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Prescribing Politics: A Call for Stronger First Amendment Protection of Physician-Patient Communications from State Interference in the Practice of Medicine

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"The health of my patient will be my first consideration; I will respect the secrets which are confided in me I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient; I will maintain the utmost respect for human life Even under threat, and I will not use my medical knowledge contrary to the laws of humanity"

-Declaration of Geneva (Physician's Oath) [\[1\]](#)

1. Introduction

The *Physicians' Oath* is the moral bedrock of medical practice that touts, above all else, to protect the best interests of the patient.^[2] Insofar as those interests are predicated on the physicians' dual knowledge of their patients' needs together with relevant clinical expertise, open and forthright physician-patient communication is vital to achieving positive health outcomes. At the same time, states have the authority to regulate physician speech that occurs pursuant to the licensed practice of medicine.^[3] Professional standards of care differ from state-to-state, though, informed consent laws in all fifty states require doctors notify their patients of the material risks accompanying a given medical treatment or procedure.^[4] To a greater extent, however, states are passing laws that seek to regulate the content of physician-patient communications beyond the scope considered for traditional informed consent. Such provisions toe a fine line between acceptable professional regulation and physicians' constitutionally protected speech.

The degree of constitutional protection afforded to physician-patient communications from government regulation is the source of on-going judicial debate. Supreme Court precedent on the issue is unclear, pushing lower courts to establish a judicial standard based on their interpretations of those narrow and ephemeral statements of the Court.^[5] The outcome is a tangled web of conflicting precedent.^[6]

Most recently, the Federal Appellate Courts examined the relationship between state regulations over the practice of medicine and physicians' First Amendment rights through several cases involving reproductive rights, gun rights, and even public rights to confidential company information.^[7] This article examines the latter cases to determine how the courts position such restrictions on physician speech within the context of the First Amendment.

Specifically Part II explores the courts' conceptualization of physician speech, and, relatedly, the level of judicial protection afforded from state regulations over physician-speech. Part III examines the current case law vis-à-vis regulations of physician speech of two distinct types: (1) those that compel physician-patient communications; and (2) those that restrict physician-patient communications. In Part IV I suggest that physician speech be granted the highest level of constitutional protection from undue government interference in professional



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practice. Applying a standard of strict scrutiny, the regulatory provisions surveyed in this article breakdown under the “sufficiently narrowly tailored to the compelling state interest” analysis.^[8] Further, I implore the courts to be especially skeptical of state-imposed regulatory laws through which the articulated state interest is markedly undermined by the law’s effect. Of particular concern are the laws that operate under the guise of a public health objective to fulfill states’ political and moral agendas. Finally, in Part V, I recommend that the Supreme Court relieve physicians from their untenable position as spokespersons for state ideology by establishing a precedent through which content-based restrictions of *any* kind between physicians and their patients are unconstitutional.

2. Physician Speech Under the First Amendment

The relationship between the First Amendment and the states’ authority to regulate the medical profession is a bit enigmatic insofar as no single, comprehensive judicial understanding of physician speech regulation has readily emerged.^[9] To the extent the Supreme Court *has* addressed the issue of restrictions on physician speech, it has done so briefly through two non-binding court opinions.^[10] Accordingly, the Federal Appellate Courts, relying on their own interpretations of these Court statements, guide our treatment of physician speech under the First Amendment.^[11] Yet the Federal Appellate Courts disagree as to whether physician-patient communication, as an inextricable component of treatment, should be classified as *conduct*, outside the scope of First Amendment protection, or, rather, as constitutionally protected *commercial speech*.^[12] Among the courts that hold physician-speech to the traditional commercial standard, proposed speech regulations receive minimal judicial scrutiny such that, generally, one is upheld so long as the language is “truthful, non-misleading, and relevant”^[13]; others apply a more stringent standard, upholding a provision only if it “directly advances” the states’ “substantial interest.”^[14] Relatedly, the issue of whether content-based and speaker-targeted regulations on physician speech should be distinguished as between those that prohibit speech and those that compel speech is an issue of protracted judicial debate.^[15] Traditionally, the courts have applied a heightened scrutiny standard exclusively to content-based restrictions.^[16]

It follows that three conflicting standards of protection have emerged within the Federal Appellate Courts: the Ninth Circuit classifies physician-patient communications as *conduct* subject to minimal First Amendment protection^[17]; the Fifth and Eighth Circuits treat physician speech like traditional commercial speech such that state-imposed regulations are subject only to rational basis review^[18]; and the Third and Fourth Circuits also apply a commercial speech standard yet they afford physician speech greater protection under the First Amendment, subjecting proposed laws to intermediate scrutiny.^[19]

First Amendment concerns are raised when a state seeks to regulate physician speech in a manner that wholly conflicts with the professional standards of practice. Of particular concern are the provisions that undermine, be it in spirit or in effect, statutorily imposed informed consent laws.^[20] By virtue of the courts’ inconsistent standards of review, state governments are, nonetheless, free to project legislative ideology onto the First Amendment language of the constitution.

3. Examining Laws That Regulate Physician-Speech

1. Laws That Compel Physician Speech

A state provision that pushes the intended boundaries of traditional informed consent, may harm the physician-patient relationship and impede upon the physician’s fundamental rights.^[21] To date, the states’ have enjoyed the broadest regulatory power in the context of reproductive rights, the latest by reason of abortion consent laws and fetal protection laws.

1. Abortion Consent Laws

In the landmark case, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Supreme Court upheld a Pennsylvania statute provision requiring physicians to share pre-scripted information with their patients prior to an abortion procedure.^[22] Under *Casey*, informed consent requirements that do not impose a “substantial obstacle” on a woman’s right to obtain an abortion are valid if they are “reasonable.”^[23] To this end, the Court defines reasonableness as “truthful, non-misleading, and relevant.”^[24] Less clear is whether the Court intended to establish the undue burden test as the *exclusive* standard for assessing the validity of state-mandated physician-speech in the context of abortion regulation; more precisely, the confusion arises from the tests application, or lack thereof, in the wake of First Amendment challenges.^[25]

The incomplete analysis of the proposed informed consent provision left room for Federal Appellate courts to interpret *Casey* as having created a rational basis standard of review for compelled-speech provisions in the context of abortion.^[26] Thus, the courts have given broad deference to the states to direct communications between physicians and their patients.^[27]

Relying on a lenient interpretation of *Casey*, many states have implemented cumbersome abortion consent requirements. For example, states such as Texas and South Dakota enacted laws requiring physicians to perform an ultrasound and to communicate certain information about the ultrasound images to patients prior to the procedure.^[28] Whereas the general abortion consent provisions require that certain information be made available, these “speech-and-display” provisions *mandate* receipt of this information, even if a physician has reason to believe that its delivery poses a danger to the woman’s health.^[29] Moreover, a number of state-mandated abortion consent provisions contain immaterial, misleading, and even inaccurate information that would, in the context of another medical procedure, be considered a breach of the professional standards of care and thus entirely at odds with the states’ informed consent laws.^[30]

This misalignment between the fundamental purpose of statutorily defined practice of medicine standards and states’ growing abortion consent provisions should raise more than a few judicial eyebrows. Still, the Supreme Court declines to institute a heightened standard of scrutiny for state-compelled physician-speech regulations and, by willfully refusing to do so, has acquiesced to promoting state interests above the health interests of patients.

2. Forced Reporting of Prenatal Substance Use

Criminalization for maternal substance use reemerged in response to public fears surrounding a substantial rise in the incidence of maternal crack use during the latter part of the nineteen-eighties and early nineteen-nineties.^[31]

Ostensibly aimed at government interests in enhancing maternal-fetal health, several states amended their neglect, abuse, and homicide statutes to include infants who are born chemically dependent on controlled substances to which they were exposed in utero.^[32] Collectively referred to as Chemical Endangerment Laws, the statutory inclusion of newborn chemical dependency as a “harm” has led to the prosecution of over two hundred women across eighteen states.^[33]

Under amended law, physicians’ rendering health care services through government subsidized facilities are required to perform a urine analysis on any patient suspected of prenatal drug use.^[34] In the event that a woman tests positive for an illicit substance, regardless of amount, these laws compel physicians’ to report the case to local authorities, thereby subjecting their *own* patients to potential criminal sanctions.^[35]

Upon enactment of the reporting mandates for prenatal substance use, the American Medical Association Board of Trustees issued a statement condemning all persecutory actions against women for fetal harm, suggesting, “[P]regnant women will be likely to avoid seeking prenatal . . . care for fear that their physicians’ knowledge of substance abuse . . . could result in a jail sentence rather than proper medical treatment.”^[36] The American College of Obstetricians and Gynecologists Committee on Ethics voiced similar concerns that these regulations undermine the physician-patient relationship and usurp the physicians’ ability to deliver proper treatment, further compromising the health of both the mother and her unborn child.^[37]

In effect, fetal protection laws directly undermine the states’ articulated objective of improving maternal-fetal health. Despite the absolute failure of these laws to achieve the states’ public health goals, the courts continue to allow the government to arrogate the parties’ rights to engage in confidential, health-promoting dialog under the First Amendment.

2. Laws That Prohibit Physician Speech

The practical effects of prohibitive speech statutes are arguably more injurious than those that compel physician speech. Information that is compelled can still be weighed against the opinion of another physician, for example, but when physician speech is banned altogether, the patient is deprived of information that *should* be communicated for the purposes of obtaining truly informed consent.^[38] The dangers posed by regulations that prohibit physician-patient communications are epitomized by Pennsylvania’s latest “fracking” provision and Florida’s law prohibiting physicians from questioning patients about gun ownership.

1. The Medical-Gag Rule

The use of hydraulic fracturing, a method used to extract natural gas and oil from the ground, expanded dramatically over the past decade with the advent of more efficient drilling technologies.^[39] As the geographical spread of “fracking” continues to grow, so too do the concerns about its health implications; notably, several of the chemical solutions used in the fracking process contain known or probable carcinogens that pose significant health risks to individuals who may be directly or indirectly exposed.^[40] Still a number of other chemical components are withheld from public knowledge under laws that protect companies’ “confidential proprietary information” or trade secrets.^[41]

In 2012, the Pennsylvania legislature amended the existing oil and gas law known as Act 13.^[42] Included for the first time were two provisions, together referred to as the “Medical Gag” rule, requiring medical professionals to sign non-disclosure agreements in the event they should need to obtain any information related to chemical trade secrets.^[43] In effect, this law bans physicians from discussing industry information with patients whom they suspect of being exposed to and/or sickened by toxic fracking chemicals.^[44] Likewise, the Act’s gag rule prohibits physicians from discussing cases of potential or known exposure with professional colleagues.^[45]

These provisions restrict the physicians’ ability to communicate critical health information and thus implicates both physicians’ ethical obligations to act in the best interests of their patients, as well as patients’ First Amendment interests in receiving non-deceptive medical advice.^[46] As a whole, the Act directly interferes with medical standards of care by prohibiting the professional exchange of information for the purposes of protecting public health, and wholly contradicts the state’s informed consent laws insofar as they limit patients’ ability to determine the underlying cause of their illness. So, physicians are positioned in an absurd catch twenty-two: they can ignore their professional and ethical duties or they can violate the law. In either event, there are serious legal and professional consequences.

Despite its questionable constitutionality, legal challenges to Act 13 under the First Amendment have thus far been unsuccessful.^[47] Still, it is inexplicable, at least from a public policy perspective, that the immediate health and safety of the public—our children, elders, and infirm—could fall second to corporate interests.

2. Limiting Communication About Gun Ownership

In 2011 the National Rifle Association (NRA) proposed, and the state of Florida approved, a law seeking to limit physician-patient communications around gun ownership.^[48] The Privacy of Firearm Owners Act, aptly referred to as the “Physician Gag Law”, seeks to prohibit physicians from inquiring about a patients’ private gun ownership or of such ownership by the patients’ family members, and from entering such information into medical records.^[49] A physician who violates the law, exposes him or herself to potential disciplinary action by the Florida Board of Medicine, substantial fines, and/or criminal charges.^[50]

Legal challenges to the Act came swiftly from doctors, medical organizations, and advocacy groups such as the American Civil Liberties Union.^[51] Upholding physicians’ First Amendment claims, the U.S. District Court for the Southern District of Florida issued a permanent injunction blocking the law from taking effect.^[52] On appeal, however, a three-judge panel of the Eleventh Circuit vacated the district court’s ruling, holding the Act to be a “presumptively reasonable regulation of professional conduct.”^[53] Since 2012, the circuit court has issued two additional opinions upholding the Act under a legal pretense that the Act protects citizens’ Second Amendment rights to bear arms.^[54] Classifying the Act as a regulation on professional conduct as opposed to speech, the Eleventh Circuit circumvented all First Amendment analysis.

All the same, these outcomes necessarily rely on a legal fiction: that state and/or federal laws permit physicians’ to interfere with their patients’ lawful ownership, possession, and/or use of firearms. Physicians’ basic questioning about gun ownership hardly constitutes a threat to patients Second Amendment rights; restricting communications about gun access *does*, however, limit the physician’s ability to assess for patient risk and undermines their professional and ethical obligations to deliver honest information regarding the safety concerns implicated by certain activities.^[55]

On June 21st, 2016, the Eleventh Circuit Court of Appeals, sitting *en banc*, heard the first round of oral arguments in this latest battle between physicians and gun-rights activists.^[56] There is a strong possibility though that this case will reach the Supreme Court on the free-speech claim. Should that be the case, the Supreme Court will have the opportunity to establish a clear position on the regulation of physician-speech, a position that, hopefully, rejects political intrusions into the practice of medicine absent the strictest level of judicial scrutiny.

4. RESTRICTIONS ON PHYSICIAN SPEECH CALL FOR STRICT JUDICIAL SCRUTINY

The cases discussed above invoke the question: to what extent does the First Amendment prevent the government from imposing additional regulations on the content of physicians' communications with their patients? Although the Supreme Court generally holds content-based restrictions on commercial speech to a heightened standard of scrutiny, the Court has failed to articulate a comparable standard for content-based regulations on physician speech.^[57] As a result, government regulations on physician-speech regularly withstand judicial review to the detriment of individuals' fundamental rights.

1. The Unfortunate Consequences of Minimal Judicial Scrutiny

As precedent stands, states are encouraged to adopt regulatory laws that unduly infringe upon citizens' rights to free-speech, no matter how attenuated the state interest may appear from the language and/or effect of the provision. Often the laws that seek to direct physician-patient dialogue are adopted under the pretense of public health; yet many of these speech-regulatory provisions contradict the evidence-based practices espoused by the medical community and, in fact, thwart the efforts of the well-suited professionals who serve the populations most frequently targeted by the laws' negative effects.^[58]

The abortion consent laws and fetal protection provisions were enacted pursuant to the states' articulated interest in protecting the health of women and that of their potential offspring.^[59] In theory this is a laudable goal, however, in effect these laws directly undermine the states' purported goals; women who defer obstetric care, take care into their own hands, or deny care all together for fear of condemnation ultimately cause greater harm to themselves and, where relevant, to their fetus'.^[60]

The fact that states' continue to rely on largely discredited scientific evidence to promote maternal-fetal health suggests that the interest being protected is one of ideology rather than of public health concern. If the states *truly* wished to protect maternal-fetal health at every stage, they would adopt policies aimed at prevention and early intervention as opposed to the existing laws that are punitive and restrictive in nature. Ensuring women have access to proper healthcare, including access to contraceptives and effective addiction treatment facilities will, in all probability, contribute to improved maternal-fetal health.^[61]

Equally, the speech-restrictive fracking and gun-ownership statutes are grounded in weak or otherwise questionable state interests.

We can only assume absent any clear articulation, that the state interest underlying the Medical Gag rule is either the protection of corporate trade secrets or the attainment of natural gases. In either event, the interest should not suffice to outweigh the tremendous public health concerns implicated by these latest fracking procedures.

As noted earlier, Florida's Physician Gag Law is grounded in the state's interest in protecting citizens' Second Amendment rights to bear arms. If we blindly accept the state's Second Amendment argument, are we then to understand that the right to bear arms unquestionably trumps both the fundamental right to free speech as well as the government's obligation to act in the best interest of the public health and welfare of its citizens?

While there is no judicial test that can unequivocally expose ideological agendas concealed within state proposed regulations, the courts *can* protect vulnerable populations from politically-motivated speech regulations by applying strict scrutiny to any provision that seeks silence or compel physician speech in the context of patient treatment.

2. Strict Scrutiny as an Appropriate Alternative

The inextricability of physician-patient communications from treatment under the practice of medicine suggests that physician speech ought to be held to a higher standard than *all* forms of commercial speech. The commercial speech standard fails to protect physicians' First Amendment rights as well as the constitutional rights and the health-related interests of their patients. Ideology-based laws threaten general welfare by undermining the kind of open and honest communication that leads to informed healthcare consumerism and, ultimately, to improved public health outcomes.^[62]

What's more, the physician's ability to communicate with his or her patient is already limited by duties imposed by state licensing and ethics boards, the violations of which carry sufficiently punitive results.^[63] Likewise, patients' are legally empowered to penalize physicians through the imposition of tort liability for medical malpractice.^[64]

Given their extensive medical knowledge and specialized training, physicians deserve the broadest freedoms to communicate with their patients so that, physician and patient *together* may determine a treatment option best suited to the patients' unique needs.

Therefore, any regulation that undermines, contradicts, or takes discretion away from physicians' to determine what is in the best interest of their patients' health, should be subject to strict scrutiny such that the provision will only survive if it is narrowly tailored to a compelling state interest that cannot be achieved through less restrictive means.

5. CONCLUSION

From women's health issues to gun safety, political intrusions into the practice of medicine is a disturbing trend. Agenda-backed laws that seek to regulate physician speech threaten evidence-based practice standards, delivery of safe, quality medical care, and undermine the trust-based relationship between physicians and their patients. Yet state-mandates on physician-speech, regardless of their ulterior aims, will continue to survive this weak standard of judicial scrutiny without so much as nod to First Amendment rights.

To bring about any *real* change, regulatory laws that lack a strong, evidence-based foundation should be repealed and, moving forward, steps taken to ensure the free exercise of professional judgement so that physicians' can deliver care that is in the best interests of their patients. To ensure that physician-patient communications enjoy as many First Amendment protections as possible, the Supreme Court should also consider an *explicit* category of professional speech that commands the highest level of judicial scrutiny regardless of the content of or the context in which such speech is delivered.

[1] World Medical Association, Declaration of Geneva, adopted by the 2nd General Assembly of the WMA, Geneva, Switzerland, 1948 (last revised by the 173rd WMA Council Session, Divonne-les-Bains, France, 2006).

[2] Though the words "best interests" are not found within the traditional language of the Declaration of Geneva, they are often read into modern forms of the Physician's Oath ; see, e.g., Peter Tyson, *The Hippocratic Oath Today*, PBS (Apr. 12, 2016, 3:54 PM), <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html>.

[3] See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992) (plurality opinion) (noting that the practice of medicine is subject to "reasonable licensing and regulation by the state"). See also, *Wollschlaeger v. Governor of Florida*, 760 F.3d 1195, 1217 (11th Cir. 2014) ("To define the standards of good medical practice and provide for administrative enforcement of those standards is well within the State's long-established authority to regulate the profession."), *aff'd*, 797 F.3d 859 (2015).

[4] See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (setting forth the standard for the types of information a physician must provide a patient prior to treatment so that a patient can make an informed decision about whether to proceed with the recommended treatment).

[5] See Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 944 ("Although the Court has decided a number of cases about professional advertising, 'the Supreme Court and lower courts have rarely addressed the First Amendment contours of a professional's freedom to speak to a client.'" (quoting Daniel Halberstam, *Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions*, 147 U. Pa. L. Rev. 771, 834 (1999))).

[6] See *infra* Part III (examining cases from the circuit courts' and discussing the courts' application of First Amendment law to physician-patient communications.).

[7] See, e.g., *Wollschlaeger*; *Casey*; *Sellers v. State*, 935 So. 2d 1207 (Ala. Crim. App. 2005); and *Gas Drilling Awareness Coalition v. Powers* (M.D. Pa. Apr. 2012) respectively.

[8] See *Sorrell v. IMS Health Inc.*, 131 S. Ct. 2653, 2667-68 (2011) ("a prohibition of professional speech is permissible only if it 'directly advances' the State's 'substantial' interest in protecting clients from ineffective or harmful professional services, and is 'not more extensive than necessary to serve that interest.'").

[9] See *Supra* note 5

[10] *Id.* at 947.

[11] See *infra* note 24.

[12] See, e.g., *Pickup v. Brown*, 740 F.3d 1208, 1227-29 (9th Cir. 2014), (using a "continuum" model to describe the difference

between regulations of “conduct,” which receive little First Amendment protection, and speech about conduct, which receives some First Amendment protection).

[13] See *King v. Governor of the State of New Jersey*, 767 F.3d 216, 236 (3d Cir. 2014) (“In the context of commercial speech, the Supreme Court has treated compelled disclosures of truthful factual information differently than prohibitions of speech, subjecting the former to rational basis review and the latter to intermediate scrutiny.”).

[14] *Id.*

[15] See *Zauderer v. Office of Disciplinary Counsel of Sup. Ct. of Ohio*, 471 U.S. 626, 651 (1985) (“The First Amendment interests implicated by disclosure requirements are substantially weaker than those at stake when speech is actually suppressed . . . where their policies implicate rights so fundamental that strict scrutiny must be applied.”).

[16] See, e.g., *Pickup*, 740 F.3d at 1231 (“[C]ontent- or viewpoint based regulation[s] . . . must be closely scrutinized.”); *Wollschlaeger*, 760 F.3d at 1239 (“Content-based statutes . . . are presumptively invalid.” (quoting *R.A.V.*, 505 U.S. at 382)).

[17] See, e.g., *supra* note 12 at 1229 (noting that where a state regulation on physician conduct has an “incidental effect on speech,” First Amendment concerns are lessened).

[18] See, e.g., *Lakey*, wherein the court dismissed a compelled-speech challenge of Texas’s display-and-describe requirement; see also, *Rounds* (turning on the application of the truthful-and-not-misleading test articulated in *Casey*).

[19] See, e.g., *Stuart v. Camnitz*, 774 F.3d 238 (4th Cir. 2014); see also, N.J. STAT. ANN. § 45:1-54 (West 2016) (prohibiting mental health professionals from practicing “conversion therapy” with minors).

[20] See, e.g., *Camnitz* at 254 (The court states: “The rupture of trust comes with replacing what the doctor’s medical judgment would counsel in a communication with what the state wishes told. It subverts the patient’s expectations when the physician is compelled to deliver a state message bearing little connection to the search for professional services that led the patient to the doctor’s door.”).

[21] See, e.g., *Gayland O. Hethcoat II, In the Crosshairs: Legislative Restrictions on Patient-Physician Speech About Firearms*, 14 *DePaul J. Health Care L.* 1, 18 (2011) (“When a regulation goes further than discriminating in content and discriminates in viewpoint . . . the odds of withstanding judicial review become even greater, if not insurmountable.”).

[22] See *Casey* at 833.

[23] *Id.*

[24] *Id.*

[25] See Lauren Paulk, Article, What Is an “Undue Burden”? The Casey Standard as Applied to Informed Consent Provisions, 20 *UCLA WOMEN’S L.J.* 71, 97 (2013) (noting that “courts differ in their manner of addressing First Amendment challenges in the context of abortion regulations, leaving a split in the [c]ircuits on how to address informed consent provisions”).

[26] See *Camnitz* at 249 (“the plurality simply stated that it saw ‘no constitutional infirmity in the requirement that the physician provide the information mandated by the State here.’ That particularized finding hardly announces a guiding standard of scrutiny for use in every subsequent compelled speech case involving abortion.” (quoting *Casey*, (plurality opinion)), *cert. denied*, (2015).

[27] See *infra* Part III

[28] See *supra* note 18.

[29] See *infra* note 28.

[30] See, e.g., *ARIZ. REV. STAT. ANN. § 36-2153* (2015) (requiring physicians to inform women seeking abortions of the medically unsubstantiated “fact” that it may be possible to reverse the effects of a medication abortion); *N.C. GEN. STAT. ANN. § 90-21.85(b)* (2011) (requiring physicians to perform ultrasounds on women seeking abortions to display the image and to describe the fetus, even if the woman actively averts her eyes), invalidated by *Camnitz* at 238; and *Rounds* at 735 (Planned Parenthood argued that the compelled disclosure was untruthful and misleading because it implied a “causal link between abortion and

suicide” that was not established by medical authority. The majority held that the state did not need to establish conclusive proof of causation between abortion and the increased risk of suicide and suicide ideation in order to mandate the disclosure of the “identification [of suicide and suicide ideation as] a medical risk.”).

[31] See Lynn M. Paltrow, et al., Year 2000 Overview: Governmental Responses to Pregnant Women Who Use Alcohol or Other Drugs, Report of the Women's Law Project and National Advocates for Pregnant Women, available at www.advocatesforpregnantwomen.org/articles/index.htm.

[32] *Id.* at 467 (“In some states that have not amended their laws, government officials have, by regulation or practice, extended existing civil child abuse laws to pregnant women despite the lack of legislative intent or specific authority to do so.”).

[33] *Id.*

[34] *Id.* at 473.

[35] *Id.*

[36] Report of American Medical Ass’n Board of Trustees, *Legal Interventions During Pregnancy*, 264 JAMA 2662, 267 (1990).

[37] American College of Obstetricians and Gynecologists, Committee on Ethics, *Committee Opinion 321 Maternal Decision Making, Ethics and the Law*, 106 *Obstetrics & Gynecology* 1127 (2005).

[38] See *supra* note 18.

[39] Hydraulic Fracturing or “fracking” refers to a method of recovering oils and natural gases from the earth; pressurized water, industrial additives, and sand are blasted down into underground wells to fracture or break open rock formations that trap oil or gas. See Philippe A. Charlez, *Rock Mechanics: Petroleum Applications* 239 (1997).

[40] See Theo Colborn et. al., *Natural Gas Operations from a Public Health Perspective*, 17 *Hum. & ecological Risk Assessment: Int'l J.* 1039, 1040, 1045-46 (2011) (listing chemicals found in fracking fluid with ten or more known adverse health effects); *Agents Classified by the IARC Monographs, Volumes 1-109*, Int'l Agency for Res. on Cancer, available at <http://monographs.iarc.fr/ENG/Classification/index.php> (last updated Oct. 30, 2013) (containing a list of chemicals suspected or known to be carcinogenic to humans).

[41] See Rebecca Jo Reser, *State and Federal Statutory and Regulatory Treatment of Hydraulic Fracturing*, 80 *DEF. COUNS. J.* 90, 93 (2013).

[42] 58 PA. CONS. STAT. ANN. § 3222.1.

[43] *Id.* § 3222.1(b)(11).

[44] *Id.*

[45] *Id.*

[46] See, e.g., *Pickup*, at 1229 (noting that the first amendment “safeguards individuals' thought processes and expression against government suppression.”); *Casey*, at 916 (Stevens, J., concurring in part and dissenting in part) (“Decisional autonomy must limit the State’s power to inject into a woman’s most personal deliberations its own views of what is best.”).

[47] See Shannon Zabel, *Docs v. Glocks: The Need For First Amendment Protection In Preventative Care*, 24 *Temp. Pol. & Civ. Rts. L. Rev.* 483 (2015).

[48] *Id.*

[49] *Id.*

[50] See FLA. STAT. § 790.338 (2014) (codifying Florida's Firearm Owners Privacy Act).

[51] See *supra* note 46.

[52] *Wollschlaeger v. Farmer*, 880 F. Supp. 2d 1251, 1257, 1270 (S.D. Fla. 2012).

[53] *Wollschlaeger*, 760 F.3d at 1203 (upholding Florida law as a legitimate regulation on physician conduct with only an incidental effect on speech).

[54] See *supra* note 46.

[55] 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.”).

[56] Kathryn Hayes Tucker, *11th Circuit to Weigh Safety Against Rights at Docs v. Glocks En Banc Hearing*, Daily Reporter, June 17, 2016.

[57] See *supra* note 16.

[58] See *Stuart v. Loomis*, 992 F. Supp. 2d 585, 597 (M.D.N.C. 2014) (stating that the Supreme Court has repeatedly acknowledged the state's “interest in protecting the integrity and ethics of the medical profession” and declaring that the “state's regulation of professional speech must be consistent with the goals and duties of the profession” (citing *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997)), *aff'd sub nom. Camnitz*, cert. denied, (2015)).

[59] David C. Brody & Heidee McMillin, Combating Fetal Substance Abuse and Governmental Foolhardiness Through Collaborative Linkages, Therapeutic Jurisprudence and Common Sense: Helping Women Help Themselves, 12 HASTINGS WOMEN'S L.J. 252 (2001).

[60] *Id.*

[61] See Page McGuire Linden, Drug Addiction During Pregnancy: A Call for Increased Social Responsibility, 4 AM. U. J. GENDER & L. 105, 134 (1995) (stating negative effects of substance abuse during pregnancy are improved by providing prenatal care and drug treatment).

[62] See *Conant v. Walters*, 309 F.3d 629, 639 (9th Cir. 2002) (“An integral component of the practice of medicine is the communication between a doctor and a patient. Physicians must be able to speak frankly and openly to patients.”); see also, *Trammel v. United States*, 445 U.S. 40, 51 (1980) (“[T]he physician must know all that a patient can articulate in order to identify and to treat disease; barriers to full disclosure would impair diagnosis and treatment.”).

[63] See *supra* note 5.

[64] See *supra* note 24.

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