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States' Rights to Protect Gun-Owners from Politicized Physician Speech

Frank Griffin, M.D., J.D.

TABLE OF CONTENTS

Introduction	442
I. Gun-Owners in Some States Need Privacy Protections to Get Care that is in Their Best Interests from Politically Biased Physicians.....	447
A. Jeopardizing Professionalism: The Best Interests of Patients are not Advanced by Medically Unnecessary Gun Ownership Inquiries and Record-Keeping or by Harassment and Discrimination Against Lawful Gun Owners	448
B. Gun Ownership May Result in Health Benefits in Many Patients' Best Interests that Should be Considered in Unbiased Professional Medical Recommendations.....	452
C. Convincing Medical Evidence Does Not Exist to Support Some Physicians' Recommendations that All Patients Forego Gun Ownership for Health Benefit.....	459
II. States Should Enhance Patient Privacy Protections Regarding Gun Ownership by Prohibiting Harmful Physician Speech Where Necessary to Protect the Best Interests of Patients	466
III. Physicians' Free Speech Rights Should Generally Give Way for the Best Interests of the Patients	470
A. The Patient-Physician Relationship is a Professional Relationship Formed to Benefit the Patient's Health—Not an Opportunity for Free Discourse on Political Topics	470
B. Compelled Physician Silence in Properly Written State Gun Privacy Laws Should Survive Constitutional Scrutiny	473
Conclusion.....	478

“For the secret of the care of the patient is in caring for the patient.”
Dr. Francis Peabody¹

INTRODUCTION

Recent mass shootings² have placed patients’ gun rights in the public spotlight and may lead some physicians to discriminate against or harass law-abiding, gun-owning patients by expressing personal political views on gun ownership inside the patient–physician relationship in ways unrelated to patients’ medical care. Politicized physician gun speech is subject to state licensing authorities’ regulation using police powers. States have the right to enact laws compelling physician silence regarding non-medical gun advice under the United States Constitution—including laws prohibiting physicians from discriminating against their lawful, gun-owning patients; from harassing those patients; or from making unnecessary inquiries or notations in their medical records.

With great trust there must also come great responsibility;³ sometimes this responsibility includes the responsibility of members of learned professions—like medicine—to forego the exercise of their own fundamental rights in order to respect the fundamental rights of those who trust them. Physicians are afforded great trust as symbolic “conquerors of disease and death.”⁴ This trust rests upon doctors’ specialized training and licensing, such that patients expect state-licensed doctors to deliver

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1. Charles S. Davidson, Book Review, 328 *NEW ENG. J. MED.* 817, 817 (1993) (reviewing PAUL OGLESBY, *THE CARING PHYSICIAN: THE LIFE OF DR. FRANCIS W. PEABODY* (1991)).

2. AJ Willingham & Saeed Ahmed, *Mass Shootings in America Are a Serious Problem—and These 9 Charts Show Just Why*, CNN, <http://www.cnn.com/2016/06/13/health/mass-shootings-in-america-in-charts-and-graphs-trnd/> [<https://perma.cc/M896-UDU8>] (last updated Nov. 6, 2017, 10:06 AM) (describing the Las Vegas shooting as “the deadliest shooting in modern US history” and noting that mass shootings are occurring at a rate of about one per month using the Congressional Research Service’s definition of a “mass shooting” as one where a gunman randomly kills four or more people in a public place).

3. Stan Lee, Steve Ditko & Artie Simek, *Spiderman!*, 1 *AMAZING FANTASY* 15, 11 (Marvel Comics Aug. 1962) (first appearance of Spiderman) (variation of the phrase “[w]ith great power there must also come great responsibility” from the story of Spiderman).

4. Paula Berg, *Toward A First Amendment Theory of Doctor–Patient Discourse and the Right to Receive Unbiased Medical Advice*, 74 *B.U. L. REV.* 201, 226 (1994).

truthful, unbiased advice based upon sound medical principles—not advice resting upon political beliefs.⁵

For politicized health issues like firearm ownership, however, doctors deliver “medical advice” along partisan lines when it comes to their expressed concerns and recommended treatment plans to patients.⁶ In general, Democratic physicians are more likely to consider gun ownership a serious health issue than their Republican counterparts.⁷ Democratic doctors more frequently advise patients to remove guns from their homes and forego their Second Amendment rights while giving “medical advice” inside the patient–physician relationship.⁸ Some doctors even have demanded disclosure of gun ownership from patients and refused to continue the patient–physician relationship with children whose parents refused to disclose their gun ownership information.⁹

Some lawmakers believe it is problematic for licensed professionals to give politically biased medical advice or to discriminate against patients for exercising fundamental rights. As such, lawmakers have passed legislation demonstrating this concern. To address this fear at the federal level regarding patients’ Second Amendment rights, the Patient Protection and Affordable Care Act (“ACA”) includes a section entitled “Protection of Second Amendment Gun Rights” that limits information that the Secretary of Health and Human Services (“HHS”) can collect or require from patients regarding lawful gun ownership.¹⁰

With a similar goal, the Florida Legislature enacted the Firearm Owners Privacy Act (“FOPA”) in 2011 to address the issue of licensed professionals providing politically biased medical advice or

5. Susan Dorr Goold & Mack Lipkin, Jr., *The Doctor-Patient Relationship*, 14 J. GEN. INTERNAL MED. S26 (1999) (discussing the patient–physician relationship as a keystone of health care delivery).

6. See Eitan D. Hersh & Matthew N. Goldenberg, *Democratic and Republican Physicians Provide Different Care on Politicized Health Issues*, 42 PROC. NAT’L ACAD. SCI. 11811, 11813–14 (2016) (finding that Democratic doctors are more concerned about firearms, while Republican doctors are more concerned about marijuana use and abortion issues).

7. *Id.*

8. *Id.* at 11813.

9. *Wollschlaeger v. Governor of Fla.*, 814 F.3d 1159, 1168 n.2 (11th Cir. 2015) (pointing out several undisputed instances of doctors discriminating against gun owners).

10. Patient Protection & Affordable Care Act, 42 U.S.C. § 300gg-17(c) (2012) (including limitations on data collection, formation of databases or databanks, determination of premium rates or health insurance eligibility, and disclosure requirements for lawful gun owners).

discriminating against lawful gun owners at the state level.¹¹ Florida lawmakers enacted FOPA in response to complaints from constituents that “medical personnel were asking unwelcome questions regarding firearm ownership, and that constituents faced harassment or discrimination . . . simply due to their status as firearm owners.”¹² FOPA includes a section entitled “Medical privacy concerning firearms”¹³ and amends Florida’s “Patient’s Bill of Rights and Responsibilities.”¹⁴ The additions include patients’ rights to “decline to answer or provide any information regarding ownership of a firearm by the patient or a family member” with the additional notation that “a health care provider . . . shall respect a patient’s legal right to own or possess a firearm.”¹⁵ FOPA also provides for disciplinary measures against violating physicians.¹⁶

FOPA includes four relevant components. First, FOPA’s record-keeping provision prevents doctors from “intentionally enter[ing]” gun ownership information into the patients’ medical record that the doctor knows is “not relevant to the patient’s medical care or safety, or the safety of others.”¹⁷ Second, FOPA’s inquiry provision says that medical professionals “shall respect a patient’s right to privacy and should refrain” from asking about firearms, unless the doctor has a good faith belief that the information “is relevant to the patient’s medical care or safety, or the safety of others.”¹⁸ Third, FOPA’s anti-discrimination provision prevents doctors and hospitals from discriminating against gun owners.¹⁹ Fourth, FOPA’s anti-harassment provision urges health care providers to refrain from harassing gun owners.²⁰

Four days after Florida lawmakers signed the bill into law, several doctors and medical organizations brought suit against Florida officials under 42 U.S.C. § 1983 by claiming FOPA violated their First and Fourteenth Amendment rights as a content-based, vague, and overbroad speech restriction.²¹ On cross-motions for summary judgment, the district

11. FLA. STAT. §§ 381.026, 456.072, 790.338 (2011).

12. *Wollschlaeger*, 814 F.3d at 1168.

13. FLA. STAT. § 790.338 (2011).

14. *Id.* § 381.026 (2006) (amended 2017).

15. *Id.* § 381.026(b)(11).

16. *Id.* § 456.072 (2006) (amended 2017).

17. *Id.* § 790.338(1).

18. *Id.* § 790.338(2).

19. *Id.* § 790.338(5).

20. *Id.* § 790.338(6).

21. Note, *First Amendment – Eleventh Circuit Upholds Florida Law Banning Doctors from Inquiring About Patients’ Gun Ownership When Such Inquiry Is*

court ruled in favor of the plaintiffs and permanently enjoined enforcement of several FOPA provisions.²² Florida appealed, and a divided Eleventh Circuit panel issued three opinions, each upholding the challenged provisions of FOPA using a different First Amendment standard of review in each opinion.²³ Exercising plenary review and applying heightened scrutiny,²⁴ however, the Eleventh Circuit, sitting *en banc*, vacated those opinions, granted a rehearing, and held that “FOPA’s content-based restrictions—the record-keeping, inquiry, and anti-harassment provisions—violate the First Amendment as it applies to the states.”²⁵ In contrast to the district court, the appellate court found that “FOPA’s anti-discrimination provision—as construed to apply to certain conduct by doctors and medical professionals—is *not* unconstitutional,” and that the unconstitutional provisions were severable from the rest of the Act.²⁶ The ultimate constitutional outcome of this controversy is far from clear, which is evident from the Eleventh Circuit’s meandering course in evaluating

Irrelevant to Medical Care – *Wollschlaeger v. Governor of Florida*, 760 F.3d 1195 (11th Cir. 2014), 128 HARV. L. REV. 1045, 1046 (2014).

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

23. See *Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195, 1219 (11th Cir. 2014) (*Wollschlaeger I*) (holding that the full scope of First Amendment protection does not apply to physicians speaking “only as part of the practice of medicine, subject to reasonable licensing and regulation by the State” (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 844 (1992))); *Wollschlaeger v. Governor of Fla.*, 797 F.3d 859, 896 (11th Cir. 2015), *vacated*, 814 F.3d 1159 (11th Cir. 2015), *vacated*, 649 Fed. App’x 647 (11th Cir. 2016), *vacated*, 848 F.3d 1293 (11th Cir. 2017) (finding that FOPA withstands the “rubric of intermediate scrutiny,” because it “directly advances a substantial State interest, and is not more extensive than is necessary to serve that interest”) (internal quotation marks omitted); *Wollschlaeger v. Governor of Fla.*, 814 F.3d 1159, 1201 (11th Cir. 2015) (finding the act “withstands strict scrutiny as a permissible restriction of speech”); Dani Kass, *Full 11th Circ. to Rehear Fight Over Fla. ‘Gun Gag’ Law*, LAW360 (Feb. 5, 2016, 7:20 PM), <https://www.law360.com/articles/755980/full-11th-circ-to-rehear-fight-over-fla-gun-gag-law> [<https://perma.cc/VP3Y-BAF5>].

24. See *Wollschlaeger*, 649 Fed. App’x 647; *Sorrell v. IMS Health, Inc.*, 564 U.S. 552, 572 (2011) (holding that for content-based, commercial speech restrictions to be constitutional, “the State must show at least that the statute directly advances a substantial governmental interest and that the measure is drawn to achieve that interest”).

25. *Wollschlaeger v. Governor of Fla.*, 848 F.3d 1293, 1301 (11th Cir. 2017).

26. *Id.* (emphasis added).

FOPA and the fact that at least 14 states have considered similar legislation since 2011.²⁷

When the fundamental rights of two parties conflict, the question of which should take precedence arises. For example, a doctor's First Amendment speech rights may conflict with a patient's Second Amendment and privacy rights.²⁸ To help settle the issue, courts should first look to respected medical scholars to place the issues related to the patient-physician relationship in proper order. The American Medical Association ("AMA") Code of Ethics states that physicians have an "ethical responsibility to place patients' welfare above the physician's own self-interest."²⁹ Although Dr. Will Mayo's statement that "the best interest of the patient is the only interest to be considered" may be too strong to apply as the sole legal test, the "best interest of the patient" should still be the focus of the legal analysis when the fundamental rights of both the patient and the doctor are at stake.³⁰

Legal analysis of conflicting fundamental rights involving doctors and patients should begin with an analysis of "the best interests of patients" before proceeding to physicians' self-interest in exercising their freedom of speech—similar to the "best interest of the beneficiaries" standard that applies to fiduciaries.³¹ Legal scholars and legislators recognize patient privacy and freedom from harassing speech as important components of

27. See Melissa Jenco, *Federal Court Strikes Down 'Physician Gag Law' on Guns*, AM. ACAD. PEDIATRICS NEWS (Feb. 16, 2017), <http://www.aappublications.org/news/2017/02/16/FloridaGun021617> [<https://perma.cc/4BUF-UPN5>] (noting that 14 other states have considered similar legislation).

28. See generally *District of Columbia v. Heller*, 554 U.S. 570, 636 (2008) (recognizing a fundamental right to handgun ownership for self-defense in the home); *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965) (discussing zones of privacy and a constitutional right to privacy emanating as a penumbra under the Bill of Rights).

29. AM. MED. ASS'N, CODE OF MEDICAL ETHICS, PRINCIPLES OF MEDICAL ETHICS: PATIENT-PHYSICIAN RELATIONSHIPS § 1.1.1 (2016), <https://www.ama-assn.org/delivering-care/patient-physician-relationships> [<https://perma.cc/9T3R-FPAB>].

30. *About Mayo Clinic*, MAYO CLINIC, <https://www.mayo.edu/mayo-clinic-college-of-medicine-and-science/about/about-mayo-clinic> [<https://perma.cc/E43V-4MUN>] (last visited Sept. 7, 2018).

31. See, e.g., Maxwell J. Mehlman, *Why Physicians are Fiduciaries for Their Patients*, 12 IND. HEALTH L. REV. 1, *1 (2015) (noting that "the law should regard physicians as fiduciaries" and that "fiduciaries are required to further the entrustors' interests" and are not "free to maximize their own self-interest").

patient care.³² In contrast, physicians' freedom to openly express their opinions on politicized health issues in the patient–physician relationship is less clearly beneficial to patient care. For example, Sir William Osler, a well-respected physician pioneer, taught young doctors to listen to their patients and minimize speech, saying “look wise, say nothing, and grunt,” and added that doctors’ “speech was given to conceal thought.”³³ Osler continued, “[I]n everything that pertains to medicine, consider the virtues of taciturnity. . . . And when you speak, assert only that which you know.”³⁴

The patient–physician relationship centers on the patient—not the physician. Legal analysis, therefore, should begin with an analysis of the patients’ rights to privacy and gun ownership, not the doctor’s free speech rights. Physician free speech rights should be considered only *after* the patients’ best interests and fundamental rights are assured.

The balance between patients’ and physicians’ rights is such that courts should find that states are constitutionally justified in passing carefully written gun privacy laws regulating medically irrelevant gun ownership inquiries, documentation, harassment, and discrimination. This Article considers first the “best interests of the patients.” Second, this Article examines states’ obligations to protect patients’ best interests. Third, this Article evaluates physicians’ free speech rights in the patient–physician relationship.

I. GUN-OWNING PATIENTS IN SOME STATES NEED PRIVACY PROTECTIONS TO GET CARE THAT IS IN THEIR BEST INTERESTS FROM POLITICALLY BIASED PHYSICIANS

Privacy protections are necessary in some states to protect gun-owning patients’ best interests. First, physicians harassing patients and discriminating against lawful gun owners is not in the best interests of patients because it undermines gun-owning patients’ trust in the objectivity and professionalism of physicians. Second, in delivering truthful, medically necessary, health-related advice, physicians should include the beneficial aspects of gun ownership along with negative risks

32. *Madsen v. Women’s Health Ctr., Inc.*, 512 U.S. 753, 768 (1994) (citing *Operation Rescue v. Women’s Health Ctr.*, 626 So. 2d 664, 673 (Fla. 1993)) (recognizing a privacy interest of patients in “medical privacy” to protect “not only the psychological, but also the physical, well-being of the patient held ‘captive’ by medical circumstance”). *See also* Health Insurance Portability & Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996).

33. *THE QUOTABLE OSLER* 29 (ed. 2010).

34. *Id.* at 30.

because gun ownership may be in the patient's best interest. Third, conclusive medical evidence is lacking to support biased recommendations by some physicians implying that all patients should forego gun ownership.

A. Jeopardizing Professionalism: The Best Interests of Patients are not Advanced by Medically Unnecessary Gun Ownership Inquiries and Record-Keeping or by Harassment and Discrimination Against Lawful Gun Owners

One of the hallmarks of professionalism underlying patient trust is the idea that the doctor will act in “an impartial, unbiased manner.”³⁵ Political bias has a very limited place inside the examination room. Politically biased advice or inquiries regarding gun ownership may damage patient trust, ultimately negatively impacting that patient's health, as discussed below.

The AMA's Code of Ethics states that “the relationship between a patient and a physician is based on trust.”³⁶ Patient trust reinforces the clinical relationship as a “health partnership,” increasing the likelihood of adherence to treatment recommendations, resultant improved health status, and decreasing the likelihood of patient withdrawal from the prescribed treatment plan.³⁷ Biased advice and discrimination causes detrimental health disparities by leading to diminished trust in the patient–physician relationship.³⁸ Untrusting patients may be less forthcoming with physicians, resulting in untreated disease, unnecessary deaths, and other complications.

A recent study showed that doctors' political affiliations bias their advice to patients regarding gun ownership and storage.³⁹ When physicians' voter registrations were linked to treatment records, Democratic doctors

35. Udo Schuklenk, *Medical Professionalism and Ideological Symbols in Doctors' Rooms*, 32 J. MED. ETHICS 1, 1–2 (2006), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563267/pdf/1.pdf> [<https://perma.cc/QK7K-6A7B>].

36. AM. MED. ASS'N, CODE OF MEDICAL ETHICS, PRINCIPLES OF MEDICAL ETHICS: PATIENT-PHYSICIAN RELATIONSHIPS § 1.1.1 (2016), <https://www.ama-assn.org/delivering-care/patient-physician-relationships> [<https://perma.cc/77JS-46JL>].

37. Steven D. Pearson & Lisa H. Raeke, *Patients' Trust in Physicians: Many Theories, Few Measures, and Little Data*, 15 J. GEN. INTERNAL MED. 509, 512 (2000).

38. Donald Musa et al., *Trust in the Health Care System and the Use of Preventive Health Services by Older Black and White Adults*, 99 AM. J. PUB. HEALTH 1293 (2009).

39. Hersh & Goldenberg, *supra* note 6, at 11812–13.

tended to view gun ownership differently than Republican doctors.⁴⁰ Specifically, Democratic doctors generally perceived firearm storage as a more serious issue than Republican doctors, with Democrats much more likely to encourage patients not to have firearms in their homes.⁴¹ Although the 42,861 doctors studied were trained similarly to each other, the fact that Democratic and Republican doctors offer such differing advice suggests political partisanship—and not medical training—influences the advice.⁴²

Often, patients rightfully consider gun ownership important and hold sincere and deep convictions on the issue, and those convictions deserve physicians' professional respect. According to the U.S. Supreme Court in *District of Columbia v. Heller*, the Constitution guarantees individuals the right to keep and bear arms—including handguns in the home.⁴³ Like other fundamental rights, the right to keep and bear arms is deeply rooted in our nation's history and tradition.⁴⁴ For centuries, many Americans have considered gun ownership essential to the concept of ordered liberty.⁴⁵ Basic civil liberties in our founding documents reinforce this value—including potential health benefits that physicians should recognize. St. George Tucker's version of Blackstone's Commentaries states that “[t]he right to self defence is the first law of nature” and considered it “the true palladium of liberty,” noting that “[w]herever . . . the right of the people to keep and bear arms is, under any colour or pretext whatsoever, prohibited, liberty, if not already annihilated, is on the brink of destruction.”⁴⁶

40. *Id.*

41. *Id.* at 11813.

42. *Id.* at 11814–15.

43. *District of Columbia v. Heller*, 554 U.S. 570, 636 (2008) (“[T]he enshrinement of constitutional rights necessarily takes certain policy choices off the table . . . includ[ing] the absolute prohibition of handguns held and used for self-defense in the home.”).

44. *Id.* at 605–20.

45. *See id.* at 615–16.

46. *Id.* at 606 (citing 1 ST. GEORGE TUCKER, BLACKSTONE'S COMMENTARIES WITH NOTES OF REFERENCE App. 300 (1803)) (emphasis added); *see also St. George Tucker 1752–1827*, LIB. VA., ENCYCLOPEDIA VA., https://www.encyclopediavirginia.org/Tucker_St_George_1752_x2013_1827 [<https://perma.cc/3DKG-Q9W4>] (last visited Sept. 7, 2018) (noting that St. George Tucker was “[o]ne of the most influential jurists and legal scholars in the early years of the United States” and wrote “the first major treatise on American law”).

Likewise, the Court in *Heller* noted that the right to bear arms facilitates the “natural right of resistance and self-preservation.”⁴⁷ American colonists from the 1760s espoused the “natural right” to “keep arms for their own defence.”⁴⁸ Early Americans recognized the “right of self-preservation” permitted citizens to “repel force by force” when societal forces “may be too late to prevent an injury.”⁴⁹ In addition, patients may see gun ownership as necessary to maintain liberty where disarmament has been used to oppress political dissidents in the past; a few examples include: (1) by the Catholic King Charles II through the 1671 Game Act disarming his Protestant enemies;⁵⁰ (2) by King James II;⁵¹ (3) by George III against American colonists in the 1760s and 1770s;⁵² and (4) by whites disarming freedmen after the Civil War.⁵³ Thus, it is understandable that 74% of today’s gun owners consider ownership of a firearm “essential to their freedom.”⁵⁴

States should be free to pass laws under the Constitution that require doctors to show professional respect toward patients who believe in centuries-old wisdom on gun ownership, regardless of whether the doctor agrees with the patient’s gun ownership philosophy. For the best interests of the patients, doctors should maintain truthful medical disclosures and avoid alienating politically diverse patient populations when discussing politically sensitive issues. The patient’s purpose for being in the physician’s office is medical advice—not biased political commentary—

47. *Heller*, 554 U.S. at 594 (quoting 1 WILLIAM BLACKSTONE, COMMENTARIES *136, *139–40).

48. *Id.* (quoting A Journal of the Times: Mar. 17, N.Y. J., Supp. 1, Apr. 13, 1769, in *Boston Under Military Rule 79* (O. Dickerson ed., 1936) (reprinted 1970)); see, e.g., Shippen, Boston Gazette, Jan. 30, 1769, in 1 THE WRITINGS OF SAMUEL ADAMS 299 (H. Cushing ed., 1904) (reprinted 1968).

49. *Heller*, 554 U.S. at 595 (quoting 1 WILLIAM BLACKSTONE, COMMENTARIES *136, *145–46 & n.42 (1803)); see also WILLIAM ALEXANDER DUER, OUTLINES OF THE CONSTITUTIONAL JURISPRUDENCE OF THE UNITED STATES 31–32 (1833).

50. *Heller*, 554 U.S. at 592 (citing J. MALCOLM, TO KEEP AND BEAR ARMS 31–53 (1994); LOIS G. SCHWOERER, THE DECLARATION OF RIGHTS, 1689 76 (1981)).

51. *Id.* (citing MALCOLM, *supra* note 50, at 31–53; SCHWOERER, *supra* note 50, at 76).

52. *Id.* at 594.

53. *Id.* at 615 (citing H.R. REP. NO. 30, pt. 2, at 229 (1st Sess. 1866)).

54. Kim Parker et al., *America’s Complex Relationship with Guns: An in-depth look at the attitudes and experiences of U.S. adults*, PEW RES. CTR. (June 22, 2017), <http://www.pewsocialtrends.org/2017/06/22/americas-complex-relationship-with-guns/> [https://perma.cc/C2MV-JYUE].

and the patient may have deeply rooted beliefs that conflict with her physician's views.

According to the AMA's Code of Ethics, "Physicians are expected to . . . respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient."⁵⁵ Yet, prior to Florida's gun privacy law, a few physicians were doing precisely that: discriminating against gun owners exercising their basic civil liberties.⁵⁶ Specifically, pediatricians were discriminating against gun owners by terminating patient-physician relationships because the patients' parents were gun owners or refused to answer questions about gun ownership.⁵⁷ In addition, one doctor advised a state legislator to remove a lawfully owned gun from his home for no medically justifiable reason, and another doctor lied to a patient by saying that disclosure of gun ownership was required for Medicaid benefits.⁵⁸ These are only the cases reported directly to the legislature, with many more patients potentially not seeking out their state legislators to report similar incidents. This pattern of behavior demonstrates a lack of respect for those patients' basic civil liberties, including gun ownership. States should be able to regulate such behavior by licensed professionals.

Further, doctors should respect patients' civil liberties, such as gun ownership and privacy, because patients are a captive audience with little opportunity to rebut or question politically biased treatment regimens.⁵⁹ Patients are in a vulnerable position and are not in the doctor's office to argue the politics of gun control or any other hot-button political issue unrelated to their medical care. When doctors masquerade their political opinions as medical advice, they place patients in the uncomfortable position of having to passively agree to comply with the doctor's recommendation in order to avoid disrupting the relationship with their

55. AM. MED. ASS'N, CODE OF MEDICAL ETHICS, PRINCIPLES OF MEDICAL ETHICS: PATIENT-PHYSICIAN RELATIONSHIPS § 1.1.7 (2016), <https://www.ama-assn.org/delivering-care/physician-exercise-conscience> [<https://perma.cc/675C-XQXK>].

56. *See* *Wollschlaeger v. Governor of Fla.*, 814 F.3d 1159, 1168 n.2 (11th Cir. 2015) (pointing out several undisputed instances of doctors discriminating against gun owners).

57. *Id.*

58. *Id.*

59. *See generally* *Madsen v. Women's Health Ctr., Inc.*, 512 U.S. 753, 768 (1994) (recognizing an interest of patients in "medical privacy" to protect "not only the psychological, but also the physical, well-being of the patient held 'captive' by medical circumstance").

doctor.⁶⁰ Physicians are in increasingly short supply, so a patient may be hesitant to jeopardize his relationship with his current physician, even when the doctor tramples over important fundamental rights.⁶¹ As patients endure the intrusion, many may lose faith in the biased doctor's objectivity, respect for the patient's beliefs, and medical scientific rigor. States should be able to act in patients' best interests by requiring doctors to restrict their regimens to truthful disclosures of nonbiased medical advice.⁶²

B. Gun Ownership May Result in Health Benefits in Many Patients' Best Interests that Should be Considered in Unbiased Professional Medical Recommendations

Politically biased, one-sided, gun ownership admonitions may cause harm to patients by denying those patients secondary health benefits related to gun ownership and gun-related recreational activities. For example, benefits from gun ownership may include: (1) self-defense, avoiding personal injury; (2) physical exercise; (3) social interaction and support; (4) mental benefits from exposure to the outdoors; (5) a positive psychological sense of autonomous self-determination and personal integrity; and (6) other less obvious health benefits both for the individual patient and for society as a whole. Further, politically biased physician admonitions are not founded upon sound medical studies, and states may reasonably decide that these conversations have no place in patient-physician treatment communications. In fact, there are many health benefits of gun ownership that politically biased physicians are potentially overlooking.

60. *Id.* (noting that some patients are "held 'captive' by medical circumstance"); Marsha Mercer, *How to Beat the Doctor Shortage*, AARP BULL. (Mar. 2013), <http://www.aarp.org/health/medicare-insurance/info-03-2013/how-to-beat-doctor-shortage.html> [<https://perma.cc/C62F-SYTA>] (noting difficulties that Medicare patients are having even finding a primary care doctor—making it difficult to consider switching doctors since they have problems finding a doctor in the first place).

61. Press Release, Association of American Medical Colleges, New research shows increasing physician shortages in both primary and specialty care (Apr. 11, 2018), https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/ [<https://perma.cc/D5W8-ZUJA>] (noting a "serious threat posed by a real and significant doctor shortage").

62. In some instances—perhaps including patients with mental illness, suicidal ideation, or young children in the home—states should not be allowed to prohibit balanced, medically relevant gun ownership conversations in the patients' best interests, as discussed *infra*.

First, the ability to defend oneself has undeniable health benefits. In addition to potentially preserving life and limb, the ability to provide for one's own autonomous self-preservation against crime likely provides significant mental health benefits because of the feeling of personal security.⁶³ One expert estimated that guns are defensively used to resist crime by up to 2.5 million Americans annually—including up to 1.9 million defensive uses of handguns annually.⁶⁴ When people use guns defensively, whether discharged or not, the potential victim's health may be preserved by avoiding assault, murder, rape, or other potential injuries. The health care system generally does not detect the outcomes of these defensive-use encounters as injuries because the gun often acts as a deterrent, thereby preventing injury in the first place.⁶⁵ Thus, doctors only see the people guns injure—not the ones guns save—leading to potential physician bias against gun ownership based on skewed professional exposure.

Further, the mere presence of guns in the community may prevent injuries related to violent crimes where potential criminals are fearful of armed citizens. One expert writes:

[S]urveys among prison inmates find that large percentages [of prisoners] report that their fear that a victim might be armed deterred them from confrontation crimes. “[T]he felons most frightened ‘about confronting an armed victim’ were those from

63. See generally David K. Sherman & Geoffrey L. Cohen, *The Psychology of Self Defense: Self-Affirmation Theory*, 38 *ADVANCES IN EXPERIMENTAL SOC. PSYCHOL.* 183, 184 (2006) (noting the importance of “psychological adaptations that help people protect their self-integrity in response to threat”); see Justin McCarthy, *More than six in ten Americans say guns make home safer*, *GALLUP* (Nov. 7, 2014), <https://news.gallup.com/poll/179213/six-americans-say-guns-home-s-safer.aspx?version=print> [<https://perma.cc/8MN5-GN57>] (implying that over six in ten Americans would feel less safe in their homes and thus feel less personal security without guns since 63% “believe having a gun in the house makes it a safer place to be”); see also Keith Ablow, M.D., *The psychology and public health benefits of gun ownership*, *FOX NEWS* (Jan. 15, 2013), <http://www.foxnews.com/opinion/2013/01/12/psychological-and-public-health-benefits-gun-ownership.html> [[https://perma .cc/AUX6-8UTG](https://perma.cc/AUX6-8UTG)] (where a psychiatrist notes the “potential widespread psychological harm that disarming Americans could cause”).

64. G. Kleck & M. Gertz, *Armed Resistance to Crime: The Prevalence and Nature of Self-Defense with a Gun*, 86 *J. CRIM. L. & CRIMINOLOGY* 150, 164 (1995).

65. See *id.* at 168 (noting that the “health system cannot shed much light on [defensive gun use], since very few of these incidents involve injuries”).

states with the greatest relative number of privately owned firearms.” Conversely, robbery is highest in states that most restrict gun ownership.⁶⁶

Thus, a reasonable argument can be made that gun owners provide secondary health benefits to non-gun owners by preventing a significant number of injuries.

Second, an overlooked health benefit of gun ownership is physical exercise, which is especially important in an increasingly sedentary and obese American population.⁶⁷ Gun ownership contributes to physical exercise and exertion through activities such as hunting, practicing at a shooting range, and other target shooting activities. Thomas Jefferson wrote: “A strong body makes the mind strong. As to the species of exercise, I advise the gun. While this gives a moderate exercise to the body, it gives boldness, enterprize, and independence [sic] to the mind.”⁶⁸

In 2017, approximately 15.63 million Americans participated in hunting activities.⁶⁹ Preparing camouflaged areas to hunt, hiking, carrying a rifle, and eye–hand coordination are aspects of hunting that require physical activity.⁷⁰ In 2016, more than 20 million Americans participated in target shooting regularly, and “nearly 50 million Americans take aim at a target each year”—including 13.8 million handgun shooters, 12.2 million rifle enthusiasts, 10 million participants in shotgun sports—like

66. Don Kates, *The Limited Importance of Gun Control from a Criminological Perspective*, in *SUING THE GUN INDUSTRY: A BATTLE AT THE CROSSROADS OF GUN CONTROL AND MASS TORTS* 62, 70 (Timothy D. Lytton ed., 2005).

67. See generally *Overweight and Obesity Statistics*, NAT’L INST. DIABETES & DIGESTIVE & KIDNEY DISEASES, <https://www.niddk.nih.gov/health-information/health-statistics/Pages/overweight-obesity-statistics.aspx> [<https://perma.cc/UJ4Z-TFAW>] (last visited Sept. 7, 2018) (noting that more than two-thirds of Americans “were considered to be overweight or to have obesity” in a national survey).

68. Thomas Jefferson Found., Inc., *Exercise*, JEFFERSON MONTICELLO, <https://www.monticello.org/site/research-and-collections/exercise> [<https://perma.cc/9T63-V699>] (last visited Oct. 1, 2018).

69. *Number of Participants in Hunting in the United States from 2006 to 2017*, STATISTA: THE STAT. PORTAL, <https://www.statista.com/statistics/191244/participants-in-hunting-in-the-us-since-2006/> [<https://perma.cc/7JMZ-UGVJ>] (last visited Nov. 12, 2018).

70. *Top 10 Health Benefits of Hunting*, HEALTH FITNESS REVOLUTION (May 8, 2015), <http://www.healthfitnessrevolution.com/top-10-health-benefits-hunting/> [<https://perma.cc/2LKJ-8AF8>].

trap or skeet—and 3.3 million muzzle-loading shooters.⁷¹ In fact, “[m]ore people participate in target shooting than play tennis, soccer, or baseball.”⁷² Shooting targets includes physical activities like preparing and refilling the throwing device, walking, carrying a shotgun, setting up a rifle, using eye–hand coordination, and maintaining sharp mental focus while shooting at the target.⁷³ In a nation in which obesity is becoming a greater health issue,⁷⁴ physicians should be encouraging participation in interests that promote physical activity like shooting sports.

Third, gun-related activities can foster a community to help establish important social networks that are crucial to patients’ health.⁷⁵ Social interaction among hunters, target shooters, and other gun owners is important in many cultures across the United States—especially in rural America.⁷⁶ Family and friends pass along hunting traditions that lead to social bonding among participants.⁷⁷ This social bonding helps solidify healthy social support networks, particularly in rural areas where there are fewer opportunities for social interaction than in more urban

71. *Target Shooting in America: An Economic Force for Conservation*, NAT’L SHOOTING SPORTS FOUND., SOUTHWICK ASSOCIATES (2018 ed.), <https://d3aya7xwz8momx.cloudfront.net/wp-content/uploads/2018/09/Target-Shooting-in-America-Economic-Impact-report-2018.zip.pdf> [<https://perma.cc/AL2J-PFNT>] (last visited Sept. 7, 2018).

72. *Id.*

73. *See generally Target Shooting in America*, NAT’L SHOOTING SPORTS FOUND., INC. (2013), <http://www.nssf.org/PDF/research/TargetShootingInAmericaReport.pdf> [<https://perma.cc/4CK5-8S27>] (last visited Oct. 1, 2018) (discussing the many different types of target shooting and economic impact nationwide); *see also* Chuck Raasch, *In Gun Debate, Its Urban Versus Rural*, USA TODAY (Feb. 27, 2013, 12:26 PM), <https://www.usatoday.com/story/news/nation/2013/02/27/guns-ingrain-ed-in-rural-existence/1949479/> [<https://perma.cc/W2NZ-E5GS>] (where a pediatrician notes that shooting sports “very much help[] the self-discipline and concentration”).

74. *Overweight and Obesity Statistics*, *supra* note 67.

75. *See generally* Kristen P. Smith & Nicholas A. Christakis, *Social Networks and Health*, 34 ANN. REV. SOC. 405, 406 (Mar. 24, 2008), <https://www.annualreviews.org/doi/pdf/10.1146/annurev.soc.34.040507.134601> [<https://perma.cc/LHX9-QLNY>] (noting that social networks affect health through many mechanisms including providing social support, social influence, social engagement, and access to resources like jobs, money and information).

76. *See* Raasch, *supra* note 73 (“In parts of the country, shooting and hunting aren’t a way of life. They are life.”).

77. *Id.* (noting that “shooting is a good outdoor family activity, a good way to get kids . . . out of sedentary lifestyles” to teach kids important values and that rural gatherings around shooting sports are not just a “way of life,” they “are life”).

environments, due simply to the decreased concentration of people in rural versus urban areas.⁷⁸

Fourth, gun-related activities often take place outdoors. Studies have shown that outdoor activities help improve mental health, lower blood pressure, decrease stress hormones, lower the risk of early death, among many other potential health benefits.⁷⁹ Whether it involves sitting in a deer stand or duck blind, walking across a pheasant field, or being outside at a target range, psychological benefits of being outside and active exist.⁸⁰ Health benefits include improved short-term memory, restored mental

78. See, e.g., Nathan Eagle et al., *Community Computing: Comparisons between Rural and Urban Societies using Mobile Phone Data* 5–6, MIT, http://realitycommons.media.mit.edu/pdfs/Eagle_community.pdf [https://perma.cc/7QB3-6UWT] (last visited Oct. 28, 2018) (noting “diversification and growth of personal networks as individuals live or move to large urban areas”).

79. See, e.g., Kevin Loria, *Being outside can improve memory, fight depression, and lower blood pressure—here are 12 science-backed reasons to spend more time outdoors*, BUS. INSIDER (Apr. 22, 2018), <https://www.businessinsider.com/why-spending-more-time-outside-is-healthy-2017-7> [https://perma.cc/82WH-D3X5] (stating that being outdoors can lead to improvements in short term memory, decrease stress hormones, reduce inflammation, decrease mental fatigue, fight depression and anxiety, protect vision, lower blood pressure, improve focus and creativity, possibly prevent cancer, boost the immune system, among other positive health effects); David Pearson, *The Great Outdoors: Exploring the mental health benefits of natural environments*, 5 (1178) FRONTIERS IN PSYCHOL. 1, 1 (Oct. 2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4204431/pdf/fpsyg-05-01178.pdf> [https://perma.cc/CG5T-H79C] (last visited Sept. 7, 2018) (citing “growing evidence that exposure to natural environments can be associated with mental health benefits”); Caroline Piccininni et al., *Outdoor play and nature connectedness as potential correlates of internalized mental health symptoms among Canadian adolescents*, 112 PREVENTIVE MED. 168 (2018), <https://reader.elsevier.com/reader/sd/CA88EA0CBC6C6201169CDF78539CFC96980037F641C6E69474032945CB809DE2B041A86C7595BF68800CCAA1C7D6EC82> [https://perma.cc/TQ8Q-CGCB] (last visited Sept. 7, 2018) (noting “[e]xposures to outdoor environments have great potential to be protective factors for the mental health of young people”).

80. *Harvard Health Letter: A Prescription for Better Health: Go Alfresco*, HARV. HEALTH PUBLICATIONS (July 2010), http://www.health.harvard.edu/newsletter_article/a-prescription-for-better-health-go-alfresco [https://perma.cc/6Y3X-GP6W]; Lauren Friedman & Kevin Loria, *Eleven Scientific Reasons You Should be Spending More Time Outside*, BUS. INSIDER (Apr. 22, 2016, 11:48 AM), <http://www.businessinsider.com/scientific-benefits-of-nature-outdoors-2016-4/#1-improved-short-term-memory-1> [https://perma.cc/4M7G-NPCF]; see also *supra* note 79.

energy, reduced stress, and many others.⁸¹ Being outside also gives today's tech-barraged society a break from phones and computers, further reducing stress and anxiety.⁸²

Fifth, people benefit from healthy meals resulting from successful hunting activities. Game meat is lean and high in protein—in other words, it is healthier than processed foods that people might otherwise consume from the supermarket.⁸³ Specifically, the average annual whitetail deer harvest alone provides around 1.4 billion healthy meals.⁸⁴ Some of these meals feed the poor, with hunters donating 11 million venison meals in 2014 alone to food banks, helping to fulfill a shortfall of “high cost meat” with “protein-rich, low fat” meat.⁸⁵ On average, a single deer yields around 50 pounds of meat that can feed 200 people at 25¢ per serving of chili or spaghetti.⁸⁶ One observer noted, “Without venison, some of these organizations would not have protein . . . to give” to the poor.⁸⁷ Similarly, in 2010, 11 million donated meals were served from 2.8 million pounds of deer, elk, antelope, moose, pheasant, and waterfowl meat.⁸⁸ Thus, nonbiased physicians should recognize that for some patients, hunting may lead to lean, healthy meals that promote health in hunters and help feed the poor.

81. Friedman & Loria, *supra* note 80.

82. *Supra* note 79.

83. *Supra* note 70; *see also* Press Release, National Shooting Sports Foundation, Hunters venison donations provide 11 million meals to people in need (Oct. 30, 2014), <https://www.nssf.org/hunters-venison-donations-provide-11-million-meals-to-people-in-need/> [<https://perma.cc/C4NW-U3VP>] (noting the donations of “protein-rich, low-fat venison”).

84. *America's Deer Harvest by the Numbers*, ROUNDTREE, <https://business.realtree.com/business-blog/america%E2%80%99s-deer-harvest-numbers> [<https://perma.cc/2A6E-98H8>] (last visited Oct. 1, 2018).

85. National Shooting Sports Foundation, *supra* note 83.

86. *Game Meat Donation Programs*, CONG. SPORTSMEN'S FOUND., <http://sports.menslink.org/policies/state/game-meat-donation-programs> [<https://perma.cc/RW23-5XHD>] (last visited Oct. 1, 2018).

87. National Shooting Sports Foundation, *supra* note 83.

88. *Id.*

Sixth, a secondary benefit related to gun ownership and deer hunting is diminishing the risk of motor vehicle accidents⁸⁹ and Lyme disease⁹⁰ by naturally thinning the deer herd. Over 10,000 people are injured each year in deer collisions.⁹¹ In 2012, over 200 people died in deer collisions, and State Farm estimates the financial cost of deer collisions at \$4 billion annually;⁹² depending on where you live, up to 1 in 41 drivers will have a claim related to collision with a deer.⁹³ The average cost per claim is around \$4,000.⁹⁴

Further, Lyme disease is a significant medical risk associated with deer ticks, and communities—even as exclusive as Martha’s Vineyard—are looking for ways to reduce deer herds.⁹⁵ In 2015, there were 14.84 million hunting license holders who paid \$821 million to their states;⁹⁶ thus, hunters can provide a cost-effective, revenue-producing, partial solution to deer-related motor vehicle crashes and to Lyme disease.

For the health benefits noted above, doctors should consider the potential health benefits of gun ownership when balancing the best interests of the patients in their professional consultations. States should

89. See Dustin L. Smoot et al., *Patterns in Deer-Related Traffic Injuries over a Decade*, SCANDINAVIAN J. TRAUMA, RESUSCITATION & EMERGENCY MED. (Aug. 2010), https://www.researchgate.net/publication/45694370_Patterns_in_deer-related_traffic_injuries_over_a_decade_the_Mayo_Clinic_experience [<https://perma.cc/QG C2-XN3P>] (“Continued study of cost-effective preventive measures aimed at reducing the number of deer crossing motor ways appears to have the best chance of decreasing the spread of this rural menace.”).

90. See David J. Morris, *Deer Herd Reduction Equals Lyme Reduction*, VINEYARD GAZETTE (Nov. 10, 2016, 6:08 PM), <https://vineyardgazette.com/news/2016/11/10/deer-herd-reduction-equals-lyme-reduction> [<https://perma.cc/NME6-RBJR>] (noting local hunters are “willing to assist in addressing this medical scourge by reducing the size of the deer herd on the Island,” which is estimated to be four times higher than appropriate).

91. *Deer vs. Car Collisions*, CULTURE SAFETY, <https://cultureofsafety.thesilverlining.com/driving/deer-vs-car-collisions> [<https://perma.cc/5LT3-DC4M>] (last visited Oct. 1, 2018).

92. *Car and Deer Collisions Cause 200 Deaths, Cost \$4 Billion a Year*, INS. J. (Oct. 24, 2012), <http://www.insurancejournal.com/news/national/2012/10/24/267786.htm> [<https://perma.cc/Z86Q-MYSD>].

93. *Lookout! Deer Damage Can Be Costly*, STATE FARM (Sept. 19, 2016), <https://newsroom.statefarm.com/state-farm-releases-2016-deer-collision-data#hwcrITrYxHTFvZ4C.97> [<https://perma.cc/3G9B-Z2CY>].

94. *Id.*

95. Morris, *supra* note 90.

96. *National Hunting License Report*, U.S. FISH & WILDLIFE SERV. (May 5, 2015), <https://wsfirprograms.fws.gov/subpages/licenseinfo/HuntingLicCertHistory20042015.pdf> [<https://perma.cc/FT5F-U5ZM>].

be able to discipline politically biased doctors who act unprofessionally by unnecessarily interrogating, harassing, or refusing to care for lawful gun owning patients.

C. Convincing Medical Evidence Does Not Exist to Support Some Physicians' Recommendations that All Patients Forego Gun Ownership for Health Benefits

Physicians have inadequate medical data to scientifically argue that ordinary patients should receive medical counseling encouraging them to forego gun ownership. In fact, much evidence exists to the contrary.

First, decreasing gun ownership in society as a whole is likely to increase homicide rates, a negative public health outcome leading to an obvious health issue for the victims—death—along with anxiety and anxiety-related health consequences in others. A 2007 study published in the *Harvard Journal of Law and Public Policy* concluded that “the long term macrocosmic evidence is that gun ownership spread *widely* throughout societies *consistently correlates* with stable or *declining* murder rates.”⁹⁷ The study notes “the consistent international pattern is that more guns equal *less* murder and other violent crime . . . [I]f firearms availability does matter, the data consistently show that the way it matters is that more guns equal *less* violent crime.”⁹⁸

As an example, the authors point out that “despite constant and substantially increasing gun ownership” in the United States during the 1990s, the country “saw progressive and dramatic reductions in criminal violence.”⁹⁹ In contrast, during that same time period of the 1990s, the United Kingdom banned and confiscated all handguns, yet “criminal violence rampantly *increased* so that by 2000 England surpassed the United States to become one of the developed world’s most violence-ridden nations.”¹⁰⁰ The authors explained that “the extent of gun ownership in a society does not spur the murder rate” because “law-abiding, responsible people . . . are not the ones who rape, rob, or murder.”¹⁰¹ Rather, “[a]lmost all murderers are extremely aberrant individuals with life histories of violence, psychopathology, substance abuse and other dangerous behaviors” with the clear majority having long

97. Don B. Kates & Gary Mauser, *Would Banning Firearms Reduce Murder and Suicide? A Review of International and Some Domestic Evidence*, 30 HARV. J.L. & PUB. POL’Y 649, 673 (2007) (emphasis added).

98. *Id.*

99. *Id.* at 656.

100. *Id.* (emphasis added).

101. *Id.* at 660–61.

criminal records.¹⁰² Therefore, routinely telling ordinary citizens in the doctor's office to forego gun ownership is not likely to provide any health benefit in population homicide avoidance.

Second, when guns are banned, citizens substitute them with other weapons. Limiting law abiding citizens' access to firearms does not decrease homicide; studies of homicides comparing countries suggest that "where guns are scarce other weapons are substituted in killings."¹⁰³ One author noted:

Gun-less societies are not necessarily less murderous than a society, such as the United States, which is often characterized as gun-ridden. Rather the gun-less societies noted here were considerably *more murderous* than the United States. Historically, for whatever reason, centuries characterized by murder decreases have gone hand-in-hand with the development and diffusion of guns in various societies. For whatever reason, in modern Europe, nations whose populations have much *higher gun ownership have much lower murder rates* than low gun ownership nations. As to the United States: the colonial period of universal gun ownership saw few murders and few of those were gun murders; the 1840s and 1850s, during which gun ownership was no longer universal, saw an apparently rapid increase in murder; the post-Civil War period—in which armament with multi-shot, rapid-firing firearms became widespread—saw a decline in murders; and *over the past sixty-five years and beyond, a vast increase in citizen gun ownership saw a sharp decrease in murder.*¹⁰⁴

Other researchers agree. As one expert noted:

[T]here is no consistent significant positive association between gun ownership levels and violence rates across (1) time, within the United States, (2) U.S. cities, (3) counties within Illinois, (4) county-sized areas in England, (5) U.S. cities, (5) [sic] regions of the United States, (6) nations, or (7) population subgroups, such as those defined by age, race, income, or marital status.¹⁰⁵

102. *Id.* at 666.

103. *Id.* at 651–52.

104. Don B. Kates & Karlisle Moody, Heller, McDonald, and Murder: *Testing the More Guns = More Murder Thesis*, 39 FORDHAM URB. L.J. 1421, 1446–47 (2012) (emphasis added).

105. GARY KLECK, TARGETING GUNS: FIREARMS AND THEIR CONTROL 22–23 (1997) (summarizing patterns of numerous studies).

Similarly, another expert, who focused primarily on the United States, found that “more guns” correlated with “less crime” after analyzing nationwide data.¹⁰⁶

Third, handgun ownership does not correlate with violence. A Johns Hopkins researcher found that there was no correlation between handgun ownership and violence:

If you are surprised by this finding, so am I. I did not begin this research with any intent to “exonerate” handguns, but there it is—a negative finding, to be sure, but a negative finding is nevertheless a positive contribution. It directs us *where not to aim public health resources*.¹⁰⁷

Researchers reviewing international and domestic evidence, like the Johns Hopkins study above, concluded that “correlations are not observed when a large number of nations are compared across the world” between more guns and more deaths, or between more stringent gun laws and reductions in criminal violence or suicides.¹⁰⁸

Physicians do not have a scientific, medical justification to adopt all-encompassing public health stances against gun ownership. Further, some studies suggest that such anti-gun stances could lead to poorer public health, more violence, and more homicide.¹⁰⁹ States should be able to require physicians to act in their patients’ best interests by recognizing both sides of firearm discussions and avoiding politically biased treatment recommendations.

Often, firearm discussions are an appropriate part of the patient–physician encounter. One such situation involves patients who might be at risk for suicide since around two-thirds of gun-related deaths are

106. *An interview with John Lott, Jr., author of More Guns, Less Crime: Understanding Crime and Gun Control Laws*, U. CHI. PRESS (1998), <http://www.press.uchicago.edu/Misc/Chicago/493636.html> [https://perma.cc/7KCH-YDA2] (discussing Lott’s book researching gun laws and their relationship with crime and stating that “[s]tates with the largest increases in gun ownership also have the largest drops in violent crimes” based upon data from “all 3,054 counties in the United States . . . from 1977 to 1994”).

107. Brandon Centerwall, *Author’s Response to “Invited Commentary: Common Wisdom and Plain Truth,”* 134 AM. J. EPIDEMIOLOGY 1264, 1264 (1991) (emphasis added).

108. Kates & Mauser, *supra* note 97, at 693–94.

109. *See generally id.*; *see also* Centerwall, *supra* note 107.

suicides.¹¹⁰ Some studies show a higher risk of suicide in homes in which a gun is present.¹¹¹ Therefore, suicidal ideation and mental illness are justifications for a clinical discussion related to gun ownership. Although removing guns from the home of a suicidal patient makes medical sense, physicians should also consider the necessity of other medical interventions; patients who are motivated to commit suicide may simply use other means.¹¹² For example, the suicide rate in gun-less Russia is four times higher than that in America.¹¹³ With regard to mental illness, patients with dementia and some other mental illnesses may also benefit from gun ownership conversations to prevent unintentional injury.¹¹⁴

Likewise, a truthful discussion about the risks of gun ownership and storage with parents of small children has medical merit—just as conversations about other risky activities like bicycle-riding or swimming have medical merit. In 2015, there were reportedly 265 incidents in which children accidentally shot either themselves or another person, totaling 83 fatalities.¹¹⁵ By comparison, in 2014, bicycle crashes injured 12,000 children age 19 and under with 91 fatalities.¹¹⁶ In addition, the Center for Disease Control (“CDC”) estimates that over 700 children die in non-boating related drownings annually with thousands of survivors sustaining

110. Kenneth Kochanek et al., *Deaths: Final Data for 2014*, 65 NAT’L VITAL STAT. REP. 44, 45 (June 30, 2016) (noting in 2014, 21,386 of 33,594 firearm-related deaths were suicides).

111. Injuries and Violence Prevention Dep’t, *Small Arms and Global Health*, WORLD HEALTH ORG. 11 (2001); see also Kochanek et al., *supra* note 110, at 45.

112. Kates & Mauser, *supra* note 97, at 662.

113. *Id.*

114. Lynn Meuleners et al., *A population based study examining injury in older adults with and without dementia*, 65(3) J. AM. GERIATRICS SOC. 520, 520 (Mar. 2017) (observing that “[o]lder adults with dementia are at greater risk for a hospital admission for an injury” and recommending safety and prevention programs for dementia patients); Gregory Simon et al., *Mortality rates after the first diagnosis of psychotic disorder in adolescents and young adults*, 75(3) J. AM. MED. ASS’N PSYCHIATRY 254, 254 (2018) (noting an increased risk of early mortality in young persons experiencing their first onset of psychosis, including an increased suicide risk).

115. Adam Lidgett, *Accidental Gun Deaths Involving Children Are a Major Problem In the U.S.*, INT’L BUS. TIMES (Jan. 6, 2016, 11:06 AM), <http://www.ibtimes.com/accidental-gun-deaths-involving-children-are-major-problem-us-2250568> [<https://perma.cc/5KMZ-2EK3>].

116. *Bicyclists and Other Cyclists: 2014 Data*, NAT’L HIGHWAY TRAFFIC SAFETY ADMIN. (May 2016), <https://crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/812282> [<https://perma.cc/44P6-LSK6>].

life-altering injuries.¹¹⁷ Thus, children are more likely to be the victims of bicycle or drowning accidents than gun accidents. So, an objective medical conversation about child healthcare discussing guns in children's homes should include other activities that have similar or higher risks; physicians should truthfully express the gun risk in relation to other risks and should discuss safe storage as an option. States should be allowed to require doctors to provide truthful, balanced, gun ownership advice—similar to some states' requirements regarding abortion counseling.¹¹⁸

Further, physicians have other more appropriate outlets to express their politicized, anti-gun sentiments outside the individual patient–physician relationship. For example, doctors can voice their opinions through political groups like the AMA. In their personal lives outside of the patient–physician relationship, “doctors are constitutionally equivalent to soapbox orators and pamphleteers, and their speech receives robust protection under the First Amendment.”¹¹⁹ The AMA released a press release in 2016 in which a past president of the AMA said, the “shooting in Orlando is a horrific reminder of the *public health crisis* of gun violence *rippling across* the United States” with “*mass killers*” prowling the streets with “lethal weapons.”¹²⁰ Some have disagreed, describing the AMA's declaration of a public health crisis as a “purely political stunt” and a “pseudoscientific . . . disservice to the debate.”¹²¹

117. *Unintentional Drowning: Get the Facts*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/homeandrecreationalsafety/water-safety/water-injuries-factsheet.html> [<https://perma.cc/C6PF-RSP6>] (last updated Apr. 28, 2016).

118. *See* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992) (“If the information the State requires to be made available to the woman is truthful and not misleading, the requirement may be permissible.”).

119. *Pickup v. Brown*, 740 F.3d 1208, 1227–28 (9th Cir. 2013).

120. Press Release, American Medical Association, *AMA Expands Policy on Background Checks, Waiting Period for Gun Buyers* (June 15, 2016), <https://www.ama-assn.org/ama-expands-policy-background-checks-waiting-period-gun-buyers> [<https://perma.cc/QR4Y-T97Z>] (emphasis added).

121. Trevor Burrus, *No, Guns Are Not ‘A Public Health Crisis’*, FORBES (June 16, 2016, 3:04 PM), <https://www.forbes.com/sites/trevorburrus/2016/06/16/no-guns-are-not-a-public-health-crisis/#294afc937b07> [<https://perma.cc/8Q4D-YM NZ>] (stating that the AMA has “put their biases against guns on the table” with “inevitabl[e] result [being] studies that focus only on the costs of guns and none of the benefits, either in the form of subjective pleasure or in personal defense”); Jason Richwine, *‘Guns Are a Public-Health Issue’ Is Not an Argument*, NAT'L REV. (June 16, 2016, 3:30 PM), <http://www.nationalreview.com/corner/436704/guns-public-health-concern-argument-disingenuous> [<https://perma.cc/4CVW-AWGH>] (describing the AMA's declaration as “covering of one's political beliefs with the veneer of scientific objectivity”).

In reality, at the time of the AMA's "crisis" proclamation that "mass killers" were "rippling" through the streets, there had been three mass shootings—killing a total of 61 people, including 49 in the Orlando shooting—in the first half of 2016, involving "mass killers" randomly killing over four people in a public place.¹²² Although these killings are terrible public tragedies, the AMA's declaration of a "crisis" seems scientifically questionable because the AMA did not proclaim public health crises for other, more common causes of preventable deaths like accidental poisoning, motor vehicle accidents, or falls.¹²³

Further, even the AMA's post-Orlando "crisis" declaration does not advocate harassment and discrimination against lawful gun owners or medically irrelevant physician inquiries and medical record entries. Instead, the declaration calls for waiting periods and background checks—a reasonable exercise of First Amendment rights in the public arena far removed from the individual patient–physician relationship.¹²⁴ Therefore, physicians should not use the AMA's "public health crisis" statement to justify harassment and discrimination against lawful gun owners.

Similarly, after the recent mass shooting in Las Vegas, some physicians again declared in a headline in the *Journal of the American Medical Association*, "Death by Gun Violence—A Public Health Crisis."¹²⁵ Pivoting from the Las Vegas shooting, the authors used medical terminology to declare guns an "epidemic" from which physicians should "reduce exposure to the cause," in effect equating guns to germs.¹²⁶ Although this rhetoric is a reasonable exercise of First Amendment rights from the public pulpit of an AMA publication, individual physicians are misguided if they interpret the hyperbole literally and use it to discriminate

122. Willingham & Ahmed, *supra* note 2 (using the definition preferred in some Congressional reports focusing on "gunmen who select victims indiscriminately"—killing four or more people and not involving gang violence or a domestic relations incident—which is in line with the point in the AMA's media release describing mass killers rippling through the streets; also, confirming that the numbers change depending upon how "mass shooting" is defined and therefore, can be manipulated for political purpose).

123. *FastStats: Accidents or Unintentional Injuries*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/nchs/fastats/accidental-injury.htm> [<https://perma.cc/9H8J-2SPV>] (last updated Mar. 17, 2017) (including examples of numerous other preventable causes of unnecessary death that are much more prevalent than "mass shootings").

124. See American Medical Association, *supra* note 120.

125. Bauchner et al., Editorial, *Death by Gun Violence: A Public Health Crisis*, 318 J. AM. MED. ASS'N 1753 (2017), <https://jamanetwork.com/journals/jama/fullarticle/2657417> [<https://perma.cc/6VUM-Y5MY>].

126. *Id.*

against or harass their law abiding, gun-owning patients. States have the authority to regulate such activity inside the patient–physician relationship.

Many physicians do not see the value of patients' fundamental rights of gun ownership and privacy.¹²⁷ This may be because of demographics, as physicians often live in upscale, suburban neighborhoods where self-defense is not an urgent concern and recreational gun-related activities are uncommon.¹²⁸ Physician bias against gun ownership also may be related to skewed professional exposure to those injured by gun use, as doctors are less likely to be aware of people who avoided injury due to defensive gun use.

Some physician research on gun violence demonstrates this naivete. For example, one oft-quoted article focused only on how many intruders were killed in homes as a sign of the benefit of gun ownership, failing to recognize overall societal and other health benefits associated with Americans' Second Amendment rights.¹²⁹

Doctors abuse their elevated positions in the workplace when they use political bias to harass or discriminate against lawful gun owners in the context of the patient–physician relationship. The best interests of patients are protected by: (1) discouraging harassment and discrimination against lawful gun owners; (2) recognizing that gun ownership can have health benefits for individual patients and for society; and (3) limiting politicized opinions to a more appropriate arena than the patient–physician relationship. States, therefore, should have the authority to regulate politicized physician speech regarding gun issues to protect patients' best interests.

127. While serving several years in physician leadership positions and while working with other doctors, I often heard some physicians express a lack of respect for basic gun ownership rights when these issues came up. *See also supra* notes 56–58.

128. *See* Roger Rosenblatt & Gary Hart, *Physicians and Rural America*, 173 W. J. MED. 348, 348–51 (2000) (describing “geographic maldistribution” of health care providers as “one of the most deep-seated characteristics of the American health care system” with physicians preferentially practicing in “relatively affluent urban and suburban areas”).

129. A.L. Kellerman & D.T. Reay, *Protection or Peril? An Analysis of Firearm-Related Deaths In the Home*, 314 NEW ENG. J. MED. 1557 (1986) (questioning the advisability of keeping firearms in homes by focusing only on the number of intruders actually killed inside homes without recognizing most of the deterrence, societal, and personal health benefits mentioned in this Article or the underlying Second Amendment benefits outlined by the Supreme Court in *Heller*).

II. STATES SHOULD ENHANCE PATIENT PRIVACY PROTECTIONS
REGARDING GUN OWNERSHIP BY PROHIBITING HARMFUL PHYSICIAN
SPEECH WHERE NECESSARY TO PROTECT THE BEST INTERESTS OF
PATIENTS

Patients' best interests may include privacy protections when it comes to politicized health issues—especially when physicians discriminate, harass, or give politicized advice. Physicians sometimes subject lawful gun owners to intrusive questioning and discriminatory behavior.¹³⁰ Therefore, gun-owning patients' health may benefit from privacy protections in states where physicians engage in medically unnecessary partisan probes regarding gun ownership.

States have wide discretion to use police power to protect the health of their citizens. The U.S. Constitution reserved a generalized police power to the states while creating a federal government of limited powers.¹³¹ The scope of the states' police power is broad and “coextensive with the necessities of the case and the safeguards of the public interest.”¹³² The police power is “as broad as the public welfare or necessity” and is one of the “least limitable of the powers of government.”¹³³ Inherent in the police power is the ability of the state to provide for the public health, general welfare, and safety of its citizens, including all matters within the states' regulation and control.¹³⁴ States have “wide discretion” to determine their own public policy and the measures necessary to “promote safety, peace, and good order of its people.”¹³⁵

Patient privacy is important. At the federal level, Congress has enacted extensive legislation to protect patient privacy—like the Health Insurance Portability & Accountability Act (“HIPAA”)—recognizing the importance of protecting patient information.¹³⁶ The U.S. Constitution includes a general right to privacy emanating as a penumbra from the Bill of Rights;

130. See *Wollschlaeger v. Governor of Fla.*, 814 F.3d 1159, 1168 n.2 (11th Cir. 2015) (outlining several instances of physicians making idle inquiries, harassing, and/or discriminating against lawful gun owners); see *infra* notes 154–58.

131. 16A C.J.S. *Constitutional Law* § 702 (2018). See *United States v. Morrison*, 529 U.S. 598, 607, 610 (2000) (noting the “powers of the legislature are defined and limited” (citing *Marbury v. Madison*, 1 Cranch 137, 176 (1803) and that “Congress' authority is limited to those powers enumerated in the Constitution”).

132. 16A C.J.S. *Constitutional Law* § 702.

133. *Id.*

134. *Id.*

135. *Id.*

136. 42 U.S.C. § 1320d (2009).

this right protects citizens from government intrusion and includes the right to make important personal decisions and avoid disclosure of important personal information.¹³⁷

Congress has specifically addressed firearm privacy rights in the ACA, which includes a section entitled “Protection of Second Amendment gun rights.”¹³⁸ The section can be characterized somewhat similarly to FOIA. First, an inquiry provision prohibits wellness prevention programs from requiring disclosures from patients regarding lawful gun or ammunition storage, possession, or use.¹³⁹ Second, a record-keeping provision prevents data collection regarding lawful gun or ammunition storage, possession or use, and further prevents the Secretary of HHS from forming databases that include gun or ammunition ownership.¹⁴⁰ Third, an anti-discrimination provision prevents consideration of lawful gun or ammunition ownership, possession or storage to be used in determining health insurance premiums.¹⁴¹ Fourth, an anti-harassment provision bans any requirements of patients to disclose lawful ownership, use, storage, or possession of guns or ammunition.¹⁴²

The constitutional right to privacy and the ACA protections, however, generally apply to government actors, not private physicians.¹⁴³ States are thus justified in placing additional privacy restrictions on state-licensed, professional relationships to protect patients' privacy rights, acknowledged in the Constitution and the ACA, against unnecessary gun ownership inquiries, data collection, harassment, or discrimination.

States should be able to require that licensed physicians collect gun ownership information from patients only when it is necessary to properly care for the patient and to require that advice be based upon medical evidence—not politics. Physicians' idle inquiries regarding gun ownership undermine the public trust necessary for patients to confidently

137. See *Eisenstadt v. Baird*, 405 U.S. 438, 454–55 (1972) (recognizing the right of privacy of unmarried persons while striking down a law barring contraceptives for unmarried persons); see also *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965) (discussing zones of privacy as a “penumbra” emanating from the Bill of Rights and other protections against governmental invasions of the “privacies of life”).

138. 42 U.S.C. §§ 300gg–17(c) (2012).

139. *Id.*

140. *Id.*

141. *Id.*

142. *Id.*

143. A private physician might arguably be a state actor when caring for Medicare, Medicaid, other government patients, or if the government directly employs him (e.g., the Veterans Administration).

communicate necessary medical information inside the patient–physician relationship.¹⁴⁴ Patients have a privacy interest in self-determination and autonomy that should be respected against third-party or political interests inside the patient–physician relationship.¹⁴⁵

Police powers empower states to enact privacy statutes to protect patients from medically unnecessary inquiries and patients’ rights of self-determination and autonomy. When a statute appears to be within the broad scope of the police power, courts “will not inquire into its wisdom and policy or undertake to substitute their discretion for that of the legislature.”¹⁴⁶ The police power encompasses “general moral and intellectual well-being and development,” including “the well-being and tranquility of a community.”¹⁴⁷ The police power extends to all laws that are “reasonably necessary” to promote public welfare.¹⁴⁸ The police power is “extensive, elastic, evolving, expanding, or contracting in response to changing conditions and needs.”¹⁴⁹

State gun privacy laws are well within states’ police power. The Supreme Court made it clear that “the protection of a person’s general right to privacy—his right to be let alone by other people—is . . . left largely to the law of the individual States.”¹⁵⁰ Unless the individual physician is a state actor, his inquiry into firearm ownership does not violate the patient’s constitutional right to privacy. But constitutional privacy law does not define the limits of state privacy laws; states often pass invasion of privacy laws that provide more protection than constitutional privacy protections.¹⁵¹ Specifically, “a state may provide its citizens with greater protection of individual rights than does the federal constitution.”¹⁵²

144. See discussion *supra* Part I.A.

145. See *Eisenstadt v. Baird*, 405 U.S. 438, 452–55 (1972); *Griswold v. Connecticut* 381 U.S. 479, 484 (1965); *Madsen v. Women’s Health Ctr., Inc.*, 512 U.S. 753, 768 (1994); Warren & Brandeis, *infra* note 153.

146. 16A C.J.S. *Constitutional Law* § 702 (2018).

147. *Id.*

148. *Id.*

149. *Id.*

150. *Katz v. United States*, 389 U.S. 347, 350–51 (1967).

151. See *Invasion of privacy*, CORNELL L. SCH. LEGAL INFO. INST., https://www.law.cornell.edu/wex/invasion_of_privacy [<https://perma.cc/MH77-X37L>] (last visited Oct. 1, 2018) (describing the “bundle of torts” defined by “invasion of privacy”).

152. J. THOMAS MCCARTHY, *THE RIGHTS OF PUBLICITY AND PRIVACY* § 5:56 (2d ed. 2016) (quoting *Wilcher v. City of Wilmington*, 139 F.3d 366, 379 (3d Cir. 1998)).

Samuel Warren and Louis Brandeis considered the “mental pain and distress” invasion of privacy causes to be “far greater than could be inflicted by mere bodily injury.”¹⁵³ A doctor’s unnecessary inquiries into lawful gun ownership in a patient’s home to satisfy idle partisan curiosity without medical justification, may inflict “mental pain and distress” on a lawful gun owner.

Florida presented evidence that physicians were making idle inquiries into patient gun ownership, giving medically unfounded advice to patients based on partisan ideas, and denying gun owning patients access to their services.¹⁵⁴ One pediatrician terminated the patient–physician relationship because a mother refused to answer the pediatrician’s questions about lawful gun possession in her home on privacy grounds.¹⁵⁵ Other doctors similarly refused care to a nine-year-old patient “because they wanted to know if [the child’s family] had a firearm in their home.”¹⁵⁶ One Florida legislator was told by a pediatrician to remove a gun from his home while consulting the physician inside the patient–physician relationship.¹⁵⁷ Another physician falsely claimed the patient was required to disclose firearm ownership as a requirement to qualify for Medicaid, although no such requirement exists.¹⁵⁸ Since many unreported incidents likely occur, these incidents may only represent the tip of the proverbial iceberg.

In response to the above incidents patients reported to the Florida Legislature, Florida’s FOPA began regulating professional conduct by prohibiting physicians’ inquiries and record-keeping about gun ownership when it is irrelevant to the patient’s medical care or the safety of others.¹⁵⁹ FOPA does not prohibit physicians’ relevant inquiries nor does it prevent firearm safety counseling in appropriate circumstances.¹⁶⁰ Until physicians from both political parties agree on gun-related issues,¹⁶¹ society should view controversial physician opinions unsupported in the medical literature as political opinions, not medical opinions.¹⁶² States should uphold laws preventing unnecessary, politically biased patient probes and

153. Samuel Warren & Louis Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193, 196 (1890).

154. *Wollschlaeger v. Governor of Fla.*, 814 F.3d 1159, 1168 n.2 (11th Cir. 2015).

155. *Id.*

156. *Id.*

157. *Id.*

158. *Id.*

159. *Supra* notes 17–18.

160. See 39 FLA. JUR. 2D *Physicians, Surgeons, and Other Healers* § 14.

161. Hersh & Goldenberg, *supra* note 6, at 11812–13 (demonstrating that medical opinions tend to differ regarding firearm issues along political party lines).

162. *Id.*

preventing distribution of political opinion masquerading as medical advice.

When patients' fundamental rights are at stake, even more scrutiny is warranted—and Americans' right to bear firearms is a fundamental right the Constitution guarantees.¹⁶³ If all physicians someday agree that citizens should avoid gun ownership, physicians must nonetheless respect patients' civil liberties and avoid discrimination and harassment of citizens exercising their civil liberties and rights—whether they agree with those personal choices or not.

State legislatures should be free to regulate physician political speech inside the exam room in the best interests of the patients. Idle inquiries, unnecessary record-keeping, harassment, and discrimination based on gun ownership are not in the best interests of patients; thus, states should be free to prohibit such unprofessional behavior—especially when it affects basic civil liberties like gun ownership.

III. PHYSICIANS' FREE SPEECH RIGHTS SHOULD GENERALLY GIVE WAY FOR THE BEST INTERESTS OF THE PATIENTS

Physician speech on gun issues is professional speech that receives diminished protection under the First Amendment. Intermediate scrutiny is the standard that should apply to politicized physician speech regarding guns. Under intermediate or strict scrutiny, well-written, patient gun privacy laws compelling physician silence on gun issues unrelated to the patient's medical care should survive constitutional challenge.

A. The Patient–Physician Relationship is a Professional Relationship Formed to Benefit the Patient's Health—Not an Opportunity for Free Discourse on Political Topics

The patient–physician relationship is a type of fiduciary relationship in which the patient is the beneficiary.¹⁶⁴ Although the AMA's Code of Medical Ethics is not binding law, it is informative of expectations in the patient–physician relationship as perceived by doctors.¹⁶⁵ Following

163. See generally *District of Columbia v. Heller*, 554 U.S. 570 (2008) (holding District of Columbia's ban on handguns violated the Second Amendment).

164. Mehlman, *supra* note 31, at 8 n.2.

165. See generally *Code of Medical Ethics Overview*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering-care/code-medical-ethics-overview> [<https://perma.cc/J6BA-8WYN>] (last visited Nov. 12, 2018) (stating that “since its adoption . . . in 1847, the AMA *Code of Medical Ethics* has articulated the

physicians' own expectations and definitions, the physician's right to express political opinion in the patient–physician relationship is extremely limited. According to the AMA, the patient–physician relationship begins with mutual consent between the patient and physician that exists when a physician “serves a patient’s medical needs.”¹⁶⁶ The AMA Code of Medical Ethics says that when it comes to patient–physician relationships, the physician has an “ethical responsibility to place patients’ welfare *above the physician’s own self-interest* or obligations to others, to use sound medical judgment on the patients’ behalf, and to advocate for their patients’ welfare.”¹⁶⁷ Those terms are typical of a fiduciary relationship.¹⁶⁸ The patient–physician relationship depends on a “collaborative effort” in a “mutually respectful alliance” in which patients are expected to be “candid.”¹⁶⁹ Physicians best contribute to the relationship when they are “patients’ advocates” and “respect[] patients’ rights.”¹⁷⁰ Patients have a right to “respect” and “dignity,” to expect “objective professional judgment,” and to have the “physician and other staff respect the patient’s privacy.”¹⁷¹ States generally have the authority to establish the boundaries of good medical practice and should be able to prevent exploitation of the patient–physician relationship by physicians wishing to offer political opinion as medical advice.¹⁷²

Physicians, however, are not defined “solely by their profession” and therefore have a right to “exercise[s] of conscience.”¹⁷³ Thus, “[c]ommon sense tells us that ‘[t]here is a difference, for First Amendment purposes,

values to which physicians commit themselves as members of the medical profession”).

166. AM. MED. ASS’N, CODE OF MEDICAL ETHICS, PRINCIPLES OF MEDICAL ETHICS: PATIENT-PHYSICIAN RELATIONSHIPS § 1.1.1 (2016), <https://www.ama-assn.org/delivering-care/patient-physician-relationships> [<https://perma.cc/9T3R-FPAB>].

167. *Id.* (emphasis added).

168. *See generally* Mehlman, *supra* note 31, at 2.

169. AM. MED. ASS’N, CODE OF MEDICAL ETHICS, PRINCIPLES OF MEDICAL ETHICS: PATIENT RIGHTS § 1.1.3 (2016), <https://www.ama-assn.org/delivering-care/patient-rights> [<https://perma.cc/UM2Q-Z2GC>].

170. *Id.*

171. *Id.*

172. *See, e.g.,* Gonzales v. Oregon, 546 U.S. 243, 271 (2006) (describing the regulation of health and safety as primarily a “local concern” (quoting Hillsborough Cty. v. Automated Med. Labs., Inc., 471 U.S. 707, 719 (1985))).

173. AM. MED. ASS’N, CODE OF MEDICAL ETHICS, PRINCIPLES OF MEDICAL ETHICS: PHYSICIAN EXERCISE OF CONSCIENCE § 1.1.7 (2016), <https://www.ama-assn.org/delivering-care/physician-exercise-conscience> [<https://perma.cc/675C-XQXK>].

between regulating professionals' speech to the public at large versus their direct, personalized speech with [patients]."¹⁷⁴ Physicians are "moral agents" informed and committed to "diverse cultural, religious, and philosophical traditions and beliefs."¹⁷⁵ Physicians "should have considerable latitude to practice in accord with well-considered, deeply held beliefs central to their self-identities."¹⁷⁶

"[P]hysicians' freedom to act according to conscience[, however,] is not unlimited."¹⁷⁷ For example, physicians must "respect basic civil liberties" and maintain "respect for patient self-determination."¹⁷⁸ Physicians should "not discriminate against or unduly burden individual patients or populations of patients" and should not "adversely affect patient or public trust."¹⁷⁹

The AMA Code of Medical Ethics seems to protect physicians' religious beliefs, not political opinions. Advocating politically biased gun ownership beliefs in the context of the patient–physician relationship should not be "central to [physician's] self-identit[y]" unless the physician's gun beliefs are somehow tied to deeply held religious beliefs.¹⁸⁰ The AMA's Code cautions doctors to "thoughtfully consider whether and how significantly an action . . . will undermine the physician's personal integrity, [or] create emotion or moral distress for the physician" before acting from the physician's personal sense of moral conscience.¹⁸¹ Following a law that forces the physician to respect patients' gun privacy rights but remain silent on his political opinions should not cause the kind of personal integrity crisis or moral distress envisioned in the AMA Code of Medical Ethics.

174. *Wollschlaeger v. Governor of Fla.*, 848 F.3d 1293, 1336 (11th Cir. 2017) (Tjoflat, J., dissenting) (quoting *Locke v. Shore*, 634 F.3d 1185, 1191 (11th Cir. 2011)).

175. AM. MED. ASS'N, CODE OF MEDICAL ETHICS, PRINCIPLES OF MEDICAL ETHICS: PHYSICIAN EXERCISE OF CONSCIENCE § 1.1.7 (2016), <https://www.ama-assn.org/delivering-care/physician-exercise-conscience> [<https://perma.cc/675C-XQXK>].

176. *Id.*

177. *Id.*

178. *Id.*

179. *Id.*

180. *Id.*

181. *Id.*

B. Compelled Physician Silence in Properly Written State Gun Privacy Laws Should Survive Constitutional Scrutiny

The First Amendment declares that states “shall make no law . . . abridging the freedom of speech.”¹⁸² “[S]peech on public issues occupies the highest rung of the hierarchy of First Amendment values, and is entitled to special protection.”¹⁸³ The Supreme Court has recognized that “the First Amendment reflects a ‘profound national commitment’ to the principle that ‘debate on public issues should be uninhibited, robust, and wide-open.’”¹⁸⁴ This is true because “above all else, the First Amendment means that government has no power to restrict expression because of its message [or] its ideas.”¹⁸⁵

However, “the fundamental right to speak secured by the First Amendment does not leave people at liberty to publicize their views whenever and however and wherever they please.”¹⁸⁶ “[I]t is well understood that the right of free speech is not absolute at all times and under all circumstances.”¹⁸⁷ The Supreme Court has offered professional speech diminished protection under two circumstances: (1) “some laws that require professionals to disclose factual, noncontroversial information in their ‘commercial speech’”; and/or (2) “[s]tates may regulate professional conduct, even though that conduct incidentally involves speech.”¹⁸⁸ Although the Supreme Court in *Becerra* recently did not find a “persuasive reason for treating professional speech as a unique category” exempt from “ordinary First Amendment principles,” the

182. U.S. CONST. amend. I; see *Gitlow v. New York*, 268 U.S. 652, 666 (1925) (noting “freedom of speech . . . [is] among the fundamental personal rights and ‘liberties’ protected by the due process clause of the Fourteenth Amendment from impairment by the States”); see also Benjamin Franklin, *On Freedom of Speech and the Press*, Pa. Gazette, Nov. 1737, reprinted in 2 THE WORKS OF BENJAMIN FRANKLIN 285 (Philadelphia, Hilliard, Gray & Co. 1840) (“Freedom of speech is a *principal pillar* of a free government; when this support is taken away, the constitution of a free society is dissolved, and tyranny is erected on its ruins.”) (emphasis added).

183. *Connick v. Myers*, 461 U.S. 138, 145 (1983) (internal quotation marks omitted).

184. *Boos v. Barry*, 485 U.S. 312, 318 (1988) (quoting *N.Y. Times Co. v. Sullivan*, 376 U.S. 254, 270 (1964)).

185. *Police Dep’t of Chi. v. Mosley*, 408 U.S. 92, 95 (1983).

186. *Wood v. Moss*, 572 U.S. 744, 134 S. Ct. 2056, 2066 (2014) (internal quotation marks omitted).

187. *Chaplinsky v. New Hampshire*, 315 U.S. 568, 571 (1942).

188. *Nat’l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2372 (2018).

Court did “not foreclose the possibility that some such reason exists.”¹⁸⁹ Regardless, well-crafted gun privacy laws can survive intermediate or strict scrutiny in ways that are clearly distinguishable from *Becerra*.

“Doctors help patients make deeply personal decisions, and their candor is crucial.”¹⁹⁰ “[W]hen a professional speaks to the public on an issue related to the practice of her profession, the state’s traditional regulatory interest in managing the professions come into play.”¹⁹¹ Professional regulations that restrict what a physician can say create a conflict between “two well-established, but at times overlapping, constitutional principles.”¹⁹² Specifically, a “collision [is created] between the power of government to license and regulate those who would pursue a profession . . . and the rights of freedom of speech . . . guaranteed by the First Amendment.”¹⁹³ As a result, “courts typically subject content-based speech regulations in that context to intermediate scrutiny.”¹⁹⁴ Here, patients’ fundamental rights to gun ownership and privacy interests also enter that collision. So, in addition to the state and physicians, the rights of the patients should enter the equation and receive an elevated status in the analysis.

States should have the power to regulate *politicized* physician speech inside the patient–physician relationship by: (1) forbidding physician record-keeping regarding gun ownership that is not relevant to the patient’s medical care; (2) requiring physicians to respect patients’ privacy regarding the exercise of their fundamental rights to gun ownership, unless the breach of privacy is related to the patient’s medical care; and (3) preventing discrimination against and harassment of lawful gun owners. In *Becerra*, the Court noted that professional speech receives diminished protection under two circumstances: (1) “[s]tates may regulate professional conduct, even though that conduct incidentally involves speech,” or (2) states

189. *Id.* at 2375 (“We do not foreclose the possibility that [a reason for treating professional speech as a unique category] exists.”).

190. *Id.* at 2374.

191. *Wollschlaeger v. Governor of Fla.*, 848 F.3d 1293, 1337 (11th Cir. 2017) (Tjoflat, J., dissenting) (citing *Ohralik v. Ohio St. Bar Ass’n*, 436 U.S. 447, 456 (1978)).

192. *King v. Governor of N.J.*, 767 F.3d 216, 229 (3d Cir. 2014), *abrogated by Becerra*, 138 U.S. 2361 (quoting *Thomas v. Collins*, 323 U.S. 516, 544–48 (1945) (Jackson, J., concurring)).

193. *Id.* (quoting *Lowe v. S.E.C.*, 472 U.S. 181, 228 (1985) (White, J., concurring)).

194. *Wollschlaeger*, 848 F.3d at 1337 (Tjoflat, J., dissenting) (citing *Ohralik*, 436 U.S. at 456).

may enforce “some laws that require professionals to disclose factual, noncontroversial information in their ‘commercial speech.’”¹⁹⁵

Well-crafted gun privacy laws qualify for the first category warranting diminished protection under *Becerra*. This is true because these laws only regulate physician conduct that “incidentally involves speech,” where they forbid record-keeping conduct regarding gun ownership that is not medically necessary, forbid discriminatory or harassing conduct based upon gun ownership, and prevent conduct involving non-medically based gun ownership inquiries.¹⁹⁶ Likewise, gun privacy laws may qualify for the second *Becerra* category because they regulate “commercial speech” by requiring doctors to collect only medically necessary information inside the patient–physician relationship that is “factual” and “noncontroversial” mirroring the disclosure laws that received diminished protection.¹⁹⁷

Further, in *Zauderer*, the Court found “material differences between disclosure requirements and outright prohibitions on speech” and subjected prohibitions on speech to intermediate scrutiny in the context of commercial speech.¹⁹⁸ Compelled physician political silence in the patient–physician commercial relationship is a restriction on speech that should be subject to intermediate scrutiny when enacted to protect patients from ineffective or harmful professional services.

In addition, the Court has long recognized that commercial speech—“truthful, non-misleading speech that proposes a legal economic transaction”—receives diminished, but some degree of, First Amendment protection.¹⁹⁹ Commercial speech has First Amendment value because it has an important “informational function” that facilitates the “free flow of commercial information” in which the state and the recipients have a “strong interest.”²⁰⁰ There is a “common-sense distinction,” however, between commercial speech and other types of protected speech because it occurs “in an area traditionally subject to government regulation.”²⁰¹ Since commercial speech is linked with the underlying commercial arrangement, the “[s]tate’s interest in regulating the underlying transaction

195. *Becerra*, 138 U.S. at 2372.

196. *Id.*

197. *Id.*

198. *Zauderer v. Office of Disciplinary Couns.*, 471 U.S. 626, 650 (1985); accord *King*, 767 F.3d at 236.

199. *King*, 767 F.3d at 233 (citing *Ohralik*, 436 U.S. at 454–59).

200. *Id.* (citing *Va. St. Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc.*, 425 U.S. 748, 763–64 (1976)); see also *Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm’n of N.Y.*, 447 U.S. 557, 566 (1980).

201. *Ohralik*, 436 U.S. at 455–56 (quoting *Va. St. Bd. of Pharmacy*, 425 U.S. at 761).

may give it a concomitant interest in the expression itself.”²⁰² Therefore, prohibitions on commercial speech are constitutional when they “directly advance” a “substantial” government interest and are “not more extensive than . . . necessary to serve that interest”—a standard the Supreme Court has labeled “intermediate scrutiny.”²⁰³ Commercial speech inside the patient–physician relationship “occurs in an area traditionally subject to government regulation” in which states traditionally have broad authority to protect the public from harmful or ineffective professional practices.²⁰⁴ States typically regulate doctors through medical practice laws and state medical boards.

For all of the reasons above, prohibitions of professional physician speech should be subject to “intermediate scrutiny” and thus permissible only if the prohibition directly advances the state’s substantial interest in protecting patients from ineffective or harmful professional services and is not more extensive than necessary to serve that interest.²⁰⁵

Properly written gun privacy laws should withstand intermediate scrutiny. First, such laws *directly advance* states’ interests in protecting patients from ineffective or harmful professional services that are not in the patients’ best interests as discussed in Parts I and II above. Gun privacy laws directly advance states interests in states where evidence shows that doctors are discriminating against gun owners, making gun ownership inquiries that alienate patients, harassing gun owners, or creating irrelevant gun ownership records inside the medical record similar to those the ACA banned as medically unnecessary.

Second, states have a *substantial interest* in maintaining local control to regulate the medical profession in *the best interests of patients*, including protecting patients from harmful speech and maintaining trust in the medical profession.²⁰⁶ Protection of individual privacy is also a substantial government interest.²⁰⁷ Irrelevant gun-related questioning, harassment, and biased recommendations affecting patients’ gun rights harm patients by diminishing trust in the state’s medical providers.²⁰⁸

202. *Edenfield v. Fane*, 507 U.S. 761, 767 (1993) (referencing *Ohralik*, 436 U.S. at 457).

203. *Cent. Hudson Gas*, 447 U.S. at 566; *see also Fla. Bar v. Went For It, Inc.*, 515 U.S. 618, 623–24 (1995) (applying “strict scrutiny” under the standard set forth in *Cent. Hudson Gas*).

204. *Cent. Hudson Gas*, 447 U.S. at 562 (quoting *Ohralik*, 436 U.S. at 455–56).

205. *King*, 767 F.3d at 234 (quoting *Went For It, Inc.*, 515 U.S. at 623–24).

206. *See supra* Part I.A.

207. *See, e.g., Falanga v. State Bar of Ga.*, 150 F.3d 1333, 1344 (11th Cir. 1998).

208. *See supra* Part I.A.

Prohibiting such speech directly advances the state interest in maintaining trust in the medical system's ability to provide nonbiased recommendations, avoid harassment, and avoid discrimination to benefit its citizens.²⁰⁹ Such a prohibition is no different than allowing states to prohibit doctors from giving medically unsound advice to treat an ailment or to peddle snake oil.²¹⁰ Thus, biased harassment and discrimination against gun owners is an "ineffectual or harmful" service that the State should prohibit when acting in the best interests of patients as a licensing agent for the profession.²¹¹ Nothing short of prohibition of biased professional speech, harassment, and discrimination will alleviate the problem in some situations.

Third, properly written laws do not bar physicians' medically relevant inquiries. Where the law is written to allow gun ownership queries when medically relevant—such as in homes with small children present or for patients with mental illness or who are contemplating suicide—that law appropriately serves the state's interest.²¹²

Gun privacy laws that protect gun owning patients' best interests directly advance states' substantial interest in ensuring that their licensed professionals are providing trustworthy, non-politicized medical advice and allow doctors to make medically relevant inquiries and recommendations. Therefore, well-written gun privacy laws should survive intermediate scrutiny if they prohibit physician speech that harasses or discriminates against gun owners, prevent idle gun ownership inquiries, or prevent creation of unnecessary gun ownership records, but still allow physicians to inquire about gun ownership when relevant to patient care.

Further, well written gun privacy laws should survive strict scrutiny because patients' fundamental rights are at stake in the analysis. Generally, content-based regulations that "target speech based on its communicative content . . . are presumptively unconstitutional and may be justified only if the government proves they are narrowly tailored to serve compelling state interests."²¹³ Surely, there can be no more "compelling state interest" than protecting patients' lawful exercise of their fundamental rights. Likewise, gun privacy laws that prevent medically unnecessary inquiry and recordkeeping regarding irrelevant private exercise of fundamental rights are narrowly tailored because they restrict only the physician's conduct related to the collection of medically irrelevant private information. They do not prevent physicians from presenting the patient with gun information

209. See *supra* Part I.A.

210. See *supra* Part I.B–C.

211. See *supra* Parts I–II.

212. See *supra* Part I.C.

213. Nat'l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361, 2372 (2018).

when it is medically relevant, nor do they compel the physician to communicate any particular viewpoint regarding gun ownership. Such laws merely prevent collection of private information regarding fundamental rights when such information is medically irrelevant and prevent politicized non-medical harassment and discrimination against lawful gun owners exercising their fundamental rights. Therefore, even if strict scrutiny were to apply, well written gun privacy laws would pass constitutional muster.

CONCLUSION

The “secret of the care of the patient is caring for the patient”—including lawful gun owners.²¹⁴ Patients’ rights and the best interests of the patients should be the focal point—not doctors’ speech rights—when it comes to the constitutionality of patient care issues. Physician leaders have emphasized the need for physicians to place patients’ needs above their own for generations.²¹⁵ Therefore, the best interests of patients should receive special attention in the analysis of the complex issues involving patient gun rights, patient privacy rights, and prohibition of physician speech.

States have a duty to properly regulate medical professionals. In states in which unprofessional treatment of lawful gun owners occurs, state legislatures are empowered and constitutionally justified in passing gun privacy laws to protect citizens from political bias inside the medical profession—including politicized speech masquerading as medical advice and alienating lawful gun owners. Regardless of the doctor’s political views, states should be allowed to require doctors to respect patients’ fundamental rights—including firearm ownership. In contrast, states should encourage scientifically backed, balanced, and truthful professional advice regarding gun ownership inside the patient–physician relationship when relevant to the patient’s reasons for seeking medical care. Well-written gun privacy laws that allow physicians to make medically relevant inquiries, while prohibiting idle interrogations, unnecessary record-keeping, harassment, or discrimination regarding lawful gun ownership, should pass constitutional scrutiny.

214. Davidson, *supra* note 1, at 817.

215. See THE QUOTABLE OSLER, *supra* note 33, at 46 (saying to a group of doctors, “[t]he motto of each of you as you undertake the examination and treatment of a [patient] should be to ‘put yourself in his place’ . . . enter into his feelings”); AM. MED. ASS’N, CODE OF MEDICAL ETHICS, PRINCIPLES OF MEDICAL ETHICS: PHYSICIAN EXERCISE OF CONSCIENCE § 1.1.7 (2016), <https://www.ama-assn.org/delivering-care/physician-exercise-conscience> [<https://perma.cc/675C-XQXK>]; *About Mayo Clinic*, *supra* note 30; Ludwig Edlestein, *The Hippocratic Oath: Text, Translation, and Interpretation*, in CROSS-CULTURAL PERSPECTIVES IN MEDICAL ETHICS 3–4 (Robert M. Veatch ed., 2d ed. 2000) (recounting the Hippocratic Oath).