

I SAW THE SIGN: NIFLA V. BECERRA AND INFORMED CONSENT TO ABORTION

*Thea Raymond-Sidel**

In 2018, the Supreme Court held in National Institute of Family & Life Advocates v. Becerra (NIFLA) that requiring a crisis pregnancy center to place a sign in its waiting room alerting people to available abortion services elsewhere violated the First Amendment. Abortion providers are often faced with similar requirements—but the Court’s cursory treatment of the First Amendment in Planned Parenthood of Southeastern Pennsylvania v. Casey left their rights in flux for decades. Commentators lamented that the Court saw fit to protect a crisis pregnancy center from state-written compelled speech but left abortion providers without the same constitutional protections. This Note argues that, far from exempting abortion providers from its holding, NIFLA in fact provides the first Supreme Court guidance since Casey for interpreting state informed consent statutes that implicate the speech of abortion providers. The reasoning of NIFLA compels the conclusion that “pure speech” for the crisis pregnancy center must be “pure speech” for the abortion provider.

This Note proceeds in three parts. Part I provides an overview of the law of compelled speech, abortion jurisprudence, and how these two disparate areas of the law have converged in the courts prior to NIFLA. Part II argues that NIFLA should force lower courts to reckon with what constitutes “conduct” in the abortion context and what must constitute “pure speech.” Part III uses NIFLA’s language to develop a framework to assess whether a restriction regulates conduct or speech in the abortion context and demonstrates how such a framework could be applied to ubiquitous informed consent restrictions passed in states across the country.

INTRODUCTION

In Kansas, any clinic that provides abortion services must place a sign where every patient can see it. It must read, in three-quarter-inch, boldfaced type, that a woman cannot be forced to have an abortion; that she may change her mind at any time; that the father must provide child support; that if she decides against having an abortion, the state can help finance the costs of childbirth; and that state agencies are available to assist with the process.¹ In California, a similar law was passed mandating

* J.D. Candidate 2020, Columbia Law School. The author would like to thank Vincent Blasi, Carol Sanger, and the staff of the *Columbia Law Review* for their thoughtful feedback and editorial assistance.

1. Kan. Stat. Ann. § 65-6709(k) (West 2019).

signs in the waiting rooms of crisis pregnancy centers (CPCs).² They read, in pertinent part:

California has public programs that provide immediate free or low-cost access to comprehensive family planning services (including all FDA-approved methods of contraception), prenatal care, and abortion for eligible women.³

In June 2018, the Supreme Court struck down the latter signage law, the California Reproductive Freedom, Accountability, Comprehensive Care, and Transparency (FACT) Act, as an unconstitutional infringement on the First Amendment rights of crisis pregnancy centers.⁴ Kansas differentiates its signage law from the California statute by requiring the sign as a precursor to a patient's voluntary and informed consent to abortion.⁵ Under *National Institute of Family & Life Advocates v. Becerra* (*NIFLA*), the Kansas statute would be subject to the rational basis review that accompanies a state-imposed informed consent requirement to a medical procedure, because, as the argument goes, the statute regulates conduct and only incidentally burdens speech.⁶ Conversely, statutes like the FACT Act, "regulat[ing] speech as speech," are subject to strict scrutiny.⁷ Applying such divergent standards to such similar regulations is not trivial: In most cases, a statute that receives rational basis scrutiny is constitutional;⁸ a statute that receives strict scrutiny is not.⁹

2. Care Net, a chain of CPCs, states that it "provide[s] compassionate support to women and men faced with difficult pregnancy decisions" and offers services like free pregnancy tests, limited ultrasounds, and "[p]regnancy decision coaching by trained advocates." What Is a Pregnancy Center?, Care Net, <https://www.care-net.org/what-is-a-pregnancy-center> [<https://perma.cc/A87V-CY9T>] (last visited Nov. 4, 2018).

3. Cal. Health & Safety Code § 123472(a)(1) (2018); Nat'l Inst. of Family & Life Advocates v. Becerra (*NIFLA*), 138 S. Ct. 2361, 2368–69 (2018). Unlicensed clinics were required to add an addendum: "This facility is not licensed as a medical facility by the State of California and has no licensed medical provider who provides or directly supervises the provision of services." Cal. Health & Safety Code § 123472(b)(1); *NIFLA*, 138 S. Ct. at 2369–70. Alternatively, clinics could satisfy the statute's requirement by dispensing a printed or digital notice. Cal. Health & Safety Code § 123472(a)(2).

4. *NIFLA*, 138 S. Ct. at 2370.

5. Kan. Stat. Ann. § 65-6709. The statute reads that "consent to an abortion is voluntary and informed only if" the abortion provider abides by a series of rigorous disclosure requirements, many with multiple subrequirements, including a twenty-four-hour waiting period, various state-written pamphlets, state-written language on the clinic's website, and the aforementioned sign. *Id.*

6. See *NIFLA*, 138 S. Ct. at 2373–74.

7. *Id.* at 2374.

8. Cf. Robert C. Farrell, Successful Rational Basis Claims in the Supreme Court from the 1971 Term Through *Romer v. Evans*, 32 Ind. L. Rev. 357, 357 (1999) (finding that in twenty-five years, the Court accepted only ten rational basis claims under the Equal Protection Clause but rejected 100 of them, for a success rate of ten percent).

9. Compare Gerald Gunther, Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection, 86 Harv. L. Rev. 1, 8 (1972) (coining the now-famous adage that strict scrutiny is "'strict' in theory and fatal in fact"), with Adam Winkler, Fatal in Theory and Strict in Fact: An Empirical Analysis of Strict

In states across the country, abortion providers are required to speak state-written scripts,¹⁰ hand out pamphlets,¹¹ perform and describe ultrasounds,¹² provide mandated counseling,¹³ mandate waiting periods,¹⁴ and put up signs,¹⁵ all in the service of ensuring the patient's informed consent to abortion.¹⁶ One might think that many of these laws infringe on the provider's freedom to speak without government interference¹⁷—or perhaps even the patient's right to refuse to listen¹⁸—but the medical context, and particularly the abortion context, is special.

Many potential First Amendment challenges to abortion restrictions were foreclosed by *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the case that laid the foundation for modern abortion jurisprudence.¹⁹ In *Casey*, the Court relegated its First Amendment consideration of an

Scrutiny in the Federal Courts, 59 Vand. L. Rev. 793, 795–96 (2006) (finding from an empirical study of applications of strict scrutiny in the federal courts that statutes survive such challenges thirty percent of the time).

10. See, e.g., Ind. Code § 16-34-2-1.1 (2019) (requiring abortion providers to inform their patients that “human physical life begins when a human ovum is fertilized by a human sperm”; that a fetus can feel pain at or before twenty weeks of gestation; and that an ultrasound is available to enable the woman to view her fetus).

11. See, e.g., Kan. Stat. Ann. §§ 65-6709(b)(1)–(2), 65-6710 (West 2019) (prescribing that physicians must tell their patients that “abortion terminates the life of a whole, separate, unique, living human being” and provide state-written materials giving information on child support, adoption services, gestational ages of the fetus, fetal pain, and the fetal heartbeat).

12. See, e.g., Wis. Stat. § 253.10(3g)(a) (2019) (compelling the abortion provider to perform an ultrasound on the pregnant patient in order to obtain informed consent, while describing the images on the screen, including the developing organs and the fetal heartbeat).

13. See, e.g., La. Stat. Ann. § 40:1061.17(B) (2019) (requiring that a woman be counselled about her abortion at least twenty-four hours before it may take place, necessitating at least two trips to the clinic and, if the patient has travelled to visit the clinic, an overnight stay).

14. See, e.g., Mo. Ann. Stat. § 188.039 (West 2019) (instituting a seventy-two-hour waiting period between counseling and an abortion except in medical emergencies).

15. See, e.g., Kan. Stat. Ann. § 65-6709(k).

16. See, e.g., Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. Ill. L. Rev. 939, 941 (“The obvious objective of [South Dakota’s informed consent statute] is to use the concept of ‘informed consent’ to eliminate abortions.”); see also Jennifer M. Keighley, *Physician Speech and Mandatory Ultrasound Laws: The First Amendment’s Limit on Compelled Ideological Speech*, 34 Cardozo L. Rev. 2347, 2348 n.2 (2013) (“I refer to ‘informed consent’ in quotes throughout this Article . . . since [laws termed as such] fall outside of the ordinary understanding of what information is necessary in order for a patient to give informed consent to a medical procedure.”).

17. See, e.g., *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943).

18. See Caroline Mala Corbin, *The First Amendment Right Against Compelled Listening*, 89 B.U. L. Rev. 939, 996–1007 (2009) [hereinafter Corbin, *Compelled Listening*]; see also Helen Norton, *Pregnancy and the First Amendment*, 87 Fordham L. Rev. 2417, 2429 (2019) (arguing that applying the First Amendment fairly to CPCs and abortion providers alike requires “tak[ing] women’s interests as listeners seriously”).

19. 505 U.S. 833 (1992).

informed consent provision to three sentences,²⁰ and many circuits have taken that light assessment to mean that First Amendment principles do not apply in full force to abortion providers, at least when seeking their patients' informed consent.²¹ The complication now, of course, is that those First Amendment principles *do* apply in full force to a crisis pregnancy center mandated to speak state-sponsored words via a sign in its waiting room, and the *NIFLA* Court did not conclusively establish where a statute like the FACT Act ends and where informed consent begins.²² Can such a wide First Amendment chasm exist between the waiting room and the examination room, between the crisis pregnancy center and the abortion provider, between Kansas and California?

This Note argues that *NIFLA* requires courts to develop a framework to determine whether an informed consent statute violates the First Amendment rights of abortion providers. Part I reexamines the compelled speech doctrine, the Court's abortion jurisprudence, and the notoriously muddied history of First Amendment doctrine as applied to abortion providers. Part II demonstrates that the analysis in *NIFLA* lends support to full First Amendment protections for doctors in consultation with their patients, and the informed consent exception, as it was applied in *NIFLA*, should serve as a basis for defining informed consent for First Amendment purposes in future cases involving abortion providers. Part III proposes a framework based on *NIFLA* for how courts should assess informed consent statutes, in order to determine whether the speech should be accorded full First Amendment protections under *NIFLA*, or may properly be defined as an informed consent requirement.

20. *Id.* at 884. For a more thorough discussion of the Court's First Amendment aside in *Casey*, see *infra* notes 66–71 and accompanying text.

21. See *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 574–75 (5th Cir. 2012) (“The plurality response to the compelled speech claim [in *Casey*] is clearly not a strict scrutiny analysis. It inquires into neither compelling interests nor narrow tailoring. The three sentences with which the Court disposed of the First Amendment claims are, if anything, the antithesis of strict scrutiny.”); *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 733–35 (8th Cir. 2008) (en banc) (holding that informed consent requirements may only be invalidated as a violation of the physician's right not to speak if they are “either untruthful, misleading or not relevant to the patient's decision to have an abortion”). But see *Stuart v. Camnitz*, 774 F.3d 238, 246 (4th Cir. 2014) (striking down a mandatory ultrasound requirement similar to that in *Lakey* because requiring a physician to show their patient that particular image in the context of an abortion is “quintessential compelled speech [as] [i]t forces physicians to say things they otherwise would not say”). For a full discussion of *Rounds* and *Stuart*, see *infra* section I.C.

22. *Nat'l Inst. of Family & Life Advocates v. Becerra (NIFLA)*, 138 S. Ct. 2361, 2373–74 (2018).

I. THE FIRST AMENDMENT IN THE ABORTION CONTEXT PRE-NIFLA

This Part provides an overview of how the Court has reacted to claims that the First Amendment should protect physician speech,²³ particularly in the abortion context, prior to *NIFLA*. This history is brief and puzzling, because abortion cases have their own complex and controversial jurisprudence, often dwarfing other doctrines that might also apply.²⁴ Section I.A first examines the Court's compelled speech doctrine in cases *not* involving abortion providers, then explains the Court's abortion jurisprudence and how it dwarfed First Amendment considerations in the first abortion cases after *Roe v. Wade* that implicated physician speech. Section I.B discusses in detail the case that laid the foundation for the clash of the Court's First Amendment and abortion doctrines, *Planned Parenthood of Southeastern Pennsylvania v. Casey*. Finally, section I.C examines the confusion that *Casey* caused in the lower courts and concludes that more guidance is needed to help lower courts understand how these two disparate and complex doctrines should interact when pitted against each other.

23. For the purposes of this Note, "physician speech" refers only to speech between physicians and their patients in the context of a medical consultation or solicitation of informed consent for a procedure. This Note does not discuss physician speech outside of that context—though commentators have agreed that restrictions on public speech by physicians would likely be content-based restrictions on speech, subject to strict scrutiny. See Post, *supra* note 16, at 947–49 (discussing the case of a Connecticut dentist who wrote an editorial protected by the First Amendment, even if the same advice given to a patient in his office would be subject to state regulation); see also Daniel Halberstam, Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions, 147 U. Pa. L. Rev. 771, 843 (1999) ("The State's permissible interest in licensing physicians is limited to practicing physicians and does not allow the State to require a license as a prerequisite for a physician to speak about medicine outside the context of professional practice.").

This Note also does not discuss medicine-related commercial speech in detail, such as pharmaceutical advertisements. For more information on such issues, see *Sorrell v. IMS Health, Inc.*, 562 U.S. 552, 557 (2011) (applying heightened scrutiny to restrictions on the use of pharmacy records for marketing purposes and holding that the state's interest in patient privacy does not satisfy that standard); *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626, 637 (1985) ("There is no longer any room to doubt that . . . 'commercial speech' is entitled to the protection of the First Amendment, albeit to protection somewhat less extensive than that afforded 'non-commercial speech.'").

24. This phenomenon—of an incoherent abortion jurisprudence inapplicable to other situations—has been called "abortion exceptionalism." See Caroline Mala Corbin, *Abortion Distortions*, 71 Wash. & Lee L. Rev. 1175, 1210 (2014) [hereinafter Corbin, *Abortion Distortions*] ("Abortion exceptionalism means the rules are different for abortion cases. . . . Instead of applying existing First Amendment jurisprudence, courts ignore fundamental principles or distort them beyond recognition. . . . These distortions not only impede women's reproductive rights but also result in highly problematic precedents."); see also Jeffrey Toobin, *The Nine* 36 (2007) ("There were two kinds of cases before the Supreme Court. There were the abortion cases—and then there were all the others.").

A. *Basic Principles: Abortion and the First Amendment*

This section lays out the basic principles that underlie the Court's compelled speech jurisprudence and its abortion jurisprudence and describes how the Court reacted when the two collided post-*Roe*. The forthcoming sections are certainly not intended to be a thorough exploration of either doctrine—but a basic understanding of both is necessary to understand how they have interacted when the Court has faced questions about the First Amendment rights of abortion providers.

1. *The Compelled Speech Doctrine.* — Just as the First Amendment protects an individual's right to speak without government interference, it protects an individual's right *not* to speak a message the government would like to broadcast.²⁵ Compelled speech can materialize as union dues,²⁶ column inches in a newspaper,²⁷ the Pledge of Allegiance,²⁸ a license plate,²⁹ and, of course, a sign in the waiting room of a crisis pregnancy center.³⁰ While the Court has applied compelled speech principles to cases in which an aggrieved party has had to facilitate others' speech on its own property,³¹ or fund speech with which they may not agree,³² this Note is primarily interested in the purest form of compelled speech: when a private entity is directly required to speak words written for them by the state. Two foundational cases in the Court's compelled speech jurisprudence are the authority on how the Court has approached required direct speech in the past: *West Virginia State Board of Education v. Barnette*³³ and *Wooley v. Maynard*.³⁴

In *Barnette*, a case challenging a requirement that children recite the Pledge of Allegiance in public schools, the Court expressed discomfort with the state being able to “compel [its people] to utter what is not in [their] mind.”³⁵ In particular, where an assertion “requires affirmation of a belief and an attitude of mind,” the state cannot invoke its “power of

25. See, e.g., *Riley v. Nat'l Fed'n of the Blind of N.C., Inc.*, 487 U.S. 781, 796–97 (1988) (“[T]he First Amendment guarantees ‘freedom of speech,’ a term necessarily comprising the decision of both what to say and what *not* to say.”).

26. *Janus v. Am. Fed'n of State, Cty. & Mun. Emps., Council 31*, 138 S. Ct. 2448, 2459–60 (2018).

27. *Miami Herald Publ'g Co. v. Tornillo*, 418 U.S. 241, 256 (1974).

28. *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943).

29. *Wooley v. Maynard*, 430 U.S. 705, 714–15 (1977).

30. *Nat'l Inst. of Family & Life Advocates v. Becerra (NIFLA)*, 138 S. Ct. 2361, 2375–76 (2018).

31. See, e.g., *Tornillo*, 418 U.S. at 258 (holding that a Florida statute creating a “right to reply” for candidates criticized in the pages of a newspaper contravened the First Amendment).

32. See, e.g., *Janus v. Am. Fed'n of State, Cty. & Mun. Emps., Council 31*, 138 S. Ct. 2448, 2460 (2018).

33. 319 U.S. at 642.

34. 430 U.S. at 714.

35. *Barnette*, 319 U.S. at 634.

compulsion” to require citizens, even and perhaps especially children, to utter it.³⁶ In *Wooley*, that principle was expanded not just to adults, who are presumably less inclined to believe speech they are required to recite,³⁷ but also to speech printed on one’s license plate and not recited at all.³⁸

There are, of course, many exceptions to this line of reasoning.³⁹ But *Wooley* and *Barnette* establish that whenever the government requires anyone⁴⁰ to speak words written for them by the state, and convey a belief in those words, that requirement would almost certainly be a content-based restriction on speech and accorded strict scrutiny.⁴¹

2. *Early Collisions: Abortion Jurisprudence and Compelled Speech.* — The greatest hits of the Supreme Court’s abortion jurisprudence are so well-known that knowledge of them might be taken for granted. After the Court found that a woman’s access to birth control was within the “penumbra” of rights guaranteed by the Fourteenth Amendment,⁴² the

36. *Id.* at 633–34, 637.

37. The recitation–belief connection outlined in *Barnette* itself has been criticized by some commentators. See, e.g., Larry Alexander, *Compelled Speech*, 23 *Const. Comment.* 147, 154 (2006) (“*Saying* what you do not believe is certainly not the same as *believing* what you do not believe, a self-contradiction. Moreover, although one can be coerced to say things, one cannot be coerced to believe them.”).

38. *Wooley*, 430 U.S. at 715 (“New Hampshire’s statute in effect requires that appellees use their private property as a ‘mobile billboard’ for the State’s ideological message or suffer a penalty . . .”). Commentators have argued that the speech at issue in *Wooley* is even less likely to coerce belief in the state’s chosen principles than the speech at issue in *Barnette*. See, e.g., Alexander, *supra* note 37, at 152 (“*Wooley* seems particularly difficult to explain as a case of coercive inculcation of beliefs/values.”).

39. For our purposes, the commercial speech doctrine—which allows the state to require companies to disclose factual, uncontroversial information to the public in their advertisements—is the most important. See *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626, 651 (1985) (“The State has attempted only to prescribe . . . that appellant include in his advertising purely factual and uncontroversial information about the terms under which his services will be available. . . . [A]ppellant’s constitutionally protected interest in *not* providing any particular factual information in his advertising is minimal.”); see also *supra* note 23 and accompanying text.

40. While *Wooley* and *Barnette* involved actual aggrieved citizens (or parents of citizens), the Court does not seem to make distinctions in its compelled speech cases based on whether the speaker is an individual, an institution, or a corporation. See Eugene Volokh, *The Law of Compelled Speech*, 97 *Tex. L. Rev.* 355, 356 n.14 (2018).

41. Under current First Amendment law, content-based restrictions on speech “are presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests.” *Reed v. Town of Gilbert*, 135 S. Ct. 2218, 2226 (2015).

42. *Griswold v. Connecticut*, 381 U.S. 479, 483–86 (1965) (married women); see also *Eisenstadt v. Baird*, 405 U.S. 438, 443 (1972) (single women). Even at this early stage in the doctrine, the Court declined to engage with First Amendment issues raised by doctor–patient discourse. Just a few years before *Griswold*, a married couple and their physician brought suit alleging that a Connecticut law criminalizing conversation about contraceptives and use of contraceptives contravened their Fourteenth Amendment rights. *Poe v. Ullman*, 367 U.S. 497, 500 (1961). The Court dismissed the case, holding that,

right to a safe, legal abortion shortly followed.⁴³ This right would not be absolute; the Court cautioned that it must be balanced against “important state interests in regulation,” including “interests in safeguarding health, in maintaining medical standards, and in protecting potential life.”⁴⁴ The grand compromise of *Roe* was thus established: During the first trimester, a woman’s right to a safe abortion, in consultation with her physician, is a fundamental right that can only be regulated by a compelling state interest, “narrowly drawn to express only the legitimate state interests at stake.”⁴⁵ Subsequent to the first trimester, the state could “regulate the abortion procedure in ways that are reasonably related to maternal health” and limit or even proscribe the procedure when the state was promoting its interest in the “life or health of the mother.”⁴⁶ Until *Planned Parenthood of Southeastern Pennsylvania v. Casey* twenty years later,⁴⁷ any state wishing to regulate abortion was forced to contend with this framework. Thus, the first cases that implicated speech in the abortion context—*City of Akron v. Akron Center for Reproductive Health* and *Thornburgh v. American College of Obstetricians & Gynecologists*—were adjudged under the *Roe* framework, rather than the compelled speech framework established by *Barnette* and *Wooley*.⁴⁸

The *Akron* ordinance required a doctor to inform a patient that “the unborn child is a human life from the moment of conception”; that in undergoing the abortion she may be at risk of “hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and

because neither the patient nor the doctor had been prosecuted, the case was not justiciable. *Id.* at 508–09.

Justice Douglas, in dissent, argued that the Court should have reached the issue, and that it contravened not only the Fourteenth Amendment but also the First: “The right of the doctor to advise his patients according to his best lights seems so obviously within First Amendment rights as to need no extended discussion. . . . The contrary thought . . . [is] at war with the philosophy and presuppositions of this free society.” *Id.* at 513–14 (Douglas, J., dissenting). When this same law was considered by the Court again four years later in *Griswold* (this time because the case began with a prosecution, forcing the issue), Douglas, now writing for the majority, referenced the First Amendment only as an element of the right to privacy. Further, the focus of the First Amendment discussion was on the right of association, not speech. *Griswold*, 381 U.S. at 482–84.

43. *Roe v. Wade*, 410 U.S. 113, 153–54 (1973) (“This right of privacy . . . is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy.”).

44. *Id.* at 154.

45. *Id.* at 155, 163–65 (citing *Griswold*, 381 U.S. at 485).

46. *Id.* at 164–65.

47. See *infra* section I.B.

48. See *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 772 (1986) (framing the decision as falling “within the limits specified in *Roe*”); *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 431–34 (1983) (discussing *Roe*’s application to the ordinance at issue). *Wooley* goes uncited in the majority opinions of both *Thornburgh* and *Akron*. *Thornburgh*, 476 U.S. at 750–72; *Akron*, 462 U.S. at 419–52. The only Justice to cite *Wooley* in either case, Justice O’Connor, does so in dissent. See *Thornburgh*, 476 U.S. at 830 (O’Connor, J., dissenting); *Akron*, 462 U.S. at 472 n.16 (O’Connor, J., dissenting); see also *infra* notes 52–62 and accompanying text.

prematurity in subsequent pregnancies”; and that “numerous public and private agencies” are available to assist the patient during pregnancy, help her find contraception, or aid her in putting the child up for adoption.⁴⁹ The Court did not mince words when it ruled that the Akron ordinance did not meet the *Roe* standard: It called the provisions of the statute that implicated speech a “parade of horrors” and stated that the statute was “designed not to inform the woman’s consent but rather to persuade her to withhold it altogether.”⁵⁰

Instead of prescribing an exact script that the abortion provider must read, as in *Akron*, the statute in *Thornburgh* required explanation of several types of information that must be relayed to the patient.⁵¹ The majority relied on its reasoning in *Akron* and concluded that requiring the physician to relay a rigid list of risks and information to every patient, regardless of their relation to her situation, cannot be narrowly tailored to effect the state’s interest in protecting women’s health.⁵² The First Amendment implications of these invasive requirements went unexplored in the majority opinions of *Akron* and *Thornburgh*.

In *Akron*, only Justice O’Connor, in dissent, addressed the application of compelled speech principles to these regulations. In the course of arguing for an “undue burden” standard to replace the strict scrutiny standard defined in *Roe*—an argument that would win the day in *Casey* nine years later⁵³—she referenced the possibility of a First Amendment argument as well.⁵⁴ Justice O’Connor did not agree that the informed consent provisions in the Akron ordinance should be

49. *Akron*, 462 U.S. at 423 & n.5. Other challenged provisions of the ordinance include a requirement that all abortions after the first trimester be performed at a hospital; a parental notification and consent requirement for unmarried minors; a twenty-four-hour waiting period between written consent and the procedure; and a requirement that the fetal remains be “disposed of in a humane and sanitary manner.” *Id.* at 422–25. Violation of any provision constituted a criminal misdemeanor. *Id.* at 425.

50. *Id.* at 444–45.

51. *Thornburgh*, 476 U.S. at 760–61. The information required included: (1) the “fact that there may be detrimental physical and psychological effects which are not accurately foreseeable”; (2) the “particular medical risks associated with the particular abortion procedure to be employed”; (3) the risks of carrying a child to term; and (4) the fact that assistance may be available for medical care associated with pregnancy and childbirth, among other things. *Id.* (internal quotation marks omitted) (quoting 18 Pa. Cons. Stat. §§ 3205, 3208 (1986)).

52. *Id.* at 763–64. The Court took particular umbrage with the requirement that the physician inform the patient of all medical risks associated with the procedure, whether or not they apply to her: “This type of compelled information is the antithesis of informed consent.” *Id.* at 764.

53. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 874–79 (1992) (plurality opinion).

54. *Akron*, 462 U.S. at 472 n.16 (O’Connor, J., dissenting) (citing *Wooley v. Maynard*, 430 U.S. 705 (1977)).

invalidated under a right to privacy under *Roe*.⁵⁵ But in a footnote, she laid the groundwork for a First Amendment argument for overruling the provision: “This is not to say that the informed consent provisions may not violate the First Amendment rights of the physician if the State requires him or her to communicate its ideology.”⁵⁶

In *Thornburgh*, Justice O’Connor, again dissenting, doubled down on her commitment to a possible First Amendment argument against an overreaching informed consent provision. Recall that instead of prescribing an exact script that the abortion provider must read, as in *Akron*, the statute in *Thornburgh* required explanation of several types of information that must be relayed to the patient.⁵⁷ Justice O’Connor expanded on her footnote in *Akron*, stating that there may be a legitimate First Amendment argument against informed consent provisions like the one at issue:

I do not dismiss the possibility that requiring the physician or counselor to read aloud the State’s printed materials if the woman wishes access to them but cannot read raises First Amendment concerns. Even the requirement that women who can read be informed of the availability of those materials, and furnished with them on request, may create some possibility that the physician or counselor is being required to “communicate [the State’s] ideology.”⁵⁸

Notice the stride Justice O’Connor had taken from *Akron* to *Thornburgh*: Not only did she recognize that perhaps a state informed consent requirement may invade the physician’s First Amendment rights under *Wooley*, she proposed extending that reasoning to a requirement that a physician offer materials written by the state.⁵⁹ Her argument that the First Amendment applies to compelled doctor speech could easily have been limited to what the state requires doctors to *say*—recall that the statute in *Akron* compelled the doctor to verbally speak state-written phrases.⁶⁰ But by extending the possibility that the First Amendment applies to state-written materials the doctor is bound to offer in

55. Id. at 472 (“The city of Akron is merely attempting to ensure that the decision to abort is made in light of that knowledge that the city deems relevant to informed choice.”).

56. Id. at 472 n.16 (citing *Wooley*, 430 U.S. 705).

57. See *supra* note 51.

58. *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 830–31 (1986) (O’Connor, J., dissenting) (alteration in original) (quoting *Akron*, 462 U.S. at 472 n.16) (citing *Wooley*, 430 U.S. 705). The plaintiffs, in their briefs to the Court, only invoked the First Amendment at length in the context of the mandatory disclosure requirements in another provision of the statute at issue. See Brief for Appellees at 30a–31a, *Thornburgh*, 476 U.S. 747 (No. 84-495), 1985 WL 669697.

59. *Thornburgh*, 476 U.S. at 830–31 (O’Connor, J., dissenting).

60. See *supra* note 49 and accompanying text.

Thornburgh,⁶¹ Justice O'Connor suggested that a slew of requirements—including those at issue in *NIFLA*⁶²—could be included in her proposed category of protected speech.

B. *Planned Parenthood of Southeastern Pennsylvania v. Casey: A Grinding Halt?*

In *Casey*, Justice O'Connor, along with Justices Souter and Kennedy, had the opportunity to finally apply the undue burden standard she argued for in *Akron* and *Thornburgh*⁶³—and elaborate on the First Amendment arguments she articulated in those cases. Faced with an informed consent provision similar to that in *Thornburgh*,⁶⁴ the plurality held that “when the government requires . . . the giving of truthful, nonmisleading information” about a procedure, its health effects, and the “probable gestational age” of the fetus, that information is compatible with the state’s interest in potential life and did not pose an undue burden on a woman seeking an abortion.⁶⁵

On the First Amendment issue, though, the plurality had only this to say:

All that is left of petitioners’ argument is an asserted First Amendment right of a physician not to provide information about the risks of abortion, and childbirth, in a manner mandated by the State. To be sure, the physician’s First Amendment rights not to speak are implicated, see *Wooley v. Maynard*, 430 U.S. 705 (1977), but only as part of the practice of medicine, subject to reasonable licensing and regulation by the

61. This is not unlike extending the First Amendment principles at issue in *Barnette*—whether the state may require its citizens to verbally affirm its values via a script—to *Wooley*—whether the state may require its citizens, on their own property, to offer up to others state-written affirmations. See *Wooley*, 430 U.S. at 714–15; *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943); see also *supra* notes 35–38 and accompanying text.

62. See *supra* note 3 and accompanying text.

63. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 874–79 (1992) (plurality opinion); *Thornburgh*, 476 U.S. at 828–32 (O'Connor, J., dissenting); *Akron*, 462 U.S. at 461–65 (O'Connor, J., dissenting).

64. The statute at issue in *Casey* required that the patient be informed of the nature of the procedure, the risks of both abortion and childbirth, and the “probable gestational age of the unborn child” at least twenty-four hours before the procedure. *Casey*, 505 U.S. at 881 (internal quotation marks omitted) (quoting 18 Pa. Cons. Stat. § 3205 (1990)). The statute also required that the woman be informed of state materials providing information on agencies able to assist with pregnancy and childbirth, child support, and adoption. *Id.* It is notable, though, that those materials were not required to be given to the patient; she was only required to be told that they were available if she would like them. *Id.*

65. *Id.* at 882 (internal quotation marks omitted) (quoting 18 Pa. Cons. Stat. § 3205). The Court overruled the majority opinions in *Akron* and *Thornburgh* to the extent that those cases disagreed, in effect widening the scope of what could be deemed an informed consent requirement under the Court’s abortion jurisprudence. *Id.*; see also *infra* section II.C.1. The only restriction the Court struck down under the undue burden standard was the requirement that a married woman must inform her husband of her decision to have an abortion. *Casey*, 505 U.S. at 893–94.

State, cf. *Whalen v. Roe*, 429 U.S. 589, 603 (1977). We see no constitutional infirmity in the requirement that the physician provide the information mandated by the State here.⁶⁶

Scholars and commentators have puzzled over this short passage for decades.⁶⁷ Some argue that it implied that restrictions on physician speech should be accorded a deferential “rational basis” standard, like regulations on commercial speech, and because the statute in *Casey* so clearly met this standard there was no need for additional discussion.⁶⁸ Some courts have interpreted this passage to mean that the First Amendment considerations of physician speech are essentially subsumed into the undue burden standard that the information be truthful and nonmisleading.⁶⁹ Others have written that this passage, along with other asides from the Court,⁷⁰ argues for a lower First Amendment standard not just for doctors but a larger class of professionals while they are advising clients.⁷¹ When teasing apart the threads of this passage, it is important that *Casey*, like *Akron* and *Thornburgh* before it, was argued without extensive briefing on the First Amendment implications of

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

67. See Halberstam, *supra* note 23, at 773–74. Daniel Halberstam states:

The passage tells us that physicians enjoy First Amendment rights, but provides little guidance about the weight given to the First Amendment interests involved. The application of *Wooley* would demand a compelling governmental interest to overcome the physician’s First Amendment rights The passage cited from *Whalen*, on the other hand, would appear to import only the basic due process limitations on nonspeech regulations of professionals. To fuse these two models in a shorthand formulation provides little indication of how to resolve any professional’s First Amendment claim other than the precise one at issue in *Casey*.

Id. (footnotes omitted); see also Post, *supra* note 16, at 946 (“Exactly how the strict First Amendment standards of *Wooley* are meant to qualify the broad police power discretion of *Whalen* is left entirely obscure.”).

68. Cf. Halberstam, *supra* note 23, at 775–77 (attempting to tease out the differences between how the courts should analyze commercial and professional speech). Because the Third Circuit in *Casey* held that the informed consent statute should be analyzed according to the lower standard of commercial speech under *Zauderer*, and the Supreme Court did not address that conclusion at all in this passage, it seems unlikely that the Court intended those standards to be the same. See *Planned Parenthood of Se. Pa. v. Casey*, 947 F.2d 682, 705–06 (3d Cir. 1991), *aff’d in part, rev’d in part*, 505 U.S. 833 (1992).

69. See, e.g., *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 734–35 (8th Cir. 2008) (en banc). For a full discussion of the reasoning in *Rounds*, see *infra* section I.C.1.

70. For a fuller discussion of the growth of the professional speech doctrine and the Court’s disavowal of it in *NIFLA*, see *infra* section II.A.1.

71. See Claudia E. Haupt, *Professional Speech*, 125 *Yale L.J.* 1238, 1257–60, 1262–63 (2016) [hereinafter Haupt, *Professional Speech*]. But see Rodney A. Smolla, *Professional Speech and the First Amendment*, 119 *W. Va. L. Rev.* 67, 79–81 (2016) (“*Casey*’s three obscure sentences are hardly enough to build a coherent body of First Amendment law.”).

compelling a physician to offer state-written materials.⁷² In particular, the plaintiffs' First Amendment argument did not distinguish between state-written speech required to be delivered in the physician's own voice as in *Akron*, state-written speech required to be delivered via a pamphlet as in *Thornburgh*, or state-written speech required to be *made available* via a pamphlet, as the Pennsylvania statute at issue in *Casey* mandated.⁷³

It has been persuasively argued that this distinction explains the Court's cursory treatment of the First Amendment issue.⁷⁴ The plurality, in its First Amendment aside in *Casey*, was careful to state that there is "no constitutional infirmity in the requirement that the physician *provide* the information mandated" by the Pennsylvania statute.⁷⁵ Further, the plurality questions whether it is an undue burden for the doctor to be required to "make available" materials written by the state to patients.⁷⁶ The fact that the state may assert its position on abortion through materials that the doctor is not required to read or force their patient to read appears significant to the Court's reasoning. As a result, the Court provides little if any guidance for situations in which the state essentially uses the doctor as its mouthpiece.⁷⁷ Justice O'Connor's concern for the First Amendment implications of that situation are evident in her dissents in *Akron* and *Thornburgh* and should not be entirely discounted even in light of the language in *Casey*.

72. See Keighley, *supra* note 16, at 2358–59 & n.46. It has been well documented that this was the plaintiffs' strategy—the legal team challenging the statute wanted to force the Court to either reaffirm or overturn *Roe*. See Toobin, *supra* note 24, at 4. In the fall of 1991, instead of petitioning for a rehearing en banc in the Third Circuit, the plaintiffs took only three weeks to file their petition for certiorari. *Id.* at 48–49. In their petition, the plaintiffs presented a single provocative question to force the Court to resolve *Roe* one way or another: "Has the Supreme Court overruled *Roe v. Wade*, holding that a woman's right to choose abortion is a fundamental right protected by the United States Constitution?" *Id.* at 49.

73. Brief for Petitioners & Cross-Respondents at 50–55, *Casey*, 505 U.S. 833 (Nos. 91-744, 91-902), 1992 WL 12006398; see also Keighley, *supra* note 16, at 2359. In their reply brief, the plaintiffs *did* argue why physician speech in the informed consent context should not be held to the lower standard of commercial speech under *Zauderer* but again did not distinguish between whether the doctor was actually required to speak state-written speech, give over state-written materials, or merely offer such materials. Reply Brief for Petitioners & Cross-Respondents at 20–22, *Casey*, 505 U.S. 833 (Nos. 91-744, 91-902), 1992 WL 551420.

74. See Keighley, *supra* note 16, at 2361–62.

75. *Casey*, 505 U.S. at 884 (emphasis added).

76. *Id.* at 882–83 ("We also see no reason why the State may not require doctors to inform a woman seeking an abortion of the availability of materials relating to the consequences to the fetus, even when those consequences have no direct relation to her health.").

77. See Keighley, *supra* note 16, at 2361.

C. *Post-Casey Confusion: Rounds, Stuart, and the In-Between*

The *Casey* Court could not have foreseen the confusion its three-sentence aside has wrought.⁷⁸ Circuits across the country, reading the same three sentences, have come to drastically different conclusions when forced to decide how much First Amendment protection doctors are allowed when seeking informed consent to an abortion. In *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds*, the Eighth Circuit held that the First Amendment applies to abortion providers only through the application of the undue burden standard, and thus upheld a statute requiring doctors to specifically speak words written for them by the state.⁷⁹ The Fourth Circuit came to almost exactly the opposite conclusion in *Stuart v. Camnitz*, applying intermediate scrutiny to a North Carolina mandatory ultrasound law.⁸⁰ These cases show how little guidance *Casey* has provided to lower courts and that more guidance is needed to confirm or deny a vision of the First Amendment that includes abortion providers.

1. *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds: Applying Casey to Explicit Compelled Speech.* — The statute at issue in *Rounds* is often cited as the most restrictive informed consent statute in the country.⁸¹ It requires the physician to provide the patient with a set of written statements that the physician must certify was read and understood in order for the patient's consent to be voluntary and informed.⁸² Among the statements required to be certified are that “the abortion will terminate the life of a whole, separate, unique, living human being” and “[t]hat the pregnant woman has an existing relationship with that unborn human being.”⁸³

78. See, e.g., Harrison Blythe, Note, Physician-Patient Speech: An Analysis of the State of Patients' First Amendment Rights to Receive Accurate Medical Advice, 65 Case W. Res. L. Rev. 795, 797–98 (2015) (“[T]he intersection of the First Amendment and physician-patient speech has become so utterly confounding that lower federal courts seem to be issuing conflicting opinions each time a physician-patient speech case arises.”).

79. 530 F.3d 724, 735 (8th Cir. 2008) (en banc); see also *Casey*, 505 U.S. at 881–82 (holding that so long as the required disclosure is “truthful and not misleading,” it is not an undue burden on a woman's right to obtain an abortion); infra section I.C.1.

80. 774 F.3d 238, 247–49 (4th Cir. 2014); see also infra section I.C.2.

81. See, e.g., Post, supra note 16, at 941 (“The obvious objective of the Act . . . is to use the concept of ‘informed consent’ to eliminate abortions.”).

82. *Rounds*, 530 F.3d at 726.

83. *Id.* (emphasis omitted) (quoting S.D. Codified Laws § 34-23A-10.1(1) (2019)). The written statement must also describe the “statistically significant risk factors” of abortion, including “[d]epression and related psychological distress” and “[i]ncreased risk of suicide ideation and suicide.” *Id.* The lack of medical evidence for “Post-Abortion Syndrome” has been argued extensively elsewhere and will not be explored in detail in this Note. See, e.g., Corbin, *Abortion Distortions*, supra note 24, at 1178–87.

The district court granted a preliminary injunction, holding that the South Dakota statute was categorically different from the statute at issue in *Casey* because, by requiring the doctor to certify that the patient read and *understood* the materials, the state required

The Eighth Circuit, sitting en banc, upheld these restrictions, reasoning that where abortion restrictions implicated the First Amendment, the only consideration was whether the statute imposed an undue burden on the patient's right to obtain an abortion.⁸⁴ In its view, an informed consent provision does not impose an undue burden if it requires the physician to disclose "truthful, non-misleading information" to their patient, and that was the standard that should properly have been applied below.⁸⁵ The Eighth Circuit then held that because the term "human being" was defined in the statute as "an individual living member of the species of *Homo sapiens*, including the unborn human being during the entire embryonic and fetal ages from fertilization to full gestation," it could properly be defined as truthful and nonmisleading information under *Casey*, as opposed to a state-endorsed ideological message that doctors were compelled to deliver.⁸⁶

The Eighth Circuit's reasoning has been criticized by commentators,⁸⁷ but more important are the doctrinal implications of reasoning in this way. The *Rounds* court accorded profound deference not just to state regulations of medicine but also to state definitions of informed consent. If the state had not labelled this statute as necessary for informed consent—as California did not (or could not) in *NIFLA*⁸⁸—a court would have reasoned through whether the statute implicated

the doctor's tacit agreement with the materials. *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 375 F. Supp. 2d 881, 886–88 (S.D.S.D. 2005) ("[T]he South Dakota statute requires the doctor to certify that the woman has read the materials and *understands* them. . . . By requiring the doctor to express the State's views as if they were the doctor's opinion, the State's viewpoint would in essence be receiving the doctor's imprimatur." (citation omitted)), vacated, 530 F.3d 724 (8th Cir. 2008) (en banc). The district court, in other words, held that the Court's dismissal of a First Amendment argument in *Casey* could not be extended to situations in which the doctor was required to communicate the state's ideology, as Justice O'Connor warned in her dissent in *Akron*. *Id.* at 886–87; see also *supra* note 56 and accompanying text.

84. *Rounds*, 530 F.3d at 733–34.

85. *Id.* at 734–35; see also *Gonzales v. Carhart*, 550 U.S. 124, 159–60 (2007) ("The State has an interest in ensuring so grave a choice [as an abortion] is well informed."). The *Rounds* Court quotes extensively from *Gonzales* dicta, despite the fact that *Gonzales* concerned a federal ban of a particular abortion procedure, a restriction that did not implicate First Amendment considerations. *Gonzales*, 550 U.S. at 132; *Rounds*, 530 F.3d at 734–36.

86. *Rounds*, 530 F.3d at 727, 735–36 (internal quotation marks omitted) (quoting S.D. Codified Laws § 34-23A-1(4)).

87. See Corbin, *Compelled Listening*, *supra* note 18, at 1006 ("[U]nless the legislature feared that women might think they are carrying dolphins or pandas instead of *Homo sapiens*, the statement clearly has a moral message." (footnote omitted)); see also Caitlin E. Borgmann, *Judicial Evasion and Disingenuous Legislative Appeals to Science in the Abortion Controversy*, 17 *J.L. & Pol'y* 15, 38–39 (2008) ("To accept the South Dakota legislature's findings as fact is to make the absurd suggestion that pregnant women do not know that the embryo or fetus they are carrying is of the human species.").

88. See *Nat'l Inst. of Family & Life Advocates v. Becerra (NIFLA)*, 138 S. Ct. 2361, 2373–74 (2018).

speech first and then applied the appropriate level of scrutiny.⁸⁹ As the doctrine is stated in *Rounds*, the level of First Amendment scrutiny is established when the state marks the regulation as necessary for informed consent, and then the disclosure is analyzed for whether it comports with the undue burden standard in *Casey*.⁹⁰ This means that a state can control the kind of First Amendment scrutiny it receives by simply making a regulation of an abortion provider an informed consent requirement, no matter how much the regulation implicates speech or how closely related it is to the conduct of providing an abortion. Especially given that *NIFLA* established that informed consent falls into one of the two professional contexts in which full First Amendment scrutiny would not apply to a content-based restriction,⁹¹ it would be incongruous to accord states such profound deference simply by using the term and defining it at will.

2. *Stuart v. Camnitz: A Narrower View of Casey*. — The Fourth Circuit, by contrast, did not understand the language in *Casey* as stating or implying that any informed consent provision that implicates speech should be free from First Amendment scrutiny. Faced with a North Carolina mandatory ultrasound requirement⁹² called the Woman's Right to Know Act,⁹³ the Fourth Circuit held that the requirement should be subjected to at least intermediate scrutiny as a restriction on professional speech⁹⁴ and found that the statute at issue could not withstand such scrutiny.⁹⁵ Forced to contend with *Casey*, and its application in *Rounds*, the panel stated:

89. See, e.g., *Reed v. Town of Gilbert*, 135 S. Ct. 2218, 2227, 2231–32 (2015) (finding a sign ordinance to be a content-based restriction of speech and in turn applying strict scrutiny).

90. See *Rounds*, 530 F.3d at 733–38.

91. See *infra* section II.A.2.

92. The North Carolina statute mandated that physicians perform an ultrasound as a precursor to establishing informed consent, requiring “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.” N.C. Gen. Stat. § 90-21.85(a)(1)–(2) (2019). Though patients could close their eyes and plug their ears to prevent themselves from hearing the description or seeing the sonogram, the provider was required to perform both. *Id.* § 90-21.85(a)–(b).

93. North Carolina was just one of many states that passed a “Woman’s Right to Know Act” via model legislation from Americans United for Life. See Ryan Sibley, *Virginia Ultrasound Law Is the Image of a Few Others*, Sunlight Found. (Mar. 7, 2012), <https://sunlightfoundation.com/2012/03/07/virginia-ultrasound-law-image-few-others/> [<https://perma.cc/8UZS-6K5N>]. For a survey of the states that impose mandatory ultrasounds as an informed consent requirement, see *Requirements for Ultrasound*, Guttmacher Inst., <https://www.guttmacher.org/state-policy/explore/requirements-ultrasound> [<https://perma.cc/3VFD-L3CJ>] (last modified Aug. 1, 2019).

94. For an explanation of the professional speech doctrine and the Supreme Court’s disavowal of it in *NIFLA*, see *infra* section II.A.

95. *Stuart v. Camnitz*, 774 F.3d 238, 247–48, 250 (4th Cir. 2014).

With respect, our sister circuits read too much into *Casey* and *Gonzales*. The single paragraph in *Casey* does not assert that physicians forfeit their First Amendment rights in the procedures surrounding abortions [T]he plurality did not hold sweepingly that all regulation of speech in the medical context merely receives rational basis review.⁹⁶

The Fourth Circuit was struck by the extension of *Casey* to so invasive a form of speech: The opinion later evokes a scene in which the physician is explaining a sonogram to a woman who has shut her eyes and covered her ears, as she is allowed to do under the North Carolina statute.⁹⁷ Such compelled speech could further no substantial government interest in maternal health or even the psychological health of women who may have an abortion and then regret it, as the Supreme Court worried in *Gonzales v. Carhart*⁹⁸—because the patient is not listening. The only interest possibly furthered by such a scenario is a government interest in preventing abortions—an interest antithetical to traditional notions of informed consent⁹⁹ but specifically permitted under the undue burden standard in *Casey*.¹⁰⁰ *Stuart* puts on full display the inadequacy of the undue burden standard as applied to informed consent restrictions on speech. If the requirement was accorded strict scrutiny as a content-based restriction of speech, a court would have to decide whether a state’s interest in deterring abortions is compelling enough to withstand such scrutiny.¹⁰¹ This would place *Casey* and the Court’s First Amendment jurisprudence in direct competition with each other—a situation, as we will see, the Court has made every effort to avoid.¹⁰² But as Part II demonstrates, the impending collision course between abortion and First Amendment jurisprudence cannot be avoided.

II. THE NIFLA SHIFT: APPLYING THE FIRST AMENDMENT TO PHYSICIAN–PATIENT SPEECH

In *NIFLA*, the Court held that requiring a crisis pregnancy center to put up a sign¹⁰³ directing those in the waiting room to resources about

96. *Id.* at 249.

97. N.C. Gen. Stat. § 90-21.85(b); *Stuart*, 774 F.3d at 252–53.

98. 550 U.S. 124, 159–60 (2007) (“While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained.”).

99. See *infra* note 166.

100. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 883 (1992) (plurality opinion) (“[W]e permit a State to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion.”).

101. See, e.g., *Reed v. Town of Gilbert*, 135 S. Ct. 2218, 2226 (2015).

102. For the Court’s discussion of *Casey* in *NIFLA*, see *infra* notes 132–138 and accompanying text.

103. For the sign’s text, see *supra* note 3 and accompanying text.

abortion was an unconstitutional infringement on the center's speech.¹⁰⁴ If such a requirement sounds familiar, it should: Many informed consent restrictions on abortion look remarkably similar to the California requirement in *NIFLA*,¹⁰⁵ but whether the same First Amendment scrutiny will apply is the question this Part seeks to answer.

This Part lays out the *NIFLA* case in detail and argues that its holding could apply to certain restrictions on abortion providers, including informed consent requirements. Section II.A outlines the history of *NIFLA*, its particular context as applied to crisis pregnancy centers, and its outlined exceptions, including the informed consent exception. Section II.B explains how *NIFLA* may be properly applied to physicians and abortion providers, using *Wollschlaeger v. Governor of Florida*, a case about physician speech in the context of the gun control debate that Justice Thomas's opinion in *NIFLA* drew heavily from, as a case study. Section II.C lays out the current state of the informed consent exception and concludes that, in order to apply *NIFLA* evenhandedly, courts must use its reasoning to assess whether informed consent statutes properly inform consent before deciding whether to apply rational basis scrutiny as a restriction on medical conduct, or strict scrutiny as a content-based restriction of speech.

A. *The NIFLA Decision and Its Outlined Exceptions*

This section provides an overview of the *NIFLA* decision in the Ninth Circuit and in the Supreme Court and gives a brief introduction to crisis pregnancy centers and how their services differ from those offered by abortion providers. Section II.A.1 gives the history of the case and the professional speech doctrine, which figured prominently in its early stages and in other cases challenging similar disclosure requirements. Section II.A.2 evaluates the *NIFLA* decision in detail, particularly its attempt to distinguish *Casey*.

1. *NIFLA in the Ninth Circuit and the Professional Speech Doctrine.* — Crisis pregnancy centers are often defined as facilities that provide some maternal health services like pregnancy tests or ultrasounds but do not refer patients for abortions or provide contraception.¹⁰⁶ CPCs are widespread and prevalent: As of 2013, there were 2,500 centers in the country, compared to 1,800 abortion providers.¹⁰⁷ They work to persuade patients who are pregnant and considering abortion to choose to carry their

104. *Nat'l Inst. of Family & Life Advocates v. Becerra (NIFLA)*, 138 S. Ct. 2361, 2375–76 (2018).

105. See *infra* section III.B.1.

106. See, e.g., Balt., Md., Health Code § 3-501 (2019) (defining “limited-service pregnancy center”).

107. Pam Belluck, *Pregnancy Centers Gain Influence in Anti-Abortion Arena*, N.Y. Times (Jan. 4, 2013), <https://www.nytimes.com/2013/01/05/health/pregnancy-centers-gain-influence-in-anti-abortion-fight.html> [<https://perma.cc/NU99-6VZ8>].

pregnancy to term¹⁰⁸ and have been criticized for misrepresenting their aims and misleading vulnerable women.¹⁰⁹ Some cities, concerned by the growing trend, attempted to regulate CPCs through disclosure requirements¹¹⁰ and were immediately faced with First Amendment challenges.¹¹¹

California's Reproductive Freedom, Accountability, Comprehensive Care, and Transparency Act, passed in 2015, was considered the gold standard of such restrictions, written to withstand First Amendment scrutiny.¹¹² It separated "licensed covered facilities" from "unlicensed covered facilities" and prescribed signage for each.¹¹³ Several lawsuits were filed immediately after the FACT Act's passage, arguing that the law unconstitutionally compelled the centers to relay information about abortion services when they would otherwise choose to remain silent.¹¹⁴

In one of these suits, *National Institute of Family & Life Advocates v. Harris*,¹¹⁵ the plaintiffs argued that the FACT Act was content-based and

108. See *supra* note 2.

109. See, e.g., Caroline Mala Corbin, *Compelled Disclosures*, 65 Ala. L. Rev. 1277, 1339–40 (2014).

110. See, e.g., Balt., Md., Health Code §§ 3-501 to 502 (requiring "limited-service pregnancy centers" to post signs stating that they did not perform abortions or provide contraception, and that they did not refer for such services).

111. See, e.g., *O'Brien v. Mayor of Balt.*, 768 F. Supp. 2d 804, 808 (D. Md. 2011) (suing to enjoin the Baltimore ordinance for infringement of First Amendment rights against compelled state-written speech).

112. See Beth Holtzman, *Have Crisis Pregnancy Centers Finally Met Their Match: California's Reproductive FACT Act*, 12 Nw. J.L. & Soc. Pol'y 78, 95–99 (2017). In particular, California's law targeted CPCs using various characteristics that included providing abortions and contraception—thus singling out CPCs through categories, rather than singling them out through definitions, as past statutes had done. *Id.* at 96–97. For the weaknesses of prior legislation, including the Baltimore, Montgomery County, Austin, New York, and San Francisco ordinances, see *id.* at 88–95.

113. Cal. Health & Safety Code §§ 123470–123473 (2018). "Licensed covered facilities" were licensed clinics "whose primary purpose is providing family planning or pregnancy-related services" and that have two or more of the following characteristics: (1) they provide ultrasounds or sonograms; (2) they provide or counsel about contraception; (3) they offer pregnancy testing; (4) they advertise prenatal ultrasounds or pregnancy options counseling; (5) they offer abortion services; or (6) they have staff that collect health information from patients. *Id.* An "unlicensed covered facility" was defined as a facility that "does not have a licensed medical provider on staff" and was required to give notice to patrons that it was not licensed as a medical facility in the state of California. *Id.*

114. See Holtzman, *supra* note 112, at 98–100.

115. While this was the name of the case at the district court and Ninth Circuit, it was renamed *National Institute of Family & Life Advocates v. Becerra* when it moved to the Supreme Court, by which time California Attorney General Kamala Harris had been elected senator and Xavier Becerra had replaced her as Attorney General. Nat'l Inst. of Family & Life Advocates v. Harris (*Harris II*), 839 F.3d 823 (9th Cir. 2016), *aff'g* Nat'l Inst. of Family & Life Advocates v. Harris (*Harris I*), No. 15CV2277 JAH/DHB, 2016 WL 3627327 (S.D. Cal. Feb. 9, 2016), *rev'd sub nom.* Nat'l Inst. of Family & Life Advocates v. Becerra (*NIFLA*), 138 S. Ct. 2361 (2018).

thus subject to strict scrutiny.¹¹⁶ The district court and the Ninth Circuit disagreed, holding that the FACT Act was a regulation of “professional speech” subject to intermediate scrutiny and that the FACT Act withstood such scrutiny.¹¹⁷

The “professional speech” doctrine has been the subject of much debate.¹¹⁸ Based largely in concurrences in *Thomas v. Collins*¹¹⁹ and *Lowe v. SEC*,¹²⁰ as well as the First Amendment language in *Casey*,¹²¹ proponents of the doctrine argue that professionals, being likely to have skills and knowledge that far outweigh those of their clients, have a kind of power over them that is compelling enough to be regulated by the state.¹²² Other scholars have argued for a professional speech doctrine by saying nearly the opposite: that professionals are self-regulating, often having extralegal considerations like ethics standards unique to their profession, and thus should warrant intermediate scrutiny, rather than

116. Verified Complaint for Declaratory, Injunctive and Other Relief at 23, *Harris I*, 2016 WL 3627327 (No. 15CV2277 JAH DHB), 2015 WL 13649178.

117. *Harris II*, 839 F.3d at 838–42; *Harris I*, 2016 WL 3627327, at *8.

118. Compare Haupt, Professional Speech, *supra* note 71, at 1258–64 (defining a First Amendment theory of professional speech), with Smolla, *supra* note 71, at 82–88 (warning of the dangers of creating too many new First Amendment doctrines and levels of scrutiny).

In the courts, the Third, Fourth, Ninth, and Eleventh Circuits have been the main movers on the professional speech doctrine. See Smolla, *supra* note 71, at 69; see also *King v. Governor of N.J.*, 767 F.3d 216, 234–37 (3d Cir. 2014) (applying intermediate scrutiny to a law that restricted mental health providers from engaging in conversion therapy); *Wollschlaeger v. Governor of Fla.* (*Wollschlaeger II*), 760 F.3d 1195, 1226 (11th Cir. 2014) (holding that the professional speech doctrine should apply intermediate scrutiny to a law proscribing doctors from asking their patients about gun ownership); *Pickup v. Brown*, 740 F.3d 1208, 1232–33 (9th Cir. 2014) (applying rational basis scrutiny to a law similar to the one at issue in *King*); *Moore-King v. County of Chesterfield*, 708 F.3d 560, 569–70 (4th Cir. 2013) (applying the professional speech doctrine to a city ordinance licensing fortune tellers). But see *Wollschlaeger v. Governor of Fla.* (*Wollschlaeger V*), 848 F.3d 1293, 1307 (11th Cir. 2017) (en banc) (reversing itself after protracted litigation and holding that content-based restrictions on doctor–patient conversations should be strictly scrutinized, and disavowing the professional speech doctrine). For a deeper discussion of *Wollschlaeger*, see *infra* section II.B.1.

119. 323 U.S. 516, 544 (1945) (Jackson, J., concurring) (joining the majority but arguing separately that perhaps a lower level of First Amendment scrutiny should apply when a lawyer is advising a client and the state should have more power to regulate speech, than when the lawyer is speaking at a rally).

120. 472 U.S. 181, 232 (1985) (White, J., concurring) (“Where the personal nexus between the professional and client does not exist . . . government regulation ceases to function as a legitimate regulation of professional practice with only an incidental impact on speech; it becomes regulation of speaking or publishing as such, subject to the First Amendment[. . .]”).

121. See *supra* notes 66–71 and accompanying text.

122. See, e.g., Smolla, *supra* note 71, at 100 (“[T]he professional has superior knowledge, expertise, experience, and stature in relation to the client that inherently places the professional in a position of superior leverage and influence . . .”).

the strict scrutiny usually applied to content-based restrictions on speech.¹²³

The district court relied on the continuum established in *Pickup v. Brown*¹²⁴ to hold that under the State’s licensing power, it may require professionals to disclose certain information based on a “substantial interest” that women are informed of their rights and treatment options.¹²⁵ The Ninth Circuit considered applying rational basis scrutiny, as suggested by the defendants, who argued that the speech was an “abortion-related disclosure” and thus subject to the standard outlined in *Casey*.¹²⁶ The court refused to do so, citing the reasoning in *Stuart* that *Casey* did not set out a new First Amendment doctrine but rather only stated that the Pennsylvania statute at issue in *Casey* would survive First Amendment scrutiny.¹²⁷ The Ninth Circuit, then, was free to hold that under the State’s licensing power, it may require professionals to disclose certain information based on a “substantial interest” that women are informed of their rights and treatment options, and thus concluded that the FACT Act would likely survive such scrutiny.¹²⁸

2. *The NIFLA Decision.* — The Supreme Court took up the case, and though the Court did conclude that the required disclosure was a content-based restriction of speech,¹²⁹ it held that the professional speech doctrine, relied upon by so many circuits, did not exist.¹³⁰ The

123. See, e.g., Haupt, Professional Speech, *supra* note 71, at 1247–51 (describing the professions as “knowledge communities” with their own ways of thinking and certain professional norms and values).

124. 740 F.3d 1208, 1227–29 (9th Cir. 2014) (holding that professional speech is most protected when a professional is engaged in a public dialogue and least protected when the professional is engaging in professional conduct (for example, advising a client) in the context of a professional–client relationship).

125. *Harris I*, No. 15CV2277 JAH DHB, 2016 WL 3627327, at *8–9 (S.D. Cal. Feb. 9, 2016).

126. *Harris II*, 839 F.3d 823, 838 (9th Cir. 2016).

127. See *id.*; see also *supra* notes 96–97 and accompanying text.

128. *Harris II*, 839 F.3d at 841–42. To survive intermediate scrutiny, the state is required to show that “the statute directly advances a substantial government interest and that the measure is drawn to achieve that interest.” *Id.* at 841 (internal quotation marks omitted) (quoting *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 572 (2011)). Because the state had a substantial interest in making sure that women were fully informed about their reproductive health options, and the Act was facially and operationally neutral and generally applicable, the Ninth Circuit ruled that the FACT Act was appropriately drawn to achieve that interest. See *id.* at 841, 844.

129. *Nat’l Inst. of Family & Life Advocates v. Becerra (NIFLA)*, 138 S. Ct. 2361, 2371 (2018) (“The licensed notice is a content-based restriction of speech. By compelling individuals to speak a particular message, such notices ‘alte[r] the content of [their] speech.’” (alterations in original) (quoting *Riley v. Nat’l Fed’n of the Blind of N.C., Inc.*, 487 U.S. 781, 795 (1988))).

130. *Id.* at 2371–72 (“[T]his court has not recognized ‘professional speech’ as a separate category of speech. Speech is not unprotected merely because it is uttered by ‘professionals.’”). As a result of this holding, scholars have begun to question whether the First Amendment has any application to professional licensing schemes. See generally

majority instead pointed to only two sets of precedents in which the Court applied a more deferential standard of review to statutes that implicate professional speech—in other words, two exceptions to full First Amendment scrutiny: The first is the category of “commercial speech,” which allows for some laws that require the disclosure of factual, noncontroversial information in advertisements.¹³¹ The second is, cryptically, “conduct [that] incidentally involves speech,” citing *Casey*.¹³²

The Court distinguished *Casey* from *NIFLA* on this basis by reasoning that the statute in *Casey*, as a regulation of informed consent to a medical procedure, only incidentally implicated speech and thus was accorded a lower standard of First Amendment scrutiny.¹³³ The majority wrote:

The licensed notice at issue here is not an informed-consent requirement or any other regulation of professional conduct. The notice does not facilitate informed consent to a medical procedure. In fact, it is not tied to a procedure at all. It applies to all interactions between a covered facility and its clients, regardless of whether a medical procedure is ever sought, offered, or performed. If a covered facility does provide medical procedures, the notice provides no information about the risks or benefits of those procedures. . . . The licensed notice regulates speech as speech.¹³⁴

Two implicit arguments are evident in this passage: The first is that the Court does not seem to view the services offered at a crisis pregnancy center—pregnancy testing, ultrasounds, and counseling, to name a few¹³⁵—to be medical procedures in nature.¹³⁶ For example, the Court

Claudia E. Haupt, *Licensing Knowledge*, 72 Vand. L. Rev. 501, 503 (2019) (“The new First Amendment-based attacks on licensing suggest that a tension exists between state regulation of the professions and speech protection. Permitting state involvement in licensing while at the same time prohibiting intrusive state involvement in professional speech presents a puzzle . . .”).

131. *NIFLA*, 138 S. Ct. at 2372 (citing *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626, 651 (1985)). The Court reasoned that *Zauderer* only applies to “purely factual and uncontroversial information” and that information about where a person can obtain an abortion is hardly “uncontroversial.” *Id.* In his dissent, Justice Breyer questioned this understanding of the meaning of “uncontroversial,” arguing that a disclosure requirement may require a speaker to provide “more information than they might otherwise be inclined to present,” even about controversial topics, if the truth of the statement is accepted and the statement does not require the speaker to serve as a mouthpiece for the viewpoint of the state. *Id.* at 2387 (Breyer, J., dissenting) (internal quotation marks omitted) (quoting *Zauderer*, 471 U.S. at 650–51). Commentators have already begun to predict that this reframing of “uncontroversial” in the commercial speech doctrine will reverberate into other areas of public health law. See generally Lauren Fowler, Note, The “Uncontroversial” Controversy in Compelled Commercial Disclosures, 87 Fordham L. Rev. 1651 (2019). These arguments, however, are beyond the scope of this Note, which is primarily concerned with the informed consent exception.

132. *NIFLA*, 138 S. Ct. at 2372.

133. *Id.* at 2373–74.

134. *Id.*

135. See *supra* note 106 and accompanying text.

did not consider the prospect that the FACT Act disclosure could be a regulation of informed consent to childbirth (or simply a regulation of informed consent to pregnancy testing and ultrasound, as preparations for childbirth), upon which the state is exercising its interest under *Casey* to ensure a decision on whether to remain pregnant that is “mature and informed.”¹³⁷ Embedded in the *NIFLA* Court’s reasoning is the notion that abortion is a procedure that requires informed consent; childbirth is not.

The second implicit argument is that an informed consent requirement needs, at least, to be “tied to a procedure”; that such a procedure be “sought, offered, or performed”; and that the “risks or benefits” of that procedure need to be elicited in order for a notice to qualify as an informed consent requirement.¹³⁸ This language is notable for its rudimentary specificity—the Court has been reticent to define informed consent in the First Amendment context for a variety of reasons.¹³⁹ And yet, in attempting to establish why the *NIFLA* statute does not fit within its vast understanding of informed consent, it has possibly narrowed that understanding for informed consent statutes that apply to abortion providers as well.

B. *Applying NIFLA to Physician–Patient Communications*

This section argues that, but for the informed consent exception outlined above, the speech framework in *NIFLA* would readily apply to abortion providers and other physician–patient communications. Using an analogous case of physician speech in the gun control context, this section establishes that the physician–patient consultation, far from receiving merely rational basis review, falls directly within the circumstances to which First Amendment doctrine would accord strict scrutiny.

136. The majority, in explaining why it has not applied a lower level of scrutiny to professional speech, explains why free discourse between doctor and patient is crucial: “Moreover, this Court has stressed the danger of content-based regulations ‘in the fields of medicine and public health, where information can save lives.’” *NIFLA*, 138 S. Ct. at 2374 (quoting *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 566 (2011)). The Court does not expand upon why this consideration should be material in *NIFLA*, which concerns pregnancy tests and ultrasounds, but unconsidered when an abortion is being sought and performed. See *id.*

Which childbirth- and abortion-related procedures should be considered “conduct” that require informed consent is beyond the scope of this Note. However, to the extent that abortion providers administer services that CPCs also furnish (ultrasounds and pregnancy tests, for example) it can be assumed that those procedures, as long as they are not provided solely so the patient can obtain an abortion, similarly would not be considered “conduct” requiring informed consent.

137. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 883 (1992) (plurality opinion).

138. *NIFLA*, 138 S. Ct. at 2373–74.

139. See *infra* section II.C.1.

Prior to *NIFLA*, applications of the First Amendment to the physician–patient context varied considerably and were subject to substantial judicial confusion.¹⁴⁰ The Eleventh Circuit, in the protracted litigation surrounding a Florida gun control law, exemplified this confusion—but in the end established that doctor–patient conversations may be accorded full First Amendment protections even for controversial issues, a conclusion that the *NIFLA* Court seemingly endorsed.

1. *Strictly Scrutinizing Regulations of Physician Speech: Wollschlaeger v. Governor of Florida.* — In 2011, the Florida legislature passed the Firearm Owners’ Privacy Act (FOPA), which limited doctors’ ability to inquire whether their patients had guns in their homes, invoking the patients’ right to privacy.¹⁴¹ After the district court held that the statute’s provisions violated the First and Fourteenth Amendments and permanently enjoined its enforcement,¹⁴² an Eleventh Circuit panel issued an astounding three opinions on the case, employing a different First Amendment standard each time.¹⁴³ Ultimately, the Eleventh Circuit reheard the case en banc, striking down most provisions of the law as content-based infringements on speech.¹⁴⁴

140. See, e.g., *supra* section I.C.

141. Fla. Stat. § 381.026(4)(b)(8)–(11) (2012). Physicians were allowed to ask about firearms if they believed “in good faith” that the information was “relevant to the patient’s medical care or safety, or safety of others.” *Id.* § 381.026(4)(b)(8). The statute also precluded physicians from recording gun ownership in their patients’ medical records unless it was relevant to their safety or that of others and forbade doctors from discriminating against patients based on gun ownership status. Fla. Stat. § 790.338(1), (5) (2012). A physician who failed to comply could be fined or otherwise censured. Fla. Stat. § 456.072(1)(u), (2)(h) (2012).

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

143. See *Wollschlaeger II*, 760 F.3d 1195, 1203, 1226 (11th Cir. 2014) (finding that FOPA, as a “legitimate regulation of professional conduct” and not speech, does not facially violate physicians’ First Amendment rights); *Wollschlaeger v. Governor of Fla. (Wollschlaeger III)*, 797 F.3d 859, 900 (11th Cir. 2015) (rehearing the case and holding that while most challenged provisions of the law implicate professional speech and not just conduct, the statute survives intermediate scrutiny); *Wollschlaeger v. Governor of Fla. (Wollschlaeger IV)*, 814 F.3d 1159, 1201 (11th Cir. 2015) (rehearing the case again and applying strict scrutiny in light of the Supreme Court’s decision in *Reed*, but nonetheless finding that the statute would survive strict scrutiny because of the state’s interest in protecting patients’ Second Amendment and privacy rights). Some commentators have noted how unusual it is for the same panel to continue to rehear the same case and issue three different opinions before the case is finally reheard en banc. See, e.g., Dahlia Lithwick & Sonja West, *The Absurd Logic Behind Florida’s Docs vs. Glocks Law*, *Slate* (Jan. 8, 2016), <https://slate.com/news-and-politics/2016/01/floridas-docs-vs-glocks-bans-doctors-from-discussing-guns.html> [<https://perma.cc/5F2E-WFAG>].

144. *Wollschlaeger V*, 848 F.3d 1293, 1311, 1319 (11th Cir. 2017) (en banc). The ruling left in place five provisions of the law: (1) one that allowed emergency medical personnel to ask about gun ownership, Fla. Stat. § 790.338(3); (2) one that allowed patients to refuse to answer questions about gun ownership, *id.* § 790.338(4); (3) one that prohibited discrimination based on gun ownership, *id.* § 790.338(5); (4) one that prohibited insurers from discriminating based on gun ownership, *id.* § 790.338(7); and (5) one that required

In its en banc opinion, the Eleventh Circuit made clear that just because conversations happen in a doctor's office does not mean they should be accorded lesser First Amendment scrutiny. While acknowledging the confusion the case had elicited,¹⁴⁵ the majority went back to basic First Amendment principles: "[C]ertain First Amendment principles can be applied with reasonable consistency, and one of them is that, subject to limited exceptions, '[c]ontent-based regulations . . . are presumptively invalid.'"¹⁴⁶ The court went on to hold that the provisions, which explicitly limit what doctors can say to their patients while acting as their doctors, are content based and speaker focused, triggering First Amendment scrutiny.¹⁴⁷ In response to the state's argument that "any effect on speech is merely incidental to the regulation of professional conduct,"¹⁴⁸ the court separated the regulation of medical conduct from the regulation of conversations *about* medical conduct: "[A] state may not, under the guise of prohibiting professional misconduct, ignore constitutional rights."¹⁴⁹

2. *NIFLA and Wollschlaeger: A Tacit Agreement.* — In *NIFLA*, the Court strongly implied that it agreed with the Eleventh Circuit's final verdict that the First Amendment broadly covers conversations between doctors and patients. In his majority opinion in *NIFLA*, Justice Thomas quoted heavily from Judge William Pryor's concurrence in *Wollschlaeger*,¹⁵⁰ highlighting both the necessity for doctors to speak freely

disciplinary action for not abiding the above provisions, id. § 790.338(8). *Wollschlaeger V*, 848 F.3d at 1318.

145. *Wollschlaeger V*, 848 F.3d at 1300 ("Despite its majestic brevity—or maybe because of it—the freedom of speech clause of the First Amendment sometimes proves difficult to apply.").

146. Id. (second alteration in original) (quoting *R.A.V. v. City of St. Paul*, 505 U.S. 377, 382 (1992)).

147. Id. at 1307.

148. Id. at 1308. The majority's reaction to this claim is particularly strong: "Saying that restrictions on writing and speaking are merely incidental to speech is like saying that limitations on walking and running are merely incidental to ambulation." Id. (citing *Wollschlaeger III*, 797 F.3d at 918–19 (Wilson, J., dissenting)).

149. Id. at 1308, 1310 (alteration in original) (internal quotation marks omitted) (quoting *NAACP v. Button*, 371 U.S. 415, 439 (1963)). The majority in *NIFLA* also quotes this passage to establish a barrier between permissible regulation of the professions and infringement on professional speech. *Nat'l Inst. of Family & Life Advocates v. Becerra (NIFLA)*, 138 S. Ct. 2361, 2373 (2018). The Eleventh Circuit closes its conversation about conduct in *Wollschlaeger V* by warning about the dangers of applying the rational basis standard to regulations clearly intended to restrict speech: "If rationality were the standard, the government could—based on its disagreement with the message being conveyed—easily tell architects that they cannot propose buildings in the style of I.M. Pei . . . or accountants that they cannot discuss legal tax avoidance techniques, and so on and so on." *Wollschlaeger V*, 848 F.3d at 1311.

150. See *NIFLA*, 138 S. Ct. at 2374. Judge Pryor's concurrence elaborates more broadly than the majority opinion on the First Amendment protections that doctors should receive, going so far as to state that *Wollschlaeger* applies the "timeless principle" of *Barnette* to speech between doctors and patients. See *Wollschlaeger V*, 848 F.3d at 1330 (Pryor, J., concurring) ("If there is any fixed star in our constitutional constellation, it is that no

with patients and the historical risks of authoritarian regimes regulating the practice of medicine: “Doctors help patients make deeply personal decisions, and their candor is crucial.”¹⁵¹ In reasoning why professional speech should not be accorded a lower level of First Amendment scrutiny, Justice Thomas called upon both the dangers of content-based restrictions in general and their particular danger in the professional context, stressing that “in the fields of medicine and public health . . . information can save lives.”¹⁵² Both *Wollschlaeger* and *NIFLA* provide strong support for the proposition that, absent intervening considerations, a statute that attempted to broadly restrict conversations between doctors and patients to certain topics would require First Amendment scrutiny and, being content-based,¹⁵³ would be presumptively unconstitutional.¹⁵⁴

But a note of caution: The statute at issue in *Wollschlaeger* and most abortion regulations that implicate speech have two profound differences. The most obvious, discussed in detail in the next section, is that abortion regulations are written, by and large, as informed consent

official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion . . .” (alteration in original) (internal quotation marks omitted) (quoting *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943))). That the *NIFLA* majority quotes from this concurrence, rather than the majority opinion in *Wollschlaeger*, is itself evidence of its agreement that doctors should be given full First Amendment protections.

151. *NIFLA*, 138 S. Ct. at 2374 (internal quotation marks omitted) (quoting *Wollschlaeger V*, 848 F.3d at 1328 (Pryor, J., concurring)). Both Pryor’s concurrence and Thomas’s opinion quote extensively from a law review article that details the historical use of state power to oppress minority opinions through the regulation of medical advice:

[D]uring the Cultural Revolution, Chinese physicians were dispatched to the countryside to convince peasants to use contraception. In the 1930s, the Soviet government expedited completion of a construction project on the Siberian railroad by ordering doctors to both reject requests for medical leave from work and conceal this government order from their patients. In Nazi Germany, the Third Reich systematically violated the separation between state ideology and medical discourse. German physicians were taught that they owed a higher duty to the ‘health of the Volk’ than to the health of individual patients.

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, 201–02 (1994) (footnotes omitted); see also *NIFLA*, 138 S. Ct. at 2374; *Wollschlaeger V*, 848 F.3d at 1328. Interestingly, Berg’s article continued with a lengthy discussion of restrictions on physician speech in the abortion context, arguing that *Casey* was wrongly decided and proceeding to develop a robust First Amendment theory of doctor–patient discourse for abortion providers and their patients. Berg, *supra*, at 202–06.

152. *NIFLA*, 138 S. Ct. at 2374 (internal quotation marks omitted) (quoting *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 566 (2011)).

153. See *Wollschlaeger V*, 848 F.3d at 1307 (“The record-keeping, inquiry, and anti-harassment provisions of FOIA are speaker-focused and content-based restrictions. They apply only to the speech of doctors and medical professionals, and only on the topic of firearm ownership.”).

154. See *Reed v. Town of Gilbert*, 135 S. Ct. 2218, 2226 (2015).

requirements—various disclosures that an abortion provider is required to make before their patient can consent to an abortion.¹⁵⁵ Because many of those disclosures come directly before a procedure, it is easier to argue that they are part and parcel of the procedure itself—speech incidental to conduct, as Florida unsuccessfully attempted to argue in *Wollschlaeger*¹⁵⁶ and the majority excepted from full First Amendment scrutiny in *NIFLA*.¹⁵⁷ Another profound difference between FOPA and common abortion regulations is that, under the Florida law, doctors were merely silenced;¹⁵⁸ under most abortion regulations, the state gives doctors or facilities something to say.¹⁵⁹

Based on some of the Court’s compelled speech precedents,¹⁶⁰ this would at first blush seem to indicate a *stronger* First Amendment argument against the requirements—it seems more invasive to require particular speech than to foreclose certain kinds of speech.¹⁶¹ But this argument forgets the reasoning for ascribing full First Amendment protections to doctors in the first place: In *Wollschlaeger*, the majority warns that regulations that restrict certain doctors from speaking about a

155. See supra notes 10–15 and accompanying text; see also infra section III.B.

156. See *Wollschlaeger V*, 848 F.3d at 1308; see also supra note 148 and accompanying text.

157. See supra notes 133–134 and accompanying text.

158. See supra note 141 and accompanying text. This seemed a particularly important distinction to Judge Pryor, who stated that the great evil the First Amendment must stand against is the silencing of unpopular opinions: “The Florida Legislature overstepped the boundaries of the First Amendment when it determined that the proper remedy for speech it considered ‘evil’ was ‘enforced silence,’ as opposed to ‘more speech.’” *Wollschlaeger V*, 848 F.3d at 1329 (Pryor, J., concurring) (quoting *Whitney v. California*, 274 U.S. 357, 377 (1927) (Brandeis, J., concurring)).

159. In Texas, for example, the physician providing the abortion is required to tell her patient a host of information—including the risks of the procedure and childbirth and the probable gestational age of the fetus when the abortion is performed. Tex. Health & Safety Code § 171.012(a)(1) (2019). The physician must also inform the patient of various state services and give her state-written materials, designed to make carrying her child to term financially possible or to prevent unwanted pregnancies in the future: medical assistance benefits, child support, contraception, and information about adoption agencies. *Id.* § 171.012(a)(3), 171.014. Finally, the physician is also required to administer a sonogram, making the heart auscultation audible for the patient to hear, describing both the image and the heartbeat. *Id.* § 171.012(a)(4); see also Tex. Med. Providers Performing Abortion Servs. v. Lakey, 667 F.3d 570, 575 (5th Cir. 2012). For an overview of the disclosures required to meet informed consent standards across the country, see Counseling and Waiting Periods for Abortion, Guttmacher Inst. (Jan. 1, 2019), <https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion> [<https://perma.cc/C9FJ-K3AP>] (last modified Aug. 1, 2019).

160. See supra notes 35–38 and accompanying text. Recall that *Wooley* and *Barnette* struck down compelled speech—via a license plate and the Pledge of Allegiance, respectively—just as *NIFLA* did with California’s FACT Act. See Nat’l Inst. of Family & Life Advocates v. Becerra (*NIFLA*), 138 S. Ct. 2361, 2373–74 (2018); *Wooley v. Maynard*, 430 U.S. 705, 717 (1977); *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943).

161. See *Barnette*, 319 U.S. at 633 (“It would seem that involuntary affirmation could be commanded only on even more immediate and urgent grounds than silence.”).

certain topic, even if the restriction does not proclaim an allegiance to a viewpoint on the topic, is particularly suspect.¹⁶² In *NIFLA*, free doctor-patient discourse was worthy of particular protection because, in that scenario, “information can save lives.”¹⁶³ Additional state-imposed information, then—even a deluge of information—might not be as suspect as state-imposed silence. Still, the *NIFLA* majority’s approving treatment of *Wollschlaeger* supports the argument that the Court would address content-based restrictions on conversations between doctors and patients under a First Amendment framework, whether the restriction proscribed speech or required it. The next section explores the speech that is excepted from that framework in *NIFLA*: that which is required to solicit informed consent to a procedure.

C. *Applying NIFLA to Informed Consent Statutes*

While the Court has historically been reticent to define informed consent in the First Amendment context, in order for it to serve as one of the main exceptions to full First Amendment scrutiny as *NIFLA* requires,¹⁶⁴ its contours must be established in order to avoid the confusion at work in *Rounds* and *Stuart*.¹⁶⁵ This section first lays out the Court’s informed consent definitions in its abortion jurisprudence and argues that *NIFLA*, while perhaps meaning to leave abortion jurisprudence untouched, in fact provided the first guidance since *Casey* for how courts should judge state informed consent statutes under a First Amendment framework.

1. *Informed Consent Definitions in the Court’s Abortion Jurisprudence.* — The Court has good reason to fear a narrow constitutional definition¹⁶⁶

162. *Wollschlaeger V*, 848 F.3d at 1307 (“Even if the restrictions on speech can be seen as viewpoint neutral . . . that does not mean that they are content-neutral.”); see also *Reed v. Town of Gilbert*, 135 S. Ct. 2218, 2229 (2015) (“Innocent motives do not eliminate the danger of censorship presented by a facially content-based statute, as future government officials may one day wield such statutes to suppress disfavored speech.”).

163. *NIFLA*, 138 S. Ct. at 2374 (internal quotation marks omitted) (quoting *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 566 (2011)).

164. See *supra* note 138 and accompanying text.

165. See *supra* section I.C.

166. Definitions of what is required to inform consent are relatively new. Only since the 1960s have courts begun to define the scope of the duty to inform, which generally consisted of “material information about a proposed course of treatment, which includes its risks and benefits as well as those of any alternative treatments.” Nadia N. Sawicki, *Modernizing Informed Consent: Expanding the Boundaries of Materiality*, 2016 U. Ill. L. Rev. 821, 827; see also *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir. 1972) (listing the requirements of the duty of informed consent, including any precautionary therapies the patient might take, information about alternative treatments, any risks of the current treatment, and any “specific information to the patient when the exigencies of reasonable care call for it”); *Post*, *supra* note 16, at 969 (defining informed consent as the duty “to make a reasonable explanation and disclosure . . . of the risks and hazards involved in a proposed course of treatment” so that patients may give informed and intelligent consent

of informed consent and as such has been reticent to provide one in the past. In *Planned Parenthood of Central Missouri v. Danforth*, faced with its first informed consent regulation after *Roe* was decided,¹⁶⁷ the Court feared that a strict definition of informed consent would not allow doctors to do their jobs adequately:

One might well wonder, offhand, just what “informed consent” of a patient is. . . . [W]e are content to accept, as the meaning, the giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession.¹⁶⁸

By “uncomfortable straitjacket,” the *Danforth* Court is likely referring to informed consent in the malpractice context—a stricter constitutional definition would require ever more cautious doctoring when preparing patients for procedures.¹⁶⁹ But even this broad definition was discomfiting: The majority in *Akron* extended the *Danforth* definition to strike down an informed consent statute,¹⁷⁰ holding that the state’s interest in obtaining informed consent may not “justify abortion regulations designed to influence the woman’s informed choice between abortion or childbirth.”¹⁷¹ The Court further extended this reading of the *Danforth*

(internal quotation marks omitted) (quoting *Wilkinson v. Vesey*, 295 A.2d 676, 686 (R.I. 1972)).

167. 428 U.S. 52, 65–67 (1976). *Danforth* is best remembered as the case that overturned a Missouri law requiring a married woman to obtain her husband’s consent before having an abortion, *id.* at 71, a holding *Casey* would reaffirm sixteen years later. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 897–98 (1992) (plurality opinion). But the statute in *Danforth* was also challenged for various other provisions, including its statutory definition of “viability,” a blanket parental consent requirement, reporting and recordkeeping requirements, and, most important for the purposes of this Note, a written informed consent requirement that asked the patient to confirm that “her consent is informed and freely given and is not the result of coercion.” *Danforth*, 428 U.S. at 58–59 (internal quotation marks omitted) (quoting H.R. 1211, 77th Gen. Assemb., 2d Reg. Sess. (Mo. 1974)).

168. *Danforth*, 428 U.S. at 67 n.8.

169. It is worth noting, however, that failure to acquire informed consent in the abortion context often carries not only malpractice liability but also administrative or even criminal penalties. See Ian Vandewalker, *Abortion and Informed Consent: How Biased Medical Counseling Laws Mandate Violations of Medical Ethics*, 19 *Mich. J. Gender & L.* 1, 7 (2012). The failure to comply with an abortion informed consent statute is often a high-level misdemeanor—and in some states, a felony. See Sonia M. Suter, *The Politics of Information: Informed Consent in Abortion and End-of-Life Decision Making*, 39 *Am. J.L. & Med.* 7, 27 n.153 (2013) (highlighting several statutes, including in Alabama and Oklahoma, that treat informed consent violations as felonies); Vandewalker, *supra*, at 7 n.21 (citing a North Dakota law that mandates a physician provide the patient with the opportunity to view an ultrasound, punishable by one year in prison, a \$2,000 fine, or both). Thus, at least in the abortion context, a stricter definition of informed consent would not have constrained doctors, but *states*, from allowing any requirement to be justified under the umbrella of informed consent.

170. For the details of the *Akron* statute, see *supra* note 49 and accompanying text.

171. *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 444 (1983).

definition in *Thornburgh*.¹⁷² In *Casey*, however, the Court ruled that *Akron* and *Thornburgh* went too far when they found constitutional violations in “the giving of truthful, nonmisleading information” to ensure informed consent.¹⁷³ The *Casey* Court allowed for a more expansive reading of the “consequences” of the abortion decision, holding that a state is permitted “to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in doing so the State expresses a preference for childbirth over abortion.”¹⁷⁴ But the majorities in *Akron*, *Thornburgh*, and *Casey* examined informed consent statutes within the Court’s abortion jurisprudence framework, not a First Amendment framework.¹⁷⁵ The questions that remained, and still remain, are whether and to what extent a state may legislate its preference for childbirth over abortion without contravening the Court’s *First Amendment* jurisprudence.

2. *Informed Consent in the First Amendment Context: The Beginnings of a Framework in NIFLA*. — The Court in *NIFLA*, perhaps inadvertently, also provided lower courts with important parameters to the concept of informed consent in the First Amendment context—and those parameters make the beginnings of the framework elucidated in Part III.¹⁷⁶ Recall that *NIFLA* excepts two categories of professional speech from full First Amendment protection: the disclosure of “factual, noncontroversial information” in a professional’s “commercial speech”¹⁷⁷ and “professional conduct [that] . . . incidentally involves speech.”¹⁷⁸ When differentiating the statutes in *NIFLA* and *Casey*,¹⁷⁹ the Court emphasized three broad requirements that must be met in order for a regulation to be seen as an informed consent requirement, and thus part of the “conduct” of medical practice: (1) The regulation must be “tied to a procedure”; (2) such a procedure must be “sought, offered, or performed”; and (3) the regulation must carry information about the “risks or benefits of those procedures.”¹⁸⁰ This section argues that the Court must use this frame-

172. *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 763 (1986) (“Under the guise of informed consent, the Act requires the dissemination of information that is not relevant to such consent, and, thus, it advances no legitimate state interest.”).

173. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992) (plurality opinion).

174. *Id.* at 883.

175. See *Casey*, 505 U.S. at 882–84; *Thornburgh*, 476 U.S. at 759–63; *Akron*, 462 U.S. at 442–45.

176. See *infra* section III.A.

177. This Note does not discuss the prospect of applying the commercial speech framework to the abortion provider. See *supra* notes 23, 131 and accompanying text.

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

179. See *supra* notes 132–134 and accompanying text.

180. *NIFLA*, 138 S. Ct. at 2373–74.

work, and in fact must expand on this framework, if it is to apply its First Amendment jurisprudence evenhandedly. If it fails to police state definitions of informed consent, states may expand the meaning of informed consent to encompass *any* regulation relating to an abortion provider, no matter how much it infringes upon the provider’s speech, nor how attenuated it is from any abortion sought or performed.

Allowing states to dictate how informed consent is defined does not accord with the reasoning the Court itself laid out in *NIFLA* for why doctors should be accorded full First Amendment rights in their conversations with patients. The Court was particularly concerned about authoritarian control of the medical context; such concerns remain present whether or not a regulation is characterized as an informed consent requirement.¹⁸¹ Further, the majority quotes Judge Pryor’s concurrence in *Wollschlaeger*: “Doctors help patients make deeply personal decisions, and their candor is crucial.”¹⁸² Such candor is just as important—if not more so—when a doctor is seeking informed consent to a procedure as when they are merely consulting with a patient.¹⁸³ Thus, if the Court must except informed consent requirements from strict scrutiny, it cannot also hand states a blank check to write their own definition of informed consent and simultaneously follow its own reasoning for applying First Amendment principles to doctors.

The statute in *NIFLA* itself, when analyzed under the Court’s own framework, exemplifies this problem. When differentiating the

181. See *id.* at 2374 (“Throughout history, governments have ‘manipulat[ed] the content of doctor-patient discourse’ to increase state power and suppress minorities.” (quoting Berg, *supra* note 151, at 201 n.3)). Justice Kennedy also remarks upon the threat of authoritarianism in the examination room in his concurrence, urging state legislatures to “understand the history of authoritarian government as the Founders then knew it[,] [and] to confirm that history since then shows how relentless authoritarian regimes are in their attempts to stifle free speech.” *Id.* at 2379 (Kennedy, J., concurring). The fact that this reasoning could just as easily apply in the abortion context was not lost on Justice Breyer: “If a State can lawfully require a doctor to tell a woman seeking an abortion about adoption services, why should it not be able, as here, to require a medical counselor to tell a woman seeking prenatal care or other reproductive healthcare about childbirth and abortion services?” *Id.* at 2385 (Breyer, J., dissenting).

182. *Id.* at 2374 (majority opinion) (internal quotation marks omitted) (quoting *Wollschlaeger V*, 848 F.3d 1293, 1328 (11th Cir. 2017) (en banc) (Pryor, J., concurring)). The Court also quotes from *Turner Broadcasting System, Inc. v. FCC*, in a passage that seems particularly applicable to the context of abortion restrictions: “As with other kinds of speech, regulating the content of professionals’ speech ‘pose[s] the inherent risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas or information.” *Id.* (alteration in original) (quoting 512 U.S. 622, 641 (1994)). It is not a very large jump from the language in *Wollschlaeger* and *Turner* to *Akron*: “[M]uch of the information required is designed not to inform the woman’s consent but rather to persuade her to withhold it altogether.” *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 444 (1983).

183. See, e.g., Blythe, *supra* note 78, at 820 (“[P]atients ha[ve] relatively little to gain from . . . speech restrictions and much to lose from being denied accurate and current information.”).

statutes in *NIFLA* and *Casey*, the Court called upon the fact that California abortion providers were not required to put the same signs up in their waiting rooms, thus establishing the notice as a regulation on speech rather than an informed consent requirement.¹⁸⁴ But imagine that abortion providers *were* required to put up the sign at issue in *NIFLA*, and the state labelled it an informed consent requirement.¹⁸⁵ It is clear that the regulation would not meet even the rudimentary informed consent framework the Court laid out in the very same passage.¹⁸⁶ Clinics that provide abortion services often provide many other services that the Court might not interpret as “procedures.”¹⁸⁷ There is no reason to suspect that a person in the waiting room, merely by being in a place where abortions are performed, would need the information on such a sign, just as a person in a waiting room at a crisis pregnancy center might not need that information.¹⁸⁸ And finally, as the Court itself stated, the signage does not provide any information about the risks or benefits of an abortion procedure¹⁸⁹—but nor would it if it were required to hang in an abortion provider’s waiting room.¹⁹⁰ It is clear from the *NIFLA*

184. *NIFLA*, 138 S. Ct. at 2374 (“Tellingly, many facilities that provide the exact same services as covered facilities—such as general practice clinics . . . are not required to provide the licensed notice.”).

185. Abortion providers are in fact required to put up similar signs in many states across the country, requiring different information for a similar purpose: to inform women of alternatives to abortion they may not have considered. See *supra* note 1 and accompanying text; *infra* section III.B.1.

186. See *supra* note 180 and accompanying text.

187. See, e.g., Our Services, Planned Parenthood, <https://www.plannedparenthood.org/get-care/our-services> [<https://perma.cc/7TBZ-KX6C>] (last visited Jan. 3, 2019). Services that might not be considered “procedures” include: birth control consultations and prescriptions; HIV testing; general health care and checkups; hormone therapy; patient education; STD testing; and pregnancy testing. *Id.* Some of these very same services are provided at CPCs. See *supra* note 2.

188. *NIFLA*, 138 S. Ct. at 2375–78 (arguing that the statute is both overinclusive because it is only providing such information in CPCs, where women may not want the information, and underinclusive because it has exempted clinics that provide abortions, where women may in fact want the information). One could even argue that, in a clinic that provides abortions compared to a CPC, the information would interest *fewer* women as a percentage of people in the waiting room; clinics that provide abortions also often provide other services to nonpregnant, trans, and male patients. See *supra* note 187. CPCs, by contrast, only provide services to people “faced with difficult pregnancy decisions.” What Is a Pregnancy Center?, *supra* note 2.

189. *NIFLA*, 138 S. Ct. at 2373–74.

190. Recall that the *Casey* Court’s definition of informed consent seemed to include regulations that allow states to express a “preference for childbirth over abortion.” *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 883 (1992) (plurality opinion). The *NIFLA* Court’s seeming requirement that an informed consent requirement give information on the risks or benefits of the procedure, *NIFLA*, 138 S. Ct. at 2373–74, at minimum, seems antithetical to the *Casey* Court’s broad understanding of the term in the context of its abortion jurisprudence. For example, information about adoption services, child support, contraceptive services, and state-subsidized pre- and postnatal care seem to fall within the *Casey* Court’s understanding of informed consent, *Casey*, 505 U.S. at 883,

decision itself that regulating an abortion provider and calling such a regulation an informed consent requirement does not make it so. Additional guidance is needed in order to determine what is a proper informed consent requirement and what merely regulates speech as speech.

III. THE *NIFLA* PHYSICIAN–SPEECH FRAMEWORK, APPLIED

This Part expands the *NIFLA* Court’s implied definition of informed consent into a larger framework—one that can help courts decide whether certain requirements are part of the conduct of medical practice and exempted from First Amendment scrutiny under *NIFLA*, or “regulate[] speech as speech” and thus accorded strict scrutiny under current First Amendment doctrine.¹⁹¹ Section III.A explains and expands upon the factors laid out in *NIFLA*: (1) whether the regulation is “tied to a procedure”;¹⁹² (2) whether a specific procedure is “sought, offered, or performed”; and (3) whether the regulation carries information about “the risks or benefits of [the] procedure[.]”¹⁹³ Section III.B will apply these factors to common informed consent requirements and explain why, under this framework, a court would be justified in applying strict scrutiny under current First Amendment doctrine rather than excepting an informed consent requirement in its entirety. Those common requirements include: (1) signage laws and mandatory website disclaimers; and (2) state-written materials required to be given out by the abortion provider and state-written scripts that abortion providers must follow.

This Part does not attempt to lay out an entire doctrine as related to physician–patient speech, as others have done;¹⁹⁴ nor does it attempt to resolve the issues this framework raises where definitions of informed consent play a role in other contexts, like professional malpractice;¹⁹⁵ nor does it attempt to resolve all conflicts that arise with the Court’s broader vision of informed consent in *Casey*, though this Part certainly discusses the implications when those conflicts occur. This Part simply attempts to

but fall short of the *NIFLA* Court’s understanding of the requirement. This fundamental disagreement about the boundaries of informed consent is one way in which the Court’s abortion and First Amendment jurisprudence are threatening to collide. For a deeper discussion of this fissure, see *infra* section III.A.3.

191. *NIFLA*, 138 S. Ct. at 2374.

192. For the purposes of this Part, the “procedure” sought (or not) is an abortion, though presumably a court could call other services performed at a clinic “procedures.” See *supra* notes 187–188.

193. *NIFLA*, 138 S. Ct. at 2373–74.

194. See *Post*, *supra* note 16, at 951; see also Carl H. Coleman, *Regulating Physician Speech*, 97 N.C. L. Rev. 843, 846 (2019); Sawicki, *supra* note 166, at 825.

195. See, e.g., *Post*, *supra* note 16, at 973 (“It would not be credible to advance an account of First Amendment value that would render ordinary informed consent doctrine constitutionally questionable, so that every malpractice case involving informed consent would suddenly entail large constitutional questions.”).

develop a mode of analysis, mentioned though not explored in *NIFLA*, through which courts can differentiate true informed consent requirements from restrictions that regulate speech, not conduct.

A. *A New NIFLA Informed Consent Framework*

This Part assumes that the mere label of informed consent does not preclude First Amendment scrutiny, building off of the informed consent benchmarks established in *NIFLA* to provide a few factors that might help to elicit the line between informed consent and mere speech. None of these factors are meant to be themselves decisive of the issue.¹⁹⁶ Rather, they are meant to be devices used to ascertain whether the regulation, on balance, serves the factors of a proper informed consent statute outlined as an exception in *NIFLA* or whether they would be more properly adjudged under the same First Amendment framework used to consider the FACT Act itself.

1. *“Tied to a procedure.”*— The first factor depends on whether the speech required is so attenuated from the actual performance of an abortion as to render it a restriction of speech, not conduct. If the speech occurs without regard to whether a patient is seeking and receiving an abortion procedure, it is more likely to be overinclusive and thus a function of the speech of the abortion provider, rather than the conduct of providing an abortion. Suppose, for example, a clinic provides abortions, but none have been requested for years.¹⁹⁷ If a state mandates speech by an abortion provider in its waiting room or on the home page

196. Nor are they meant to be the only relevant factors on the matter. This Part, by relying on the First Amendment rights of the doctor to freely give medical advice, does not consider the possible First Amendment rights of the *patient* not to hear disclosures required by the state, or a positive right to hear accurate medical advice. See Corbin, *Compelled Listening*, *supra* note 18, at 996–1000 (outlining a patient’s right against compelled listening to state-mandated disclosures); Blythe, *supra* note 78, at 815–21 (discussing a patient’s right to accurate medical information and a more patient-centered understanding of the First Amendment). Others have suggested the possibility that, after *NIFLA*, the expressiveness of the regulation should be a factor that requires certain restrictions to be assessed under a First Amendment framework. See Laura Portuondo, *Abortion Regulation as Compelled Speech*, 67 *UCLA L. Rev.* (forthcoming Jan. 2020) (manuscript at 4), https://papers.ssrn.com/abstract_id=3359721 (on file with the *Columbia Law Review*) (“Relying on *NIFLA* and other recent developments in First Amendment jurisprudence, this Article outlines a compelled speech claim against certain fetal-protective abortion regulations, including fetal demise and fetal burial laws, which ‘express respect for potential life.’”).

197. While this is an unlikely scenario, even the most well-known abortion providers perform few abortions compared to the other services they offer. See Planned Parenthood, 2016–2017 Annual Report 7, 31 (2017), https://www.plannedparenthood.org/uploads/filer_public/d4/50/d450c016-a6a9-4455-bf7f-711067db5ff7/20171229_ar16-17_p01_lowres.pdf [<https://perma.cc/48H9-29QH>] (stating that of the 9.5 million services it provided between October 2015 and September 2016, Planned Parenthood performed only 321,384 abortion procedures, or roughly 3.3% of total services provided).

of its website,¹⁹⁸ it cannot be tied to an abortion procedure—and thus cannot be a function of informed consent—because there are none being performed. Such a restriction is thus more likely to be simply content-based speech required only of abortion providers in all circumstances, regardless of whether it is tied to a particular abortion procedure.

2. “*Sought, offered, or performed.*” — The second factor depends on how attenuated the designated speaker is from the procedure itself—if a patient has not begun the process of requesting an abortion, the regulation cannot be a function of informed consent. Take again the example of an abortion clinic that has performed no abortions. While the clinic does “offer” the procedure in the broadest sense of the term, that cannot be enough to trigger the informed consent exception if there are no patients whose consent must be informed. But, unlikely scenarios aside, this factor applies to the *process* of seeking an abortion as well: The closer the speech is to the *actual* procedure sought or performed, the more likely it is to be a regulation of conduct, not pure speech. Thus, for example, the speech of the doctor performing the abortion would be less protected as their speech is more likely to be a function of the conduct of performing the procedure.¹⁹⁹ On the other hand, mandated speech of a nonmedical volunteer in a waiting room, or a state-written pamphlet required to be delivered to a patient,²⁰⁰ would be more protected, as these requirements are fundamentally less connected both to the procedure itself and any particular patient.

3. “*Risks or benefits of the procedure.*” — The third factor depends on the type of information the state requires the physician give in order to obtain informed consent and depends entirely upon how “risks or benefits” of an abortion are defined. In *Casey*, the Court has appeared to define it broadly, holding that required information about “the nature of the procedure, the health risks of abortion and those of childbirth, and the ‘probable gestational age’” of the fetus is information relevant to

198. For an analysis of signage and website disclosure laws under this framework, see *infra* section III.B.1.

199. This factor may conflict with some commentators who suggest that doctors themselves should be *more* protected by the First Amendment in the treatment context, especially when the state may require them to be a mouthpiece for its views or give inaccurate medical advice. See, e.g., Corbin, *Abortion Distortions*, *supra* note 24, at 1176 (“[D]espite the fact that compelling someone to articulate the government’s ideology is anathema in free speech jurisprudence, courts have upheld mandatory abortion counseling laws that force doctors to serve as mouthpieces for the state’s viewpoint.” (footnote omitted)). Even *NIFLA* itself implied that doctors are part of the “marketplace of ideas” protected by First Amendment doctrine. *Nat’l Inst. of Family & Life Advocates v. Becerra (NIFLA)*, 138 S. Ct. 2361, 2374–75 (2018) (citing *McCullen v. Coakley*, 134 S. Ct. 2518, 2529 (2014)). Still, because this Part explores the particular context in which states are attempting to regulate *conduct*, not pure physician speech, the line between the doctor and other speakers in the clinic context is a helpful device for ascertaining whether a procedure has been “sought, offered, or performed.” *Id.* at 2373.

200. For an analysis of state-written materials under this framework, see *infra* section III.B.2.

the psychological and physical well-being of the patient and thus allowable as a possible “risk” of an abortion.²⁰¹ And yet, there is no reason why the definition of the relevant risks or benefits of the procedure should be the same under the Court’s First Amendment doctrine. The information required by the FACT Act, for example—the availability of “comprehensive family planning services”²⁰² elsewhere—was apparently not a risk or benefit of any medical procedure.²⁰³ If the Court applies this precedent evenhandedly, requiring patients to read or hear that similar services are available for *childbirth*—pre- or neonatal care, adoption services, or child support requirements, to name a few—would not be a risk or benefit of their procedure, especially if the information does not apply to them. If the information is more attenuated from the medical context, especially the context of the particular procedure sought by the patient, it is less likely to inform their consent and more likely to be a direct infringement upon speech.²⁰⁴

B. *Applying the Framework to Existing Informed Consent Laws*

This section applies the framework outlined above to various requirements that implicate speech in the abortion context. Section III.B.1 discusses its application to signage laws and mandatory website disclosures, the restrictions on abortion providers that most mirror California’s restrictions on CPCs. Section III.B.2 expands the lens to discuss other requirements that implicate conduct and speech in more complex ways, including state-written materials and state-imposed scripts.

1. *Signage Laws and Mandated Website Disclosures.* — The most obvious abortion restrictions that might be implicated by the factors laid out above are signage laws and website disclosures. Many states, as a necessary element of informed consent, require abortion providers to place signs in their waiting rooms to provide certain information to possible patients. Kansas’s signage requirement mandates language regarding child support, Medicaid services, and agencies “willing to provide assistance so that you may carry your child to term.”²⁰⁵ Louisiana’s requirement mandates the sign read: “The law allows adoptive parents to pay costs of prenatal care, childbirth

201. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992) (plurality opinion) (quoting 18 Pa. Cons. Stat. § 3205(a)(1)(ii) (1990)).

202. Cal. Health & Safety Code § 123472(a)(1) (2018); see also *supra* note 3 and accompanying text.

203. *NIFLA*, 138 S. Ct. at 2373–74.

204. This was arguably the deciding factor in *Stuart v. Camnitz*—recall the Fourth Circuit’s discomfort with requiring a doctor to explain a sonogram to a woman who has closed her eyes and covered her ears. See 774 F.3d 238, 252–53 (4th Cir. 2014); see also *supra* notes 97–100 and accompanying text. In other words, if the patient rejects receipt of the information, and thus it cannot inform her consent, it is pure speech to require the doctor to continue to provide it.

205. Kan. Stat. Ann. § 65-6709(k) (West 2019); see also *supra* note 1 and accompanying text.

and newborn care.”²⁰⁶ Texas requires clinics and hospital emergency departments to place signs in consult rooms and restrooms that read: “[A] woman who needs help may call or text a state or national organization that assists victims of human trafficking and forced abortions”²⁰⁷ In addition to signage requirements, some states also require specific information and language to appear on clinics’ websites. Kansas requires that every website for an abortion provider directly link to state-written materials and other visual information, including sonogram images.²⁰⁸ Abortion providers must abide by these requirements whether or not any abortions are actually sought or performed. They are not specific to the risks or benefits of any particular procedure or any particular patient. Patients not seeking an abortion (indeed, patients who are not pregnant) must see them. As a result, like the FACT Act’s required signage, they do not meet the definition of informed consent set out in *NIFLA* and should properly be accorded strict scrutiny as content-based restrictions on speech.

2. *State-Written Materials and State-Imposed Scripts.* — Other requirements that are triggered after an abortion is sought may still contravene the informed consent framework established in *NIFLA*. Current informed consent statutes require clinics to make visible to patients information on human trafficking,²⁰⁹ emergency contraception,²¹⁰ child support,²¹¹ adoption services,²¹² and public funding for prenatal, neonatal, and postpartum care,²¹³ to name a few. While the first two factors of the *NIFLA* framework are likely met—a procedure has been sought by a patient—whether such information would be a risk or benefit of this *particular* procedure and this *particular* patient is an open question. If, for example, a doctor is aware that such information will not

206. La. Stat. Ann. § 40:1061.15(B)(1) (2019).

207. Tex. Health & Safety Code §§ 241.011, 245.025 (2019).

208. Kan. Stat. Ann. § 65-6709(1). The link must read: “The Kansas Department of Health and Environment maintains a website containing information about the development of the unborn child, as well as video of sonogram images of the unborn child at various stages of development. The Kansas Department of Health and Environment’s website can be reached by clicking here.” *Id.*

209. See, e.g., Tex. Health & Safety Code § 241.011.

210. See, e.g., *id.* § 171.012(a)(2)(C) (2019) (requiring the provision of information about emergency contraception for victims of rape and incest).

211. See, e.g., *id.* § 171.012(a)(2)(B) (requiring that physicians inform pregnant women that “the father is liable for assistance in the support of the child without regard to whether the father has offered to pay for the abortion”).

212. See, e.g., N.D. Cent. Code § 14-02.1-02(11)(b)(2) (2019) (requiring a physician to provide “printed materials” that “list agencies that offer alternatives to abortion” at least twenty-four hours before the procedure).

213. See, e.g., Tex. Health & Safety Code § 171.012(a)(2)(A) (requiring the physician to inform the patient that “medical assistance benefits may be available for prenatal care, childbirth, and neonatal care”).

apply to their patient and yet is required to give it,²¹⁴ such a law is a restriction on pure speech and should be properly adjudged under the First Amendment. If, like in *Stuart v. Camnitz*, a doctor is required to impart information but the patient may cover her ears, this too would be compelled speech, because the patient is not being informed, as she is not listening.²¹⁵ This factor, in particular, would directly contradict the language in *Casey* that allows states to convey their interest in childbirth over abortion through informed consent statutes²¹⁶—in fact, it would directly contradict the holding in *Casey*.²¹⁷ And yet, such information may not be material to the patient’s decision—it may not be a risk or benefit of her particular procedure under *NIFLA*. If it is not, and more particularly if the doctor and patient alike know it is not, it is more likely to be a restriction on pure speech for the doctor to be required to give it anyway.

Even ostensibly medical information mandated to be provided by the state might be suspect under this framework. Consider the requirement in *Casey* that the doctor inform the patient of the “probable gestational age of the unborn child.”²¹⁸ Many states have taken this requirement much further—requiring doctors to give patients materials that display a fetus at nearly every stage of development.²¹⁹ While *Casey*

214. In practice, such requirements can be wrenching for the doctor and hurtful to the patient. Consider, for example, a situation in which a doctor must share information on state-sponsored adoption services to a patient who is getting an abortion because they know their child will not survive. See, e.g. N.D. Cent. Code § 14-02.1-02(11)(b)(2), 02.1(1)(a) (requiring physicians to give and describe state-written materials that state that “[t]he state of North Dakota strongly urges you to contact one or more of these agencies before making a final decision about abortion”). For North Dakota’s state-written materials, see N.D. Dep’t of Health, Information About Pregnancy and Abortion (2016), http://www.ndhealth.gov/familyhealth/preg_abortion_booklet_final.pdf [<https://perma.cc/TA48-JN67>].

215. 774 F.3d 238, 247–48, 252–53 (4th Cir. 2014).

216. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 883 (1992) (plurality opinion) (“[W]e permit a State to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion.”).

217. The statute in *Casey* required patients to be offered information from the state on agencies able to assist with pregnancy and childbirth, child support, and adoption. See *supra* note 64. Recall though that *Casey*’s language carefully leaves open the possibility that while offering state-written materials does not violate the First Amendment, requiring that doctors give them or verbally explain them might. See *supra* notes 74–77 and accompanying text.

218. *Casey*, 505 U.S. at 881 (internal quotation marks omitted) (quoting 18 Pa. Cons. Stat. § 3205(a)(1)(ii) (1990)).

219. See, e.g., Ind. Code § 16-34-2-1.1, 16-34-2-1.5 (2018). In Indiana, doctors are required to give patients a brochure that shows a fetus at twenty stages of development, from two to three weeks to full term. See Ind. State Dep’t of Health, Abortion Informed Consent Brochure 2–6 (2018), https://www.in.gov/isdh/files/Abortion_Informed_Consent_Brochure.pdf [<https://perma.cc/LV54-VUE2>]. Only one of these stages would be directly relevant to the patient’s procedure, and eleven of them show the fetus after twenty weeks, the time at which abortion becomes illegal in Indiana.

held that the age of the fetus is accurate, nonmisleading information and thus allowable under the undue burden standard,²²⁰ it does not necessarily follow that requiring a doctor to give their patient graphic information about every possible stage of the fetus's development is information necessary to understand the risks or benefits of her procedure under the *NIFLA* standard.

Only if “risks or benefits of a procedure” were defined as all medical and nonmedical risks or benefits of any possible abortion, for any possible patient, would all of the above informed consent restrictions comport with the Court’s framework set out in *NIFLA*. But such a definition belies evenhandedness, does not comport with *NIFLA*’s own holding, and begs Justice Breyer’s question: “If a State can lawfully require a doctor to tell a woman seeking an abortion about adoption services, why should it not be able . . . to require a medical counselor to tell a woman seeking prenatal care or other reproductive healthcare about childbirth and abortion services?”²²¹

CONCLUSION

The majority in *NIFLA* is careful to except *Casey* from its holding, using the informed consent requirement of a medical procedure to distinguish otherwise similar regulations. But many abortion regulations, in practice, do not act merely as vehicles for informed consent. They may serve the state’s interest in deterring abortions, as they are allowed under *Casey*,²²² but they may also be drastically overinclusive in the First Amendment context. They infect not just speech related to an abortion but, as Justice Thomas warned of the disclosure at issue in *NIFLA*, speech that is “not tied to a procedure at all,”²²³ and certainly not tied to the patient’s particular procedure. For a regulation that implicates speech to inform consent and thus be exempted from First Amendment scrutiny, more is required than merely that an abortion provider provide abortions. A regulation that prescribes what abortion providers may say in all instances, regardless of whether a procedure is sought or performed or the particular characteristics and needs of the patient, should properly be regarded as a content-based restriction and subject to strict scrutiny under current First Amendment law.

In an era of ever-expanding First Amendment protections, a doctrine that protects in nearly every context but the abortion clinic and nearly every person but the abortion provider is worthy of suspicion. And

But see Ind. Code § 16-34-2-3 (allowing for an exception to the twenty-week ban when the life or health of the pregnant patient is at risk).

220. *Casey*, 505 U.S. at 883.

221. Nat’l Inst. of Family & Life Advocates v. Becerra (*NIFLA*), 138 S. Ct. 2361, 2385 (2018) (Breyer, J., dissenting).

222. *Casey*, 505 U.S. at 883.

223. *NIFLA*, 138 S. Ct. at 2373.

as informed consent requirements balloon in states across the country, it seems almost certain that the Court's abortion jurisprudence and First Amendment jurisprudence are on a collision course—one that will require federal courts to decide what is a true informed consent requirement and what, to tweak Justice Thomas's phrase, regulates signs as signs.²²⁴ If courts continue to let states dictate First Amendment scrutiny by labeling regulations of abortion providers as informed consent requirements, they risk applying a weakened First Amendment in Kansas—while the one in California remains as robust as ever.

224. See *id.* at 2374.

Reproduced with permission of copyright owner. Further reproduction prohibited without permission.