading what many gun rights supporters see as unsound anti-gun propaganda").

327. *See* Erin P. Lynch, Comment, *Federal Gun Storage Legislation: Will This Keep Guns Out of the Hands of Our Children?*, 16 J. CONTEMP. HEALTH L. & POL'Y 211, 220 (1999) (discussing the history of child-access-prevention statutes). In fact, Florida was the *first state* to enact such a statute. *Id.*; *see* 1989 Fla. Laws 2739, 2739–42 (codifying, in Senate Bill 18-B, Florida's regulation regarding the safe storage of firearms).

328. Hethcoat II, *supra* note 28, at 31.

329. Brian Falls, *Legislation Prohibiting Physicians from Asking Patients About Guns*, 39 J. PSYCHOL. & L. 441, 446 (2011).

330. *See id.* at 447 (noting that accidents cause most domestic child firearm deaths).

331. *See id.* (illustrating that 41 percent of "gun-related homicides would not occur without access to guns in the home").

332. *See id.* ("Gunshots are by far the most lethal method of suicide attempts; up to 96% result in death, whereas overdose is lethal in about 2–7% of cases.").

Additionally, the patient's right to refuse to answer diminishes the efficacy of the inquiry and record-keeping provisions. Under § 790.338(4) of the Florida Statutes, patients have the right to "decline to answer or provide any information regarding ownership of a firearm"[333] without fear of physician retaliation.[334] Consequently, patients are capable of protecting their own privacy beyond any assistance from the State's inquiry and record-keeping protections. Since these two provisions are functionally irrelevant after considering § 790.338(4), FOPA burdens more speech than necessary to further Florida's substantial government interest in protecting privacy.

Similarly, FOPA burdens more speech than necessary by banning all inquiries related to the possession of firearms instead of tailoring the prohibition to only those who object. Undoubtedly, some patients appreciate inquiries regarding firearm ownership, use, and possession as part of their preventative care. Florida could provide those patients their desired care by implementing a carve-out provision that allows welcomed inquiries.[335] But FOPA does not include an exception that allows a patient to consent to the inquiry. Rather, it silences all inquiries into firearm ownership, use, and possession—even those that are requested. By doing so, FOPA burdens far more speech than is needed to further its substantial state interest.

Finally, there is seemingly no reason why Florida could not enact a regulation that would punish physicians after a case-by-case analysis of whether the physician impermissibly plunged into a patient's private matters. Instead of targeting and banning one specific topic, this regulatory scheme would allow consideration of additional factors, for instance: whether other medical associations recommend the questioning, the patient's need for specific treatment, or the previous relationship between the patient and physician. Although the legality of most questioning under FOPA assumedly would not

333. FLA. STAT. § 790.338(4) (2014).

334. *See id.* ("A patient's decision not to answer a question relating to the presence or ownership of a firearm does not alter existing law regarding a physician's authorization to choose his or her patients.").

335. *See* Burk v. Augusta-Richmond Cty., 365 F.3d 1247, 1255 (11th Cir. 2004) (observing that the county in that case "could, for example, target only offensive behavior or the manner of delivery of speech without regard to viewpoint or subject matter," rather than enacting an unconstitutionally burdensome ordinance regulating protests in public places).

change,[336] the chilling effect[337] on questioning would.[338] Accordingly, physicians would likely be more inclined to "express[] their views and provid[e] information to patients"[339] about any appropriate topic.

CONCLUSION

As Judge Wilson sensibly posited in *Wollschlaeger v. Governor of Florida*, "doctors have a First Amendment right to convey [a] message."[340] Although the police power of the states certainly permits broad regulation of the medical field, this capability should not be interpreted to authorize an override of the imperative protective facilities provided by the First Amendment. Even when acting as professionals, citizens retain their First Amendment rights. Thus, as applied to physicians, courts and legislatures should not ignore Justice Douglas's reminder that "[t]he right of the doctor to advise his patients according to his best lights seems so obviously within First Amendment rights as to need no extended discussion."[341]

Framing First Amendment coverage of physician speech around the government's supposed interest in protecting patients' privacy rights erodes the foundation of trust upon which the physician–patient relationship rests. Patients seek medical care because they lack, and are thus seeking, knowledge that is critical to their health. When states restrict specific physician speech, however, they mislead patients' decisionmaking process and lessen trust in the physician. While states may assert that they are acting in the patients' best interest by ensuring proper care, this argument ignores the fact that physicians are already obligated to act in their patients' best interest. Furthermore, when states prohibit physician speech, patients have no sufficiently reliable alternative avenue by which to acquire that information. Thus, physician speech should presumptively enjoy coverage of the First Amendment's protective shield so long as the

336. FOPA *allows* questioning when relevant. *See, e.g.*, FLA. STAT. § 790.338(2) (creating an exception for relevant questioning). Under the proffered patient privacy regulation, anything beyond the realm of relevancy would likely be considered an impermissible line of questioning.

337. *See* Wollschlaeger v. Governor of Fla., 797 F.3d 859, 906 (11th Cir. 2015) (Wilson, J., dissenting) (explaining FOPA's chilling effect).

338. *See* David H. Gans, *Strategic Facial Challenges*, 85 B.U. L. REV. 1333, 1367–68 (2005) (arguing that any chilling effect is greatly weakened when the state does not target specific speech).

339. *Wollschlaeger*, 797 F.3d at 902 (Wilson, J., dissenting).

340. *Id.*

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

speech at issue is (1) rendered in a trusting, physician–patient relationship, and (2) the information given or requested is truthful and nonmisleading.

But providing First Amendment coverage does not strip the state of its regulatory powers. By contrast, the state can restrict physician speech so long as the regulation passes constitutional muster. Given the prominent similarities between commercial speech and physician speech, the two should receive the same degree of First Amendment protection—intermediate scrutiny. And FOPA meets its demise at intermediate scrutiny. Restricting integral physician speech on one specific topic imposes a mountainous barrier to medical care. Furthermore, supplementary federal regulations achieve the same interest allegedly furthered by FOPA—protecting patient privacy. Consequently, FOPA fails to directly advance any substantial government interest without burdening more speech than necessary.

Only time will tell how courts and state legislatures will react to the *Wollschlaeger* decision. Assumedly, other states may believe that they now have a "green light" to restrict physician speech through FOPA-like statutory regimes. That decision, however, would be a terrible mistake. It destroys the trust of the physician–patient relationship and relegates it to obscurity.