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Toward a First Amendment Theory of Doctor-Patient Discourse and the Right to Receive Unbiased Medical Advice

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The practice of medicine invariably reflects and reinforces a culture's dominant ideology and its patterns of social and economic organization.\(^1\) During certain historical periods, however, governments have overtly politicized the practice of medicine, restricting access to medical information and directly manipulating the content of doctor-patient discourse.\(^2\) For example, during the Cultural Revolution, Chinese physicians were dispatched to the countryside to convince peasants to use contraception.\(^3\)


The medical system is an ordered, coherent body of ideas, values, and practices embedded in a given cultural context from which it derives its signification. It is an important part of the cultural world and as such it is constructed, like any other segment of social reality, by the regnant body of symbolic meanings.

Medical systems function along the lines of the cultural dialectic, relating and treating both individual and social realities.

\(^2\) This Article uses the terms “doctor-patient discourse,” “doctor-patient speech,” and “doctor-patient communication” interchangeably to refer to oral communication between physicians and patients that occurs after the formation of a professional relationship concerning diagnosis, treatment alternatives, and the wide range of subjects that are commonly discussed in the course of treatment decision making.

\(^3\) See Penny Kane, *Family Planning in China, in Health Care and Traditional Medicine in China 1800-1982*, at 426, 431 (S.M. Miller & J.A. Jewell eds., 1983). A more radical proposal to manipulate the content of doctor-patient discourse is currently pending in China. To reduce the number of disabled people in the Chinese population, the Minister of Public Health recently proposed legislation that would require physicians to “advise” pregnant women diagnosed as having infectious diseases or carrying abnormal fetuses to have an abortion. Patrick E. Tyler, *China
In the 1930s, the Soviet government expedited completion of a construction project on the Siberian railroad by ordering doctors to both reject requests for medical leave from work and conceal this government order from their patients. In Nazi Germany, the Third Reich systematically violated the separation between state ideology and medical discourse. German physicians were taught that they owed a higher duty to the "health of the Volk" than to the health of individual patients. Recently, Nicolae Ceausescu's strategy to increase the Romanian birth rate included prohibitions against giving advice to patients about the use of birth control devices and disseminating information about the use of condoms as a means of preventing the transmission of AIDS.

In the United States, ideology-based restrictions on doctor-patient speech have thus far been limited to discussions about abortion and contraception. Several jurisdictions have enacted statutes that criminalize

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6 See Robert J. Lifton, The Nazi Doctors: Medical Killings and the Psychology of Genocide 30 (1986) (describing a manual advocating that doctors embrace a public duty to maintain racial purity). The government also required physicians to report the names of persons with genetic illnesses for possible sterilization. Id. at 25; see also Kater, supra note 5, at 121 (noting the addition of “race hygiene” courses into medical schools’ curricula).

7 David J. Rothman & Sheila M. Rothman, How AIDS Came to Romania, N.Y. Rev. Books, Nov. 8, 1990, at 5. Ceausescu’s “pronatal campaign” also required government investigations into the death of any infant under the age of one year. To avoid these investigations, Romanian physicians used drastic means to keep children alive until after their first birthday, including unnecessary prophylactic injections of antibiotics and whole blood, which resulted in the spread of AIDS among young children from the use of unsterile needles. Id. at 6-7.

8 Restrictions on physician speech in this country have been less extreme than those in Germany and the U.S.S.R. However, in developing a First Amendment theory of doctor-patient discourse, this Article adopts the “pathological perspective” described by Professor Vincent Blasi:

[In adjudicating first amendment disputes and fashioning first amendment doctrines, courts ought to adopt what might be termed the pathological perspective. That is, the overriding objective at all times should be to equip the first amendment to do maximum service in those historical periods when intolerance of unorthodox ideas is most prevalent and when governments are most able and most likely to stifle dissent systematically. The first amendment, in other words, should be targeted for the worst of times.]
physician speech about these subjects.\textsuperscript{9} In 1988, the Bush Administration implemented a regulation forbidding doctors working in publicly funded clinics from counseling patients about abortion.\textsuperscript{10} In addition to silencing doctors' speech, some states have passed laws compelling physicians to make specific statements to patients in order to persuade them to make medical decisions in conformity with governmental opinion.\textsuperscript{11} Illinois enacted a law requiring physicians to give the following written statement to all patients seeking an abortion: "The 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."\textsuperscript{12}


\textsuperscript{9} Statutes criminalizing physician speech about contraception and abortion have not survived judicial scrutiny. Most courts have, however, rested their decisions on privacy grounds rather than on the First Amendment. \textit{See}, e.g., Griswold v. Connecticut, 381 U.S. 479, 485 (1965) (holding that a Connecticut statute prohibiting counseling on contraception violated the right to privacy). In Guam Soc. of Obstetricians & Gynecologists v. Ada, 776 F. Supp. 1422, 1428-29 (D. Guam 1990), \textit{aff'd}, 962 F.2d 1366 (9th Cir.), \textit{cert. denied}, 113 S. Ct. 633 (1992), the district court held that the section of a statute prohibiting the solicitation of women to have abortions violated the First Amendment, \textit{id.} at 1429 n.9, and that the entire statute violated the right to privacy, \textit{id.} at 1429. The court's First Amendment holding appears to rest on the view that the statute violated physicians' right to speak, not patients' right to receive medical advice. The Ninth Circuit affirmed the district court's decision that the statute violated the right to privacy; the First Amendment discussion was not addressed on appeal. Guam Soc. of Obstetricians & Gynecologists v. Ada, 962 F.2d 1366 (9th Cir.), \textit{cert. denied}, 113 S. Ct. 633 (1992).


\textsuperscript{12} Pub. Act 81-1078, § 3.5(2), 1979 Ill. Laws 4108, 4115 (repealed 1984). In Charles \textit{v.} Carey, 627 F.2d 772 (7th Cir. 1980), the court upheld a permanent injunction preventing the state from enforcing portions of the law, including a section that
On several occasions over the past 30 years, the United States Supreme Court has considered the constitutionality of statutes that included provisions directly regulating the content of doctor-patient speech.\(^\text{13}\) However, until \textit{Rust v. Sullivan}\(^\text{14}\) and \textit{Planned Parenthood v. Casey},\(^\text{15}\) the Supreme Court never had to face the issue of whether restrictions on the content of doctor-patient speech violate the First Amendment.\(^\text{16}\) Prior to \textit{Rust} and \textit{Casey}, advocates challenging statutes that included restrictions on physician speech about contraception or abortion did not assert that those provisions violated the First Amendment.\(^\text{17}\) Instead, they argued

imposed criminal penalties on physicians who failed to give this policy statement to patients. The court held that the statute unconstitutionally violated physicians' First Amendment rights. \textit{Id.} at 789. Illinois did not appeal the decision, and an appeal by a private physician to the Supreme Court was dismissed for lack of jurisdiction. \textit{Diamond v. Charles}, 476 U.S. 54, 71 (1986).

\(^{13}\) See \textit{Webster v. Reproductive Health Servs.}, 492 U.S. 490, 511 (1989) (considering a statute that forbade public employees from counseling a woman to have an abortion not necessary to save her life); \textit{Thornburgh v. American College of Obstetricians & Gynecologists}, 476 U.S. 747, 760-64 (1986) (invalidating a statute requiring that certain information be given to a woman before she consents to an abortion); \textit{City of Akron}, 462 U.S. at 444-45 (invalidating informed consent provisions designed to persuade a woman not to have an abortion); \textit{Planned Parenthood v. Danforth}, 428 U.S. 52, 65-67 (1976) (upholding a provision requiring a woman to give written consent to an abortion); \textit{Griswold v. Connecticut}, 381 U.S. 479, 480 (1965) (considering a statute prohibiting counseling about contraception and family planning); \textit{Poe v. Ullman}, 376 U.S. 497, 498 (1961) (same).

The other abortion cases that have reached the Supreme Court have not concerned statutes regulating the content of doctor-patient discourse. See, e.g., \textit{H.L. v. Matheson}, 450 U.S. 398, 400 (1981) (requirement of parental notification when minors sought abortions); \textit{Harris v. McRae}, 448 U.S. 297, 302 (1980) (prohibition of the use of federal funds to perform certain abortions); \textit{Maher v. Roe}, 432 U.S. 464, 466 (1977) (prohibition of the use of state funds for nontherapeutic abortions); \textit{Roe v. Wade}, 410 U.S. 113, 117-18 (1973) (criminalization of attempts to administer or procure abortions); \textit{Doe v. Bolton}, 410 U.S. 179, 184 (1973) (requirement that abortions be performed in a hospital only after approval by a hospital committee and confirmation from two physicians).


\(^{15}\) 112 S. Ct. 2791 (1992) (plurality opinion).

\(^{16}\) U.S. CONST. amend. I ("Congress shall make no law . . . abridging the freedom of speech . . .").

\(^{17}\) Despite provisions directed at the content of doctor-patient speech about abortion or contraception, no First Amendment argument was made to the Supreme Court in \textit{Poe, Danforth, City of Akron}, or \textit{Thornburgh}. In \textit{Webster}, the appellees conceded that a First Amendment challenge to a Missouri statute restricting public employees from speaking about abortion within the scope of their employment was moot because of the state's assertion that this provision was not aimed at the conduct of any public or private health care provider. See \textit{Webster}, 492 U.S. at 512.

Appellants in \textit{Griswold} argued that the statutes at issue violated physicians' First Amendment rights. Brief for Appellants at 91-94, \textit{Griswold} (No. 64-496). However,
that the entire enactment, including the speech-related provisions, violated the privacy right established in *Griswold v. Connecticut.* Thus, *Rust* and *Casey* presented the Supreme Court with a historic opportunity to delineate the extent to which the First Amendment restrains government from politicizing the practice of medicine by manipulating the content of doctors' conversations with patients.

Unfortunately, the Rehnquist Court did not rise to the occasion. Instead, with little or no First Amendment analysis, the Court upheld the speech restrictions at issue in both cases and, in the process, recognized a government power to impose viewpoint-based regulations on doctor-patient speech in both publicly and privately financed settings. By doing so, the Rehnquist Court reversed the position of the Burger Court,

the Court did not address these arguments in its opinion. There is a dearth of scholarly discussion of the relationship between the First Amendment and doctor-patient discourse. Indeed, there are no articles analyzing the First Amendment status of communication within the confines of relationships between any type of licensed professional and his or her patients or clients.

18 381 U.S. 479 (1965). In retrospect, it appears that a better strategy might have been to assert that restrictions on *conduct* associated with performing abortions violated women's right to privacy, while restrictions on *speech* about abortion violated both the right to privacy and patients' rights under the First Amendment. This two-pronged strategy might have placed women's right to obtain information about abortion and contraception from their physicians on a more secure constitutional footing. The relatively liberal Burger Court might have recognized that the First Amendment protects doctor-patient discourse and prohibits the government from imposing viewpoint-based restrictions to limit patients' acquisition of information.

19 In several abortion and contraception cases involving speech restrictions upon physicians, dissenting Justices noted the possibility of a First Amendment violation, even though this argument had not been made to the Court. In their opinions, however, the dissenting Justices exclusively concentrated on the restrictions' impact on physicians' right to speak and ignored the effects on patients' right to receive unbiased information. See, e.g., City of Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416, 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 physicians if the State requires him or her to communicate its ideology."); *Griswold,* 381 U.S. at 507-508 (Black, J., dissenting) ("I can think of no reasons at this time why their expressions of views would not be protected by the First and Fourteenth Amendments, which guarantee freedom of speech"); *Poe,* 367 U.S. at 513 (Douglas, J., dissenting) ("The right of the doctor to advise his patients [about contraception] according to his best lights seems so obviously within [the] First Amendment . . . as to need no extended discussion.").

20 Viewpoint-based regulations "aim at ideas or information, in the sense of singling out actions for government control or penalty either (a) because of the specific message or viewpoint such actions express, or (b) because of the effects produced by awareness of the information or ideas such actions impart." Laurence H. Tribe, *American Constitutional Law* § 12-2, at 789 (2d ed. 1988).

21 See infra notes 87-92 and accompanying text.
which had repeatedly invalidated viewpoint-based restrictions on physician speech on right to privacy grounds.\(^{22}\) Although the Rehnquist Court set limits on this newly recognized government prerogative,\(^{23}\) it did not sufficiently restrain the government from using doctor-patient discourse as a tool for indoctrination, nor did it protect patients' interest in receiving the information they need to exercise meaningfully their constitutional right to determine the course of their medical treatment.\(^{24}\)

The purpose of this Article is twofold. First, it critiques \textit{Rust} and \textit{Casey} and suggests that the Rehnquist Court relied on faulty logic in reaching its conclusion about the right of government to regulate the content of physician speech. Specifically, it argues that the Court misunderstood the dynamics of doctor-patient interaction, and as a result, grossly underestimated the danger that patients will be coerced and confused by government messages delivered by physicians.\(^{25}\) Moreover, the Court did not recognize that the principal constitutional threat posed by government restrictions on the content of doctor-patient speech is not their infringement on physicians' speech rights. Rather, the more serious peril of such measures is that they enable government to impose its orthodoxy on medical decision making by limiting and biasing the medical information available to patients.\(^{26}\)

Second, this Article strives to succeed where \textit{Rust} and \textit{Casey} failed by developing a First Amendment theory of doctor-patient discourse that appreciates and protects patients' interests in receiving complete, unbiased medical information and advice.\(^{27}\) This theory proceeds from the premise that government regulation of doctor-patient speech may in some cases be necessary to increase the flow of information to patients, thereby facilitating the attainment of consent and thus advancing the First Amendment goals of self-fulfillment and autonomy.\(^{28}\) The practical

\(^{22}\) See Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 760 (1986) (stating that the state cannot require the delivery of information aimed at persuading a patient to choose childbirth over abortion). The Burger Court's view that speech restrictions that seek to influence patients' medical decisions are unconstitutional reflects its more sophisticated understanding of the asymmetrical nature of doctor-patient communication, see infra notes 123-45 and accompanying text, and its appreciation of the danger of coercion that exists when physicians become mouthpieces for state policy, see, e.g., \textit{Thornburgh}, 476 U.S. at 763 (noting that forcing physicians to present the state's view to patients makes them agents of the state and places physicians' imprimatur upon this view).

\(^{23}\) See infra text accompanying note 93.

\(^{24}\) Cruzan v. Director, 497 U.S. 261, 278 (1990) (stating that competent patients have a constitutional liberty interest in refusing unwanted medical treatment).

\(^{25}\) See infra notes 123-45 and accompanying text.

\(^{26}\) See infra notes 149-50 and accompanying text.

\(^{27}\) See discussion infra part V.

\(^{28}\) This necessity of regulation emanates from the long history of physicians withholding information from patients about alternative treatments and associated risks.
objective of a First Amendment theory of doctor-patient speech therefore must be to aid courts in distinguishing between regulations that encourage the disclosure of information necessary for rational, autonomous medical choices, and those that impose official dogma upon medical choices.

Parts I and II of this Article discuss and critique the Supreme Court's decisions in Rust and Casey regarding government restrictions on doctor-patient speech. Part III analyzes the appropriate level of First Amendment protection for doctor-patient speech in light of the free speech values that it implicates. Part IV examines the problem of government restrictions that silence physician speech. Finally, Part V examines the First Amendment implications of regulations compelling physician speech and proposes a test for assessing such regulations' constitutionality.

I. THE SUPREME COURT'S FIRST AMENDMENT ANALYSIS OF DOCTOR-PATIENT DISCOURSE

In Rust v. Sullivan, the Court was asked to determine the constitutionality of the Department of Health and Human Services' (HHS) 1988 reinterpretation of Title X of the Public Health Services Act. The Act authorizes the Secretary of HHS to administer grants and enter into contracts to establish and operate family planning projects that offer "a broad range of acceptable and effective family planning methods." No

For a discussion of this history and the evolution of the doctrine of informed consent, which requires the disclosure of treatment alternatives and associated material risks to patients, see 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 (1986); JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).


31 Id. § 300(a).
funds appropriated under the Act can be "used in programs where abortion is a method of family planning." 32

In 1988, HHS issued interpretive regulations to provide "clear and operational guidance" to grantees about how to preserve the distinction between Title X programs and abortion as a method of family planning. 33 To this end, the regulations imposed a panoply of restrictions upon the conduct34 and speech of Title X grantees, including physicians who worked in publicly funded family planning clinics. 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. 35 In response to a specific request for a referral to an abortion provider, the regulations suggested that physicians respond by stating that "the project does not consider abortion an appropriate method of family planning and therefore does not counsel or refer for abortion." 36

The doctors37 who mounted a facial challenge to the regulations38 argued that the regulations interfered with the First Amendment rights of

32 Id. § 300a-6.
34 The restrictions imposed on the conduct of Title X grantees prohibit lobbying for legislation that could increase the availability of abortion, using legal action to make abortion more available, paying dues to any pro-choice group, and failing to maintain a financial and physical separation between Title X-funded projects and any abortion-related activities. 42 C.F.R. § 59.9 (1991).
35 Id. § 59.8(a)(1). The regulations also restricted grantees' speech by prohibiting the development and dissemination of written materials advocating abortion, and by prohibiting pro-abortion speakers. Id. § 59.10(a). This prohibition may also interfere with patients' acquisition of medical information. However, a comprehensive analysis of whether restrictions on written communication between doctors and patients violate the First Amendment is beyond the scope of this Article.
36 Id. § 59.8(b)(5). The regulations do not, however, require physicians to utter the suggested response to patients who request abortion counseling or referrals; penalties are imposed only when physicians provide abortion counseling or referrals. For the purpose of this analysis, this Article assumes that these regulations compel silence, rather than physician speech.
37 The petitioners, suing on behalf of themselves and their patients, were Title X grantees and doctors who supervised Title X funds. Rust, 111 S. Ct. at 1766. For simplicity, this Article refers to the petitioners as "doctors" and to the respondents as the "Government."
38 By mounting a facial challenge to the regulations, as opposed to an as-applied challenge, the doctors faced a very heavy burden. Id. at 1767. Specifically, they were required to "establish that no set of circumstances exists under which the Act would be valid. The fact that [the regulations] might operate unconstitutionally under some conceivable set of circumstances is insufficient to render [them] wholly invalid." Id. (alterations in original) (citing United States v. Salerno, 481 U.S. 739, 745 (1987)).
Title X health care providers and Title X patients. Specifically, they alleged that the regulations: (1) impermissibly discriminated on the basis of viewpoint; and (2) conditioned the receipt of Title X funds upon the surrender of a fundamental right to freedom of expression. While the doctors conceded that government can place certain conditions upon the receipt of public funds, they argued that the First Amendment forbids the state from denying federal subsidies for the purpose of suppressing "dangerous ideas."

In addressing the doctors' arguments, the majority did not begin by determining the appropriate level of protection for doctor-patient speech—the traditional starting point for a First Amendment inquiry. Indeed, Chief Justice Rehnquist's majority opinion did not include a First Amendment analysis of the regulations, from the standpoint of either doctors' speech or patients' right to receive medical information.

Instead, the Court's analysis of the speech-related restrictions was rooted in its interpretation of the doctrine of unconstitutional conditions, as developed in \textit{Maher v. Roe} and \textit{Harris v. McRae}. In those

\begin{footnotes}
39 Brief for Petitioners at 13, \textit{Rust} (No. 89-1391). Petitioners also argued that the regulations violated the Fifth Amendment by obstructing a woman's decision making about her pregnancy. \textit{Id.} at 31.

Three federal appellate courts considered constitutional challenges to these HHS regulations. The First Circuit held that the regulations violated the First Amendment. \textit{Massachusetts v. Secretary of Health \\& Human Servs.}, 899 F.2d 53, 73 (1st Cir. 1990) ("[T]he prohibited speech will often involve communications between a patient and doctor, an area (given the 'life' and 'liberty' interests potentially involved) warranting particularly strong protection."). The Second Circuit held that the regulations did not violate the First Amendment because providers and patients were free to speak about abortion outside the confines of a Title X program. \textit{New York v. Sullivan}, 889 F.2d 401, 412-14 (2d Cir. 1989). The Tenth Circuit held that the regulations violated the First Amendment rights of doctors and patients. \textit{Planned Parenthood Fed'n of Am. v. Sullivan}, 913 F.2d 1492, 1505 (10th Cir. 1990) (holding that the regulations "infringe upon the doctor-patient relationship by limiting the free flow of information from the doctor to the patient regarding abortion services").

40 Brief for Petitioners, \textit{Rust} (No. 89-1391).

41 \textit{Id.} at 17 (citing \textit{Cammarano v. United States}, 358 U.S. 498, 513 (1959)).

42 \textit{Rust}, 111 S. Ct. at 1771.

43 \textit{Id.} at 1771-72.


45 432 U.S. 464 (1977) (upholding the state's refusal to fund nontherapeutic abortions under the Medicaid program).
decisions, the Court held that the government does not violate a woman’s right to an abortion by refusing to fund it. Women deprived of federal assistance technically remain free to have an abortion, the Court reasoned, albeit without the benefit of federal funds.47

Relying on this analysis, the Rust Court determined that the HHS regulations were a constitutional exercise of the government’s power to fund some activities and not others.48 According to the Court, conditioning the receipt of federal funds on remaining silent about abortion is consistent with the government’s power to make funding choices in accordance with its preference for childbirth over abortion.49 With respect to the impact of the regulations upon physicians’ speech, the Court explained that

a doctor employed by the project may be prohibited in the course of his project duties from counseling abortion or referring for abortion.

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.50

Thus, the Rust majority endorsed the proposition that government may, to promote its viewpoint, censor the speech of publicly funded speakers, including physicians. The Court recognized, however, that the government’s power to impose viewpoint-based restrictions upon the speech of recipients of public funds is not unlimited. It acknowledged that government interference with the content of publicly funded speech would be suspect in three areas: public fora,51 areas “expressly dedicated to speech activity,”52 and “traditional spheres of free expression . . . fund-

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47 Id. at 316-17.
48 See Rust, 111 S. Ct. at 1772 (citing Maher, 432 U.S. at 474 (holding that the government may “make a value judgment favoring childbirth over abortion, and . . . implement that judgment by the allocation of public funds.”))).
49 Id. The Court stated:
The Government can, without violating the Constitution, selectively fund a program to encourage certain activities it believes to be in the public interest, without the same time funding an alternate program . . . . 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.
Id.
50 Id. at 1772-73.
51 Id. at 1776. Public fora include “those places historically associated with First Amendment activities, such as streets, sidewalks, and parks.” Tribe, supra note 20, § 12-24, at 987.
52 Rust, 111 S. Ct. at 1776 (citing United States v. Kokinda, 110 S. Ct. 3115, 3119 (1990)). The Court’s reliance on Perry Educ. Ass’n v. Perry Local Educators’ Ass’n, 460 U.S. 37, 45 (1983), suggests that this phrase also refers to “public property which the State has opened for use by the public as a place for expressive activity . . . even if
damental to the functioning of our society." While the Court acknowledged that the doctor-patient relationship may resemble a "traditional sphere of free expression," which is entitled to First Amendment protection, it ultimately rejected this analogy for two reasons. First, the Court reasoned, the HHS regulations did not significantly impinge upon the doctor-patient relationship because they did not require doctors to represent the government's opinions as their own. Second, since Title X clinics do not provide post-conception medical care, the Court determined that the relationship between clinic doctors and patients was not sufficiently "all-encompassing" to justify patients' expectation that they would receive comprehensive medical advice. Therefore, the Court concluded, a Title X clinic doctor's silence about abortion during a presentation of post-pregnancy alternatives could not reasonably be construed by a patient as emanating from the doctor's personal opposition to abortion.

Because the regulations at issue in Rust applied only to publicly funded physicians, and because the case was decided under the doctrine of unconstitutional conditions, the Rust opinion left unclear whether the Court would permit government to impose viewpoint-based regulations on doctor-patient speech that occurred in private settings. There is, however, a passage in the majority's analysis that strongly implies that speech restrictions affecting both public and private physicians would be unconstitutional.

In analyzing whether the Rust "gag rule" violates a woman's Fifth Amendment right to decide whether to have an abortion, the Court distinguished the HHS regulations from the speech restrictions that were invalidated in City of Akron v. Akron Center for Reproductive Health, Inc. and Thornburgh v. American College of Obstetricians & Gynecologists. In City of Akron and Thornburgh, the Burger Court invalidated enactments that required physicians to make statements to patients for the purpose of influencing their decisions about abortion. Specifically, the City of Akron ordinance compelled physicians to tell patients that it was not required to create the forum in the first place." Id. at 45. Examples cited in Perry are university meeting facilities, school board meetings, and municipal theaters. Id. at 45-46.

63 Rust, 111 S. Ct. at 1776.
64 Id.
65 Id.
66 Id.
67 Id.
68 The Court ultimately rejected the Petitioners' Fifth Amendment argument. Id. at 1776-78.
“the unborn child is a human life from the moment of conception.”

Moreover, both the City of Akron ordinance and the Thornburgh statute compelled physicians to make statements to patients that humanized the fetus and conveyed the message that the government preferred childbirth over abortion. Finally, both measures compelled physicians to emphasize the potential risks and complications associated with the abortion procedure.

In assessing the constitutionality of these restrictions, the Burger Court flatly rejected the proposition that the Constitution permits government to manipulate the content of doctor-patient speech for the purpose of


62 The City of Akron ordinance required that physicians inform a pregnant woman of the fetus’ gestational age and anatomical and physiological characteristics and provide information about the fetus’ “appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members.” Id.


63 The City of Akron ordinance compelled physicians to tell patients about the availability of birth control, prenatal, and adoption services, and to provide a list of these agencies if requested. Akron Codified Ordinances § 1870.06(B)(6)-(7).

The Thornburgh statute also required that physicians tell patients: that medical assistance benefits were available for prenatal care, childbirth, and neonatal care; that the father was liable for child support, even if he has offered to pay for the abortion; and that printed materials were available from the Commonwealth that described the fetus and listed agencies offering alternatives to abortion. 18 Pa. Cons. Stat. Ann. § 3205(a)(2). The printed materials included the following statement:

There are many public and private agencies willing and able to help you to carry your child to term, and to assist you and your child after your child is born, whether you choose to keep your child or to place her or him for adoption. The Commonwealth of Pennsylvania strongly urges you to contact them before making a final decision about abortion. The law requires that your physician or his agent give you the opportunity to call agencies like these before your undergo an abortion.

Id. § 3208(a)(1).

64 The City of Akron ordinance required that physicians tell patients “[t]hat abortion is a major surgical procedure which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may . . . worsen any existing psychological problems she may have, and can result in severe emotional disturbances.” Akron Codified Ordinances § 1870.06(B)(5).

The Thornburgh statute required that physicians express the “fact that there may be detrimental physical and psychological effects of abortion which are not accurately foreseeable” and the particular medical risks associated with the particular abortion procedure to be employed. 18 Pa. Cons. Stat. Ann. § 3205(a)(1)(ii)-(iii).
influencing patients' decision making.\textsuperscript{65} The Court reaffirmed its holding in \textit{Planned Parenthood v. Danforth}\textsuperscript{66} that government may legitimately require physicians to convey information to patients to ensure informed consent,\textsuperscript{67} but it may not impose speech restrictions intended to influence patients' decision making in accordance with governmental ideology.\textsuperscript{68}

In \textit{Rust}, however, the majority relied on a factual distinction between the HHS regulations and the statutes at issue in \textit{City of Akron} and \textit{Thornburgh} to circumvent the Burger Court's rejection of content restrictions on physician speech. The \textit{Rust} Court noted that the HHS regulations applied only to publicly funded physicians, while the \textit{City of Akron} and \textit{Thornburgh} restrictions had applied to both publicly and privately financed physicians.\textsuperscript{69} This distinction suggests that the Court would deem viewpoint-based restrictions on physician speech unconstitutional if they applied to \textit{all} physicians in a jurisdiction.

In \textit{Planned Parenthood v. Casey},\textsuperscript{70} decided only one year after \textit{Rust}, the Court jettisoned this implied limit on the government's power to impose viewpoint-based regulations on physician speech. \textit{Casey} involved the constitutionality of 1988 and 1989 amendments to a Pennsylvania statute\textsuperscript{71} that revived many of the provisions previously invalidated by the Burger Court in \textit{Thornburgh}.\textsuperscript{72} In addition to imposing limitations on physicians' conduct,\textsuperscript{73} the amended statute's "informed consent" pro-

\textsuperscript{65} \textit{Thornburgh}, 476 U.S. at 760 ("[T]he State may not require the delivery of information designed to 'influence the woman's informed choice between abortion and childbirth.'") (quoting \textit{City of Akron}, 462 U.S. at 443-44).

\textsuperscript{66} 428 U.S. 52 (1976).

\textsuperscript{67} \textit{Id.} at 66-67 (upholding state's informed consent provisions).

\textsuperscript{68} \textit{Thornburgh}, 476 U.S. at 763.

\textsuperscript{69} \textit{Rust}, 111 S. Ct. at 1777.

\textsuperscript{70} 112 S. Ct. 2791 (1992) (plurality opinion).


\textsuperscript{72} See supra notes 62-65 and accompanying text.

\textsuperscript{73} As amended, § 3209 prohibited a physician from performing an abortion on a married woman who had not provided the physician with a signed statement either that she had notified her husband of her intention to have an abortion, or that she fell within one of four limited exceptions. 18 PA. CONS. STAT. ANN. § 3209 (1983 & Supp. 1993). Section 3205 prohibited a physician from performing an abortion less than 24 hours after satisfying the "informed consent" requirements. \textit{Id.} § 3205. Section 3206 criminalized the performance of an abortion on a woman under 18 years old without parental consent. \textit{Id.} § 3206. Section 3214 required that abortion facilities file reports, to be made available for public inspection, 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 patients, whether notice was provided to the husband. \textit{Id.} § 3214.
vision required that physicians tell every abortion-seeking patient about the health risks of abortion and childbirth\textsuperscript{74} and the probable gestational age of the fetus.\textsuperscript{75} It also mandated that physicians\textsuperscript{76} tell patients about the availability of printed materials, which described the fetus and listed agencies that offered alternatives to abortion; stated that the child’s father was liable for financial assistance to support the child (even if he had offered to pay for the abortion); and stated that medical assistance may be available for prenatal care, childbirth, and neonatal care.\textsuperscript{77}

Unlike the restrictions at issue in \textit{Rust}, the so-called informed consent provisions in \textit{Casey} did not silence physician speech. Like the HHS regulations, however, the Pennsylvania statute’s speech-related provisions directly regulated the content of physician-patient discourse for the purpose of persuading patients to elect a governmentally preferred course of action.\textsuperscript{78} Thus, in \textit{Casey} the Court again faced the question of whether the First Amendment prohibited government from imposing viewpoint-based restrictions on doctor-patient speech.

The United States Court of Appeals for the Third Circuit had considered and rejected the petitioners'\textsuperscript{79} argument that the Pennsylvania statute’s informed consent provisions violated the First Amendment.\textsuperscript{80} The court held that doctor-patient discourse was commercial speech,\textsuperscript{81} and that government could compel disclosures provided they were not false

\textsuperscript{74} \textit{Id.} § 3205(a)(1)(i), (iii).
\textsuperscript{75} \textit{Id.} § 3205(a)(1)(ii).
\textsuperscript{76} The statute allowed a physician to delegate his or her obligation to inform patients about the availability of the state’s written materials to another health care professional, such as a physician’s assistant, health care practitioner, technician, or social worker. \textit{Id.} § 3205(a)(2).
\textsuperscript{77} \textit{Id.} § 3205(a)(2)(i)-(iii).
\textsuperscript{78} The Pennsylvania General Assembly’s preference for childbirth over abortion is clearly expressed in the statute:

\textit{In every relevant civil or criminal proceeding in which it is possible to do so without violating the Federal Constitution, the common and statutory law of Pennsylvania shall be construed so as to extend to the unborn the equal protection of the laws and to further the public policy of this Commonwealth encouraging childbirth over abortion.}

\textit{Id.} § 3202(c).

\textsuperscript{79} The petitioners in \textit{Casey} were five abortion clinics and a physician who represented a class of doctors who performed abortion services in the state. Planned Parenthood v. Casey, 947 F.2d 682 (3d Cir. 1991), \textit{modified}, 112 S. Ct. 2791 (1992) (plurality opinion). For the sake of clarity, this Article will describe the \textit{Casey} petitioners as “doctors” and the respondents as the “state” or the “government.”

\textsuperscript{80} \textit{Id.} at 705-06.

\textsuperscript{81} \textit{Id.} at 705 (“This case involves commercial speech, and the clinics do not dispute this point.”). To support its conclusion, the court cited Zauderer v. Office of Disciplinary Counsel, 471 U.S. 626 (1985), which involved restrictions on attorney advertising, not doctor-patient conversations that occur after the formation of a fiduciary relationship.
or unverifiable, and were reasonably related to the state's interest in preventing consumer deception. The Third Circuit reasoned that denying the state's power to impose these disclosure requirements upon physicians threatened to uproot a large body of law requiring disclosures by professionals and businesses.

The Supreme Court plurality opinion, however, skirted a fully developed First Amendment analysis of the informed consent provisions. Instead, the *Casey* plurality's discussion of the statute's speech-related aspects was based on an analysis of whether they "unduly burden" a woman's privacy right to choose an abortion.

Aside from the Third Circuit, no court has ever held that speech between doctors and patients after the formation of a professional relationship is commercial speech. Dicta in a Supreme Court case and the Court's commercial speech decisions strongly suggest that the Third Circuit's characterization of doctor-patient speech as commercial speech is mistaken. See infra notes 188-203 and accompanying text.

82 *Casey*, 947 F.2d at 704-05.

83 *Id.* at 706 n.19. The Third Circuit's fear that invalidation of the Pennsylvania statute's informed consent provisions would require the invalidation of disclosure requirements for "cigarette packages, advertisements and billboards," *id.*, is unwarranted because these measures are directed at a fundamentally different type of speech. The Pennsylvania statute is targeted at speech within the confines of a doctor-patient relationship, which is closely related to the discovery of truth and preserving patients' liberty. See infra notes 166-86 and accompanying text. Cigarette packages, advertisements, and billboards, on the other hand, all involve advertising that has a far more attenuated relationship to the discovery of truth and personal liberty. See infra notes 189-91 and accompanying text. Moreover, even within the context of noncommercial, fiduciary relationships it is possible to differentiate between governmental restrictions that subvert First Amendment values and those that do not. See infra notes 197-203 and accompanying text.


85 In the Supreme Court, the petitioners argued that the statute's informed consent provisions violated physicians' First Amendment rights by forcing them "to convey the state's message at the cost of violating their own conscientious beliefs and professional commitments." Brief for Petitioners and Cross-Respondents at 53-55, *Casey* (Nos. 91-744, 91-902). They did not argue that the provisions interfered with patients' First Amendment right to receive information from their doctors, thus ignoring the audience-based concerns of the First Amendment. See discussion infra part V. The organizations representing health care providers failed to make any First Amendment argument. See Brief for the American College of Obstetricians and Gynecologists et al. as *Amicus Curiae* in Support of the Petitioners, *Casey* (Nos. 91-744, 91-902).

None of the separate opinions in *Casey* that argued in favor of upholding the informed consent provisions mentioned the Third Circuit's conclusion that doctor-patient discourse is commercial speech. This suggests that these Justices did not agree with the conclusion, because adoption of this ruling would have provided a ready means of upholding the restrictions under the more lenient standard applicable to restrictions on commercial speech. See infra notes 189-91 and accompanying text.

86 *Casey*, 112 S. Ct. at 2820.
The plurality concluded that the speech-related provisions did not violate the First Amendment, and expressly overruled portions of City of Akron and Thornburgh that held that government may not use doctor-patient conversation as an instrument for expressing a viewpoint or for persuading patients to opt for a governmentally preferred course of action:

[W]e depart from the holdings of Akron I and Thornburgh to the extent that we 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 so doing the State expresses a preference for childbirth over abortion.87

Thus, the plurality held that government may promote its viewpoint by imposing content regulations on all doctor-patient speech, not just speech that occurs in a publicly funded setting.

The plurality also expressly rejected the holdings in both Akron and Thornburgh that the state may not compel physicians to make statements to patients that are unrelated to their particular health needs and interests.88 Moreover, the plurality explicitly endorsed the power of the State to require physicians to make statements to patients about how their medical decision could affect third parties.89

While the plurality acknowledged that the challenged regulations implicated physicians’ speech rights,90 they 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.”91 Thus, Justices O’Connor, Kennedy, and Souter grounded the newly rec-

87 Id. at 2824.
88 Id. at 2823 (“We also see no reason why the State may not require doctors to inform a woman seeking an abortion of the availability of materials relating to the consequences to the fetus, even when those consequences have no direct relation to her health.”).
89 Id. As an example, the plurality approved a state requirement that physicians tell patients in need of a kidney transplant about the “risks to the donor as well as risks to himself or herself.” Id. For a discussion of the free speech implications of regulations that require physicians to discuss the impact of a patient’s medical decision upon third parties, see infra notes 306-08 and accompanying text.
90 Casey, 112 S. Ct. at 2824 (“All that is left of petitioners’ argument is an asserted First Amendment right of a physician not to provide information about the risks or abortion, and childbirth, in a manner mandated by the State. To be sure, the physician’s First Amendment rights not to speak are implicated.”).
91 Id. The Court’s reliance on Whalen v. Roe, 429 U.S. 589 (1977), to support this conclusion is misplaced. Whalen concerned a statute that required doctors to provide the state of New York with the names of patients who received prescriptions for certain drugs. Id. at 591. Unlike Casey, Whalen did not involve a statute that directly regulated the content of doctor-patient discourse. Such regulations involve a range of free speech concerns, which are not implicated by requiring doctors to disclose patients’ names to the state. See discussion infra part IV.
ognized power of government to impose viewpoint regulations on doctor-patient speech in the states' police power to license and regulate physicians.92

The plurality did not vest the state with an absolute power to dictate the content of physicians statements to patients by compelling physician speech. Regulations are unconstitutional, according to the plurality, if they require physicians to make statements to patients that are false or misleading.93

Chief Justice Rehnquist, joined by Justices White, Scalia, and Thomas, endorsed the plurality's recognition of the government's power to compel physician speech.94 According to the Chief Justice, the government may compel doctors to utter any information that is both rationally related to a legitimate state interest and "relevant," which he defines as information that may "create some uncertainty and persuade."95 As such, this proposed due process-based standard for assessing governmental regulation of the content of doctor-patient discourse is less stringent than the First

92 The plurality also upheld a provision of the statute that requires physicians, as opposed to nonphysicians, to deliver the mandated information to patients. Casey, 112 S. Ct. at 2824-25. In City of Akron, this requirement was deemed unconstitutional. City of Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416, 448 (1983). The Casey plurality, however, overruled this portion of City of Akron, again on the basis of the state's power to license and regulate physicians. Casey, 112 S. Ct. at 2824 ("[T]he Constitution gives the States broad latitude to decide that particular functions may be performed only by licensed professionals, even if an objective assessment might suggest that those same tasks could be performed by others.").

93 Casey, 112 S. Ct. at 2823.

94 Id. at 2867-68 (Rehnquist, C.J., concurring in part and dissenting in part). Thus, taken together, the separate opinions in Casey reveal that seven Justices adhere to this view. Justices Blackmun and Stevens strongly dissented from the other Justices' endorsement of the principle that government may impose viewpoint-based restrictions upon the content of doctor-patient speech. Justice Stevens expressed concern that compelling persuasive speech by physicians may be unduly influential because of patients' heightened vulnerability when faced with a momentous medical decision and procedure. Id. at 2840 (Stevens, J., dissenting in part). Justice Blackmun's dissent focused on the danger of indoctrination when government is permitted to compel physicians to express ideological messages during discussions with patients. According to Justice Blackmun, the plurality authorizes the substitution of "state medicine" for a doctor-patient dialogue driven by patients' needs and interests. Id. at 2850 (Blackmun, J., dissenting in part).

95 Id. at 2868 (Rehnquist, C.J., concurring in part and dissenting in part). Chief Justice Rehnquist did not address petitioner's First Amendment claim, but instead based his reasoning and conclusions solely on right-to-privacy jurisprudence. He argued that abortion is a liberty interest protected, if at all, by the Due Process Clause; however, he would subject such state regulation of such interests to a mere "rational basis" standard of review. Id. at 2867.
Amendment standard applicable to commercial speech. Regulation of commercial speech, which has a far more attenuated relationship to free speech values, must be based on a substantial government interest and be "no more extensive than necessary to serve that interest."

II. Critique of the Supreme Court's First Amendment Analysis of Doctor-Patient Discourse

The various opinions in Rust and Casey reveal that a majority of the Rehnquist Court adheres to the view that the First Amendment does not prohibit the government from attempting to influence patients' medical decision making through regulation of the content of doctor-patient discourse occurring in either a private or public setting. Under Rust, the right to make funding decisions empowers the government to prevent publicly funded physicians from discussing certain medical procedures, as long as patients cannot reasonably expect to receive complete medical advice and physicians are permitted to distance themselves from the state's message. Under Casey, the authority to license and regulate the practice of medicine empowers states to compel publicly and privately financed physicians to make viewpoint-based statements to patients, as long as those statements further a legitimate state interest and are not false or misleading.

The Court's recognition of a governmental power to restrict doctor-patient speech is diametrically opposed to the bedrock First Amendment principle that speech regulations may not "favor some viewpoints or ideas at the expense of others," unless they are aimed at "low value" communication such as obscenity or "fighting words." Despite recent unequivocal reaffirmations of this principle in other contexts, the

96 Chief Justice Rehnquist has previously indicated that he views doctor-patient discourse about medical procedures to be no more than a commercial transaction. See, e.g., Roe v. Wade, 410 U.S. 113, 172 (1973) (Rehnquist, J., dissenting) ("A transaction resulting in an operation such as [an abortion] is not 'private' in the ordinary usage of that word."). See infra notes 189-91 and accompanying text.

97 See infra notes 189-91 and accompanying text.


99 See supra notes 70-96 and accompanying text.

100 See Tribe, supra note 20, § 12-18, at 928-29.

101 Members of the City Council v. Taxpayers for Vincent, 466 U.S. 789, 804 (1984). This First Amendment principle against viewpoint-based regulation of speech is partially rooted in the audience-based concern that the public's consideration of issues will be skewed if government is permitted to throw its weight behind one position. See infra notes 248-84 and accompanying text.

102 See Tribe, supra note 20, § 12-18, at 928-29.

Rehnquist Court abandoned it in the context of content regulations directed at doctor-patient speech. While one suspects that the Court’s conclusions in these cases reflect the majority’s views on the highly volatile subject of abortion, the Court did not limit its holdings to this narrow context. Instead, by basing its validation of speech restrictions on the government’s power to make funding decisions and to regulate the practice of medicine, the Court vested the state with broad authority to regulate the content of doctor-patient discourse about any medical subject.

The Court’s approval of content restrictions on physician speech rests upon several flaws in its analysis of the regulations at issue in Rust and Casey. The most fundamental of these flaws is that the Court approaches its analysis of government restrictions on the content of doctor-patient discourse exclusively from the standpoint of their interference with physicians’ right to speak. The Court ignores that the regulation of physician speech also impacts on patients’ receipt of medical information. The unconstitutional conditions doctrine, upon which the Rust Court based its analysis, balances the government’s need to make funding decisions against the constitutional rights of government agents and employees while performing official duties. The doctrine does not address the impact that funding restrictions may have on the First Amendment rights of listeners who depend upon publicly financed speakers for informa-

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104 The Court’s tendency to focus on the rights of physicians and to ignore the rights of patients has plagued its decisions concerning reproductive rights. For discussions of this problem, see Susan F. Appleton, More Thoughts on the Physician’s Constitutional Role in Abortion and Related Choices, 66 WASH. U. L.Q. 499, 499 (1988) (arguing that the Court’s focus in abortion cases on physician’s rights stems from sex-based discrimination, as evidenced by “laws that single out . . . female patients for different and often paternalistic treatment”); Susan F. Appleton, Doctors, Patients and the Constitution: A Theoretical Analysis of the Physician’s Role in Private Reproductive Decisions, 63 WASH. U. L.Q. 183, 226 (1985) (arguing that the Court’s focus on the physician as the decision maker in the abortion context has eclipsed analysis of the female patient’s rights); Andrea Asaro, The Judicial Portrayal of the Physician in Abortion and Sterilization Decisions: The Use and Abuse of Medical Discretion, 6 HARV. WOMEN’S L.J. 51, 51, 102 (1983) (arguing that by characterizing abortion as a fundamentally medical decision, the courts have reaffirmed the dominant role of the typically male physician and eroded the rights of the female patient); Mary A. Wood & Cole Durham, Jr., Counseling, Consulting, and Consent: Abortion and the Doctor-Patient Relationship, 1978 B.Y.U. L. REV. 783, 845 (arguing for implementation of greater avenues for doctor counseling and patient consent as a means of enhancing the genuine exercise of female patients’ autonomy).

tion. The *Rust* Court’s reliance on the doctrine of unconstitutional conditions, rather than on the First Amendment rights of patients, leads it to overlook the danger that restrictions on the speech of publicly funded physicians pose to patients’ audience-based interests.

The Court’s analysis of the speech restrictions at issue in *Casey* is similarly physician-focused. Compelling physician speech, like silencing it, implicates both doctors’ right to speak and patients’ right to receive information. Yet, the plurality and the Rehnquist opinions acknowledged only that Pennsylvania’s informed consent provisions implicate physicians’ First Amendment right not to speak, and ignore patients’ audience-based interest in receiving information from their physicians. Thus, the Court characterized and decided the case as if it involved a bipartite conflict between physicians’ right to speak and states’ right to regulate professionals, rather than a tripartite conflict among physicians’ speech rights, government’s power to regulate professionals, and patients’ audience-based right to receive information.

106 For an excellent general discussion of the inadequacy of the doctrine of unconstitutional conditions as a theory for analyzing the constitutionality of restrictions on the speech of publicly funded speakers, see David Cole, *Beyond Unconstitutional Conditions: Charting Spheres of Neutrality in Government-Funded Speech*, 67 N.Y.U. L. REV. 675, 701 (1992) (“In both its scholarly and judicial forms, however, the unconstitutional conditions doctrine fails to address the audience-related concerns raised by selective funding of speech.”).

107 The term “audience-based” refers to the receptive, rather than the expressive, aspect of communication, and focuses on the value of speech to the listener, rather than the speaker. See Thomas M. Scanlon, Jr., *Freedom of Expression and Categories of Expression*, 40 U. PITT. L. REV. 519, 527 (1979) (“The central audience interest in expression, then, is the interest in having a good environment for the formation of one’s beliefs and desires.”).


109 Justice White’s concurring opinion in *Lowe v. SEC*, 472 U.S. 181, 211 (1985), a case involving government regulations that mandated professionals’ speech, is similarly inattentive to the independent audience-based interests of clients. In *Lowe*, the SEC sought to enjoin the petitioner, whose SEC registration as an investment advisor was revoked after he was convicted of misappropriating client funds, from violating its order and the statute’s registration requirement by publishing a newsletter containing investment advice. *Id.* at 184–85. The petitioner argued that the registration requirement violated the First Amendment. *Id.* at 189. The majority ruled in favor of the petitioner on statutory, not constitutional, grounds. *Id.* at 211.

Although Justice White concurred in the judgment, in a separate opinion he argued that the statute’s registration and disclosure requirements violated the First Amendment. *Id.* (White, J., concurring). According to Justice White, the case involved “a collision between the power of government to license and regulate those who would pursue a profession or vocation and the rights of freedom of speech and of the press guaranteed by the First Amendment.” *Id.* at 228. To resolve such cases, Justice White offered a simple solution. Under its power to regulate the professions, government may legitimately regulate the professional’s speech if a professional-client relationship
The Court’s single-minded focus in *Rust* and *Casey* on physicians’ rights blinds it to the chief threat that viewpoint-based regulation of doctor-patient discourse poses to the Constitution in general and the First Amendment in particular. Because the purpose of such restrictions is to influence individual medical choices by restricting access to information or promoting a biased understanding of available options, the restrictions distort the decision-making process of patients. Just as viewpoint-based regulation of the content of political speech distorts political decision making and infringes on citizens’ constitutional right to determine their political destiny, viewpoint-based regulation of medical speech distorts medical decision making, and thus infringes on patients’ constitutional right to determine the destiny of their bodies.

exists. However, if this relationship does not exist, any government restrictions upon professional speech implicate the First Amendment. *Id.* at 232. In his analysis, Justice White mistakenly assumed that the government’s interest in regulating professional speech will always be identical to the interests of listeners. He ignored the possibility that government regulation of professional speech implicates the independent audience-based rights of clients and raises the spectre of government indoctrination. Despite its legitimate interest in protecting clients from unscrupulous professionals, government certainly cannot be given carte blanche to force doctors, lawyers, or investment advisors to become mouthpieces for state ideology and foot soldiers in a campaign of indoctrination.

See Edward H. Ziegler, Jr., *Government Speech and the Constitution: The Limits of Official Partisanship*, 21 B.C. L. REV. 578, 579 (1980) (“[A] characteristic distinguishing democratic from totalitarian government is that while a democracy attempts to facilitate and ascertain public opinion and establish policy in accordance therewith, an autocracy attempts to engineer public opinion in support of its decisions.” (footnote omitted)). For an interesting examination of government distortion of communication and its relationship to political legitimacy, see Claus Mueller, *The Politics of Communication: A Study in the Political Sociology of Language, Socialization, and Legitimation* 178 (1973) (arguing that distorted communication thwarts the public’s critical examination of the rationales used by the state to legitimate its system and policies).

Patients’ right to control their medical treatment is rooted in the Constitution. See *Cruzan v. Director*, 497 U.S. 261, 278 (1990) (“The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.”). It also stems in part from the doctrine of informed consent. See *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.) (“The root premise [in the doctrine of informed consent] is the concept, fundamental in American jurisprudence, that ‘[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . .’” (quoting *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914))), *cert. denied*, 409 U.S. 1064 (1972). The right is also embodied in the common law of battery. See *Mohr v. Williams*, 104 N.W. 12, 16 (Minn. 1905) (holding defendant doctor liable for operating on a patient’s body without her prior consent, on the ground that such operation constitutes assault and battery).
The Court's neglect of these audience-based concerns led it to formulate standards for judging the constitutionality of content restrictions on doctor-patient speech that do not protect patients. Under *Rust*, restrictions on publicly funded physicians are unconstitutional only if patients have an "all-encompassing" relationship with their doctor that gives rise to a reasonable expectation of receiving comprehensive medical advice.\(^{112}\) This implies that publicly funded specialists, such as those who are reimbursed by Medicaid and Medicare, could be silenced from speaking to patients about a particular medical procedure.\(^{113}\) Additionally, as several commentators have noted, *Rust* has grave implications for the quality of doctor-patient discourse under a reformed health care system that is more dependent upon public funds than the current system.\(^ {114}\)

Under *Rust*, government may not impose viewpoint-based restrictions that do not afford publicly financed physicians the opportunity to distance themselves from the state's message. However, while the opportunity for physicians to disclaim agreement with state-dictated silence may be sufficient to protect their First Amendment rights,\(^ {115}\) it is not sufficient to safeguard patients' audience-based interests. Although physicians may distance themselves by uttering disclaimers, they are not likely to do so if

\(^{112}\) See *Rust* v. Sullivan, 111 S. Ct. 1759, 1776 (1991) (finding that because doctor-patient relationships at issue were limited to prenatal care, patients had limited expectations).

\(^{113}\) As a consequence, access to information about specific medical procedures would be denied to population groups that historically have been denied access to equal participation in American life, such as recipients of Medicaid—who are typically poor and disproportionately people of color—and recipients of Medicare—who are elderly. For a discussion of the harmful impact of *Rust* on the availability of reproductive health information to women of color, see Dorothy E. Roberts, *Rust* v. Sullivan and the Control of Knowledge, 61 GEO. WASH. L. REV. 587, 590 (1993) ("By promoting ignorance among these women, the [*Rust*] Court erected one more layer of the 'structural entrapment' that keeps poor Black women at society's margins.").

\(^{114}\) George J. Annas, Restricting Doctor-Patient Conversations in Federally Funded Clinics, 325 NEW ENGL. J. MED. 362, 364 (1991) (arguing that under a national health insurance system, the *Rust* principle could be applied more broadly); Wendy K. Mariner, Mum's the Word: The Supreme Court and Family Planning, 82 AM. J. PUB. HEALTH 296, 300 (1992) (noting that the increase in the number of federally funded clinics allows the *Rust* principle to be widely applied).

\(^{115}\) There is authority, however, for the proposition that the opportunity to disclaim agreement with a restriction may not even be sufficient to protect physicians' First Amendment rights. See Pacific Gas & Elec. Co. v. Public Utils. Comm'n, 475 U.S. 1, 16 (1986) (stating that a "forced response is antithetical to the free discussion that the First Amendment seeks to foster"); Miami Herald Publishing Co. v. Tornillo, 418 U.S. 241, 241 (1974) (holding that a forced right of reply violates newspaper's right to be free from forced dissemination of views it would not voluntarily disseminate). But see Pruneyard Shopping Ctr. v. Robins, 447 U.S. 74, 87-88 (1980) (holding that availability of effective disclaimer was sufficient to eliminate infringement upon negative free speech rights).
they agree with the government's position about a particular treatment. In the case of compelled silence, the patients of these physicians will be deprived of governmentally disfavored information without notice that they are receiving only partial information and advice. In the case of compelled speech, these patients will hear a biased message intended to steer them toward the government's preferred course of treatment, with no knowledge that the message stems from state opinion rather than from their physician's best medical judgment.\textsuperscript{116}

The Court's standards for judging the constitutionality of enactments that compel speech by publicly and privately funded physicians also fail to address or protect patients' audience-based interest in receiving medical information. Under \textit{Casey}, the state may require both publicly and privately funded physicians to make viewpoint-based statements to patients as long as the statements are not false, misleading, or unrelated to a legitimate state interest.\textsuperscript{117} The Court thus vests the state with the right to determine medical truth and falsity, even though the First Amendment vests the people, not the state, with the right to determine truth and falsity for themselves.\textsuperscript{118}

\textsuperscript{116} The Supreme Court's misplaced reliance on disclaimers has appeared in other contexts as well. In \textit{Meese v. Keene}, 481 U.S. 465, 471 (1987), the Court considered the constitutionality of a section of the Foreign Agents Registration Act of 1938, 22 U.S.C. §§ 611-621, which required disseminators of materials broadly defined as "political propaganda" to display a label disclosing certain information to the audience. An attorney who wanted to exhibit three Canadian films about acid rain and nuclear war, but did not want to be regarded by the public as a foreign propagandist, argued that the disclosure requirements violated the First Amendment. The Court found that the disclosure requirements actually fostered the First Amendment because the statute did not prevent distributors such as the attorney from counteracting any bias generated by the government-mandated label by explaining before, during, and after the film that it ought not to be discounted because the government had deemed it "political propaganda." \textit{Id.} at 477-85. The Court's reasoning, which relied upon the traditional antidote of "more speech," reflects the same inattentiveness to the danger of listener coercion that plagued its decisions in \textit{Rust} and \textit{Casey}. Specifically, the Court did not acknowledge that whenever government compels speakers to utter its message there is a heightened risk of bias and coercion because the state's weight and authority are thrown behind one idea and not others. The risk of coercion is even greater when government-mandated statements denigrate or stigmatize a competing position. The speaker compelled to make the officially sanctioned statement may immediately utter a negation. However, this may not be sufficient to counteract the persuasive effect of the government's statement, derived from the mere fact that it is backed by the state's power and authority. Similarly, a physician's disclaimer of agreement with a mandated expression of government opinion may be insufficient to counteract its coercive effect on patients.

\textsuperscript{117} \textit{See supra} notes 92-96 and accompanying text.

\textsuperscript{118} \textit{See First Nat'l Bank v. Bellotti}, 435 U.S. 765, 791 (1978) ("[T]he people in our democracy are entrusted with the responsibility for judging and evaluating the rela-
Moreover, the categories of "truth" and "falsity" do not capture a range of statements that, while "true," threaten to undermine patients' autonomous decision making. For example, bald viewpoint-based assertions to patients such as "the State believes that you should not undergo a heart bypass operation," or "the federal government believes that you should agree to donate your organs" would be permitted under *Casey* because they are not false and are, arguably, reasonably related to a legitimate state interest.\(^1\) Yet, when uttered by a physician in the context of a doctor-patient relationship, these statements can be coercive.\(^2\) Additionally, an inquiry limited to determining truth or falsity also would not prevent government from forcing physicians to make statements that are plainly intended to capitalize on patients' fear and vulnerability within the structure of the doctor-patient relationship.\(^3\)

Furthermore, the concepts of objective truth and falsity are inappropriate standards for judging the constitutionality of compelled speech within the context of relationships between professionals and their patient/clients, because those concepts deny the fundamentally subjective nature of these affiliations. Patient/clients form professional relationships because they lack the information needed to make a rational decision on their own about a problem that is within the professional's area of expertise. The goal of this relationship is to identify the patient/client's particular needs and interests and to obtain expert advice about the most appropriate course of action. The forced assertion by the state of information that is objectively true but unduly persuasive to the patient/client, or unmind-

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\(^1\) Since states have a broad range of interests in many aspects of health care delivery—from monitoring the quality of care to protecting against consumer fraud—it is difficult to conceive of a regulation that could *not* be linked to a legitimate state interest. For example, a state could justify a requirement that physicians dissuade patients from undergoing coronary bypass surgery on the ground that it is more expensive than other options. The government also could justify a requirement that physicians urge patients to donate their organs on the ground that it is necessary to increase the supply of available organs.

\(^2\) See infra notes 123-46 and accompanying text.

\(^3\) For example, this standard would not prevent government from compelling physicians to describe certain procedures in especially gory, but accurate, detail as a way to steer patients toward a governmentally preferred course of treatment.
ful of his or her particular needs and interests, is antithetical to this goal and threatens to undermine the purpose of the relationship.122

The other central problem with the Court's analysis of the content restrictions at issue in Rust and Casey is that it implicitly relies upon a dubious model of doctor-patient interaction. The Court assumes that patients will respond to physician expressions of state policy rationally and critically, and that they will not be unduly influenced or confused. According to the Court's vision, as a matter of course patients will simply question physicians who fail to distance themselves from a governmentally dictated message to determine if their advice or silence is an expression of professional judgement or of state policy. Likewise, when physicians verbally distance themselves from state-imposed messages, patients will accept their disclaimers at face value and be unaffected by the apparent dissonance between the views of the doctor and the state.

The Court's assumptions about how patients will respond to and be affected by state messages conveyed by physicians are in conflict with a large body of research into the dynamics of doctor-patient communication.123 As this research shows, the purpose and structure of the doctor-patient relationship vest physicians with immense authority and power in the eyes of patients.124 Physicians' authority derives from their superior

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122 Of course, under certain circumstances, government regulation is needed to protect clients from fiduciaries' over-reaching and nondisclosure. See George J. Benson, Government Constraints on Political, Artistic, and Commercial Speech, 20 CONN. L. REV. 303, 321 (1988):

"If one accepts the notion that speech should not be constrained because those who would do the restricting do not know the "truth," then society can justify restrictions on advice-giving only when it can show that the receiver cannot distinguish between beneficial and harmful speech or when the net negative externalities are overwhelmingly great."


124 Maynard, supra note 123, at 448 (stating that studies of the doctor-patient relationship uniformly describe "an asymmetry of knowledge and authority that allows doctors to promulgate a biomedical model of disease and to simultaneously undermine patients' own experience and understanding").

Researchers have used several theoretical constructs to describe the asymmetry between doctor and patient. A number of scholars have analogized the relationship between a doctor and patient to that between a parent and child. See, e.g., Katz,
knowledge and education, their prestigious social and economic status, and the “charismatic authority” that derives from their symbolic role as conquerors of disease and death. As one researcher writes, “[p]atients are aware that medicine deals with powerful forces not completely amenable to reason. Life and death are arbitrary, so it is not surprising that doctors are invested with the ability to relieve suffering and fear by means that are not strictly scientific or even rational.” The confluence of these factors leads to an institutionalization of physicians’ “professional dominance” within the structure of doctor-patient interaction that in itself legitimates physician expressions.

In the face of this dominance, patients suspend their critical faculties and defer to physicians’ opinions. Patients’ disempowered position

supra note 28, at 143 (observing that when persons are ill and beset by fears and anxiety, “infantile hopes and fears surface most insistently. . . . Patients’ hopes that they have finally found an all-comforting parent-caretaker who will relieve all suffering spring eternal.”); Leonard L. Riskin, Informed Consent: Looking for Action, 1975 U. ILL. L.F. 580, 597 (stating that a sick patient tends to “regress into a childlike state and enter into a transference relationship with his physician whom he thrusts into the role of a parent”). Others have noted its similarity to the relationship between the priest and believer. See, e.g., Howard Brody, The Symbolic Power of the Modern Personal Physician: The Placebo Response Under Challenge, 18 J. DRUG ISSUES 149, 153 (1988) (arguing that the modern physician “shares with the priest the role of bridge between the impersonal, transcendental powers of the universe and the concrete humanity of the patient”).

125 See Katz, supra note 28, at 88 (noting that physicians’ esoteric knowledge supports their insistence on “complete authority over their patients’ medical needs”); Parsons, supra note 123, at 463 (“[T]he physician is a technically competent person whose competence and specific judgments and measures cannot be competently judged by the layman.”).

126 Freidson, supra note 123, at 113-14 (“[T]he patient may grant deference to the physician because the physician is of an upper middle-class background and is a member of an old, honorable, and superlatively prestigious profession.”).

127 Id. at 15 (“[T]he physician is the symbol of healing whose authority takes precedence over all others.”).

128 Peter Tate, Doctors’ Style, in Doctor-Patient Communication, supra note 123, at 78.

129 Freidson, supra note 123, at 119-20. (“A professional’s advice should be obeyed because it is a professional who gives it, not because the advice is or can be evaluated on its evidential merits.”).

130 Id. at 113 (explaining that the authority associated with physicians may cause the patient to “swallow his anxiety and restrain his demands, feeling that the physician is too important to be bothered by the trivial or that he is too busy to be expected to explain”); Katz, supra note 28, at 124 (explaining that “illness—including the fears and hopes it engenders, the ignorance in which it is embedded, the realistic and unrealistic expectations it mobilizes—can contribute to tilting the balance in patients and physicians further toward irrationality and choices that, on reflection, both might wish to reconsider”).
stems from a number of factors, including lack of medical knowledge, the anxiety that accompanies illness, and the need to believe that physicians have the power and competence needed to cure them.

Patients' lack of power within the structure of the doctor-patient relationship leads to passivity and a reluctance to question or challenge physicians. A large body of research has demonstrated that patients rarely ask questions during conversations with physicians or take control of topics that are discussed. Patients typically ask only one to four questions during an encounter with a physician. One study of interaction between adult patients and their long-term general practitioners found that patients initiated fewer than one percent of the total utterances during medical interviews. The same study also revealed that patients frequently preface their questions to physicians with either a request for permission to ask a question, or notice that a question is about to be asked. When patients do marshal the courage to seek information,

131 SUE FISHER, IN THE PATIENT'S BEST INTEREST: WOMEN AND THE POLITICS OF MEDICAL DECISIONS 46 (1990) ("Patients enter medical interactions from a position of relative weakness. . . . They enter unfamiliar surroundings in which all of the other participants seem to share a common language. This language is, for the most part, unintelligible and frightening to them."); see FREIDSON, supra note 123, at 109 ("[L]ay clients do not necessarily share the professional's universe of discourse. Indeed, lay clients are by definition lacking in the educational or experiential prerequisites that would allow them to decide, on grounds shared with the professional, whether to accept any particular piece of professional advice.").

132 FREIDSON, supra note 123, at 114.

133 See, e.g., Analee Beisecker & Thomas Beisecker, Patient Information-Seeking Behaviors When Communicating with Doctors, 28 MED. CARE 19, 27 (1990) (finding that patients rarely ask questions of physicians); Debra L. Roter, Patient Participation in the Patient-Provider Interaction: The Effects of Patient Question Asking on the Quality of Interaction, Satisfaction, and Compliance, 5 HEALTH EDUC. MONOGRAPHS 281, 283 (1977) (stating that most patients, particularly in clinics, are "passive and powerless" in their interaction with physicians, and rarely ask questions or volunteer information that is not specifically requested); Wesley Sharrock, Portraying the Professional Relationship, in HEALTH EDUCATION IN PRACTICE 125, 143 (Digby C. Anderson ed., 1979) (stating that patients feel constrained from asking their doctors questions); Candace West, "Ask Me No Questions . . .": An Analysis of Queries and Replies in Physician-Patient Dialogues, in SOCIAL ORGANIZATION, supra note 123, at 76 (stating that patient-initiated utterances to physicians tend to be "anything but questions")


136 Id. at 240-41.
they may be misunderstood or ignored by physicians who perceive a threat to their professional dominance.

The client, lacking professional training, is thought to be unequipped for intelligent evaluation or informed cooperation with his consultant. Essentially, he is expected either to have faith in his consultant and do what he is told without question or else to choose another consultant in whom he does have faith.

These structural inequities also counteract patients’ ability to question physicians and redirect the course of a conversation, even if patients have an acute desire to acquire information. Moreover, socio-economic differences between doctor and patient, particularly differences of race, class, gender, or age, further impede communication.

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137 Patients often have difficulty formulating questions that match their concerns because they are anxious and lack scientific language. See Mishler, supra note 123, at 110 (describing a study that found that patients often strain to speak in “medical” language, usually unsuccessfully, and then revert to their own language, “which may even have become more vague or ‘regressed’ as a result of the failure of expression”); West, supra note 133, at 96-97 (finding that 50% of questions asked by patients evidenced “speech disturbances,” such as stuttering and repeated self-correction).

138 See Marie Haug & Bebe Lavin, Consumerism in Medicine: Challenging Physicians’ Authority 75-76 (1983) (finding that only 35% of physicians studied accept patients’ right to read their own medical records); Diana Shye et al., Patient Initiatives and Physician-Challenging Behaviors: The Views of Israeli Health Professionals, 31 Soc. Sci. & Med. 719, 725 (1990) (stating that the Israeli physicians studied “do not take a positive view of patient behaviors which express independence and initiative in the doctor-patient interaction”); Howard Waitzkin, Medicine, Superstructure and Micropolitics, 13A Soc. Sci. & Med. 601, 606 (1979) (arguing that physicians withhold medical information as a way to maintain patterns of dominance and subordination within the doctor-patient relationship); Howard Waitzkin & John D. Stoeckle, Information Control and the Micropolitics of Health Care: Summary of an Ongoing Research Project, 10 Soc. Sci. & Med. 263, 264 (1976) (arguing that doctors may withhold information as means of maintaining control over patients).

139 Freidson, supra note 123, at 142.

140 Beisecker & Beisecker, supra note 133, at 26 (“[P]atients’ strong stated desire for information about their medical condition did not prompt them to engage frequently in information seeking behavior.”).

141 See Ronald D. Adelman et al., Issues in Physician-Elderly Patient Interaction, 11 Ageing and Society 127, 133 (1991) (stating that when doctors’ and patients’ sociodemographic characteristics match, communication may be facilitated).


143 See Eisenberg, supra note 142, at 958 (noting that “the bulk of the available literature implies a significant relation between social class and decisions regarding
The insights of social science into doctor-patient interaction strongly indicate that the Supreme Court has overestimated the extent to which patients' critical rationality and inquisitiveness will neutralize the coercive effect of government messages that are delivered by physicians. Patients are not likely to challenge physicians' governmentally dictated silence or biased presentation of medical options. Rather, patients are likely to give great weight to physicians' expressions of state preferences, not because they are persuaded by the messages, but merely because the messages are delivered by physicians. The asymmetrical, highly emo-

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144 See Alexandra D. Todd, Intimate Adversaries: Cultural Conflict Between Doctors and Women Patients 33-35 (1989) (noting studies that have found that doctors take female patients less seriously, and condescend to them more than to male patients); Candace West, Routine Complications: Troubles with Talk Between Doctors and Patients 24 (1984) (discussing studies that indicate that doctors tend to underestimate patients' knowledge of medical terms, and that male doctors are more likely to make such a mistake when the patients are female). But see Elizabeth M. Hooper et al., Patient Characteristics That Influence Physician Behavior, 20 Med. Care 630, 633 (1982) (finding that physicians were more empathetic toward, and gave more information to, female patients); Waitzkin, Doctor-Patient Communication, supra note 143, at 2442 (finding that women received more time and more information from doctors).

145 See Adelman et al., supra note 141, at 142 (stating that physicians were more abrupt, condescending, and indifferent with older patients, who were less assertive than younger patients).

146 In drafting the Uniform Anatomical Gift Act, which seeks to promote organ donation, the National Conference of Commissioners on Uniform State Laws seems to have recognized that physicians may unduly influence patients. The statute does not compel physicians to discuss organ donation with patients or family members. Instead, it states that this discussion should be initiated by a hospital administrator, or
tional quality of doctor-patient interaction makes it probable that patients—particularly those who are nonwhite, poor, elderly, or female—will be intimidated by physician expressions of the state’s viewpoint and respond with confusion and deference.

Furthermore, the Court’s reliance upon physician disclaimers to prevent patient coercion is also misplaced. Physicians’ nonverbal messages are as important, and may even be more important, than their verbal expressions. Patients’ heightened sensitivity to nonverbal communication may render ineffective their physician’s oral disclaimers.

It is curious that the Rehnquist Court failed to recognize the substantial risk of undue influence from governmentally dictated, viewpoint-based messages delivered by physicians. The doctrine of informed consent, in effect in most states, was developed to counteract the phenomenon of professional dominance and institutionalized deference by increasing the flow of information to patients to both decrease the imbalance in knowledge and power and protect patients from physician coercion. Apparently, however, the Rehnquist Court failed to see that the qualities of doctor-patient interaction that increase the risk of coercion by  


Nonverbal messages involve

subtle cues which complement and illustrate aspects of the verbal interaction and often provide messages and express feelings that are not subject to direct conscious analysis by the interactants. A patient’s grimace, smile, or expression of fear, as well as a nurse’s comforting touch or facial expression of disgust, are communicative acts which may be even more important than the matter under verbal discussion.


See Doctor-Patient Communication, supra note 123, at 21 (stating that patients are highly attentive to doctors’ nonverbal behavior for cues about how they ought to behave); Friedman, supra note 147, at 95 (observing that sensitivity to nonverbal messages is great among the ill, “who are also seeking factual information about the nature and severity of their illness and social comparison information as to what they should be feeling in a time of emotional uncertainty. So even the slightest inconsistency [between verbal and nonverbal cues] is unlikely to go unnoticed.”); Mishler, supra note 123, at 117 (“Clinical observation and more recent research suggests that much communication, especially of feelings, between doctor and patient occurs through nonverbal channels.”).

See Richard E. Simpson, Note, Informed Consent: From Disclosure to Patient Participation in Medical Decisionmaking, 76 NW. U. L. Rev. 172, 175 (1981) (“[P]atient participation in medical decisionmaking is necessary to avert the danger that physicians will exploit patients by subjecting them to treatment that is not in their best interests.”).
physicians also lead to a heightened risk of coercion by government when physicians are deputized into ideological service.\textsuperscript{150}

In sum, \textit{Rust} and \textit{Casey} acknowledge that content restrictions on doctor-patient speech implicate the constitutional guarantee of free speech. Yet in both cases, the Court did not engage in a systematic First Amendment analysis of these restrictions. Instead, the Court myopically focused on physicians' rights, neglecting patients' audience-based interests and ignoring the likelihood that patients will respond with bewilderment and deference to viewpoint-based messages that are delivered by physicians. Moreover, the Court did not appreciate or address the most serious constitutional problem posed by content restrictions on physician speech: They enable the government to promote its partisan views by stifling the availability of medical information and distorting patients' decision-making process. As such, content restrictions on doctor-patient discourse raise traditional free speech concerns that must be analyzed under traditional First Amendment doctrine. This analysis requires a theory that permits government regulations to maximize the opportunity for genuine patient consent by increasing the flow of relevant, truthful information, while at the same time preventing the state from enforcing its orthodoxy. Such a theory must rest on First Amendment principles.

\textbf{III. Doctor-Patient Discourse and the First Amendment}

The Supreme Court has never held that the First Amendment protects only speech related to politics\textsuperscript{161} or "matters of public concern."\textsuperscript{162} Most

\textsuperscript{150} This connection was not lost on Justice Blackmun, whose opinions were consistently sensitive to the impact of the doctor-patient relationship upon patients' ability to rationally assess the real or perceived opinions of their physicians:

In our society, the doctor/patient dialogue embodies a unique relationship of trust. The specialized nature of medical science and the emotional distress often attendant to health-related decisions requires that patients place their complete confidence, and often their very lives, in the hands of medical professionals. One seeks a physician's aid not only for medication or diagnosis, but also for guidance, professional judgment, and vital emotional support. Accordingly, each of us attaches profound importance and authority to the words of advice spoken by the physician.\textit{Rust}, 111 S. Ct. at 1785 (Blackmun, J., dissenting).

\textsuperscript{161} \textit{Abood v. Detroit Bd. of Educ.}, 431 U.S. 209, 232 (1977) ("Nothing in the First Amendment or our cases discussing its meaning makes the question whether the adjective 'political' can properly be attached to those beliefs the critical constitutional inquiry."); \textit{Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council}, 425 U.S. 748, 765 (1976) ("[E]ven if the First Amendment were thought to be primarily an instrument to enlighten public decisionmaking in a democracy, we could not say that the free flow of [commercial] information does not serve that goal." (footnote omitted)); \textit{id.} at 779 (Stewart, J., concurring) ("Ideological expression, be it oral, literary, pictorial, or theatrical, is integrally related to the exposition of thought—thought that may shape our concepts of the whole universe of man."); \textit{Thornhill v. Alabama}, 310 U.S. 88, 102 (1948) ("Freedom of discussion, if it would fulfill its historic function in
frequently, the Court regards the constitutional guarantee of free speech as an instrument to advance the discovery of truth by protecting a “marketplace of ideas” in which opinions compete with each other for public acceptance.\textsuperscript{153} As Thomas Emerson explains, “freedom of expression is an essential process for advancing knowledge and discovering truth. An individual who seeks knowledge and truth must hear all sides of the question, consider all alternatives, test his judgment by exposing it to opposition, and make full use of different minds.”\textsuperscript{154}

In somewhat broader terms, the Court has also recognized that the First Amendment safeguards individuals’ thought processes and expression against government suppression. For example, the Court has stated that the First Amendment protects speech related to the “intellect and spirit,”\textsuperscript{155} individual self-expression\textsuperscript{156} and fulfillment,\textsuperscript{157} and the “exposition of ideas.”\textsuperscript{158}

\textsuperscript{153} Abrams v. United States, 250 U.S. 616, 630 (1919) (Holmes, J., dissenting) (“[T]he best test of truth is the power of the thought to get itself accepted in the competition of the market . . . .”).


\textsuperscript{156} First Nat'l Bank v. Bellotti, 435 U.S. 765, 777 n.12 (1978) (“The individual's interest in self-expression is a concern of the First Amendment separate from the concern for open and informed discussion, although the two often converge.”).

\textsuperscript{157} Police Dep't v. Mosley, 408 U.S. 92, 95-96 (1972) (“To permit the continued building of our politics and culture, and to assure self-fulfillment for each individual, our people are guaranteed the right to express any thought, free from government censorship.”).

\textsuperscript{158} See Chaplinsky v. New Hampshire, 315 U.S. 568, 572 (1942) (holding that “fighting words” may constitutionally be restricted as they do not further any exposition of ideas); see also Abood v. Detroit Bd. of Educ., 431 U.S. 209, 231 (1977)
Most scholars reject the view that the First Amendment only protects political speech and the marketplace of ideas model. Instead, they

("[O]ur cases have never suggested that expression about philosophical, social, artistic, economic, literary, or ethical matters—to take a nonexhaustive list of labels—is not entitled to full First Amendment protection."); Young v. American Mini Theaters, 427 U.S. 50, 70 (1976) (plurality opinion) (arguing that the First Amendment fully protects against regulation of the expression of social, political, or philosophical messages); Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, 425 U.S. 748, 779 (1976) (Stewart, J., concurring) ("Ideological expression . . . is integrally related to the exposition of thought—thought that may shape our concepts of the whole universe of man."); Roth v. United States, 354 U.S. 476, 484 (1957) ("All ideas having even the slightest redeeming social importance—unorthodox ideas, controversial ideas, even ideas hateful to the prevailing climate of opinion—have the full protection of the guarantees . . . .")

159 Robert Bork and Alexander Meiklejohn are the chief proponents of the view that the protection of political speech is the sole objective of the First Amendment, although Meikljohn’s perspective has broadened over time. For their views, see ALEXANDER MEIKLEJOHN, FREE SPEECH AND ITS RELATION TO SELF-GOVERNMENT 22-27 (1948) [hereinafter MEIKLEJOHN, FREE SPEECH] (analogizing the limits of Free Speech protections to the town meeting); Robert H. Bork, Neutral Principles and Some First Amendment Problems, 47 IND. L.J. 1, 20 (1971) ("There is no basis for judicial intervention to protect any . . . form of expression [other than political speech], be it scientific, literary or that variety of expression we call obscene of pornographic."); Alexander Meikeljohn, The First Amendment Is Absolute, 1961 SUP. CT. REV. 245, 256-267 (arguing for a broader conception of protected political speech, including all thought and speech by which citizens govern).

For critics of this position, see Estlund, supra note 152, at 45 (contending that Bork’s view of the First Amendment would yield predictable results “at the cost of excluding from protection almost all literature, art, science, history, discussion of the economic system and the activities of powerful nongovernment persons and organizations, and much speech on matters of widespread public controversy that had yet to coalesce into specific proposals for government intervention”); Martin H. Redish, The Value of Free Speech, 130 U. PA. L. REV. 591, 601 (1982) ("The mistake of Bork and Meiklejohn, then, is that they have confused one means of obtaining the ultimate value with the value itself.").

The case of government regulation of doctor-patient speech reveals the fallacy of the position that the First Amendment only protects political speech. The freedom to engage in unconstrained speech about politics would mean little in the lives of individuals in a society in which the state dictated the content of doctor-patient conversations about the most intimate and life-altering decisions they make. See Poe v. Ullman, 367 U.S. 497, 515 (1961) (Douglas, J., dissenting) ("A society that tells its doctors under pain of criminal penalty what they may not tell their patients is not a free society.").

160 See, e.g., C. EDWIN BAKER, HUMAN LIBERTY AND FREEDOM OF SPEECH 6-7 (1989) (claiming that marketplace theory is based on false assumptions that truth is objective and people are rational); CATHERINE A. MACKINNON, FEMINISM UNMODIFIED: DISCOURSES ON LIFE AND LAW 129 (1987) (arguing that women and members of ethnic and racial minorities are silenced and denied equal access to modes of
tend to view the purpose of the First Amendment as ensuring more than the continued existence of a democratic political system or the free flow of information needed to make rational public decisions. Amidst a wide array of opinions about the specific values warranting First Amendment protection, the predominant theory is that speech warrants protection because it facilitates individual development and shields a sphere of personal liberty against government infiltration.\(^{161}\)

Proponents of a First Amendment theory that focuses on the relationship between speech and personal liberty have articulated several specific “free speech values” that deserve constitutional protection. In one view, speech that fosters individual autonomy and self-determination must be fully protected in order to maintain the integrity of the individual and protect private decision making from undue government intrusion.\(^{162}\) As David Richards explains, “[t]he value of free expression . . . rests on its deep relation to self-respect arising from autonomous self-determination without which the life of the spirit is meager and slavish.”\(^{163}\) Most propo-

expression); Owen M. Fiss, *Why the State?*, 100 HARV. L. REV. 781, 788 (1987) (arguing that the market “might be an effective institution for producing cheap and varied consumer goods and for providing essential services . . . but not for producing the kind of debate that constantly renews the capacity of a people for self-determination”); Stanley Ingber, *The Marketplace of Ideas: A Legitimizing Myth*, 1984 DUKE L.J. 1, 36-37 (concluding that the marketplace theory’s assumption of equal access is no longer defensible).


The liberty model holds that the free speech clause protects not a marketplace but rather an arena of individual liberty from certain types of governmental restrictions. Speech is protected not as a means to a collective good but because of the value of speech conduct to the individual. The liberty theory justifies protection because of the way the protected conduct fosters individual self-realization and self-determination without improperly interfering with the legitimate claims of others.

\(^{162}\) Baker, supra note 160, at 24 (positing that “freedom 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”); Scanlon, Jr., supra note 107, at 531 (stating that “the legitimate powers of government are limited to those that can be defended on grounds compatible with the autonomy of its citizens”); 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) (“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.”).

\(^{163}\) Richards, supra note 162, at 62.
ments of this view agree that speech fostering individual self-realization\textsuperscript{164} and self-fulfillment\textsuperscript{168} is fully protected by the First Amendment.

Under both the marketplace of ideas and the personal liberty models, doctor-patient discourse constitutes speech that should be fully protected.\textsuperscript{166} Doctor-patient discourse facilitates the discovery of two levels of "truth" that warrant protection under the marketplace of ideas model. First, a primary goal of doctor-patient discourse is to discover the "patient's truth"—the best course of medical treatment in light of that patient's unique configuration of objective and subjective characteristics. When a patient is diagnosed with an illness and must decide on a course of treatment, the "marketplace of ideas" that informs his or her decision making is provided mainly by physicians.\textsuperscript{167} In conversations with physicians, patients seek to discover the nature of the medical problem, its possible causes, alternative treatments and their risks, and factors that could affect whether a possible treatment will fail or succeed.\textsuperscript{168} Patients' discovery of their medical truth—that is, of the particular course of treat-

\textsuperscript{164} See, e.g., \textit{Steven H. Shiffrin, The First Amendment, Democracy, and Romance} 167 (1990) (stating that the proper First Amendment focus would result in protection of many values currently seen as tied to free speech analysis, including dignity and cathartic values); Redish, \textit{supra} note 159, at 593 (arguing that the guarantee of free speech only promotes the value of "individual self-realization"); Thomas M. Scanlon, Jr., \textit{A Theory of Freedom of Expression}, 1 PHIL. & PUB. AFF. 204, 217-18 (1972) (noting that restrictions on free speech inhibit individual autonomy and judgment); see also Bruce J. Winick, \textit{The Right to Refuse Mental Health Treatment: A First Amendment Perspective}, 44 U. MIAMI L. REV. 1, 75 (1989) (arguing that First Amendment's protection of mental processes extends to the forced administration of psychotropic drugs).

\textsuperscript{165} \textit{Emerson, supra} note 154, at 6 (arguing that freedom of expression is an "essential" means of ensuring self-fulfillment).

\textsuperscript{166} This analysis relies on an idealized model of doctor-patient interaction. For an examination of doctor-patient communication, see \textit{supra} notes 123-45 and accompanying text. It is, however, appropriate to consider expressive conduct in its ideal form when determining its proper level of First Amendment protection. To do otherwise would deny constitutional protection to forms of expressive conduct that, for one reason or another, fail to achieve their communicative potential. A theatrical flop is no less deserving of full First Amendment protection than a tour-de-force.


\textsuperscript{168} \textit{Richard L. Street, Jr., Information-Giving in Medical Consultations: The Influence of Patients' Communicative Styles and Personal Characteristics}, 32 SOC. SCI. & MED. 541, 541 (1991) ("[F]or the patient, information fosters an understanding of one's health status which in turn may reduce uncertainty, alleviate concerns, and improve health.").
ment that is best for them—depends on an unconstrained flow of information from physicians.\footnote{Similarly, restrictions on commercial speech have repeatedly been invalidated on the grounds that they impede consumers' discovery of information. See, e.g., Bates v. State Bar, 433 U.S. 350, 377 (1977) (stating that a ban on attorney advertising "serves to increase the difficulty of discovering the lowest cost seller of acceptable ability"); Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, 425 U.S. 748, 763-65 (1976) (concluding that a ban on advertising by pharmacists interfered with consumers' ability to compare costs and exercise economic choice).}\footnote{Doctor-patient speech also advances the discovery of scientific and medical truth. Through discussions, the physician gathers information in order to diagnose and treat the patient.\footnote{Although the Supreme Court has not directly decided the question, there is a consensus among scholars that the First Amendment protects scientific expression and expressive conduct related to scientific experimentation. See, e.g., Richard Delgado et al., Can Science Be Inopportune? Constitutional Validity of Government Restrictions, 31 UCLA L. Rev. 128, 160 (1983) ("[W]here the Court to address the issue directly, it is highly probable that scientific expression would receive full protection under the first amendment.").} Additionally, conversations with numerous patients over time enhance doctors' scientific and medical knowledge about diseases, medications, procedures, symptomology, diagnoses, and the practice of medicine in general.\footnote{Free market theorists might also argue that the free flow of information between doctor and patient facilitates a patient's ability to make rational economic decisions about treatments and whether to retain the physician's services. Thus, in the aggregate, protecting doctor-patient discourse enhances the efficiency of the market for medical treatments and physicians' services.} Thus, the marketplace of ideas model of the First Amendment, focusing on the relationship between access to information and the discovery of truth, supports the full protection of doctor-patient discourse.\footnote{Doctors impart scientific and experiential information about disease and the benefits and risks of available treatments to their patients.}

Doctor-patient speech also implicates a number of free speech values that are central to personal liberty. When patients seek physicians' advice for medical problems, the ensuing discourse consists of expressions of fact, opinion, and persuasion.\footnote{See Riley v. National Fed'n of the Blind, 487 U.S. 781, 796 (1988) (holding that the First Amendment protects speech that contains elements of commercial solicitation and noncommercial persuasion); Bigelow v. Virginia, 421 U.S. 809, 822 (1974) (holding that the First Amendment applies to speech that "involve[s] the exercise of the freedom of communicating information and disseminating opinion"); Kingsley Int'l Pictures Corp. v. Regents of the Univ. of the State of N.Y., 360 U.S. 684, 689 (1959) (stating that the Constitution "protects expression which is eloquent no less than that which is unconvincing"); Thomas v. Collins, 323 U.S. 516, 537 (1945) (stating that the First Amendment protects the "opportunity to persuade to action, not merely to describe facts").}
able treatments. Patients inquire about what they do not understand, express their fears, and convey facts relevant to the doctor's assessment of the likely success of different treatment alternatives. In this discourse, doctors and patients also often discuss a wide range of subjects including the patient's medical, psychological, family, and sexual histories; ethical and religious beliefs; and any other factor that may affect the patient's physical or mental well-being. Additionally, patients commonly seek physicians' advice for highly personal, nonmedical problems. When it works, the outcome of this discourse is a mutually determined treatment decision that reflects the best judgment of the doctor and patient about how to proceed.

Doctor-patient speech is essential to maintaining patients' autonomy, self-determination, and dignity in the face of illness. In addition to determining treatment, another objective of doctor-patient discourse is to democratize the medical decision-making process and empower patients to participate actively in determining what happens to their bodies. There are few decisions that are as intimate, personal, and life-defining as one about how to cope with a medical condition. Information is a patient's only shield against fear and uncertainty, which can reduce even powerful, educated, and self-assertive individuals to

174 See Adelman et al., supra note 141, at 127 ("[E]ven in initial medical encounters which involve the meeting of two strangers, patients and physicians deal with concerns as diverse as life and death as well as other intimate or personal issues.").

175 Lewis Thomas, On the Science and Technology of Medicine, in DOING BETTER AND FEELING WORSE: HEALTH IN THE UNITED STATES, 42 (J.H. Knowles ed., 1977) (reporting that a study found that 75% of all patient visits were for the purpose of getting advice on family, economic, or social issues, or to get reassurance about physical symptoms).

176 David Cole persuasively argues that the close relationship between doctor-patient discourse and individual autonomy justifies the creation of a "neutrality exception" to the doctrine of unconstitutional conditions, which permits government to compel the expression of opinion within the boundaries of publicly funded programs. See Cole, supra note 106, at 743-47. Of course, patients of privately funded physicians are no less dependent upon doctor-patient discourse to preserve their autonomy than patients of publicly funded physicians. Therefore, Cole's argument in favor of imposing a requirement of neutrality upon government-dictated speech by physicians applies with equal force to both publicly and privately funded doctors.

177 See Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir.) ("True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each."); cert. denied, 409 U.S. 1064 (1972).

178 See Simpson, supra note 149, at 174 ("The value of patient participation in medical decisionmaking lies in its tendency to humanize the treatment process by ensuring that the patient retains the status of an autonomous being, capable of assimilating information and making decisions that affect his or her life.").
quaking passivity.\textsuperscript{179} Through candid discussions with their physicians, patients are able to retain autonomy and control over their lives and their bodies.

Doctor-patient speech also promotes patients’ self-realization. A critical component of the medical decision-making process is the identification and articulation of patients’ values, personal strengths, and weaknesses. In deciding how to cope with a medical condition, patients often discover aspects of themselves that their healthy life never revealed. For example, women diagnosed with breast cancer who face the choice of a mastectomy or lumpectomy must examine their feelings about attractiveness, sexuality, and the possibility of death. Patients who learn that they are HIV-positive must wrestle with having an incurable disease, while summoning the psychological strength that can help them remain healthy.\textsuperscript{180} Crucial to patients’ ability to attain these insights is the quality of their conversations with their doctors.\textsuperscript{181} Frank, open discussions with doctors encourage patients’ self-realization and self-fulfillment; stifled discourse in which conversation about certain topics is off-limits or prescribed impedes them.\textsuperscript{182}

The right to engage freely in conversations with doctors about treatment alternatives is a corollary to the constitutional right to refuse “unwanted medical treatment”\textsuperscript{183} and the right of bodily integrity underlying the doctrine of informed consent.\textsuperscript{184} The Supreme Court has recognized that First Amendment protection of the right to receive ideas is a “necessary predicate” to the “meaningful exercise of the rights of speech, press, and political freedom.”\textsuperscript{185} Government regulations that confine patients’ knowledge to only state-approved treatments sabotage the con-

\textsuperscript{179} See supra notes 132-36 and accompanying text.

\textsuperscript{180} Indeed, there is evidence that high-quality doctor-patient communication may contribute to long-term survival of HIV infection. See Michael Calle\n
\textsuperscript{181} William B. Stiles et al., Interaction Exchange Structure and Patient Satisfaction with Medical Interviews, 17 Med. Care 667 (1979) (reporting that patients are more satisfied with physician visits when allowed to express themselves in their own words, and when physicians are more informative).

\textsuperscript{182} Patients are generally more satisfied with physician visits, and experience improved health, if allowed to discuss a wide range of psychological and social, in addition to medical, issues that concern them. See Zeev Ben-Sira, Primary Medical Care and Coping with Stress and Disease, 21 Soc. Sci. & Med. 485 (1985) (stating that patients may judge the quality and efficacy of medical treatment on the physician’s “affective” behavior).

\textsuperscript{183} Cruzan v. Director, 497 U.S. 261, 278 (1990).


stitutional right to make autonomous medical decisions and chart the
course of one's health care. Indeed, preserving and protecting patients'
ability to acquire complete medical information may be the most effective
means of promoting sound health care decisions, and the best defense
against the imposition of state medicine.  

Thus, contrary to the Third Circuit's ruling in Casey, conversations
between doctors and patients about diagnosis and treatments are not
commercial speech. Commercial speech is expression that does no
more than "propose a commercial transaction." Consistent with the
attenuated relationship between commercial speech and free speech values,
government restrictions on commercial speech are not subject to the
rigorous scrutiny that they receive when they apply to fully protected speech.

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186 Scholars have long recognized the relationship between the First Amendment's
protection of access to information and self-governance. See, e.g., Meiklejohn, Free
Speech, supra note 159, at 26 ("Just so far as . . . the citizens who are to decide an
issue are denied acquaintance with information or opinion or doubt or disbelief or
criticism which is relevant to that issue, just so far the result must be ill-considered, ill-
balanced planning for the general good."); Letter from James Madison to W.T. Barry
(Aug. 4, 1822), in 9 Writings of James Madison 103 (G. Hunt ed., 1910) ("A popular
Government, without popular information, or the means of acquiring it, is but a
Prologue to a Farce or a Tragedy; or, perhaps both. Knowledge will forever govern
ignorance: And a people who mean to be their own Governors, must arm themselves
with the power which knowledge gives.").

187 See supra note 81 and accompanying text.

188 The Supreme Court has recognized that commercial speech that concerns a
lawful activity and is not misleading or fraudulent is covered by the First Amendment,
but is entitled to less protection against government regulation than fully protected
categories of speech. Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer
Council, 425 U.S. 748, 770 (1976). Legal scholars have hotly debated whether com-
mercial speech deserves any First Amendment protection. Compare Martin Redish,
The First Amendment in the Marketplace: Commercial Speech and the Values of Free
Expression, 39 Geo. Wash. L. Rev. 429, 434 (1971) (arguing that commercial speech
further the First Amendment purposes) with C. Edwin Baker, Commercial Speech: A
Problem in the Theory of Freedom, 62 Iowa L. Rev. 1, 13 (1976) (arguing that com-
mercial speech does not further First Amendment values).

However, when speech that proposes a commercial transaction is "inextricably inter-
twined" with speech that is informative and persuasive, the entire expression is fully

190 Board of Trustees of State Univ. of N.Y. v. Fox, 492 U.S. 469, 477-78 (1989)
(reasoning that the limited measure of protection for commercial speech is com-
mensurate with its subordinate position in the hierarchy of First Amendment values).

191 To comply with the First Amendment, restrictions on fully protected speech
must serve a compelling state interest and be narrowly tailored to serve that interest.
Perry Educ. Ass'n v. Perry Local Educators' Ass'n, 460 U.S. 37, 45 (1983). Restric-
tions on commercial speech do not violate the First Amendment as long as they are
It should be clear from the foregoing discussion of the relationship between medical speech and the discovery of truth, autonomy, and self-realization that conversations between doctors and patients do more than propose a commercial transaction. That doctor-patient discourse often takes place within a profit-making context does not deprive it of full protection under the First Amendment. As the Supreme Court has held, "speech does not lose its First Amendment protection because money is spent to project it."\(^{192}\)

Although the Supreme Court has never held that the rendering or receipt of medical advice is fully protected speech,\(^ {193}\) several decisions support this conclusion, most notably *Board of Trustees of the State University of New York v. Fox.*\(^ {194}\) In Fox, the Court considered whether a state university's regulation banning commercial activities on school property and in students' dormitory rooms violated the First Amend-

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\(^{192}\) *Virginia Pharmacy,* 425 U.S. at 761; see also *Riley,* 487 U.S. at 801 ("It is well settled that a speaker's rights are not lost merely because compensation is received; a speaker is no less a speaker because he or she is paid to speak."); *Bigelow v. Virginia,* 421 U.S. 809, 818 (1975) ("The State was not free of all constitutional restraint merely because . . . appellant's motive or the motive of the advertiser may have involved financial gain . . . ."); *Tribe,* supra note 20, § 12-15, at 891 (arguing that profit motive does not strip the speaker of all First Amendment protection).

\(^{193}\) In analyzing the constitutionality of the gag rule, the dissenting Justices in *Rust* applied the strict scrutiny test applicable to fully protected speech, rather than the lower standard applicable to commercial speech. *Rust,* 111 S. Ct. at 1783. It appears, therefore, that these Justices consider doctor-patient speech to be fully protected under the First Amendment. No lower federal court has explicitly held that doctor-patient discourse is fully protected speech, although several courts have suggested that it is. See, e.g., *Massachusetts v. Secretary of Health & Human Servs.,* 899 F.2d 53, 72-73 (1st Cir. 1990) (holding that HHS regulation prohibiting physician from discussing abortion with patients violated the First Amendment); Planned Parenthood Fed'n of Am. v. Sullivan, 913 F.2d 1492, 1504 (10th Cir. 1990) (same); *Charles v. Carey,* 627 F.2d 772, 789 (7th Cir. 1980) (stating that the regulations at issue "force[] the physician to act as a mouthpiece for the state's theory of life"); *Guam Soc. of Obstetricians & Gynecologists v. Ada,* 776 F. Supp. 1422, 1429 n.9 (D. Guam 1990) (stating that statute prohibiting doctors from soliciting patients for abortion violated the First Amendment), *aff'd,* 962 F.2d 1366 (9th Cir.), *cert. denied,* 113 S. Ct. 633 (1992); Planned Parenthood v. City of Wichita, 729 F. Supp. 1282, 1288 (D. Kan. 1990) (stating that women have a First Amendment right to receive information about abortion from doctors); *Meyer v. Massachusetts Eye & Ear Infirmary,* 330 F. Supp. 1328, 1332 (D. Mass. 1971) (holding that doctor's allegation that hospital's practice of preventing him from disclosing dangers of certain medical procedures stated a cause of action under the First Amendment).

\(^{194}\) 492 U.S. 469 (1989).
ment. Students filed suit after a housewares seller was forcibly ejected by
campus guards from a dormitory room. Determining that the regulation
was overbroad because it reached several categories of clearly noncom-
mercial speech, the Court stated:

On the record before us here, [the regulation] must be deemed to
reach some non-commercial speech. . . . [A deponent testified that
it] would prohibit tutoring, legal advice, and medical consultations
provided (for a fee) in students’ dormitory rooms. While these
examples consist of speech for a profit, they do not consist of speech
that proposes a commercial transaction, which is what defines com-
mercial speech. Some of our most valuable forms of fully protected
speech are uttered for a profit.\footnote{\textit{Id.} at 482 (first emphasis added) (citations omitted).}

Several other Court opinions involving professional advertising and
solicitation\footnote{None of these decisions analyzing the First Amendment status of professional
advertising and solicitation concerning physicians involved other types of licensed
professionals, such as lawyers, pharmacists, and optometrists. For an analysis of the
application of the commercial speech doctrine to physician advertising, see William C.
Canby & Ernest Gellhorn, \textit{Physician Advertising: The First Amendment and the Sher-
man Act}, 1978 \textit{Duke L.J.} 543, 546-564.} also support the proposition that speech occurring within
the confines of a doctor-patient relationship is fully protected by the First
Amendment. In these cases, the Court has suggested that professional
advertising and solicitation, which it has relegated to the category of com-
mercial speech, do not include communication occurring after the form-
ation of a professional relationship.\footnote{\textit{See, e.g.}, Zauderer v. Office of Disciplinary Counsel, 471 U.S. 626, 637 n.7
(1985) (noting that attorney advertisements that included statements regarding the
legal rights of persons injured by the Dalkon Shield “in another context, would be
fully protected speech”); \textit{In re} Primus, 436 U.S. 412, 426 n.17 (1977) (citing with
approval appellees’ concession that appellant lawyer’s meeting with prospective client
to give advice concerning legal rights was fully protected under the First
Amendment).} Moreover, the Court’s repeated
characterization of professional advertising\footnote{\textit{See, e.g.}, Peel v. Attorney Reg. & Disciplinary Comm’n, 496 U.S. 91, 99-106
(1990) (holding that state’s censuring attorney’s use of letterhead that advertised his
certification as a trial specialist implicated commercial speech); Shapero v. Kentucky
Bar Ass’n, 486 U.S. 466, 476-78 (1988) (holding that attorney letter soliciting clients
from pool of people with particular legal problems involved commercial speech);
Zauderer, 471 U.S. at 637-38 (holding that attorney advertisements soliciting clients
were commercial speech); \textit{In re} R.M.J., 455 U.S. 191, 206 (1982) (finding that Mis-
souri prohibition on attorney advertising affected commercial speech); Bates v. State
Bar, 433 U.S. 350, 381-84 (1977) (holding that bar association rule prohibiting adver-
tising by attorneys affected commercial speech); Carey v. Population Servs. Int’l, 431
U.S. 678, 700-02 (1977) (finding that statute banning advertising of contraceptive
devices affected commercial speech); Virginia State Bd. of Pharmacy v. Virginia Citi-}
tion as commercial speech does not refute the conclusion that doctor-patient discourse about medical treatment is fully protected, noncommercial speech. The purpose of professional advertising and in-person solicitation, which occur prior to the formation of a fiduciary relationship, is to acquire employment for the professional. Prospective patient/client listeners receive little from advertisements other than the offer of future professional advice. Even when professional advertisements include general advice, it is unsolicited and of little value to the listener. As such, these expressions are only minimally related to personal liberty or the discovery of truth. Expressions after the formation of this relationship, on the other hand, identify and resolve patient/clients' unique medical or legal problems and thus implicate a number of First Amendment values.


Conversations between doctors and patients about medical treatment always occur after the establishment of a formal doctor-patient relationship. Under the common law of tort and contract, the doctor-patient relationship, which gives rise to a full range of fiduciary duties, is created by either an express or implied agreement. A doctor-patient relationship is impliedly formed once a physician examines a patient, renders a diagnosis, or discusses treatment. Therefore, all conversations between doctors and patients about diagnosis and treatment occur within the confines of a doctor-patient relationship. See Heller v. Peekskill Community Hosp., 603 N.Y.S.2d 548, 549 (N.Y.A.D. 1993) (holding that doctor-patient relationship was created when professional services were rendered and accepted); Childs v. Weis, 440 S.W.2d 104, 107 (Tex. Ct. App. 1969) (finding no implied doctor-patient relationship because doctor did not examine or treat patient); Ricks v. Budge, 64 P.2d 208, 211 (Utah 1937) (finding that doctor-patient relationship was formed when physician undertook treatment and recommended hospitalization).

Arguably, advertising and in-person solicitation present a greater danger of overreaching by professionals, making more compelling the need for government regulation to ensure the accuracy of professional expression made before professional relationships are formed. Indeed, the Court has often expressed concern about this danger of overreaching and undue influence that exists during communication between professionals and prospective patients/clients. See Virginia Pharmacy, 425 U.S. at 773 n.25 ("Physicians and lawyers, for example, do not dispense standardized products; they render professional services of almost infinite variety and nature, with the consequent enhanced possibility for confusion and deception if they were to undertake certain kinds of advertising."); Ohralik, 436 U.S. at 457-58 (suggesting that in-person solicitation by attorneys may deserve society's interests).

Ohralik, 436 U.S. at 459 ("A lawyer's procurement of remunerative employment is a subject only marginally affected with First Amendment concerns.").

See supra notes 168-82 and accompanying text.
It is important to understand that categorizing doctor-patient speech as fully protected under the First Amendment does not preclude any and all government regulation. It merely recognizes that doctor-patient discourse, like other forms of fully protected speech, has special status within First Amendment jurisprudence because of its essential role in protecting and preserving personal liberty and the discovery of truth.

It is clear that patients are extremely vulnerable to physician coercion and misrepresentation, and that government regulation is needed to safeguard patients' receipt of truthful, nondeceptive information. Yet, as previously stated, the qualities of doctor-patient speech that make patients vulnerable to physician coercion also make them vulnerable to government coercion. After properly categorizing doctor-patient discourse as fully protected speech, the challenge is to fashion a theory that will permit government regulations that promote patients' receipt of truthful information necessary to make informed, autonomous, and rational decisions, but that will simultaneously prohibit regulations that silence or compel speech for the purpose of enforcing a medical orthodoxy. The next two parts of this Article will undertake this challenge.

IV. First Amendment Analysis of Government Regulations That Silence Physician Speech

Regulations that silence publicly or privately funded physicians' speech infringe upon patients' audience-based First Amendment interests in several ways. First, regulations prohibiting physicians from discussing particular treatments distort patients' health care decision making by fostering an incomplete understanding of medical alternatives. Second, the

204 Doctor-patient communication already enjoys a unique status in the law of evidence. The doctor-patient testimonial privilege reflects the judgment that the discovery of possibly probative evidence is less important than protecting the integrity of doctor-patient communication and preserving patients' privacy. See William Strong et al., 1 McCormick on Evidence § 98, at 368 (4th ed. 1992).

205 A comprehensive analysis of lawyer-client speech under the First Amendment is beyond the scope of this Article. However, many of the arguments made here apply with equal force to communication between lawyers and clients after the formation of a professional relationship. From the standpoint of the marketplace of ideas model, lawyer-client communication facilitates a lawyer's discovery of the "truth" about how best to handle a particular legal problem. On a "macro" level, unhindered lawyer-client communication also advances the efficient and equitable operation of the legal system. From the standpoint of the personal liberty model, lawyer-client speech may be closely related to preserving client autonomy. On the other hand, some types of lawyer-client communication—namely those concerned with commercial matters—would appear to fall within the category of "commercial speech," because they merely concern commercial transactions, and thus have a more attenuated relationship to the discovery of truth and personal liberty.

206 See supra notes 124-46 and accompanying text.

207 See infra notes 225-26 and accompanying text.
state-dictated omission of a potential medical treatment from doctor-patient discourse necessarily destroys the possibility of authentic patient consent. 208 Finally, regulations that prevent physicians from informing patients about particular treatments subvert patient autonomy by, in effect, making government a silent partner in medical decision making. 209

Under established constitutional jurisprudence, government regulations that prevent publicly or privately funded physicians from discussing particular treatments violate patients' First Amendment rights. 210 It is well-settled that government restrictions censoring what people may say or hear strike at the very heart of a free society. 211 Justice Brandeis's famous concurrence in Whitney v. California 212 contains one of the earliest and most eloquent warnings against the assault on audience-based rights, which occurs when government excises ideas from discourse:

Those who won our independence believed that the final end of the state was to make men free to develop their faculties, and that in its government the deliberative forces should prevail over the arbitrary... Believing in the power of reason as applied through public discussion, they eschewed silence coerced by law—the argument of force in its worst form. 213

The danger of government censorship extends beyond the silenced speaker. Listeners also have a right to receive information that is independent of speakers' First Amendment right to express ideas. 214

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208 See infra note 232 and accompanying text.
209 For example, if a patient with coronary artery disease was prevented by the state from hearing about nonsurgical options, such as angioplasty, and thereafter chose to undergo triple-bypass surgery, that ultimate decision would be as much an exercise of governmental preference as of the patient's free will.
210 They may also violate physicians' speech rights. See supra note 90 and accompanying text. However, the purpose of this analysis is to establish a jurisprudential foundation for patients' First Amendment right to receive complete, unbiased medical advice from their physicians.
211 Texas v. Johnson, 491 U.S. 397, 414 (1989) (stating that the "bedrock principle underlying the First Amendment... is that government may not prohibit the expression of an idea simply because society finds the idea itself offensive or disagreeable").
212 274 U.S. 357, 375 (1927) (Brandeis, J., concurring).
213 Id. at 375-76.
214 First Nat'l Bank v. Bellotti, 435 U.S. 765, 783 (1978) ("[T]he First Amendment goes beyond protection of the press and the self-expression of individuals to prohibit government from limiting the stock of information from which members of the public may draw"); 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."); Stanley v. Georgia, 394 U.S. 557, 564 (1969) (stating that it is "now well established that the Constitution protects the right to receive information and ideas"); Lamont v. Postmaster Gen., 381 U.S. 301, 305 (1965) (invalidating statute that required Postmaster to detain and deliver only upon addressee's
Indeed, the extension of constitutional protection to commercial speech rests upon the recognition of the right of listeners to receive information. 210 Protecting this audience-based right to receive information requires more than simply prohibiting governmental interference with willing speakers. It implies a constitutional right to accumulate knowledge and thereby retain control over one’s own thought processes. 216

In order to protect the rights of both speakers and listeners, government regulations censoring expression by particular speakers on the basis of content are subject to the strictest scrutiny, 217 and consequently such measures are rarely upheld. 218 While some Supreme Court opinions

 request mail containing communist literature, because it interfered with addressee’s First Amendment rights; id. at 308 (Brennan, J., concurring) (“It would be a barren marketplace of ideas that had only sellers and no buyers.”); Martin v. City of Struthers, 319 U.S. 141, 146-147 (1943) (asserting that freedom to distribute information to those who desire it is vital to the preservation of a free society).


 216 Stanley, 394 U.S. at 566 (“Whatever the power of the state to control public dissemination of ideas inimical to the public morality, it cannot constitutionally premise legislation on the desirability of controlling a person’s private thoughts.”); Griswold v. Connecticut, 381 U.S. 479, 482 (1965) (“[T]he State may not, consistently with the spirit of the First Amendment, contract the spectrum of available knowledge.”); Meyer v. Nebraska, 262 U.S. 390, 400 (1923) (reversing teacher’s conviction for teaching German in violation of state law because, among other reasons, it interfered with “the opportunities of pupils to acquire knowledge”); see also Kreimer v. Bureau of Police, 958 F.2d 1242, 1255 (3d Cir. 1992) (“Our review of the Supreme Court’s decisions confirms that the First Amendment does not merely prohibit the government from enacting laws that censor information, but additionally encompasses the positive right of public access to information and ideas.”); National Treasury Employees Union v. King, 798 F. Supp. 780, 785 (D.D.C. 1992) (“[T]he First Amendment protects the rights of citizens to receive information and to acquire useful knowledge.”); Thomas I. Emerson, Legal Foundations of the Right to Know, 1976 WASH. U. L.Q. 1, 2 (arguing that we ought to consider “the right to know” as an integral part of the system of free expression embodied in the First Amendment).

 217 See Geoffrey R. Stone, Content Regulation and the First Amendment, 25 WM. & MARY L. REV. 189, 196-97 (1983) (noting that no matter what formulation it uses, the Court applies a “different and more stringent standard” to content-based restrictions than to content-neutral restrictions on speech).

 218 See, e.g., Bellotti, 435 U.S. at 784-85 (invalidating statute that prohibited corporations from making contributions to influence certain votes, on grounds that government cannot “dictat[e] the subjects about which persons may speak and the speakers
refer to a complete lack of governmental authority to censor the content of speech.\textsuperscript{219} Recent decisions have used less absolute terms, and have held that restrictions that censor speech on the basis of its content are presumptively invalid\textsuperscript{220} unless they apply to categories of expression that are constitutionally proscribable.\textsuperscript{221}

Content-based regulations need not explicitly target a particular viewpoint to run afoul of the First Amendment. Restrictions that silence speech about certain subjects also fall within the First Amendment's prohibition against content-based regulations\textsuperscript{222} because they distort full debate and informed decision making\textsuperscript{223} and impede the discovery of truth.\textsuperscript{224} Moreover, subject-matter restrictions give rise to a presumption of viewpoint discrimination.\textsuperscript{225}

who may address a public issue’’); see also Stone, supra note 217, at 196 (noting that “the Court has invalidated almost every content-based restriction that it has considered in the past quarter century”). But see Burson v. Freeman, 112 S. Ct. 1846, 1849 (1992) (upholding Tennessee statute prohibiting solicitation of votes and distribution of campaign literature within 100 feet of polling place on election day).

\textsuperscript{219} See, e.g., Police Dep't v. Mosley, 408 U.S. 92, 95 (1971) (“Above all else, the First Amendment means that government has no power to restrict expression because of its message, its ideas, its subject matter, or its content.”).

\textsuperscript{220} See R.A.V. v. City of St. Paul, 112 S. Ct. 2538, 2542-43 (1992) (holding that content-based regulations are presumptively invalid unless the speech falls within limited exceptions); see also Simon & Schuster, Inc. v. Members of N.Y. State Crime Victims Bd., 112 S. Ct. 501, 504 (1991) (holding statute imposing financial burden on speakers based on speech content presumptively incompatible with the First Amendment); Consolidated Edison Co. v. Public Serv. Comm’n, 447 U.S. 530, 536 (1980) (stating that permissible restriction on speech may not be based on content or subject matter).

\textsuperscript{221} Proscribable speech includes statements that are obscene, false, or defamatory. R.A.V., 112 S. Ct. at 2543.

\textsuperscript{222} Burson, 112 S. Ct. at 1850 (“This Court has held that the First Amendment's hostility to content-based regulation extends not only to a restriction on a particular viewpoint, but also to a prohibition of public discussion of an entire topic.” (citing Consolidated Edison, 447 U.S. at 537)).

\textsuperscript{223} See Stone, supra note 217, at 217 (asserting that content-based regulations restrict communication of only some messages and thus affect public debate generally).

\textsuperscript{224} See Abrams v. United States, 250 U.S. 616, 630 (1919) (Holmes, J., dissenting) (asserting that the “best test of truth” is the power of an idea to survive the competition in the marketplace).

\textsuperscript{225} See Consolidated Edison, 447 U.S. at 536 (stating that “when regulation is based on the content of speech, governmental action must be scrutinized more carefully to ensure that communication has not been prohibited 'merely because public officials disapprove the speaker's views.' ” (quoting Niemotko v. Maryland, 340 U.S. 268, 282 (1951) (Frankfurter, J., concurring))); see also Stone, supra note 217, at 231 (stating that restrictions directed at a particular item of information raise a substantial
Prior restraints that prohibit publicly or privately funded physicians from speaking to patients about medical treatments raise the free speech concerns that generally plague content and subject-matter restrictions. Measures that prohibit physicians from discussing therapies distort patients' assessment of the relative risks and benefits of available therapies, and thus distort the decision-making process as a whole. A patient who is not told about a certain treatment is not likely to choose it, and may end up selecting from among treatments that are not the best for him or her. In this way, restrictions barring publicly or privately funded physicians from discussing certain treatments destroy the possibility of genuine consent, autonomy, and the discovery of truth by preventing patients from learning about options that they otherwise might have chosen.

The distortion caused by these restrictions is substantial because patients have no comparable alternative means of acquiring medical information. This is particularly true for restrictions that apply to all physicians because patients often lack the background necessary to educate themselves about unspoken treatments. Restrictions that bar a finite class of physicians from discussing a medical option also cause substantial distortion because patients are likely to find it impractical, if not

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risk that the restriction was adopted because regulators disagreed with the information).

226 Any restriction that distorts the content of communication implicates First Amendment concerns, but this distortion is substantial if speakers have no alternative means of expression and listeners have no alternative means to acquire the forbidden information. See Stone, supra note 217, at 217; see also Benston, supra note 122, at 315-16 ("Fear of an imposed orthodoxy is justified where there is a significant limitation on the expression of alternative or supplementary speech."). However, an alternative means analysis makes little sense in the context of restrictions that bar a physician from mentioning a treatment to a patient. In order for patients to acquire information elsewhere, they must know that they did not receive complete information, as well as the identity of the missing item of information. In some cases, common knowledge may alert patients to the absence of a specific treatment, such as the option of abortion as a treatment for an unwanted pregnancy. More typically, however, the range of treatment alternatives is not common knowledge, and patients are not likely to detect that an option was missing from the doctor's presentation and to recognize the need for an alternative information source.

227 An example of such a restrictions is the "gag rule" at issue in Rust, which barred only those physicians who work in publicly financed clinics from discussing abortion with patients. See supra notes 29-33 and accompanying text. In justifying its decision to uphold the gag rule, the Supreme Court noted that patients were still free to acquire information about abortion from privately financed physicians. Rust, 111 S. Ct. at 1777. This rationale has been roundly criticized by commentators who argue that if publicly financed clinic patients had the financial resources to obtain private health care, they would not be clinic patients in the first place. See supra note 113 and accompanying text.
impossible, to consult several physicians in order to acquire complete information about alternative treatments.228

Any restriction on physicians’ speech about treatments also raises the spectre of viewpoint discrimination.229 Whenever government silences discussion about a particular treatment, it suggests a preference for other treatments. The “gag rule” at issue in Rust230 and statutes prohibiting physician speech about contraception and abortion231 are plainly based on government’s disapproval of those options and its preference for other alternatives.

Finally, regulations that censor physicians’ speech about treatment alternatives destroy an essential precondition of the meaningful exercise of patients’ constitutional right to control the course of their medical treatment.232 Patients cannot meaningfully exercise the right to refuse unwanted medical treatment or to control what happens to their bodies unless they can make decisions informed by open, frank discussions with their physicians about medical options.

Thus, a prior restraint prohibiting physicians from discussing certain treatments absolutely violates patients’ constitutional right to receive such information.233 Moreover, because the degree to which a restriction interferes with patients’ audience-based rights is constant, whether it censors publicly financed physicians or all physicians is immaterial. Restric-

228 It is financially prohibitive for most patients to consult a number of physicians in order to obtain complete information, and it is unlikely that insurance companies would reimburse patients who have multiple consultations for this purpose. Even if such coverage were available, it would likely contribute to an unnecessary increase in the overall cost of health care.

229 See supra note 20; see also Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, 425 U.S. 748, 771 (1976) (holding that a statute prohibiting pharmacists from advertising drug prices violated the First Amendment because it “singles out speech of a particular content and seeks to prevent its dissemination completely”).

230 See supra notes 29-36 and accompanying text.

231 See supra notes 11-12.

232 Cruzan v. Director, 497 U.S. 261, 278 (1990) (stating that patients have a Fourteenth Amendment liberty interest in determining the course of their medical treatment).

233 Perhaps the only constitutionally defensible restriction would be one barring physicians from discussing treatments that had been empirically proven harmful to patients. Under a marketplace of ideas analysis, such a restriction does not touch upon First Amendment concerns, because it pertains to information that is empirically false. Virginia Pharmacy, 425 U.S. at 771 (“Untruthful speech, commercial or otherwise, has never been protected for its own sake.”). Additionally, doctor-patient discussions about harmful treatments contribute nothing to protecting patients’ personal liberty interests. Finally, government has a compelling interest in protecting the public health by shielding patients from harmful treatments, particularly because patients cannot evaluate the effectiveness of treatments for themselves.
tions that silence publicly funded physicians from discussing certain treatments violate the First Amendment no less than restrictions that silence private physicians.\footnote{See supra note 113 and accompanying text.}

Consider, for example, a restriction barring physicians from discussing unproven or experimental treatments\footnote{The term “experimental treatment” as used here describes therapies that have been developed in the laboratory, but have not been approved by the Federal Drug Administration for distribution to patients. On the average, this approval process takes 12 years. Dale E. Weirenga, The Drug Development and Approval Process, in AIDS Reference Guide ¶ 1306, at 9 (1993) (on file with the Boston University Law Review).} with patients. Unlike a restriction barring discussion of treatments that have proved ineffective, a ban on discussions of experimental treatments would be based to a large degree on inference, opinion, and interpretation. Whenever government determines the truth or falsity of matters that are within the realm of opinion rather than fact, free speech concerns are implicated.\footnote{See Franklyn S. Haiman, Speech and Law in a Free Society 187 (1981) ("[W]here empirical questions are almost inseparable from inference and interpretation, there is the danger that authoritative attempts to say what is or is not ‘true’ would lead to the establishment of orthodoxies and heresies that have no place in a democratic society."); see also First Nat’l Bank v. Bellotti, 435 U.S. 765, 791 (1978) ("[T]he people in our democracy are entrusted with the responsibility for judging and evaluating the relative merits of conflicting arguments."); New York Times Co. v. Sullivan, 376 U.S. 254, 271 (1963) ("Authoritative interpretations of the First Amendment guarantees have consistently refused to recognize an exception for any test of truth—whether administered by judges, juries or administrative officials . . . .")} Moreover, the suppression of physician speech about unproven therapies may actually interfere with the discovery of truth. Many therapies are effective for some people and not others, or they may prove effective over time through clinical use.\footnote{For an interesting discussion of the evolving nature of scientific truth and its impact upon government restriction of scientific expression, see Martin Redish, Product Health Claims and the First Amendment: Scientific Expression and the Twilight Zone of Commercial Speech, 43 Vand. L. Rev. 1433, 1443 (1990) (arguing that, from a broad historical perspective, any governmental attempt to "lock in a prevailing scientific consensus" is likely to be either futile or dangerous, and will undermine the search for knowledge and the development of free and open exchange of information and opinion).} This is particularly true in the case of new diseases like AIDS. In a sense, all treatments for HIV-infection and associated opportunistic infections are experimental,\footnote{This point is illustrated by the recent shift in the National Institute of Allergy and Infectious Disease (NIAID) policy toward treatments for HIV-infection. The NIAID recently retreated from its earlier recommendation in favor of the use of antiretroviral medicines, such as Zidovudine (AZT). Now, NIAID emphasizes that doctors and patients should decide together whether and when use of such treatments} and doctors’ ability to apprise patients of experimental treatments contributes to our
knowledge about AIDS in general and the effectiveness of treatments for it in individual cases.

Doctor-patient discourse about experimental treatments also facilitates patients’ personal liberty interests. The right to determine the course of one’s medical treatment does not turn on governmental preference for that decision. Patients with an incurable disease have the right to opt for an unproven treatment that offers hope, however dim, of relief or cure.\(^{239}\) Restrictions that bar physicians from discussing experimental treatments\(^{240}\) thus prevent patients from managing their illness and conducting their lives according to their personal values.\(^{241}\)

V. A First Amendment Analysis of Government Regulations That Compel Physician Speech

Regulations that compel physician speech present several discrete dangers to patients’ audience-based interests. First, patients’ privacy and control over their own thinking are compromised when they are forced to hear objectionable messages under circumstances in which escape is not feasible.\(^{242}\) Second, such regulations may unduly influence patients who is appropriate. See Merle A. Sande et al., Antiretroviral Therapy for Adult HIV-Infected Patients, 270 JAMA 2583, 2584 (1993).

\(^{239}\) In fact, physicians may be liable for failing to disclose the existence of experimental treatments to patients, under the doctrine of informed consent. See Appelbaum et al., supra note 28, at 41-49.

\(^{240}\) Of course, preserving patients’ personal liberty also requires that doctors inform patients when a treatment is experimental. See, e.g., Estrada v. Jaques, 321 S.E.2d 240, 254 (N.C. Ct. App. 1984). Many jurisdictions have passed statutes and regulations requiring informed consent for human experimentation. See, e.g., N.Y. PUB. HEALTH LAW § 2442 (McKinney 1993) (requiring written informed consent of all human subjects of research); see also 45 C.F.R. § 46.116 (1992) (requiring informed consent of human subjects of federally funded scientific experimentation). For a discussion of the First Amendment implications of informed consent statutes that compel rather than silence physician speech, see infra part V.

\(^{241}\) The government’s interest in protecting patients from experimental treatments that may help them is considerably less compelling than its interest in protecting patients from treatments that will certainly harm them. There are less restrictive ways for government to prevent the use of questionable treatments, ways that do not implicate free speech rights. For example, the government can enjoin drug manufacturers to remove experimental drugs from the marketplace or prosecute doctors who prescribe them. The government can also issue public service messages warning people of the suspected dangers of unproven drugs. These measures would prevent the harm that might result from the imprudent use of unproven therapies, without undermining patients’ free speech interests.

\(^{242}\) For example, patients who oppose the use of artificial contraception would likely feel trapped and offended if forced to listen to their physician deliver a speech expressing the government’s view that women ought to practice artificial birth control.
hold physicians in high regard or whose ability to think critically is impaired by illness and lack of medical expertise. Third, compelled physician speech may result in a biased description of available treatments, thus distorting patients' understanding of their medical choices and undermining patient autonomy and consent.

The First Amendment, in addition to prohibiting government censorship, also protects "negative speech rights," or the right not to be forced to speak. Negative speech rights safeguard speakers' freedom of thought and belief, promote the expression of dissent, and prevent the imposition of government orthodoxy, all of which are threatened whenever government forces individuals to utter certain words.

Negative speech rights supply the foundation for analyzing the effect of regulations compelling physicians' speech on their constitutional rights. However, negative speech rights cannot constitute the foundation of a patient-based theory, which must rest instead on decisions that establish that the First Amendment affords listeners a right to receive unbiased information or to avoid unwanted expression altogether.

Several Court decisions imply a right of listeners to be protected from intrusive speech and to receive unbiased information. The Court has recognized, for example, that the First Amendment protects captive audiences from being forced to listen to unwanted government propa-

243 See discussion supra part II.
244 Riley v. National Fed'n of the Blind, 487 U.S. 781, 796 (1987) (stating that in the context of protected speech, the difference between compelled speech and compelled silence "is without constitutional significance"); Wooley v. Maynard, 430 U.S. 705, 714 (1976) ("[T]he 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.").
245 West Virginia State Bd. of Educ. v. Barnette, 319 U.S. 624, 637 (1943). The Court has correctly observed that government resorts to compelling speech when it fails to achieve consensus by means of legitimate persuasion, and this necessity in itself suggests that its position is defective. See id. at 640 ("As first and moderate methods to attain unity have failed, those bent on its accomplishment must resort to an ever-increasing severity."). The enactment of measures that compel physicians to discourage patients from choosing to have an abortion demonstrates the Court's thesis. Having failed to achieve a national consensus to outlaw abortion by means of persuasion, anti-abortion regulators have resorted to direct manipulation of the content of medical discourse.
246 While a comprehensive analysis of this issue is beyond the scope of this Article, government measures that compel physicians to make statements about a preferred treatment or a disfavored option may violate the First Amendment by infringing on physicians' negative speech rights. See Wooley, 430 U.S. at 717 ("[W]here the State's interest is to disseminate an ideology, no matter how acceptable to some, such interest cannot outweigh an individual's First Amendment right to avoid becoming a courier for such message."). However, patients' audience-based rights under the First Amendment arguably suffer an even greater blow from such regulations. See discussion supra part IV.
Forcing captive audiences to listen to unwanted messages not only violates First Amendment interests by intruding upon their private mental processes, it also skews the marketplace of ideas and subverts individuals' personal liberty. The Supreme Court has also implied that this audience-based right to avoid unwanted messages is particularly strong when the message contains government propaganda.

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Erznoznik v. City of Jacksonville, 422 U.S. 205, 208 (1975) ("This Court has considered analogous issues—pitting the First Amendment rights of speakers against the privacy rights of those who may be unwilling viewers or auditors . . . ."); Lehman v. City of Shaker Heights, 418 U.S. 298, 307 (1974) (Douglas, J., concurring) ("While petitioner clearly has a right to express his views to those who wish to listen, he has no right to force his message upon an audience incapable of declining to receive it."); Rowan v. United States Post Office Dep't, 397 U.S. 728, 738 (1970) ("[N]o one has a right to press even good ideas on an unwilling recipient."); Public Utils. Comm'n v. Pollak, 343 U.S. 451, 463-66 (1952) (rejecting plaintiffs' First Amendment claim, but acknowledging that forcing unwanted messages upon captive audiences raises constitutional concerns); Kovacs v. Cooper, 336 U.S. 77, 86-87 (1949) ("The unwilling listener is not like the passer-by who may be offered a pamphlet in the street but cannot be made to take it. In his home or on the street he is practically helpless to escape this interference . . . except through the protection of the municipality." (footnote omitted)); cf. Frisby v. Schultz, 487 U.S. 474, 485 (1988) ("[W]e have repeatedly held that individuals are not required to welcome unwanted speech into their own homes and that the government may protect this freedom.").

For varying perspectives on the constitutional origins, scope, and purpose of the captive audience doctrine, see Charles L. Black, Jr., He Cannot Choose but Hear: The Plight of the Captive Auditor, 53 COLUM. L. REV. 960, 967 (1953) ("Forced listening destroys and denies, practically and symbolically, that unuttered interplay and competition among ideas which is the assumed ambient of the communication freedoms."); Franklyn S. Haiman, Speech v. Privacy: Is There a Right Not to Be Spoken to? 67 NW. U. L. REV. 153, 194-95 (1972) (arguing that listeners ought to be protected from intrusive messages if they are physically captive, unable to "turn off" the message, involuntarily within earshot of the message, and have exhausted all means of avoidance); Note, I'll Defend to the Death Your Right to Say It . . . But Not to Me—The Captive Audience Corollary to the First Amendment, 1983 S. ILL. U. L.J. 211, 212 ("The captive audience doctrine arises from the same First Amendment values which serve to protect freedom of speech. The doctrine is therefore not an exception to the mandates of the First Amendment, but a necessary corollary of free speech.").

In such instances, the government's power and weight are thrown behind one viewpoint, while drowning out the expression of all others.

Pollak, 343 U.S. at 463. In Pollak, citizens claimed that their First Amendment right "to listen only to such points of view as the listener wishes to hear," was violated by the radio broadcasting on public buses of programs selected by the municipality that owned and operated the transit system. Id. The Pollak Court implied that the municipality's broadcasts might have violated the First Amendment if they had contained "objectionable propaganda," rather than music, commercial advertising, or announcements. Id. ("There is no substantial claim that the programs have been used for objectionable propaganda. There is no issue of that kind before us."). In separate opinions, Justices Black and Douglas echoed the view that First Amendment concerns
The power of the First Amendment to shield listeners from intrusive messages was also the basis of the Court's decision in *Burson v. Freeman.* In *Burson,* the Court upheld a Tennessee statute that prohibited solicitation of votes and the display of campaign materials within 100 feet of the entrance to a polling place on election day. A plurality of the Court reasoned that Tennessee's interest in protecting voters from "intimidation" during the "last 15 seconds before [they] enter the polling place" outweighed candidates' First Amendment right of political expression. *Burson* may be read to establish the principle that on the eve of exercising a constitutionally protected right, listeners are entitled to a zone free from speech that is intimidating, confusing, or unduly influential. Indeed, in *Burson* the Court struck a balance that protected voters' audience-based rights, even though this meant upholding a gov-

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are especially urgent when the government subjects captive listeners to its views. According to Justice Black, "the broadcasting of news, public speeches, views, or propaganda of any kind and by any means would violate the First Amendment." *Id.* at 466 (Black, J., concurring). Taking a characteristically absolutist position, Justice Douglas asserted that the First Amendment is violated when the government foists any type of message upon a captive audience, because this practice interferes with the "sanctity of thought" and gives "the propagandist a powerful weapon." *Id.* at 468-69 (Douglas, J., dissenting). Justice Douglas's view that government is absolutely prohibited from forcing its message upon captive audiences is overstated. There are many examples of captive audiences that benefit greatly from receiving government messages and who would be substantially harmed by such a blanket prohibition. One example is prisoners in need of AIDS education.

*Pollak* is the only captive audience case that balanced the government's right to disseminate information against captive listeners' right to avoid unwanted messages. In all other captive audience cases, the First Amendment challenge was brought by private speakers prevented from projecting their message by government restrictions; the government then defended the restrictions on the ground that they shielded captive audiences from unwanted intrusions. See supra note 248.

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251 112 S. Ct. 1846 (1992) (plurality opinion).

252 TENN. CODE ANN. § 2-7-111(b) (Supp. 1991).

253 The plurality opinion was announced by Justice Blackmun and joined by Chief Justice Rehnquist and Justices White and Kennedy. Justice Scalia concurred in the judgment upholding the statute's constitutionality, but on the grounds that it was a reasonable, viewpoint-neutral regulation of a nontraditional public forum, and thus need not be subjected to exacting scrutiny. *Burson,* 112 S. Ct. at 1859-61 (Scalia, J., concurring in judgment).

254 *Id.* at 1851.

255 *Id.* at 1857.

256 *Id.* at 1858.

257 *Id.* at 1856 ("The only way to preserve the secrecy of the ballot is to limit access to the area around the voter.").
ernment restriction on political speech, which has traditionally enjoyed the most protection under the First Amendment.\footnote{Eu v. Democratic Cent. Comm., 489 U.S. 214, 223 (1989) ("[T]he First Amendment 'has its fullest and most urgent application' to speech uttered during a campaign for political office." (quoting Monitor Patriot Co. v. Roy, 401 U.S. 265, 272 (1971))); Mills v. Alabama, 384 U.S. 214, 218 (1966) ("[T]here is practically universal agreement that a major purpose of [the First] Amendment was to protect the free discussion of governmental affairs."); Garrison v. Louisiana, 379 U.S. 64, 74-75 (1964) ("For speech concerning public affairs is more than self-expression; it is the essence of self-government.").} Public education decisions are also useful in developing a patient-based theory of doctor-patient speech. As several commentators have observed, public education presents unique dangers to audience-based interests by creating ideal conditions for indoctrination.\footnote{See, e.g., Tribe, supra note 20, § 12-4, at 812 ("Public schools . . . can be powerful means of indoctrination."); Mark Yudof, When Government Speaks: Politics, Law and Government Expression in America 211 (1983): In some ways, public schools are a communications theorist's dream: the audience is captive and immature; the channel can't be changed (although students may only pretend to listen); the messages are labelled as educational (and not as advertising); the teacher can respond individually to the student (unlike the television set); adult communicators often have relatively high status in the eyes of the audience; and a system of rewards and punishments is available to reinforce the message.} The injection of ideological bias into a curriculum conflicts with the underlying purpose of education, which is to expose students to a "robust exchange of ideas" so that the truth can be discovered "out of a multitude of tongues, [rather] than through any kind of authoritative selection."\footnote{Keyishian v. Board of Regents of the Univ. of the State of N.Y., 385 U.S. 589, 603 (1967) (quoting United States v. Associated Press, 52 F. Supp. 362, 372 (1943)) (alteration in original), aff'd, 326 U.S. 1 (1945).} Moreover, as a check
on government’s ability to use public education as an instrument of propaganda, the Court has attributed constitutional significance to the concept of “academic freedom,” vesting teachers with the right to shape the specific content of academic discourse within the contours of a curriculum established by the state.263

Finally, the Supreme Court’s First Amendment analysis of the “fairness doctrine,”264 which requires broadcasters to present a balanced discussion of public issues, is useful in determining whether, and under what circumstances, listeners have a right to receive unbiased and balanced information. In Red Lion Broadcasting Co. v. Federal Communications Commission,265 the Court assessed the constitutionality of government regulation of broadcasting, and recognized that the First Amendment affords listeners an affirmative right to receive a balanced presentation of views when there are a limited number of sources from which to acquire information.266 Although the Court recognized that the Constitution

262 The Court has often held that a state’s effort to inject religious bias into the public school curriculum violates the First Amendment’s Establishment Clause. See, e.g., Edwards v. Aguillard, 482 U.S. 578 (1987) (invalidating Louisiana statute that required teaching creation science when teaching evolution); Stone v. Graham, 449 U.S. 39 (1980) (invalidating Kentucky statute requiring posting of the Ten Commandments on public school walls); Epperson, 393 U.S. at 97 (invalidating statute banning teaching of evolution); Abington Sch. Dist. v. Schempp, 374 U.S. 203 (1963) (invalidating state requirement that Biblical passages be read at the beginning of the school day); Engle v. Vitale, 370 U.S. 421 (1962) (invalidating state requirement that official prayer be recited at the beginning of the school day); see also Pelzoa v. Capistrano Unified Sch. Dist., 782 F. Supp. 1412, 1419 (C.D. Cal. 1992) (upholding school district’s reprimand of biology teacher for espousing creationism and reasoning that students “have a right to be taught biology without the added comments and religious biases” of the teacher).


266 Id. at 390 (“It is the purpose of the First Amendment to preserve an uninhibited marketplace of ideas . . . rather than to countenance monopolization of that market . . . .”); see also FCC v. League of Women Voters, 468 U.S. 364, 380 (1984) (stating that the fairness doctrine is necessary to “secure the public’s First Amendment interest in receiving a balanced presentation of views on diverse matters of public concern”); CBS, Inc. v. Democratic Nat’l Comm., 412 U.S. 94, 122 (1973) (“ ‘[W]hat is
protects broadcasters' freedom to "broadcast whatever they choose," in light of the scarcity of radio frequencies, the Court held that the audience's "collective right to have the medium function consistently with the ends and purposes of the First Amendment" was "paramount." Accordingly, the Court upheld the fairness doctrine as a constitutionally necessary means of preserving listeners' audience-based right to receive "social, political, esthetic, moral and other ideas and experiences" within a communications marketplace monopolized by only a few voices.

Under this reasoning, government regulations that compel physicians to utter viewpoint-based messages violate patients' First Amendment right to receive unbiased medical advice from physicians. Patients in a physician's office, medical clinic, or hospital are a "captive audience," since their presence there is compelled by illness. Once in the presence of a physician, substantial physical and psychological barriers make government-mandated messages extremely difficult, if not impossible, to ignore. While patients can simply discard printed materials, they have "no choice but to sit and listen, or perhaps to sit and to try not to listen" when the state's message is communicated orally.

Doctor-patient communication possesses many of the same characteristics that in public education lead to a substantial risk of government

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267 Red Lion, 395 U.S. at 386.
268 Id. at 390.
269 Id.
270 Id. at 400-01.
271 Although doctors' advice is occasionally sought for conditions that do not threaten health, in most cases patients consult physicians because they are ill and need treatment.
272 The patient's medical condition and the timing of the message may make avoidance physically impossible. This would be true, for example, if the patient was nonambulatory or if the message was delivered after the patient had disrobed.
273 In some circumstances, patients could arguably avoid an unwanted written government message. For example, patients could readily avoid government flyers that were stacked in a waiting room simply by choosing not to pick one up. On the other hand, patients could not reasonably avoid government posters affixed to the wall of a waiting room where they were required to sit before seeing a physician, or written forms that they were required to read before undergoing treatment. Under these circumstances, patients are less able to avoid unwanted written messages than are passengers surrounded by advertisements while riding buses and subways. Cf. Lehman v. City of Shaker Heights, 418 U.S. 298, 304 (1974) (upholding municipality's refusal to display political advertisements on city buses because it minimized the chances of abuse, the appearance of favoritism, and the risk of imposing a message upon a captive audience).
indoctrination. Because they hold physicians in such high regard and because they lose their sense of control during illness, patients are highly impressionable and tend to become infantilized, impairing their own ability to evaluate government-sponsored messages critically. Further, the perception that physicians can mete out rewards or punishment may also hamper patients’ capacity to evaluate such a message. Finally, patients’ critical capacities may be further impeded when a government message is disguised as medical advice rather than presented as an expression of state opinion.

Red Lion and its progeny also reveal that the First Amendment’s goal of promoting the discovery of truth and protecting listeners’ personal liberty may, in some circumstances, require more than merely allowing a multiplicity of speakers to enter the information marketplace. When the structure and nature of the marketplace limit the number of possible speakers and sources of information, an audience’s right to receive information becomes the primary constitutional concern. In such a circumstance, the First Amendment’s goals can only be advanced by requiring that the few existing speakers present a balance of views. Thus, Red Lion and its progeny establish that to protect audience-based interests, the First Amendment requires content neutrality in an information marketplace monopolized by only a few speakers.

The information marketplace that informs patients’ decision making is monopolized by physicians. When faced with illness and the necessity

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275 The chief distinction between public education and doctor-patient discourse is that students are subjected to teachers’ oral communication day after day, while physicians communicate with patients far less frequently, thus diminishing the potential for government indoctrination. On the other hand, students’ opinions will likely be shaped by a number of other voices, such as parents, peers, and the media. Patients, on the other hand, tend to rely exclusively on physicians to form opinions about medical treatment. See supra note 261 and accompanying text.

276 See supra notes 123-29 and accompanying text.

277 See supra notes 136-45 and accompanying text.

278 If patients assume that physicians agree with the government’s message, they may fear that rejection of it will impair their relationship with the physician and may even result in lower-quality health care. When physicians distance themselves from the government’s message, the same concerns may cause patients to fear acceptance of government’s opinion.

279 For example, the statement “the State of California believes that everyone should donate their organs after death” is clearly an expression of governmental opinion, and patients’ ability to identify the source of the information facilitates their evaluation of it. In contrast, when government promotes its position by compelling physicians to make statements that are infused with medical facts and terminology, patients may be unable to identify the government as the speaker, and instead may attribute the underlying viewpoint to their trusted physician.

280 See Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir.) (“The average patient has little or no understanding of the medical arts, and ordinarily has only his physician
of deciding among an array of treatment alternatives, patients rely exclusively upon physicians—and usually only one—to acquire necessary information. There are no reasonable alternative means for patients to acquire medical information other than through physicians. Thus, given the scarcity of voices that inform patients’ medical decision making, First Amendment goals can only be advanced by ensuring that physicians’ description of treatment alternatives is balanced and unbiased.

Finally, in accordance with the reasoning underlying Burson, patients’ right to be shielded from expressions of government views about treatment options on the eve of medical decision making may deserve greater constitutional protection than the government’s power to compel physicians to deliver its views. Physician speech that conveys the government’s preference to patients presents audience-based concerns similar to those involved in political campaigning near polling places. An analogous audience-based danger would arise if government expressed its view to voters on a particular referendum item as they entered polling places. Moreover, unlike private speakers’ right to engage in political speech, which has an exalted status within First Amendment jurisprudence, the First Amendment may not protect the government’s right to speak.

Of course, a blanket prohibition on all regulation of doctor-patient discourse would prevent the government from forcing doctors to bias their presentation of treatment alternatives. Such a prohibition, however, would come at great cost. Unlike restrictions that censor physician speech or violate patients’ audience-based interests, regulations that compel physician speech can both advance and infringe First Amendment interests. Government regulations compelling physician speech infringe upon patients’ audience-based interests if they capitalize on physicians’ authority within the structure of the doctor-patient relationship, and unduly influence or confuse patients on the eve of exercising their constitutional right to determine medical treatment. However, regulations compelling physician speech promote First Amendment values and patients’ audience-based interests if they facilitate rational medical deci-

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to whom he can look for enlightenment with which to reach an intelligent decision."), cert. denied, 409 U.S. 1064 (1972).

281 See supra note 227.

282 Patients’ ability to rationally and critically evaluate government speech is adversely affected by the short interval between delivery of the message and the need to make a decision. State-sponsored medical messages may therefore be unduly influential and confusing in part because they are heard moments before the patient must make a medical decision.

283 The Supreme Court has never held that the First Amendment protects government speech. For scholarly consideration of the question, see Mark G. Yudof, When Governments Speak: Toward a Theory of Government Expression and the First Amendment, 57 Tex. L. Rev. 863, 867 (1979) (arguing that “the considerations favoring constitutionalization of a government right to speak are neither persuasive nor attractive”).
sion making through required disclosure of information that would otherwise be withheld. It is likely, therefore, that the government advances listeners' constitutional right to receive information when it compels speech by speakers who have a commercial incentive to conceal information, or who, like physicians, have a notorious history of inadequate disclosure.\footnote{284}{For analyses of this history, see Applbaum et al., supra note 28; Faden & Beauchamp, supra note 28; David J. Rothman, Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making (1991).}

As previously discussed, however, Casey ignores the paradoxical quality of compelled physician speech and its threat to patients' audience-based interest in receiving information.\footnote{285}{See discussion supra part II.} As a result, Casey does not distinguish adequately between regulations that facilitate patient consent by increasing the availability of medical information, and those that undermine it by turning physicians into instruments of state propaganda.\footnote{286}{Several scholars have examined the Court's inattention to the danger of state-sponsored indoctrination that generally plagues its jurisprudence involving government speech. As one writer explains, [t]he paradoxical nature of government speech makes it difficult to decide which way constitutional protection should cut. Expression by government is critical to democratic processes, but the power of governments to communicate is also the power to destroy the underpinnings of government by consent. The power to teach, inform, and lead is also the power to indoctrinate, distort judgment, and perpetuate the current regime. Persuasion, like coercion, can be employed for many different purposes, some more acceptable than others. Yudof, supra note 259, at 42; see Steven Shiffrin, Government Speech, 27 UCLA L. Rev. 565 (1980); Ziegler, Jr., supra note 110.}

The Supreme Court's First Amendment analysis of other government regulations that mandate speech\footnote{287}{There are a vast number of federal statutes that regulate the content of speech by mandating disclosures by private speakers. See, e.g., 15 U.S.C. § 77a-78lill (1988) (disclosure requirements in securities regulations); 15 U.S.C. § 1667a (1988 & Supp. IV 1992) (disclosure requirements in consumer leases); 39 U.S.C. § 3685 (1988) (disclosure requirements for publications with periodical mailing privileges).} is similarly inadequate because the Court assumes that the interests of government and the listening public are identical, and ignores the possibility that such measures can be used for state indoctrination. As a result, the Court generally resolves these cases merely by balancing the affected speakers' negative speech rights against the government's interest in protecting the public.\footnote{288}{See, e.g., Riley v. National Fed'n of the Blind, 487 U.S. 781, 788-95 (1988) (balancing fundraisers' rights of expression against the state's interest in preventing fraud); Pacific Gas & Elec. Co. v. Public Utils. Comm'n, 475 U.S. 1, 19-21 (1986) (balancing public utility's negative speech rights against the state's interest in effective ratemaking proceedings and promoting speech).}
An adequate constitutional theory of government regulations that compels physician speech must provide courts with a means of distinguishing measures that bring medical decision making into conformity with the state’s viewpoint from those that facilitate the full disclosure of relevant, factual medical information. To achieve this, the following test is proposed. To comport with the First Amendment, a statute or regulation that compels physician speech must: (1) have a medical pur-

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289 A number of commentators have generally examined the problem of government speech and proposed various approaches to determining when the state’s speech facilitates or undermines audience-based interests. See, e.g., Yudof, supra note 259, at 301-06 (arguing for a variation of a “legislative remand” system to evaluate government speech); Shiffrin, supra note 286, at 611 (arguing for an eclectic balancing approach to evaluate government speech); Yudof, supra note 283, at 917 (arguing for an “ultra vires” technique that would prohibit government speech activities that are “particularly offensive and that are likely to interfere with individual judgment, unless they are specifically authorized by legislative bodies”).

290 The first two prongs of the proposed test are adapted from the Supreme Court’s test announced in Lemon v. Kurtzman for discerning whether government regulations affecting the content of public school curricula violate the Establishment Clause. 403 U.S. 602 (1971). To satisfy the Lemon test a statute first “must have a secular legislative purpose; second, its principal or primary effect must be one that neither advances nor inhibits religion; finally, the statute must not foster an excessive government entanglement with religion.” Id. at 612-13 (citation omitted); see also Edwards v. Aguillard, 482 U.S. 578, 585-94 (1987) (applying the Lemon test and holding that a state statute requiring teaching of “creation science” whenever evolution theory is taught in the public schools violated the Establishment Clause); cf. Lee v. Weisman, 112 S. Ct. 2649, 2655 (1992) (declining to apply the Lemon test and holding that the Establishment Clause prohibits a rabbi from offering prayers as part of a public school graduation ceremony).

Adaptation of the Lemon test for cases involving government speech about subjects other than religion is somewhat problematic. The plain language of the Establishment Clause commands that government not endorse a particular religious viewpoint. The First Amendment, on the other hand, does not plainly forbid the government from “establishing” any other type of viewpoint, such as one about particular medical procedures. Nevertheless, incorporating a modified version of the Lemon test to assess the constitutionality of state-compelled physician speech is defensible. First, the biases that underlie viewpoint-based regulation of doctor-patient speech are commonly rooted in a particular religious viewpoint. For example, regulations governing physician speech about contraception and abortion are grounded in part in the religious belief that life begins at conception. Second, the first two prongs of the Lemon test are designed to assess the purpose of government regulations compelling speech. The test recognizes that the government’s legitimate and necessary role in the regulation of academic discourse ought not to permit it to promote a particular religious viewpoint by foisting it upon an impressionable and captive audience. To safeguard students’ audience-based interests, the test provides a mechanism for distinguishing between government regulations that serve legitimate and illegitimate purposes. To protect patients from governmental manipulation and distortion of medical discourse, it is similarly necessary to distinguish between regulations that aim
pose, as opposed to an ideological or religious purpose;\textsuperscript{291} (2) not advance a particular viewpoint regarding medical treatment or how the patient ought to respond to a particular illness, diagnosis, or medical condition, including pregnancy; (3) contain truthful, factually verifiable information;\textsuperscript{292} and (4) avoid excessive government entanglement in determining the content of doctor-patient discourse. Patients' audience-based interests are unaffected by whether medical care is delivered by privately or publicly funded physicians; thus, to protect patients' First Amendment rights, courts must apply this test to regulations that compel physician speech in either setting.

This test assumes that only the government's interest in protecting the health of its citizens justifies the imposition of content restrictions on physician speech. To ascertain whether a regulation's purpose is medical or ideological, and whether it is intended to advance the government's viewpoint about a particular treatment, courts must examine the statute's language, overall content, and, if necessary, its legislative history.\textsuperscript{293} The
to maintain the integrity of medical discourse and those that impose a particular viewpoint upon vulnerable patients.

\textsuperscript{291} The Supreme Court has repeatedly refused to invalidate otherwise constitutional statutes because of the underlying legislative motivation. See Palmer v. Thompson, 403 U.S. 217, 224 (1971) ("[N]o case in this Court has held that a legislative act may violate equal protection solely because of the motivation of the men who voted for it."); United States v. O'Brien, 391 U.S. 367, 383 (1968) ("It is a familiar principle of constitutional law that this Court will not strike down an otherwise constitutional statute on the basis of alleged illicit legislative motive."). However, the Court commonly considers legislative intent when determining the validity of statutes. See, e.g., Califano v. Goldfarb, 430 U.S. 199, 216-17 (1977) (plurality opinion) (invalidating statute discriminating on basis of gender because legislative motive was based on stereotyped assumptions); Village of Arlington Heights v. Metropolitan Hous. Dev. Corp., 429 U.S. 252, 270 (1977) (upholding zoning change because complainants failed to prove discriminatory legislative intent); Washington v. Davis, 426 U.S. 229, 232, 238-39 (1976) (upholding validity of test used to screen applicants for police force, despite disparate effect on minority applicants, due to failure to demonstrate discriminatory intent). For probing analyses of legislative intent as an element of constitutional review, see Tribe, supra note 20, § 12-6, at 821-25; John H. Ely, Legislative and Administrative Motivation in Constitutional Law, 79 Yale L.J. 1205 (1970).

\textsuperscript{292} The basis of this requirement is self-evident. By promulgating regulations that would force physicians to utter false information, the state would impede the discovery of truth and undermine patients' personal liberty interests. The Supreme Court specifically endorsed a truthfulness requirement for government regulation of physician speech in Casey. See Planned Parenthood v. Casey, 112 S. Ct. 2791, 2823 (1992) (plurality opinion) (noting that when the state requires that information be given to a patient, such information must be truthful and not misleading).

\textsuperscript{293} The Supreme Court has used this method of divining legislative purpose to determine whether regulations of public school curricula are based on the desire to promote a particular religious viewpoint. See, e.g., Edwards, 482 U.S. at 594 ("A court's finding of improper purpose behind a statute is appropriately determined by
government could satisfy this prong of the test by proving that the statute's purpose is to protect or promote the physical or mental health of the patient or the public. However, if the government enacted a law that compels physicians to express a clear preference for a particular medical treatment or an opinion about what course of action a patient should follow, the law would be unconstitutional because it promoted an ideological viewpoint.

In addition to examining a regulation's words, courts must determine whether the compelled message, taken as a whole, expresses government partisanship. One indicia of improper partisanship is underinclusiveness—that is, the imposition on doctors of unbalanced disclosure requirements that create the impression that government prefers one treatment to another. Regulations that single out a particular medical procedure by requiring a detailed description of its associated risks, while not mandating a similarly detailed recitation of the risks associated with alternative treatments, suggest impermissible viewpoint bias. For example, a statute that required detailed descriptions of the nature and risks of coronary bypass surgery, but failed to require similar discussions about alternative treatments, would give rise to a presumption of improper government partisanship against such surgery.

Regulations that require doctors to convey information within patients' common knowledge also suggest viewpoint bias. For example, a statute

the statute on its face, its legislative history, or its interpretation by a responsible administrative agency.

See, e.g., Pub. Act 81-1078, § 3.5(2), 1979 Ill. Laws 4108, 4115 (repealed 1984) ("The 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."); 42 C.F.R. § 59.8(b)(5) (1991) ("[T]he project does not consider abortion an appropriate method of family planning.

In other constitutional contexts, this standard has been used to determine improper motive. See, e.g., Edwards, 482 U.S. at 593 (finding that statute's purpose to promote religious viewpoint was revealed by fact that it singled out one subject among many in public school curriculum); First Nat'l Bank v. Bellotti, 435 U.S. 765, 793 (1978) (stating that underinclusiveness of statute suggests improper legislative motive to silence expression).

Anti-abortion regulators have employed the technique of requiring physicians to present a lopsided depiction of medical risks as a way to persuade patients to opt for childbirth. See supra notes 62-64.

To determine whether enactments that compel physician speech about abortion violated a woman's right to privacy, the Burger Court recognized the need to scrutinize the overall context of the speech. See City of Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416, 444-45 (1983) (invalidating an ordinance that required physicians to describe numerous physical and psychological complications of abortion, because its intent was to influence rather than inform by requiring the recitation of a "parade of horribles" intended to suggest that abortion is a particularly dangerous procedure").
that forced physicians to tell pregnant patients that their decision to have an abortion would result in the termination of fetal development would suggest an intent to advance childbirth over abortion, rather than to ensure the disclosure of unknown, necessary information.\textsuperscript{298} Such a regulation is very different from one that requires physicians to generally discuss with pregnant patients the possible impact of medications and procedures on the developing fetus. Such regulations would serve a medical purpose because they provide patients with information related to the health of the fetus, do not single out particular medications or treatments for regulation, and convey information beyond the scope of patients' common knowledge.\textsuperscript{299}

Finally, the fourth prong of the proposed test aims to protect physicians' discretion to tailor the content of conversations with patients to their individual needs and interests.\textsuperscript{300} Recognition of physicians' right to determine the content of conversations with patients, the medical analogue of academic freedom, is not intended to protect the free speech rights of physicians; nor does it mean that physicians have a greater right to free speech than others. Rather, raising a doctor's right to determine the content of conversations with patients to a constitutional level acknowledges that doctors are in a unique position to indoctrinate, and that a check against governmental excesses is needed.\textsuperscript{301}

Thus, informed consent laws, which establish standards for disclosure\textsuperscript{302} but leave the specific content to the physician's discretion, satisfy

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\item \textsuperscript{298} Arguably, such a regulation would not satisfy the first prong of the proposed test, because it is difficult to identify the medical purpose served by any regulation that compels doctors to tell patients what they already know.
\item \textsuperscript{299} A regulation of this type also satisfies the fourth prong of the test because it would not supplant a physician's ability to tailor the specific content of conversations with patients.
\item \textsuperscript{300} In City of Akron, the Burger Court held that a provision of the ordinance that insisted "upon the recitation of a lengthy and inflexible list of information" was unconstitutional. \textit{Id}. at 445. However, its conclusion was meant to safeguard physicians' discretion to control disclosure, not patients' audience-based right to receive information. \textit{Id}. at 447.
\item \textsuperscript{301} Judicial recognition of the concept of "medical freedom" is not an unfettered grant of discretion to doctors to determine the content of conversations with patients. The government retains the power to enact informed consent statutes, which require physicians to discuss alternative treatments and their material risks. Additionally, medical licensing statutes vest the state with the power to ensure a minimum level of competence among physicians.
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the proposed test. Indeed, informed consent laws that do no more than establish the subjects that doctors and patients must discuss resemble regulations that mandate the subjects that must be included in a public school’s curriculum but leave teachers free to determine the specific content of each course. Similarly, a statute that required physicians to discuss the subject of organ donation with patients, but did not require the expression of the government’s opinion and left the specific content of the conversation to the doctor’s discretion, would likely satisfy the test.

Depending on the evidence of legislative motive, regulations that compel physicians to discuss the impact of a patient’s medical decision upon third parties may or may not meet the proposed test. Consider, for

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303 Informed consent statutes serve the medical purpose of providing patients with empirical and experiential information about possible medical treatment options and associated risks. They neither advance a particular viewpoint regarding a particular treatment nor foster excessive government involvement in determining the specific content of doctors’ conversations with patients.

304 The National Organ Transplantation Act, 42 U.S.C. § 274e (1988), satisfies the proposed test. It aims to promote the public health by increasing the supply of organs available for transplant. It does not advance the government’s view about organ donation, but merely requires that doctors discuss this subject with patients.

305 Statutes requiring physicians to counsel HIV-positive patients about the methods of HIV transmission and the need to ensure that their body fluids do not enter the bodies of others satisfy the test, provided that the government requires similar counseling for patients who have other kinds of infectious or communicable diseases. See, e.g., Fla. Stat. Ann. § 381.004(e) (West 1993) (requiring physicians to counsel patients subjected to the HIV test about methods of transmission, the availability of health care services, and the benefits of notifying contacts). These statutes aim to protect the public health by seeking to curtail the spread of disease. They do not advance a particular viewpoint regarding medical treatment; they contain truthful, factual information; and they do not foster an excessive government entanglement in the specific content of doctor-patient discourse. However, a statute requiring physicians to tell HIV-positive patients to stop having sex would violate the proposed test because it advocates a specific viewpoint regarding how patients should respond to their illness. It also fosters an excessive government entanglement in determining the specific content of doctor-patient conversations.
example, a regulation that specifically required physicians to disclose to a prospective kidney transplant recipient the risks to the live donor of removing the organ. If the statute failed to compel physicians to disclose the risks to third parties of donating other bodily parts or fluids, such as bone marrow, this would suggest the impermissible purpose of discouraging patients from undergoing kidney transplants.

Undeniably, the proposed test strips the government of a powerful and potentially effective means of communicating messages that many would consider valuable and in the public interest. However, government remains free to add its voice to public debate over medical treatments in a variety of ways that do not infringe upon patients' audience-based interests.

**CONCLUSION**

Recent history confirms that basic democratic and humanitarian values are endangered by government manipulation of the content of doctor-patient discourse for the purpose of advancing an ideology. The medical-ization of state ideology in Nazi Germany should remind us of the potential dangers of permitting government to enlist physicians in a propaganda campaign. In the United States, governmental efforts to regulate the content of physician-patient discourse have not yet extended beyond conversations about contraception and abortion. However, as medical advances continue to present issues that challenge fundamental beliefs about life and death, it is certainly conceivable that regulators who oppose the availability of certain procedures or treatments may try to prevent their use, on purely ideological grounds, by enacting measures that limit or distort doctor-patient discourse about those subjects.

In *Rust* and *Casey*, the Rehnquist Court confronted for the first time in Supreme Court history the issue of whether the First Amendment limits the right of government to impose viewpoint-based restrictions upon the content of doctor-patient discourse. Although the Court shirked a comprehensive free speech analysis of the question, it adopted the principle

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307 Of course, under informed consent standards, the risks of removing the kidney must be disclosed to the potential live donor.

308 For example, a consensus may exist that people ought to donate their organs, yet the proposed test would prohibit the government from compelling physicians to express this viewpoint to patients.

309 For example, government can communicate its viewpoint about a medical treatment in handbills, television campaigns, or the print media. See *Riley* v. National Fed'n of the Blind, 487 U.S. 781, 800 (1988) (invalidating as insufficiently narrow a statute that compelled solicitors of charitable contributions to make certain disclosures to potential donors, on grounds that the state could publish such information itself).
that the First Amendment does not rob government of the right to impose viewpoint-based restrictions upon the content of doctor-patient speech that occurs in the course of delivering both publicly and privately financed health care. While the Court imposed some limitations on government's discretion in this realm, these restrictions succeed only in protecting physicians' speech rights. They fail to protect patients' audience-based right to receive complete, unbiased medical information from their physicians.

To prevent the imposition of the government's will upon the most private and personal aspects of everyday life, it is critical to maintain a separation between the state and doctor-patient discourse. The extension of full First Amendment protection to doctor-patient discourse is necessary to secure freedom of speech, to safeguard patients' constitutional right to determine their medical treatment, and to prevent government from imposing its orthodoxy upon medical decision making. Regulations that silence physicians from speaking to patients about accepted or experimental medical treatments violate the First Amendment because they eliminate an entire category of information from doctor-patient discourse. They also raise the spectre of viewpoint discrimination, and distort patients' ability to make rational treatment decisions.

Similarly, regulations that compel physician speech may subvert patients' audience-based interests if they have an ideological or religious, as opposed to a medical, purpose; advance a particular viewpoint regarding medical treatment or how a patient should respond to a certain diagnosis or condition; contain factually false information; or supplant physicians' discretion to tailor the content of conversations to patients' particular needs. It is therefore necessary to apply these criteria to determine the constitutionality of regulations that compel physician speech. The test is not designed to prevent the government from enacting viewpoint-neutral regulations intended to inform medical decision making. It would, however, render unconstitutional any enactments that required physicians to convey the government's partisan message about a particular treatment, or that biased a physician's presentation of medical alternatives in accordance with government preferences.