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IN THE CROSSHAIRS: LEGISLATIVE RESTRICTIONS ON PATIENT–PHYSICIAN SPEECH ABOUT FIREARMS

Gayland O. Hethcoat II*

ABSTRACT

Several state legislatures have recently considered legislation to restrict the extent to which physicians and other health care practitioners may speak to their patients about firearms and enter any solicited information into a medical record. Backed by the firearm lobby, these legislative efforts have been described by proponents as necessary to protect citizens’ Second Amendment and privacy rights. This Article focuses on recent legislation of this kind in Florida, which is the first and only state to enact such legislation. Mindful of the effect that the Florida legislation could have on similar efforts in other states, this Article argues that the Florida statute is unconstitutional as a matter of law and unsound as a matter of policy. Constitutionally, the statute infringes patient–physician speech under various free-speech doctrines that derive from the Free Speech Clause of the First Amendment. Beyond the dispositive constitutional shortcomings, the statute is further unnecessary in light of other laws that serve the statute’s purported privacy interest in data about patients’ firearms, and it is uncertain in its effect on other legal doctrines, such as the doctrine of medical malpractice. The sum of this analysis compels invalidation of the statute on constitutional and policy grounds, and requires other legislatures to avoid following in Florida’s stead.

I. INTRODUCTION

Chinese Communist leader Mao Zedong’s famous declaration that “[p]olitical power grows out of the barrel of a gun”1 resonates in the American psyche. Though they may shudder at the source, many of the millions of private firearm owners in the United States would agree.2 In the

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American translation, though, the power of which Mao spoke vests not in the government but against the government. One need look no further than the Second Amendment to the U.S. Constitution to find the marriage of firearm and political liberty: With the preface that “[a] well regulated Militia” is “necessary to the security of a free State,” it proclaims that “the right of the people to keep and bear Arms, shall not be infringed.”

American “gun culture,” however, is more nuanced than first appearances indicate. Occasionally, tragedies of national proportion cause the collective conscience to turn inward and reflect on public policies and attitudes toward firearms. The school shootings of Columbine, Colorado; Blacksburg, Virginia; and other cities across the country come to mind. More recently, Tucson, Arizona gained notoriety for a mass shooting.

The circumstances in Tucson were as civic and innocuous as one could imagine. Congresswoman Gabrielle Giffords was speaking to a couple about Medicare at a “Congress on Your Corner” event at a supermarket when another attendant, Chief Judge John Roll of the U.S. District Court for Arizona, greeted her. Suddenly, shots rang out, and the judge collapsed. When the gunman, Jared Lee Loughner, emptied the thirty-three-round magazine of his nine-millimeter Glock semiautomatic pistol, twenty people were shot, including Representative Giffords. Six people died; among them were Chief Judge Roll and Christina Taylor-Green, a nine-year-old girl born on September 11, 2001, who was at the event “to see how democracy worked.”

Almost immediately, the shootings became a referendum on the vitriolic rhetoric that defined the 2010 midterm election. Fundamentally different philosophies about government lay at the heart of the election, stirred largely by the passage of President Barack Obama’s signature health reform legislation, the Patient Protection and Affordable Care Act. The legislation was so controversial that the first order of business for the new Republican-majority House of Representatives was to repeal it—a priority disrupted by the Tucson shootings. Representative Giffords

3. U.S. CONST. amend. II.
herself viscerally experienced the division surrounding the health reform overhaul. At a 2009 “Congress on Your Corner” gathering, one man was removed by police when a pistol fell from a holster he wore as he protested Giffords’ support for reform. And in March of 2010, on the verge of the House passing the legislation, the glass door to Giffords’ Tucson office was shattered in apparent vandalism. Giffords, known for her moderate stance on firearm control, maintained her resolve: “I have a Glock 9-millimeter,” she said, “and I know how to use it.”

After the initial shock and grief of the Tucson massacre subsided, questions about the wisdom of prevailing firearm policy emerged. At the federal level, Congress considered banning “large-capacity” ammunition magazines like the one the Tucson gunman used and possession of a firearm within certain distances of legislators. Despite their relatively modest scope compared with other proposals, these measures struggled to succeed in a legislative session that was supposed to focus on economic growth and employment.

Meanwhile, in state legislatures across the country—many of which, like the U.S. House, gained Republican majorities in 2010—firearm deregulation proceeded in novel ways, seemingly undisturbed by the Tucson shootings. Some firearm proposals evoked the source of ire for many 2010 voters: the federal health reform legislation and specifically its so-called “individual mandate” provision, which requires most Americans

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to acquire health insurance by 2014 or else pay a penalty.\textsuperscript{16} In South Dakota, for example, the legislature considered a “gun mandate,” which would require all state citizens twenty-one years and older to “purchase or otherwise acquire a firearm suitable to their temperament, physical capacity, and personal preference sufficient to provide for their ordinary self-defense.”\textsuperscript{17} The point was not actually to pass the measure into law but to express legislators’ disdain toward the insurance requirement of the federal reform.\textsuperscript{18} 

In other states, such as Minnesota and Oklahoma, legislators introduced bills that would restrict the extent to which physicians could speak to their patients about firearms and enter any solicited information into a medical record.\textsuperscript{19} Legislators in Virginia and West Virginia proposed similar bills in 2006, but they failed to gain enough support for passage.\textsuperscript{20} With the enactment of federal health reform, however, these efforts gained renewed attention out of concern that the legislation would allow the federal government to collect and disseminate information about firearms to health insurance companies, which could charge firearm owners higher premiums than non-firearm owners.\textsuperscript{21} Currently, legislation to regulate the patient–physician relationship in this manner has passed the full legislature of only one state: Florida.\textsuperscript{22} But given the National Rifle Association’s support for such legislation\textsuperscript{23} and the support that it received in other legislatures—for example, the Oklahoma bill passed that state’s full Senate—these legislative attempts may plausibly arise elsewhere.

This Article endeavors to analyze the unique Florida statute, mindful of the effect that it could have on similar efforts in other states. To this end, the Article argues that the Florida statute is unconstitutional as a
matter of law and unsound as a matter of policy. Constitutionally, the statute infringes patient–physician speech under various free-speech doctrines that derive from the Free Speech Clause of the First Amendment. Beyond the dispositive constitutional shortcomings, the statute is further unnecessary in light of other laws that serve the statute’s purported privacy interest in data about patients’ firearms, and it is uncertain in its effect on other legal doctrines, such as the doctrine of medical malpractice. The sum of this analysis compels invalidation of the statute on constitutional and policy grounds, and requires other legislatures to avoid following in Florida’s stead.

This Article is organized by analyses of the statute’s constitutional defects and the policy considerations that the statute raises. Part II discusses the provisions of the statute, the background to the statute’s passage, and the competing arguments for and against its enactment. Part III constitutionally analyzes the statute in two subparts. Subpart A analyzes the statute under the First Amendment “professional speech” doctrine, which generally allows the government to regulate a professional’s speech in tandem with its regulation of the underlying profession; and Subpart B analyzes the statute under more protective doctrines that safeguard against government regulation on the basis of the content and viewpoint of speech. Part IV addresses the statute’s policy implications with respect to patient privacy, medical malpractice, firearm control, and patient–physician relations.

II. RESTRICTING PATIENT–PHYSICIAN SPEECH ABOUT FIREARMS: FLORIDA’S EXPERIENCE

When Amber Ullman finished a seemingly routine check-up at the office of her children’s Ocala, Florida, pediatrician, the mother of three was in need of a new family physician. At first, all was fine. While examining Mrs. Ullman’s four-month-old daughter Temperance, the pediatrician, Dr. Chris Okonkwo, asked the mother several household safety questions. Among them, he posed what many pediatricians consider a typical query: Were firearms in Mrs. Ullman’s house? Surprised and offended, Mrs. Ullman refused to answer. The question, in her view, was irrelevant to her child’s health and safety. In Dr. Okonkwo’s opinion, though, the question was relevant. It was akin to asking parents during the summertime whether they have pools, which, if not maintained properly, could pose safety risks to their children. Indeed, the question was important enough to the physician that when Mrs. Ullman reaffirmed her refusal to answer, he informed her that she had thirty days to find a new
pediatrician. For him, Mrs. Ullman’s response demonstrated a lack of trust—the cornerstone of the patient–physician relationship. For Mrs. Ullman, trust was not at stake as much as her privacy. “Now,” she told a reporter, “my children have to suffer because of this and that’s not right.”

Fortunately for Mrs. Ullman, the 2011 Florida Legislature dedicated itself to making sure she did not have to face such questions again. Citing her story as leading “many to question whether it should be an accepted practice for a doctor to inquire about a patient’s firearm ownership,” lawmakers in both legislative chambers proposed a measure that would effectively prohibit physicians and other health care practitioners—without exception—from inquiring verbally or in writing about a patient’s or patient family member’s ownership or storage of a firearm by deeming such an inquiry a violation of privacy. A violation of privacy in this regard would be a third-degree felony, which could result in a fine of up to $5 million if the health care practitioner “knew or reasonably should have known that the conduct was unlawful.” As the proposal cycled through committee debate, legislators amended the bill to decriminalize its provisions and reduce the fines it imposed. Additionally, legislators mitigated the measure’s absolutism with limited exceptions as to when a health care practitioner could permissibly raise questions about firearms; for example, a physician or nurse could make such inquiries if necessary to treat a patient “during the course and scope of a medical emergency which specifically includes, but is not limited to, a mental health or psychotic episode where the patient’s conduct or symptoms reasonably indicate that the patient has the capacity of causing harm to himself, herself, or

26. STAFF OF S. CRIMINAL JUSTICE COMMITTEE, 113TH SESS., BILL ANALYSIS AND FISCAL STATEMENT FOR SB 432, at 2 (Fla. 2011) [hereinafter FEB. 12, 2011 SENATE ANALYSIS].
27. Florida law defines a “firearm” as “any weapon (including a starter gun) which will, is designed to, or may readily be converted to expel a projectile by the action of an explosive; the frame or receiver of any such weapon; any firearm muffler or firearm silencer; any destructive device; or any machine gun.” FLA. STAT. § 790.001(6) (2010).
29. S. 432 § 1; H.R. 155 § 1. A Senate legislative analysis noted that “[t]he bill does not clearly make it a crime for a doctor to ask a patient about firearms because it does not specify that such conduct is prohibited or is a criminal act, but it does provide that doing so is an invasion of a patient’s privacy.” FEB. 12, 2011 SENATE ANALYSIS, supra note 26, at 3. The analysis recommended that the language in the bill “should be amended to clarify that not only is the verbal or written inquiry an invasion of privacy, but that if the inquiry is made it will be a criminal act punishable as a third degree felony, if that is the bill’s intent.” Id. at 5.
As enacted by the legislature and signed by Governor Rick Scott, the legislation retains a modified restriction on health care practitioner questions. The statute now states that health care practitioners "shall respect a patient’s right to privacy and should refrain from making a written inquiry or asking questions concerning the ownership of a firearm or ammunition" by the patient or a patient family member, or the presence of a firearm in such person’s home. Notwithstanding this provision, a health care practitioner who “in good faith believes that this information is relevant to the patient’s medical care or safety, or the safety of others, may make such a verbal or written inquiry.” Similarly, a health care practitioner “may not intentionally enter any disclosed information concerning firearm ownership into the patient’s medical record if the practitioner knows that such information is not relevant to the patient’s medical care or safety, or the safety of others.”

An emergency medical technician or paramedic also “may make an inquiry concerning the possession or presence of a firearm if he or she, in good faith, believes that [such] information . . . is necessary to treat a patient during the course and scope of a medical emergency or that the presence or possession of a firearm would pose an imminent danger or threat to the patient or others.”

The statute includes other provisions. One allows a patient to “decline to answer or provide any information” about firearm ownership or presence in the home. Although a patient’s exercise of this right “does not alter existing law regarding a physician’s authorization to choose his or her patients,” a health care practitioner “may not discriminate against a patient based solely upon the patient’s exercise of the constitutional right

31. H.R. 155; S. 432.
32. FLA. STAT. § 790.338(2) (West 2011); see also FLA. STAT. § 381.026(4)(b)(8) (West 2011) (codifying this provision in the Florida Patient’s Bill of Rights and Responsibilities). This restriction applies to both licensed health care practitioners and licensed health care facilities. For brevity, this Article notes its application only to health care practitioners. See FLA. STAT. § 456.001(4) (2010) (defining “health care practitioner” as a person licensed under various chapters of the Florida Statutes, including physicians and nurses).
33. § 790.338(2); see also § 381.026(4)(b)(8) (codifying this provision in the Florida Patient’s Bill of Rights and Responsibilities).
34. § 790.338(1).
35. Id. § 790.338(3).
36. Id. § 790.338(4); see also § 381.026(4)(b)(9) (codifying this provision in the Florida Patient’s Bill of Rights and Responsibilities).
37. § 790.338(4); see also § 381.026(4)(b)(9) (codifying this provision in the Florida Patient’s Bill of Rights and Responsibilities).
to own and possess firearms or ammunition. Moreover, a health care practitioner “shall respect a patient’s legal right to own or possess a firearm and should refrain from unnecessarily harassing a patient about firearm ownership during an examination.” A violator of these provisions and the provisions limiting questioning about firearms is subject to disciplinary action by the Florida Board of Medicine. Such action may include permanent revocation of a license and a fine of up to $10,000 per offense.

The legislation—popularly referred to as the “docs ‘n’ Glocks” law—has generated considerable debate. On one side, supporters argue that firearm ownership is a fundamental right protected by the Second Amendment to the U.S. Constitution and generally a private matter. They further claim that firearms are not a public-health issue. Firearm experts—not physicians—accordingly should dispense advice about owning, handling, and storing firearms. In fact, proponents speculate, what many physicians package as “advice” is really an expression of their “anti-gun political agenda.” For support, they point to the American Academy of Pediatrics, which takes a pro-regulatory approach to firearms and asserts that the “most effective measure to prevent firearm-related injuries to children and adolescents is the absence of guns from homes and

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38. § 790.338(5); see also § 381.026(4)(b)(10) (codifying this provision in the Florida Patient’s Bill of Rights and Responsibilities).

39. § 790.338(6); see also § 381.026(4)(b)(11) (codifying this provision in the Florida Patient’s Bill of Rights and Responsibilities).

40. § 790.338(8). Section 790.338(8) of the Florida Statutes states that only “[v]iolations of the provisions of subsections (1)-(4) constitute grounds for disciplinary action under ss. 456.072(2) and 395.1055.” As amended, however, section 456.072 provides that “[v]iolating any of the provisions of § 790.338 shall constitute grounds for disciplinary action. FLA. STAT. § 456.072(1)(mm) (West 2011) (emphasis added). Moreover, as legislative analyses pointed out, section 395.1055 “does not provide for any disciplinary action and instead requires the Agency for Health Care Administration to adopt rules that relate to standards of care, among other things.” STAFF OF S. BUDGET COMMITTEE, 113TH SESS., BILL ANALYSIS AND FISCAL STATEMENT FOR SB 432, at 9 (Fla. 2011) [hereinafter APR. 14, 2011 SENATE ANALYSIS]; see also, e.g., STAFF OF H.R. HEALTH & HUMAN SERVS. COMMITTEE, 113TH SESS., BILL ANALYSIS AND FISCAL STATEMENT FOR H.B. 155, at 7-8 (Fla. 2011) [hereinafter APR. 7, 2011 HOUSE ANALYSIS].

41. See § 456.072(2).


Naturally, opponents of the statute disagree with these assessments. Rather than safeguard patients’ privacy interests, they contend, the statute violates them by cutting into the patient–physician relationship. They also counter that firearms do implicate public-health risks, particularly with respect to children. Firearms—as well as bicycles, pools, and other fixtures in the home—can be dangerous if one uses or manages them improperly. Therefore, physicians—especially pediatricians—ask many questions in imparting “anticipatory guidance” to their patients; that is, advice about preventing accidental injuries. \footnote{Allen, supra note 44.}

To the extent that politics is involved, opponents argue that the statute serves no public policy need and amounts to “ham-fisted pandering”\footnote{Scott Maxwell, Op-Ed, *Gun Law Costs You Money, Tramples Rights*, ORLANDO SENTINEL, June 12, 2011, at B1; *see also*, e.g., Tom Lyons, Op-Ed, *Anti-Regulation, Unless It Makes NRA Happy*, SARASOTA HERALD-TRIB., June 9, 2011, at B1.} to the National Rifle Association, which lobbied for and helped write the statute. \footnote{See Allen, supra note 44; Douglas C. Lyons, *Face to Face: A Conversation with the NRA’s Marion P. Hammer*, S. FLA. SUN-SENTINEL, Apr. 24, 2011, at 2F; Catherine Whitenburg, *Growing NRA Clout Pushes Three Bills*, TBO.COM (Apr. 29, 2011), http://www2.tbo.com/news/politics/2011/apr/29/MENEWS08-growing-nra-clout-pushes-three-bills-ar-203421/. The National Rifle Association’s involvement with the statute has gone beyond legislative advocacy and extended into litigation advocacy. In the pending federal challenge to the statute, the organization filed a motion to intervene on behalf of the defendants, who are various state officials. The district court denied the motion, however, finding that “the NRA has failed to show that the existing defendants will not represent its interests [in defending the statute] adequately.” Wollschlaeger v. Scott, No. 11-22026-Civ, 2011 WL 2672250, at *1 (S.D. Fla. July 8, 2011); *cf.* Lizette Alvarez, *Facing Flurry of Lawsuits, a Governor Loses a Round*, N.Y. TIMES, Aug. 16, 2011, at A13 (discussing the varied litigation facing Governor Scott).}

Opponents also base their objection in the Constitution: the First Amendment’s Free Speech Clause. These opponents include various physicians and health care organizations, who, only days after the statute’s passage, filed a federal lawsuit against Governor Scott and other state officials alleging that the statute infringes the First Amendment rights of both health care practitioners and their patients. \footnote{See Complaint for Declaratory and Injunctive Relief, Wollschlaeger v. Scott, No. 1:11-cv-22026 (S.D. Fla. filed June 6, 2011), 2011 WL 2177374 [hereinafter Complaint]. Days before Governor Scott signed the bill, the attorneys for the plaintiffs sent the governor a letter outlining the constitutional infirmities of the legislation and informing him that they would challenge the bill in court if he did not exercise his veto power. *See* Letter from Bruce S. Manheim, Jr., & Douglas H. Hallward-Driemeier, Ropes & Gray LLP, to Rick Scott, Fla. Governor (May 27, 2011), http://www.scribd.com/doc/56933551/Gov-Scott-Request-to-Veto-Doctor-Gun-Bill. Because the plaintiffs challenged the bill almost as soon as it became law, and *
determination of the statute’s validity thus appears to be outside the bounds of the political branches and within the domain of the judiciary. Importantly, the pending case, Wollschlaeger v. Scott, could determine the scope of the statute for health care practitioners across Florida—with potential implications for patient advice and care. On a broader level, the case could incentivize or discourage efforts in other states to enact legislation similar to Florida’s.

III. THE CONSTITUTIONALITY OF RESTRICTING PATIENT–PHYSICIAN SPEECH ABOUT FIREARMS

Though supporters and opponents of the Florida firearm statute have used the Second and First Amendments, respectively, to frame the law, the First Amendment ultimately controls the constitutional analysis. The significance of the Second Amendment—which has been expansively interpreted by the U.S. Supreme Court in two recent decisions, District of Columbia v. Heller and McDonald v. City of Chicago—is mostly symbolic. Because neither with nor without the statute Florida has done anything to infringe Second Amendment rights, which are applicable only against the state, the Second Amendment is analytically irrelevant.

As to the First Amendment, by contrast, the earliest legislative analyses of the statute reveal concern that restrictions on patient–physician speech about firearms “may be subject to challenge as violating one’s First Amendment right to freedom of speech.” This amendment, which through the Fourteenth Amendment protects against the states “abridging the freedom of speech,” appears to be triggered most obviously with

because the plaintiffs comprise organizational and individual parties, the court adjudicating the matter is likely to rule, at least initially, on issues of ripeness and standing—both of which are beyond the scope of this Article. Cf., e.g., Int’l Acad. of Oral Med. & Toxicology v. N.C. State Bd. of Dental Exam’rs, 451 F. Supp. 2d 746, 748 (E.D.N.C. 2006) (holding that a First Amendment free-speech challenge to a dental board’s alleged restriction of dentists’ speech concerning mercury-related dental practices was unripe).

51. No. 1:11-cv-22026, supra note 49.
53. 130 S. Ct. 3020 (2010).
55. STAFF OF H.R. CRIMINAL JUSTICE SUBCOMM., 113TH SESS., BILL ANALYSIS AND FISCAL STATEMENT FOR H.B. 155, at 5 (Fla. 2011) [hereinafter MAR. 9, 2011 HOUSE ANALYSIS]; see also FEB. 12, 2011 SENATE ANALYSIS, supra note 26, at 4 (“[I]t should not be forgotten that the individual’s right to exercise free speech is only regulated in the most egregious of circumstances.”).
respect to the statutory provision that cautions health care practitioners to "refrain from making a written inquiry or asking questions concerning the ownership of a firearm or ammunition by the patient or by a family member of the patient, or the presence of a firearm in a private home or other domicile . . . ." Other provisions, though, also call for freedom-of-speech analysis. The restriction on health care practitioners "unnecessarily harassing" a patient about firearm ownership does not define "harass[ment]," and, as the Wollschlaeger plaintiffs note, "under any natural reading of the statute (however narrow or broad), such ‘harass[ment]’ would largely or entirely consist of a practitioner’s speech regarding firearms directed to a patient." Similarly, the restriction on "discrimination" against a patient based on the patient’s exercise of firearm rights does not define "discriminat[ion]" and is susceptible to a comparable construction.

In curbing speech between patients and physicians, this statutory scheme raises unresolved questions regarding the First Amendment dimensions of the patient-physician relationship. Courts and commentators have espoused divergent perspectives on the scope of protection for patient-physician speech. The Supreme Court suggested that such speech has some First Amendment protection, but "only as part of the practice of medicine, subject to reasonable licensing and regulation by the

58. Id. § 790.338(6).
59. Complaint, supra note 49, ¶ 43.
60. See id. § 790.338(5); Complaint, supra note 49, ¶ 45.
61. See, e.g., Rust v. Sullivan, 500 U.S. 173, 200 (1991) ("It could be argued . . . that traditional relationships such as that between doctor and patient should enjoy protection under the First Amendment from Government regulation, even when subsidized by the Government. We need not resolve that question here, however . . . ."); Daniel Halberstam, Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions, 147 U. Pa. L. Rev. 771, 834 (1999) ("[T]he Supreme Court and lower courts have rarely addressed the First Amendment contours of a professional's freedom to speak to a client."); Howard C. Kim, Physicians and the First Amendment, 31 J. Legal Med. 423, 427–28 (2010) ("[T]he question of whether the government can prohibit the speech of physicians not employed by the state remains largely unanswered."); Robert Post, Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech, 2007 U. Ill. L. Rev. 939, 944 (describing as "complex and difficult [the] relationship between the First Amendment and the regulation of professional speech of doctors").

The First Amendment right to freedom of association between patients and physicians has proved less viable than the right to free speech between patients and physicians. See Behar v. Pa. Dep't of Transp., 791 F. Supp. 2d 383, 396 (M.D. Pa. 2011) ("Dr. Behar's association with a patient is an association in the broadest sense, i.e. an association of two, however, it is not the type of association protected by the First Amendment. Dr. Behar is dispensing fee-based mental health treatment to his patients; the association is not one formed for the purposes of advocacy or other First Amendment activity."); Conant v. McCaffrey, No. C 97–0139 FMS, 1998 WL 164946, at *3 (N.D. Cal. Mar. 16, 1998) ("The government argues the relationship between an individual patient and doctor is not the kind of association whose communications are protected by the First Amendment right to freedom of association. The Court agrees.").
Some argue, however, that "doctor-patient discourse about medical treatment is fully protected, noncommercial speech," which "has special status within First Amendment jurisprudence because of its essential role in protecting and preserving personal liberty and the discovery of truth." As the following subparts explore in greater detail, the Florida statute fails to pass constitutional muster within a professional speech framework, a comparatively more stringent framework that presumes that content- and viewpoint-based speech restrictions are unconstitutional, and a commercial speech framework.

A. Patient–Physician Speech as Professional Speech

Insofar as the Supreme Court has developed a First Amendment jurisprudence governing patient–physician speech, courts and commentators frequently attribute two abortion cases from the 1990s to its formation: Rust v. Sullivan and Planned Parenthood of Southeastern Pennsylvania v. Casey. In the former case, family-planning agencies and affiliated physicians alleged that federal regulations prohibiting federally subsidized projects from counseling about, providing referrals for, and advocating abortion as a method of family planning violated the First Amendment rights of the fund recipients, their staffs, and their patients. The Court rejected this argument, holding that "Congress . . . merely refused to fund [abortion-related activities] out of the public fisc, and the Secretary [of the Department of Health and Human Services] . . . simply required a certain degree of separation from the Title X project in order to ensure the integrity of the federally funded program." As to the physicians and health care providers specifically, the Court held that these same principles applied to their First Amendment arguments: The regulations restricted their freedom of speech to the limited extent that

64. 500 U.S. 173.
65. 505 U.S. 833; see, e.g., Conant v. Walters, 309 F.3d 629, 636 (9th Cir. 2002) (citing Rust and Casey as recognizing “that physician speech is entitled to First Amendment protection because of the significance of the doctor-patient relationship”); Berg, Toward a First Amendment Theory, supra note 63, at 204 (noting that “until Rust v. Sullivan and Planned Parenthood v. Casey, the Supreme Court never had to face the issue of whether restrictions on the content of doctor-patient speech violate the First Amendment” (footnotes omitted)).
66. Rust, 500 U.S. at 192.
67. Id. at 198.
they voluntarily participated in a federal funding scheme. Notably, the Court raised the possibility that "traditional relationships such as that between doctor and patient should enjoy protection under the First Amendment from Government regulation, even when subsidized by the Government." The Court refused to probe the issue, though, because, as a program of limited scope that did not compel a "doctor to represent as his own any opinion that he does not in fact hold," the funding initiative did not "significantly impinge upon the doctor-patient relationship.

A year later, the Court reexamined patient-physician speech and the First Amendment in Casey. In a series of fractured opinions, the Court focused primarily on the effects of a Pennsylvania statutory regime on a woman's constitutional right to obtain an abortion under Roe v. Wade. But in its discussion of a provision that required physicians, except in emergencies, to inform a woman of an assortment of information about the abortion procedure, a plurality of the Court briefly considered "an asserted First Amendment right of a physician not to provide information about the risks of abortion, and childbirth, in a manner mandated by the State." The plurality noted that "the physician's First Amendment rights not to speak were implicated, but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State." Having earlier determined that the statute required the giving only of "truthful, nonmisleading information," the plurality concluded that the disputed provision was constitutional.

Together, Rust and Casey have come to stand for the proposition that patient-physician speech is due some protection under the First Amendment but that the state may regulate such speech commensurately with its wide latitude to regulate the medical professions. This construction has at least two components. First, it implies a discernable distinction between "professional speech" and "speech by a professional." In a challenge to government-mandated disclaimers on pregnancy resource

68. Id. at 198-99.  
69. Id. at 200.  
70. Id.  
72. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 884 (1992) (plurality opinion). The statute specifically required a physician, at least twenty-four hours before performing an abortion, to apprise the patient of the nature of the abortion procedure, the health risks of abortion and of childbirth, and the "probable gestational age of the unborn child." Id. at 882. Additionally, the physician had to direct the patient to state-furnished material in print describing the fetus and discussing alternatives to abortion. Id.  
73. Id. (citing Wooley v. Maynard, 430 U.S. 705 (1977); Whalen v. Roe, 429 U.S. 589, 603 (1977)).  
74. Id. at 882-84.  
75. Post, supra note 61, at 949.
centers operated by nonmedical staff, a federal district court recently defined the former as speech “given in the context [of] a quasi-fiduciary—or actual fiduciary—relationship, wherein the speech is tailored to the listener and made on a person-to-person basis.” This speech contrasts with speech by a professional; that is, according to the court, “generalized speech related to traditionally ‘professional’ subject matter . . . .”

Professor Robert Post notes that “[t]he difference between professional speech and speech by a professional is constitutionally profound”: Whereas speech by a professional benefits substantially from the safeguards of the First Amendment in order to enrich the “marketplace of ideas,” professional speech is subjected to a different, stricter regulatory approach because “in the context of medical practice we insist upon competence, not debate . . .”

Second, if as Casey in particular instructs, state power to regulate physician speech is tied to state authority to regulate the practice of medicine, then “the constitutional category of professional speech extends only so far as the practice of medicine.” “Physician speech, even physician speech in the presence of a client during the course of medical practice,” Professor Post observes, “is not professional speech if it forms no part of the practice of medicine.” As a related proposition, “most people assume [that a speech restriction that is part of the ‘practice of medicine’] is characterized by scientific facts.” Casey assumes as much in its formulation that the state may regulate patient-physician speech as long as “truthful, nonmisleading information” remains accessible.

The issue arises as to who determines what is factual, thereby shaping the parameters of speech that the state may regulate. Casey suggests that at least some deference is owed to the state in judging factual information.

77. Id. at 466.
78. Id. at 466.
79. Id. at 466.
80. Id. at 949.
81. Id. at 949.
84. See id. at 882 (“It cannot be questioned that psychological well-being is a facet of health. Nor can it be doubted that most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision. In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully
Such deference presumably must have limits, though, lest the state easily evade constitutional liability by couching its ideological agenda in “scientific, nonideological terms . . . .”85 One potential buffer to such evasion is incorporation of the views of the medical profession in setting the boundaries of speech regulation. The doctrine of informed consent is illustrative in this regard. Through the imposition of tort liability, this doctrine regulates speech by imposing a duty upon a physician generally “to make a reasonable explanation and disclosure to his patient of the risks and hazards involved in a proposed course of treatment to the end that whatever consent given by the patient to the prescribed treatment may be an informed and intelligent consent . . . .”86 Jurisdictions differ as to whether the medical profession or the “prudent patient” determines the scope of this duty.87 But, “[u]nder either standard, physicians are obligated to disclose only those risks ‘of which the physician should have been aware,’ which is to say only those risks that are ‘recognized within the medical community.’”88 Casey itself acknowledged the importance of the medical community’s views in scrutinizing a speech regulation, noting that an exception to the disputed statute’s disclosure requirements did “not prevent the physician from exercising his or her medical judgment.”89

The foregoing principles of the professional speech doctrine cast doubt on Florida’s ability to justify its firearm statute as a permissible restriction of professional speech. Though the statute regulates the threshold definition of professional speech—individualized counseling about firearms within a fiduciary relationship—the statute exceeds regulating speech “as part of the practice of medicine, subject to reasonable licensing and regulation by the State.”90 As a textual matter, the statute does not “purport to concern medical facts or risks,”91 other than to leave open potentially heightened carve-outs for inquires about firearms in

85. Post, supra note 61, at 957 (“For purposes of determining the constitutionality of a compelled disclosure, the meaning of the disclosure must be ascertained in light of how it would be understood by a reasonable person, not in terms of how a state legislature might arbitrarily stipulate its meaning.”); see also Robbins, supra note 82, at 174 (“Casey did not give the state an absolute power to dictate the content of physicians’ statements to patients.”).
89. Casey, 505 U.S. at 884 (plurality opinion).
90. Id.
91. Post, supra note 61, at 960.
the face of medical emergencies; imminent dangers or threats; or other “relevant” circumstances. For the most part, the statute “deliberately and provocatively incorporates the language of ideological controversy,” suggesting with words such as “discriminate” and “harassing” that those who may critically question a person’s exercise of his or her firearm rights are on the “wrong” side of the “gun debate.” Contemporaneous statements by legislators and other supporters confirm this understanding. One legislator—a medical doctor—described the measure as a necessary check on the “fringe, extremist political theology” of physicians who ask about firearms. Marion P. Hammer, the former president of and lobbyist for the National Rifle Association, elaborated on the statute’s political focus in an interview:

The NRA is trying to protect the privacy rights of gun owners. It’s a known fact that the American Academy of Pediatrics supports banning guns. They also encourage pediatricians to tell families who own guns to get rid of them and to tell families that don’t own guns not to buy them. So, it’s a political agenda that has invaded medical examination rooms. Parents take their children to see pediatricians and doctors for medical care, not to be lectured on safety, not to be lectured by a physician on firearm safety and how to store firearms. They’re simply not qualified to do it. The political agenda needs to stop.

92. See Fla. Stat. § 790.338(2)-(3) (West 2011). The main carve-out—which provides that health care practitioners “should refrain” from inquiring, either verbally or in writing, about firearms, subject to a “good-faith” “relevance” exception, § 790.338(2)—potentially imposes a steep hurdle when juxtaposed to the more specific carve-out. The latter allows an emergency medical technician or paramedic to “make an inquiry concerning the possession or presence of a firearm [only] if he or she, in good faith, believes that [such] information is necessary to treat a patient during the course and scope of a medical emergency or that the presence or possession of a firearm would pose an imminent danger or threat to the patient or others.” Id. § 790.338(3) (emphasis added). Because “relevance” is undefined in the former carve-out, health care practitioners legitimately have, in the words of the Wollschlaeger plaintiffs, “a very concrete basis to fear that the statute will be construed to prohibit inquiring or entering information except in circumstances related to a medical emergency or imminent threat to health or safety.” Complaint, supra note 49, ¶ 49. This concern is supported by earlier drafts of the statute, which would allow inquiries about firearms in very limited circumstances. See H.R. 155, 2011 Leg., 113th Sess. § 1 (Fla. 2011) (as amended by H.R. Criminal Justice Subcomm., Mar. 8, 2011) (allowing any public or private physician, nurse, or other medical personnel to make a prohibited inquiry “if such inquiry is necessary to treat a patient during the course and scope of a medical emergency which specifically includes, but is not limited to, a mental health or psychotic episode where the patient’s conduct or symptoms reasonably indicate that the person has the capacity of providing harm to himself, herself, or others”); S. 432, 2011 Leg., 113th Sess. § 1 (Fla. 2011) (as amended by S. Comm. on Criminal Justice, Feb. 22, 2011) (containing a similar exception).

93. Post, supra note 61, at 956–57.
94. See § 790.338(3)-(6).
96. Lyons, supra note 48.
The views of the medical profession reinforce that the statute goes beyond regulating speech as part of the practice of medicine. Medical groups such as the American Medical Association and the American Academy of Pediatrics have taken clear stances on the dangers of firearms, especially with respect to children, and these groups promote open communication between patients and physicians about firearm use and possession. The statute, however, disregards the views of the medical community—particularly the views of the American Academy of Pediatrics, as Marion Hammer’s comments demonstrate—by limiting such open communication. Consequently, the statute ensures that some patients will receive less information about firearms than they want or need. As Professor Eugene Volokh notes in reference to a Virginia proposal similar to the Florida statute, “[P]erfectly accurate and reasonable advice about preventing gun injury is covered alongside exaggeration and hysteria.” To this end, the statute stifles the flow of the kind of “truthful, nonmisleading information” found by the Supreme Court plurality to be present (and permissibly compelled) in Casey. Ultimately, because it is ideologically fixated on clamping down on speech associated with an opposing “ideology,” the statute does not regulate professional speech in a constitutionally cognizable manner. The statute, therefore, must be subject to an alternative framework—one more protective of speech that may be singled out by the government for political or ideological reason.

B. Patient–Physician Speech as Content- and Viewpoint-Protected Speech

Of the myriad doctrines that originate from the Free Speech Clause, one of the most important is the doctrine governing “content-based” regulations of speech, or regulations that cannot be “justified without reference to the content of the regulated speech.” Determination of

97. See, e.g., POLICIES OF THE AM. MED. ASS’N HOUSE OF DELEGATES H-145.9990 (2010), https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fama%2fpub%2fupload%2fmm%2fpolicyfinder%2fpolicy%2fh%2fh-145.990.HTM (encouraging members to “inquire as to the presence of household firearms as a part of childproofing the home”); sources cited supra note 45. The Massachusetts Medical Society recently went as far as to adopt a resolution that opposes “legislative interference in the right of physicians and patients or parents and guardians to discuss gun ownership, storage or safety in the home.” Health Care Reform Leads List of Resolutions Adopted by Physicians of the Massachusetts Medical Society at Annual Meeting of House of Delegates, MASS. MED. SOC’Y (May 21, 2011), http://www.massmed.org/AM/Template.cfm?Section=MMS_News_Releases&CONTENTID=55156&TEMPLATE=/CM/ContentDisplay.cfm.


whether a regulation is content-based, rather than "content-neutral," is crucial because a content-based regulation ordinarily triggers "strict scrutiny," which requires a court to presume that the regulation is unconstitutional.\textsuperscript{100} Under the applicable doctrinal test, the regulation will survive such scrutiny only if the government demonstrates that it is "justified by a compelling government interest and is narrowly drawn to serve that interest."\textsuperscript{101} The Supreme Court recently stated that this standard is so demanding that "[i]t is rare that a regulation restricting speech because of its content will ever be permissible."\textsuperscript{102} When a regulation goes further than discriminating in content and discriminates in viewpoint—the particular message of the speech—the odds of withstanding judicial review become even greater, if not insurmountable.\textsuperscript{103}

Since the Court decided Rust and Casey, lower courts have introduced some of these First Amendment principles into the patient–physician speech context. The issue of the government’s power to prohibit patient–physician speech based on content and viewpoint ripened particularly in a line of decisions that surfaced from the Ninth Circuit after California legalized medical marijuana in 1996. In light of that change in state law, the federal government put forth an executive policy to seek criminal and administrative action against physicians who "recommended" medical marijuana.\textsuperscript{104} A group of physicians, patients, and nonprofit organizations sued to enjoin the policy, arguing that "because physician–patient communication is protected speech under the First Amendment, the government may neither prosecute nor administratively sanction physicians for recommending medical use of marijuana."\textsuperscript{105} The question in the case, Conant v. Walters,\textsuperscript{106} thus was purely speech-focused, separate from the question—answered in the affirmative by the Supreme Court—
whether federal narcotics law superseded California’s medical marijuana law.107

In preliminarily enjoining the government policy, the district court agreed that the policy carried potentially grave consequences in violation of the First Amendment.108 As an initial matter, the court expressed concern that the policy was both content-based (i.e., focused on speech about medical marijuana) and viewpoint-based (i.e., premised on “disagreement with plaintiff physicians’ views about the efficacy of medical marijuana”).109 Seemingly to go further than Rust and Casey, the court concluded:

Although the practice of medicine is subject to state regulation, it does not automatically follow that speech that would otherwise be protected if between two ordinary citizens somehow loses that protection when it occurs in the context of the physician-patient relationship. At the very least, courts confronted with the issue of regulation of physician speech have presupposed that speech between physicians and their patients is protected by the First Amendment. Moreover, sound policy reasons justify special protection of open and honest communication between those groups.110

With a different judge presiding, the same district court later returned to the scope of protected patient-physician speech in deciding whether to

107. See Gonzales v. Raich, 545 U.S. 1, 22 (2005) (upholding, under the Commerce Clause, the federal government’s enforcement of the Controlled Substances Act to prohibit marijuana that was locally grown and used in accordance with California’s medical marijuana law); United States v. Oakland Cannabis Buyers’ Coop., 532 U.S. 483, 486 (2001) (holding that the Controlled Substances Act provided no medical necessity exception to the Act’s prohibitions on manufacturing and distributing marijuana for medical marijuana patients).

108. The court enjoined the government from prosecuting “California physicians unless the government in good faith believes that it has probable cause to charge under the federal aiding and abetting and/or conspiracy statutes.” Conant, 172 F.R.D. at 701. But cf. Pearson v. McCaffrey, 139 F. Supp. 2d 113, 121 (D.D.C. 2001) (denying an application for preliminary injunction, in a case involving virtually the same facts as Conant, in part because “[e]ven though state law may allow for the prescription or recommendation of medicinal marijuana within its borders, to do so is still a violation of federal law under the [Controlled Substances Act]”).


110. Id. at 695. Compare, e.g., Bennett v. N.H. Bd. of Med, No. 05-E-0478, slip op. at 8 (N.H. Super. Ct. June 30, 2006) (“[T]he Court does not agree that the decision by a person to subject him or herself to the regulation of a licensed profession necessarily limits his or her right to speak freely . . . .”), with, e.g., Pearson, 139 F. Supp. 2d at 121 (holding that the government’s sanctioning of physicians’ recommendation and prescription of medical marijuana was permissible under Casey’s “reasonable regulation” standard), and, e.g., Pitre v. Curhan, Nos. CIV.A.00-0053, CIV.A.99-1138, CIV.A.00-2506, CIV.A.98-3610, 2001 WL 770941, at *4 (R.I. Super. Ct. July 10, 2001) (“Although health care providers possess the same free speech rights as other citizens, this Court finds that by choosing to engage in the practice of medicine they have surrendered a portion of their free speech rights.”).
permanently enjoin the government policy. The court reiterated that the policy implicated physicians' free-speech rights but, building from the previous judge's suggestion that patient-physician speech deserves special protection, deemed *Casey's* "reasonable regulation" standard inapplicable. The case was not controlling, according to the court, because it involved a compulsion of speech, whereas the present case involved a prohibition of speech. Given these "stark differences," the court applied a balancing test from a Supreme Court case in which a state bar sanctioned an attorney for speaking to the press about a pending case. Within this framework, the court weighed physicians' First Amendment interests against the government's regulatory interests.

In the wake of the Supreme Court's emphatic rejection of interest-balancing in the First and Second Amendment contexts in *District of Columbia v. Heller*, decided almost ten years after *Conant*, the district court's approach is no longer viable. But to the extent that the factors in this balancing test support heightened protection for patient-physician speech, the case suggests that the values the First Amendment has long endeavored to protect—the marketplace of ideas, democratic participation, and the preservation of autonomy—are very much present in the patient-physician relationship. A cancer or AIDS patient, for example, advised about medical marijuana by a physician "may choose to honor the federal [narcotics] law but, armed with the doctor's recommendation, may urge the federal government to change that law." "In the marketplace of ideas," the court elaborated, "few questions are more deserving of free-speech protection than whether regulations affecting health and welfare are sound public policy." The court further suggested that restrictions on patient-physician speech about medical marijuana could have an adverse effect on individual autonomy, disabling many patients who depend on their physicians for medical information "from understanding their own situations well enough to participate in the debate." The court concluded that "[t]his factor alone" tipped "the balance of considerations . . . firmly

112. *Id.* at *14.
113. *Id.* at *13-14 (relying on *Gentile* v. State Bar of Nev., 501 U.S. 1030 (1991)).
114. *Id.* at *13 (quoting *Gentile*, 501 U.S. at 1075).
117. *Id.*
118. *Id.*
on the side of protecting sincere medical recommendations" and permanently enjoined the government policy.

On appeal, the Ninth Circuit reaffirmed these principles. The court recognized that the patient–physician relationship strikes at “core First Amendment values,” going as far to say that speech between patients and physicians “may be entitled to ‘the strongest protection our Constitution has to offer.’” The court also observed, like the district court, that the disputed government policy was both content- and viewpoint-based, which raised substantial constitutional concerns. Appearing to apply heightened scrutiny, the court held that the government policy lacked “narrow specificity” because a “recommendation” turned “largely on the meaning the patient attributes to the doctor’s words.” The government cited Rust and Casey for support, but the court deemed them inapposite: Rust was a spending case, not strictly a speech case; and Casey involved a statutory scheme that “did not ‘prevent the physician from exercising his or her medical judgment,’ unlike the policy before the court.” The court summarily affirmed.

Combined, the Conant decisions mark an important step in the evolution of patient–physician speech, bearing a potentially damaging effect on the Florida firearm statute. Much as the federal government’s

119. Id.
120. Id. at *16. Specifically, the court enjoined the government from “(i) revoking a class-member physician’s [Drug Enforcement Agency] registration merely because the doctor recommends medical marijuana to a patient based on a sincere medical judgment and (ii) from initiating any investigation solely on that ground.” Id. The court stipulated that “[t]his injunction applies whether or not the physician anticipates that the recommendation will, in turn, be used by the patient to obtain marijuana in violation of federal law.” Id. The court also granted the plaintiffs partial summary judgment insofar as the policy was impermissible as a matter of statutory authority. Id. at *7.
122. Conant, 309 F.3d at 637-38.
123. Id. at 639; see also Bennett v. N.H. Bd. of Med, No. 05-E-0478, slip op. at 11 (N.H. Super. Ct. June 30, 2006) (holding that a regulation that required physicians to treat patients with "compassion and respect for human dignity and rights" failed to comply with the narrow specificity requirement under strict scrutiny because “whether a person is treated with dignity and respect are, at least initially, subjective determinations left to the sensitivities of the listener").
125. Judge Kozinski concurred to emphasize patients’ interest in receiving potentially life-saving information about medical marijuana and California’s interest in experimenting as a “laboratory of innovation.” Id. at 639–48 (Kozinski, J., concurring).
126. As a matter of precedent, the Conant opinions would not be binding on a federal court adjudicating a challenge to the Florida statute, which necessarily would be within the Eleventh Circuit. Still, the substance of those opinions would command a court’s consideration.
policy in Conant was focused on speech about marijuana, the Florida statute focuses entirely on speech about firearms. As if its fixation on content were not enough to cloud the statute’s fate, the statute unabashedly discriminates based on the viewpoint of health care practitioners’ speech: Only speech that is “discriminatory” or “harassing” of a patient’s firearm rights, or otherwise does not fall within the narrow safe harbors is restricted.127 Speech that, by contrast, praises or is favorable toward a patient’s firearm rights appears to be outside the statutory scope. Earlier drafts of the statute—different in language but similar in spirit—substantiate that it seeks to suppress viewpoints critical of firearms. In enumerating limited exceptions to the restriction on inquiries about firearms, the draft bills provided that the exceptions would “not apply to a person’s general belief that firearms or ammunition are harmful to health or safety.”128 The conclusion is evident: The statute has no regard for the “bedrock principle underlying the First Amendment . . . that the government may not prohibit the expression of an idea simply because society finds the idea itself offensive or disagreeable.”129

Though the near-absolute principle forbidding viewpoint discrimination confirms the statute’s unconstitutionality,130 whether the statute would pass strict scrutiny still warrants consideration in light of Florida legislators’ apparent anticipation that a court may scrutinize the statute under this standard. Legislative analyses repeatedly noted that content-based restrictions on speech are “subject to the strict scrutiny standard of judicial review,” pursuant to which “the state may regulate the content of constitutionally protected speech in order to promote a compelling interest if it chooses the least restrictive means to further the articulated interest.”131 Notably, these analyses failed to proffer any “compelling interest” in restricting health care practitioners’ speech about firearms or any explanation as to how the proposal was the “least restrictive means” to pursue this unstated interest.

130. See, e.g., 1 SMOLLA, supra note 99, § 3:11 (“[i]t is doubtful that the Court would ever look with much favor upon a form of speech regulation that discriminates on the basis of viewpoint . . . .”).
131. APR. 14, 2011 SENATE ANALYSIS, supra note 40, at 9; STAFF OF S. JUDICIARY COMMITTEE, 113TH SESS., BILL ANALYSIS AND FISCAL STATEMENT FOR SB 432, at 8 (Fla. 2011) [hereinafter APR. 13, 2011 SENATE ANALYSIS]; STAFF OF S. HEALTH REGULATION COMMITTEE, 113TH SESS., BILL ANALYSIS AND FISCAL STATEMENT FOR SB 432, at 8 (Fla. 2011) [hereinafter MAR. 29, 2011 SENATE ANALYSIS]; MAR. 9, 2011 HOUSE ANALYSIS, supra note 55, at 5.
A fair reading of the statute nevertheless suggests at least three related interests that the state might claim are compelling: its interest in safeguarding Second Amendment rights, its interest in maintaining patient privacy about firearms, and its interest in protecting patients from what may be biased or harassing speech. The first of these interests is undermined by the current scope of the right afforded by the Second Amendment: a “personal right [outside the militia context] to keep and bear arms for lawful purposes, most notably for self-defense within the home.” In the two recent Supreme Court cases interpreting this amendment, the Court stressed that the Second Amendment right is “not unlimited,” assuring that “nothing” in its opinions should “cast doubt on longstanding prohibitions on the possession of firearms by felons and the mentally ill, or laws forbidding the carrying of firearms in sensitive places such as schools and government buildings, or laws imposing conditions and qualifications on the commercial sale of arms.” Because the Second Amendment right presumably would have little or no force in as “sensitive” a place as the physician’s examining room, the state would be strained to argue that it has a “compelling” interest in preserving patients’ Second Amendment rights at the cost of health care practitioners’ speech. Indeed, this putative interest is analogous to the federal government’s attempt in Conant to “sanction physicians on the unremarkable and undisputed proposition that the government can regulate distribution and possession of drugs.” Although Florida and all other states now must respect the Second Amendment right after the Supreme Court incorporated it against the states in McDonald v. City of Chicago, its binding nature “does not allow the government to quash protected speech about it.”

The state’s presumable interest in patient privacy scarcely fares better. To invoke such an interest as compelling, the state “would need to demonstrate that the harms are real, not merely conjectural, and that the [statute] will in fact alleviate these harms in a direct and material way.”

133. District of Columbia v. Heller, 554 U.S. 570, 626–27 & n.26 (2008) (describing these “presumptively lawful regulatory measures only as examples”); McDonald, 130 S. Ct. at 3047 (plurality opinion) (reiterating these limitations).
135. The Court was split in its rationale for incorporating the Second Amendment against the states. A plurality reasoned that the amendment applied to the states under the Due Process Clause, McDonald, 130 S. Ct. at 3044–48 (plurality opinion), while Justice Thomas reasoned that this right applied under the Privileges or Immunities Clause, id. at 3058–88 (Thomas, J., concurring in part and concurring in the judgment).
In deliberating and enacting the statute, however, legislators showed little more than that “intrusive” physician questioning about firearms was a problem in the novel, headline-grabbing story of the Ullman family. The legislature made no larger studies about the alleged harms from such questioning; every legislative analysis merely summarizes the incident with the Ullmans and concludes that “[t]his incident has led many to question whether it should be an accepted practice for a doctor to inquire about a patient’s firearm ownership.” A news story captured the reasoning of many of the statute’s supporters: They “don’t know how many other times such an incident has occurred in the state, [but] they said once is enough.” National Rifle Association lobbyist Marion P. Hammer offered some further clarity, claiming in an interview that physician inquiry about firearms is “a growing problem that has been going on for eight or nine years” and that the firearm lobby group considered legislative action as far back as six years. But beyond scattered anecdotes, the state is hard-pressed to establish that the supposed problem is in fact “real” enough to justify potentially career-ending punishment for health care practitioners. Simply put, “once is enough” is not enough under the Constitution.

Further, the viability of a “compelling” interest in sheltering patients from biased or harassing speech is questionable after Sorrell v. IMS Health Inc., the Supreme Court’s most recent freedom-of-speech case in the health care setting. The case involved a First Amendment challenge to a Vermont statute that, among other things, restricted the use of information about physicians’ prescription practices for marketing by pharmaceutical manufacturers. Applying a demanding level of heightened scrutiny, the Court invalidated the statute. In doing so, it rejected the State’s attempt to justify the statute to protect prescribing physicians from disruptive and repeated marketing visits by pharmaceutical sales representatives, which supposedly amounted to harassment and coercion. Although this

_sys., Inc. v. FCC, 512 U.S. 622, 664 (1994)).
138. See supra Part II.
139. See, e.g., FEB. 12, 2011 SENATE ANALYSIS, supra note 26, at 2.
140. Rosica, supra note 43 (emphasis added).
141. Lyons, supra note 48.
143. Id. at 2659–61.
144. Compare id. at 2667 (concluding that the statute violated the First Amendment “whether a special commercial speech inquiry or a stricter form of judicial scrutiny is applied”), with id. at 2673 (Breyer, J., dissenting) (arguing that the majority applied “far stricter, specially ‘heightened’ First Amendment standards . . . to this instance of commercial regulation” than allowed by Court precedent).
145. Id. at 2669–70 (majority opinion).
asserted interest is not necessarily the same as an interest in protecting
patients from such conduct, IMS Health suggests that an interest in
combating harassment in the medical setting must be premised on more
than a legislative finding that “‘a few’ [individuals] may have ‘felt coerced
and harassed’ . . . [to] sustain a broad content-based rule . . . .” 146 For
the reasons described above, however, the Florida firearm statute fails to buoy
itself on more than the Ullman case.

Finally, the statute is not narrowly drawn to protect any compelling
interest. The statute became considerably more moderate from draft to
enactment, but its final form retains what the Fifth Circuit described in the
abortion context as “potentially significant civil and administrative
penalties, including fines and license revocation, which can be
characterized as quasi-criminal.” 147 Much as Vermont failed to explain in
IMS Health “why remedies other than content-based rules would be
inadequate” to vindicate its interest in defending physicians from
harassment—namely, physicians giving “‘No Solicitation’ or ‘No
detailing’ instructions to their office managers or to receptionists at their
places of work” 148—Florida has failed to explain why patients cannot
sufficiently thwart “harassing” physician inquiries about firearms by
simply declining to answer them. As physician stories in the media bear
out, 149 moreover, the statutory language—specifically, such undefined
terms as “respect,” “relevant,” “discriminate,” and “harassing” 150—is so
vague, and thus so potentially expansive, that a health care practitioner
risks unpredictable consequences every time he or she asks a patient about
firearms. “[O]ne patient,” the Wollschlaeger plaintiffs observe, “may
regard as ‘harassment’ an inquiry and discussion of gun safety that another

146. Id. at 2669 (doubting that the Vermont Legislature’s finding that “‘a few’ physicians who may have
‘felt coerced and harassed’ by pharmaceutical marketers could sustain a broad content-based rule like [the
statutory restriction]”).
148. IMS Health, 131 S. Ct. at 2669–70.
wording of the law means to her practice”); Allen, supra note 44 (quoting a specialist in adolescent
medicine as wondering, in reference to a “relevance” exception to health practitioner inquiries about
firearms: “What if I have an adolescent who’s been bullied, who’s not suicidal? I don’t think under the
current bill, I’m allowed to ask him if there’s a gun in the home, or if he’s carried a gun to school, or if he’s
thinking of harming someone else with a gun”).
150. The imprecision of these terms is compounded by the variance in which the provisions appear to be
mandatory or directory: A health care practitioner “shall” respect a patient’s privacy and firearm rights,
“should” refrain from irrelevant inquiries and unnecessary harassment, and “may” not discriminate against
a patient based solely upon the patient’s exercise of firearm rights. The absence of other enacted legislation
of this kind further precludes comparing and potentially illuminating the text by cross-reference.
The patient would welcome." The situation is parallel to that in *Conant*, where the Ninth Circuit held that the federal government’s vague policy on medical marijuana lacked “narrow specificity” because the targeted speech, physician “recommendations,” “depend[ed] largely on the meaning the patient attribute[d] to the doctor’s words.”

A final consideration remains: whether the state could validate the statute as a regulation of commercial speech—“expression related solely to the economic interests of the speaker and its audience.” Under this doctrine, the government may regulate such expression based on its content, subject to a standard of review traditionally less rigorous than strict scrutiny. The staff of the Florida Senate amended its analyses to suggest that in a challenge to the statute this standard may be applicable over strict scrutiny. “Unlike the case of personal speech,” the analyses note, “it is not necessary to show a compelling state interest in order to justify infringement of commercial speech through regulation.” Still, the analyses explain, “[c]ommercial free speech that concerns lawful activity and is not misleading may be restricted [only] where the asserted governmental interest is substantial, the regulation directly advanced that interest, and the regulation is no more extensive than necessary to serve that interest.”

Insofar as it has addressed the issue, the Supreme Court conveyed skepticism toward the importation of commercial speech principles in the patient-physician setting. Before *Casey* arrived to the Court, the Third Circuit, relying on a case where the Court upheld a regulation of attorney advertising, held that the contested disclosure provision there was a permissible regulation of commercial speech. During oral argument, however, the Supreme Court doubted the commerciality of a physician’s

151. Complaint, supra note 49, ¶ 50.
152. Conant v. Walters, 309 F.3d 629, 639 (9th Cir. 2002); see also Bennett v. N.H. Bd. of Med., No. 05-E-0478, slip op. at 12–13 (N.H. Super. Ct. June 30, 2006) (“The statute, rule, and principle relied upon by the Board [to investigate and adjudicate complaints by patients about a physician’s statements] give only general descriptions of what is expected of physicians. They do not define, with any manner of specificity, what conduct constitutes unprofessional conduct nor what it means to treat, or fail to treat, persons with ‘human dignity and rights.’”).
154. APR. 14, 2011 SENATE ANALYSIS, supra note 40, at 9 (quoting Fla. Canners Ass’n v. State, Dep’t of Citrus, 371 So. 2d 503, 519 (Fla. 1979)); APR. 13, 2011 SENATE ANALYSIS, supra note 131, at 9 (quoting same).
155. APR. 14, 2011 SENATE ANALYSIS, supra note 40, at 9; APR. 13, 2011 SENATE ANALYSIS, supra note 131, at 9.
dispensing advice to a patient and appeared dubious of the Commonwealth’s position to the contrary, distinguishing case law involving attorney advertising.\textsuperscript{157} The Court ultimately did not resolve this question in its written opinion, though, and instead articulated the “reasonable regulation” standard that, as noted, has become identified with the professional speech doctrine.\textsuperscript{158}

Assuming that an attempt to apply the commercial speech standard of review in the patient-physician context could withstand this scrutiny from the Supreme Court, the Florida firearm statute would nevertheless fail the doctrinal test for reasons similar to those explored in the strict-scrutiny analysis. The government still bears the burden to show that a regulation on commercial speech targets “real” harms\textsuperscript{159}—a burden that the government here has yet to meet in any measurable way other than by pointing to a “sensational case [that] overshadowed the reasonable exchanges patients and doctors have about guns every day . . . .”\textsuperscript{160} Furthermore, though

\begin{quote}
[the Government is not required to employ the least restrictive means conceivable, . . . it must demonstrate narrow tailoring of the challenged regulation to the asserted interest—“a fit that is not necessarily perfect, but reasonable; that represents not necessarily the single best disposition but one whose scope is in proportion to the interest served.”]\textsuperscript{161}
\end{quote}

Even with a certain permissible amount of “imperfection,” this requirement is not satisfied by the statute: An “injury” to a patient’s firearm rights or privacy is reciprocated with a menu of punishments that include loss of one’s professional license and a fine of several thousands of dollars per violation. Whatever the limits of “proportionality,” this ratio between offense and retribution falls outside them.

The constitutional defects of the statute are by now clear. Within the

\textsuperscript{157} See Transcript of Oral Argument at 37–38, Casey, 505 U.S. 833 (Nos. 91-744, 91-902); see also Berg, Toward a First Amendment Theory, supra note 63, at 239–40 (arguing that, “contrary to the Third Circuit’s ruling in Casey, conversations between doctors and patients about diagnosis and treatments are not commercial speech” (footnote omitted)); Kim, supra note 61, at 429–30 (“While the practice of medicine has commercial \textit{elements}, the doctor-patient relationship should not be viewed as a commercial \textit{practice} and therefore subject to a lower level of First Amendment protection.”).

\textsuperscript{158} See supra Part III.A.


\textsuperscript{160} Samples, supra note 149.

\textsuperscript{161} Greater New Orleans Broad. Ass’n, 527 U.S. at 188 (quoting Bd. of Trs. of State Univ. of N.Y. v. Fox, 492 U.S. 469, 480 (1989)).
First Amendment paradigms that limit the government’s ability to regulate the content and viewpoint of speech, the statute fails short at every analytical step. A reviewing court should readily find the statute unconstitutional.

**IV. POLICY CONSIDERATIONS TO RESTRICTING PATIENT–PHYSICIAN SPEECH ABOUT FIREARMS**

If the constitutional shortcomings of the Florida firearm statute are not enough to dissuade other states from following Florida’s course, then the policy implications of the statute should give lawmakers pause. Questions emerge whether the statute is redundant and even inconsistent with other federal and state laws.

As a threshold matter, the very necessity of legislative action is doubtful. To the extent that privacy about firearms undergirds the statute, the most recent federal health reform legislation, the Patient Protection and Affordable Care Act (PPACA), unequivocally ensures this privacy. In a section governing reporting requirements for health insurers, the Act disallows the collection, maintenance of records, and disclosure of information relating to the lawful ownership, possession, use, and storage of firearms. The Act also precludes discrimination in premium rates on the basis of lawful ownership, possession, use, and storage of firearms. Thus, ironically, the federal legislation that influenced the enactment of the Florida statute endeavors to achieve the same goal as the latter: preventing the government, insurance companies, and other third parties—not necessarily individual health care practitioners—from obtaining and using information about patients’ firearms.

163. Id. § 300gg-17(c)(4).
164. See Sharockman, supra note 21 (quoting the House sponsor of the legislation as saying: “What we don’t want to do is have law-abiding firearm owners worried that the information is going to be recorded and then sent to their insurance company . . . . If the overreaching federal government actually takes over health care, they’re worried that Washington, D.C., is going to know whether or not they own a gun and so this is really just a privacy protection”); see also Hammer, supra note 23 (“Horified parents have described nurses entering the answers to gun questions into laptop computers to become a part of medical records. They have become concerned about whether those records can be used by the government or by insurance companies to deny health care coverage because a family exercises a civil right in owning firearms.”); David Koppe, Doctors and Guns, THE VOLOKH CONSPIRACY (Feb. 28, 2006, 2:42 PM), http://volokh.com/archives/archive 2006 02 26-2006 03 04.shtml#1141159376 (noting the trend toward centralization of medical data and suggesting that centralization of firearm data could lead to confiscation of firearms and erosion of the constitutional right to keep and bear arms). But see Jay MacDonald, Health Reform and Gun Rights?, BANKRATE.COM (Mar. 8, 2011, 10:00 AM), http://www.bankrate.com/financing/insurance/health-reform-and-gun-rights/ (observing that PPACA protects against reporting about firearms and discrimination in premium rates based on firearm ownership or possession); Aaron Sharockman, Florida Lawmaker Says Gun Bill Is Needed Because of the Health
The federal Health Insurance Portability and Accountability Act (HIPAA) and its state analogues also may guard information about firearms that patients impart to health care practitioners. Among other things, HIPAA dictates how health care providers and other covered entities must keep, and to what extent they may divulge, patients' "personal health information." Federal regulation defines this information as "individually identifiable health information," which is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) That identifies the individual; or (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

As a legislative analysis of the Florida statute points out, "if information concerning firearms' qualifies as [personal health information], it would appear that HIPAA already prohibits and penalizes" disclosure of information about firearms to third parties.

Furthermore, the statute's effect on existing legal regimes is unclear. The law of medical malpractice is one area susceptible to impact. To avoid malpractice liability, a defendant-physician generally must show that he or she acted with "the standard of care, skill, and knowledge of physicians or surgeons engaged in the same general type of practice as the defendant or rendering the same or similar services." Given this standard's deference

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166. See, e.g., FLA. STAT. § 456.057(7) (2010) (providing generally that a health care practitioner may not furnish a patient’s medical record or discuss a patient’s medical condition with a third party without the patient’s written authorization).
168. MAR. 9, 2011 HOUSE ANALYSIS, supra note 55, at 6; see also Lisa A. Cosgrove, Florida Infringes on Patient-Physician Relationship, 45 PEDIATRIC NEWS, May 2011, at 18 (“The bill is an unnecessary intrusion into the physician-patient relationship as privacy regarding patient visits is currently covered under national law under the Health Insurance Portability and Accountability Act.”).
to industry norms, practice guidelines promulgated by medical organizations may serve as the standard of care in a given case. One organization that contributes such guidelines is the American Academy of Pediatricians, whose firearm guidelines—consistent with the position of many other medical organizations—suggests "that a reasonably prudent pediatrician should inquire about the presence of guns in the home and counsel patients about the risks of firearms." The Florida statute, however, is at tension with this guideline and therefore may discourage physicians from inquiring and rendering anticipatory guidance about firearms. Thus, one could now conceive a case in Florida where a pediatrician—deterred by the statute from counseling about firearms—is held, or at least alleged to be, liable for an omission that resulted in the death or injury of, for example, a teenager who displayed suicidal tendencies.

At least one writer, Dr. Frederick Paola, argues that such liability is unlikely. Citing a study in which fifty-nine percent of internists and seventy-three percent of surgeons reported that they “never” talked to patients about firearms, Dr. Paola asserts that “plaintiff patients would have a difficult time proving that the conduct of the defendant-physician (who failed to engage his patient in a discussion of gun safety) had fallen below the standard of care.” This assertion is notably overbroad, failing to consider at least one subset of physicians much more likely to talk to their patients about firearms (and arguably more likely to face hypothetical liability): pediatricians—seventy-one percent of whom, according to a 2008 national, random sample, “always” or “sometimes” counseled parents to unload and lock firearms. As to the causation element of liability, Dr. Paola submits that a defendant-physician who fails to warn

171. See id; see also Chelsea Conaboy, Physicians Say Firearm Safety Is a Matter of Public Health; the NRA Says It's a Privacy Issue, B. GLOBE, June 13, 2011, at 13 (quoting David Hemenway, director of the Harvard Injury Control Research Center and author of the book Private Guns, Public Health, as saying: “It would almost be malpractice if the doctor didn’t talk about guns”); Ronald Pies, Muzzling Doctors Who Ask Questions About Gun Safety, PSYCHCENTRAL, http://psychcentral.com/blog/archives/2011/05/19/muzzling-doctors-who-ask-questions-about-gun-safety/ (last visited July 15, 2011) (noting that if a physician or other clinician “fails to inquire about gun possession because it is not deemed ‘relevant’, and the patient goes on to commit some act of gun-related violence, the physician may be held liable for failing to ask the ‘relevant’ questions”).
about the dangers of a firearm could "credibly and in good faith argue that there was no reason for him to foresee, nor is there any reason in hindsight to believe that such a warning would have convinced the patient to rid herself of the gun, since he (the physician) has no special expertise in the area." The assumption here is that firearm safety is not a medical issue—an assumption that was championed by supporters of the Florida statute but that pushes against the weight of medical opinion, which effectively sets the standard of care.

In addition to facing liability for failure to counsel patients about firearms, physicians may be liable, or at least may confront an actionable claim, for counseling about firearms in a manner violative of the statute—a situation that Dr. Ronald Pies describes as a "medico-legal 'double bind.'" At a minimum, the latter liability is plausible under the tort of invasion of privacy. The Florida Legislature seems to have anticipated this plausibility too: The statute explicitly recognizes a "patient's right to privacy," and legislative analyses mention this tort in discussing patient privacy about firearms, concluding that a draft bill "appear[ed to] create[ ] a new statutory category in the area of invasion of privacy torts." Though the risk of liability in this regard may be low, as it may be where a physician fails to counsel patients about firearms, the mere plausibility—and plausibility in both scenarios—illustrates the "disjunction between the requirements of [the Florida statute] and a physician’s obligations to his or her patients under traditional legal principles . . . ." The statute could have the additional effect of eroding the public policy underlying firearm control legislation. Most states have, for example, "child access prevention" statutes, which impose criminal liability on adults who negligently or recklessly leave firearms accessible to minors or otherwise allow minors access to firearms. Florida was the

174. Paola, supra note 172, at 91.
175. See, e.g., POLICIES OF THE AM. MED. ASS’N HOUSE OF DELEGATES H-145.997 (2007), https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2ffHnE%2fH-145.997.HTM (recognizing "that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public’s health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths").
176. Pies, supra note 171.
177. FLA. STAT. § 790.338(2) (West 2011).
178. FEB. 12, 2011 SENATE ANALYSIS, supra note 26, at 3 n.10; cf. MAR. 9, 2011 HOUSE ANALYSIS, supra note 55, at 3 n.10 (noting that though "invading someone’s privacy is not a criminal act . . . there is a common law tort claim of invasion of privacy").
179. Vernick et al., supra note 170, at 2169.
first state to enact a law of this kind in the late 1980s, after which other states followed course and modeled their laws after Florida’s. Its statute provides that a person who negligently “stores or leaves, on a premise under his or her control, a loaded firearm” that a minor (age sixteen or younger) could access “shall keep the firearm in a securely locked box or container or in a location which a reasonable person would believe to be secure or shall secure it with a trigger lock . . . .” Violation of this provision is a second-degree misdemeanor if, as a result of improper storage, a minor acquires the firearm without the permission of a parent or guardian, and possesses or exhibits it publicly or “[i]n a rude, careless, angry, or threatening manner . . . .” The Florida Legislature premised this legislation on finding that

a tragically large number of Florida children have been accidentally killed or seriously injured by negligently stored firearms; that placing firearms within the reach or easy access of children is irresponsible, encourages such accidents, and should be prohibited; and that legislative action is necessary to protect the safety of our children.

These findings support, if not encourage, physicians and other health care practitioners to exercise broad discretion in inquiring about patients’ firearms. If, as one Florida pediatrician predicted, the statutory limitations on discussion about firearms cause many pediatricians to “think twice about asking about firearms and discussing firearms safety,” with the probable consequence that “there’ll be more children injured and killed with firearms in the home that are not properly stored,” then this public policy would essentially be contravened.

Finally, and perhaps most fundamentally, the Florida statute could have an acute impact on the patient–physician relationship. Law and society regard this relationship as unique—one that deals with the most intimate details of personhood, implicating issues of life and death. Its foundation is trust, which works in both directions: The patient trusts that the physician will exercise his or her knowledge, experience, and

182. FLA. STAT. § 790.174(1) (2010). The statute provides an exception when a person is carrying a firearm on his or her body or when a firearm is so close to a person’s body that it is practically attached thereto. Id.
183. Id. § 790.174(2).
185. Allen, supra note 44.
objectivity in a patient-centered way, and the physician trusts that the patient will candidly disclose information necessary for the best treatment. Of course, the relationship is not necessarily equal. Studies show that patients—even curious, information-seeking ones—defer greatly to physicians, in part because of the informational divide between them. Physicians thus must take special care to dispense only “truthful, non-judgmental, non-misleading information” to ensure informed patient decision-making and effective treatment.

The Florida firearm statute seems to have little respect for these tenets of the patient-physician relationship. In contrast to other laws that facilitate open communication between patients and physicians—for example, the patient-physician evidentiary privilege—the statute treats patients and physicians as arms-length, transactional parties. Out of apparent paternalistic concern, the statute assumes that physicians, left to their own devices, may be unable to refrain from speaking to patients about firearms in a manner that is not “relevant,” “discriminatory,” or “harassing.” The net result is one that favors neither physicians nor patients: Physicians will be hindered in the information-gathering pertinent to diagnosis and treatment, and patients will have access to less information, potentially widening the information gulf between them and their caregivers. Because of this preexisting rift, moreover, it is improbable that the average patient will solicit advice about firearms from the patient’s physician. Clearly, then, physicians need ample space to inquire, speak, and take notes about patients’ firearms and the dangers to health and safety they may present.

These observations show that the Florida statute is unnecessary and could wreak adverse, unforeseen consequences. Other states accordingly should hesitate to follow suit. Poorly thought-out legislation that serves no real public policy and muddles other public policies runs too great a risk: forcing change on the patient-physician relationship that comes not “from the sphere of medicine but from the halls of the legislature.”

186. See, e.g., Analee Beisecker & Thomas Beisecker, Patient Information-Seeking Behaviors when Communicating with Doctors, 28 MED. CARE 19, 27 (1990) (“[E]ven though patients expressed a strong desire for medical information, they showed little communication behavior designed to elicit this information.”).
187. Robbins, supra note 82, at 164.
188. See, e.g., FED. R. EVID. 501.
189. Robbins, supra note 82, at 193.
V. CONCLUSION

The firearm holds a special place in American law and culture. So too does the patient–physician relationship. The Florida firearm statute demands that the latter yield to the former. The result is both unconstitutional as a matter of law and unsound as a matter of policy. Constitutionally, the statute infringes patient–physician speech under various free-speech doctrines: the professional speech doctrine, the doctrine that demands the most heightened judicial scrutiny of content- and viewpoint-based speech regulations, and the commercial speech doctrine. From a policy perspective, the statute proves unwarranted and unpredictable. Federal law and potentially state law already prohibit the collection, storage, usage, and dissemination of data regarding patients’ firearms, thereby undermining the need to silence health care practitioners in the name of patient privacy. The effects that the statute could impose on other areas of law, such as tort law and firearm control law, further show that the statute is overreaching in ways presumably unintended by legislators. The statute’s overreach is particularly, and perhaps most profoundly, apparent in neutering physicians’ discretion and replacing it with the state’s paternalistic dictates.

Time will tell whether the desire to regulate the patient–physician relationship in this novel fashion represents a political fad or a persistent public policy concern. In the meantime, Florida is a case study in shortsightedness. By neglecting the impact that its firearm statute would bear on free speech and other public policies, it proved that its aim is imprecise. Other states should take note of Florida’s misfire.