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LOST IN A DOCTRINAL WASTELAND: THE EXCEPTIONALISM OF DOCTOR- PATIENT SPEECH WITHIN THE REHNQUIST COURT'S FIRST AMENDMENT JURISPRUDENCE

Paula E. Berg†

I. INTRODUCTION

OVER THE YEARS, there have been frequent attempts by both public and private entities to regulate the content of doctor-patient speech to advance a particular ideology or accomplish an end unrelated to the promotion of patient health.¹ At various times since the early 1960s, the federal government and certain states have restricted physician-patient speech about contraception and abortion because of ideological opposition to these practices.² More recently, managed care organizations

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1. This Article uses the term doctor-patient speech to refer to oral communication between physicians and patients that occurs after the formation of a professional relationship concerning symptoms, diagnosis, treatment alternatives, and the wide range of subjects that are commonly discussed in the course of medical decision making.

2. Many cases involving these restrictions have come before the courts. *See, e.g.*, *Griswold v. Connecticut*, 381 U.S. 479 (1965) (considering a Connecticut statute prohibiting physicians from counseling patients about contraception and holding that forbidding the use of contraceptives unconstitutionally intrudes upon the right of marital privacy); *Charles v. Carey*, 627 F.2d 772 (7th Cir. 1980) (finding unconstitutional [on marital privacy grounds] an Illinois statute requiring physicians to deliver a written statement to patients stating that the state views a fetus as a living human being whose life should be preserved). For a more complete description of these measures, see Paula Berg, *Toward a First Amendment Theory of Doctor-Patient Discourse and the Right to Receive Unbiased Medical Advice*, 74 B.U.L. REV. 201, 202-03 n.9, 204 n.13 (1994) [hereinafter Berg] (noting that most courts have struck down statutes that criminalize physician speech about contraception and abortion on privacy rather than First Amendment grounds, and listing specific cases that have considered the validity of such statutes).

have sought to maximize profits and minimize consumer dissatisfaction by including "gag clauses" in provider contracts. These clauses bar physicians from discussing treatment alternatives and financial incentive arrangements with patients.³ In 1996, following the November election, federal officials sought to prevent Californians from exercising their newly won right to use marijuana for medical purposes⁴ by threatening to criminally prosecute physicians who discussed this subject with patients.⁵ Finally, after several juries acquitted Dr. Jack Kevorkian of criminal charges for illegally assisting patient suicides, frustrated prosecutors dispatched police to interrupt his conversations with patients.⁶

3. In 1996, the Health Care Financing Administration (HCFA) barred Medicare and Medicaid HMOs from requiring physicians to withhold information about incentive arrangements and medically necessary treatments from patients. *See* Medicare and Medicaid Programs: Requirements for Physician Incentive Plans, 42 C.F.R. § 417.479(a) (1998); *Clinton Orders HHS to Issue Warning Against Gag Rules in Medicaid HMOs*, 6 BNA HEALTH L. REP. 332, (1997) (describing HHS prohibitions on contractual clauses limiting discussions of treatment options by physicians in Medicaid and Medicare HMOs). Additionally, during the past few years, many states have enacted statutes prohibiting managed care organizations from including gag clauses in their contracts with providers. *See, e.g.*, CAL. BUS. & PROF. CODE, § 2056.1(b) (West Supp. 1998) (banning health care service providers from including contractual provisions that interfere with a physician's ability to communicate with patients about treatment options, alternative plans, or coverage arrangements); *See* DEL. CODE ANN. tit. 18, § 6407 (1996) (barring HMOs from preventing physicians from giving patients information about diagnoses, prognoses, and treatment options). Congress has yet to act upon legislation prohibiting gag clauses. *See* 143 CONG. REC. 51734-02, 51745 (daily ed. Feb. 27, 1997) (prohibiting contractual provisions that restrict providers' medical communications with patients).

4. *See* CAL. HEALTH & SAFETY CODE § 11362.5(a) (West Supp. 1998) (decriminalizing medicinal marijuana use under California law). Voters in Arizona approved a similar measure in 1996. *See* ARIZ. REV. STAT. ANN., § 13-3412.01 (West Supp. 1997) (amending a statute criminalizing marijuana to permit use by terminally and seriously ill patients pursuant to a prescription by a medical practitioner).

5. *See* *Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997) (holding that threats by federal drug enforcement officials to prosecute physicians for advising patients about the medical use of marijuana after enactment of the California Compassionate Use Act of 1996 violated physicians' and patients' rights under the First Amendment).

6. A majority of states criminalize assisting another person to commit suicide. *See* *Washington v. Glucksberg*, 117 S.Ct. 2258, 2263 (1997) (listing cases which have found assisting in suicide to be criminal). Under the common law, a physician's advice about how to commit suicide amounts to the crime of aiding and abetting a suicide if the advice is given with the intention that it be used and the patient actually commits suicide. *See* J.C. SMITH & BRIAN HOGAN, *CRIMINAL LAW* 380 (7th ed. 1992). If these requirements are satisfied, a physician's speech assisting a suicide is not constitutionally protected because the First Amendment generally does not protect speech utilized to accomplish a crime. *See generally* Frederick Schauer, *The Aim and the Target in Free Speech Methodology*, 83 NW. U. L. REV. 562, 563 (1989) (stating that crimes committed through linguistic communication are not protected by the First Amendment); Kent Greenawalt, *Speech and Crime*, 1980 AM. B. FOUND. RES. J. 645 (1980) (stating that the First Amendment does not cover all linguistically communicative acts).

The Supreme Court has periodically considered the constitutionality of restrictions on the content of doctor-patient speech.⁷ Until recently, however, these provisions, which concerned contraception and abortion, were challenged on the ground that they violated the constitutional right to privacy⁸ rather than the free speech rights of patients or doctors.⁹

In the early 1990s, however, the Rehnquist Court considered a pair of cases that offered an opportunity to situate doctor-patient speech within First Amendment jurisprudence and to establish the principle that the Constitution prohibits the federal government from politicizing the practice of medicine by manipulating the content of physicians' conversations with patients. *Rust v. Sullivan*¹⁰ concerned the constitutionality of regulations promulgated during the Reagan administration¹¹

7. See, e.g., *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 511 (1989) (considering and upholding a statute that forbade public employees from counseling a woman to have an abortion not needed to save her life); *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986), *overruled by* *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (invalidating a statute requiring that certain information be given to a woman before she consents to an abortion); *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 444-45 (1983) (invalidating an informed consent provision designed to persuade women not to have abortions), *overruled by* *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992); *Planned Parenthood v. Danforth*, 428 U.S. 52, 65-67 (1976) (upholding a provision requiring a woman to give written consent for an abortion); *Griswold v. Connecticut*, 381 U.S. at 480 (holding a statute prohibiting counseling about contraception and family planning unconstitutional); *Poe v. Ullman*, 376 U.S. 497, 498 (1961) (seeking a ruling on the constitutionality of a statute prohibiting the use of contraceptives and the giving of advice regarding their use; the Supreme Court dismissed the case for failing to present a justiciable question).

8. See *Griswold*, 381 U.S. at 479 (holding that a Connecticut law forbidding the use of contraceptives intrudes unconstitutionally upon the right of marital privacy) and *Roe v. Wade*, 410 U.S. 113, 153 (1973) (explaining that the Constitution does guarantee certain fundamental areas, or zones, of personal privacy, including a woman's right to terminate her pregnancy up to a point before the State asserts a compelling state interest).

9. Justices noted the possibility of a First Amendment violation in several of these cases. See, e.g., *City of Akron*, 462 U.S. at 472 n.16 (O'Connor, J., dissenting) ("This is not to say that the informed consent provisions may not violate the First Amendment rights of the physician if the State requires him or her to communicate its ideology"); *Griswold*, 381 U.S. at 507-08 (Black, J., dissenting) ("I can think of no reasons at this time why [physicians'] expressions of views would not be protected by the First and Fourteenth Amendments, which guarantee freedom of speech"); *Poe*, 376 U.S. at 513 (Douglas, J., dissenting) ("The right of the doctor to advise his patients according to his best lights seems so obviously within First Amendment rights as to need no extended discussion.").

10. 500 U.S. 173 (1991).

11. On January 22, 1993, President Clinton issued a memorandum order directing the Secretary of Health and Human Services (HHS) to suspend this rule because it interfered with the doctor-patient relationship. The Title X "Gag Rule," 58 Fed. Reg. 7455 (1993) (stating that the Gag Rule endangers women's lives by preventing them from receiving information that their doc-

that restricted the conduct¹² and speech of physicians working in family planning clinics funded under Title X of the Public Health Services Act.¹³ The speech-related regulations prohibited physicians from providing “counseling concerning the use of abortion as a method of family planning” and from providing referrals to women seeking an abortion.¹⁴ For patients who requested referrals, the regulations recommended a pre-scripted response: “the project does not consider abortion an appropriate method of family planning and therefore does not counsel or refer for abortion.”¹⁵

In turning its attention to whether these regulations violated the First Amendment rights of doctors or patients, the Supreme Court did not determine whether they were aimed at the content of expression or whether they were viewpoint-based — the traditional method for analyzing a First Amendment claim.¹⁶ Indeed, the Court’s opinion contains no First Amendment analysis of the regulations whatsoever. Instead, the Rehnquist Court skirted the free speech issue entirely, deciding that the regulations were a constitutional exercise of the government’s power to fund some activities and not others. As the Court explained, “This is not the case of the Government ‘suppressing a dangerous idea,’ but of a prohibition on a project grantee or its employees from engaging in activities outside of its scope.”¹⁷ The Court hinted that governmental restrictions on doctor-patient speech might violate the Constitu-

tion would otherwise be ethically and morally obligated to provide).

12. The restrictions imposed on the conduct of Title X grantees prohibited lobbying for legislation that could increase the availability of abortion services, using legal action to make abortion more available, paying dues to any pro-choice group, and failing to maintain a physical separation between Title X-funded projects and any abortion-related activities. *See* 42 C.F.R. § 59.9 (1997).

13. 42 U.S.C. Sections 300-300a-6 (1994) (prohibiting the use of funds appropriated for family planning services in programs where abortion is a method of family planning); 42 C.F.R. section 59.15 (1997) (restricting disclosure of information about individuals receiving services except as “necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality”).

14. 42 C.F.R. § 59.8(a)(1) (1997). The regulations also restricted grantees’ speech by prohibiting the dissemination of written materials advocating abortion, and by prohibiting pro-choice speakers. *See also* 42 C.F.R. § 59.10 (a) (1997).

15. 42 C.F.R. § 59.8(b)(5) (1997).

16. *See*, LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 12-2, at 789-94 (2nd ed. 1988) (explaining the two tracks of analysis for First Amendment claims).

17. *Rust*, 500 U.S. at 194.

tion if, for example, doctors were not permitted to disclaim agreement with the government's opinions, or if the doctor-patient relationship was sufficiently "all-encompassing" to justify a patient's expectation of comprehensive medical advice.¹⁸

In *Planned Parenthood v. Casey*,¹⁹ decided one year after *Rust*, the Court endorsed an even broader governmental right to manipulate the content of physicians' conversations with patients.²⁰ *Casey* challenged the constitutionality of amendments to a Pennsylvania abortion statute that revived provisions invalidated by the Burger Court six years earlier.²¹ In addition to imposing various limitations on the conduct of all Pennsylvania physicians who performed abortions,²² the so-called informed consent provisions required doctors — at the risk of losing their medical license — to provide every patient seeking an

18. See *id.* at 200.

19. 505 U.S. 833 (1992) (plurality opinion). The plurality opinion was co-authored by Justices O'Connor, Kennedy, and Souter.

20. In addition to the authors of the plurality opinion, Justices Rehnquist, Scalia, White, and Thomas similarly sanctioned the imposition of viewpoint-based restrictions on physician speech. *Id.* at 967-68 (Rehnquist, C.J., concurring in part and dissenting in part) (joined by White, J., Scalia, J., and Thomas, J.) (allowing states to compel doctors to utter any information to patients that is relevant and rationally related to legitimate government interest). Only Justices Stevens and Blackmun rejected this proposition. See *id.* at 914 (Stevens, J., concurring in part and dissenting in part) ("[I]n order to be legitimate, the State's interest must be secular; consistent with the First Amendment the State may not promote a theological or sectarian interest"); and *id.* at 934-35 (Blackmun, J., concurring in part and dissenting in part) (arguing that the state cannot compel physicians to convey biased information to patients).

21. See *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986). In *Thornburgh*, the Burger Court reaffirmed its holding in *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), that government may legitimately require physicians to convey information to patients to ensure informed consent, but that speech restrictions intended to influence patients' decision making in accordance with governmental ideology violated the constitutional right to privacy recognized in *Roe v. Wade*. *Id.* at 765-67.

22. The statute prohibited a physician from performing an abortion on a married woman who had not provided the physician with a signed statement that she had notified her husband of her intention to have an abortion, unless the case fell within one of four exceptions to this requirement. 18 PA. CONS. STAT. ANN. § 3209 (West Supp. 1997). It also prohibited a physician from performing an abortion less than 24 hours after satisfying the "informed consent" requirements. *Id.* at § 3205 (West 1983 & Supp. 1997). Any person performing an abortion on a woman under 18 years old without parental consent was subject to license suspension and civil action. *Id.* at § 3206 (West 1983 & Supp. 1997). Finally, the statute required that abortion facilities file reports showing the total number of abortions performed in each trimester, the age of each patient, each patient's prior number of pregnancies and abortions, the weight of each aborted fetus, the marital status of each patient, and, in the case of married parents, whether notice was provided to the husband. *Id.* § 3214 (West 1983 & Supp. 1997). The Supreme Court invalidated the provision requiring spousal notification on the ground that it imposed an undue burden on women seeking an abortion. See *Casey*, 505 U.S. at 895.

abortion with certain pre-scripted information intended to convey the State's preference for childbirth over abortion.²³ Like *Rust*'s "gag rules," the Pennsylvania statute's speech-related provisions directly regulated the content of physician-patient discourse for the purpose of influencing patients to make a medical decision that conformed to government ideology.

In *Casey*, as in *Rust*, the Court did not analyze whether the provisions interfered with the speech rights of physicians or the audience-based right of patients to receive information. While the Court tipped its hat to the idea that the challenged regulations implicated physicians' speech rights, it summarily dismissed this concern, stating that advising patients is merely a "part of the practice of medicine, subject to reasonable licensing and regulation by the State."²⁴ Thus, according to Justices O'Connor, Souter, and Kennedy, who jointly authored the plurality opinion, the state's authority to license and regulate the medical profession includes the power to compel physicians to communicate pre-scripted, viewpoint-based statements to patients for the purpose of persuading them to make the medical choices preferred by the state, as long as those statements are not false or misleading.²⁵

Taken together, the Rehnquist Court's decisions in *Rust* and *Casey* stand for the troubling proposition that the First Amendment does not prohibit the federal government from manipulating the content of physician-patient speech, in both publicly and privately financed settings, in order to promote a particular ideology or to accomplish a policy unrelated to patient health.

As several commentators noted at the time, both *Rust* and *Casey* are inconsistent with traditional First Amendment jurisprudence.²⁶ It is now apparent that *Rust* and *Casey* are also

23. The statute required physicians to tell patients seeking an abortion about the availability of printed materials that described the fetus and listed agencies that offered alternatives to abortion; stated that the child's father was liable for financial assistance; and stated that medical assistance might be available for prenatal care, childbirth, and neonatal care. *See* PA. CONS. STAT. ANN. § 3205(a)(2)(i)-(iii) (West 1983 & Supp. 1997).

24. *Casey*, 505 U.S. at 884.

25. *Id.* at 882. Since the Court rooted this authority in the state's power to regulate the medical profession, the federal government, which lacks this regulatory authority, presumably does not enjoy the same authority to impose viewpoint-based restrictions on doctor-patient speech.

26. *See, e.g.*, Christina E. Wells, *Abortion Counseling as Vice Activity: The Free Speech*

strikingly inconsistent with the Rehnquist Court's *own* free speech jurisprudence, which has largely taken shape since those decisions were issued. While *Rust* and *Casey* suggested that the Court might adopt a tolerant posture toward speech regulations promoting government policy, this has not turned out to be true. Rather, while members of the Rehnquist Court have been deeply divided about many other issues, they have been unusually harmonious in First Amendment cases in demanding strict viewpoint neutrality, and in passionately protecting speakers and listeners from government paternalism. As a result, doctor-patient speech exists within the Rehnquist Court's free speech jurisprudence in a doctrinal wasteland where it is exceptionally vulnerable to governmental manipulation — more so, in fact, than significantly less meaningful and valued forms of expression.

II. VIEWPOINT NEUTRALITY

The central focus of the Rehnquist Court's First Amendment methodology is whether a government regulation is aimed at the content of expression or whether it is content-neutral.²⁷ Accordingly, the Court generally begins any First Amendment analysis by determining whether a restriction suppresses or advances a particular viewpoint or alters the content of the expression.²⁸ To protect expression from these most heinous

Implications of Rust v. Sullivan and Planned Parenthood v. Casey, 95 COLUM. L. REV. 1724 (1995) (discussing the Supreme Court's departure from traditional First Amendment analysis in *Rust* and *Casey*); Berg, *supra* note 3, at 219 (noting that, when considering doctor-patient speech, the Rehnquist Court has abandoned the First Amendment principle that speech regulations may not favor one viewpoint over another); Michael Fitzpatrick, *Rust Corrodes: The First Amendment Implications of Rust v. Sullivan*, 45 STAN. L. REV. 185, 200 (1992) (discussing how *Rust* is inconsistent with the Supreme Court's historic intolerance of viewpoint-based restrictions); Janet Benshoof, *The Chastity Act: Government Manipulation of Abortion Information and the First Amendment*, 101 HARV. L. REV. 1916, 1931-33 (1988) (arguing that one-sided presentation of pregnancy options, as sanctioned by *Rust*, conflicts with the First Amendment).

27. As Professor Mark Tushnet explains:

Over the past decade the Supreme Court has re-conceptualized free speech law. The Warren Court began to organize free speech law around a new set of concepts, but the modern law of the First Amendment crystallized more recently. Today the central organizing concept of First Amendment doctrine is the distinction between content-based regulations and content-neutral ones.

Mark Tushnet, *The Supreme Court and Its First Amendment Constituency*, 44 HASTINGS L.J. 881, 882 (1993) (describing the Supreme Court's changing approach to free speech cases).

28. Unfortunately, the Court's distinction between viewpoint-based and content-based

forms of government distortion, regulations that are content- or viewpoint-based are subject to the "most exacting scrutiny."²⁹ The highly protective nature of this standard is evidenced historically by the consequences of its application. No viewpoint-based and virtually no content-based restriction of speech has ever survived strict scrutiny review.³⁰

There are, however, several exceptions to these rules. First, while commercial speech may not be restricted on the basis of viewpoint,³¹ its content may be regulated subject to a less demanding intermediate standard of review.³² Though more generous than that applied to fully protected speech, the protective nature of this standard is considerable. In the past five years, its application has led the Court to uphold only one restriction on the content of commercial speech.³³ Indeed, sev-

discrimination has not always been precise. See Marjorie Heins, *Viewpoint Discrimination*, 24 HASTINGS CONST. L.Q. 99, 101 (1996) (stating that "the Court's First Amendment decisions have ricocheted between a focused emphasis on viewpoint discrimination as the ultimate First Amendment evil, and broader condemnations of 'content discrimination'").

29. Government restrictions that are content-based must be necessary to serve a compelling state interest and narrowly drawn to that end. See *TRIBE*, *supra* note 17, § 12-13 at 798-99.

30. See Geoffrey R. Stone, *Content Regulation and the First Amendment*, 25 WM. & MARY L. REV. 189, 196 (1983) (stating that the Supreme Court "has invalidated almost every content-based restriction that it has considered in the past quarter century"). But see *Burson v. Freeman*, 504 U.S. 191 (1992) (plurality opinion) (upholding the constitutionality of a restriction on political speech within 100 feet of entrance to polling places).

31. See *R.A.V. v. City of St. Paul*, 505 U.S. 377, 393 (1992) (stating that states may not, for example, single out and regulate commercial advertising that depicts men in a demeaning fashion).

32. See *Central Hudson Gas & Electric Corp. v. Public Serv. Comm'n*, 447 U.S. 557 (1980) (declaring that a state must establish a substantial interest in order to regulate commercial speech). Under this standard, the State's interests must be substantial, the challenged regulation must directly and materially advance the interest, and the extent of the speech restriction must be in reasonable proportion to the interests served. See *id.* at 564.

33. Since 1992, the Supreme Court has decided seven commercial speech cases, invalidating the restrictions in five cases and upholding them in only two. See *Ibanez v. Florida Dept. of Bus. Prof'l. Regulation, Bd. of Accountancy*, 512 U.S. 136 (1994) (holding that the board of accountancy's censure of an accountant for referring to herself as a certified financial planner violated the First Amendment); *Edenfield v. Fane*, 507 U.S. 761 (1993) (holding that a ban on in-person solicitations by accountants violated the First Amendment); *Rubin v. Coors Brewing Co.*, 514 U.S. 476, 483-84 (1995) (holding that a labeling ban on beer prohibiting the display of alcohol content violated the First Amendment); *44 Liquormart, Inc. v. Rhode Island*, 517 U.S. 484 (1996) (holding that a statute prohibiting liquor advertisements by retailers violated the First Amendment); *Cincinnati v. Discovery Network, Inc.*, 507 U.S. 410 (1993) (invalidating a ban on news racks containing commercial handbills). But see *Florida Bar v. Went For It, Inc.*, 515 U.S. 618 (1995) (upholding a ban on lawyer solicitations of personal injury clients within 30 days of an accident); *United States v. Edge Broadcasting Co.*, 509 U.S. 418 (1993) (holding that a federal statute banning the broadcast of lottery advertisements in states that do not allow lotteries did not violate the First Amendment).

eral recent opinions indicate that a majority of courts favor applying strict scrutiny review to restrictions on most commercial speech.³⁴

Additionally, certain categories of “low value” expression — specifically, obscenity, fighting words, defamatory falsehoods, and messages advocating imminent lawlessness — may be more freely regulated without violating the Constitution.³⁵ These categories of speech hold this lowly status within First Amendment jurisprudence because they are viewed as contributing little to public discourse or the discovery of truth.³⁶

When considered within this jurisprudential framework, *Rust* and *Casey* relegate doctor-patient speech to a category outside the protection of the First Amendment along with defamation, obscenity, fighting words, and speech advocating imminent lawlessness. Like these types of low-value expression, doctor-patient speech is exempt from the requirement of viewpoint neutrality. Indeed, physician-patient speech is arguably even less constitutionally protected than these categories of expression because, according to the Rehnquist Court’s decision in *R.A.V. v. St. Paul*,³⁷ they may *not* be regulated on the basis of viewpoint.³⁸ Also, government restrictions on doctor-

34. See *City of Cincinnati v. Discovery Network, Inc.*, 507 U.S. 410, 421-24 (1993) (stating that intermediate scrutiny should apply to “‘core’ commercial speech,” which does no more than propose a transaction, while commercial, informational speech, which is related to the economic interests of the speaker and its audience, should be fully protected).

35. See *R.A.V.*, 505 U.S. at 382 (stating that “a limited categorical approach [for protected speech] has remained an important part of our First Amendment jurisprudence”). Defamation involving public officials and public figures is reviewed under a more rigorous standard than that involving private figures. To be liable for defaming a public official or public figure, the defendant must have known that his or her statement was false or have acted with reckless disregard of the statement’s truth or falsity. See also *New York Times v. Sullivan*, 376 U.S. 254, 279-80 (1964); *Curtis Publishing Co. v. Butts*, 388 U.S. 130 (1967) (stating that the right to free expression, while it is a general right, is not an unconditional right and may be regulated under some circumstances without violating the Constitution). Defamatory falsehoods against private persons may be proscribed, consistent with the Constitution, if made negligently.

36. See *R.A.V. v. St. Paul*, 505 U.S. at 382 (citing *Chaplinsky v. New Hampshire*, 315 U.S. 568, 572 (1942)) (noting that obscenity, fighting words, and defamation may be proscribed communications because of their “slight social value as a step to truth [and] that any benefit that may be derived . . . is clearly outweighed by the social interest in order and morality”).

37. *Id.* at 377.

38. See *id.* at 383-84 (stating that “areas of [low-value] speech can, consistently with the First Amendment, be regulated because of their constitutionally proscribable content . . . [However], they are [not] categories of speech entirely invisible to the Constitution, so that they may be made the vehicles for content discrimination unrelated to their distinctively proscribable content”).

patient speech, like restrictions on low-value expression, need only satisfy a due process or negligence standard of constitutional review.³⁹

Thus, within the Rehnquist Court's First Amendment paradigm, doctor-patient speech has less constitutional value than commercial speech or hate speech. Ironically, a doctor's television advertisement offering to perform a medical procedure for a fee is more protected than a physician's intimate conversations with a patient about symptoms, diagnosis, treatments, and the range of other subjects that are often discussed in the context of this professional relationship.⁴⁰

With the notable exceptions of *Rust* and *Casey*, the Rehnquist Court has not only faithfully adhered to the requirement of viewpoint neutrality, it has been unusually sensitive to the danger posed by this type of government regulation. Indeed, the Court has expanded the definition of viewpoint-based regulation, leading to the invalidation of restrictions that are far less flagrantly viewpoint-based, and far less likely to lead to government coercion, than *Rust's* gag rule or *Casey's* "informed consent" statute.

For example, in *Lamb's Chapel v. Center Moriches Union Free District*,⁴¹ an evangelical church sought permission from a public school to use its facilities after hours to show a film series offering a Christian perspective on child rearing and

39. In both *Rust* and *Casey*, the Court specifies the types of viewpoint-based regulation of doctor-patient speech that might be unreasonable, and therefore, unconstitutional. In *Rust*, the Court suggested that a viewpoint-based regulation censoring the speech of publicly funded physicians would violate the First Amendment if the doctors were required to represent the government's opinions as their own, or if their relationships with patients were sufficiently all-encompassing to justify the expectation of receiving complete medical advice. See *Rust*, 500 U.S. at 200. Under the *Casey* plurality, viewpoint-based regulations on doctor-patient speech are unreasonable if physicians are required to utter statements that are false or misleading. *Casey*, 505 U.S. at 882.

40. Similarly, it is ironic that, under the Rehnquist Court's First Amendment jurisprudence, the railings of anti-abortion protesters (euphemistically referred to as "sidewalk counselors") at women as they enter an abortion clinic are afforded greater First Amendment protection than the conversations between these patients and their doctors once inside the medical facility. See *Schenck v. Pro-Choice Network of Western New York*, 117 S.Ct. 855, 864 (1996) (noting that content-neutral injunctions restricting the time, place, and manner of anti-abortion speech outside abortion clinics are subject to an intermediate standard of review, insuring that the restriction serves a significant government interest); accord *Madsen v. Women's Health Ctr.*, 512 U.S. 753, 765 (1994) (holding that a content-neutral injunction would be upheld if its challenged provisions burdened no more speech than necessary to serve significant government interests).

41. 508 U.S. 384 (1993).

family problems.⁴² The school board denied the request on the ground that its regulations did not expressly authorize the use of its facilities for religious purposes.⁴³ The school board argued that its policy of barring all religious groups from using its facilities was consistent with the Supreme Court's decision in *Cornelius v. NAACP Legal Defense and Educational Fund*,⁴⁴ which distinguished between a restriction controlling access to a non-public forum based on the subject of the proposed speech or the identity of the proposed speaker, which was permissible, and viewpoint-based discrimination, which was not.⁴⁵ Under *Cornelius*, the conclusion that a restriction was viewpoint-based could not be inferred merely from an exclusion based on subject matter or speaker identity. Rather, to be deemed impermissibly viewpoint-based, the Court required evidence that the restriction was *intended* to deny "[a]ccess to a speaker *solely* to suppress the point of view he expresses *on an otherwise includible subject*."⁴⁶

In *Lamb's Chapel*, however, the Court held that the mere

42. See *id.* at 387-88, 388 n.3 (describing the request for permission by the church to show movies, and listing the movies illustrating Christian perspectives on childrearing).

43. The board's regulations were promulgated in accordance with a New York statute authorizing local boards to adopt regulations for the use of school property for 10 specified purposes. The list in the statute did not include meetings for religious purposes. The school board's regulations authorized its facilities to be used only for social, civil, recreational, and political purposes, which were included as permissible purposes under the statute. See *id.*

44. 473 U.S. 788 (1985).

45. The Court stated: "Control over access to a nonpublic or limited public forum can be based on subject matter and speaker identity so long as the distinctions drawn are reasonable in light of the purpose served by the forum and are viewpoint neutral." *Id.* at 806.

46. *Id.* (emphasis added). See also *Ward v. Rock Against Racism*, 491 U.S. 781, 791 (1989) (explaining that "[t]he government's purpose is the controlling consideration" in deciding whether a speech restriction is content-based or content-neutral). The Rehnquist Court continues to send mixed messages about the role of motive in assessing the constitutionality of content-based regulations. For example, in *Madsen v. Women's Health Ctr.*, 512 U.S. 753 (1994), which was decided one year after *Lamb's Chapel*, the Court endorsed the notion that governmental purpose is the key to determining whether a regulation is viewpoint-based or viewpoint-neutral. The Court stated: "That petitioners all share the same viewpoint regarding abortion does not in itself demonstrate that some invidious content- or viewpoint-based purpose motivated the issuance of the order." *Id.* at 763. Ambivalence about the role of motive in assessing the constitutionality of government regulation of speech is not new. See Robert Post, *Recuperating First Amendment Doctrine*, 47 STAN. L. REV. 1249, 1268 (1995) ("There is a pervasive ambiguity as to whether courts are to assess the justification for a regulation [the reasons that can be adduced for its passage] or the motivation for a regulation [the actual psychological intentions of those who enacted it]. These are very different inquiries, and yet the Court has persistently equivocated as to which it means to require."). For a compelling argument in favor of inquiring into governmental motive, see generally Elena Kagan, *Private Speech, Public Purpose: The Role of Governmental Motive in First Amendment Doctrine*, 63 U. CHI. L. REV. 413 (1996).

fact that the school board's regulations had the effect of excluding the entire subject of religion from the list of permitted uses was itself sufficient to demonstrate that the restriction constituted "overt, viewpoint-based discrimination" in violation of the First Amendment.⁴⁷ Similarly, in *Rosenberger v. Rector & Visitors of the University of Virginia*,⁴⁸ the Court held that the decision of the publicly funded University of Virginia to deny a religious student organization's request for school funds violated the organization's free speech rights.⁴⁹ As in *Lamb's Chapel*, the basis for the exclusion was the subject of the speech (religion) not the particular religious viewpoint (Christian) that the organization sought to express. Nevertheless, the Court deemed the university's decision not to fund *all* religious expression impermissible viewpoint discrimination, despite the absence of evidence of any intent to discriminate against or promote a particular religious viewpoint.⁵⁰

It is difficult to reconcile the Rehnquist Court's concern about the danger of viewpoint-based regulations in *Lamb's Chapel* and *Rosenberger* with its lack of appreciation for the pernicious effect of viewpoint-based restrictions on doctor-patient speech.⁵¹ Patients are especially vulnerable to undue influence from government-dictated, viewpoint-based messages delivered by their physicians. Studies continue to show that patients are largely passive and deferential within the structure of the doctor-patient relationship,⁵² and that doctors may respond badly when patients attempt to participate actively in

47. *Lamb's Chapel*, 508 U.S. at 343-47 (1993) (Kennedy, J., concurring in part and concurring in the judgment).

48. 515 U.S. 819, 842-45 (1995) (holding that the university's denial of funding to print a Christian student newspaper amounted to unlawful viewpoint discrimination).

49. The petitioners challenged the university's decision on the ground that it violated their rights under the Free Speech Clause of the First Amendment. The university denied a free speech violation and argued additionally that its decision to grant the students' request for funding would have run afoul of the Establishment Clause of the First Amendment. *See id.* at 819-20. A majority of the Court rejected the university's Establishment Clause argument. *Id.* at 819-21.

50. *See id.* at 831.

51. For an analysis of the possible negative impact on patients and medical decision making of viewpoint-based restrictions on physician speech, see Berg, *supra* note 2, at 225-31.

52. *See* Debra L. Roter et. al., *Communication Patterns of Primary Care Physicians*, 277 JAMA 350, 355 (1997) (reporting that 66% of physician visits studied were physician-dominated, narrowly focused on biomedical concerns, and characterized by low levels of patient control over communication).

conversations.⁵³ All patients, especially those who are poor, uneducated, young, elderly, and/or members of racial and ethnic minorities have considerable difficulty asking questions and challenging physicians' authority.⁵⁴ Moreover, there is evidence that managed care may further constrain patients' ability to question or challenge physicians.⁵⁵ As a result, when confronted with the expression of a viewpoint about a preferred medical treatment that carries with it the considerable weight of the State *and a physician*, it is likely that patients will respond with silence, timidity, confusion, and deference.

III. SPEAKER AUTONOMY

In addition to being acutely sensitive to the danger of viewpoint-based regulations, the Rehnquist Court has, since *Rust* and *Casey*, been fiercely protective of speaker autonomy, particularly in the area of negative speech rights.⁵⁶ Indeed, the Court has often discussed the bar against government-compelled speech, particularly when ideologically based, in absolute terms. For example, Justice Souter, the author of the plu-

53. One recent British study found that a majority of doctors had a negative opinion of patients who bring written lists of concerns to medical consultations, describing them as "obsessional," "neurotic," "manipulative," and "authoritarian." See J. Middleton, *Written Lists in the Consultation: Attitudes of General Practitioners to Lists and the Patients Who Bring Them*, 44 BRIT. J. GEN. PRAC. 309 (1994) (concluding that it is necessary to overcome doctors' negative stereotypes of patients and advocating the use of written lists to improve communication between doctors and patients).

54. See Sherrie H. Kaplan et al., *Patient and Visit Characteristics Related to Physicians' Participatory Decision-Making Style*, 33 MED. CARE 1176, 1182-84 (1995) (interpreting data suggesting that patients over 75 and under 40 exhibit less assertive conversational behaviors [such as question-asking, interrupting, and asserting opinions] than middle-aged patients); P.N. Butow et al., *Computer-based Interaction Analysis of the Cancer Consultation*, 71 BRIT. J. CANCER 1115, 1118 (1995) (patients asked an average of 5.6 questions and spoke for less than 25% of 30-minute cancer consultations). See also Berg, *supra* note 2, at 227 n.133 (listing several articles discussing research showing that "patients rarely ask questions during conversations with physicians or take control of topics that are discussed").

55. See Ezekiel J. Emanuel & Nancy Neveloff Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 JAMA 323, 328 (1995) (discussing the effects that productivity requirements imposed by managed care organizations may have on opportunities for physician-patient communication); Kaplan et al., *supra* note 55, at 1185 (presenting data indicating that short office visits are associated with decreased patient participation in conversations with physicians).

56. The term "negative speech rights" refers to the right not to be compelled to speak. See *Wooley v. Maynard*, 430 U.S. 705, 714 (1976) ("The right of freedom of thought protected by the First Amendment against state action includes both the right to speak freely and the right to refrain from speaking at all").

rality opinion in *Casey*, recently stated:

Although the State may at times 'prescribe what shall be orthodox in commercial advertising' by requiring the dissemination of 'purely factual and uncontroversial information' . . . outside that context it may not compel affirmance of a belief with which the speaker disagrees Indeed, this general rule that the speaker has the right to tailor the speech, applies not only to expressions of value, opinion, or endorsement, but equally to statements of fact the speaker would rather avoid.⁵⁷

This heightened intolerance of restrictions on negative speech rights has led the Court to invalidate regulations that are far less constraining of speaker autonomy than those it upheld in *Rust* and *Casey*. For example, in *McIntyre v. Ohio Elections Commission*,⁵⁸ a pamphleteer challenged a fine imposed by the Ohio Elections Commission for distributing an anonymous leaflet in connection with a referendum on a proposed school tax levy. The fine was assessed in accordance with a state statute that required persons producing campaign literature to identify themselves.⁵⁹ The state argued that the statute's mandated disclosure requirement facilitated informed political decision making and maintained the integrity of the electoral process, a rationale strikingly similar to that proffered by the state to justify the compelled speech requirement in *Casey*.⁶⁰

In deeming the fine unconstitutional, Justice Souter, writing for the majority, firmly grounded the Court's holding in the personal liberty theory of the First Amendment,⁶¹ stating that "an author's decision to remain anonymous, like other decisions concerning omissions or additions to the content of publi-

57. *Hurley v. Irish-American Gay, Lesbian and Bisexual Group of Boston*, 515 U.S. 557, 573 (1995) (finding that a state court's application of a civil rights law to require organizers of a St. Patrick's Day parade to admit a contingent of gay and lesbian marchers violated the organizers' First Amendment rights).

58. 514 U.S. 334 (1995) (holding that Ohio's statutory prohibition against the distribution of any anonymous campaign literature violated the First Amendment).

59. *Id.* at 338 n.3 (citing OHIO REV. CODE ANN. § 3599.09 (A) (1988) (repealed 1995)).

60. See *McIntyre*, 514 U.S. at 341 ("Ohio maintains that the statute under review is a reasonable regulation of the electoral process").

61. For a general discussion of the personal liberty theory of the First Amendment, see C. EDWIN BAKER, *HUMAN LIBERTY AND FREEDOM OF SPEECH* 24 (1989) ("[F]reedom of speech may be defensible, not because of the marketplace of ideas' supposed capacity to discover truth, but because freedom of speech embodies respect for the liberty or autonomy and responsibility of the participants").

cation, is an aspect of the freedom of speech protected by the First Amendment.”⁶² Speaker autonomy is unconstitutionally constrained, according to Justice Souter, even when government compels an individual to speak or write something as seemingly innocuous and viewpoint-neutral as his or her own name.⁶³

In *Hurley v. Irish-American Gay, Lesbian and Bisexual Group of Boston*,⁶⁴ the Court again invalidated a state restriction that infringed upon speaker autonomy in a far more attenuated way than the regulations at issue in *Rust* and *Casey*. *Hurley* dealt with the constitutionality of a Massachusetts court’s ruling ordering the organizers of a St. Patrick’s Day parade to admit a contingent of gay and lesbian marchers. The state court had ruled that a parade is not expression, but is rather an event subject to a law barring discrimination on the basis of sexual orientation in public accommodations.⁶⁵ The Supreme Court disagreed. Again, Justice Souter, this time writing for a unanimous Court, held that the state court order violated the “fundamental rule of protection under the First Amendment, that a speaker has the autonomy to choose the content of his own message.”⁶⁶

When considered in light of the plurality opinion in *Casey*, Justice Souter’s opinions in *McIntyre* and *Hurley* are rather remarkable. First, the State undoubtedly offends speaker autonomy by compelling individuals to sign their names to a leaflet when they would otherwise choose not to. However, a far more substantial infringement of speaker autonomy occurs when, as in *Rust* and *Casey*, individuals are compelled to speak when they would otherwise choose to remain silent, and are compelled to express a viewpoint not their own. While permitting physician/speakers to disclaim agreement with the government’s message may lessen the regulation’s coercive

62. *McIntyre*, 514 U.S. at 340.

63. *See id.* at 342 (declaring interest in having published materials enter the marketplace of ideas outweighs need for disclosure of the anonymous author’s identity).

64. 515 U.S. 557 (1995) (limiting state’s right to alter expressive content of parade on grounds of First Amendment protection).

65. *Hurley*, 515 U.S. at 563 (stating that the state court “concluded that the parade is not an exercise of [the Council’s] constitutionally protected right of expressive association, . . .”).

66. *Id.* at 573.

effect on listeners, a disclaimer does not diminish the distortion of the speaker's mental process, or autonomy in determining the content of his or her expression.

Furthermore, the court-ordered inclusion of a group of gay and lesbian marchers in a St. Patrick's Day parade in *Hurley* is far less constraining of speaker autonomy than the measures at issue in *Rust* and *Casey*. *Hurley*'s court order did not require any alteration in the words spoken by any individual, nor did it interfere with the thinking or expression of any speaker.⁶⁷ Rather, by requiring the inclusion of a government-selected group in a parade (which already included such diverse contingents as those protesting the presence of England in Northern Ireland and those opposed to illegal drugs), the government altered the *context* or *form* of the organizers' expression, while leaving alone the thinking and speech of individual participants.⁶⁸ This far more mediated interference with individual speech, thought, and autonomy was nevertheless deemed unconstitutional by a unanimous Court.

The Rehnquist Court's failure to perceive an unacceptable infringement on physicians' speech rights in *Rust* and *Casey* may, as one commentator has approvingly suggested, rest upon its acceptance of the proposition that speaker autonomy is not implicated unless the expression involved originates in the intentions and free communicative will of an individual.⁶⁹ According to this theory, since physician speech about diagnosis and treatment is shaped by the norms of the medical profession, it is the profession, and not the individual doctor, that is the speaker.⁷⁰ Viewed from this perspective, the measures at

67. The Supreme Court describes the interference as "intimately connected with the communication advanced . . .," rather than as an infringement of individual speech or thought. *Id.* at 576.

68. "[W]e use the word 'parade' to indicate marchers who are making some sort of collective point, not just to each other but to bystanders along the way Parades are thus a form of expression, not just motion . . ." *Id.* at 568 (citations omitted).

69. See Randall P. Bezanson, *Institutional Speech*, 80 IOWA L. REV. 735, 765 (1995) (describing speech that belongs to no individual and is not "traceable to the speech intentions of other natural persons" as not protected from government regulation under the First Amendment).

70. There is language in *Casey* to support Professor Bezanson's view that the Court views professional speech as having an attenuated connection to First Amendment values because it is shaped by professional norms. See *Casey*, 505 U.S. at 884 (referring to a physician's First Amendment right not to speak as "only a part of the practice of medicine . . ."). However, more recently, Justice O'Connor, writing for the majority, seemed to take the opposite view in stating

issue in *Rust* and *Casey* do not infringe upon speaker/physician autonomy, because doctors lack free choice in determining the content of their conversations with patients.

However, the conclusion that physician speech rights are not at stake in conversations with patients rests upon several highly questionable premises. First, the claim that the norms of the medical profession supplant physician autonomy during conversations with patients is overstated. The content of physician speech is certainly influenced (one hopes) by the ethical standards of the medical profession, and parts of it, particularly those regarding diagnosis and treatment, may at times be wholly determined by the science of medicine. Nonetheless, it is individual physicians, and not the medical profession, who retain the ultimate authority in determining what to say to patients and whether to speak at all. This balance of power between individual doctors and the profession is reflected in the therapeutic exception to the doctrine of informed consent, under which physicians may remain silent about a patient's condition or a treatment alternative if they reasonably believe that speaking would cause the patient harm.⁷¹

Additionally, the view that speaker autonomy is not implicated unless speech is entirely a product of individual free will is grounded in an overly atomistic and decontextualized concept of autonomy. An individual's decision about what words to utter when communicating with another human being is always influenced, to varying degrees, by existing social relations and roles, by cultural and institutional norms, and by the

that the speech of professionals in the context of a professional relationship is fully protected by the First Amendment. See *Florida Bar v. Went For It, Inc.*, 515 U.S. 618, 634 (1995) ("Speech by professionals obviously has many dimensions. There are circumstances in which we will accord speech by attorneys on public issues and matters of legal representation the strongest protection our Constitution has to offer"). This inconsistency suggests that the plurality opinion in *Casey*, of which Justice O'Connor was a co-author, was not driven by a general First Amendment theory of professional speech, but by the fact that the physician speech at issue in that case concerned the contentious subject of abortion. See footnote 95, *infra*, and accompanying text.

71. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 788-89 (D.C. Cir. 1972) (recognizing an exception to the duty of informed consent if the physician reasonably concludes that the disclosure of risks would threaten a patient's well-being); *Bernard v. Char*, 903 P.2d 676, 683 (Haw. Ct. App. 1995), (recognizing that risk information may be withheld if detrimental to patients under the therapeutic exception to informed consent) *modified on other grounds* by 903 P.2d 667 (Haw. 1995) (establishing an objective standard for informed consent in Hawaii); N.Y. PUB. HEALTH LAW § 2805-d(4)(d) (McKinney 1993) (stating exception to the duty of informed consent if physician reasonably believes that disclosure would adversely affect patient).

ideas and expectations of others. Very little human expression would qualify for First Amendment protection if it had to be free of the influence of intellectual disciplines, social relations, and institutional norms.⁷²

Finally, *Casey's* conclusion that physician speech should be deprived of full First Amendment protection because "it is subject to reasonable licensing and regulation by the State" turns traditional First Amendment methodology on its head.⁷³ Rather than focusing on the necessity of limiting speech under certain circumstances, the traditional method for determining whether speech is protected in the first instance is to assess whether the expression facilitates First Amendment values. It is the function of the constitutional standard of review to protect the speech when it facilitates those values, and to permit government regulation in those exceptional instances when those values are outweighed by the expression's negative impact.

IV. LISTENER AUTONOMY

Since *Rust* and *Casey*, the Rehnquist Court has, as a general matter, presumed that listeners are capable of defining, and therefore ought to be free to define, their own communicative needs and interests.⁷⁴ Consequently, the Court has been highly circumspect when considering regulations that are justified on the ground that a State-structured dialogue is needed to protect listeners' informational needs. In the absence of empirical supporting evidence, the Rehnquist Court has consistently rejected the argument that a regulation is necessary to safeguard audience-based interests.

The Rehnquist Court's reverence toward listener autonomy is most apparent in a series of commercial speech cases illustrated by *Edenfield v. Fane*.⁷⁵ Here, the Court considered the

72. For an argument that speech should be protected precisely because of its relationship to social structures and relations, see Post, *supra* note 46, at 1250 (asserting that the constitutional value of speech inheres not in speech itself, but in particular social practices facilitated by speech).

73. *Casey*, 505 U.S. at 884.

74. The Rehnquist Court recently strongly endorsed the principle that the First Amendment protects the audience-based right to receive information. See, e.g., *Turner Broadcasting System, Inc. v. FCC*, 512 U.S. 622, 663 (1994) ("[A]ssuring that the public has access to a multiplicity of information sources is a governmental purpose of the highest order, for it promotes values central to the First Amendment").

75. See, e.g., *44 Liquormart, Inc. v. Rhode Island*, 517 U.S. 484 (1996) (holding that a

constitutionality of a Florida ban on in-person solicitations by accountants. The state argued that the ban was necessary to protect consumers from fraud and overreaching by accountants eager for new clients. The state did not, however, offer any evidence to support this claim. The Court held that the state's unsupported "suppositions" about the inability of consumers to judge for themselves the appropriateness of the accountants' speech was insufficient to justify the regulation.⁷⁶

Since *Rust* and *Casey*, the Rehnquist Court has upheld only one regulation that was justified on the ground that it was needed to protect audience-based interests.⁷⁷ In this case, however, which involved a ban on the use of direct mail by personal injury lawyers soliciting new clients, the state produced a lengthy empirical study demonstrating that the public did in fact need government protection from this speech.⁷⁸

In contrast to this line of commercial speech cases, neither *Rust* nor *Casey* analyzes the restrictions from the standpoint of their infringement on the audience-based, informational interests of listeners. Instead, these opinions, insofar as they are concerned with speech rights at all, focus on the impact of the regulations on physicians' speech rights.⁷⁹

Moreover, both opinions take a highly paternalistic attitude toward the audience-based interests of patients by assuming that they lack the capacity to assess their own informational needs. In the view of the *Casey* plurality, a woman's "mature

statute prohibiting liquor advertisements by retailers violated the First Amendment); *Rubin v. Coors Brewing Co.*, 514 U.S. 476, 483-84 (1995) (holding that a labeling ban on beer prohibiting the display of alcohol content violated the First Amendment); *Ibanez v. Florida Dept. of Bus. Prof'l Regulation, Bd. of Accountancy*, 512 U.S. 136 (1994) (reversing a lower court's finding that the Florida Board of Accountancy properly reprimanded an accountant for advertising her credentials as CPA and CFP in her commercial communications concerning her law practice, and finding a violation of her First Amendment rights); *Edenfield v. Fane*, 507 U.S. 761 (1993) (holding that a ban on in-person solicitations by accountants violated the First Amendment).

76. *Edenfield*, 507 U.S. at 770 (noting that the State produced no studies or anecdotal evidence to support the assumption that consumers would be misled or overwhelmed by in-person solicitations by CPAs).

77. See *Florida Bar v. Went For It, Inc.*, 515 U.S. 618 (1995) (holding that the Florida Bar has a "substantial interest both in protecting the privacy and tranquility of personal injury victims" and remarking that studies show that "the harms targeted by the ban are quite real").

78. *Florida Bar*, 515 U.S. at 618 (stating that the study summary contained both statistical and anecdotal data supporting the Florida Bar's position).

79. For a more extensive analysis of *Rust* and *Casey* from the standpoint of patients' audience-based rights under the First Amendment, see Berg, *supra* note 2, at 219-31.

and informed” decision about whether to continue a pregnancy to term can be ensured only if the State structures the doctor-patient dialogue, mandates the communication of certain information, and compels the expression of the State’s preference for childbirth over abortion immediately before the procedure is performed.⁸⁰ Unlike its approach in commercial speech cases, the Court in *Casey* did not demand proof that pregnant women seeking an abortion lack this information or themselves consider it relevant to their decision.⁸¹

The dissonance between the Rehnquist Court’s rejection of unproved assumptions to justify restrictions on commercial speech and its acceptance of unproved assumptions to justify restrictions on doctor-patient speech in *Rust* and *Casey* may be yet another example of a long-standing tradition of distrusting women’s capacity for rational decision making, particularly in the area of reproduction.⁸² For example, rather than mandating disclosure of information about the risks and benefits of participating in medical research and then permitting pregnant women to make their own decisions, the law has summarily excluded them from such participation.⁸³ Similarly, New York

80. *Casey*, 505 U.S. at 883 (“[W]e permit a State to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in doing so the State expresses a preference for childbirth over abortion”).

81. One commentator has concluded that the available evidence does not support the conclusion of the State and the Court that women need the information mandated by the “informed consent” statute in *Casey*. See Robert D. Goldstein, *Reading Casey: Structuring the Woman’s Decisionmaking Process*, 4 WM. & MARY BILL OF RTS. J. 787, 817-18 (1996) (stating that evidence from the tort system and Reagan Administration study do not support the conclusion that women do not understand the “moral” or psychological risks of abortion prior to undergoing the procedure).

82. Several commentators have observed that a distrust for women’s capacity for rational decision making is apparent in reproduction jurisprudence. See, e.g., Paula Abrams, *The Tradition of Reproduction*, 37 ARIZ. L. REV. 453, 463 (1995) (stating that “woman has been judged historically as incapable of rational thought” and “[t]he pervasiveness of this tradition throughout religion, philosophy, science, and ultimately law, distorts modern day cultural and legal evaluation of women’s reproductive autonomy”); Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492 (1993) (exploring the different ways in which the medical and legal professions approach women’s reproductive choices and the willingness of courts to intervene in women’s choices).

83. A number of legal scholars have analyzed the problem of gender bias in clinical research and the law. See, e.g., Karen H. Rothenberg, *Gender Matters: Implications for Clinical Research and Women’s Health Care*, 32 HOUS. L. REV. 1201, 1203 (1996) (explaining that in clinical practice “the majority of drugs have never been tested on pregnant women, primarily because of fetal protection policies that prohibit the inclusion of women of childbearing potential in most drug trials”); Vanessa Merton, *The Exclusion of Pregnant, Pregnable, and Once-Pregnable People (a.k.a. Women) from Biomedical Research*, 19 AM. J.L. & MED. 369 (1993)

recently enacted, and many states are considering, legislation that supplants new mothers' authority to decide whether to test their newborns for HIV.⁸⁴ These measures, which mandate the testing of all newborns and the disclosure of the results,⁸⁵ rest upon the unproven assumption that new mothers cannot be trusted to make a rational decision about testing their babies for HIV even if fully informed about the benefits of learning their infant's HIV status.

V. THE FUTURE CONSTITUTIONAL STATUS OF DOCTOR-PATIENT SPEECH

Since the time of Hippocrates, the highest ethical duty of physicians has been to regard the interests of patients as paramount to those of all others, including the State.⁸⁶ A patient-centered medical ethic does more than facilitate the identification and satisfaction of the health care needs of individual patients; it also creates a crucial boundary between the State and the practice of medicine. In doing so, it serves several important functions: it protects the medical decision making of patients from governmental coercion; it protects the intellectual freedom of physicians to practice their profession according to their best judgment; and, equally important, it safeguards the integrity of medicine from the potentially corrupting effects of a State agenda.⁸⁷

(arguing that stereotypes about women underlie, and are reinforced by, gender-based exclusionary criteria for biomedical research); L. Elizabeth Bowles, *The Disenfranchisement of Fertile Women in Clinical Trials: The Legal Ramifications of and Solutions for Rectifying the Knowledge Gap*, 45 VAND. L. REV. 877 (1992) (analyzing the "history and ramifications of exclusion of women from clinical trials").

84. N.Y. PUB. HEALTH LAW § 2500-f (McKinney Supp. 1997-98) (ordering creation of a program to deal with problems associated with HIV-positive newborns). In 1996, Congress amended the Ryan White CARE Act of 1990, which provides funds for AIDS-related services and treatment, to include financial incentives for states to adopt mandatory HIV testing of all newborns and the disclosure of the results. 42 U.S.C.A. § 300ff-37 (West Supp. 1997) (allowing disqualified states to receive grant money if they establish mandatory HIV testing).

85. N.Y. PUB. HEALTH LAW § 2500-f (McKinney Supp. 1997-98) (creating a program to test newborns for HIV).

86. STEDMAN'S MEDICAL DICTIONARY 716-717 (25th ed. 1990).

87. We need not speculate about what can come to pass when the allegiance of doctors shifts from their patients to the State. In the 1930s and '40s, German physicians were taught that they owed a higher duty to the health of the State than to the health of their patients. The substitution of State policy for a patient-based medical ethic led substantial numbers of German doctors to lend their support to the Nazi agenda and its theories of racial superiority, and to

While the Constitution includes several provisions that, like the patient-centered teaching of Hippocrates, shield a sphere of individual liberty against government infiltration, none of these is more towering than the First Amendment. By prohibiting the State from distorting speech, the First Amendment aspires to insure that the formation of belief about all matters related to the “intellect and spirit”⁸⁸ occurs within a free and unfettered context. To achieve this aim, the First Amendment protects both positive and negative speech rights — the right to speak, the right *not* to speak, the right to receive ideas by listening to others, and the right *not* to be compelled to listen to unwanted speech.⁸⁹ As one First Amendment scholar has stated: “Freedom of expression . . . supports a mature individual’s sovereign autonomy in deciding how to communicate with others; it disfavors restrictions on communication imposed for the sake of the distorting rigidities of the orthodox and the established.”⁹⁰

A dispassionate application of established First Amendment doctrine in *Rust* and *Casey* would have led the Rehnquist Court to conclude that doctor-patient speech is protected expression that cannot be regulated on the basis of viewpoint.⁹¹

participate in the sterilization and extermination of “undesirable” patients. See Jeremiah A. Baroness, *Medicine Against Society: Lessons From the Third Reich*, 276 JAMA 1657, 1658-61 (1996) (describing the restructuring of the German medical profession and the consequences of its transformation into an arm of State policy).

88. See *Wooley v. Maynard*, 430 U.S. 705, 715 (1977) (quoting *West Virginia Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943) to determine that requiring a motorist to display the motto “Live Free or Die” invaded the sphere of the intellect and spirit [protected by] the First Amendment”).

89. *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council*, 425 U.S. 748, 756 (1976) (“Freedom of speech presupposes a willing speaker. But where a speaker exists . . . the protection afforded is to the communication, to its source and to its recipients both.”); *Wooley*, 430 U.S. 705, 714 (“The right of freedom of thought protected by the First Amendment against state action includes both the right to speak freely and the right to refrain from speaking at all.”); *Rowan v. United States Post Office Dep’t*, 397 U.S. 728, 737-38 (1970) (noting that the Constitution does not compel citizens to listen to or view unwanted communications, including those sent by mail); *Stanley v. Georgia*, 394 U.S. 557, 564 (1969) (stating that “[i]t is now well established that the Constitution protects the right to receive information and ideas”).

90. David A.J. Richards, *Free Speech and Obscenity Law: Toward a Moral Theory of the First Amendment*, 123 U. PA. L. REV. 45, 62 (1974).

91. I have argued elsewhere that doctor-patient speech is protected under the First Amendment because it is intimately connected to patients’ autonomy and audience-based interests in receiving information. See *Berg supra* note 2, at 221-31. For alternative theories for protecting doctor-patient speech, see Robert C. Post, *Subsidized Speech*, 106 YALE L. J. 151, 174 (1996) (arguing that the First Amendment prohibits viewpoint-based regulation of medical counseling

Affording First Amendment protection to doctor-patient speech would not altogether displace the right of government to impose some content-based regulations. Informed consent requirements, for example, would survive even the most exacting standard of review because they are viewpoint-neutral and serve the compelling state interest of facilitating informed medical decision making.⁹² Additionally, unlike the paternalistic rationale advanced to support the viewpoint-based disclosure requirements in *Casey*, there is extensive historical and empirical evidence supporting patients' need for governmental intervention to prevent coerced medical decisions by insuring that doctors communicate complete information about diagnosis and alternative treatments.⁹³ Indeed, the evidence supporting the need for informed consent requirements is as compelling as that deemed sufficient by the Rehnquist Court to justify a content-based regulation of political speech in *Burson v. Freeman*.⁹⁴

The Rehnquist Court's highly protective free speech jurisprudence since *Rust* and *Casey* supports the thesis, advanced by some at the time,⁹⁵ that the constitutional protection of

because "patients expect the independent judgment of physicians to trump inconsistent managerial demands"); Goldstein, *supra* note 81, at 853 (arguing that the First Amendment protects doctor-patient speech because of "substantial individual and societal interests in physicians' free speech"). For an argument reaching the opposite conclusion, see Bezanson, *supra* note 69, at 766 (describing physician speech as "representational speech" not protected by the First Amendment).

92. For another formulation of a standard of review for restrictions on doctor-patient speech specifically designed to protect patients' First Amendment right to receive unbiased medical advice, see Berg, *supra* note 3, at 260-65.

93. For a history of the doctrine of informed consent, see generally PAUL S. APPELBAUM ET. AL., *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* (1987); RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* (in collaboration with Nancy M.P. King 1986) (exploring the origin and nature of informed consent, concentrating on conceptual issues, particularly the conditions under which informed consent is obtained). See also JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984).

94. 504 U.S. 191 (1992) (plurality opinion) (holding that a Tennessee statute restricting political campaigning near the entrance to polling places did not violate the First Amendment). Of particular relevance to the plurality in *Burson* was the extensive history of voter intimidation and the widespread existence of state statutes limiting polling place speech. *Id.* at 200-04. It is similarly well-established that physicians have historically deprived patients of accurate and complete information about diagnosis and alternative treatments, and thereby undermined the voluntariness of medical decisions. To address this problem, every state imposes informed consent requirements on physicians either as a matter of common law or by statute. For an analysis of the various types of informed consent requirements, see Peter H. Schuck, *Rethinking Informed Consent*, 103 *YALE L.J.* 899, 916-17 (1994).

95. See, e.g., Berg, *supra* note 2, at 219 (stating that "[w]hile one suspects that the Court's conclusions in these cases reflect the majority's views on the highly volatile subject of abortion,

doctor-patient speech was forfeited to accommodate profound disagreements about the practice of abortion among the Court's members.⁹⁶ Unfortunately, it is doubtful that this distortion of free speech jurisprudence will be remedied in the near future. If history is any indication, prospective Supreme Court challenges to government regulation of doctor-patient speech are likely to involve measures requiring physicians to utter increasingly pointed statements opposing abortion,⁹⁷ or to express the State's viewpoint concerning some other highly controversial medical practice about which members of the Court are likely to disagree.⁹⁸ Indeed, the most recent First Amendment chal-

the Court did not limit its holdings to this narrow context"); Wells, *supra* note 26, at 1724 (arguing that "[i]n its hurry to dismantle abortion rights... the Court also pulled apart the fundamental tenets of the First Amendment").

96. It has also recently become apparent that Justice Souter's sanctioning of the imposition of viewpoint-based regulations on physician speech may be an aspect of a larger theory that doctors' professional roles appropriately include overseeing patients' moral health. See *Washington v. Glucksberg*, 117 S.Ct. 2258, 2288 (1997) (Souter, J., concurring) (stating that "the good physician is not just a mechanic of the human body whose services have no bearing on a person's moral choices, but one who does more than treat symptoms, one who ministers to the patient").

97. For example, in 1975, Illinois enacted a statute that required physicians to inform patients that "[t]he State of Illinois wants you to know that in its view the child you are carrying is a living human being whose life should be preserved. Illinois strongly encourages you not to have an abortion but to go through to childbirth." ILL. ST. CH. 38 §§ 81-23.5(1975), *repealed* by P.A. 83-1128, § 2 (1984) (text of repealed statute is reprinted in part in *Charles v. Carey*, 627 F.2d 772, 781 n.13 (7th Cir. 1980) While this statute was held to violate the First Amendment at the time, it could survive constitutional review today under the standard set forth in *Casey*.

98. State statutes patterned on the Pennsylvania statute in *Casey* requiring physicians to communicate to patients the government's ideological opposition to abortion have been generally upheld. See, e.g., *Fargo Women's Health Organization v. Schafer*, 18 F.3d 526 (8th Cir. 1994) (upholding a statute that requires the physician or physician's agent to inform a woman seeking an abortion that medical assistance benefits may be available, that the father is liable for child support, and that she has a right to review printed materials describing the fetus and listing abortion alternatives); *Planned Parenthood v. Miller*, 63 F.3d 1452 (8th Cir. 1995) (upholding a district court ruling striking a parental notification provision because it failed to provide a "parental bypass mechanism," and also holding that South Dakota may constitutionally require physicians to provide patients with certain information 24 hours before performing an abortion), *cert. denied sub nom.*, *Jamklow v. Planned Parenthood*, 116 S.Ct. 1582 (1996); *Utah Women's Clinic, Inc. v. Leavitt*, 844 F.Supp. 1482 (D.Utah 1994) (deciding that a Utah abortion statute requiring informed consent and a 24-hour waiting period was unconstitutional). However, on July 2, 1997, a Florida state court judge enjoined the implementation of the "Women's Right to Know Act," which mandated that physicians convey viewpoint-based information to patients seeking an abortion. The plaintiffs asserted that the bill violated a woman's constitutional right to privacy, due process, and equal protection in requiring "the physician to be... an arm of the state in advising his patient... and forces the physician to steer his patient in favor of parenthood regardless of his true beliefs about the best interest of his patient and the expressed desire of his patient, who has come to him for an abortion." *Judge Enjoins Implementation of Abortion Right to Know Law*, 6 BNA HEALTH L. REP., 1091, 1091 (1997) (quoting from complaint in the case).

lenge to a government restriction on doctor-patient speech concerned the contentious issue of the medicinal use of marijuana.⁹⁹ One can only hope, therefore, that the next time the Rehnquist Court confronts a viewpoint-based regulation of physician-patient speech, it will hold its nose and adhere to the dictates of the First Amendment, which, above all else, protects expression regarding practices or subjects that some condemn.

99. *See Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997) (holding that threats by federal drug enforcement officials to prosecute physicians for advising patients about medical uses of marijuana after enactment of the California Compassionate Use Act of 1996 violated physicians' and patients' rights under the First Amendment).

