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NOT YOUR MOUTHPIECE: ABORTION, IDEOLOGY, AND COMPELLED SPEECH IN PHYSICIAN-PATIENT RELATIONSHIPS

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INTRODUCTION

Roe v. Wade's affirmation of a woman's constitutional right to have an abortion has not secured women's access to this procedure. Rather, abortion opponents have enacted laws that,

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while avoiding an outright ban, have still impeded women's ability to exercise their right to an abortion. One common method has been to use state legislatures' regulatory power over the medical profession to compel physicians to impart an anti-abortion ideological message to patients. This government interference with doctors' professional speech¹ in the context of the physician-patient relationship is disturbing not only because it infringes upon both physicians' and patients' free speech rights, but because it does so with the aim and consequence of obstructing the exercise of other constitutional rights.

In this article, I argue that physicians should not be reduced to mouthpieces for a state's ideological preferences. In Part I, I start by discussing the growth of compelled physician speech as a tool for disseminating a state's anti-abortion message, and place such provisions into three categories: those requiring doctors 1) to state factually false or misleading assertions; 2) to present an ideological statement as fact; and 3) to convey certain truthful information in an unbalanced manner that impairs a physician's ability to impart an accurate, neutral assessment of a patient's medical options. Next, in Part II, I provide justifications for First Amendment protections of professional speech, especially in the medical context, and rebut arguments against protecting doctors' free speech. Based on these justifications, in Part III I analyze the three categories of problematic provisions and argue that they are unconstitutional. Finally, in Part IV, I discuss courts' failure to protect physicians' professional speech against infringements by these laws. I conclude by briefly discussing why, regardless of one's stance on abortion, this permissive attitude toward compelled ideological speech has disturbing broader implications.

I. OVERVIEW OF LAWS COMPELLING ANTI-ABORTION IDEOLOGICAL SPEECH BY DOCTORS

A. Recent Trends in State-Level Anti-Abortion Legislation

State legislatures have been enacting anti-abortion legislation at unprecedented rates. According to the Guttmacher Institute, states adopted 288 new abortion restrictions in the period from 2011-2015, compared to 292 in the fifteen preceding years combined.² 396 restrictive measures were considered in 46 states and 57 were of these were adopted in the 2015 legislative session alone.³

Although the most popular targets of abortion restrictions were medication abortions, private insurance coverage, and minors' access,⁴ state legislatures also targeted physicians' professional speech in the context of the doctor-patient relationship. Many such laws mandate physicians impart the state's anti-abortion message to their patients,⁵ thereby raising First

¹ Following Daniel Halberstam, Robert Post, and Claudia Haupt, I define "professional speech" as speech "uttered in the course of professional practice" as distinct from "speech . . . uttered by a professional." Daniel Halberstam, *Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions*, 147 U. PA. L. REV. 771, 843 (1999); Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 947; Claudia E. Haupt, *Professional Speech*, 125 YALE L.J. 1238, 1238 n.1 (2016).

² Elizabeth Nash et. al, *Laws Affecting Reproductive Health and Rights: 2015 State Policy Review*, GUTTMACHER INSTITUTE, <http://www.guttmacher.org/statecenter/updates/2015/statetrends42015.html> [https://perma.cc/6JA9-ANDN].

³ *Id.*

⁴ *Id.*

⁵ See Parts I.B., C., and D, *infra*. Some state laws may raise other First Amendment or free speech issues,

Amendment concerns about compelled speech. Generally speaking, these provisions can be grouped into three categories: those requiring doctors 1) to state factually false or misleading assertions; 2) to present an ideological statement as fact; and 3) to convey certain truthful information in an unbalanced manner that impairs a physician's ability to impart an accurate, neutral assessment of a patient's medical options.

B. Factually False or Misleading Assertions

Laws that fall within this category require physicians to tell patients medically incorrect or scientifically invalid statements concerning abortion procedures, risks, side effects, alternatives, or other such information. A provision of Arizona's SB 1318—codified as Ariz. Rev. Stat. Ann. § 36-2153(A)(2)(h)-(i)—is particularly outrageous.⁶ It requires physicians to tell women, orally and in person, that medication induced abortions are reversible and to refer them to a state-run website containing information about reversal in order to obtain informed consent for *any* type of abortion whatsoever.⁷ Arkansas's more succinct informed consent provision mandates that doctors tell women, orally and in person, "information on reversing the effects of abortion-inducing drugs."⁸

Most laws requiring doctors to provide incorrect information to patients are not so inventive, and instead rely on more conventional abortion myths. South Dakota is one state that, as part of informed consent for an abortion, requires a physician to tell patients, in writing and in person, that an increased risk of depression, suicidal ideation and suicide were "known medical risks of the procedure and statistically significant risk factors to which the pregnant woman would be subjected,"⁹ despite the lack of credible studies supporting negative post-abortion psychological outcomes.¹⁰ In Mississippi and Texas, clinicians must orally provide women

but that is outside this article's scope.

⁶ S.B. 1318, 52nd Leg., 1st. Reg. Sess (Ariz. 2015).

⁷ *Id.*; Ariz. Rev. Stat. Ann. § 36-2153(A)(2)(h)-(i). There is no evidence that medication induced abortions can be reversed. Doctors testifying in support of SB 1318 have claimed that the hormone progesterone can be used to stop medication abortions; however, the only support for this assertion seems to be an article containing an incompletely documented collection of anecdotes by physicians trying to counter the effects of mifepristone, the first part of a two-pill combination used in medication abortions. David Grimes provides a detailed review of the various scientific errors associated with the "study," including the use of a non-peer-reviewed progesterone developed by the founder of an explicitly pro-life fertility clinic, a tiny sample size of six patients, a lack of control group, and the misuse of epidemiological terms. For his complete assessment, see David Grimes, *The 'Science' Behind Arizona's Mandatory 'Abortion Reversal' Advice*, REWIRE (Apr. 8, 2015, 2:11 PM), <https://rewire.news/article/2015/04/08/science-behind-arizonas-mandatory-abortion-reversal-advice/> [<https://perma.cc/FW76-T2PB>].

⁸ Ark. Code Ann. § 20-16-1703(b)(1)(G)(West 2017).

⁹ S.D. Codified Laws § 34-23A-10.1(e)(i)-(ii) (West 2016).

¹⁰ Abortions causing mental health problems is an enduring but scientifically baseless myth. The American Psychological Association's Task Force on Mental Health and Abortion (TFMHA) produced a report evaluating the scientific research on the mental health factors associated with abortion. In the Executive Summary of the Task Force Report, the TMFHA stated that the majority of the literature on this subject "suffered from methodological problems, often severe in nature," and accordingly "emphasized the studies it judged to be most methodologically rigorous to arrive at its conclusions." The TFMHA concluded that relative risk of mental health problems among women receiving elective first-trimester abortions and women who delivered a pregnancy were the same. Task Force on Mental Health and Abortion, *Executive Summary of the Task Force Report*, AMERICAN PSYCHOLOGICAL ASSOCIATION (2008), <http://www.apa.org/pi/>

seeking abortions with false information about an increased risk of breast cancer as a consequence of obtaining an abortion.¹¹

C. Ideological Statements Presented as Facts

Laws in this grouping require doctors to present the state's ideological views about abortion, such as when human life begins, as facts. These laws require doctors to disseminate the pro-life viewpoint on this issue as if it were objective, medical truth. South Dakota's informed consent law again serves as an ideal example: physicians must tell patients, in writing and in person, that "the abortion will terminate the life of a whole, separate, unique, living human being," and various assertions about the nature of her relationship with "that unborn human being."¹² Indiana requires doctors to inform women seeking abortions, orally and in writing, that "human physical life begins when a human ovum is fertilized by a human sperm."¹³

D. Unbalanced Presentation of Information Obstructing a Neutral Medical Assessment

Laws in this category require physicians to give patients objectively truthful information, but in an unbalanced manner that obstructs doctors' abilities to provide ideologically neutral medical assessments. This compelled speech "demands the communication of irrelevant information toward an arguably nonscientific ideological end."¹⁴ Doctors may be required to present only the risks of one treatment option but not another, perform medically irrelevant procedures, or give information that is true but medically contraindicated.

Some mandatory ultrasound laws fall into this category. North Carolina's and Texas' laws are particularly noteworthy because of the related litigation. North Carolina's law requires:

at least four hours before a woman having any part of an abortion performed or induced, and before the administration of any anesthesia or medication in preparation for the abortion on the woman, the physician who is to perform the abortion, or qualified technician working in conjunction with the physician, shall do each of the following:

women/programs/abortion/executive-summary.pdf [https://perma.cc/57HH-GC59].

¹¹ Miss. Code. Ann. § 41-41-33(1)(a)(ii) (West 2017); Tex. Health & Safety Code Ann. § 171.012(a)(1)(B)(iii) (West 2015). This is another persistent but unfounded myth about abortion. *See Abortion and Breast Cancer*, NATIONAL WOMEN'S HEALTH NETWORK, <https://www.nwhn.org/abortion-and-breast-cancer-2/> [https://perma.cc/ART8-AN6M] (discussing the persistence of the mythical abortion-breast cancer link). Since 2003, the National Cancer Institute and the American College of Obstetricians and Gynecologists have concluded no causal link between abortions and breast cancer exists, and early studies suggesting otherwise were methodologically flawed. Studies since then have continued to support their findings. Their 2009 report—reaffirmed in 2015—provides further details. Committee on Gynecologic Practice, *Induced Abortion and Breast Cancer Risk*, ACOG COMMITTEE OPINION NO. 434 (2009; reaffirmed 2015), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Induced-Abortion-and-Breast-Cancer-Risk> [https://perma.cc/Z3Z8-BGTT].

¹² S.D. Codified Laws § 34-23A-10.1(B)-(D) (West 2016).

¹³ Ind. Code Ann. § 16-34-2-1.1(a)(1)(E) (West 2016).

¹⁴ *See* Haupt, *supra* note 1, at 1299 (discussing mandatory ultrasound requirements).

(1) Perform an obstetric real-time view of the unborn child on the pregnant woman.

(2) Provide a simultaneous explanation of what the display is depicting, which shall include the presence, location, and dimensions of the unborn child within the uterus and the number of unborn children depicted. The individual performing the display shall offer the pregnant woman the opportunity to hear the fetal heart tone. The image and auscultation of fetal heart tone shall be of a quality consistent with the standard medical practice in the community. If the image indicates that fetal demise has occurred, a woman shall be informed of that fact.

(3) Display the images so that the pregnant woman may view them.

(4) Provide a medical description of the images, which shall include the dimensions of the embryo or fetus and the presence of external members and internal organs, if present and viewable.¹⁵

This law does not contain the typical informed consent exception allowing a doctor to forgo providing information if, in his or her medical judgment, doing so would be harmful to a patient's physical or psychological health, but does grant that "nothing in this section shall be construed to prevent a pregnant woman from averting her eyes from the displayed images or from refusing to hear the simultaneous explanation and medical description."¹⁶ The Texas law is substantively similar; the most significant differences are that viewing the images is "optional"¹⁷ but that patients are "required by law to hear an explanation of the sonogram images" except in cases involving sexual assault, rape, other criminal activity, or fetal abnormality.¹⁸ Again, there is no exception for a physician's determination that presenting this information would be harmful.

II. PROFESSIONAL SPEECH IS ENTITLED TO FIRST AMENDMENT PROTECTIONS

Historically, the "Supreme Court and lower courts have rarely addressed the First Amendment contours of a professional's freedom to speak to a client,"¹⁹ and legal literature and court decisions lack comprehensive theories of professional speech.²⁰ In this context, scholars have articulated "widely differing views of the constitutional status of professional speech[,]"²¹ from maintaining that it is "fully protected, non-commercial speech"²² and vital to an individual's

¹⁵ N.C. Gen. Stat. Ann. § 90-21.85(a)(1)-(4) (West 2016).

¹⁶ *Id.* at (b).

¹⁷ But the sonogram must be performed so that the patient can see the images.

¹⁸ Tex. Health & Safety Code Ann. § 171.012(a)(4)-(5) (West 2015).

¹⁹ Halberstam, *supra* note 1, 834 (1999).

²⁰ "What is strikingly—and perhaps somewhat surprisingly—still absent from the case law and the legal literature is a comprehensive theory of professional speech." Haupt, *supra* note 1, at 1241.

²¹ Post, *Informed Consent to Abortion*, at 944.

²² Paula E. Berg, *Toward a First Amendment Theory of Doctor-Patient Discourse and the Right to Receive Unbiased Medical Advice*, 74 B.U. L. REV. 201, 242 (1994).

autonomous ability to communicate,²³ to contending the link between professional speech and medical conduct that the state can regulate makes First Amendment protections for physician speech within the doctor-patient context quite limited.²⁴ Some scholars have analogized professional speech to commercial speech to support physician speech protections,²⁵ but such analogies fail to fully account for the unique nature of the doctor-patient relationship that entitles it to greater First Amendment consideration.²⁶

Below, I begin in Part A by discussing recent Supreme Court cases and theories of professional speech as analogous to commercial speech. Parts B and C describe the unique First Amendment concerns of doctors and patients, while Part D addresses criticisms of free speech protection in this context.

A. Existing Frameworks: Recent Cases and Commercial Speech Analogies

1. Recent Cases Related to Professional Speech and Required Disclosures

The Supreme Court has not provided a clear framework for evaluating the constitutionality of state interference with professional speech, but it has ruled on cases involving commercial speech by professionals and required disclosures. Although the extent of their potential application by courts is unclear, sometimes inconsistent, and does not directly address constitutional issues related to the type of professional-client speech addressed here, these cases' topical proximity means that they merit discussion.

In *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*,²⁷ the Supreme Court addressed limitations on lawyers' commercial speech. There, the Court upheld a state law requiring attorneys to include only "purely factual and uncontroversial information" in their advertisements.²⁸ Although this case involved speech by professionals, this speech occurred in a commercial context outside of the professional-client relationship; thus, the Court treated the case as solely dealing with commercial speech.²⁹ This distinction between commercial speech made by professionals and professional speech occurring within the professional-client relationship is

²³ Paula E. Berg, *Lost in a Doctrinal Wasteland: The Exceptionalism of Doctor-Patient Speech Within the Rehnquist Court's First Amendment Jurisprudence*, 8 HEALTH MATRIX 153, 174 (1998).

²⁴ See Katharine McCarthy, *Conant v. Walters: A Misapplication of Free Speech Rights in the Doctor-Patient Relationship*, 56 ME. L. REV. 447, 464-65 (2004). She interprets the Supreme Court's decision in *Casey*, *infra* note 32, to mean that "the Supreme Court recognized that the First Amendment applies in limited circumstances within the doctor-patient relationship, but that the state's interest in regulating physician conduct" derived from its police powers can outweigh the free speech interests in the patient-physician context. McCarthy suggests that California could have limited physician discussions about marijuana under its police powers, since "the states retain the power to regulate the professional conduct of physicians, even when speech may be used to carry that conduct out." For the reasons discussed *infra*, Part II.D.1, First Amendment protections for physician-patient speech do not prevent states from regulating the medical profession.

²⁵ See Part II.A., *infra*.

²⁶ See Haupt, *supra* note 1, at 1264-68 (discussing theories of professional speech based on analogies to commercial speech doctrine and noting their shortcomings).

²⁷ 471 U.S. 626 (1985).

²⁸ *Id.* at 2281.

²⁹ *Id.*

echoed by some scholars, and has produced ambiguity as to whether *Zauderer* applies outside the context of advertising.³⁰ Additionally, there remains some uncertainty regarding *Zauderer*'s application to advancing legitimate state interests beyond preventing the deception of consumers,³¹ and the Supreme Court has declined to directly address this issue.³²

Current case law on required disclosures by professionals also provides only minimal guidance. In one of the most recent such cases, *Milavetz v. United States*,³³ the Court evaded addressing the ambiguity surrounding First Amendment protections for professional speech through a narrow construction of the contested law. The Court upheld a federal law forbidding lawyers from advising their clients to incur more debt in contemplation of filing for bankruptcy as regulation of unethical and abusive conduct rather than protected speech.³⁴ Although there was no further elaboration on the free speech implications, this case at least suggests that a profession's standards should and do play a significant role in delineating the boundaries of professional speech protections.³⁵

2. Analogies to Commercial Speech

David Halberstam and Robert Post provide two influential frameworks for analyzing professional speech through the lens of the more developed commercial speech literature. For Halberstam, commercial speech and professional speech possess a "deep" theoretical "kinship,"³⁶ as he considers them both "bounded speech institutions."³⁷ He likens the "relational" aspect of the vendor-customer dyad to the physician-patient situation,³⁸ and suggests courts apply "a constitutional theory of bounded speech institutions, based on its perception of various socially

³⁰ See, e.g., Nat'l Ass'n of Manufacturers v. S.E.C., No. 13-5252, 2015 WL 5089667, at *3 (D.C. Cir. Aug. 18, 2015) ("[T]he Supreme Court's opinion in *Zauderer* is confined to advertising, emphatically and, one may infer, intentionally").

³¹ Compare Nat'l Ass'n of Mfrs. v. S.E.C., 748 F.3d 359 (D.C. Cir. 2014) (reiterating that the *Zauderer* test is "limited to cases in which disclosure requirements are 'reasonably related to the State's interest in preventing deception of consumers'") with *Am. Meat Inst. v. U.S. Dep't of Agric.*, 760 F.3d 18 (D.C. Cir. 2014) (holding that the use of *Zauderer* is not limited to cases where the state's interest is preventing consumer deception). See also Jennifer Keighley, *Can You Handle the Truth? Compelled Commercial Speech and the First Amendment*, 15 U. PA. J. CONST. L. 539, 542 (2012) (concluding that the "curing consumer deception" standard is only one of many permissible government goals). There is also disagreement between Circuits. For a summary of such cases, see *Amarei v. City of Chicago*, 2015 U.S. Dist. LEXIS 154992, 5-7 (N.D. Ill. Nov. 17, 2015) (discussing the various approaches of courts and Circuits to this question).

³² The Supreme Court has had occasion to address the role of *Zauderer* in the abortion context. In *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747 (U.S. 1986), the Court struck down laws similar to those discussed *supra*. The dissent, however, viewed these laws as legitimate regulations of the medical profession, and cited *Zauderer* for support. *Id.* at 802-804. *Thornburgh* was later overruled in *Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992), discussed *infra*, Part II.D.

³³ 559 U.S. 229 (2010).

³⁴ *Id.* at 244-246.

³⁵ Timothy Zick, *Professional Rights Speech*, 47 ARIZ. ST. L.J. 1290, 1350 (2015). This concept and scholarly support for the use of the medical community's own standards are discussed extensively *infra*.

³⁶ Halberstam, *supra* note 1, at 776-77.

³⁷ *Id.* at 778.

³⁸ *Id.* at 851.

defined relationships between interlocutors and, accordingly, rendering contextual judgments about the extent of government intervention that is both necessary for and compatible with the preservation of the particular institution.”³⁹ He further argues that states may only regulate or define the “boundaries of the discourse,”⁴⁰ but not the content itself,⁴¹ and thus “[t]he government may neither suppress the speech entirely nor remodel the institution [vendor-consumer or physician-patient relationships] to its liking.”⁴²

Post has a different view of the similarities between commercial and professional speech. He argues that, unlike speech as part of public discourse, the focus of commercial and professional speech is its informational value.⁴³ So, the guiding principle for the permissibility of government interference with speech in these situations is the public’s right to receive truthful, non-misleading information.⁴⁴ Thus, content- and viewpoint-based regulations and disclosure requirements are permitted only when they ensure the accuracy and accessibility of information.⁴⁵

But Post complicates this analogy by distinguishing professional speech from commercial speech on two grounds.⁴⁶ The first distinction — the dissemination of information generally or to a specific client — may be obsolete with the expanding use of targeted advertising in the commercial context.⁴⁷ The second difference lies in the unequal power dynamic inherent in the physician-patient relationship but not in the commercial context.⁴⁸

Although initially appealing, “the analogy to commercial speech should not be pressed too far.”⁴⁹ Not only does commercial speech have its own confusing, imprecise, and “tormented” doctrinal history,⁵⁰ but the qualitative differences between vendor-consumer and physician-patient relationships make the First Amendment considerations in each context distinct. For instance, despite Halberstam’s concession that the “deeper relationship between physician and patient . . . lead[s], at least in some cases, to protection beyond that afforded to commercial speech,”⁵¹ his version fails to fully account for the asymmetric power and knowledge dynamics in the doctor-patient context.

³⁹ *Id.* at 778.

⁴⁰ *Id.* at 857.

⁴¹ “The Court rejects government prescriptions as unconstitutional when they infringe on the integrity of an established framework for discourse.” *Id.* at 828.

⁴² *Id.* at 862.

⁴³ Robert Post, *The Constitutional Status of Commercial Speech*, 48 UCLA L. REV. 1, 4 (2000); Post, *Informed Consent to Abortion*, *supra* note 1, at 974-75. Haupt further ties informational function expounded by Post to First Amendment self-governance concerns. Haupt, *supra* note 1, at 1268.

⁴⁴ Post, *Informed Consent to Abortion*, *supra* note 1, at 975.

⁴⁵ *Id.* Currently, the case law related to professional speech and required disclosures is somewhat unclear. See Part II.A.1, *supra*.

⁴⁶ ROBERT C. POST, DEMOCRACY, EXPERTISE, AND ACADEMIC FREEDOM: A FIRST AMENDMENT JURISPRUDENCE FOR THE MODERN STATE, 46-47 (2012)(referring to professional speech as “expert knowledge”).

⁴⁷ *Id.*; Haupt, *supra* note 1, at 1268.

⁴⁸ *Cf.* Haupt, *supra* note 1, at 1268 (suggesting that “extensive psychological research on the part of advertisers makes the speaker and the listener unequal in the commercial speech context as well. Product placement, subconscious messaging, and the like give a distinct advantage to commercial speakers over their audiences”).

⁴⁹ Post, *Informed Consent to Abortion*, *supra* note 1, at 980.

⁵⁰ *Id.*

⁵¹ Halberstam, *supra* note 1, at 838.

Further, physicians and other professionals like lawyers often provide advice related to constitutional rights or access to constitutionally guaranteed services like abortion.⁵² By preventing professionals from informing clients of their rights and how to challenge violations of these rights,⁵³ restrictions on professional speech allow states to indirectly block the vindication of constitutional rights. Because of knowledgeable physicians' fiduciary relationships with emotionally vulnerable and relatively uninformed patients, special attention should be paid to the First Amendment considerations of both doctor and patient within their professional relationship.

B. Physician-Focused First Amendment Concerns

Although discussions of First Amendment concerns within the physician-patient dyad often emphasize patients' rights, protection of physicians' speech stands on its own merits. First Amendment considerations focused on physicians' rights as speakers are informed by doctors' mutually reinforcing dual roles as advisors to patients and as participants in the wider medical community. Doctors exchange and generate new medical knowledge as part of a community of medical professionals, and then adapt, apply, and transmit that information in a way appropriate to each patient's needs.⁵⁴ In turn, physicians' clinical experience often influences the exchange and generation of new medical knowledge within the greater medical community.⁵⁵ The conceptual placement of doctors' professional speech to patients within this wider sphere implicates traditional protections for autonomy and development of the marketplace of ideas.⁵⁶ Additionally, professional speech related to the exercise of constitutional rights can serve an important role in facilitating dialogue and public discourse outside of the immediate professional-client relationship.⁵⁷

1. Autonomy

First Amendment rights fundamentally serve to protect an individual's right to autonomy and self-determination, which traditionally has justified protections against government-compelled ideological speech.⁵⁸ For these reasons, the "liberty" model posits that freedom of speech is worth protecting for its value to the individual, without reference to larger societal concerns.⁵⁹ As Jennifer Keighley suggests,

⁵² Zick, *supra* note 35, at 1295 ("professionals are frequently involved in educating, facilitating, and mediating the enjoyment and exercise of clients' constitutional rights").

⁵³ *See id.* at 1294 ("These regulations suppress, alter, or dictate professional rights speech—professional-client communications about, concerning, or relating to the recognition, scope, or exercise of constitutional rights").

⁵⁴ *See* Haupt, *supra* note 1, at 1269-70 (conceptualizing physicians as members of a "knowledge community").

⁵⁵ *See id.* (discussing the doctor's role within the wider knowledge community).

⁵⁶ *Id.* Haupt also states that democratic self-governance interests are implicated independent of the effect of the listener, but does not provide much reasoning to support this assertion. *Id.* at 1276-77.

⁵⁷ *See* Zick, *supra* note 35, at 1316 (discussing the overlooked role of professional speech and advice in public discourse related to constitutional rights).

⁵⁸ Jennifer M. Keighley, *Physician Speech and Mandatory Ultrasound Laws: The First Amendment's Limit on Compelled Ideological Speech*, 34 CARDOZO L. REV. 2347, 2373 (2013).

⁵⁹ *Id.* (citing C. Edwin Baker, *Scope of the First Amendment Freedom of Speech*, 25 UCLA L. REV. 964,

This interest in individual liberty and autonomy, in fact, is one of the primary justifications for restricting the state's ability to compel citizens to engage in the state's ideological speech. While physicians may have more limited autonomy interests when engaging in the practice of medicine, this does not mean that they surrender all of their ordinary First Amendment rights against compelled ideological speech. Physicians retain the core First Amendment right of ordinary citizens to refuse to be the mouthpiece for the state's ideological advocacy.⁶⁰

In addition to individual autonomy interests, physicians have autonomy interests relevant to their place in the learned medical community.⁶¹ The medical community has its own interests in maintaining its independence to continue developing, refining, and transmitting the specialized scientific information that makes it socially valuable.⁶² In Paul Horwitz's words, "expertise based on a body of specialized knowledge is the very basis of the value and legitimacy" of professional speech.⁶³ Converting individual doctors into "mouthpieces for the state's ideological advocacy" would undermine the integrity of the medical profession as a whole and its ability to advance scientific knowledge and social welfare. Therefore, in addition to universal autonomy interests, physicians have a unique interest in communicating in line with acceptable medical standards and without ideological impositions by the state.⁶⁴

2. Marketplace of Ideas

Although "the professional does not seek to subject her professional opinion" to the competition of the marketplace of ideas "when speaking within the confines of the professional-client relationship," these interactions do implicate First Amendment protections for the marketplace of ideas.⁶⁵ Every profession has an internal marketplace of ideas which advances the formation of professional knowledge.⁶⁶ Considering the mutually reinforcing relationship between the generation of new information and clinical experience, interfering with physician-patient speech necessarily affects the development of new ideas within the wider medical community.⁶⁷ Preventing states from interjecting ideological propaganda into medical settings thus complements

966 (1978)).

⁶⁰ *Id.* Even an opportunity to repudiate the required speech will not cure the harm of compelled ideological speech; compelling an individual to speak contrary to his or her beliefs is, in and of itself, and infringement on personal liberty. *See* *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943) (holding that compelling a flag salute "transcend[ed] constitutional limitations" and infringed on free speech and personal liberties); *Pac. Gas & Elec. Co. v. Pub. Utils. Comm'n of Cal.*, 475 U.S. 1, 15-16 (1986) ("Were the government freely able to compel corporate speakers to propound political messages with which they disagree, this protection would be empty, for the government could require speakers to affirm in one breath that which they deny in the next.").

⁶¹ Haupt, *supra* note 1, at 1272.

⁶² *Id.*

⁶³ PAUL HORWITZ, *FIRST AMENDMENT INSTITUTIONS* 248 (2012).

⁶⁴ Haupt, *supra* note 1, at 1272-73.

⁶⁵ *Id.*

⁶⁶ *Id.* at 1274-75.

⁶⁷ *Id.*

doctors' professional autonomy interests and helps preserve the integrity of the discourse and the medical community's "search for truth."⁶⁸

Further, professional-client speech, and particularly advice related to constitutional rights, can have broader implications for public discourse. Government lies—here, using physicians as mouthpieces—“pose especially grave instrumental threats to democratic self-governance in contexts where such deliberate falsehoods are unlikely to be addressed by counterspeech” and when misrepresentations are used to manipulate the public’s assessment of differing policy options.⁶⁹

These concerns exist when states conscript physicians to perpetuate misinformation related to reproductive health. Even though professional speech to clients occurs in a private setting, it still has public value and can influence public discourse regarding reproductive rights. As Zick states,

Far more often than is typically acknowledged, professional-client interactions address issues relating to constitutional and other legal rights. Licensed professionals play an important role in ensuring the free flow of accurate information about constitutional rights. They educate clients with respect to the scope and exercise of rights. Their advice may provoke political activism with respect to rights. More generally, professionals facilitate the exercise of a wide variety of rights. Thus, restrictions on professional communications may affect far more than the provision of professional advice regarding a client’s personal concerns. Some restrictions may impact discussions and decisions regarding the exercise of civil and constitutional rights relating to matters such as reproductive rights and racial equality.⁷⁰

Thus, since state interference with physician speech can stifle public discourse on important constitutional issues and harm the marketplace of ideas, such speech should be protected.

C. Patient-Centered First Amendment Concerns

In the physician-patient context, various factors create an unequal power dynamic that renders patients particularly susceptible to state ideological coercion or indoctrination, including: doctors’ monopoly on medical knowledge and the resulting informational asymmetry; physicians’ relatively high social status; patients’ emotional and/or physical vulnerability; and difficulty discriminating between the state’s and the physician’s message. Patients’ positions as “captive audiences” in a private setting have additional implications for their ability to avoid unwanted state ideological intrusions. In this context, state ideological imposition can obstruct patients’

⁶⁸ *Id.*; see also Helen Norton, *The Government’s Lies and the Constitution*, 91 Ind. L.J. 73, 102 (2015): government lies can frustrate the search for truth and the dissemination of knowledge . . . Just as government efforts to prohibit the expression of certain views contrary to its own can undermine First Amendment enlightenment values, so too can be the case of government lies that successfully distort public discussion of a particular matter or viewpoint.

⁶⁹ Norton, *supra* note 68, at 101-02.

⁷⁰ Zick, *supra* note 35, at 1316.

receipt of unbiased information, threaten their ability to make independent decisions, distort their choices, and ultimately undermine their bodily and decisional autonomy.⁷¹ Because such choices often involve vindication of constitutional rights or access to constitutionally guaranteed services, interference with patients' ability to receive accurate and unbiased advice is especially troubling.⁷²

1. Unequal Power Dynamic Creates Susceptibility to Indoctrination

Doctors are informed intermediaries for their patients, adapting and translating the medical community's knowledge into something individual patients can use to make informed treatment decisions.⁷³ Patients "are presumed to be dependent upon professional judgment and unable themselves independently to evaluate its quality,"⁷⁴ as "the average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision."⁷⁵ Further, doctors have a "monopoly" on medical knowledge, making it difficult for patients to assess the accuracy of physicians' advice by consulting sources outside the profession.⁷⁶ Although patients ultimately decide what course of treatment to pursue, they rely on physicians' expert advice and trust that it is unbiased and based on scientific and medical considerations.⁷⁷ Patients seek out doctors' advice precisely for these reasons.⁷⁸

Even if patients considered other sources of information, they likely would defer to the doctor's opinion.⁷⁹ To their patients, physicians have "immense authority and power" derived not only from their superior knowledge and education, but also from their "prestigious and economic social status and the 'charismatic authority' that derives from their symbolic role as conquerors of disease and death."⁸⁰ Combined with the emotional and physical vulnerability of seeking medical treatment, patients have limited capacity to utilize "critical rationality and inquisitiveness [to] neutralize the coercive effect of government messages that are delivered by physicians."⁸¹ Also, in this context, patients will have difficulty distinguishing between the physician's scientifically-backed advice and the state's message, particularly if ideological statements are couched in medical terminology that patients may not understand.⁸² Thus, "patients are likely to give great

⁷¹ I define this as the listener's ability to make decisions independently. Here, it is particularly important with regard to the psychological or physical integrity of the patient. Although our definitions are not exactly the same, see Haupt, *supra* note 1, at 1270 (discussing listener's "decisional autonomy interests").

⁷² Zick, *supra* note 35, at 1294.

⁷³ See Part II.B., *supra*.

⁷⁴ POST, DEMOCRACY, EXPERTISE, AND ACADEMIC FREEDOM 47 (2012).

⁷⁵ *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972).

⁷⁶ See Paula Berg, *supra* note 22, 257-58 (1994) (discussing the particular First Amendment concerns when "an information marketplace is monopolized by only a few speakers").

⁷⁷ See Haupt, *supra* note 1, at 1271 (discussing the knowledge asymmetry between doctors and patients).

⁷⁸ See *id.*

⁷⁹ Berg, *supra* note 22, at 226.

⁸⁰ *Id.* at 225-26.

⁸¹ *Id.* at 229.

⁸² *Id.* at 257 (stating that "patients' critical capacities may be further impeded when a government message is disguised as medical advice rather than presented as an expression of state opinion"); Nadia N. Sawicki, *Informed*

weight to physicians' expressions of state preferences, not because they are persuaded by the messages, but merely because the messages are delivered by physicians."⁸³ Finally, a patient's position as a "captive audience" compounds the coercive effect of state-compelled ideological speech by physicians.⁸⁴

2. Patient Rights

For the reasons discussed above, patients are particularly susceptible to ideological coercion when the state's message is delivered during a medical consultation. "Decisional autonomy must limit the State's power to inject into a woman's most personal deliberations its own views of what is best."⁸⁵ "Just as viewpoint-based regulation of the content of political speech distorts political decision making and infringes on citizens' constitutional right to determine their political destiny, viewpoint-based regulation of medical speech distorts medical decision making, and thus infringes on patients' constitutional right to determine the destiny of their bodies."⁸⁶ Such interference is especially troubling from a constitutional perspective due to patients' reliance on physicians' advice for information about and access to constitutionally guaranteed rights and services like abortion.⁸⁷ As a result, state ideological interference in patient-doctor discourse can substantially interfere with patients' liberty of thought, undermine their psychological and bodily autonomy, and impermissibly obstruct the exercise of constitutional rights.

a. Unwanted Ideological Intrusions

Unwanted ideological intrusion through compelled physician ideological speech threatens patient autonomy. Supreme Court jurisprudence implies a right to be free from unwanted ideological intrusion by the government or other citizens, particularly within a private setting.⁸⁸ For instance, the First Amendment prevents the government from forcing captive audiences to listen to unwanted propaganda.⁸⁹ Forcing captive audiences to listen to ideological speech threatens their autonomy by "intruding" on their "mental processes" and subverts their

Consent as Compelled Professional Speech: Fictions, Facts, and Open Questions, 50 *Wa. U. J. of L. & Pol'y* 11, 48 (2016) ("Where informed consent mandates require physicians to communicate messages dictated by the state, there is a substantial risk that patient-listeners will not recognize the true origins of the speech.").

⁸³ Berg, *supra* note 22, at 229. Due to the dynamics of physician-patient interactions, even explicit repudiation of the state's ideological message is not enough to cure this problem. *See id.* at 225-30 (stating that patients are particularly vulnerable to coercion and will likely be confused and unduly influenced by state ideological messages communicated by physicians, even when there are disclaimers). *See also* Sawicki, *supra* note 82, at 50 ("even messages that are clearly identified as state-sponsored may be problematic when compelled in the specific context of medical care . . . intervention of a government message into a sphere that patients expect to be a locus of professional independence may jeopardize the trust inherent in the physician-patient relationship").

⁸⁴ *See* Part II.C.2, *infra*.

⁸⁵ *Casey*, 505 U.S. at 916 (Stevens, J., concurring in part and dissenting in part).

⁸⁶ Berg, *supra* note 22, at 221.

⁸⁷ Zick, *supra* note 35, at 1294.

⁸⁸ Berg, *supra* note 22, at 251-52.

⁸⁹ *Id.* For an extensive list of Supreme Court cases evoking this right, *see id.* at 252 n. 247.

personal liberty,⁹⁰ and these concerns are especially urgent when government propaganda is involved.⁹¹

In the physician-patient relationship, patients are a captive audience: patients cannot alter the trajectory of the conversation;⁹² the messages are conveyed in medical terms and are not clearly ideological statements imposed by the state; it occurs in a setting where such messages are unexpected; medical consultation involves face-to-face, one-on-one interaction; physicians are viewed as authority figures and have high social status; and access to needed or desired medical care is predicated on complying with the state's requirements.⁹³

The private, rather than public, setting in which this ideological intrusion occurs triggers more solicitude for captive audience concerns. Lately, the Supreme Court has been unsympathetic to listeners' rights to avoid unwanted speech in public;⁹⁴ however, even Justices particularly skeptical of captive audience doctrine have acknowledged its validity in private areas.⁹⁵ Further, the Court has protected individuals' rights to not engage in undesired conversation or receive unwanted solicitations, even of a political nature, on their private property and in the home.⁹⁶ Such solicitude for listeners' rights at the costs of speakers' rights is noteworthy, as the Court has consistently supported speakers' rights in public.⁹⁷ Finally, since the First Amendment protects individuals and not the government,⁹⁸ the analysis here weighs even more heavily in favor of

⁹⁰ *Id.* at 252.

⁹¹ *See id.* at 252-53 n. 250 (discussing *Pollak*, particularly Justice Black's concurrence).

⁹² Although nothing "prevent[s] a pregnant woman from averting her eyes from the displayed images or from refusing to hear the simultaneous explanation and medical description." N.C. Gen. Stat. Ann. § 90-21.85(b).

⁹³ For example, receiving a medically unnecessary ultrasound. *See* Part II.C.1, *supra*.

⁹⁴ *See Snyder v. Phelps*, 562 U.S. 443, 458-459 (2011) (holding that although the speech was offensive or upsetting, that Snyder could not be held liable for it because it was in a public place and relevant to a public issue; further, that even though the unwilling audience was at a funeral, that did not trigger protections for them as a captive audience and that the burden fell on the listener to avoid hearing or seeing the offensive speech); *McCullen v. Coakley*, 134 S. Ct. 2518, 2529 (2014) (As a general rule, in such a [public] forum the government may not "selectively . . . shield the public from some kinds of speech on the ground that they are more offensive than others").

⁹⁵ *See Hill v. Colorado*, 530 U.S. 703, 751-53 (2000) (Scalia, J., dissenting). Although Justice Scalia harshly criticized the majority for recognizing a "right to be let alone" in public spaces, he acknowledged and even approved of a line of cases permitting limitations on speakers' First Amendment rights when they intrude into the privacy of the home. He also implied that the First Amendment protects a speaker's right to be free from government interference with their speech.

⁹⁶ *Rowan v. Post Office Dept.*, 397 U.S. 728, 736-38 (1970) (upholding a statute allowing a homeowner to restrict the delivery of mail to his home); *Frisby v. Schultz*, 487 U.S. 474, 484-85 (1988) (upholding a statute prohibiting picketing "before or about" any individual's residence); *see also Watchtower Bible & Tract Soc'y of N.Y., Inc. v. Vill. of Stratton*, 536 U.S. 150, 168 (2002) (striking down an ordinance but recognizing an individual's "unquestioned right to refuse to engage in conversation with unwelcome visitors" and to post "No Solicitation" signs to protect themselves from unwanted speech or other privacy intrusions).

⁹⁷ *See, e.g., McIntyre v. Ohio Elections Comm'n*, 514 U.S. 334, 347 (1995) ("handing out leaflets in the advocacy of a politically controversial viewpoint . . . is the essence of First Amendment expression"; "[n]o form of speech is entitled to greater constitutional protection"); *Schenck v. Pro-Choice Network of Western N.Y.*, 519 U.S. 357, 377 (1997) ("Leafletting and commenting on matters of public concern are classic forms of speech that lie at the heart of the First Amendment").

⁹⁸ *See Columbia Broad. Sys., Inc. v. Democratic Nat'l Comm.*, 412 U.S. 94, 139 (1973) (Stewart, J., concurring) (stating that the First Amendment protects the freedoms of individuals and "confers no analogous protection

listeners' rights. Although the home may be a constitutionally special space,⁹⁹ the privacy interests and expectations in medical settings are also quite high,¹⁰⁰ and so similar protections should apply.

b. Access to Unbiased Information

The right to have access to unbiased information is a close conceptual cousin of the interest in freedom from unwanted ideological intrusions. Patients need accurate information to make autonomous, informed decisions about their healthcare,¹⁰¹ and compelling physicians to deliver ideological messages “may result in a biased description of available treatments, thus distorting patients’ understanding of their medical choices and undermining patient autonomy and consent.”¹⁰²

Many of the same concepts and cases that support protecting patients from unwanted ideological intrusions underwrite patients’ right to access unbiased, accurate information.¹⁰³ Manipulating listeners through lies and misrepresentations harms their autonomy and dignity.¹⁰⁴

The most irreducibly bad thing about lies is that they contrive to interfere with, and to impair, our natural effort to apprehend the real state of affairs. They are designed to prevent us from being in touch with what is really going on. In telling his lie, the liar tries to mislead us into believing that the facts are other than they actually are. He tries to impose his will on us.¹⁰⁵

Government lying—here, by using physicians as conscripted mouthpieces for lies and

on the Government” (citing *N.Y. Times Co. v. United States*, 403 U.S. 713, 728-39 (Stewart, J., concurring))). Although beyond this article’s scope, it is an interesting, unsettled question whether states and local governments have First Amendment protections against the federal government. *See generally*, Eugene Volokh, *Do State and Local Governments Have Free Speech Rights?*, THE VOLOKH CONSPIRACY (June 24, 2015), <https://www.washingtonpost.com/news/volokh-conspiracy/wp/2015/06/24/do-state-and-local-governments-have-free-speech-rights> [https://perma.cc/X9A6-PAKG]; David Fagundes, *State Actors as First Amendment Speakers*, 100 Nw. U. L. Rev. 1637, 1638-39 (2006).

⁹⁹ *See Hill*, 530 U.S. at 751-53 (Scalia, J., dissenting) (relying upon the “‘unique nature of the home,’” citing *Frisby v. Schultz*, 487 U. S. 474, 484 (1988)).

¹⁰⁰ Laws like HIPAA and the social norm of privacy surrounding medical appointments and issues, especially in the reproductive context, support this. Medical offices are even designed to advance privacy and avoid intrusion into doctor-patient interactions: examination rooms are often separated from the waiting area and patients are usually seen in private rooms. Also, doctors typically request permission for medical students and other trainees to observe consultations or examinations.

¹⁰¹ Although this point is rather obvious, *see generally* Berg, *supra* note 22.

¹⁰² *Id.* at 251.

¹⁰³ *See* Part ILC.2.a., *supra* for a more detailed discussion. Although increasingly disfavored, the Supreme Court’s First Amendment “fairness doctrine” addressing the issue of bias in broadcasting weighs in favor of patient access to unbiased information in the medical sphere. For a more detailed analysis in the medical context, *see* Berg, *supra* note 22, at 255-56 (discussing the “fairness doctrine” in light of compelled physician speech).

¹⁰⁴ Norton, *supra*, at 68.

¹⁰⁵ *Id.* (quoting Harry Frankfurt, *On Truth, Lies, and Bullshit*, in THE PHILOSOPHY OF DECEPTION 37, 37 (Clancy Martin ed., 2009)).

misrepresentations—creates additional, more tangible problems, particularly when such lies coerce individuals to waive constitutional rights. According to Helen Norton, government lies in the context of abortion meet this threshold of coercion under the Due Process Clause:

[T]he Supreme Court has suggested that laws subjecting women seeking abortions to the government’s inaccurate or misleading speech about abortion—presumably including, but not limited to, government lies about the legal or health consequences of abortion—can pose an impermissible undue burden to a woman’s reproductive rights. Although to date courts’ discussion of this possibility has been very cursory, we might understand such lies as coercive of women’s reproductive choices. Indeed, the Court has suggested in other contexts that women seeking abortions at health care facilities can be considered “‘captive’ by medical circumstance[s]” (i.e., with limited possibilities for exit or rebuttal)—a dynamic that increases the potential for coercion.¹⁰⁶

Further,

[g]overnment lies on certain topics or to certain audiences may be especially successful in manipulating listeners because they may be more likely to be believed and less amenable to rebuttal by counterspeech;¹⁰⁷ in particular, “[t]he coercive effects of such lies may also increase if the government requires that they be uttered by health care providers upon whom patients rely for trusted and expert advice.¹⁰⁸

This Due Process analysis intersects with the First Amendment concerns under discussion here:

[T]he most powerful argument in favor of government authority to restrict deception, and the most powerful argument against government-imposed deception, are the same: the manipulative, domineering, and fundamentally disrespectful invasion of autonomy worked by deception.¹⁰⁹ Just as government laws that require or prohibit certain beliefs undermine individual autonomy, so too may be the case of government lies that manipulate their listeners into adopting beliefs or expression of the government’s choice. Such government lies can be especially effective in manipulating listeners when directed to a vulnerable or captive audience where neither exit nor rebuttal is a

¹⁰⁶ See *id.* at 96.

¹⁰⁷ *Id.* at 79.

¹⁰⁸ *Id.* at 96 (citing Leslie Gielow Jacobs, *Bush, Obama and Beyond: Observations on the Prospect of Fact Checking Executive Department Threat Claims before the Use of Force*, 26 Const. Comment. 433, 443 (2010))(citing Robert C. Post, *Subsidized Speech*, 106 Yale L.J. 151, 172-75(1996)).

¹⁰⁹ *Id.* at 101 (citing Jonathan D. Varat, *Deception and the First Amendment: A Cental, Complex, and Somewhat Curious Relationship*, 53 UCLA L. Rev. 1107, 1110 (2006)).

meaningful option . . . ¹¹⁰

Due to the physician-patient relationship's character, patients are particularly vulnerable to manipulation when doctors are used to propagate government lies and misrepresentations. "The nature of the professional-client relationship gives rise to fiduciary duties. To bridge the knowledge gap, and to ensure the protection of the client's decisional autonomy interests, the professional has to communicate "information that is accurate (under the knowledge community's current assessment), reliable, and personally tailored to the [patient's] specific situation."¹¹¹ Because the patient is particularly vulnerable to ideological coercion or indoctrination in the medical setting and unable to independently evaluate the accuracy of the information, the state undermines this defining aspect of the physician-patient relationship when it compels doctors to convey falsehoods. Since the ultimate decision rests with patients,¹¹² ideologically manipulating the information available distorts their decision-making process and undermines their agency and decisional autonomy.

This information manipulation is especially troubling considering patients' reliance on physicians for information about and access to constitutionally guaranteed rights and services like abortion.¹¹³ Although other professionals have a much more prominent role in advising clients about constitutional rights,¹¹⁴ patients often rely on physicians and other medical professionals for information pertaining to the exercise of constitutional rights. A particularly relevant example is the physician's role as a source of information for patients about "products, devices, and procedures that affected the exercise of fundamental constitutional rights, including the right to use contraception and to procure an abortion."¹¹⁵ For the reasons discussed earlier, a patient may not be able to get accurate information about how to exercise their right to access contraception or abortion through any source other than a physician, and will be likely to believe that information provided by a physician is correct and exhaustive. So, interfering with a physician's ability to provide this information seriously infringes on the patient's right to receive accurate information and inhibits the autonomous exercise of these constitutional rights. Thus, because physician professional speech "fosters individual autonomy and self-determination," it should be "protected in order to maintain the integrity of the individual and protect private decision making from undue

¹¹⁰ *Id.* at 102 (citing Jeffrey M. Cohen, *The Right to Learn: Intellectual Honesty and the First Amendment*, 29 *Hastings Const. L.Q.* 659, 683 (2012)).

¹¹¹ Haupt, *supra* note 1, at 1271.

¹¹² *Id.*

¹¹³ Zick, *supra* note 35, at 1294.

¹¹⁴ Lawyers are the obvious example. As Zick observes,

lawyers are frequently 'vindicators of constitutional rights against the state.' Lawyers' advice and other professional activities can have a profound impact on the scope and enjoyment of constitutional rights for individual clients and the public at large. Through their expressive activities, including the advice they provide to individual clients, lawyers frequently seek to check governmental power and protect the constitutional rights of clients. *Id.* at 1316 (citing Kathleen Sullivan, *Intersection of Free Speech and the Legal Profession: Constraints on First Amendment Rights*, 67 *Fordham L. Rev.* 569, 571 (1998)).

¹¹⁵ *See id.* at 1317 (discussing challenges to laws preventing physicians from advising patients on services or products they were constitutionally entitled to access).

government intrusion.”¹¹⁶

D. Criticisms of First Amendment Protections in the Physician-Patient Context

Many criticisms of First Amendment protections for physician-patient speech focus on concerns about the state’s ability to regulate the profession¹¹⁷ and on the continued validity of informed consent laws.¹¹⁸ Regulating the medical profession and informed consent laws can serve laudable ends; but, First Amendment protections for professional speech do not preclude the benefits of either.

1. Regulation of the Medical Profession

First Amendment protection for professional speech would not harm a state’s ability to regulate the medical profession because the three main areas of such regulations—advertising, access to the profession, and unauthorized practice—do not involve professional speech¹¹⁹ “uttered in the course of professional practice.”¹²⁰ Advertising is not professional speech because it does not entail the provision of medical advice to a patient.¹²¹ Determining licensing requirements and educational and other fitness standards for the profession deal with an individual’s ability to become a doctor, not a physician’s speech to patients during the practice of medicine.¹²² Finally, unauthorized practice regulation “polices the formation of a professional-client relationship rather than the communication of professional advice within such a relationship.”¹²³ Thus, the state has extensive latitude to regulate the medical profession without interfering with professional speech.

Another type of state professional “regulation”—the malpractice tort—does concern speech by physicians to patients.¹²⁴ The tort regime addresses bad advice; that is, inaccurate advice inconsistent with professional standards defined by the medical community.¹²⁵ Professional

¹¹⁶ Berg, *supra* note 22, at 234 (citing C. Edwin Baker, *Scope of the First Amendment Freedom of Speech*, 25 UCLA L. REV. 964, 966 (1978)).

¹¹⁷ See, e.g., Katherine McCarthy, *supra* note 24 (disapproving of a Ninth Circuit ruling invalidating a law on physician free speech grounds, arguing that the ruling impermissibly undermines the state’s ability to regulate the medical profession).

¹¹⁸ See, e.g., Sawicki, *supra* note 82, at 15 (“If the First Amendment imposes substantial limits on the type of physician speech that states can compel, then every state informed consent law—from the most benign to the most controversial—is potentially at risk.”).

¹¹⁹ Haupt, *supra* note 1, at 1277.

¹²⁰ See Haupt, *supra* note 1, at 843; Post, *supra* note 1, at 947; Haupt, *supra* note 1, at 1238 n.1.

¹²¹ See *id.* at 1280-82 (explaining that advertising is commercial speech, not professional speech, as “[t]he professional advertising her services is not speaking as part of the knowledge community to transmit advice to a client. She speaks only as a private commercial actor.”).

¹²² See Haupt, *supra* note 1, at 1282-83 (suggesting that establishing barriers to entry does not directly affect professional speech).

¹²³ *Id.* at 1283.

¹²⁴ *Id.* at 1285.

¹²⁵ See *id.* at 1285-86 (“Malpractice liability ensures that the professional’s speech accurately communicates the knowledge community’s insights within the professional-client relationship [A] doctor commits malpractice when

speech protections are based on the physician's interest in transmitting the accurate scientific knowledge of the medical community and the patient's interest in receiving accurate medical information;¹²⁶ so, inaccurate information that does not convey the medical community's scientific understanding is arguably not professional speech.¹²⁷ Further, liability is based on deviation from standards of care set by the professional community, not by the state;¹²⁸ the state may hold physicians liable for "bad speech," but physicians define what speech is good or bad. The First Amendment "vests the people, not the state, with the right to determine truth and falsity for themselves,"¹²⁹ so a malpractice scheme where the profession decides what speech is accurate is consistent with First Amendment values.¹³⁰ Thus, since "liability [in the malpractice scheme] is properly measured against the standard of care determined by the profession, the knowledge community's formation of this standard should remain uncorrupted and its application within the professional-client relationship should receive robust First Amendment protection."¹³¹

2. Informed Consent

Some commentators believe "if the First Amendment imposes substantial limits on the type of physician speech that states can compel, then every state informed consent law—from the most benign to the most controversial—is potentially at risk."¹³² This alarm is unwarranted; professional speech protections and informed consent are derived from the same principles and protect the same First Amendment interests, and so can coexist.

a. Informed Consent Generally

The doctrine of informed consent addresses informational asymmetries by increasing the flow of accurate information to patients.¹³³ Some argue that to achieve this goal, states must be able to mandate physicians disclose particular information.¹³⁴ But, specific mandated disclosures instead endanger the interests informed consent promotes: rather than reducing the informational asymmetry between doctors and patients, states have used physicians as unwilling ideological mouthpieces to effectively indoctrinate patients by taking advantage of patients' relative

he treats a patient in a way that deviates from the norms established by the medical profession.") (internal quotations omitted).

¹²⁶ See Parts II.B-C., *supra*.

¹²⁷ See Haupt, *supra* note 1, at 1285-87 (discussing how liability for "unprofessional speech" does not negatively impact protections for professional speech).

¹²⁸ *Id.* at 1286.

¹²⁹ Berg, *supra* note 22, at 223.

¹³⁰ See *id.* at 223-24, n. 118 (contending that the primary goal of the First Amendment is to prevent the government from dictating truth and falsehood and ensuring people have the opportunity to decide for themselves).

¹³¹ Haupt, *supra* note 1, at 1244-45.

¹³² Sawicki, *supra* note 82, at 15.

¹³³ Berg, *supra* note 22, at 230.

¹³⁴ See David Orentlicher, *Abortion and Compelled Physician Speech*, Robert H. McKinney School of Law Legal Studies Research Paper No. 2014-31, at 3 (arguing that informed consent is best viewed "as a carve-out from standard First Amendment doctrine," and thus "as long as the state is mandating speech that serves the goals of informed consent, the requirements should not raise First Amendment concerns.").

ignorance and inability to independently assess the validity of medical information.¹³⁵

Although some contend that patients could be protected against such ideological impositions by a requirement that “mandated speech be truthful and not misleading”¹³⁶ or convey “purely factual and uncontroversial information,”¹³⁷ these standards beg the questions: what is “truthful and not misleading,” “purely factual and uncontroversial,” and who decides?¹³⁸ If the state makes this determination, then such a requirement easily becomes mere pretense.¹³⁹ Perhaps courts could decide, but they often lack the same level of medical and scientific expertise as physicians and may be prone to the same ideological biases as state legislatures.¹⁴⁰ If physicians themselves decide what is truthful, the requirement merely reiterates traditional “informed consent laws, which establish standards for disclosure but leave the specific content to the physician’s discretion,” that satisfy both patient and physician First Amendment concerns.¹⁴¹

Another variation of the argument that particular mandated disclosures are necessary for informed consent avers that physicians are providing biased information to their patients in favor of abortion and that the state must step in to correct this imbalance and ensure patients are fully informed.¹⁴² Even assuming the claims of bias were true, the mandated speech in the laws above does not advance the claimed interest in ensuring informed consent. First, the laws that provide incorrect information or purely ideological information masked as fact clearly harm, not further, the state’s interest in informed consent: rather than increasing the patient’s knowledge, such inaccuracies decrease the patient’s factual understanding and thus reduce her capability to independently assess the situation and make decisions accordingly. Such misinformed consent thus undermines informed consent.

As for “truthful” but one-sided statements in favor of a pro-birth stance, the state does not ensure that women are fully informed and receive a balanced representation of options by merely exchanging physicians’ alleged ideological bias for its own. Even worse, since this pro-birth speech is required of all physicians, patients have no opportunity to receive information contrary to the state’s ideological stance, whereas even in the case of widespread bias among a

¹³⁵ See Berg, *supra* note 22, at 230-31 (criticizing the Rehnquist Court for “fail[ing] to see that the qualities of doctor-patient interaction that increase the risk of coercion by physicians also lead to a heightened risk of coercion by government when physicians are deputized into ideological service.”).

¹³⁶ Orentlicher, *supra* note 134, at 9.

¹³⁷ Sawicki, *supra* note 82, at 14.

¹³⁸ For a discussion of these questions and the difficulties current Supreme Court jurisprudence poses in regard to answering them, see *id.* at 14-23.

¹³⁹ For examples, one need only refer to the laws *supra*, Part I.B.

¹⁴⁰ See Part IV., *infra*.

¹⁴¹ Berg, *supra* note 22, at 263-64. This traditional model of informed consent is also consistent with the concept of the First Amendment as having the primary goal of preventing the government from dictating truth and falsehood and ensuring people have the opportunity to decide for themselves. *Id.* at 223-24, n.118.

¹⁴² See, e.g., Americans United for Life, Right to Know Act: Model Legislation and Policy Guide at 5, <http://www.aul.org/wp-content/uploads/2012/11/WRTK-Informed-Consent-2013-LG.pdf> [<https://perma.cc/6MMN-VN3B>] (stating, as part of proposed legislation, that “Many abortion facilities or providers hire untrained and unprofessional ‘counselors’ to provide pre-abortion counseling, but whose primary goal is actually to ‘sell’ or promote abortion services”); National Right to Life Committee, The State of Abortion in the United States at 33 (Jan. 2016), <http://www.nrlc.org/uploads/communications/stateofabortion2016.pdf> [<https://perma.cc/UT4M-4KF5>] (suggesting that pro-choice advocates want to withhold information from women in order to encourage them to get abortions).

knowledge community, there will be practitioners with differing views that patients could consult for a second opinion.¹⁴³ If states are concerned about physician bias, the general principle of informed consent as determined by the medical community—to tell patients the relevant risks and benefits of procedures, other possible options, and the risks and benefits of these alternatives—already provides an adequate, ideologically balanced standard. If physicians are indeed failing to adhere to this community-determined standard within a specific medical context, patients already have recourse to medical malpractice and the tort system. Indeed, even in *Casey* itself, discussed *infra*, the language required physicians to disclose the risks of *both* childbirth and abortion to patients, and not just one or the other, as part of ensuring informed consent.¹⁴⁴ Thus, trading one alleged bias for another would not further the interest in an informed decision.

b. State Interest in Dissuasion and Casey

A final contention meriting discussion here is that such particularized disclosures are permissible because they advance a state’s legitimate interest in dissuading women from obtaining abortions under *Casey*. But, even under the relatively restrictive view of physician free speech assumed in *Casey*, the particularized disclosures contained in the laws above do not properly advance these interests.

*Casey*¹⁴⁵ simultaneously departed from prior Supreme Court jurisprudence according broad respect for non-interference with physician speech and recognized that states have a legitimate interest in dissuading women from obtaining abortions. *Casey* involved the constitutionality of amendments to a Pennsylvania statute,¹⁴⁶ including additions to the “informed consent” provision requiring physicians to tell every abortion-seeking patient (regardless of her individual medical needs)¹⁴⁷ about the health risks of abortion and childbirth and the probable gestational age of the fetus.¹⁴⁸ These regulations were put in place specifically to further the state’s ideological preference for childbirth over abortion, as explicitly stated in the statute itself.¹⁴⁹ The Supreme Court dismissed any First Amendment concerns in an unfortunately cursory manner,¹⁵⁰ and, in an opinion joined by three other Justices, Chief Justice Rehnquist suggested

¹⁴³ Indeed, even a cursory Google search produces a substantial number of anti-choice physician advocacy groups and practitioners.

¹⁴⁴ *Casey*, 505 U.S. at 881 (quoting 18 PA. CONS. STAT. § 3205(a)(1)(ii) (1990)). The provision allowed the doctor to withhold the disclosures if he determined they would be harmful to the patient, consistent with the medical community’s existing standards regarding informed consent. *Id.* at 883-84.

¹⁴⁵ See the more detailed discussion, *infra* at Section III.A.

¹⁴⁶ 1988 Pub. L. 262, No. 31, § 4; 1989 Pub. L. 592, No. 64, § 2 (amending Abortion Control Act, 1982 Pub. L. 476, No. 138, § 1 (codified as amended at 18 PA. CONS. STAT. ANN. §§ 3201-3220 (1983 & Supp. 1993))).

¹⁴⁷ 18 Pa. Cons. Stat. Ann. § 3205(a)(1)(i), (iii) (1983 & Supp. 1993).

¹⁴⁸ *Id.* § 3205(a)(1)(ii).

¹⁴⁹ *See Id.* § 3202(c):

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

¹⁵⁰ Despite the free speech implications of these rules, the Supreme Court’s *Casey* plurality opinion ducked a close First Amendment analysis of the informed consent provisions. *See Berg, supra* note 22, at 215 n. 85 (discussing the

that the government may compel doctors to give patients any “relevant” information (defined as able to “create some uncertainty or persuade”) that is rationally related to a state’s legitimate interest,¹⁵¹ including encouraging a woman to continue a pregnancy.

But the state’s right to encourage women to carry pregnancies to term is hardly limitless; although *Casey* indeed permits a state to clearly articulate its own ideological preference, such laws dealing with informed consent should still be designed to ensure a “mature” and “informed” decision.¹⁵² States may only persuade, and cannot coerce, women into carrying a pregnancy to term; the state’s legitimate interest ends when persuasion becomes coercion.¹⁵³

For the myriad reasons already discussed, forcing doctors to provide falsehoods, ideological messages disguised as facts, and one-sided information about risks and benefits of possible medical treatments is sufficiently coercive to invalidate these statutes. The knowledge monopolies of physicians and informational asymmetries, the trust placed in physicians by patients, the difficulty distinguishing the state’s ideological insertions from the physician’s own scientifically-backed advice, and emotional and physical vulnerability of captive patients—who sometimes are literally naked and undergoing a procedure at the time they are receiving the state’s misinformation—renders these laws coercive. Moreover, this coercion seeks to prevent the exercise of constitutional rights. Thus, informed consent does not undermine protections for professional speech¹⁵⁴ and mandating disclosures does not further the patient-oriented goals of informed consent.

pleadings and lack of First Amendment analysis in the opinion). Instead, the Court evaluated impositions on speech within the general test for whether a law places an “undue burden” on a patient’s right to choose. *Casey*, 112 U.S. at 876. The plurality expressly overruled earlier jurisprudence forbidding governments from using physician-patient consultation to promote its ideological viewpoints “to the extent that we permit a State to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion.” *Id.* at 2824. For a more detailed discussion, see Berg, *supra* note 22, at 217. First Amendment concerns were summarily dismissed, as the Court merely considered advising patients to be “part of the practice of medicine, subject to reasonable licensing and regulation by the State.” *Casey*, 505 U.S. at 883.

¹⁵¹ *Id.* at 2867-68; Berg, *supra* note 22, at 217 n. 95 (discussing Rehnquist’s proposed standard). This standard is lower than that for commercial speech, in spite of the compelling reasons for providing higher protections for professional speech. See Part II.B., C., *supra*. Regulation of commercial speech “must be based on a substantial government interest and be no more extensive than necessary to serve that interest.” Berg, *supra* note 22, 218.

¹⁵² *Casey*, 505 U.S. at 883.

¹⁵³ *Id.* at 877-78, 930; see also Zick, *supra* note 35, at 21.

¹⁵⁴ As Haupt puts it:

The scope of disclosure is bound only by what is material to medical, as opposed to non-medical, interests. Cabining the information that physicians must disclose to that which is material to patients’ medical decisions avoids holding physicians accountable for matters that go beyond their expertise. It is again the knowledge community’s professional knowledge that circumscribes the relevant information. And it is therefore necessary to keep the knowledge community’s information-process free from outside interference. Thus, imposing an informed consent requirement does not technically restrict the professional’s First Amendment rights if appropriate disclosure is considered a part of medically necessary information flow within the doctor-patient relationship. It is ‘unprofessional speech—or ‘unprofessional’ silence—that is punished.

Haupt, *supra* note 1, at 1289 (internal quotation marks omitted).

III. APPLICATION TO EXISTING LAWS

Considering the discussion above, the first two categories of abortion laws compelling physician speech—requiring doctors to 1) tell patients factually false or misleading assertions or 2) present ideological statements as facts—clearly impair the First Amendment values surrounding physician speech. Forcing physicians to give patients factually false information undermines physicians’ individual and professional autonomy interests, undermines the medical profession’s integrity, and interferes with the formation and exchange of ideas within the larger medical intellectual community.¹⁵⁵ Further, it adversely affects broader public discourse related to issues such as reproductive rights and abortion.¹⁵⁶

Such provisions also harm patients’ decisional autonomy by preventing them from having the accurate information necessary to make informed, independent decisions about their bodies and medical treatment.¹⁵⁷ Making doctors present ideological statements as facts likewise infringes on physicians’ First Amendment interests.¹⁵⁸ Injecting ideological statements into physician-patient dialogue is particularly insidious; not only does this form of presentation block patients’ access to accurate information, but the state is taking advantage of patients’ particularly vulnerable position due to anxiety and informational asymmetries.¹⁵⁹ This manipulation is especially egregious considering physicians’ roles in educating patients about how they can exercise constitutional rights.¹⁶⁰ Most commentators—including those not particularly fond of strong protections for professional speech—agree that such compelled speech is impermissible.¹⁶¹

Although the analysis for laws involving truthful but medically unnecessary and one-sided speech is more nuanced, these laws are just as invalid. Requiring women to listen to unnecessary, unwanted descriptions of ultrasounds (as the North Carolina and Texas laws mandate) implicates their interests against unwanted speech intrusions in a private setting.¹⁶² It smacks of intimidation because of the particularly exposed, vulnerable position of women during medical exams, when they receive this superfluous information.¹⁶³ Such coercion is especially troubling because it occurs while a woman is trying to exercise her constitutional rights, and a physician is providing her advice on how to do so.¹⁶⁴

The physician’s autonomy interests are implicated as well; by being forced to participate in a medically unnecessary procedure designed to intimidate women into adopting the state’s ideological position, the doctor’s personal liberty interests and professional responsibilities to the

¹⁵⁵ See Part II.B., *supra*.

¹⁵⁶ *Id.*

¹⁵⁷ See Part II.C., *supra*.

¹⁵⁸ See Part II.B., *supra*.

¹⁵⁹ See Part II.C., D., *supra*.

¹⁶⁰ *Id.*

¹⁶¹ See, e.g., Sawicki, *supra* note 82, at 52 (“a state law compelling physician speech would have to be reasonably related to the regulation of the medical profession, and would have to compel factual, uncontroversial, and non-ideological speech”).

¹⁶² See Part II.C., *supra*.

¹⁶³ We have protections against a lawyer repeatedly asking a witness the same question or forcing him or her to repeat the same facts over and over again at trial for the same reason.

¹⁶⁴ See Part II.C., *supra*.

patient to give appropriate care and advice based on purely scientific considerations are compromised.¹⁶⁵ Further, by conscripting doctors for its ideological agenda, the state undermines the medical community's *raison d'être*—the development and transmission of medical knowledge—by interfering with this goal; mars the community's reputation as independent, objective scientists; and thus ultimately diminishes the medical community's social value.¹⁶⁶

IV. TREATMENT BY COURTS

Historically, courts had held far more respect for protections for physician professional speech;¹⁶⁷ however, since *Casey*,¹⁶⁸ protections for such speech in the abortion context have eroded steadily. Further, this weakened standard of protection may be expanding beyond abortion. This trend is particularly disturbing, since states often seek to constrain professional speech to obstruct the exercise of other constitutional rights. A few recent decisions, however, suggest that courts may be reconsidering their permissive stance towards state interference with physician professional speech.

A. Recent Cases Restricting Professional Speech Protections

Many recent cases continue to narrow or ignore existing protections for physician professional speech. Consider, for example, the *Planned Parenthood of Minnesota, North Dakota,*

¹⁶⁵ See Part II.B., *supra*; Haupt, *supra* note 1, at 1299-1300 (discussing mandatory ultrasound requirements in light of the individual physician's place within the larger medical community, she states, "Under the knowledge community-focused theory of professional speech, the professional is to decide what is relevant professional information. The knowledge community's insights not only determine what accurate information is, but also what is relevant in any given situation according to the specific circumstances of the client").

¹⁶⁶ See Part II.B., *supra*.

¹⁶⁷ In *City of Akron v. Akron Center for Reprod. Health*, 462 U.S. 416 (1983), and *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986), the Court held unconstitutional laws requiring doctors to make statements to patients to influence their decisions about abortion. The statutes invalidated in these cases very closely resembled many currently in force today involving false statements, ideological statements, and the one-sided provision of information. For a detailed discussion of these cases, see Berg, *supra* note 22, at 211-13.

¹⁶⁸ 505 U.S. 833 (1992). An earlier decision, *Rust v. Sullivan*, 111 S. Ct. 1759 (1991), paved the way for *Casey*. In *Rust*, physicians challenged a provision of Title X that forbids physicians from "provid[ing] counseling concerning the use of abortion as a method of family planning or provide referral for abortion as a method of family planning." 42 CFR § 59.8(a)(1) (1989). Further, under Title X, physicians may not refer patients to an abortion provider even upon their specific request; the recommended response to such inquiries is "'the [public health] project [funded by Title X] does not consider abortion an appropriate method of family planning and therefore does not counsel or refer for abortion.'" *Rust*, 111 S. Ct. at 1765; 42 CFR § 59.8(b)(5).

Despite the fact that physicians challenging the law raised First Amendment free speech grounds in their pleadings, the majority opinion did not independently assess First Amendment concerns from the vantage point of either the physician or patient. Brief for Petitioners at 13, *Rust* (No. 89-1391; *Rust*, 111 S. Ct. at 1771-72. Rather, the Court analyzed these issues solely through the lens of unconstitutional conditions doctrine, and on that basis concluded that this prohibition "[wa]s not the case of the Government 'suppressing a dangerous idea,' but of a prohibition on a project grantee or its employees from engaging in activities outside of its scope." *Rust*, 111 S. Ct. at 1772-73; for a more in-depth discussion, see Berg, *supra* note 22, at 209-11. Thus, the *Rust* majority endorsed government censorship of the speech of publicly funded physicians, including speakers, in order to promote its ideological viewpoint. Berg, *supra* note 22, at 210.

*South Dakota v. Rounds*¹⁶⁹ decision upholding South Dakota’s informed consent legislation. This law both requires doctors to give patients inaccurate information (that abortion leads to suicidal ideation and other mental health issues)¹⁷⁰ and convey the state’s ideological message (“the abortion will terminate the life of a whole, separate, unique, living human being,” and various assertions about the nature of the patient’s relationship with “that unborn human being”).¹⁷¹ The Eighth Circuit upheld the law, ruling that the statement “the abortion will terminate the life of a whole, separate, unique, living human being” was factual and not ideological because the state’s definition of “human being” included the “unborn” at any stage of development.¹⁷² This definition, however, does not turn an ideological statement into a factual one; whether or not a fetus is a human being is one of the most important ideological disputes between the pro-choice and anti-abortion movements. The Eighth Circuit also permitted South Dakota to continue requiring doctors to give patients false information about mental health connections to abortion, suggesting that advising patients of an “increased risk” of suicide after having an abortion does not imply a causal connection.¹⁷³ But, this textual justification is unconvincing; the statement is still misleading, and most people would interpret the link causally.

Following *Rounds*, the Fifth Circuit upheld Texas’s ultrasound requirements¹⁷⁴ in *Texas Med. Providers Performing Abortion Servs. v. Lakey*.¹⁷⁵ The Fifth Circuit analyzed the First Amendment concerns within *Casey*’s unconstitutional conditions framework and held that “such laws are part of the state’s reasonable regulation of medical practice and do not fall under the rubric of compelling ‘ideological’ speech that triggers First Amendment strict scrutiny.”¹⁷⁶ The Court also stated that “‘relevant’ informed consent may entail not only the physical and psychological risks to the expectant mother facing this ‘difficult moral decision,’ but also the state’s legitimate interests in ‘protecting the potential life within her.’”¹⁷⁷ Essentially, the Court considers the state’s ideological interests relevant information to the patient’s decision-making, separate from the patient’s own medical or moral concerns. Thus, the state can compel doctors to deliver its ideological message to women.

Although the state can seek to persuade women to forego abortion under *Casey*, the Court did not recognize that the regulations here were impermissibly coercive.¹⁷⁸ Further, although the Eighth Circuit acknowledged the district court’s concerns about women being required to listen to a sonogram description against their will, the opinion never addresses this particular issue.¹⁷⁹

¹⁶⁹ 530 F.3d 724 (8th Cir. 2008).

¹⁷⁰ See Part I.B., *supra*.

¹⁷¹ See Part I.B., *supra*.

¹⁷² *Rounds*, 530 F.3d at 735-36.

¹⁷³ *Planned Parenthood Min., N.D., S.D. v. Rounds*, 686 F.3d 889, 898-99 (2012) (stating that “Planned Parenthood argues that these studies do not examine the correlation between abortion and suicide in sufficient detail to prove a causal link . . . but, as we concluded above, the suicide advisory does not require disclosure of a causal link”).

¹⁷⁴ See Part I.D., *supra*.

¹⁷⁵ 667 F.3d 570 (5th Cir. 2012).

¹⁷⁶ *Id.* at 576.

¹⁷⁷ *Id.* (citing *Casey*, 505 U.S. at 871).

¹⁷⁸ *Id.* at 577-80.

¹⁷⁹ The Eighth Circuit concludes that requiring women to declare that they are victims of rape or incest to

B. Recent Decisions Evinced Respect for Professional Speech Protections

In a welcome deviation, the Fourth Circuit in *Stuart v. Loomis*¹⁸⁰ struck down North Carolina’s similar mandatory ultrasound law as unconstitutional. The Fourth Circuit held that “this compelled speech [related to the ultrasound] . . . is ideological in intent and in kind”¹⁸¹ and therefore violated the First Amendment. After acknowledging that the law was a regulation of the medical profession,¹⁸² the Court stated that this provision “extend[ed] well beyond” the normal measures used to ensure informed consent,¹⁸³ “impose[d] a virtually unprecedented burden on the right of professional speech that operates to the detriment of both speaker and listener,”¹⁸⁴ and “simultaneously threaten[ed] harm to the patient’s psychological health, interfer[ed] with the physician’s professional judgment, and compromise[d] the doctor-patient relationship.”¹⁸⁵

Some laws restricting physician speech on other topics—for example, discussions of medical uses for marijuana¹⁸⁶ and gun ownership¹⁸⁷—have been held unconstitutional as well. Ideally, these examples represent the start of a new trend of courts giving greater consideration to First Amendment concerns in physician professional speech cases; in light of the longstanding trend restricting protections for such speech, however, it is too soon to be more than cautiously optimistic.

V. CONCLUSION

Protecting professional speech from governmental ideological interference secures the First Amendment rights of patients and doctors to decisional, professional, intellectual, and physical autonomy and integrity. Despite the important interests at stake, through the misapplication of *Casey*, courts have condoned states’ infringement of these rights and have been complicit in states’ attempts to turn physicians into ideological mouthpieces. Consequently,

avoid listening to the sonogram is not problematic because if the State could properly decline to grant any exceptions to the informed-consent requirement, it cannot create an inappropriate burden on free speech rights where it simply conditions an exception on a woman’s admission that she falls within it. Indeed, such an infirmity could just as well be cured by striking down the exceptions alone as by striking down the requirement of written certification. Because the general requirement is valid, we see no constitutional objection to the certification required for an exception. But, there is no discussion about the issues associated with this “general requirement” or why such a provision does not implicate the patient’s First Amendment interests. *Id.* at 578.

¹⁸⁰ 992 F. Supp. 2d 585 (M.D.N.C. 2014), *aff’d sub nom.* *Stuart v. Camnitz*, 774 F.3d 238 (4th Cir. 2014), *cert. denied sub nom.* *Walker-McGill v. Stuart*, 135 S. Ct. 2838 (2015).

¹⁸¹ *Stuart*, 774 F.3d at 242.

¹⁸² *Id.*

¹⁸³ *Id.*

¹⁸⁴ *Id.* at 252.

¹⁸⁵ *Id.* at 250.

¹⁸⁶ *See* *Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997), *aff’d sub nom.* *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002) (invalidating a federal policy forbidding physicians from recommending or prescribing medical marijuana to patients).

¹⁸⁷ *See* *Wollschlaeger v. Governor of Fla.*, 848 F.3d 1293 (Feb. 16, 2017) (finding Florida’s law forbidding physicians from discussing firearm ownership with patients to be an unconstitutional content-based restriction on physicians’ speech).

states' trespasses on doctor-patient discourse have become increasingly flagrant and oppressive, and continue to expand within and beyond the abortion context. A few recent cases provide hope that courts may be rethinking their permissive approach to state impositions on physicians' professional speech, but considering the long trend towards greater restriction, the fight to regain proper protection for such speech will likely be an uphill battle.

Although professional speech has been especially important in the abortion regulation context, the same interests govern other areas of medicine and other professions. Already, states have sought to take advantage of this lower standard and courts' permissive approach to the persuasion-coercion distinction to constrain physician-patient discussion of marijuana and firearms. Indeed, nothing limits this standard to physicians; it could be extrapolated easily to other professional speech contexts, including the law. Such restrictions on professional speech are especially disturbing considering the important role professionals and their advice play in the exercise of constitutional rights. But the First Amendment can and has historically protected individuals and professionals from becoming mouthpieces of the state. Such protections for professional speech should be restored.

