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Physician Speech and State Control: Furthering Partisan Interests at the Expense of Good Health

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Physician Speech and State Control: Furthering Partisan Interests at the Expense of Good Health

Janet L. Dolgin*

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INTRODUCTION

In the last few years, states have promulgated a variety of laws that control physician speech through bans or mandates. This Article focuses on laws of this type that serve ideological and financial interests and that do not further individual or population health. These laws interfere with the patient-physician relationship, ask physicians to violate professional codes, and stymie good health care.¹ This Article reviews the jurisprudential and social shifts that have facilitated the appearance of such laws with regard to matters as far-ranging as gun ownership and hydraulic fracturing operations and argues that laws of this sort have no place in a just society.

A 2012 essay by Steven Weinberger and co-authors, published in the *New England Journal of Medicine*² called attention to laws of the sort considered in this Article. Most of these laws do not serve—and were not intended to serve—the public’s health. The first example involves a Pennsylvania law that limits information that doctors can discuss with patients exposed to chemicals released in the process of hydraulic fracturing. A Florida law (later rescinded), provides the second example. That law prohibited physicians from asking patients or their family members about gun ownership. A third type of law requires doctors to perform specific diagnostic tests on women seeking abortions (whether or not the women consent) and to discuss fetal images with patients. In addition to these examples, the article considers a California law that bans mental health professionals from offering conversion therapy (aimed at changing sexual orientation) to minors. The last example is included for the sake of comparison. It arguably prohibits physician speech but was intended to safeguard the health and welfare of minors. This Article examines the social and legal parameters of each instance and attempts to contextualize each within the shifting contours of the doctor-patient relationship within the last half century.

¹ Until recently, states limited such laws to the regulation of abortion or contraception. 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, 202 (1994).

² Steven E. Weinberger et al., *Legislative Interference with the Patient-Physician Relationship*, 367 NEW ENG. J. MED. 1557 (2012), available at <http://www.nejm.org/doi/full/10.1056/NEJMs1209858>. In May of 2013, the Executive Board of The American College of Obstetricians and Gynecologists approved a “Statement of Policy” about legislation that interferes with the patient-doctor relationship and with medical decision making, more generally. The American College of Obstetricians and Gynecologists, *Statement of Policy: Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, ACOG (May 2013), <http://www.acog.org/~media/Statements%20of%20Policy/Public/2013LegislativeInterference.pdf>.

The first Section of Part I reviews two U.S. Supreme Court decisions, *Rust v. Sullivan*³ and *Planned Parenthood of Southeastern Pennsylvania v. Casey*.⁴ Each decision addressed the limits of permissible legislative interference with physician speech.⁵ These cases provide a framework for considering subsequent challenges to the constitutionality of statutes that place controls on physician speech. Section B then examines one lower federal court case decided in the wake of *Rust* and *Casey*. The case considered the constitutionality of government-imposed limits on physician speech. Part II considers the four examples described above in detail and examines the contours and implications of these statutory intrusions on clinician speech. Part III then contextualizes the laws examined in Part II in light of a wider set of social and legal shifts in assumptions about the physician-patient relationship. And Part IV categorizes the statutes reviewed in Part II in light of two intersecting categorizations that concern, respectively, the structure and the goals of each statute. It then concludes that laws controlling physician speech for ends unrelated to health care (or the public welfare more generally) are almost always a harmful usurpation of states' legislative powers.

I. Controlling Physician Speech: Judicial Responses to Laws Prohibiting or Mandating Physician Speech

This Section reviews *Rust* and *Casey*. Both cases arose within the nation's debate about abortion. Then, Section B of this Part reviews *Conant v. Walters*,⁶ a lower federal court case decided after the Supreme Court decisions in *Rust* and *Casey*. *Conant* provides a useful background to the discussion (in Part II) of California's law prohibiting therapists from treating minors with conversion therapy.

A. The Supreme Court and Physician Speech

Rust and *Casey* both occurred in the context of the nation's discourse about abortion. But the Court's decisions in these cases hold discomfoting implications for challenges to other laws involving controls on physician speech. This Section reviews these cases, considers their implications for state controls on physician speech, and notes assumptions about the physician-patient relationship that undergird the Court's approach in both cases. Although both cases can be interpreted in light of the national debate about abortion, each also offers insights into the Court's view of constitutional limits on laws that control physician speech.

³ 500 U.S. 173 (1991).

⁴ 505 U.S. 833 (1992).

⁵ See *Rust*, 500 U.S. at 177–79; *Casey*, 505 U.S. at 844.

⁶ 309 F.3d 629 (9th Cir. 2002), *cert. denied*, 540 U.S. 946 (2003).

1. *Rust v. Sullivan*

Plaintiff-petitioners in *Rust* challenged federal regulations that limited physician speech. The regulations, issued by the Department of Health and Human Services, prohibited employees of clinics supported through the so-called Title X program from providing "counseling concerning the use of abortion as a method of family planning" and from "referral for abortion as a method of family planning."⁷

Congress created Title X programs⁸ in the 1970s to offer poor women family planning services⁹ and "to decrease the number of unwanted pregnancies in the United States."¹⁰ Title X funds were not available to pay for abortions.¹¹ The regulations at issue in *Rust* were a product of the Reagan Administration's interest in restricting Title X's scope.¹² Promulgated in 1988, the regulations banned Title X clinics from providing counseling about abortion or abortion referrals.¹³ In effect, they favored childbirth and disfavored abortion.¹⁴

Petitioners in *Rust* (clinics and their physicians) challenged the regulations on several grounds.¹⁵ Petitioners' First Amendment claim is of

⁷ *Rust v. Sullivan*, 500 U.S. 173, 179 (1991) (internal quotation marks omitted). The regulation at issue in *Rust* was suspended by President Clinton who ordered HHS to repeal the funding restriction. Kristen L. Burge, Comment, *When It Rains, It Pours: A Comprehensive Analysis of the Freedom of Choice Act and Its Potential Fallout on Abortion Jurisprudence and Legislation*, 40 CUMB. L. REV. 181, 211 n.169 (2009) (citing Title X 'Gag Rule' Is Formally Repealed, 3 THE GUTTMACHER REP. ON PUB. POL'Y, no. 4, Aug. 2000, available at <http://www.guttmacher.org/pubs/tgr/03/4/gr030413.html>).

⁸ Family Planning Services and Population Research Act of 1970, 42 U.S.C. §§ 300, 300a-6 (2006).

⁹ Michael Selmi, *Remedying Societal Discrimination Through the Spending Power*, 80 N.C. L. REV. 1575, 1613-14 (2002).

¹⁰ Alexandra A.E. Shapiro, *Title X, the Abortion Debate, and the First Amendment*, 90 COLUM. L. REV. 1737, 1738 (1990).

¹¹ *Id.*; see also 42 U.S.C. § 300a-6 (prohibiting use of Title X funds in family-planning programs that provided for abortions as a means of family planning).

¹² Selmi, *supra* note 9. Earlier HHS regulations permitted Title X clinics to provide abortion referrals for patients who sought pregnancy terminations. Shapiro, *supra* note 10, at 1739 & n. 18. The 1988 regulations also rendered it virtually impossible for Title X clinics to work with private clinics that counseled patients about abortion. See 42 C.F.R. § 59.9 (1988).

¹³ Shapiro, *supra* note 10, at 1739; see also 42 C.F.R. § 59.9 (1988).

¹⁴ See Shapiro, *supra* note 10, at 1740.

¹⁵ Petitioners challenged the regulations on First Amendment and Fifth Amendment grounds as well as on statutory grounds. *New York v. Sullivan*, 889 F.2d 401, 404 (2d Cir. 1989), *aff'd sub nom. Rust v. Sullivan*, 500 U.S. 173 (1991); see also *Planned Parenthood Fed'n of Am. v. Sullivan*, 913 F.2d 1492, 1504 (10th Cir. 1990) (challenging the Title X regulations, before *Rust*, based on the First and Fifth Amendments); *Massachusetts v. Sec'y of Health &*

greatest relevance to the issues at stake in this Article. Petitioners argued that the regulations undermined First Amendment rights in that they “impermissibly discriminate[d] based on viewpoint[.]” More specifically, the regulations “prohibit[ed] all discussion about abortion as a lawful option,” and simultaneously compelled clinic counselors “to provide information that promotes continuing a pregnancy to term.”¹⁶

Rust followed two Supreme Court decisions that upheld limitations on state and federal funding for abortions.¹⁷ First, in *Maher v. Roe*, the Court validated a statutory “limitation on the authority of a state to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds.”¹⁸ Then, in *Harris v. McRae*, the Court validated the Hyde Amendment, which precluded the use of federal Medicaid funds for abortions.¹⁹ In both cases, the Court applied a rational-review test to the funding limitations.²⁰ These cases set the stage for the Court’s decision in *Rust*—that the ban on clinicians’ speech at issue in the case was simply a congressional decision not to fund communications about abortion.²¹

In short, the Court elided the First Amendment concerns raised by the petitioners by stressing that the provision of federal funding for Title X programs was a legislative decision that need not have been reached.²² That is to say, there was no obligation to fund such clinics at any point. Thus, the Court declared that the regulations did not “deny[] a benefit to anyone” but that they merely “insist[ed] that public funds be spent for the purposes for which they were authorized.”²³ Relying on *Maher*, the Court

Human Servs., 899 F.2d 53, 72 (1st Cir. 1990) (challenging the Title X regulation, before *Rust*, on First Amendment grounds).

¹⁶ *Rust v. Sullivan*, 500 U.S. 173, 192 (1991) (internal quotation marks omitted). Petitioners also argued that the regulations violated a Fifth Amendment right to choose abortion over continuation of a pregnancy. See *id.* at 201.

¹⁷ *Harris v. McCrae*, 448 U.S. 297, 297 (1980); *Maher v. Roe*, 432 U.S. 464, 466 (1977) (validating a state regulation that provided Medicaid recipients with coverage for childbirth but not for abortion).

¹⁸ 432 U.S. at 474.

¹⁹ *Harris*, 448 U.S. at 302, 316, 326–27 (noting that “regardless of whether the freedom of a woman to choose to terminate her pregnancy for health reasons lies at the core or the periphery of the due process liberty recognized in [*Roe v. Wade*], it simply does not follow that a woman’s freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices”).

²⁰ *Id.* at 324–26; *Maher*, 432 U.S. at 478–80.

²¹ See Dorothy E. Roberts, *Rust v. Sullivan and the Control of Knowledge*, 61 GEO. WASH. L. REV. 587, 589 (1993).

²² *Rust*, 500 U.S. at 191.

²³ *Id.* at 196.

concluded:

The Government can, without violating the Constitution, selectively fund a program to encourage certain activities it believes to be in the public interest, without at the same time funding an alternative program which seeks to deal with the problem in another way. In so doing, the Government has not discriminated on the basis of viewpoint; it has merely chosen to fund one activity to the exclusion of the other.²⁴

In *Rust*, the Court drew presumptively acceptable limitations on physician speech and thus facilitated legislative restrictions on doctor-patient conversation.²⁵ The presumption of neutrality is belied, however, by the consequences for poor women (for whom Title X clinics provided care)²⁶ and by the consequences for the clinician-patient relationship, more generally.²⁷

Rust relied on an unfortunate set of assumptions about the relationship between physicians and patients (or at least between physicians and the poor women who used Title X clinics). According to the Court, Title X patients were not justified in expecting "comprehensive medical advice" from physicians.²⁸ "[A] doctor's silence with regard to abortion," the Court continued, "cannot reasonably be thought to mislead a client into thinking that the doctor does not consider abortion an appropriate option for her."²⁹ That claim is challenged insofar as patients *do* look to their doctors for assistance in making medical decisions.³⁰ In sum, *Rust* extended constitutional validity to a vision of doctors and patients that does not serve either group well.³¹

²⁴ *Id.* at 193 (relying, *inter alia*, on *Maier*, 432 U.S. at 474).

²⁵ See Roberts, *supra* note 21, at 589, 593 (citing David A. Kaplan & Bob Cohn, *Take the Money and Shut Up!: The Government's New Efforts to Regulate Speech*, NEWSWEEK, Jan. 20, 1992, at 55).

²⁶ See *id.* at 593-94.

²⁷ See generally *id.* at 589.

²⁸ *Rust*, 500 U.S. at 200.

²⁹ *Id.*

³⁰ Roberts, *supra* note 21, at 600. Roberts further declared that "[t]he physician's failure to discuss abortion as a legal option is likely to lead at least some patients to conclude incorrectly that abortion is not such an option." *Id.*

³¹ See Roberts, *supra* note 21, at 604 (noting that Title X patients might have been better off without the Title X option because they might then have "managed to receive full and accurate information about abortion elsewhere"). Roberts notes that excluding people, especially powerless people, from knowledge reinforces powerlessness. See *id.* at 626.

2. *Planned Parenthood v. Casey*, Ultrasound, and Mandated Speech

Casey further undermined the possibility of robust, trusting communications between physicians and patients. *Casey* asked the Court to determine the constitutionality of a Pennsylvania mandatory speech requirement, framed as an informed-consent rule. The statutory requirement obliged physicians to offer women seeking abortions information about “the nature of the procedure, the health risks of the abortion and of childbirth, and the ‘probable gestational age of the unborn child.’”³² Additionally, the statute mandated that women seeking abortions be given materials prepared by the state that described the fetus and that presented “information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion.”³³

The *Casey* plurality grounded the validity of “viewpoint regulations” on a balance between the power of the state to regulate the practice of medicine and the right of doctors to free speech. In this balance, the state won the day because, in the Court’s view, the statute did not require doctors to make untruthful or misleading statements.³⁴ The plurality’s opinion lacked serious concern for the physician’s right to speak and for the patient’s right to know.³⁵

In *Casey*—primarily noted for testing the limits of the right to abortion, first defined in *Roe v. Wade*,³⁶ and for upending *Roe*’s trimester approach to abortion jurisprudence—the Supreme Court answered some questions about physician speech that *Rust* did not address. The consequences have not been felicitous. *Casey* provided constitutional protection for laws requiring physicians to provide patients with state-mandated information. The Court framed the only limit on such laws by noting that they could not require physicians to communicate false and misleading information to patients.³⁷ The possibility that no speech also carries a message—a possibility that may be tantamount to the communication of false and misleading information—was elided in *Casey*.

Most consequential for subsequent state efforts to control physician

³² *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 881 (1992) (plurality opinion) (quoting 18 PA. CONS. STAT. § 3205 (1990)).

³³ *Id.*

³⁴ *Id.* at 882.

³⁵ See Lauren R. Robbins, Comment, *Open Your Mouth and Say “Ideology”: Physicians and the First Amendment*, 12 U. PA. J. CONST. L. 155, 173 (2009).

³⁶ 410 U.S. 113, 164–65 (1973).

³⁷ *Casey*, 505 U.S. at 882 (plurality opinion).

speech in a wide set of contexts, *Casey* justified state interference with the physician's right to speak on the grounds that "the practice of medicine[is] subject to reasonable licensing and regulation by the State."³⁸ Such state authority could thus displace the physician's right to be free from communicating even viewpoint-based statements to patients.³⁹ As Justice Blackmun, who dissented in *Casey*, concluded, the decision represented "state medicine imposed upon the woman, not the professional medical guidance she seeks, and it officially structures—as it obviously was intended to do—the dialogue between the woman and her physician."⁴⁰ After *Casey*, the right of physicians to discuss medical matters with patients as they deem appropriate dimmed.⁴¹ And in *Casey*'s wake, Pennsylvania's informed-consent mandate became a model for legislation in other states.⁴² *Rust* and *Casey* forged a constitutional path along which states could further ideological and political ends at the expense of patients and their doctors.⁴³

B. Conant: *Speaking About Medical Marijuana*

After *Casey*, a number of federal district and circuit courts entertained challenges to state laws requiring physicians to communicate specific information to women seeking abortion.⁴⁴ This Section considers one case that involved a challenge to a state law that controlled physician speech in a controversial context, but not one involving abortion. Much as was true of *Casey* and of lower court abortion cases about physician speech that followed *Casey*, *Conant* entertained a law controlling physician speech in a context shaped by ideological disputes and fraught with emotional responses. However, *Conant* involved physician speech about medical

³⁸ *Id.* at 884.

³⁹ Paula E. Berg, *Lost in a Doctrinal Wasteland: The Exceptionalism of Doctor-Patient Speech Within the Rehnquist Court's First Amendment Jurisprudence*, 8 HEALTH MATRIX 153, 158 (1998).

⁴⁰ *Casey*, 505 U.S. at 936 (Blackmun, J., concurring in part and dissenting in part) (quoting *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 762–63 (1986)).

⁴¹ *See id.* at 884 (plurality opinion) ("To be sure, the physician's First Amendment rights not to speak are implicated . . . but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State We see no constitutional infirmity in the requirement that the physician provide the information mandated by the State here.").

⁴² Scott W. Gaylord & Thomas J. Molony, *Casey and a Woman's Right to Know: Ultrasounds, Informed Consent, and the First Amendment*, 45 CONN. L. REV. 595, 597 (2012).

⁴³ *See infra* Part II.

⁴⁴ *See, e.g., Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 576 (5th Cir. 2012) (validating informed-consent laws that "require truthful, nonmisleading, and relevant disclosures"); *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 738 (8th Cir. 2008) (striking down a preliminary injunction which prevented a state law that regulated informed consent in abortion setting from taking effect).

marijuana, not abortion.⁴⁵

Conant, decided by the Ninth Circuit, challenged a federal policy restricting physician conversations with patients. California's Compassionate Use Act (passed as a voter initiative in 1996), decriminalized the use of marijuana "for medical purposes."⁴⁶ The law protected doctors who discussed medical uses of marijuana with a patient.⁴⁷ However, the federal government imposed a policy that involved "investigating" or proceeding against physicians who recommended the use of marijuana.⁴⁸ Such physicians risked revocation of their authority to prescribe all controlled substances,⁴⁹ and for most physicians that authority is essential to practicing medicine. Individual patients and physicians as well as a patient's and a physician's organization brought suit, seeking an injunction that precluded "enforcement of the government's policy insofar as it threatened to punish physicians for communicating with their patients about the medical use of marijuana."⁵⁰

The district court enjoined the defendants from "'threatening or prosecuting physicians . . . based upon conduct relating to medical marijuana that does not rise to the level of a criminal offense.'"⁵¹ The Ninth Circuit affirmed. Its decision rested on a narrow distinction between informing a patient about marijuana's medical use and helping a patient obtain marijuana.⁵² The court stressed that the federal policy undermined "core First Amendment interests of doctors and patients" and thus an "integral component of the practice of medicine"—"communication between a doctor and a patient. Physicians must be able to speak frankly and openly to patients. That need has been recognized by courts," for

⁴⁵ See *Conant v. Walters*, 309 F.3d 629, 632 (9th Cir. 2002), *cert. denied*, 540 U.S. 946 (2003).

⁴⁶ CAL. HEALTH & SAFETY CODE § 11362.5(b)(1)(A) (West 2013). The provision further required that marijuana be used only in cases in which "use is deemed appropriate and has been recommended by a physician." *Id.*; see also Sandra H. Johnson, *Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, 53 ST. LOUIS U. L.J. 973, 1003 (2009); *Courts Protect Ninth Circuit Doctors Who Recommend Medical Marijuana Use*, 32 J.L. MED. & ETHICS 174, 174 (2004).

⁴⁷ CAL. HEALTH & SAFETY CODE § 11362.5(c). The law provided that "recommend[ing] marijuana to a patient for medical purposes" could not result in a doctor being "punished, or denied any right or privilege." *Id.*

⁴⁸ *Conant*, 309 F.3d at 636. Marijuana is a Schedule I controlled substance. See *id.* at 632.

⁴⁹ *Id.*

⁵⁰ *Id.* at 633.

⁵¹ *Id.* (quoting *Conant v. McCaffrey*, 172 F.R.D. 681, 685 (N.D. Cal. 1997)). The district court issued a temporary injunction. *Conant*, 172 F.R.D. at 682. Three years later, the injunction (with a few changes) was made permanent. See *Conant v. McCaffrey*, No. C 97-00139 WHA, 2000 WL 1281174, at *6, *16 (N.D. Cal. Sept. 7, 2000).

⁵² *Conant*, 309 F.3d at 635.

many years, “through the application of the common law doctor-patient privilege.”⁵³

In *Conant*, the Ninth Circuit distinguished both *Rust* and *Casey*. *Rust*, the court explained, did not directly validate speech restrictions because it applied only in settings dependent on *federal funding*.⁵⁴ And *Casey*, the court noted, challenged a law that did not compel doctors “to comply if they had a reasonable belief that the information would have a ‘severely adverse effect on . . . the patient,’ and thus the statute did not ‘prevent the physician from exercising his or her medical judgment.’”⁵⁵

In short, the Ninth Circuit concluded that physicians should be allowed to discuss treatment options with patients, even if those options might seem to encourage illegal conduct—in this case, the medical use of marijuana. Physicians, the court explained, must be able to have open conversations with their patients.⁵⁶ Anything else undermines the physician-patient relationship and contravenes the protections afforded by the First Amendment.⁵⁷

II. Chemicals, Guns, Abortion, and Conversion Therapy

The first three Sections of this Part offer startling illustrations⁵⁸ of efforts by state legislatures to control physician speech in the service of financial or ideological interests not directly related to patient care. The first illustration, which involves hydraulic fracturing, was primarily motivated by financial interests. The other two illustrations—involving guns and abortion—fall into an arena of public discourse with strong ideological overtones.⁵⁹

The fourth Section of this Part offers another illustration of a law arguably limiting clinician speech. The law in question, passed in California in 2012, prohibits mental health professionals from treating

⁵³ *Id.* at 636.

⁵⁴ *Id.* at 638.

⁵⁵ *Id.*

⁵⁶ *Id.* at 636.

⁵⁷ Judge Schroeder’s decision for the Ninth Circuit became the final ruling on the matter when the Supreme Court denied certiorari. See generally *id.*, cert. denied sub nom. *Walters v. Conant*, 540 U.S. 946 (2003).

⁵⁸ Weinberger, *supra* note 2, at 1557–58 (discussing these three illustrations—hydraulic fracturing, guns, and abortion—though not necessarily the particular laws discussed here).

⁵⁹ Each of these latter two sets of laws developed within and reflected the nation’s “culture wars.” The term “culture war” seems to have been used first by conservatives. See Elizabeth M. Iglesias & Francisco Valdes, *Latcrit at Five: Institutionalizing a Postsubordination Future*, 78 DENV. U. L. REV. 1249, 1277 n.77 (2001) (noting that the term “culture war” was first used by former Presidential candidate Patrick Buchanan in his remarks delivered at the 1992 Republican National Convention).

minors with conversion therapy. It offers a point of comparison for analysis of the other three laws considered here. Conversion therapy (also sometimes referred to as reparative therapy or sexual-orientation change therapy) aims to alter a person's sexual orientation. Responses to the provision have stemmed from and engendered ideological debate, but the provision differs from the first three considered here because it is supported by evidence-based research.⁶⁰

A. *Limiting Conversations About Oil and Gas: "Fracking"*⁶¹ and *Physician Speech*

This Section considers a Pennsylvania law that bans physicians from imparting certain information to patients about chemicals used in the hydraulic fracturing process. The Section begins by providing some background. It describes the character, benefits, and potential risks of the hydraulic fracturing process. Subsection 2 then reviews the statute banning physician speech.

1. The Fracking Process, Its Benefits and Risks

In the last few years, the status of energy sources in the United States has shifted dramatically.⁶² In the early twenty-first century, energy companies turned to high-pressure hydraulic fracturing (often known as "fracking" and sometimes known as "hydrofracking")⁶³ to extract natural gas from shale formations deep below the earth's surface. Although the fracking process has been used to extract natural gas since 1949,⁶⁴ the development of high-pressure technology⁶⁵ has altered the enterprise dramatically. The new technology uses far more water and chemicals than

⁶⁰ See *infra* Part II.D.

⁶¹ The term *fracking* is variously used to refer to a specific process for removing natural gas from shale rock and, sometimes, for a variety of other methods of developing oil and gas supplies. Evan J. House, *Fractured Fairytales: The Failed Social License for Unconventional Oil and Gas Development*, 13 WYO. L. REV. 5, 6–7 (2013). This Article intends the former use of the term.

⁶² David B. Spence, *Federalism, Regulatory Lags, and the Political Economy of Energy Production*, 161 U. PA. L. REV. 431, 434 (2013).

⁶³ Stephanie Karisny, Note, *Hydraulic Fracturing in Michigan: Reassessing State Regulations in Light of New Drilling in the Collingwood and Utica Shales*, 57 WAYNE L. REV. 627, 627 (2011); Ian Urbina, *Gas Swells Recycle Water, But Toxic Risks Persist*, N.Y. TIMES, Mar. 2, 2011, at A1, available at 2011 WLNR 4038197. This Article uses the term *fracking* in reference to the hydraulic fracturing process.

⁶⁴ Walter Brasch, *FRACKING: Health, Environmental Impact Greater Than Claimed*, PEDNEWS.COM (Mar. 20, 2012, 6:20 AM), <http://www.opednews.com/articles/FRACKING-Health-Environm-by-Walter-Brasch-120320-878.html> [hereinafter Brasch, *FRACKING*].

⁶⁵ *Id.*

did older technology.⁶⁶ It has also increased output: during the first decade of the twenty-first century, the production of shale gas in the United States increased about 1,300%.⁶⁷ Some analysts predict that the United States could soon become a net exporter of natural gas.⁶⁸ The financial interests for the oil and gas industry and for the nation are enormous.

Fracking now routinely relies on extremely high-pressure injections of water and chemicals into shale formations thousands of feet beneath the surface of the earth.⁶⁹ The method creates fissures in the rock with a resulting release of natural gas (methane).⁷⁰ Among the most significant shale formations in the United States are those in Texas (the Eagle Ford shale formation) and in the northeast (the Marcellus shale formation).⁷¹

Fracking has strong proponents and detractors. Supporters point to the potential for expanded U.S. energy production and the consequential benefit to the nation's economy.⁷² They note fracking's potential to decrease the cost of energy;⁷³ lower emissions of sulfur, carbon, and nitrogen;⁷⁴ and create thousands of new jobs.⁷⁵ In his State of the Union address in 2012,

⁶⁶ *Id.*

⁶⁷ See House, *supra* note 61, at 9.

⁶⁸ See, e.g., *id.* (citing U.S. ENERGY INFO. ADMIN., ANNUAL ENERGY OUTLOOK 2012: WITH PROJECTIONS TO 2035, at 3 (2012), available at [http://205.254.135.7/forecasts/aeo/pdf/0383\(2012\).pdf](http://205.254.135.7/forecasts/aeo/pdf/0383(2012).pdf)).

⁶⁹ Walter Brasch, *The American Fracking Gag on Health Care Professionals*, PACIFIC FREE PRESS, Mar. 20, 2012 [hereinafter Brasch, *Fracking Gag*], <http://www.pacificfreepress.com/opinion/11240-the-american-fracking-gag-on-health-care-professionals.html>. Brasch reports that fracking occurs at pressures as high as 15,000 pounds per square inch and that it reaches rock as much as 10,000 feet below the surface of the earth. *Id.*

⁷⁰ See *id.*

⁷¹ See Rebecca Jo Reser, *State and Federal Statutory and Regulatory Treatment of Hydraulic Fracturing*, 80 DEF. COUNS. J. 90, 93 (2013). In addition to the Eagle Ford and Marcellus formations, there are minor shale formations in a number of other states, including "Oklahoma, New Mexico, Colorado, Utah, Wyoming, Montana, North Dakota, Illinois, Indiana, Arkansas, Kansas, and Nebraska." *Id.* The Marcellus formation—the largest known shale formation in the United States—lies below Pennsylvania, Ohio, West Virginia, and New York. John Light & Julie Conley, *The Facts on Fracking*, MOYERS & COMPANY (Apr. 19, 2013), <http://billmoyers.com/content/the-facts-on-fracking/>.

⁷² See Ian Urbina, *Deadliest Danger Isn't at the Rig but on the Road*, N.Y. TIMES, May 14, 2012, http://www.nytimes.com/2012/05/15/us/for-oil-workers-deadliest-danger-is-driving.html?_r=0.

⁷³ Coal is cheaper than natural gas. However, natural gas is cheaper than oil. See Light & Conley, *supra* note 71.

⁷⁴ Spence, *supra* note 62, at 440–41; Brasch, *Fracking Gag*, *supra* note 69. More specifically, fracking lowers harmful emissions as compared with the production of oil and coal. *Id.*

⁷⁵ Brasch, *FRACKING*, *supra* note 64. A blogger (and VP at Exxon Mobil) on ExxonMobil's "Perspectives" site refers to "inaccurate accounts of natural gas production" that have "overshadowed" the facts. Ken Cohen, *Facts on the Hydraulic Fracturing Process*, EXXONMOBIL

President Obama referred to a “supply of natural gas that can last America nearly 100 years,” and added that “development of natural gas will create jobs and power trucks and factories that are cleaner and cheaper, proving that we don’t have to choose between our environment and our economy.”⁷⁶

Detractors point to significant environmental contamination and health risks for people living in communities where fracking occurs.⁷⁷ They also note the remarkable drain on water supplies.⁷⁸ Health risks include: the presence of carcinogens in some fracking fluid; the presence of arsenic, radioactive elements, and other toxins in wastewater produced by fracking; the release of methane (a greenhouse gas) into the atmosphere; the release of carbon dioxide (created in the burning of methane, another greenhouse gas); and the contamination of groundwater wells with methane or fracking fluids.⁷⁹ In 2011, the House Energy and Commerce Committee released a report on an investigation of fracking carried out between 2005 and 2009. The investigators reported that within that period, fracking operations injected over 30 million gallons of diesel products⁸⁰ into the ground.⁸¹ The consequences for sources of drinking water were unclear.

PERSPECTIVES (June 17, 2011), <http://www.exxonmobilperspectives.com/2011/06/17/facts-hydraulic-fracturing-process/>. The author of the “perspective,” Ken Cohen, is identified as “vice president of public and government affairs for Exxon Mobil Corporation.” *About Perspectives*, EXXONMOBIL PERSPECTIVES, <http://www.exxonmobilperspectives.com/about/> (last visited Mar. 1, 2014).

⁷⁶ The White House, Remarks by the President in State of the Union Address (Jan. 24, 2012), available at <http://www.whitehouse.gov/the-press-office/2012/01/24/remarks-president-state-union-address>. President Obama also called for the industry to “disclose the chemicals they use” when drilling on public land. *Id.*

⁷⁷ Spence, *supra* note 62, at 434, 440.

⁷⁸ Reser, *supra* note 71, at 95.

⁷⁹ Spence, *supra* note 62, at 440–46; Light & Conley, *supra* note 71.

⁸⁰ Fracking is not exempt from the Safe Drinking Water Act if the fluids used contain diesel. See *Energy & Commerce Committee Fracking Investigation Reveals Millions of Gallons of Diesel Fuel Injected into Ground Across U.S.*, DIANA DEGETTE (Feb. 1, 2011) [hereinafter *Fracking Investigation*], available at <http://degette.house.gov/media-center/press-releases/energy-commerce-committee-fracking-investigation-reveals-millions-of>. Companies injecting diesel fuel as part of fracking operations are required to obtain permits. The investigation reported that:

[N]o oil and gas service companies have sought—and no state and federal regulators have issued—permits for diesel fuel use in hydraulic fracturing. This appears to be a violation of the Safe Drinking Water Act. It also means that the companies injecting diesel fuel have not performed the environmental reviews required by the law.

Id.

⁸¹ *Id.*; see also Kate Sheppard, *For Pennsylvania’s Doctors, A Gag Order on Fracking Chemicals*, MOTHER JONES (Mar. 23, 2012, 2:00 AM), <http://www.motherjones.com/environment/2012/03/>

However, it seemed that none of the fracking companies involved were able to provide relevant data on the proximity of fracking operations to drinking-water sources.⁸²

At present, there are more anecdotal reports of fracking's risks to health than evidence-based studies.⁸³ Some of the scientific studies that have been conducted suggest that fracking entails worrisome health risks. One study, carried out over three years by researchers at the Colorado School of Public Health at the University of Colorado, found an increase in cancer and some other conditions (such as headaches) among people living near fracking sites.⁸⁴ Another study conducted at Duke University disputed the claim of industry representatives that chemicals injected into the ground in the course of fracking are contained by layers of rock.⁸⁵ The Duke study reported that gases and liquids injected through the fracking process may pollute water as a result of leaking wells, or even, though less likely, as the result of a flow of gas and liquids from deep underground toward the earth's surface.⁸⁶ The study noted "systematic evidence for methane contamination of drinking water associated with shale-gas extraction" in the Marcellus shale area in Pennsylvania.⁸⁷ The presence of some methane is not surprising in any aquifer. However, the researchers

fracking-doctors-gag-pennsylvania.

⁸² *Fracking Investigation*, *supra* note 80.

⁸³ See Bernard D. Goldstein et al., *Challenges of Unconventional Shale Gas Development: So What's the Rush?*, 27 NOTRE DAME J.L. ETHICS & PUB. POL'Y 149, 172–74 (2013). In 2011, gas and oil executives asserted the absence of even one reported case in which fracking resulted in the contamination of a fresh water aquifer. However, the Environmental Protection Agency has declared that contaminated wells may exist. Indeed, the agency documented the existence of one such well, but settlement of that dispute included confidentiality clauses that precluded public investigation of claims about contamination. Rhonda Wasserman, *Secret Class Action Settlements*, 31 REV. LITIG. 889, 917 & nn.136–37 (2012) (citing Ian Urbina, *A Tainted Water Well, and Concern There May Be More*, N.Y. TIMES, Aug. 4, 2011, at A13, available at 2011 WLNR 15390732).

⁸⁴ Lisa M. McKenzie et al., *Human Health Risk Assessment of Air Emissions from Development of Unconventional Natural Gas Resources*, 424 SCI. TOTAL ENV'T 79, 80, 86 (2012), available at <http://cogcc.state.co.us/library/setbackstakeholdergroup/Presentations/Health%20Risk%20Assessment%20of%20Air%20Emissions%20From%20Unconventional%20Natural%20Gas%20-%20HMcKenzie2012.pdf> (concluding that "air emissions" due to fracking "are most likely to occur" in areas near the well pads); see also Goldstein, *supra* note 83, at 174.

⁸⁵ Michael Kelley, *New Fracking Research Disputes a Fundamental Industry Claim*, BUSINESS INSIDER (July 10, 2012), <http://www.businessinsider.com/new-research-debunks-fundamental-fracking-industry-claim-2012-7>.

⁸⁶ *Id.*; see also Stephen G. Osborn et al., *Methane Contamination of Drinking Water Accompanying Gas-Well Drilling and Hydraulic Fracturing*, 108 PNAS 8172, 8172 (May 17, 2011), available at <http://www.nicholas.duke.edu/cgc/pnas2011.pdf>.

⁸⁷ Osborn, *supra* note 86.

found contamination of water *as a result of* fracking. The authors asked that more data on the quality of groundwater (preferably made available to the public)⁸⁸ be collected before any drilling begins so that “long-term monitoring of groundwater” can occur.⁸⁹ Importantly, the potential harms of fracking can appear years after exposure and can last a lifetime.⁹⁰

Current federal policy strongly favors efforts to increase the nation’s independence from other countries’ energy supplies,⁹¹ but there is little relevant federal regulation of fracking operations.⁹² The Safe Drinking Water Act (SDWA)⁹³ might protect the public from contaminated water due to fracking operations. The law aims to safeguard public drinking water⁹⁴ by protecting underground water that will be used for drinking.⁹⁵ However, the Energy Policy Act of 2005 excluded almost all fracking operations from SDWA’s purview.⁹⁶ Moreover, oil and gas waste is exempt from several other federal laws that might have regulated fracking.⁹⁷

⁸⁸ See Wasserman, *supra* note 83, at 917 (noting that the Environmental Protection Agency documented the existence of a contaminated well but settlement of the dispute included confidentiality clauses, precluding the case being made known to the public).

⁸⁹ Osborn, *supra* note 86, at 8176.

⁹⁰ Terence J. Centner, *Oversight of Shale Gas Production in the United States and the Disclosure of Toxic Substances*, 38 RESOURCES POL’Y 233, 233 (2013) (citing Theo Colborn et al., *Natural Gas Operations from a Public Health Perspective*, 17 HUM. & ECOLOGICAL RISK ASSESSMENT 1039 (2011)).

⁹¹ House, *supra* note 61, at 11 (citing Energy Independence and Security Act of 2007, Pub. L. No. 110-140, 121 Stat. 1492 (2007) (“An Act to move the United States toward greater energy independence and security.”)).

⁹² Matt Willie, Comment, *Hydraulic Fracturing and “Spotty” Regulation: Why the Federal Government Should Let States Control Unconventional Onshore Drilling*, 2011 BYU L. REV. 1743, 1751 (2011). A few federal statutes regulate some aspects of fracking. See Rebecca Jo Reser & David T. Ritter, *State and Federal Legislation and Regulation of Hydraulic Fracturing*, 57 THE ADVOC. 31, 31–33 (2011) (noting that the Safe Drinking Water Act, the Clear Water Act, and the Comprehensive Environmental Response Compensation and Liability Act (known as the “Superfund”) could have possible relevance to fracking regulation); see also Hannah Wiseman, *Untested Waters: The Rise of Hydraulic Fracturing in Oil and Gas Production and the Need to Revisit Regulation*, 20 FORDHAM ENVTL. L. REV. 115, 146 (2009) (stating that while federal statutes may apply “sporadic[ally],” states largely control fracking regulation).

⁹³ Safe Drinking Water Act, Pub. L. No. 93-523, § 2(a), 88 Stat. 1660 (1974) (codified at 42 U.S.C. §§ 300f to 300j-26 (2006)).

⁹⁴ See 42 U.S.C. §§ 300g to 300g-9 (2006).

⁹⁵ See 42 U.S.C. § 300g-1(b)(1)(A) (2006).

⁹⁶ See 42 U.S.C. § 300h(d)(1)(B)(ii) (2006); Reser & Ritter, *supra* note 92, at 32. The exclusion is sometimes known as the “Halliburton Loophole.” Sheppard, *supra* note 81.

⁹⁷ See Centner, *supra* note 90, at 235; John R. Nolon & Steven E. Gavin, *Hydrofracking: State Preemption, Local Power, and Cooperative Governance*, 63 CASE W. RES. L. REV. 995, 1001 (2013) (noting exemption of oil and gas waste from the Comprehensive Environmental Response, Compensation and Liability Act and from the Resource Conservation and Recovery Act).

In short, control over fracking has largely been left to the states.⁹⁸ Yet, only a few states have laws that regulate fracking, and only to a limited extent. Texas, for instance, passed legislation in 2011 that requires those operating fracking wells publically to post the volume of water used in the fracking process as well as certain chemicals used.⁹⁹ The provision provides for withholding information if a trade secret might be revealed.¹⁰⁰ Over a dozen other states have laws requiring some sort of disclosure of the chemicals used in fracking operations.¹⁰¹ None of these states require disclosure to the public.¹⁰²

2. Pennsylvania's Act 13

In 2012, the Pennsylvania legislature passed, and state Governor Tom Corbett signed, a law known as Act 13.¹⁰³ It replaced the state's existing oil and gas laws.¹⁰⁴ Act 13 included disclosure requirements about chemicals used in fracking, but limited their effectiveness by banning physicians from discussing information disclosed by the industry with patients who might have been sickened by the consequences of fracking operations. The law justified the ban as necessary to protect industry trade secrets and confidential proprietary information.¹⁰⁵

Two subsections within Act 13, read together, are particularly striking. They pertain to health professionals¹⁰⁶ whose care of ill patients may

⁹⁸ Wiseman, *supra* note 92.

⁹⁹ TEX. NAT. RES. CODE ANN. § 91.851(a)(1)(B) (West 2012).

¹⁰⁰ *Id.* § 91.851(a)(3); *see also infra* Part II.A.2 (questioning "trade secret" protection).

¹⁰¹ Reser, *supra* note 71, at 101.

¹⁰² *Id.* at 102. Some of the state laws require only disclosure to state agencies. *Id.*

¹⁰³ *See* Marie Cusick, *Pennsylvania Supreme Court Strikes Down Controversial Portions of Act 13*, NPR (Dec. 19, 2013, 3:41 PM), <http://stateimpact.npr.org/pennsylvania/2013/12/19/state-supreme-court-strikes-down-act-13-local-zoning-restrictions/> (noting that the Pennsylvania Supreme Court invalidated portions of Act 13 on the ground that certain local zoning restrictions violated the Pennsylvania Constitution).

¹⁰⁴ *See* 58 PA. CONS. STAT. ANN. § 3201 (West 2013); *see also* Robinson Twp. v. Pennsylvania, 52 A.3d 463, 468 (Pa. Commw. Ct. 2012). Reporting requirements are contained in section 3222, and section 3222.1 includes requirements for disclosure of hydraulic fracturing chemicals. The relevant provision is part of a broader section (termed "Hydraulic fracturing chemical disclosure requirements"). The broader section requires operators of "hydraulic fracturing of unconventional wells" to complete a "chemical disclosure registry form" that must be posted on the relevant registry. The statute specifically protects trade secrets and confidential proprietary information. § 3222.1(b)(3)–(5).

¹⁰⁵ *See* Reser, *supra* note 71, at 102.

¹⁰⁶ The statute defines "health professional" to include "[a] physician, physician assistant, nurse practitioner, registered nurse or emergency medical technician licensed by the Commonwealth." 58 PA. CONS. STAT. ANN. § 3203.

depend on knowing which chemicals are used in fracking operations and the concentration of those chemicals. The first subsection requires the following disclosures from the industry:

A vendor, service company or operator shall identify the specific identity and amount of any chemicals claimed to be a trade secret or confidential proprietary information to any health professional who requests the information in writing *if the health professional executes a confidentiality agreement* and provides a written statement of need for the information indicating all of the following:

- (i) The information is needed for the purpose of diagnosis or treatment of an individual.
- (ii) The individual being diagnosed or treated may have been exposed to a hazardous chemical.
- (iii) Knowledge of information will assist in the diagnosis or treatment of an individual.¹⁰⁷

The second subsection provides for medical emergencies:

If a health professional determines that a medical emergency exists and the specific identity and amount of any chemicals claimed to be a trade secret or confidential proprietary information are necessary for emergency treatment, the vendor, service provider or operator shall immediately disclose the information to the health professional upon a verbal acknowledgment by the health professional that the information may not be used for purposes other than the health needs asserted and that the health professional shall maintain the information as confidential. The vendor, service provider or operator may request, and the health professional shall provide upon request, a written statement of need and a confidentiality agreement from the health professional as soon as circumstances permit, in conformance with regulations promulgated under this chapter.¹⁰⁸

In sum, the provision allows health care professionals to obtain information from fracking companies if that information is needed to diagnose or treat a patient. But, in return for the information, doctors and other health care professionals are required to sign a confidentiality agreement that precludes their disclosing the information to anyone—including the patient, it would seem. This ban can interfere with patient care insofar as it restricts communications between patient and physician, and it limits a patient's knowledge of the causes of his or her condition.¹⁰⁹

¹⁰⁷ *Id.* § 3222.1(b)(10) (emphasis added).

¹⁰⁸ *Id.* § 3222.1(b)(11).

¹⁰⁹ See generally S.B. 544, 197th Gen. Assemb., Reg. Sess. (Pa. 2013) ("An Act Amending

Further, such non-disclosure agreements limit information that can reach the public about health risks to those residing near fracking sites. They also can discourage researchers interested in studying the health consequences of fracking. David Masur, Executive Director of PennEnvironment, expressed concern that doctors will avoid research in this area because of the fear that they could be sued by industry.¹¹⁰ This is especially troubling insofar as fracking can be done with less risk to public health and the environment than is now the case.¹¹¹ Safer operations depend on research and, correlatively, on public awareness of the dangers fracking now poses.

At least two legal cases have challenged the provision—*Robinson*

Title 58 (Oil and Gas) of the Pennsylvania Consolidated Statutes, in development, further providing for hydraulic fracturing chemical disclosure requirements.”). This provision allows for some disclosures precluded by the confidentiality agreements provided for in the current law. The relevant provision of the proposed statute reads:

A health professional may not disseminate the trade secret or confidential proprietary information disclosed . . . , except in the following instances:

- (i) The disclosure relates to the diagnosis or treatment of a patient and the disclosure is provided to another health professional, the patient, designee of the patient or any other person whose knowledge the health professional deems important to the diagnosis or treatment of the patient or the prevention of future health issues.

Id.

The amended provision would allow for additional disclosures, including disclosure for research and public health needs. *See id.* The bill was referred to the Environmental, Resources and Energy Committee in February of 2013. S.B. 544, 197th Gen. Assemb., Reg. Sess. (Pa. 2013) (bill tracking and history). No further action has been taken since then. *See id.*

¹¹⁰ Sheppard, *supra* note 81. PennEnvironment’s website describes the organization as “a statewide, citizen-based environmental advocacy organization.” *About PennEnvironment*, PENNENVIRONMENT, <http://www.pennenvironment.org/page/pae/about-pennenvironment> (last visited Mar. 1, 2014). In April 2013, PennEnvironment Research & Policy Center and a number of other groups delivered 100,000 signatures to the state’s government asking for a “moratorium on gas drilling in Pennsylvania” until environmental and health protections are in place. Adam Garber, *100,000 Signatures for a Moratorium on Fracking Delivered to Gov. Tom Corbett*, PENNENVIRONMENT (April 30, 2013), <http://www.pennenvironment.org/news/pae/100000-signatures-moratorium-fracking-delivered-gov-tom-corbett>. Supporters of Pennsylvania’s law focus on the disclosures that industry is required to make. Patrick Henderson, an energy executive in the office of Pennsylvania Governor Tom Corbett, framed the provision as one facilitating industry disclosures. Susan Phillips, *Lawmaker Proposes to Clarify Doctor “Gag Rule”*, STATEIMPACT PENNSYLVANIA (May 22, 2013) <http://stateimpact.npr.org/pennsylvania/2013/05/22/lawmaker-proposes-to-clarify-doctor-gag-rule/> (comment by Patrick Henderson).

¹¹¹ *See* Centner, *supra* note 90 (citing P. Aldhous, *Drilling Into the Unknown*, NEW SCIENTIST, January 28, 2012, at 8, 9, available at <http://biology.duke.edu/jackson/drilling%20into%20the%20unknown.pdf>).

*Township v. Pennsylvania*¹¹² and *Rodriguez v. Krancer*.¹¹³ *Robinson Township* was commenced by a group of plaintiffs, including municipalities and individuals.¹¹⁴ One of the plaintiffs, an Allegheny County family doctor named Mehernosh Khan, contended that the section of Act 13 that required health care professionals to sign confidentiality agreements violated the state's constitution in that it

treats the oil and gas industry differently than other industries regarding the disclosure of critical diagnostic information and as having more than a single subject in violation [of the state's constitution] because it deals with both the health care of patients and a different subject, the regulation of oil and gas operations.¹¹⁵

Dr. Kahn explained that he treats patients who may “come into contact with oil and gas operations” and that the provision limited his ability to care for those patients.¹¹⁶ Further, Dr. Khan asserted that the provision “require[d] him to disregard general ethical duties and affirmative regulatory and statutory obligations and to hide information [health care professionals] have gained solely because it was produced by an industry favored by the General Assembly.”¹¹⁷

Judge Pellegrini denied standing to Dr. Khan because he had not yet had a patient in the relevant situation. The court explained that

[U]ntil he has requested the information which he believes is needed to provide medical care to his patients and that information is not supplied or supplied with such restrictions that he is unable to provide proper medical care, the possibility that [Dr. Khan] may not have the information needed to provide care is not sufficient to give him standing.¹¹⁸

One day after Judge Pellegrini rendered his decision in *Robinson Township*, another physician, Dr. Alfonso Rodriguez, a nephrologist, filed a lawsuit similarly challenging the constitutionality of the provision in Act 13 that requires physicians to sign non-disclosure agreements before receiving information from fracking companies.¹¹⁹ Rodriguez's complaint identified § 3222.1(b)(11) as the “Medical Gag Rule” of Act 13.¹²⁰ Rodriguez,

¹¹² 52 A.3d 463 (Pa. Commw. Ct. 2012).

¹¹³ No. 3:12-cv-1458, 2013 WL 5744866 (M.D. Pa. Oct. 23, 2013).

¹¹⁴ *Robinson Twp.*, 52 A.3d at 468 & n.3.

¹¹⁵ *Id.* at 477.

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 478.

¹¹⁸ *Id.*

¹¹⁹ See Complaint at 1–3, *Rodriguez v. Krancer*, No. 3:12-CV-1458, 2013 WL 5744866 (M.D. Pa. July 27, 2013).

¹²⁰ *Id.* at 1–2; see also *Rodriguez*, 2013 WL 5744866, at *1.

seeking an injunction prohibiting enforcement of the provision, contended that “[t]he First Amendment does not permit such a gross and content-based intrusion on speech.”¹²¹ Rodriguez further asserted that the provision interfered with his ability to comply with the American Medical Association’s medical ethics rules¹²² and put his license to practice medicine at risk.¹²³

The primary justification offered for the striking limitation on health care professionals’ right to disclose information relevant to patient health is the industry’s right to protect trade secrets. Paul Rossi, the attorney for Dr. Rodriguez, debunked that interest, asserting that industry claims about trade secrets were largely bogus.¹²⁴ Rossi contended that the trade secret justification for limiting disclosures about chemicals used in fracking provided a front for another, less legitimate, concern. Industry’s real concern, he argued, was not revelation of “secret[s]” to competitors, but their revelation to the public.¹²⁵ Whether or not Rossi’s allegations are accurate, it is troubling that the Pennsylvania law lacks a process for validating “trade secret” claims.¹²⁶

An amicus brief for Dr. Rodriguez submitted to the court by

¹²¹ Complaint, *supra* note 119, at 3.

¹²² *Id.* at 10–11. The complaint alleged that the Medical Gag Rule interfered with Dr. Rodriguez’s ability to offer “competent medical care, with compassion and respect for human dignity and rights,” to “respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient,” to “continue to study, apply, and advance scientific knowledge . . . , [to] make relevant information available to patients, colleagues, and the public, [to] obtain consultation and use the talents of other health professionals when indicated,” among other matters. *Id.* at 10.

¹²³ *See id.*

¹²⁴ *See* Elizabeth Skrapits, *AG Seeks Dismissal of ‘Gag Rule’ Lawsuit*, THE CITIZENS’ VOICE (Oct. 17, 2012), <http://citizensvoice.com/news/ag-seeks-dismissal-of-gag-rule-lawsuit-1.1389165>.

¹²⁵ *Id.*

¹²⁶ In contrast, federal law delineates four requirements that must be met to sustain a “trade secret” claim about a hazardous chemical and other similar substances. *See* 42 U.S.C. § 11042(b) (2006). The four factors, in brief, are: (1) The one holding the secret has not revealed it to others (with certain exceptions); (2) no federal or state law requires revelation of the information at issue; (3) revelation of the information at issue “is likely to cause” a competitive disadvantage to its holder; and (4) “[t]he chemical identity is not readily discoverable through reverse engineering.” *Id.* at (b)(1)–(b)(4); *see also* Brief of Amici Curiae Physicians, Scientists, and Engineers for Healthy Energy and Physicians for Social Responsibility in Support of Plaintiff at 5, *Rodriguez*, 2013 WL 5744866 [hereinafter Brief of Amici Curiae].

Moreover, federal law provides that nothing in 42 U.S.C. § 11042 “shall authorize any person to withhold information which is required to be provided to a health professional, a doctor, or a nurse in accordance with section 11043 of this title.” 42 U.S.C. § 11042(e).

Physicians, Scientists, and Engineers for Healthy Energy (PSE) and Physicians for Social Responsibility (PSR) argues:

Act 13's physician gag rule interferes with PSE and PSR's ability to treat and care for patients; to advise and educate other medical professionals on possible treatment regimens; and to build a body of knowledge within the medical, public health, and broader scientific community on how to best treat exposure to these chemicals. Act 13's barriers also interfere with PSE and PSR's ability to educate citizens and policymakers on proper emergency protocols and policies for exposure to hydraulic fracturing chemicals, and on law and regulations governing the use of such chemicals.¹²⁷

Even if the industry's trade-secret claims are justifiable, the limitation on physicians' ability to discuss information about fracking chemicals with patients, patients' family members and neighbors, professional colleagues, and researchers is deeply worrisome and, from a policy perspective, should trump protection of industry's "secrets."¹²⁸ Compelling physicians to sign confidentiality agreements with industry may have serious consequences for community health in areas in which fracking operations are carried out. It stymies public health efforts by hiding information about potential threats to the public's health. And it assumes an unfortunate model of the physician's obligation to, and of the physician's relationship with, patients.

B. *Limiting Physician-Patient Conversations About Gun Ownership*

A Florida law, signed by Governor Rick Scott in 2011, offers another, equally troubling, instance of a state statute that attempted to limit open communication between physicians and patients for non-medical ends.¹²⁹ The law, invalidated by a U.S. district court in 2012,¹³⁰ prohibited physicians from seeking information about a patient's ownership of a firearm or ammunition or of such ownership by family members of a

¹²⁷ Brief of Amici Curiae, *supra* note 126, at 4.

¹²⁸ David Post noted the provision in an August 1, 2012 piece posted on the Volokh Conspiracy. David Post, *Fracking, Trade Secrets, and the First Amendment*, THE VOLOKH CONSPIRACY, Aug. 1, 2012, available at 2012 WLNR 16138125. He remarked that he could not "recall seeing anything quite like it" and then wondered if it was a product of "healthcare lobbying, or oil and gas lobbying. My guess is the latter," he surmised. "[T]he oil and gas folks are hoping this provides them some cover via the implied negative in the bill (that they don't have to give out the information except in the specified circumstances[.])." *Id.*

¹²⁹ See Act Relating to the Privacy of Firearm Owners, 2011 Fla. Sess. Law Serv. Ch. 2011-112 (West) (codified at FLA. STAT. ANN. §§ 790.338, 381.026, 456.072, 395.1055).

¹³⁰ *Wollschlaeger v. Farmer*, 880 F. Supp. 2d 1251, 1257, 1270 (S.D. Fla. 2012).

patient.¹³¹ A physician who violated the statute could have faced disciplinary action by the Florida Board of Medicine.¹³² An earlier version of the law took a much harsher form. It criminalized violation of the law and provided that a physician who asked a patient or a patient's family member about ownership of firearms or ammunition could have been penalized with as much as five years imprisonment and a fine as high as \$5 million.¹³³

There was not even the pretense that the statutory ban on physician speech served a medical end. Florida Governor Scott characterized the provision in question as a protection of Second Amendment rights.¹³⁴ "I believe," he was quoted as having said, "the citizens have a right to bear arms . . . I believe that we should be able to lead our lives without people intruding on them."¹³⁵ The irony of that statement seems to have gone unnoted.

Apparently, Florida lawmakers enacted the statute in direct response to a woman who complained that her child's physician asked about firearms in the home.¹³⁶

In recent months, there has been media attention surrounding an incident in Ocala, Florida, where, during a routine doctor's visit, a pediatrician asked a patient's mother whether there were firearms in the home. When the mother refused to answer, the doctor advised her that she had 30 days to find a new pediatrician. The doctor stated that he asked all of his patients the same question in an effort to provide safety advice in the event there was a firearm in the home. He further stated that he asked similar questions about whether there was a pool at the home,

¹³¹ FLA. STAT. ANN. § 790.338(2). The provision made an exception for "a health care practitioner or health care facility that in good faith believes that this information is relevant to the patient's medical care or safety, or the safety of others . . ." *Id.* Such exceptions are less useful than they may seem because clinicians are often unsure about the exceptions' actual reach.

¹³² See *id.* § 790.338(8); see also Curt Anderson, *Patients with Guns? Don't Ask, Doc Physicians Fight Florida Law that Limits Their Questions About Firearms*, HOUS. CHRON., July 14, 2011, at A6, available at 2012 WLNR 1396713.

¹³³ *Pediatrician's Editorial in JAMA Makes a Strong Case for Lifesaving Discussions*, STATES NEWS SERV., Dec. 21, 2012 [hereinafter *Pediatrician's Editorial*], available at <http://med.miami.edu/news/pediatricians-editorial-in-jama-makes-a-strong-case-for-lifesaving-discussi>.

¹³⁴ See Anderson, *supra* note 132.

¹³⁵ *Id.*

¹³⁶ The mother apparently claimed that after refusing to provide the pediatrician in question with information about guns in her home, the physician asked her to seek medical care elsewhere. *Id.*; see also *Wollschlaeger*, 880 F. Supp. 2d at 1256. Under the common law, physicians may refuse to continue treating a patient if they provide adequate notice, allowing the patient to find alternative care. See, e.g., *Ricks v. Budge*, 64 P.2d 208, 211-12 (Utah 1937); *Payton v. Weaver*, 131 Cal. App. 3d 38, 45 (1982).

and whether teenage drivers use their cell phone while driving for similar reasons—to give safety advice to patients. The mother, however, felt that the question invaded her privacy. This incident has led many to question whether it should be an accepted practice for a doctor to inquire about a patient's firearm ownership.¹³⁷

Soon after the law's promulgation, various physician groups as well as individual Florida physicians challenged the statute on the grounds that it violated the federal Constitution.¹³⁸ The plaintiffs asked for declaratory and injunctive relief, claiming that the law—which they termed the “Physician Gag Law”—“chill[ed] speech and would punish health care professionals simply for asking questions of, and providing information to, their patients about firearm safety.”¹³⁹ Further, plaintiffs contended that the “Physician Gag Law” violated their First and Fourteenth Amendment rights

(a) By abridging the freedom of Plaintiffs . . . to communicate with and to counsel their patients, using their best medical judgment in practicing preventive medicine, regarding minimizing the risks associated with firearms;

(b) By failing to give Plaintiffs . . . adequate notice of the conduct prohibited under the Physician Gag Law; and

(c) By abridging the freedom of Plaintiffs' and their members' patients to receive such information as part of their preventive care.¹⁴⁰

Judge Cooke,¹⁴¹ writing for the Southern District of Florida, noted that plaintiffs in the case (*Wollschlaeger v. Farmer*) provided evidence that clinicians “routinely ask and counsel patients about a number of potential health and safety risks, including household chemicals, swimming pools, drugs, alcohol, tobacco, and firearms.”¹⁴² Moreover, several professional groups, including the American Academy of Pediatrics, “recommend that

¹³⁷ REPRESENTATIVE BRODEUR, FINAL BILL ANALYSIS, CS/CS/HB 155 – PRIVACY OF FIREARM OWNERS 2 (Fla. 2011), available at www.myfloridahouse.gov/Sections/Documents/load.doc.aspx?FileName=h0155z.JDC.DOCX&DocumentType=Analysis&BillNumber=0155&Session=2011 (citing Fred Hiers, *Family and Pediatrician Tangle Over Gun Question*, OCALA STAR BANNER (July 23, 2010, 6:31 PM), <http://www.ocala.com/article/20100723/news/100729867/1402/news?p=1&tc=pg>).

¹³⁸ *Wollschlaeger*, 880 F. Supp. 2d at 1257.

¹³⁹ First Amended Complaint for Declaratory & Injunctive Relief at 1, *Wollschlaeger*, 880 F. Supp. 2d 1251 (S.D. Fla. 2011) (No. 11-CV-22026), 2011 WL 4074922.

¹⁴⁰ *Id.* at 34–35.

¹⁴¹ Given the political character of the issues at stake in this case, it is noteworthy that Judge Marcia Cooke was appointed to the federal bench by President George W. Bush. See Anderson, *supra* note 132.

¹⁴² *Wollschlaeger*, 880 F. Supp. 2d at 1257.

physicians provide counseling and anticipatory guidance on the prevention of injuries.”¹⁴³ Such counseling may include guidance on “diet, second-hand smoke, alcohol abuse, household chemicals, use of swimming pools, use of bicycle helmets, automotive safety, and firearms safety.”¹⁴⁴

The court found the state’s claimed interest in protecting the right to bear arms “rest[ed] on a legislative illusion.” The law at issue, explained Judge Cooke, did “not affect nor interfere with a patient’s right to continue to own, possess, or use firearms.”¹⁴⁵ Further, the court opined that open communication between physicians and patients is essential to health care and viewed the law under attack as an intrusion by the state into that relationship. The court concluded that the law imposed a “burden [. . . on] speech necessary to the proper practice of preventive medicine.”¹⁴⁶ Thus, the court enjoined the state from enforcing the provision.¹⁴⁷

In fact, physicians’ conversations with patients about gun ownership promote public health interests. A wide set of medical, as well as other, professional groups have suggested that physicians should hold discussions with patients about guns.¹⁴⁸ Yet, for those who favor legislation such as Florida’s Privacy of Firearm Owners Act, physicians’ conversations with patients about firearms are viewed to intrude on the public’s right to own guns.¹⁴⁹

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Id.* at 1264. Further, the court explained that the state’s assertion that the law protected privacy was belied by existing regulations and by the fact that “[i]nformation regarding firearm ownership is not sacrosanct.” *Id.* at 1265.

¹⁴⁶ *Id.* at 1265–66.

¹⁴⁷ The court enjoined enforcement of §§ 790.338(1), (2), (5), (6), and § 790.338(8) “to the extent that it provides that violation of § 790.338(1) and (2) constitute grounds for disciplinary action” as well as other relevant provisions of the law. *Wollschlaeger*, 880 F. Supp. 2d at 1270. Soon after Judge Cooke rendered her decision, the state’s Attorney General filed a notice of appeal with the Eleventh Circuit. *Florida A.G. Appeals Ruling Permanently Blocking ‘Glocks vs. Docs’ Gag Law*, STATES NEWS SERV., July 30, 2012 (available on Westlaw NewsRoom).

¹⁴⁸ Brian Falls, *Legislation Prohibiting Physicians from Asking Patients About Guns*, 39 J. PSYCHIATRY & L. 441, 450 (2011). A meta-analysis (by experts from 15 nations) reported that two interventions clearly reduce the rate of suicide. One entails limiting “lethal methods” of suicide. The other entails educating clinicians about how to identify and treat depression. *Id.* at 448. Further, Falls reported that for people not diagnosed as mentally ill, yet suicidal, the rate of suicide increases “32-33-fold” if the home contains firearms. *Id.* at 448–49.

¹⁴⁹ *Id.* at 442–43. Almost two decades ago, Congress passed a law that prevented the Centers for Disease Control and Prevention from analyzing data on gun safety. Maggie Kozel, M.D., *Putting a Gag on Doctors: The Wrong Approach for Gun Rights*, POL. DAILY BLOG, Jan. 2, 2013, available at 2013 WLNR 118206. The law was apparently passed in response to NRA lobbying. Peter Wallsten & Tom Hamburger, *NRA Fingerprints in Landmark Health-Care Law*, WASH. POST, Dec. 31, 2011, available at <http://articles.washingtonpost.com/2012-12-31>

Among the states, only Florida actually passed a law limiting physicians' conversations with patients about firearms.¹⁵⁰ But at least nine other states have entertained laws similar to that at issue in *Wollschlaeger*.¹⁵¹ Surprisingly, a provision apparently furthering gun-lobby interests made its way into the Patient Protection and Affordable Care Act (ACA).¹⁵² That provision (the "Protection of Second Amendment Gun Rights") prohibits state exchanges created pursuant to the ACA from charging different rates to gun owners and to others, and it also prohibits physicians from accessing databases containing information about the use of guns by patients.¹⁵³ The provision provides, in part:

(c) Protection of second Amendment gun rights

(1) Wellness and prevention programs—A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to—

(A) the presence or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or

(B) the lawful use, possession, or storage of a firearm or ammunition by an individual.

(2) Limitation on data collection.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall

30/politics/36678995_1_gun-violence-gun-ownership-gun-control. Others have suggested that limitations on the CDC's sponsoring research about the risk of guns in homes slanted debate about gun ownership in response to episodes of indiscriminate shootings (such as that in Newtown). *See id.* In fact, before the 1996 law that limited CDC research on guns, CDC-sponsored work about the causes of firearm violence found that gun ownership did not further the protection of those in the home but rather faced significantly higher risks of both homicide and suicide. *Id.*

¹⁵⁰ David Wahlberg, *Health Groups Oppose Bill to Ban Doctors from Asking Patients About Guns*, WIS. ST. J., June 19, 2013, available at 2013 WLNR 14927951.

¹⁵¹ Wahlberg reports that other states in which similar bills were introduced include "Alabama, Kansas, Minnesota, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, and West Virginia." *Id.*

¹⁵² Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2717 (2010), available at <http://www.ncsl.org/documents/health/ppaca-consolidated.pdf>. The provision was added to the ACA by Sen. Harry Reid (D-Nev.). Wallsten & Hamburger, *supra* note 149. Wallsten and Hamburger suggest that Reid's support of the provision was grounded on his facing a "difficult reelection campaign in 2010." *See id.* The NRA did not oppose Reid in his bid for reelection even though the group had earlier criticized his support for President Obama's nominees to the United States Supreme Court. *Id.*

¹⁵³ Dara Kam, *NRA Slipped Surprise into Health Law*, PALM BEACH POST, Jan. 24, 2013, available at 2013 WLNR 1959802.

be construed to authorize or may be used for the collection of any information relating to—

- (A) the lawful ownership or possession of a firearm or ammunition;
- (B) the lawful use of a firearm or ammunition; or
- (C) the lawful storage of a firearm or ammunition.¹⁵⁴

Physicians have worried that the provision might be interpreted to preclude conversations between them and patients about gun ownership.¹⁵⁵ In response to such concerns, President Obama offered clarifying guidance. In early 2013, the President announced executive action on a wide set of matters related to controlling gun violence.¹⁵⁶ At that time, he clarified that the ACA does not preclude physicians and other health care providers from entertaining conversations with patients about guns.¹⁵⁷ Similarly, in early 2013, the White House issued a pamphlet declaring:

Doctors and other health care providers also need to be able to ask about firearms in their patients' homes and safe storage of those firearms Some have incorrectly claimed that language in the Affordable Care Act prohibits doctors from asking their patients about guns and gun safety. Medical groups also continue to fight against state laws attempting to ban doctors from asking these questions.¹⁵⁸

¹⁵⁴ Patient Protection and Affordable Care Act § 2717.

¹⁵⁵ Kam, *supra* note 153.

¹⁵⁶ *FactChecking GOP Response to Obama Gun Plan*, FACTCHECK.ORG (Jan. 24, 2013), <http://www.factcheck.org/2013/01/factchecking-gop-response-to-obama-gun-plan/>; *HIPAA Privacy Rule and the National Instant Criminal Background Check System*, REGULATIONS.GOV (Apr. 23, 2013), <http://www.regulations.gov/#!documentDetail;D=HHS-OCR-2013-0002-0001>.

¹⁵⁷ Kam, *supra* note 153; *List: Obama's 23 Executive Actions on Gun Violence*, WASH. WIRE, (Jan. 16, 2013, 12:23 PM), <http://blogs.wsj.com/washwire/2013/01/16/list-obamas-23-executive-actions-on-gun-violence/>; Matt MacBradaigh, *Obama Gun Control Speech: His 23 Executive Orders Won't Accomplish Much*, POLICYMIC (Jan. 16, 2013), <http://www.policymic.com/article/s/23437/obama-gun-control-speech-his-23-executive-orders-won-t-accomplish-much>.

¹⁵⁸ NOW IS THE TIME: THE PRESIDENT'S PLAN TO PROTECT OUR CHILDREN AND OUR COMMUNITIES BY REDUCING GUN VIOLENCE 9 (2013), available at http://www.whitehouse.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf. Further, the Center for Consumer Information and Insurance Oversight has posted responses to Frequently Asked Questions offered by the Department of Health and Human Services, among others. Ctr. for Consumer Info. & Ins. Oversight, *Affordable Care Act Implementation FAQs—Set 11*, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html (last visited Jan. 14, 2014). The other Departments offering answers to relevant FAQs are the Departments of Labor and Treasury. *Id.* The Center offered this response to a question about the effects of Public Health Service Act, § 2717(c), on conversations between patients and providers about firearms or ammunition:

Yet, the provision remains part of the ACA, and despite reassurances from the Obama administration, it may continue to worry clinicians concerned about permissible collection and uses of information about firearms possessed by patients.¹⁵⁹

Responses to Obama's executive action suggest the politicized character of the issue. Some commentators, apparently misunderstanding Obama's announcement, claimed that he had ordered physicians to talk to patients and get information from them about gun ownership. For example, one blogger for the Health Care Blog, asked about "mandating doctors to ask patients about gun possession[.] You can count me out on that one. This is an invasion of privacy, and worse, will do nothing to curtail the periodic catastrophe that occurred at Sandy Hook."¹⁶⁰ And in a more inflammatory vein, the *Drudge Report* presented a graphic on its website after Obama announced his response to the ACA provision providing "Second Amendment gun rights." It read: "War on Crazy: Obama Deputizes Doctors."¹⁶¹

The next Section considers another type of state law controlling physician speech that has also aroused intense responses from the public. It differs from the two sets of laws examined above in that it does not ban physician speech. Rather, it requires physicians to include government-mandated information in their conversations with patients.

C. Mandating Physician Speech: Information About Fetuses

As of January 2014, twenty-two states had laws regulating the use of ultrasound by abortion providers.¹⁶² Some required providers to perform ultrasounds and mandated further that the provider show, offer to show,

While we have yet to issue guidance on this provision, the statute prohibits an organization operating a wellness or health promotion program from requiring the disclosure of information relating to certain information concerning firearms. However, nothing in this section prohibits or otherwise limits communication between health care professionals and their patients, including communications about firearms. Health care providers can play an important role in promoting gun safety.

Id.

¹⁵⁹ See Wallsten & Hamburger, *supra* note 149.

¹⁶⁰ David Mokotoff, MD, *Lawyers, Guns and Doctors*, THE HEALTH CARE BLOG (Jan. 25, 2013), <http://thehealthcareblog.com/blog/2013/01/25/lawyers-guns-and-doctors/>.

¹⁶¹ Sergio Munoz, *Drudge and Limbaugh Misrepresent What Obama and the Affordable Care Act Say About Doctors and Guns*, MEDIA MATTERS FOR AM. (Jan. 16, 2013), <http://mediamatters.org/blog/2013/01/16/drudge-and-limbaugh-misrepresent-what-obama-and/192286>.

¹⁶² GUTTMACHER INST., STATE POLICIES IN BRIEF: REQUIREMENTS FOR ULTRASOUND (2014), available at http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf.

and/or describe the fetal ultrasound images to the pregnant woman.¹⁶³ Such laws seem to have been inspired by discourse about abortion more than by concern for the physician-patient relationship or for the quality of medical care offered by abortion providers.¹⁶⁴ More specifically, laws mandating pre-abortion ultrasonography for non-medical purposes were developed in an effort to discourage abortion, not to further the health of pregnant women and not to encourage trusting clinician-patient relationships.¹⁶⁵ The consequences of these laws for patients, physicians, the physician-patient relationship, and even, sometimes, for the quality of health care can be far-reaching. But states that have passed such a law apparently viewed those consequences as essentially incidental to the law's primary thrust—to limit the reach of judicial decisions that have preserved a right to abortion.¹⁶⁶

A law promulgated in Oklahoma in 2010 is especially striking in its readiness to undermine the doctor-patient relationship and even to restrict good medical care in order to further an anti-abortion agenda.¹⁶⁷ The law, enjoined by Oklahoma's highest court in 2012,¹⁶⁸ required Oklahoma abortion providers to perform an ultrasound before doing an abortion.¹⁶⁹ The provider was not given the option of choosing between methods of ultrasonography in light of the medical issues at stake. Rather, the statute mandated that the provider choose between a vaginal or an abdominal transducer, depending not on the needs of the patient, but on an assessment of which technique would likely provide a "clear[er]" image of the fetus or embryo.¹⁷⁰ The requirement did not provide for conformity

¹⁶³ *Id.*

¹⁶⁴ See Sue H. Abreu, Note, *The Doctor's Dilemma With the Oklahoma Abortion Law Ultrasound Requirement*, 37 OKLA. CITY U. L. REV. 253, 277 (2012).

¹⁶⁵ For those believing that personhood begins at conception, laws that discourage abortion are viewed as furthering health, though not of the pregnant woman. See CHRISTOPHER KACZOR, *THE ETHICS OF ABORTION: WOMEN'S RIGHTS, HUMAN LIFE, AND THE QUESTION OF JUSTICE* 91–120 (2010) (offering secular argument that personhood begins at conception); *When Does Human Personhood Begin?: Belief 1: It Happens at Conception*, RELIGIoustOLERANCE, http://www.religioustolerance.org/abo_when4.htm (last visited Jan. 14, 2014).

¹⁶⁶ Maya Manian, *Lessons from Personhood's Defeat: Abortion Restrictions and Side Effects on Women's Health*, 74 OHIO ST. L.J. 75, 77 (2013).

¹⁶⁷ See OKLA. STAT. ANN. tit. 63, §§ 1-730–741.12 (West 2013). In *Nova Health Sys. v. Pruitt*, Oklahoma's highest court affirmed a state district court's decision to enjoin the statute's enforcement permanently. 292 P.3d 28 (2012). The governor vetoed the bill, but the state legislature overrode that veto. 2010 Okla. Sess. Laws ch. 173 (H.B. 2870) (West). The only exception in the statute's mandate is that of a medical emergency. OKLA. STAT. ANN. tit. 63, § 1-738.3d(D) (excluding a psychological condition); *id.* § 1-738.1(A)(5).

¹⁶⁸ *Pruitt*, 292 P.3d at 29.

¹⁶⁹ OKLA. STAT. ANN. tit. 63, § 1-738(3)(d).

¹⁷⁰ *Id.* § 1-738(3)(d)(B)(1). In cases in which the law would call for a vaginal transducer, the

with medical standards.¹⁷¹ Further, the law required the physician (or other health care provider carrying out the procedure) to “[p]rovide a medical description of the ultrasound images, which shall include the dimensions of the embryo or fetus, the presence of cardiac activity, if present and viewable, and the presence of external members and internal organs, if present and viewable.”¹⁷²

Nova Health Systems, the Oklahoma Coalition for Reproductive Justice, and a physician who provided abortions asked a state trial court to enjoin the law’s enforcement, contending that the law violated several provisions of the Oklahoma Constitution.¹⁷³ The state trial court agreed and enjoined enforcement of the law.¹⁷⁴ Oklahoma’s highest court affirmed.¹⁷⁵

method could have imposed a real burden on at least some patients, especially those who objected to the technique. Use of a vaginal transducer may be “an intrusive procedure because of the need to introduce the probe into the vagina. Such a vaginal intrusion may be unpleasant or disturbing to some women.” Abreu, *supra* note 164, at 263. Moreover, the vaginal method does not always offer a patient the best care from a medical perspective. In the view of Sue Abreu, herself a medical doctor as well as an attorney, “no physician would recommend the [vaginal] procedure unless the procedure were clearly necessary.” *Id.* at 264. She asserts that even the basic ultrasound examination (however conducted) is not always medically necessary before an abortion. However, even in cases in which ultrasound is indicated, the type of transducer used should follow from “clinical judgment,” not from a law aimed at convincing a woman to abandon her plan to terminate her pregnancy. *Id.* at 263.

¹⁷¹ Abreu, *supra* note 164, at 267–68. Dr. Abreu suggested that the statute was probably void for vagueness on the basis of the “clear[ness]” requirement. *Id.* at Part VI.A.

¹⁷² OKLA. STAT. ANN. tit. 63, § 1-738.3d. Although prosecution pursuant to the law would have been unlikely, the penalties, should prosecution have occurred, were heavy. A physician found to disobey the law could have been subjected to disciplinary action from the state medical board or found guilty of a felony with a possible prison sentence and fine. *Id.* § 1-738.5(D); OKLA. STAT. ANN. tit. 21, § 9 (West 2013); *see also* Abreu, *supra* note 164, at 255.

¹⁷³ Petition for Writ of Certiorari, Brief in Opposition at 8, *Pruitt v. Nova Health Systems*, 292 P.3d 28 (Okla. 2012) (No. 12-1170), 2013 WL 2428980.

¹⁷⁴ *Id.* at 9.

¹⁷⁵ *Pruitt*, 292 P.3d at 28–29 (citing *Planned Parenthood v. Casey*, 505 U.S. 833 (1992)). The court in *Pruitt* did not explain its conclusion that the “matter is controlled by the United States Supreme Court decision in *Planned Parenthood v. Casey* . . .” *See id.* In March 2013, Oklahoma petitioned the United States Supreme Court to grant a writ of certiorari. Petition for Writ of Certiorari at 36, *Pruitt*, 292 P.3d 28 (No. 12-1170), 2013 WL 1225690. Petitioners urged the Court to hear the case because, among other things, ultrasound statutes of the sort at issue provide women seeking to abort pregnancies with essential information. *See id.* at 35. That information was presumably understood as encouraging many women to proceed with the pregnancy rather than terminate it. *Id.* at 8 (noting that “[t]he record . . . shows that for many women, actually seeing the ultrasound images has a necessary and critical impact in their decision-making process as to whether to terminate or continue their pregnancy to term” and noting a significant increase in percent of women viewing ultrasounds who chose to continue, rather than terminate their pregnancies).

The political and ideological underpinnings of Oklahoma's ultrasound requirements are framed powerfully through reference to another law passed at the same time.¹⁷⁶ Maya Manian compares the two laws:

On the same day that Oklahoma passed legislation mandating that abortion patients undergo a forced ultrasound, it also passed a law protecting from tort liability physicians who fail to disclose fetal anomalies to prenatal patients. In other words, Oklahoma law forces unwanted information on some pregnant patients, while at the same time empowering physicians to conceal wanted information from others. . . . Proponents of [the liability-preclusion] law claim that precluding liability for doctors who fail to reveal material information that they otherwise would have a duty to disclose under standard principles of informed consent only thwarts women who would seek an abortion if they knew of a fetal anomaly.¹⁷⁷

Reading the two laws together renders the ideological aims of each of the laws transparent.

Oklahoma's law mandating physician speech and particular medical procedures (whether or not indicated medically) for women seeking abortions as well as similar laws in other states¹⁷⁸ do not advance patient care. Rather, they aim to discourage abortion.¹⁷⁹ And in that, a value-laden system of belief can trump good health care.

D. *Conversion Therapy*: Welch v. Brown¹⁸⁰ and Pickup v. Brown¹⁸¹

California's SB 1172 resembles laws considered in the first three Sections of this Part. But it differs from them in an essential regard: it is grounded in evidence-based research and thus serves the public's health and welfare. The law, passed by the state's legislature in 2012, prohibits mental health professionals from offering therapy aimed at changing

¹⁷⁶ Act of Apr. 22, 2010, ch. 173, 2010 Okla. Sess. Laws 598; Act of Apr. 22, 2010, ch. 171, 2010 Okla. Sess. Laws 593; see also Maya Manian, *Lessons from Personhood's Defeat: Abortion Restrictions and Side Effects on Women's Health*, 74 OHIO ST. L.J. 75, 104 (2013) (comparing the two laws).

¹⁷⁷ Manian, *supra* note 176, at 104–05.

¹⁷⁸ GUTTMACHER INST., *supra* note 162, at 1–2. By early June 2013, two states, Louisiana and Texas, had laws resembling the law enjoined in Oklahoma. *Id.* Seven additional states mandated ultrasonography before an abortion and mandated the abortion provider to inform the patient that she could view the fetal images. *Id.* The seven states are Alabama, Arizona, Florida, Indiana, Kansas, Mississippi, and Virginia. *Id.*

¹⁷⁹ See *id.* at 1 (noting that ultrasonography is not routinely recommended for an abortion during the first trimester of pregnancy and it is expensive).

¹⁸⁰ Welch v. Brown, 907 F. Supp. 2d 1102, 1102 (E.D. Cal. 2012).

¹⁸¹ Pickup v. Brown, 728 F.3d 1042, 1048 (9th Cir. 2013).

sexual orientation to people under eighteen.¹⁸² It was the first of its ilk in the United States. (In 2013, a similar bill became law in New Jersey.)¹⁸³ Two cases—*Welch v. Brown* and *Pickup v. Brown*—challenged the constitutionality of California’s SB 1172.

The type of therapy SB 1172 bans is known variously as “conversion therapy,” “reparative therapy,” and “sexual orientation change efforts” (SOCE).¹⁸⁴ The law subjects mental health providers who offer the therapy in question to minors to disciplinary proceedings by the relevant licensing authority.¹⁸⁵ As was true of the other statutes considered in this Part, the implications of SB 1172 extend beyond the permissibility of controls on clinicians’ speech. Responses to SB 1172 touch on a wide set of controversies that broadly marked the American culture wars¹⁸⁶ during the last several decades. Among other things, the law implicates views of family, gender, sexuality, and religious belief.

However, unlike laws prohibiting physician speech about guns, chemicals used in fracking, and fetal images, SB 1172 reflects sound science. California’s legislature expressly promulgated the statute in order to protect lesbian, gay, bisexual, and transgender (LGBT) minors from

¹⁸² *Id.* at 1058. The law prohibits mental health providers from “engag[ing] in sexual orientation change efforts with a patient under eighteen years of age,” without exception. *Id.*

¹⁸³ See N.J. STAT. ANN. § 45:11-55 (WEST 2013); see also Cheryl Wetzstein, *N.J. Moves to End Gay ‘Change’ Therapies for Youth*, WASH. TIMES (June 27, 2013), <http://www.washingtontimes.com/news/2013/jun/27/nj-moves-to-end-gay-change-therapies-for-youths/>. Governor Christie signed the bill in August 2013. Tina Susman, *Chris Christie Signs N.J. Bill Banning Gay Conversion Therapy*, L.A. TIMES, (Aug. 19, 2013), <http://articles.latimes.com/2013/aug/19/nation/la-na-nn-chris-christie-gay-conversion-20130819>. The New Jersey statute, “virtually identical” to the California law, was also challenged by practitioners who claimed that the law violated their rights to free speech under the First Amendment. *King v. Christie*, No. 13–5038, 2013 WL 5970343, at *1, *13 n.18 (D. N.J. Nov. 8, 2013); see also *infra* notes 218, 220.

¹⁸⁴ Chana Wilson, *Gay Conversion Therapy Is Not Free Speech*, HUFF. POST (Apr. 16, 2013), http://www.huffingtonpost.com/chana-wilson/hay-conversion-therapy-is-not-free-speech_b_3087980.html. Conversion therapy can include a variety of techniques including “behavioral therapy, electrical shock therapy, chemical aversive therapy [including drugs to induce vomiting], drug and hormone therapy, subliminal therapies designed to inculcate ‘feminine’ or ‘masculine’ behavior, and ‘covert desensitization’ therapies that teach a young person to associate homosexual feelings with disgusting images.” Tyler Talbot, *Reparative Therapy for Homosexual Teens: The Choice of the Teen Should Be the Only Choice Discussed*, 27 J. JUV. L. 33, 40 (2006) (citing John Alan Cohan, *Parental Duties and the Right of Homosexual Minors to Refuse “Reparative” Therapy*, 11 BUFF. WOMEN’S L.J. 67, 76 (2004)).

¹⁸⁵ *Welch*, 907 F. Supp. 2d at 1105–06.

¹⁸⁶ Cf. Dustin Racioppi, *Gay Conversion Therapy Sparks Culture War in N.J.*, USA TODAY (Mar. 31, 2013, 12:52 AM), <http://www.usatoday.com/story/news/nation/2013/03/31/gay-conversion-therapy-culture-war/2038981/>.

"sham therapies."¹⁸⁷ In 1973, the American Psychological Association removed homosexuality from the list of mental disorders included in the Diagnostic and Statistical Manual of Mental Disorders.¹⁸⁸ And a review of the literature on conversion therapy includes no "conclusive evidence" that the therapy benefits patients.¹⁸⁹ In fact, studies that have claimed success have often reported clients' increased capacity to control same-gender behavior, but not shifts in sexual orientation.¹⁹⁰ Such "successfully" treated patients continue to feel attracted to same-gender partners but remain celibate.¹⁹¹ Many of those supporting SB 1172 have concluded that conversion therapy is not merely ineffective: it harms youth subjected to it by treating them as abnormal.¹⁹² A review of the relevant literature by Laura Hein and Alicia Matthews lists a variety of reported harms among those treated with conversion therapy, including anxiety, depression, "avoidance of intimacy or sexual dysfunction," "post-traumatic stress disorder," demasculinization (for male patients), "lack of self-confidence and self-efficacy," shame or guilt, and "suicidality."¹⁹³ In short, conversion therapy stigmatizes an unchangeable condition in the LGBT community, generally.¹⁹⁴

This notwithstanding, therapists, minors, and parents challenged the California law in two cases, arguing that it violated free speech and freedom of religion, and that it intruded on the clinician-patient relationship and parental rights.¹⁹⁵ The claims resemble those made by

¹⁸⁷ *Pickup*, 728 F.3d at 1048; see *Welch*, 907 F. Supp. 2d at 1105–06.

¹⁸⁸ Kenji Yoshino, *Covering*, 111 YALE L.J. 769, 798 (2002).

¹⁸⁹ Laura C. Hein & Alicia K. Matthews, *Reparative Therapy: The Adolescent, the Psych Nurse, and the Issues*, 23 J. CHILD & ADOLESCENT PSYCHIATRIC NURSING 29, 31 (2010).

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² Wilson, *supra* note 184 ("[The] national mental health organizations of psychologists, psychiatrists, social workers and marriage and family therapists, as well as the American Academy of Pediatrics, have all concluded that efforts to change sexual orientation are both ineffective and harmful. Such treatments can result in anxiety, hopelessness, self-hatred, isolation, increased substance abuse, grief, guilt and suicide.").

¹⁹³ See Hein & Matthews, *supra* note 189, at 32 (citing several relevant studies in connection with each of the adverse sequelae of conversion therapy noted).

¹⁹⁴ Christopher J. Ferguson, *Gay 'Cures' Don't Work But Banning Them Helps Nobody*, 2888 NEW SCIENTIST 24, 24–25 (Oct. 29, 2012), available at <http://www.newscientist.com/article/mg21628880.200-gay-cures-dont-work-but-banning-them-helps-nobody.html#.UspL6GRDukY>.

¹⁹⁵ A spokesperson for the Pacific Justice Institute (representing clients in one of the cases) explained: "[T]he law 'is a clear violation of the freedom of speech, free exercise of religion, the counselor-client patient privilege, and parental rights.'" Cheryl Wetzstein, *Law on Sex Orientation Therapy for Youth Heads to Court*, WASH. TIMES (Apr. 15, 2013), <http://www.washingtontimes.com/news/2013/apr/15/law-on-sex-orientation-therapy-for-youths-heads->

opponents of other laws controlling physician speech.¹⁹⁶ Plaintiffs in one of the challenges to SB 1172—*Welch v. Brown*—included a therapist, a physician, a psychologist, and “an adult who had had same-sex attractions.”¹⁹⁷ In *Welch*, the district court granted plaintiffs’ motion for a preliminary injunction:

Because the court finds that SB 1172 is subject to strict scrutiny and is unlikely to satisfy this standard, the court finds that plaintiffs are likely to succeed on the merits of their 42 U.S.C. § 1983 claims based on violations of their rights to freedom of speech under the First Amendment. Because plaintiffs have also shown that they are likely to suffer irreparable harm in the absence of an injunction, that the balance of equities tips in their favor, and that an injunction is in the public interest, the court grants plaintiffs’ motion for a preliminary injunction.¹⁹⁸

The *Welch* court concluded that “at least some forms of [conversion therapy, referred to by the court as SOCE,] . . . involve speech.”¹⁹⁹ The court explained that “even if SB 1172 is characterized as primarily aimed at regulating conduct, it also extends to forms of SOCE that utilize speech.”²⁰⁰ As a result, the court concluded, assessing the constitutionality of SB 1172 demanded strict scrutiny review because the law was not “content- and viewpoint-neutral.”²⁰¹

In the second challenge to SB 1172—*Pickup v. Brown*—a federal district court in California denied plaintiffs’ request to enjoin the law.²⁰² Plaintiffs in *Pickup* grounded their motion for an injunction on the First and Fourteenth Amendments.²⁰³ Their First Amendment claims²⁰⁴ are most relevant to this Article and will thus be reviewed insofar as they address the limits of state controls on clinician speech.²⁰⁵ In addressing those claims,

to/?page=all (quoting Brad Dacus, President of the Pacific Justice Institute).

¹⁹⁶ See *supra* Part II.A–C.

¹⁹⁷ 907 F. Supp. 2d 1102, 1106 (E.D. Cal. 2012).

¹⁹⁸ *Id.* at 1105.

¹⁹⁹ *Id.* at 1112.

²⁰⁰ *Id.*

²⁰¹ See *id.* at 1117. The court explained that it would be “hard-pressed” to see the law as content- and viewpoint-neutral. *Id.*

²⁰² *Pickup v. Brown*, No. 2:12-CV-02497-KJM-EFB, 2012 WL 6021465, at *26 (E.D. Cal. Dec. 4, 2012).

²⁰³ *Id.* at *21–22.

²⁰⁴ The court summarized the free speech claim with three separate arguments: SB 1172 violates plaintiff therapists’ rights by discriminating based on viewpoint and/or content; SB 1172 violates plaintiff minors’ rights to receive information; and SB 1172 is unconstitutionally vague. *Id.* at *22.

²⁰⁵ Plaintiffs’ Fourteenth Amendment claim concerned the statute’s putative interference with the right of parents to raise their children as they deem appropriate. *Id.* at *16–17.

district court Judge Mueller differentiated between “content” and “viewpoint” discrimination: the first “occurs when the government chooses the subjects that may be discussed,” and the second occurs “when the government prohibits speech by particular speakers, thereby suppressing a particular view about a subject.”²⁰⁶ *Conant v. Walters*, described above, offered an interesting precedent from the same circuit.²⁰⁷ Yet, Judge Mueller distinguished²⁰⁸ *Conant* because the law at issue there provided for disciplining a physician on the basis of speech alone while that at issue in *Pickup* did not preclude “the mention of SOCE or a referral to a religious counselor or out-of-state practitioner.”²⁰⁹

Judge Mueller further concluded that plaintiffs, in the nature of the case, were not likely to succeed with the claim that SOCE constituted speech.²¹⁰ Stringent levels of review were thus deemed unnecessary, and the court found a rational relation between SB 1172 and “a legitimate state interest.”²¹¹ Among possible justifications for the law, the court specifically noted protection of minors from “a therapeutic practice deemed unproven and potentially harmful.”²¹² Thus, the district court in *Pickup* denied the plaintiffs’ motion to enjoin SB 1172 from taking effect.

Defendants in *Welch* and plaintiffs in *Pickup* appealed to the Ninth Circuit.²¹³ That court rejected each of the plaintiffs’ constitutional challenges to SB 1172. More specifically, Judge Graber, writing for the Ninth Circuit, concluded that “SB 1172, as a regulation of professional conduct, does not violate the free speech rights of SOCE practitioners or minor patients, is neither vague nor overbroad, and does not violate parents’ fundamental rights.”²¹⁴ Of central importance, the court categorized SB 1172 “as a regulation of professional conduct.”²¹⁵ The Ninth

²⁰⁶ *Id.* at *24.

²⁰⁷ See *supra* Part I.B.

²⁰⁸ See *Pickup*, 2012 WL 6021465, at *27–29. The court also distinguished *Wollschlaegger v. Farmer*, 880 F. Supp. 2d 1251 (S.D. Fla. 2012). *Wollschlaegger* is considered *supra*, notes 130–47.

²⁰⁹ *Pickup*, 2012 WL 6021465, at *28–29.

²¹⁰ *Id.* at *10–11 (citing *O’Brien v. U.S. Dep’t of Health & Human Servs.*, 894 F. Supp. 2d 1149 (E.D. Mo. 2012)).

²¹¹ *Id.* at *26. The court wrote: “The court need not engage in an exercise of legislative mind reading to find the California Legislature and the state’s Governor could have had a legitimate reason for enacting SB 1172.” *Id.*

²¹² *Id.* Further, the court characterized this interest as more than “legitimate.” *Id.*

²¹³ *Pickup v. Brown*, No. 2:12-CV-02497-KJM-EFB, 2013 WL 411474, at *1 (E.D. Cal. Jan. 29, 2013). However, the court stayed its order in the case pending the outcome of an appeal to the circuit court. *Id.*

²¹⁴ *Pickup v. Brown*, 728 F.3d 1042, 1048 (9th Cir. 2013), *superseded by*, 740 F.3d 1208 (9th Cir. 2013).

²¹⁵ *Id.*

Circuit stressed that SB 1172 did not prohibit mental health providers from talking about SOCE, “expressing their views to patients,” regardless of age, recommending the therapy, providing the therapy to adults, or “referring minors to unlicensed counselors, such as religious leaders.” And it did not prevent such unlicensed providers from offering SOCE to minors and adults, nor did it prevent minors from seeking the therapy outside California.²¹⁶ The court also noted that “within the confines of a professional relationship, First Amendment protection of a professional’s speech is somewhat diminished.”²¹⁷ But careful attention to that matter was elided by the conclusion that SB 1172 regulated “professional conduct,” and that any effect on speech was deemed “incidental.”²¹⁸ The Ninth Circuit explained:

Senate Bill 1172 regulates conduct. It bans a form of medical treatment for minors; it does nothing to prevent licensed therapists from discussing the pros and cons of SOCE with their patients. Senate Bill 1172 merely prohibits licensed mental health providers from engaging in SOCE with minors. It is the limited reach of SB 1172 that distinguished the present case from *Conant v. Walters* in which the government’s policy prohibited speech wholly apart from the actual provision of treatment.²¹⁹

Thus defined as conduct, not speech, SB 1172 survived constitutional challenge. The court found a “rational relationship” between the bill and a “legitimate state interest”—safeguarding the welfare of “lesbian, gay, bisexual and transgender youth” from harm that might be caused by

²¹⁶ *Id.* at 1049–50.

²¹⁷ *Id.* at 1054.

²¹⁸ See *id.* at 1055. Relying on the Ninth Circuit’s reasoning in *Pickup*, the federal court in New Jersey reached the same conclusion with respect to the New Jersey law, described by the court as “virtually identical” to the California’ SB 1172. See *King v. Christie*, No. 13–5038, 2013 WL 5970343, at *11, *13 n.18 (D. N.J. Nov. 8, 2013) (“[T]he *Pickup* panel’s explanation of the reach of the California law applies with equal force to [the New Jersey law], given the statutes’ similarities.”). Writing for the New Jersey court, Judge Wolfson determined that the New Jersey law does not “prevent[] licensed professionals from voicing their opinions on the appropriateness or efficacy of SOCE, either in public or private setting.” *Id.* Rather, Judge Wolfson wrote, “the statute only prohibits a licensed professional from engaging in counseling for the purpose of actually practicing SOCE.” *Id.* In fact, Judge Wolfson seemed to go beyond the Ninth Circuit in his conclusion that “no speech or expressive conduct is incidentally burdened by [the New Jersey statute’s] prohibition.” *Id.* at *21.

²¹⁹ *Pickup*, 728 F.3d at 1055. The court further rejected the plaintiffs’ argument in *Pickup* that SB 1172 interfered with their First Amendment right to freedom of association, *id.* at 1057, and it rejected the argument that SB 1172 was unconstitutionally vague, *id.* at 1058, and that it was overbroad, *id.* at 1059. Finally, the court opined that SB 1172 did not interfere with a parent’s right to make medical choices for his or her children. *Id.* at 1060–61.

efforts to alter their sexual and gender orientation.²²⁰

Most recently, the Ninth Circuit denied appellants' request for a rehearing en banc²²¹ but agreed to stay its mandate for 90 days in light of appellants' intention to petition to the United States Supreme Court for a writ of certiorari.²²² In seeking the stay, appellants explained that their petition to the Court would "argue that the panel's decision departs from substantial Supreme Court precedent on professional speech and parental rights and from this Circuit's previous decisions in similar cases."²²³

III. Contextualizing Laws That Control Physician Speech

The four types of laws considered in Part II involve state control over communications between physicians and patients.²²⁴ This Part begins by contextualizing such laws within the shifting social and economic contours of medicine within the last half century. It then reviews three sets of relevant developments (two legal, one commercial) that, taken as a group, offer a useful social and historical perspective on laws that intrude upon physician-patient relationships. Section A summarizes shifts in the social and economic contours of American medicine since the last decades of the twentieth century. Section B illustrates the shift through reference to the development of the informed-consent doctrine. Section C then considers the appearance of "gag" orders in physicians' contracts with managed care companies at the end of the twentieth century. Now mostly banned by state statutes, these gag orders involved direct limitations on physician speech that were imposed by industry. Finally, Section D reviews a set of public health laws that require physicians to report otherwise confidential

²²⁰ *Id.* at 1056–57. The court declined to consider whether it would have been a "rational" exercise of legislative lawmaking had the state's legislature banned SOCE for adults. *Id.* at 1057 n.8.

Similar to the Ninth Circuit's decision in *Pickup*, Judge Wolfson in New Jersey found that the New Jersey statute is "rationally related" to the state's interest in "protecting minors from professional counseling it deems harmful." *King*, 2013 WL 5970343, at *20–21.

²²¹ *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2013) (amended decision published on Jan. 29, 2014 to reflect the order denying the petition for a rehearing en banc).

²²² Order, *Pickup*, 740 F.3d 1208 (9th Cir. 2013) (No. 12-17681), available at http://cdn.ca9.uscourts.gov/datastore/general/2014/02/03/12-17681_order_staying_mandate.pdf (order of stay filed on Feb. 3, 2014).

²²³ Motion to Stay the Mandate Pending Resolution of Petition for Certiorari, *Pickup*, 740 F.3d 1208 (9th Cir. 2013) (No. 12-17681), available at http://cdn.ca9.uscourts.gov/datastore/general/2014/01/31/12-17681_Stay_Mandate_motion.pdf (motion filed on Jan. 31, 2014).

²²⁴ See *supra* Part II. The laws at issue in Part II control the speech of a variety of health care professionals. This Article focuses on physician speech. However, much of what is said about physician speech in Part III is also relevant to controls on the speech of other licensed health care professionals.

information about patients to relevant state agencies and sometimes even to other individuals. This final Section illustrates state controls on the physician-patient relationship that can be justified because they serve public health goals.

A. *Medicine's Shifting Social Contours*²²⁵

A momentous shift in the social and economic parameters of American medicine has facilitated lawmakers' readiness to control physician speech to serve ends unrelated—or only indirectly related—to the public's health care needs. This Section summarizes that transformation. In the United States, the traditional doctor-patient relationship assumed an essentially hierarchical relationship between doctor and patient and depended, at least putatively, on trust and loyalty.²²⁶ For the most part, the state did not presume to regulate the content of communications between doctors and patients.

The traditional model provided for state licensing of physicians who expected to be paid for their work. Despite the commercial aspect of the physician-patient relationship, that relationship resembled relationships within American families far more than it resembled relationships within the commercial marketplace. Thus the physician-patient relationship presumed hierarchy rather than equality, connection rather than autonomy, and trust rather than wariness. The model favored compassionate care, at least as an ideal. Yet, it largely precluded patients from participating in their medical decision making. During much of the twentieth century, physicians had successfully defined themselves as a profession. They enjoyed significant status and financial success. Yet, they operated largely free from state law and corporate imposition.²²⁷ Moreover, the public viewed physicians positively, seeing them as trusted, compassionate care providers.²²⁸

By the last decades of the twentieth century, the model was displaced by another which upended medicine as a cottage industry, comparatively independent from state regulation and commercial pressures with a model of medicine as a commercial enterprise, heavily beholden to the

²²⁵ Much of the discussion in this subsection is indebted generally to PAUL STARR'S *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* ix–xi (1982), which offers history of shifts in the world of American medicine. See also Janet L. Dolgin, *Debating Conflicts: Medicine, Commerce and Contrasting Ethical Orders*, 35 *HOFSTRA L. REV.* 705, 711–12 (2006).

²²⁶ Dolgin, *supra* note 225, at 706–12. As medicine became a “profession,” the doctor-patient relationship remained essentially unchanged from the mid-nineteenth century to the middle half of the twentieth century. *Id.*

²²⁷ STARR, *supra* note 225, at 4–5, 337.

²²⁸ Dolgin, *supra* note 225, at 712.

marketplace. The causes of the shift include the appearance of biomedical technology, passage of Medicare and Medicaid in the 1960s, dramatic increases in the costs of health care, and the construction of managed care plans that replaced private payment from patient to physician and indemnity insurance.²²⁹ Stated simply, by the end of the twentieth century, medicine had been commercialized.²³⁰ Concomitantly, a new model of the physician-patient relationship began rapidly replacing the traditional model. The change—much as the shifts that transformed family relationships in the U.S. in the last decades of the twentieth century—displaced a world that valued hierarchy, trust, and community with one that valued equality, negotiation, and autonomy.²³¹

B. Development and Elaboration of the Informed-Consent Doctrine

For about a century, states have required physicians to obtain patient consent before rendering treatment. Justice Cardozo's famous words in *Schloendorff v. Society of the N.Y. Hospital* constructed the basis for consent laws in 1914: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages."²³²

Schloendorff predicated care on consent. It did not, however, impose an obligation on doctors to provide patients with enough information (or even with *any* information) to help them make medical decisions knowledgeably. Only in the 1970s did lawmakers begin to require physicians to provide patients consenting to (or refusing) care with sufficient information about the nature of the medical condition at stake and the dimensions of the care recommended so as to allow patients to make *informed* medical choices.²³³

In *Canterbury v. Spence*, the circuit court for the District of Columbia—one of the first courts to require *informed* consent—grounded that requirement on assumptions supporting a traditional understanding of the

²²⁹ See STARR, *supra* note 225, at 428–29; Arnold S. Relman, *The Health of Nations: Medicine and the Free Market*, NEW REPUBLIC, Mar. 7, 2005, at 23, 24–25.

²³⁰ DONALD L. BARTLETT & JAMES B. STEELE, CRITICAL CONDITION: HOW HEALTH CARE IN AMERICA BECAME BIG BUSINESS AND BAD MEDICINE 76 (2006).

²³¹ Dolgin, *supra* note 225, at 705–12, 716–17. This discussion concerns assumptions underlying the world of traditional medicine and changes in that world and the assumptions that undergirded it in the last decades of the twentieth century. Thus, it focuses on values. Whether the modern world of medicine actually provides for equality, negotiation, and autonomy is clearly important, but it is a different matter.

²³² 105 N.E. 92, 93–94 (N.Y. 1914).

²³³ See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972) (holding physician responsible for *informed* consent).

physician in relation to the patient. The court explained that the physician's duty to his or her patient extends "beyond those associated with armslength transactions."²³⁴ The consequences of this ruling did not, however, cement traditional assumptions about patients and doctors. Instead, fairly quickly, the informed-consent rule upended the notion that "doctor knows best" and soon balanced—and sometimes even, replaced—it with the patient's lament, "but it's my body."²³⁵

Insofar as the traditional patient-physician relationship assumed hierarchy at its core—physicians (presumed to be experts) made decisions, and presumptively grateful patients acquiesced—the informed-consent rules reflected and affected a new form of relationship. This new model of physician-patient relationship sometimes left physicians surprised underdogs, unable to make sense of the new rules.²³⁶ More specifically, elaborations of the informed-consent doctrine began openly to suggest new understandings that worked to undermine physicians, even as they assayed to inform the patient.²³⁷

A few cases requiring physicians to communicate information about their own inadequacies as part of the informed-consent discussion provide striking illustrations of this sort of elaboration of the informed-consent doctrine. In *Johnson v. Kokemoor*, Wisconsin's highest court obliged a neurosurgeon to have told his patient about other neurosurgeons, more experienced than he at the sort of procedure the patient required.²³⁸ If

²³⁴ *Canterbury*, 464 F.2d at 782. In a footnote, the court noted a place for armslength transactions between patients and physicians. That involved generally extra-medical aspects of their relationship: "That element [armslength transactions] comes to the fore in litigation involving contractual and property dealings between physician and patient." *Id.* at n.28.

²³⁵ Gerald Dworkin, *Can You Trust Autonomy?*, 33 HASTINGS CENT. REP. 42, 42 (Mar.–Apr. 2003).

²³⁶ See *infra* notes 238–43 (discussing *Johnson v. Kokemoor*, 545 N.W.2d 495 (Wis. 1996)).

²³⁷ See *infra* notes 238–43 and accompanying text.

²³⁸ 545 N.W.2d 495 (Wis. 1996). The Wisconsin court in *Kokemoor* wrote:

[W]hile there may be a general risk of ten percent that a particular surgical procedure will result in paralysis or death, that risk may climb to forty percent when the particular procedure is performed by a relatively inexperienced surgeon. It defies logic to interpret [a state] statute [requiring a doctor to disclose "the availability of all alternative, viable medical modes of treatment" plus "the benefits and risks of those treatments"] as requiring that the first, almost meaningless statistic [about success rates for the procedure at issue when performed by "the most accomplished" specialists] to a particular patient while the second, far more relevant statistic [about far lower success rates when the procedure was performed by a surgeon with the defendant's "limited experience"] should not be Under [state law] the second statistic would be

Canterbury reflected society's developing respect for patient autonomy, *Kokemoor* would seem to reflect a more troubling challenge—patient distrust of physicians.²³⁹

A California case, *Truman v. Thomas*, decided less than a decade after *Canterbury*, represents a different sort of elaboration of the informed-consent doctrine.²⁴⁰ In *Truman*, California's highest court concluded that Rena Truman's doctor was liable for having failed adequately to inform his patient about the need for a pap smear. The case was brought by Truman's surviving children after their mother died of cervical cancer.²⁴¹ The court concluded that "[t]o hold now that patients who reject their physician's advice have the burden of inquiring as to the potential consequences of their decisions would be to contradict *Cobbs* [a California case that resembled *Canterbury*]."²⁴² Justice Clark, dissenting in *Truman*, focused on the implications of expanding the informed-consent doctrine to oblige physicians to reveal the consequences of refusing recommended care: "In short, today's ruling mandates doctors to provide each such patient with a summary course covering most of his or her medical education."²⁴³

Cases such as *Kokemoor* and *Truman* reflect a new vision of the physician-patient relationship—one largely eviscerating an earlier image of the relationship as one that assumed hierarchy, trust, and loyalty. Furthermore, the doctrine offered a presumptively "moral" justification for shifts in the physician-patient relationship. By the end of the twentieth century, the ground had been set for even further incursions into the traditional relationship between doctors and their patients. However, efforts by the health care industry to muzzle physicians in service to industry's financial success (considered in the next Section), were eventually judged to have gone too far.

material to the patient's exercise of an intelligent and informed consent regarding treatment options.

545 N.W.2d at 507. *Kokemoor* was not widely followed. However, in *Howard v. Univ. of Med. & Dentistry*, 800 A.2d 73, 83–85 (N.J. 2002), the Supreme Court of New Jersey concluded that a physician had not provided his patient with adequate information about the physician's professional credentials.

²³⁹ See JANET L. DOLGIN & LOIS SHEPHERD, *BIOETHICS AND THE LAW* 60 (3d ed. 2013) (considering implications of informed-consent cases).

²⁴⁰ 611 P.2d 902 (Cal. 1980). *Truman* was also decided within a decade of a California case, *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972), which reached a conclusion similar to that reached in *Canterbury*.

²⁴¹ *Truman*, 611 P.2d at 904.

²⁴² *Id.* at 906. *Cobbs*, much like *Canterbury*, imposed an obligation on a physician to predicate a patient's consent on the communication of adequate information. *Cobbs*, 502 P.2d at 10.

²⁴³ *Truman*, 611 P.2d at 910 (Clark, J., dissenting).

C. Contractual "Gag" Order

The inclusion of gag provisions in contracts presented to physicians by managed care companies was among the more troubling developments incident to the commercialization of medicine in the second half of the twentieth century.²⁴⁴ Public media first focused on these contract clauses and revealed them to a public audience in the mid-1990s.²⁴⁵ The provisions were products of private negotiations—though the extent to which they were in fact "negotiated" is not clear. The gag clauses did not raise First Amendment issues, and in that regard, they differ from statutes prohibiting or mandating physician speech. But they do suggest an understanding of the physician-patient relationship that resembles the understanding that underlies statutory controls on physician speech.

The contractual gag provisions imposed by managed care companies could be interpreted to have banned doctors from informing patients about treatments (even treatments that they might otherwise have recommended) that the patient's managed care company did not cover.²⁴⁶ In a few cases, the clauses explicitly prohibited physicians from describing uncovered treatment options.²⁴⁷ In other cases, the gag provisions did not explicitly muzzle doctors ready to discuss uncovered treatment options with their patients, but that interpretation was reasonable.²⁴⁸ For instance, one contract between physicians and Choice Care in Cincinnati is reported to have provided: "Physician shall take no action nor make any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, plan sponsors or the public in Choice Care, or in the quality of care which Choice Care enrollees receive."²⁴⁹

These clauses created significant consternation by intruding into the center of the physician-patient relationship and precluding comprehensive informed consent. In 1997, the administration of then-President Clinton opposed the use of these clauses—both those that were explicit gag orders and those that were less explicit—in contracts between managed care

²⁴⁴ Robert Pear, *Doctors Say H.M.O.'s Limit What They Can Tell Patients*, N.Y. TIMES, Dec. 21, 1995, at A1, available at 1995 WLNR 3816034. In contracts, the gag provisions are generally referred to as "confidentiality" provisions. *Id.*

²⁴⁵ Joan Krause, *The Brief Life of the Gag Clause: Why Anti-Gag Clause Legislation Isn't Enough*, 67 TENN. L. REV. 1, 2 (1999); Pear, *supra* note 244.

²⁴⁶ Justin D. Harris, *Review of Selected 1996 California Legislation: Health and Welfare: The Timely Demise of "Gag Orders" in Physicians' Contracts with Managed Care Providers*, 28 PAC. L.J. 906, 906 (1997).

²⁴⁷ Krause, *supra* note 245, at 10; see, e.g., Pear, *supra* note 244.

²⁴⁸ See William M. Sage, *Physicians as Advocates*, 35 Hous. L. REV. 1529, 1542 (1999).

²⁴⁹ Pear, *supra* note 244.

companies and Medicare and Medicaid.²⁵⁰ More broadly, physicians and the public strongly opposed the inclusion of gag orders in managed care contracts,²⁵¹ and by the end of the twentieth century, many states had banned them.²⁵² These laws provide some protection to physicians and their patients. However, the threat of at-will termination may have continued to discourage physicians from criticizing a plan or even from participating in a patient's appeal of a denial of care.²⁵³ Industry's readiness to treat physicians as tools serving its own commercial ambitions starkly suggests the scope of the change in society's vision of medicine.²⁵⁴

Laws precluding physician speech about guns or fracking, or laws requiring doctors to describe ultrasound images to women seeking abortions, may meet a fate similar to that met by the managed care gag

²⁵⁰ Laurie McGinley, *Clinton to Prohibit HMO 'Gag Clauses' Under Medicaid*, WALL ST. J., Feb. 20, 1997, at A22. The federal government banned the clauses in Medicare and Medicaid managed care arrangements. *Interference with Health Care Professionals' Advice to Enrollees Prohibited*, 42 C.F.R. § 422.206 (2012).

²⁵¹ Opinion, *A Gagged Physician Cannot Fully Serve the Patient: If the Offending HMOs Persist, New Laws May Be Needed*, L.A. TIMES, Apr. 21, 1996, available at 1996 WLNR 5104804 (noting opposition of "consumer groups and labor unions" as well as a variety of legislative moves to ban gag orders by 1996).

²⁵² Sage, *supra* note 248, at 1539–40; Tracy E. Miller, *Managed Care Regulation*, 278 JAMA 1102, 1105 (1997). Miller reports that laws prohibiting gag clauses were enacted in 18 states in 1995–1996. Miller, *supra*; Krause, *supra* note 245 (arguing that the laws that were passed were of less importance than many legislators, physicians, and patients believed). By the end of the twentieth century, the gag clauses had been banned in almost every state. Krause, *supra* note 245.

²⁵³ Gisela M. Munoz et al., *The Two Faces of Gag Provisions: Patients and Physicians in a Bind*, 17 YALE L. & POL'Y REV. 249, 255 (1998). Munoz and co-authors note that physicians fired pursuant to at-will clauses because they criticized a plan or participated in an appeal have little or no recourse. *Id.* But see *Harper v. Healthsource N.H., Inc.*, 674 A.2d 962, 964–67 (N.H. 1996) (declaring that terminated physician would have grounds to bring suit against a managed care organization if the termination resulted from "malice or bad faith in retaliation for action taken or refused by the employee"); *id.* at 965 (quoting *Centronics Corp. v. Genicom Corp.*, 562 A.2d 187, 191 (N.H. 1989)).

²⁵⁴ Joan Krause characterized industry's motivation accurately:

A patient with no knowledge of a treatment denial has no reason to invoke . . . procedural protections [ranging from internal appeals to judicial review]; thus, the uninformed MCO patient is a less expensive patient. And because patients usually get their treatment information directly from their physicians, it becomes necessary as a practical matter for MCOs to involve their physicians in this code of silence.

Krause, *supra* note 245, at 10. Similarly, patients unaware of their managed care companies' denial policies are far less likely to explore options offered by competitor companies. Again, the ignorant patient is the patient least likely to interfere with a managed care company's profit expectations. *Id.* (noting that the ignorant patient is the "less expensive patient").

orders. In some regard, the gag provisions were easier to defend.²⁵⁵ Although they clearly served industry's financial goals, they resulted, at least putatively, from private negotiations that led to contractual agreements between the companies and physicians.

Managed care's contractual gag provisions did resemble the laws addressed in Part II of this Article in that in all of these cases, limits on doctors' speech were crafted and implemented to serve ends that significantly affected, even though they were generally not aimed explicitly at re-shaping, the physician-patient relationship. And all of them reflect the extent to which social respect for physicians is no longer adequate to safeguard the physician-patient relationship from such incursions. All of these examples involve important restrictions on physicians' and patients' control over medical decisions.²⁵⁶ They interfere with good patient care and may confront physicians with serious conflicts between obeying laws (or conforming to contract clauses) that control their communications with patients and adhering to professional codes.²⁵⁷

D. *Social Acceptance of Laws That Interfere with the Physician-Patient Relationship*

Some laws that interfere with the physician-patient relationship have long been accepted by society and the profession. A wide variety of reporting laws are illustrative. Aimed at notifying public health or other governmental authorities (or sometimes even particular individuals) about threats to public and individual health, these laws do not control clinicians' communication with patients, but they generally trump the expectation that anything a clinician learns about or from a patient remains confidential.²⁵⁸

²⁵⁵ The industry focused on clauses that arguably served accepted business goals. *See* Krause, *supra* note 245, at 11. So, for instance, industry claimed that clauses banning discussions with patients about treatments that had not yet been authorized by a plan were aimed at furthering accurate conversations between physicians and patients about treatments covered by a patient's plan. *Id.* Interestingly, managed care companies have justified clauses that ban the revelation to a patient of a plan's rates of payment as safeguards against the dissemination of trade secrets and proprietary information to competitors and potential competitors. Opinion, *supra* note 251; Munoz, *supra* note 253, at 254.

The trade-secret justification foreshadows that offered by the fracking industry as it now responds to those who disfavor laws banning physicians from providing patients with information about chemicals used in fracking that might cause physical harm to patients. *See supra* Part II.A.

²⁵⁶ Munoz, *supra* note 253, at 251.

²⁵⁷ *Id.* at 252.

²⁵⁸ The explosion of reporting laws has recently given rise to some concern about surveillance of medical information in the name of public health. *See* Wendy K. Mariner,

It is telling that reporting laws were originally grounded in discomforting class expectations. That may explain some part of the early acceptance of such laws. In particular, reporting laws, implemented in the late nineteenth century, required doctors to report cases of contagious diseases such as smallpox.²⁵⁹ The middle- and upper-classes associated such diseases with poor people and thus did not feel implicated by the reporting laws.²⁶⁰ Indeed, they saw the laws as protective of their interests. Since that time, state reporting laws have only infrequently been challenged in court.²⁶¹

Laws requiring clinicians (and often, others) to report public health risks now mandate reports, among other matters, of child abuse and neglect,²⁶² elder abuse or neglect,²⁶³ injuries caused by deadly weapons,²⁶⁴ and illnesses that pose a risk to public health.²⁶⁵ Authority for all of these

Mission Creep: Public Health Surveillance and Medical Privacy, 87 B.U. L. REV. 347, 347–51 (2007).

²⁵⁹ *Id.* at 349 (citing JAMES A. TOBEY, PUBLIC HEALTH LAW 133 (3d ed. 1947)).

²⁶⁰ *Id.* at 349.

²⁶¹ *Id.* at 376.

²⁶² See, e.g., TRACY BATEMAN FARRELL, JOHN A. GEBAUER & JANE E. LEHMAN, 88 N.Y. JUR. *Public Welfare and Old Age Assistance* § 308 (2013); Sharla J. Williams, *Reforming Mandated Reporting Laws After Sandusky*, 22 KAN. J.L. & PUB. POL'Y 235, 251 (2013). Generally, physicians, along with teachers and others in a position to become aware of child abuse, are included as mandated reporters. Danny R. Weilleux, *Validity, Construction, and Application of State Statute Requiring Doctor or Other Person to Report Child Abuse*, 73 A.L.R. 4th 782 (1989).

²⁶³ See, e.g., ALASKA STAT. ANN. § 47.24.010 (West 2013) (listing mandated reporters of suspected elder abuse or neglect to include health care providers, mental health professionals, pharmacists, nursing home administrators or employees, among others); see also Andrew R. Fischer, Note, *Elder Abuse: A Private Problem That Requires Private Solutions*, 8 J. HEALTH & BIOMEDICAL L. 81, 83 (2012); Seymour Moskowitz, *Saving Granny from the Wolf: Elder Abuse and Neglect—The Legal Framework*, 31 CONN. L. REV. 77, 80 (1998).

²⁶⁴ Mia M. McFarlane, *Mandatory Reporting of Domestic Violence: An Inappropriate Response for New York Health Care Professionals*, 17 BUFF. PUB. INT. L.J. 1, 13 (1998–99).

²⁶⁵ States have long sanctioned interference with liberty in an effort to safeguard public health. See, e.g., Jessica Berg, *All for One and One for All: Informed Consent and Public Health*, 50 HOUS. L. REV. 1, 16–17, 34 (2012). Most conditions that must be reported as public health risks involve contagious conditions. However, some do not. For instance, states may require screening for and data collection about obesity in schools. Michael A. Stoto, *Public Health Surveillance in the Twenty-First Century: Achieving Population Health Goals While Protecting Individuals' Privacy and Confidentiality*, 96 GEO. L.J. 703, 704 n.5 (2008) (citing UNIV. OF ARK. FOR MED. SCI. FAY W. BOOZMAN COLL. OF PUB. HEALTH, YEAR THREE EVALUATION: ARKANSAS ACT OF 2003 TO COMBAT CHILDHOOD OBESITY 27 (2006)). Sometimes reporting obligations may even include a requirement that specific individuals who may be affected by the conduct or condition at issue be notified. See, e.g., *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 353 (Cal. 1976) (placing obligation on University mental health professional to have warned an individual who was threatened by one of the mental health professional's patients).

reporting laws stems from the Tenth Amendment,²⁶⁶ which authorizes states to promulgate laws and regulations that serve the welfare of the public.²⁶⁷ For over a century, that authorization has been understood as including the power to limit individual liberties where necessary to safeguard the public's health and safety.²⁶⁸ And for at least a half-century, it has been read to provide for laws mandating that clinicians (and sometimes health care institutions) report health threats (including "communicable" diseases) to local departments of health or to the state.²⁶⁹

Reporting laws resemble the laws at issue in this Article in that they can undermine principles central to the preservation of the physician-patient relationship (e.g., confidentiality, trust). Indeed, the obligation imposed on physicians by reporting laws generally trumps the doctor-patient privilege.²⁷⁰ Yet, for the most part, such laws have gone unchallenged, in part because they seem at least primarily concerned with safeguarding public and individual health.²⁷¹

IV. Distinguishing Among Laws that Control Physician Speech

This Part reconsiders the laws reviewed in Part II and distinguishes each set from the others through reference to two intersecting distinctions. The first distinction separates laws that prohibit physician speech from those that mandate physician speech. The second distinction separates laws that are important to protecting public health and welfare from those that serve other ends. The first Section of this Part describes these distinctions and it categorizes the laws examined in Part II in light of them. Then, Section B suggests that of the four types of laws considered in Section A, only one can be justified.

²⁶⁶ See U.S. CONST. amend. X.

²⁶⁷ See *id.*

²⁶⁸ *Jacobson v. Massachusetts*, 197 U.S. 11, 25–26 (1905).

²⁶⁹ Wendy Mariner, *Mission Creep: Public Health Surveillance and Medical Privacy*, 87 B.U. L. REV. 347, 349 (2007) (citing JAMES A. TOBEY, PUBLIC HEALTH LAW 133 (3d ed. 1947)).

²⁷⁰ See AM. BAR ASS'N, CRIMINAL JUSTICE SECTION, REPORT TO THE HOUSE OF DELEGATES, RESOLUTION 104B, at 13 [hereinafter ABA Report], available at http://www.americanbar.org/content/dam/aba/administrative/house_of_delegates/2013_hod_midyear_meeting_executive_summaries_index.authcheckdam.pdf. The Resolution was withdrawn on January 4, 2013. ABA News, 104B—WITHDRAWN—Urges Review of Mandatory Abuse and Neglect Laws, Sept. 20, 2013, available at http://www.americanbar.org/news/abanews/aba-news-archives/2013/08/104b_-_withdrawn-u.html. The ABA Report also notes that in the context of child-abuse reporting, the privilege between attorney and client is generally affirmed. See ABA Report, *supra*.

²⁷¹ But see *supra* notes 258–71 and accompanying text (noting class component of early acceptance of public health reporting laws).

A. Categorizing Laws Controlling Physician Speech

Two intersecting distinctions appear among the statutes controlling physician speech that are considered in Part II.²⁷² First, some of the statutes at issue banned physician speech while others required physicians to transmit specific information to patients. Florida's gun law, Pennsylvania's oil and gas law, and, arguably, California's ban on conversion therapy are of the first sort. Each prohibits physicians (and others) from revealing certain facts or from initiating conversations about particular topics with patients.²⁷³

In commercial contexts, some courts have distinguished First Amendment claims involving banned speech from claims involving mandated speech.²⁷⁴ However, some of these courts have determined one form of control to be more objectionable and some, the other form.²⁷⁵ The line between speech prohibitions and speech mandates is often thin. Mandates can be constructed so that the speaker is not permitted to offer his or her own view of the mandated speech, and mandated speech may resemble banned speech insofar as the speech that must be uttered may in effect displace utterances with conflicting implications.²⁷⁶ Even so, bans on physician speech are more discomfoting (at least from the patient's perspective)²⁷⁷ than mandated speech because bans hide information. Speech not uttered is never open to contemplation, investigation, or to being discounted or rejected and is thus more worrisome—even if only marginally so—than mandated speech.

The second distinction concerns the aims of controls on physician speech. Three of the four statutes reviewed in Part II did not aim primarily—or, more strikingly, did not aim at all—to serve public health and welfare or the health and welfare of individual patients. Rather, they reflect the efforts of lobbying groups representing various ideological or

²⁷² See *supra* Part II. Other distinctions can be made. This Part focuses on distinctions that seem especially relevant to assessments of the laws at issue.

²⁷³ See *supra* Part II. California's law banning conversion therapy may not ultimately be interpreted as banning speech. See *supra* notes 214–23 and accompanying text.

²⁷⁴ Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 980–81 (2007).

²⁷⁵ See *id.*

²⁷⁶ Roberts, *supra* note 21, at 600.

²⁷⁷ From the physician's perspective, the mandated speech may be more discomfoting than banned speech. See Post, *supra* note 274, at 979–80. "It is one thing," explained the Sixth Circuit, "to force someone to close her mouth; it is quite another to force her to become a mouthpiece." *Mich. Pork Producers Ass'n, Inc. v. Veneman*, 348 F.3d 157, 163 (6th Cir. 2003), *vacated sub nom.* *Mich. Pork Producers Ass'n, Inc. v. Campaign for Family Farms*, 544 U.S. 1058 (2005).

commercial interests.²⁷⁸ The physician-patient relationship has provided a *modus vivendi* to further financial or ideological goals unrelated to health care. Of the laws reviewed in Part II, only California's SB 1172, banning conversion therapy, escapes this description because only in that case, among the four laws considered, did the legislative aim reflect evidence-based research.²⁷⁹

Pennsylvania's oil and gas law requiring doctors to sign a confidentiality agreement explicitly serves industry's financial interests,²⁸⁰ not the health needs of people who live in areas in which fracking occurs.²⁸¹ Florida's law prohibiting physicians from asking patients or patients' family members about gun possession²⁸² reflected the goals of the National Rifle Association (NRA) and those supporting the NRA, not public health goals.²⁸³ Lastly, the physician speech required by Oklahoma's abortion law served openly ideological goals.²⁸⁴

B. Assessing Laws Controlling Physician Speech

Thus, among the four state laws considered in Part II (described here for ease of reference as laws about, respectively, fracking, guns, fetal images, and conversion therapy), two—involving fracking and guns—imposed bans on physician speech and aimed to further financial interests (in the case of the Pennsylvania fracking law) or to further ideological goals (in the case of the Florida gun law). One of the laws—the Oklahoma law requiring clinicians to describe fetal images to women seeking abortions—mandated physician speech and resembled the gun law in primarily

²⁷⁸ This description would seem to apply to Pennsylvania's Act 13, to Florida's Act Relating to the Privacy of Firearm Owners, and to Oklahoma's abortion law, OKLA. STAT. ANN. tit. 63 (West 2013), at issue in *Nova Health Sys. v. Pruitt*, 292 P.3d 28 (Okla. 2012).

²⁷⁹ See *supra* Part II.D. Of course, the New Jersey statute prohibiting conversion therapy would likewise escape this description.

²⁸⁰ The text refers to the Florida and Oklahoma laws in the past tense because courts have invalidated them. The Pennsylvania law has not been invalidated and is thus referred to in the present tense.

²⁸¹ *Doctor Sues Over Pennsylvania Fracking Law*: Rodriguez v. Krancer, 30 WESTLAW J. TOXIC TORTS, no. 14, Aug. 22, 2012, at 5, available at 2012 WL 3597725; see *supra* Part II.A.2.

²⁸² See *supra* Part II.B.

²⁸³ Carl Hiaasen, *Florida Loses Another Ridiculous Legal Battle*, N. PORT SUN (Jul. 10, 2012), available at 2012 WLNR 14847716.

²⁸⁴ See *Rust v. Sullivan*, 500 U.S. 173, 211 (1991) (Blackmun, J., dissenting). Dissenting in *Rust*, Justice Blackmun described the prohibition on physician speech at issue there as "the type of intrusive, ideologically based regulation of speech" that cannot be justified through reference to federal funding. *Id.* Even more, explained Justice Blackmun, "[o]ne can imagine no legitimate governmental interest that might be served by suppressing such information [about abortion]." *Id.* at 215.

serving ideological interests. Finally, the California law banning conversion therapy for minors involves a ban on therapy involving speech²⁸⁵ and justifies that ban through reference to evidence-based research showing that psychological health risks attended use of the therapy in question.²⁸⁶

The least acceptable of such laws—at least from a patient’s perspective²⁸⁷—are those that preclude speech in order to further an interest not directly connected to the protection of the public’s health and welfare. That category includes Florida’s gun law and Pennsylvania’s fracking law. Laws aimed at affecting financial or ideological goals that mandate physician speech may be marginally less worrisome, as a general matter; though in practice, mandated physician speech may harm patients and the physician-patient relationship as much as banned physician speech.²⁸⁸ The Oklahoma ultrasound law falls into this category of physician speech. In spite of arguable differences in the harmfulness of laws that prohibit physician speech and laws that mandate physician speech, each of these laws—whether it prohibits or mandates speech—should be invalidated (as the Florida gun law and the Oklahoma abortion law²⁸⁹ have been). Neither serves public health and each undermines good medical care.

The fourth law reviewed in Part II—California’s law prohibiting conversion therapy—is of a different order insofar as it reflects scientific evidence and it aims primarily to safeguard the health and welfare of minors. This law poses challenging questions. It does impose state control over clinicians’ mental health care decisions. Moreover, conversion therapy almost always includes speech as part and parcel of the treatment. Given that, one might argue that the law should be enjoined. However, SB 1172 does not ban clinicians from informing minors about the banned therapy, and it does not prohibit them from referring minors to therapists in other states in which conversion therapy is available. Most importantly, it safeguards minors from forms of therapy unlikely to help them and likely to cause them harm. For these reasons, SB 1172 is adequately distinct from

²⁸⁵ *Pickup v. Brown*, No. 2:12-CV-02497-KJM-EFB, 2012 WL 6021465, at *1 (E.D. Cal. Dec. 4, 2012). The law banned a form of treatment by mental health professionals and thus could arguably be characterized as banning therapy rather than speech (or speech as well as therapy or therapy shaped through speech); see *supra* Part II.D.

²⁸⁶ See *supra* notes 187–94 and accompanying text.

²⁸⁷ From a physician’s perspective, mandated speech may be more disturbing than banned speech. See *supra* notes 274–77 and accompanying text.

²⁸⁸ See *supra* Part IV.A (noting that mandated speech can displace other messages and, in that regard, becomes more like banned speech).

²⁸⁹ See *supra* Parts II.B–C. Similar laws exist elsewhere, however. See *supra* Parts II.B–C. As of July 2013, two states had laws that resembled Oklahoma’s. See GUTTMACHER INST., *supra* note 162, at 2.

the other laws reviewed in Part II in that it alone, among these laws, should survive judicial challenge.

CONCLUSION

The laws considered in this Article are troubling because they have the potential to undermine the capacity of physicians to develop trusting relationships with their patients and to nurture those relationships over time. Most of the laws discussed here gained support from devotees of particularistic interests. These laws did not explicitly target physicians and patients; rather doctors and patients became unwitting tools of ideological and commercial ambitions.²⁹⁰ Additionally, and most distressingly, those ambitions have trumped the healing power of a trusting, untrammelled relationship between physician and patient.

The laws reviewed here reflect a broader set of social shifts. Society's view of the doctor as first, and most important, a healer has been increasingly elided by alternative understandings. These new understandings define the doctor and the doctor-patient relationship through the language of the commercial marketplace (e.g., individualism, negotiated relationships, autonomy) rather than through the language of home and family (e.g., trust, loyalty, compassion). Patients—that is to say, the public—deserve access to information that may have significant consequences for health, safety, and welfare. Insofar as physicians are in a unique position to discuss, forthrightly, important matters relating to health with patients, it is especially troubling to undermine that possibility in the effort to serve unrelated economic or ideological ends.

Sometimes, laws requiring physicians to speak or laws that ban them from speaking can be justified in the name of public health or individual health care. The informed-consent doctrine, understood broadly, mandates speech. However, the doctrine's requirements are rarely specific and, at least in most cases,²⁹¹ they aim to serve patient health and welfare. Whether they achieve that end can be debated, but informed-consent rules have been constructed in the name of the patient's right to participate in medical

²⁹⁰ See Lydia Saad, "Pro-Choice" Americans at Record-Low 41%, GALLUP (May 23, 2012), <http://www.gallup.com/poll/154838/pro-choice-americans-record-low.aspx> (reporting that in 2012, 41% of Americans called themselves "pro-choice" and 50% called themselves "pro-life"); see also Lydia Saad, *Americans Still Split Along "Pro-Choice," "Pro-Life" Lines*, GALLUP (May 23, 2011), <http://www.gallup.com/poll/147734/americans-split-along-pro-choice-pro-life-lines.aspx> (reporting that in 2011, 45% of Americans called themselves "pro-life" and 49% called themselves "pro-choice").

²⁹¹ See *supra* Part III.B. Certain cases may offer elaborations that unduly distort the use of the informed-consent doctrine. See, e.g., *Johnson v. Kokemoor*, 545 N.W.2d 495, 504 (Wis. 1996); *Truman v. Thomas*, 611 P.2d 902, 905–08 (Cal. 1980).

decision making. Reporting laws (involving the revelation of information about, rather than to, patients) offer another example; these laws serve public health and should thus trump expectations about the confidentiality of the physician-patient relationship. Only one of the laws considered in Part II of this Article (California's SB 1172) aims to further patient welfare. Thus, with that exception, the laws reviewed in this Article cannot be justified and should not survive or become models for lawmakers in other states. The cost to individual health and public welfare is too high. Laws that unabashedly undermine the physician-patient relationship in service to economic ends and partisan belief systems have no place in a society even putatively committed to protecting the health and welfare of its citizenry.