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The Future of Physicians' First Amendment Freedom: Professional Speech in an Era of Radically Expanded Prenatal Genetic Testing

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The Future of Physicians' First Amendment Freedom: Professional Speech in an Era of Radically Expanded Prenatal Genetic Testing

Wynter K. Miller & Benjamin E. Berkman*

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I. Introduction

Genetic testing is advancing at an unprecedented pace.¹ Until recently, the testing techniques available in the prenatal context were invasive and risky.² The introduction of non-invasive prenatal testing (NIPT) in 2011 has dramatically reduced the overall incidence of standard diagnostic procedures like amniocentesis and chorionic villus sampling (CVS).³ Nevertheless, the genetic information available to prospective parents (PPs)

1. See Ignatia B. Van den Veyver, *Recent Advances in Prenatal Genetic Screening and Testing*, F1000RESEARCH, Oct. 28, 2016, at 3 (noting the “unprecedented rapid evolution” of certain forms of genetic testing).

2. See *id.* at 5 (noting that non-invasive tests are a recent development).

3. See *id.* at 4 (noting that “likely because of intense marketing, many women are being offered cffDNA screening, irrespective of *a priori* risk, and [as a result] the number of diagnostic procedures performed has dramatically declined”). According to Van den Veyver, NIPT has prompted many women to forego confirmatory testing entirely. See *id.* at 5.

today is still largely limited to targeted testing for severe early-onset conditions.⁴ But the emergence of prenatal whole genome sequencing (PWGS) will eliminate the barriers between targeted testing and testing for everything.⁵ Soon, it will be possible to interrogate an entire fetal genome.⁶ As PWGS transforms the pregnancy experience, PPs can anticipate access to an incredible amount of genetic information about their offspring—from late-onset medical conditions like breast cancer, to manageable medical conditions like hemochromatosis, to non-medical traits like athletic ability, to aesthetic characteristics like eye color.⁷ While some technical barriers remain, clinical availability of prenatal whole genome sequencing (PWGS) is now a question of “when,” not “if.”⁸ And by most accounts, “when” may be in as few as five years.⁹

PWGS presages a paradigm shift.¹⁰ Genetic information will become far more accessible, but its contents will be less

4. See *id.* at 6 (“Thus, until non-invasive tests become more accurate and comprehensive, the growing trend of replacing diagnostic testing with cfDNA screening comes at a cost of missed prenatal genetic diagnoses.”).

5. See Lisa Hui & Diana W. Bianchi, *Recent Advances in the Prenatal Interrogation of the Human Fetal Genome*, 29 *TRENDS GENETICS* 84, 84–91 (2013) (noting the increases in “overcom[ing] several major technical barriers to the non-invasive assessment of the whole fetal genome”).

6. See *id.* (noting the increases in interrogating the human fetal genome).

7. Hemochromatosis is a commonly inherited condition caused by mutations in the HFE gene that can be easily and effectively managed if treatment is initiated early enough. See M.J. Burt et al., *The Significance of Haemochromatosis Gene Mutations in the General Population: Implications for Screening*, 43 *BMJ* 830, 835 (1998).

8. See Malorye Allison, *Genomic Testing Reaches into the Womb*, 31 *NATURE BIOTECHNOLOGY* 595, 600 (2013) (noting the likelihood that whole genome sequencing will soon be utilized).

9. See *id.* (suggesting eventual routinization of PWGS, but stating that “[w]hether it’s 5, 10, or 20 years is more difficult to say”); Elaine R. Mardis, *The Impact of Next-Generation Sequencing Technology on Genetics*, 24 *TRENDS GENETICS* 133, 134 (2008) (stating that next-generation sequencing “will provide a comprehensive picture of normal human genome variation in the next few years”); John A. Robertson, *The \$1000 Genome: Ethical and Legal Issues in Whole-Genome Sequencing of Individuals*, *AM. J. BIOETHICS*, Summer 2003, at 35, 36 [hereinafter *The \$1000 Genome*] (estimating the timeframe for clinical availability of WGS at ten to fifteen years).

10. See Hui & Bianchi, *supra* note 5, at 84–91 (noting that PWGS will create more data).

understood.¹¹ Indeed, even in professional populations genetic literacy is low.¹² Clinicians report feeling inadequately prepared to order genetic tests, to interpret genetic results, and to counsel their patients.¹³ Likely, their concerns are warranted.¹⁴ Genetics is an entirely separate specialty from obstetrics and gynecology, and surveys show that most OB/GYNs have received little or no genetics training.¹⁵ To compound the problem, the United States is facing a shortage of genetics experts.¹⁶ The number of clinical geneticists (the specialists most directly involved with patient care)¹⁷ is decreasing just as the volume of patients utilizing genetic technologies is increasing.¹⁸ There is also a well-documented

11. *See id.* (“Whatever technological platform is eventually used to assess the fetus, whether targeted or whole genome, data interpretation, storage, and management will be major challenges for future clinicians and diagnostic services.”).

12. Julia L. Piechan et al., *NIPT and Informed Consent: An Assessment of Patient Understanding of a Negative NIPT Result*, 25 J. GENETIC COUNSELING 1127, 1135 (2016).

13. *See* Michelle J. Bayefsky et al., *Views of American OB/GYNs on the Ethics of Prenatal Whole-Genome Sequencing*, 36 PRENATAL DIAGNOSIS 1250, 1253 (2016) (“Furthermore, a large majority of OB/GYNs believe that they will not have sufficient resources to interpret and communicate PWGS results.”).

14. *See id.* (“Prenatal whole-genome sequencing will vastly increase the amount of information we can learn about a fetus’s genome, which could have far-reaching societal consequences.”).

15. *See id.* (noting the unfamiliarity of most OBGYNs with genetic data).

16. *See* Wynter K. Miller, Note, *Trust and Anti-Trust: State-Based Restrictions in Telemedicine*, 50 U. CAL. DAVIS L. REV. 1807, 1813 & nn.37–43 (2017) (“The United States is facing an impending healthcare crisis: there are not enough doctors.”).

17. Judith A. Cooksey et al., *The Medical Genetics Workforce: An Analysis of Clinical Geneticist Subgroups*, 8 GENETICS MED. 603, 603 (2006) (“MD clinical geneticists comprise the primary medical specialist group trained and certified in clinical genetics.”).

18. Clinical genetics has historically attracted fewer physicians than other specialties. Further, the typical geneticist’s patient load “is substantially smaller than that reported by physicians practicing in other specialties,” perhaps due in part to differences in time allocation. *Id.* On average, geneticists allocate seven hours to each new patient and three-and-a-half hours to follow-up. *See* V.L. Hannig et al., *Expansion of Genetic Services Utilizing a General Genetic Counseling Clinic*, 23 J. GENETIC COUNSELING 64, 64 (2014) (“[A]n average of 7 h was spent on each new genetics patient (including all time spent by all professionals) and 3.5 h on each follow up patient.”). By contrast, the average pediatrician spends between eleven and twenty minutes with each patient; the

shortage of Master's-level genetic counselors.¹⁹ In short, the supply of geneticists is insufficient to meet current demand, let alone provide adequate counseling to the millions of PPs making reproductive decisions each year.²⁰ By necessity, geneticists will not be the only professionals, or even the primary professionals, offering genetic testing to PPs.²¹ Obstetricians and other prenatal providers will need to act as genetic gatekeepers.²² How they perform that role—what they say to patients and when they say it—is the focus of this Article.²³

This issue warrants attention because the implications of PWGS are not limited to the medical landscape.²⁴ PWGS is also injecting new urgency into an entrenched political debate.²⁵ For well over a century, abortion has been one of the most radioactive issues in America.²⁶ Its legal status—specifically, the legality or

average internist spends twenty-six minutes. See David C. Dugdale et al., *Time and the Patient-Physician Relationship*, 14 J. GEN. INTERNAL MED. S34, S36 (1999) (discussing patient visit lengths); Gery P. Guy Jr. & Lisa C. Richardson, *Visit Duration for Outpatient Physician Office Visits Among Patients with Cancer*, 8 J. ONCOLOGY PRACTICE 2s, 7s tbl.3 (2012) (comparing average time spent with patients by oncologists (24.7 minutes) versus non-oncologists (21.1 minutes)).

19. See Benjamin E. Berkman & Michelle Bayefsky, *Prenatal Whole Genome Sequencing: An Argument for Professional Self-Regulation*, AM. J. BIOETHICS, Jan. 2017, at 26, 26–27 (noting “the well-documented dearth of genetic counselors”). In a comprehensive national survey of the genetics workforce, Cooksey et al. found that geneticists rely heavily on genetic counselors with respect to patient care. Indeed, most geneticists have three or more genetic counselors on staff, and 64% to 77% of geneticists report that genetic counselors see *many* or *all* of their new patients. Cooksey et al., *supra* note 17, at 609.

20. See Berkman & Bayefsky, *supra* note 19, at 26–27 (noting that the medical community lacks enough geneticists).

21. See *id.* (“[G]iven the well-documented dearth of genetic counselors, there is reason for concern that doctors will have to rely on genetic counseling services provided by the genetic testing companies themselves.”).

22. See *id.* (noting that prenatal providers will have to interact with genetic testing companies to determine how to relay information to patients).

23. See *infra* Parts II–IV.

24. See Berkman & Bayefsky, *supra* note 19, at 26–28 (noting the interplay between abortion and PWGS).

25. See *id.* (noting, among other arguments, that PWGS may lead to arguments “that aborting affected fetuses amounts to disability discrimination”).

26. See Leigh Ann Caldwell, *Abortion: A Polarizing, Emotional Debate 41 Years After Court Ruling*, CNN (Jan. 22, 2014) <https://www.cnn.com/2014/01/22/politics/abortion/index.html> (last visited Jan. 6, 2019) (noting that abortion has remained a controversial issue for many years)

illegality of its performance—stands as “the coveted jewel in the political crown.”²⁷ *Roe v. Wade*²⁸ stands as a bulwark against outright bans.²⁹ Thus, the “general strategy” of pro-life advocates has been to make abortion harder—“harder legally, financially, emotionally, and practically.”³⁰ Historically, pro-life legislators sought to construct legal hardships by way of logistical obstacles—e.g., mandatory waiting periods,³¹ hospital-admitting privilege requirements,³² insurance coverage restrictions,³³ state-mandated counseling,³⁴ parental notification,³⁵ and the

(on file with the Washington and Lee Law Review).

27. CAROL SANGER, ABOUT ABORTION: TERMINATING PREGNANCY IN TWENTY-FIRST CENTURY AMERICA xi (2017).

28. 410 U.S. 113 (1973).

29. *See id.* at 166–67 (stating that abortions cannot be criminalized in certain situations).

30. *See* Sanger, *supra* note 27, at xi (describing the strategy of some pro-life advocates).

31. In 1992, the Supreme Court upheld Pennsylvania’s 24-hour waiting period under *Roe*’s undue burden standard. *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 887 (1992). Today, twenty-seven states require observance of a waiting period between when a woman receives pre-abortion counseling and when the abortion is performed. In fourteen states, the waiting period is of sufficient duration (e.g., laws in Missouri, North Carolina, Oklahoma, South Dakota, and Utah mandate a 72-hour waiting period) so as to require two separate trips to the clinic. *See An Overview of Abortion Laws*, GUTTMACHER INST., <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws> (last updated Apr. 1, 2019) (last visited Apr. 16, 2019) (describing the abortion laws of many states) (on file with the Washington and Lee Law Review).

32. *See An Overview of Abortion Laws*, *supra* note 31 (“19 states require an abortion to be performed in a hospital after a specified point in the pregnancy.”).

33. *See id.* (“11 states restrict coverage of abortion in private insurance plans.”).

34. *See id.* (“18 states mandate that women be given counseling before an abortion.”).

35. *See id.* (“37 states require some type of parental involvement in a minor’s decision to have an abortion.”).

like.³⁶ Though markedly effective in many cases,³⁷ logistical obstacles have nonetheless failed to secure for pro-lifers the coveted jewel: *Roe*'s overturn.³⁸ And so, the hardship construction project continues.³⁹

In this context, states have begun to legislate.⁴⁰ In 1923, Rudyard Kipling infamously described words as “the most powerful drug used by mankind.”⁴¹ Perhaps in cognizance of the power of words, physician speech has recently become a target for anti-abortion regulation.⁴² Texas, for example, compels physicians to warn pregnant women that an abortion may increase their risk

36. According to the Guttmacher Institute, nineteen states require abortions to be performed in a hospital after a specified point in the pregnancy (usually viability); eleven states restrict coverage of abortion in private insurance plans; eighteen states mandate pre-abortion counseling; and thirty-seven states require parental consent or notification. See *An Overview of Abortion Laws*, *supra* note 31 (providing an overview of abortion law in the United States).

37. Logistical obstacles tend to “have a dramatic impact on women who live farthest from major metropolitan areas.” See Lisa R. Pruitt & Marta R. Vanegas, *Urbannormativity, Spatial Privilege, and Judicial Blind Spots in Abortion Law*, 30 BERKELEY J. GENDER L. & JUST. 76, 79 (2015) (discussing the disproportionate toll abortion restriction laws have on women who are both rural and poor); see also Linda Greenhouse & Reva B. Siegel, *Casey and the Clinic Closings: When Protecting Health Obstructs Choice*, 125 YALE L.J. 1428, 1449–50 (2016) (assessing so-called TRAP laws (i.e., targeted regulation of abortion providers) in the *Casey* framework and concluding that “the practical impact of these health restrictions . . . is to dramatically shrink abortion providers’ infrastructure, clos[e] clinics and disabl[e] doctors”).

38. See Caldwell, *supra* note 26 (noting that *Roe* has not been overturned).

39. See *supra* note 36 and accompanying text (noting that “construction” projects continue).

40. See Woman’s Right to Know Act, TEX. HEALTH & SAFETY CODE § 171.012 (2003) (requiring certain warnings to be given prior to an abortion).

41. Rudyard Kipling, *Surgeons and the Soul*, in A BOOK OF WORDS 237, 237 (2007). A similar sentiment has guided the Supreme Court’s First Amendment jurisprudence. Perhaps most famously, Justice Louis Brandeis wrote in *Whitney v. California*, “If there be time to expose through discussion the falsehood and fallacies . . . the remedy to be applied is more speech, not enforced silence.” 274 U.S. 357, 377 (1927). See also *Abrams v. United States*, 250 U.S. 616, 630 (1919) (Holmes, J., dissenting) (recognizing that “the theory of our Constitution” calls for vigilance against attempts to stymie “free trade in ideas”); *Wooley v. Maynard*, 430 U.S. 705, 714 (1977) (“[F]reedom of thought protected by the First Amendment against state action includes both the right to speak freely and the right to refrain from speaking at all.”).

42. See Woman’s Right to Know Act, TEX. HEALTH & SAFETY CODE § 171.012 (2003) (requiring certain warnings to be given prior to an abortion).

of developing breast cancer,⁴³ despite an absence of medical authority supporting the claim.⁴⁴

South Dakota's legislature decided that women seeking abortions may be subject to "clouded judgement, and a willingness to violate conscience."⁴⁵ The state thus compels physicians to warn women that an abortion may increase their risk for suicidal ideation and suicide.⁴⁶ The medical evidence supporting a link between abortion and negative mental health sequelae is similarly lacking.⁴⁷ More recently, states have begun to consider abortion bans on the basis of fetal genetic abnormalities (ABGAs).⁴⁸

These recent legislative attempts to regulate physician speech were undertaken in response to emerging prenatal testing technologies. In 2011, pregnant women in the United States gained access to NIPT, a new technology that makes fetal genetic testing easier than ever before.⁴⁹ The first ABGAs were introduced near

43. *See id.* ("Consent to an abortion is voluntary and informed only if the physician who is to perform the abortion informs the pregnant woman . . . [of] the possibility of increased risk of breast cancer following an induced abortion and the natural protective effect of a completed pregnancy in avoiding breast cancer.").

44. *See* Am. Coll. of Obstetricians & Gynecologists (ACOG), *Committee Opinion No. 434: Induced Abortion and Breast Cancer*, 113 OBSTETRICS & GYNECOLOGY 1417, 1417 (2009), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co434.pdf?dmc=1&ts=20190416T1638572043> ("[R]igorous recent studies demonstrate no causal relationship between induced abortion and a subsequent increase in breast cancer risk.").

45. S.D. CODIFIED LAWS § 34-23A-10.1 (2005) ("The Legislature further finds that a woman seeking to terminate the life of her unborn child may be subject to pressures which can cause an emotional crisis, undue reliance on the advice of others, clouded judgment, and a willingness to violate conscience to avoid those pressures.").

46. *See id.* (listing the written notices that a doctor must provide to the patient).

47. *See* Vignetta E. Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 CONTRACEPTION 436, 448–49 (2008) ("A clear trend emerges from this systematic review: the highest quality studies had findings that were mostly neutral, suggesting few, if any, differences between aborters and their respective comparison groups in terms of mental health sequelae.").

48. *See infra* notes 51–59 and accompanying text (discussing state legislation attempting to restrict abortions).

49. *See infra* Part I (explaining how NIPT is less invasive and more cost

instantaneously. Indeed, the national pro-life organization Americans United for Life drafted and disseminated model legislation for ABGAs a mere three months after NIPT became clinically available.⁵⁰ In 2013, North Dakota became the first state to outlaw abortions “because the unborn child has been diagnosed with either a genetic abnormality or a potential for a genetic abnormality.”⁵¹ Within the last five years, twenty-two states have considered similar legislation.⁵² Some states’ considerations have been dogged. Missouri unsuccessfully attempted to pass some version of an ABGA in 2013, 2014, 2015, 2016, and 2017.⁵³ In January of 2018, Missouri State Senator David Sater and State Representative Shamed Dogan introduced an ABGA identical to the one that failed in 2017, which was identical to the one that

effective compared to other genetic testing methods).

50. See *North Dakota Becomes First State to Limit Abortions Based on Sex-Selection and Genetic Abnormalities Using AUL Model Legislation*, AM. UNITED FOR LIFE (Mar. 26, 2013), <https://aul.org/2013/03/26/north-dakota-becomes-first-state-to-limit-abortions-based-on-sex-selection-and-genetic-abnormalities-using-aul-model-legislation/> (last visited Apr. 16, 2019) (praising North Dakota for following AUL’s model legislation) (on file with the Washington and Lee Law Review).

51. N.D. CENT. CODE ANN. § 14-02.1-04.1(1)(b) (2012).

52. See Mary A. Scott, *Hard Choices: Where to Draw the Line on Limiting Selection in the Selective Reduction of Multifetal Pregnancies*, 100 MINN. L. REV. 1211, 1219 (2016) (listing the states that have considered legislation similar to North Dakota); these states are Hawaii, Illinois, Indiana, Kentucky, Louisiana, Mississippi, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Texas, and Utah.

53. See *Legislative Tracker*, REWIRE NEWS, <https://rewire.news/legislative-tracker/law-topic/genetic-anomalies-abortion-ban/> (last visited Apr. 16, 2019) (listing the status of ABGA legislation at the state level) (on file with the Washington and Lee Law Review).

failed in 2016.⁵⁴ Currently, four states—Indiana,⁵⁵ Louisiana,⁵⁶ North Dakota,⁵⁷ and Ohio⁵⁸—have passed ABGAs, and four more (counting Missouri) pre-filed 2018 proposals.⁵⁹

In most respects, ABGAs are broad and punitive. In the case of North Dakota, for example, “genetic abnormality” is defined as “*any* defect, disease, or disorder that is inherited genetically. The term includes any physical disfigurement, scoliosis, dwarfism, Down syndrome, albinism, amelia, or any other type of physical or mental disability, abnormality, or disease.”⁶⁰ The penalties for performing an abortion on genetic grounds include revocation of medical license, a year in prison, a fine of \$3,000, or any combination of the three.⁶¹ In a technical sense, laws like North

54. Compare S.B. 724, 99th Gen. Assemb., 2d Reg. Sess. (Mo. 2018) (introducing a companion bill to H.B. 1867 (2018) that is identical to S.B. 96 (2017)), with S.B. 96, 99th Gen. Assemb., 1st Reg. Sess. (Mo. 2017) (introducing a bill that was nearly identical to its predecessors, S.B. 802 and H.B. 1815, both of which failed to pass in 2016).

55. See IND. CODE § 16-18-2-1.5 (2016) (presenting Indiana’s ABGA); Indiana’s provision was passed as part of an omnibus bill that was enjoined, but ostensibly the genetic abnormality ban remains in effect per the bill’s severability provision. See *Planned Parenthood of Ind. & Ky., Inc. v. Comm’r, Ind. State Dep’t of Health*, 273 F. Supp. 3d 1013, 1043 (S.D. Ind. 2017) (granting preliminary injunction that prohibits the State from enforcing a portion of the omnibus bill, but does not affect § 16-18-2-1.5), *aff’d*, 896 F.3d 809 (7th Cir. 2018).

56. See LA. STAT. ANN. § 40:1061.1.1 (2016) (presenting Louisiana’s ABGA).

57. See N.D. CENT. CODE ANN. § 14-02.1-04.1(1)(b) (2012) (presenting North Dakota’s ABGA).

58. See 2017 Ohio Laws 29 (presenting Ohio’s ABGA). However, Ohio was “enjoined from implementing and enforcing [the bill].” *Preterm-Cleveland v. Himes*, 294 F. Supp. 3d 746, 758 (S.D. Ohio 2018); see Lauren del Valle, *Ohio Judge Blocks Legislation Preventing Abortions in Down Syndrome Cases*, CNN, <https://www.cnn.com/2018/03/14/health/court-block-ohio-abortion-down-syndrome/index.html> (last updated Mar. 14, 2018, 8:58 PM) (last visited Apr. 16, 2019) (summarizing *Preterm-Cleveland*) (on file with the Washington and Lee Law Review).

59. See H.B. 4210, 100th Gen. Assemb., Reg. Sess. (Ill. 2018) (introducing an ABGA); S.B. 1430, 56th Leg., 2d Sess. (Okla. 2018) (same); S.B. 1867, 99th Gen. Assemb., 2d Reg. Sess. (Mo. 2018) (same); H. 4833, 122nd Gen. Assemb., Reg. Sess. (S.C. 2018) (same).

60. N.D. CENT. CODE ANN. § 14-02.1-02(7) (2018) (emphasis added).

61. See N.D. CENT. CODE ANN. § 12.1-32-01 (2018) (defining penalties for Class A misdemeanors); N.D. CENT. CODE ANN. § 43-17-30.1 (2018) (defining disciplinary action and grounds therefor).

Dakota's might have profound effects on the pregnancy experience in that state. Imagine that a woman living in North Dakota discovers she is pregnant. At her first prenatal exam, around the tenth week of gestation, she furnishes her OB/GYN with a vial of blood. Depending on the case load of her provider, and the availability of a genetic counselor, she may or may not be told what the blood test is for and the type of results she should be prepared to receive. Given that there are five prenatal genetic counselors currently employed in North Dakota, it is unlikely she will receive anything close to sufficient counseling.⁶² Five to eight days after her appointment, the woman gets a phone call. She is told that the results of her blood test show there is an increased risk that she is carrying a baby with a genetic condition called trisomy 18. She is told that babies with trisomy 18 usually die in utero or within the first month of life, but 5–10% live past their first year, often with severe physical and intellectual disabilities.⁶³ If the woman opts for confirmatory testing, she will be scheduled for a CVS shortly thereafter.⁶⁴ But because she lives in North Dakota, if CVS gives a definitive diagnosis of trisomy 18, the woman will be unable, as a matter of state law, to terminate the pregnancy.⁶⁵ The same would be true if the baby had Down syndrome or trisomy 13.⁶⁶

62. See *Find a Genetic Counselor*, NAT'L SOC'Y GENETIC COUNS., <https://www.nsgc.org/page/find-a-gc-search> (last visited Dec. 27, 2018) (setting search criteria in the State/Province field for "North Dakota" and Types of Specialization field for "Prenatal") (on file with the Washington and Lee Law Review).

63. See *Trisomy 18*, GENETICS HOME REFERENCE, <https://ghr.nlm.nih.gov/condition/trisomy-18> (last visited Dec. 27, 2018) (discussing the life expectancy and side-effects of individuals diagnosed with Trisomy 18) (on file with the Washington and Lee Law Review).

64. See *Chromosome Study from Amniotic Fluid and CVS*, NAT'L CTR. FOR BIOTECH. INFO., <https://www.ncbi.nlm.nih.gov/gtr/tests/556622/> (last updated July 4, 2018) (last visited Dec. 27, 2018) (providing an overview of the prenatal test and listing the conditions that it diagnoses) (on file with the Washington and Lee Law Review).

65. See N.D. CENT. CODE ANN. § 14-02.1-04.1(1)(b) (2012) ("[A] physician may not intentionally perform or attempt to perform an abortion with knowledge that the pregnant woman is seeking the abortion solely . . . [b]ecause the unborn child has been diagnosed with either a genetic abnormality or a potential for a genetic abnormality.").

66. Trisomy 13 is a disorder associated with heart defects, brain or spinal cord abnormalities, very small or poorly developed eyes, extra fingers or toes, an opening in the lip or roof of the mouth, and weak muscle tone. See *Trisomy 13*,

With PWGS's inevitable clinical adoption, the above scenario would change in two respects. First, the woman might receive a positive prenatal diagnosis for any number of genetic disorders above and beyond what NIPT can currently screen for, such as Huntington's disease (a fatal genetic disorder that usually manifests after age 30), depression, Duchenne Muscular Dystrophy, schizophrenia, breast cancer, malignant hyperthermia, autism, diabetes, bipolar disorder—the list is near limitless.⁶⁷ Second, though she might receive her diagnosis at the same time (i.e., the tenth week of gestation), she would not need an amniocentesis or CVS to confirm.⁶⁸ All it would take is a blood test.⁶⁹ Under laws like North Dakota's, regardless of the medical severity of the condition, this woman would be legally barred from pursuing an abortion.⁷⁰

The demonstrated eagerness of pro-lifers to apply the “general strategy” in ever-imaginative ways suggests that these first attempts to control NIPT presage an equally vigorous legislative response to PWGS. The genomic era will not be exempt from abortion politics. As such, it is clearly not too soon to talk about free speech, genetic gatekeepers, and PWGS. This Article explores the First Amendment questions PWGS is likely to raise. It argues that most of the foreseeable options for state intervention in conversations between physicians and PPs about genetic sequencing should trigger at least heightened scrutiny. Part I provides an overview of the most recent advances in genetic

GENETICS HOME REFERENCE, <https://ghr.nlm.nih.gov/condition/trisomy-13#> (last visited Apr. 16, 2019) (providing an overview of Trisomy 13) (on file with the Washington and Lee Law Review).

67. See *What Is Noninvasive Prenatal Testing (NIPT) and What Disorders Can It Screen For?*, GENETICS HOME REFERENCE, <https://ghr.nlm.nih.gov/primer/testing/nipt> (last visited Apr. 16, 2019) (providing an overview of NIPT and discussing their limitations) (on file with the Washington and Lee Law Review).

68. See Greer Donley, *Does the Constitution Protect Abortions Based on Fetal Anomaly?: Examining the Potential for Disability-Selective Abortion Bans in the Age of Prenatal Whole Genome Sequencing*, 20 MICH. J. GENDER & L. 291, 297 (2013) (discussing trends and major breakthroughs in the field of whole-genome sequencing).

69. See *id.* (explaining the benefits of whole-genome sequencing).

70. See *supra* notes 65–66 and accompanying text.

testing. It assesses the ongoing impact of NIPT for providers and patients and charts the course from NIPT to PWGS. Part II establishes a foundational background for evaluating First Amendment claims. Part II.A describes the development of First Amendment jurisprudence, focusing on the doctrinal distinctions between levels of judicial scrutiny. Part II.B explores historical Supreme Court case law addressing professional speech. Part III surveys the current legal landscape. Using a handful of recent Circuit cases, Part III.A demonstrates that the legal frameworks for assessing physician speech qua professional speech are shambolic. Part III.B provides an overview of the most recent Supreme Court ruling on professional speech in the 2018 case *National Institute of Family and Life Advocates v. Becerra*.⁷¹ Part IV uses the material in Parts I–III to predict how legislative efforts to limit reproductive decision-making are likely to manifest in the PWGS context. Based on the case analyses in Part III, Part IV identifies the Fourth and Eleventh Circuit approaches as the most defensible for future judicial interventions. This Article concludes that state-based restrictions on PWGS-related speech would be vulnerable to First Amendment challenges and unlikely to survive heightened judicial scrutiny.

II. Advancements in Prenatal Genetics

It has long been standard practice to offer genetic testing to pregnant women.⁷² Until recently, amniocentesis and chorionic villus sampling (CVS) were the available offerings.⁷³ Both involve

71. 138 S. Ct. 2361 (2018).

72. ACOG recommends first trimester screening for all pregnant women. See *Committee Opinion No. 693: Counseling About Genetic Testing and Communication of Genetic Test Results*, AM. C. OBSTETRICIANS & GYNECOLOGISTS, <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Genetics/Counseling-About-Genetic-Testing-and-Communication-of-Genetic-Test-Results> (last visited Apr. 16, 2019) [hereinafter *Committee Opinion No. 693*] (noting that prenatal screenings “have been routine components of prenatal care for several decades”) (on file with the Washington and Lee Law Review).

73. See *What Is NIPT?*, GENETICS EDUC. PROGRAMME (Dec. 18, 2017, 12:15 PM), <https://www.genomicseducation.hee.nhs.uk/news/item/403-what-is-nipt/> (last visited Apr. 16, 2019) (discussing the differences between NIPT and invasive screening techniques) (on file with the Washington and Lee Law Review).

inserting a large needle into the uterus and both are associated with high levels of fear and anxiety amongst pregnant women.⁷⁴ Perhaps more critically, both tests are classified as diagnostic rather than screening tests.⁷⁵ And the distinction between “diagnostic” and “screening” is more than semantic. Diagnostic tests identify abnormalities with higher levels of confidence than screening tests but are also more invasive and involve a measurable risk of miscarriage.⁷⁶

In the late 1990s, there was great interest in developing safer alternatives to amniocentesis and CVS. In 1997, Dennis Lo and Noemi Corbetta discovered circulating fetal DNA (i.e., cell-free fetal DNA or “cffDNA”) in maternal plasma and serum.⁷⁷ Their discovery demonstrated that it was possible to screen the fetus for genetic conditions using a blood sample from the mother.⁷⁸ Prior to 1997, fetal DNA samples were obtainable only by invasive extraction from the mother’s amniotic fluid (amniocentesis) or placenta (CVS).⁷⁹ Subsequent work by Lo et al. indicated that plasma DNA analysis—now called NIPT—was less susceptible than amniocentesis or CVS to false-positive results.⁸⁰

74. See P. Sarkar et al., *Maternal Anxiety at Amniocentesis and Plasma Cortisol*, 26 *PRENATAL DIAGNOSIS* 505, 506 (2006) (discussing the physiological effect that amniocentesis has on pregnant women).

75. See CTR. FOR GENETICS EDUC., *FACT SHEET 26: DIAGNOSTIC TESTS DURING PREGNANCY 1–2* (2018).

76. The risk of miscarriage occurs at a rate of .22% and .25% for CVS and amniocentesis, respectively. See Marion S. Verp, *Prenatal Genetic Screening and Diagnostic Testing*, in *PRENATAL & PREIMPLANTATION DIAGNOSIS: THE BURDEN OF CHOICE* 18–22 (Joann Paley Gast & Marion S. Verp eds., 2015); ACOG, *Practice Bulletin No. 162: Prenatal Diagnostic Testing for Genetic Disorders*, 127 *OBSTETRICS & GYNECOLOGY* e108, e111–12 (2016).

77. See Y.M. Dennis Lo et al., *Presence of Fetal DNA in Maternal Plasma and Serum*, 350 *LANCET* 485, 486–87 (1997) (discussing the results of the experiment).

78. See *id.* at 485 (discussing the implications of discovering cffDNA).

79. See Rossa W.K. Chiu et al., *Non-Invasive Prenatal Assessment of Trisomy 21 by Multiplexed Maternal Plasma DNA Sequencing: Large Scale Validity Study*, 2011 *BMJ* 342, 342 (2011) (discussing the available methods for prenatal diagnosis of trisomy 21).

80. See Y.M. Dennis Lo et al., *Rapid Clearance of Fetal DNA from Maternal Plasma*, 64 *AM. J. HUM. GENETICS* 218, 223 (1999) (discussing the benefits of plasma DNA analysis).

The discovery of cfDNA has drastically altered the pregnancy experience. Today, invasive diagnostic tests are rarely a first-line offer.⁸¹ In most cases, amniocentesis and CVS are offered selectively for reasons like advanced maternal age or an abnormal screening result, or upon explicit patient request.⁸² Instead, access to fetal genetic information that once required an invasive outpatient procedure—as well as a small but cognizable risk of fetal injury or loss—is now attainable with a simple blood test.⁸³

A. From Non-Invasive Prenatal Testing . . .

Non-invasive prenatal testing (NIPT) is technically classified as a screening method (versus a diagnostic test).⁸⁴ But it offers “an information load approaching that of invasive diagnostic genetic tests.”⁸⁵ Since its clinical introduction in 2011,⁸⁶ a handful of commercial providers have established a robust market for NIPT.⁸⁷

81. See *Amniocentesis*, MAYO CLINIC (Mar. 8, 2019), <https://www.mayoclinic.org/tests-procedures/amniocentesis/about/pac-20392914> (last visited Apr. 16, 2019) (explaining the circumstances in which amniocentesis may be appropriate) (on file with the Washington and Lee Law Review).

82. Cf. EMILY OSTER, EXPECTING BETTER: WHY CONVENTIONAL PREGNANCY WISDOM IS WRONG—AND WHAT YOU REALLY NEED TO KNOW 121 (2014) (noting that even given explicit patient requests, physicians and insurers are often reluctant to provide invasive testing to women under 35).

83. See *supra* notes 67–69 and accompanying text.

84. See Mollie A. Minear et al., *Noninvasive Prenatal Genetic Testing: Current and Emerging Ethical, Legal, and Social Issues*, 16 ANN. REV. GENOMICS & HUM. GENETICS 369, 371 (2015) (stating that clinical guidelines emphasize that NIPT is a screening test and discussing recommendations by some professional societies to change the abbreviation to NIPS). Non-Invasive Prenatal Diagnosis (NIPD) also refers to the same technique.

85. *Id.* at 370.

86. Hong Kong was the first to offer clinical access to NIPT in August 2011. It was available in the U.S. in October 2011. See Megan Allyse et al., *Non-Invasive Prenatal Testing: A Review of International Implementation and Challenges*, 7 INT'L J. WOMEN'S HEALTH 113, 114 (2015) (discussing the origins and commercialization of NIPT).

87. The global market value for NIPT reached an estimated \$1.19 billion in 2015. See *Non-Invasive Prenatal Testing Market to Gain from Enhanced Demand in End-Use Industries Till 2025: Grand View Research*, ABNEWswire (Mar. 30, 2017), http://www.abnewswire.com/pressreleases/noninvasive-prenatal-testing-market-to-gain-from-enhanced-demand-in-enduse-industries-till-2025-grand-view-research-inc_107221.html (last visited Apr. 16, 2019) (highlighting the growth of the NIPT market) (on file with the Washington and Lee Law Review).

The leading U.S.-based providers have proprietary informatics on their respective products,⁸⁸ but in terms of content, NIPT panels are roughly comparable. NIPT generally screens for the three most common trisomies,⁸⁹ certain sex chromosome abnormalities⁹⁰ and microdeletions,⁹¹ and select inherited diseases.⁹² By some

North America holds the largest revenue share at 47%. *See* Allyse et al., *supra* note 86, at 115 (providing market share statistics); GRAND VIEW RESEARCH, NON-INVASIVE PRENATAL TESTING (NIPT) MARKET ANALYSIS (2016), <http://www.grandviewresearch.com/industry-analysis/noninvasive-prenatal-testing-market>.

88. For an expanded discussion and comparison of the different approaches for conducting NIPT and the various bioinformatics platforms for post-hoc data analysis, *see* Errol R. Norwitz & Brynn Levy, *Noninvasive Prenatal Testing: The Future Is Now*, 6 REVS. OBSTETRICS & GYNECOLOGY 48, 56 (2013) (“Each entity utilizes a unique and proprietary algorithm for interpretation of the genetic data.”). For an overview of the NIPT intellectual property landscape, *see* Ashwin Agarwal et al., *Commercial Landscape of Noninvasive Prenatal Testing in the United States*, 33 PRENATAL DIAGNOSIS 521, 524–27 (2013) (identifying active patents with claims covering uses of cfDNA for prenatal genetic testing and discussing ongoing patent litigation).

89. NIPT screening is widely available for Down syndrome (trisomy 21), Patau syndrome (trisomy 13), and Edwards syndrome (trisomy 18). Trisomies 9 and 16 are also included on NIPT panels, but less commonly. *See NIPT Education for Health Care Professionals—FAQ*, ILLUMINA, <https://www.illumina.com/clinical/reproductive-genetic-health/nipt/healthcare-providers.html> (last visited Apr. 16, 2019) (screening for trisomies 13, 18, and 21, but not screening for trisomies 9 or 16) (on file with the Washington and Lee Law Review).

90. For example, monosomy X (Turner syndrome), Klinefelter syndrome (47, XXY), Triple X syndrome, and Jacob’s syndrome (47, XYY). *See id.* (listing the conditions that NIPT can identify).

91. Microdeletions are chromosome deletions that occur randomly (e.g., regardless of genetic risk factors, maternal age, or race) and can (but do not always) produce negative effects. NIPT panels screen for the 5 most common microdeletions: 22q11.2 syndrome (DiGeorge syndrome), 1p36 syndrome, 15q11.2 syndrome (Angelman syndrome and Prader-Willi syndrome), 4p-syndrome (Wolf-Hirschhorn syndrome), and 5p-syndrome (Cri du Chat syndrome). *See Microdeletion: The Genetic Disorder You’ll Want to Know About Before Birth*, WHAT TO EXPECT, <https://www.whattoexpect.com/pregnancy/microdeletion/> (last updated Nov. 11, 2018) (last visited Apr. 16, 2019) (listing the types of microdeletions that NIPT can identify) (on file with the Washington and Lee Law Review).

92. In May 2017, Natera announced the launch of a new NIPT test (“Vistara”) capable of screening for 30 single-gene mutations, including Noonan syndrome, osteogenesis imperfecta, craniosynostosis syndromes, achondroplasia, and Rett syndrome. *See Natera, Inc. Announces Launch of Vistara Single-Gene*

estimates, NIPT screening reduces the need for invasive testing by as much as 90%,⁹³ and greatly improves overall pregnancy management.⁹⁴ Early clinical experiences with NIPT have been positive,⁹⁵ and reinforced by aggressive marketing practices, consumer demand for NIPT is strong.⁹⁶ Intuitively, it is

Mutation NIPT, NATERA (May 8, 2017), <https://www.natera.com/press-releases/natera-inc-announces-launch-vistara-single-gene-mutation-nipt> (last visited Apr. 16, 2019) (discussing Vistara's expanded capabilities compared to other NIPT) (on file with the Washington and Lee Law Review).

93. See Pam Belluck, *Test Is Improved Predictor of Fetal Disorders*, N.Y. TIMES WELL BLOG, <https://well.blogs.nytimes.com/2014/02/26/new-dna-test-better-at-predicting-some-disorders-in-babies-study-finds/> (last updated Feb. 27, 2014) (last visited Apr. 16, 2019) (“Nine out of 10 women who are currently being referred for further testing would not need invasive tests.”) (on file with the Washington and Lee Law Review).

94. See Joris Robert Vermeesch et al., *Prenatal and Pre-implantation Genetic Diagnosis*, 17 NATURE REVIEWS: GENETICS 643, 646 (2016) (discussing how NIPT results “yield valuable information on both fetal and maternal health . . . [which] substantially improve overall pregnancy management”). For example, several studies indicate NIPT may also accurately screen for other fetal aneuploidies (e.g., trisomies 7, 15, and 16), and occult malignancy and presymptomatic cancer in pregnant women. See Frédéric Amant et al., *Presymptomatic Identification of Cancers in Pregnant Women During Noninvasive Prenatal Testing*, 1 JAMA ONCOLOGY 814, 814 (2015) (showing that NIPT may also enable screening for presymptomatic maternal tumors—e.g., ovarian carcinoma, follicular lymphoma, and Hodgkin lymphoma); Baran Bayindir et al., *Noninvasive Prenatal Testing Using a Novel Analysis Pipeline to Screen for All Autosomal Fetal Aneuploidies Improves Pregnancy Management*, 23 EUR. J. HUM. GENETICS 1286, 1291 (2015) (demonstrating NIPT identification for trisomies other than 13, 18, and 21); Diana W. Bianchi et al., *Noninvasive Prenatal Testing and Incidental Detection of Occult Maternal Malignancies*, 314 JAMA 162, 168 (2015) (demonstrating NIPT detection of asymptomatic occult malignancy in 3 out of 8 pregnant women).

95. See GARETH M. THOMAS, NUFFIELD COUNCIL ON BIOETHICS, DECISION-MAKING BY EXPECTANT PARENTS: NIPT, NIPD, AND CURRENT METHODS OF PRENATAL SCREENING FOR DOWN'S SYNDROME (EVIDENCE REVIEW) (2016), <http://orca.cf.ac.uk/98686/1/Gareth-Thomas-evidence-review-decision-making-nipt.pdf> (collecting studies reporting women's positive experiences of NIPT); Celine Lewis et al., *Women's Experiences and Preferences for Service Delivery of Non-Invasive Prenatal Testing for Aneuploidy in a Public Health Setting: A Mixed Methods Study*, 11 PLOS ONE 1, 8 (2016) (finding that pregnant interviewees were “overwhelmingly positive” about NIPT); Ellika Sahlin et al., *Positive Attitudes towards Non-Invasive Prenatal Testing (NIPT) in a Swedish Cohort of 1,003 Pregnant Women*, 11 PLOS ONE 1, 10 (2016) (concluding that the “overwhelming majority” of interviewees viewed NIPT positively).

96. See Blake Murdoch et al., *Non-Invasive Prenatal Testing and the Unveiling of an Impaired Translation Process*, 39 J. OBSTETRICS & GYNAECOLOGY CAN. 10, 12–14 (2017) (citing evidence that commercial pressure and perceived

unsurprising that PPs broadly favor incorporating NIPT into standard patient care. After all, when confronted with a 22-gauge needle or transvaginal probe, it is not difficult to believe that many women would opt instead for a quick blood draw.

Notwithstanding its realized and potential benefits, however, NIPT has considerable limitations. It does not, for instance, screen for neural tube defects;⁹⁷ early onset preeclampsia,⁹⁸ or structural abnormalities including physical defects of the heart, abdominal wall, and skeleton.⁹⁹ NIPT cannot detect the vast majority of chromosomal abnormalities or most inherited diseases, and its results are less reliable in cases of fetal and placental mosaicism,¹⁰⁰ twin pregnancies,¹⁰¹ and maternal obesity.¹⁰² Essentially, NIPT is “a very good screening test for what it’s designed to screen

risk of legal liability can drive uptake, influence public and professional opinion, and bias research outcomes).

97. See Jean Gekas et al., *Non-Invasive Prenatal Testing for Fetal Chromosome Abnormalities: Review of Clinical and Ethical Issues*, 9 APPLICATION CLINICAL GENETICS 15, 19 (2016) (discussing the limitations of NIPT screening).

98. See Wybo Dondorp et al., *Non-Invasive Prenatal Testing for Aneuploidy and Beyond: Challenges of Responsible Innovation in Prenatal Screening*, 23 EUR. J. HUM. GENETICS 1438, 1442 (2015) (comparing NIPT and combined first trimester screening and noting that only the latter tests for pregnancy complication risks, e.g., pre-eclampsia or intra-uterine growth retardation).

99. See A. Theresa Wittman et al., *Patient Perception of Negative Noninvasive Prenatal Testing Results*, 6 AM. J. PERINATOLOGY REPS. e391, e395 (2016) (discussing the nuances in patient comprehension regarding NIPT’s inability to screen for nonstructural and structural abnormalities).

100. See Peter Benn, *Non-Invasive Prenatal Testing Using Cell Free DNA in Maternal Plasma: Recent Developments and Future Prospects*, 3 J. CLINICAL MED. 537, 550 (2014) (“Discordancy due to undetected mosaicism can be expected to arise regardless of which NIPT methodology is used.”).

101. See *id.* at 548 (noting that while NIPT’s performance is unaffected in cases of monozygotic twins, “[f]or dizygotic twins and higher multiples NIPT is more problematic”). But see Tze Kin Lau et al., *Non-Invasive Prenatal Screening of Fetal Down Syndrome by Maternal Plasma DNA Sequencing in Twin Pregnancies*, 26 J. MATERNAL-FETAL & NEONATAL MED. 434, 436 (2013) (arguing that NIPT detection of fetal aneuploidy from maternal plasma is “theoretically feasible” in twin pregnancies but acknowledging that “direct proof is lacking”).

102. See Mary C. Livergood et al., *Obesity and Cell-Free DNA “No Calls”: Is There an Optimal Gestational Age at Time of Sampling?*, 216 AM. J. OBSTETRICS & GYNECOLOGY 413.e1, 413.e3 (2017) (confirming a lower NIPT detection rate of abnormalities among overweight and obese women as compared to normal-weight women).

for”—but it is designed to screen for a small number of medically severe conditions.¹⁰³ NIPT thus represents only an incremental shift in the practice of prenatal genetic testing. NIPT's recent and arguably premature clinical uptake has only intensified consumer demand for more expansive genetic forecasting.¹⁰⁴ NIPT is meant to supplement rather than replace traditional screening, at least in its current iteration.¹⁰⁵ But NIPT's demonstrated commercial viability has had a galvanizing effect on fetal genomic research. Less than a year after NIPT's debut, researchers began developing true replacements for amniocentesis and CVS.¹⁰⁶ Since 2011, several independent studies have successfully demonstrated proof-of-principle that it is possible to use NIPT to non-invasively sequence the whole prenatal genome.¹⁰⁷

103. Belluck, *supra* note 93 (quoting Dr. Van den Veyver, who also voices concern “that if women stop [at NIPT], they miss the opportunity to have a diagnostic test like amnio that can detect other chromosomal abnormalities”).

104. See Megan Allyse & Christopher Thomas Scott, *Too Much of a Good Thing*, in Allison, *supra* note 8, at 598 (“[A] commercial model that encourages widespread distribution of such tests as NIPTs may emphasize clinical uptake over clinical utility.”); Minear et al., *supra* note 84, at 375 (commenting that the “pace of clinical translation has made it difficult for provider education to keep up,” and describing the problem of conveying reliable and accurate information to PPs as “virtually impossible”); Murdoch et al., *supra* note 96, at 14 (concluding that NIPT commercialization has polluted public and professional perception such that “fast adoption” has occurred without appropriate evidence of cost-efficacy and clinical utility). *Contra* Benn, *supra* note 100, at 551 (arguing that the lower positive predictive value of NIPT does not justify withholding it from women with low prior risk); Ken Song et al., *Clinical Utility and Cost of Non-Invasive Prenatal Testing with cfDNA Analysis in High-Risk Women Based on a US Population*, 26 J. MATERNAL-FETAL & NEONATAL MED. 1180, 1183–84 (2013) (finding NIPT superior in terms of accuracy and cost-effectiveness over first-trimester combined screening and integrated screening).

105. See Allison, *supra* note 8, at 596–97 (explaining that NIPTs are typically only offered to pregnant women with a “high risk of carrying a fetus with a defect,” whereas women with low risk of carrying a defective fetus receive traditional invasive screening tests).

106. See H. Christina Fan et al., *Non-Invasive Prenatal Measurement of the Fetal Genome*, 487 NATURE 320, 320 (2012) (demonstrating that the prenatal genome can be determined non-invasively).

107. See *id.* (describing how a molecular counting method can be clinically applied to prenatal genome determination); Jacob O. Kitzman et al., *Non-Invasive Whole Genome Sequencing of a Human Fetus*, 137 SCI. TRANSLATIONAL MED. 137ra76, 137ra81 (2012) (demonstrating non-invasive prediction of the whole-genome sequence of a human fetus); Y.M. Dennis Lo et al., *Maternal Plasma DNA Sequencing Reveals the Genome-Wide Genetic and Mutational Profile of the Fetus*, 2 SCI. TRANSLATIONAL MED. 61, 91 (2010) (constructing a

B. . . . And Whole-Genome Sequencing . . .

The first generations of genetic sequencing technology focused only on pre-identified “variants of interest.” Genotyping, for example, returns small data sets on specific bases in the genome associated with recognized diseases.¹⁰⁸ This type of single-gene testing is highly effective for confirming expressed symptoms, or for identifying suspected mutations early.¹⁰⁹ Imagine you are trying to remember the exact phrasing of *Pride and Prejudice*’s infamous first sentence. Genotyping is like a card catalog—it is an effective tool for finding the sentence in the library, but only if you already know *Pride and Prejudice* is the book you are looking for. In medicine, card catalogs can be incredibly valuable. If a young male patient begins exhibiting symptoms like delay of motor milestones, muscle wasting, and abnormal levels of dystrophin in the blood, a genetic test targeting the DMD gene can help establish a diagnosis of Duchenne muscular dystrophy (DMD).¹¹⁰ Similarly, if PPs have a family history of DMD, genetic testing can determine if an individual is a carrier and, if so, the risk of passing on the genetic mutation.¹¹¹ Importantly, in both cases, the physician must know that Duchenne causes symptoms like the patient’s and that the disease is associated with a DMD gene mutation.¹¹² That is, in

genome-wide genetic map of a fetus from maternal plasma DNA sequences and from information about the paternal genotype and maternal haplotype).

108. See Mark Wanner, *Genomes Versus Exomes Versus Genotypes*, JACKSON LABORATORY (Sept. 21, 2016), <https://www.jax.org/news-and-insights/jax-blog/2016/september/genomes-versus-exomes-versus-genotypes> (last visited Apr. 16, 2019) (providing an overview of genotyping) (on file with the Washington and Lee Law Review).

109. See *id.* (“[G]enotyping focuses on specific bases in the genome known to vary from person to person.”).

110. See *Learning About Duchenne Muscular Dystrophy*, NAT. HUM. GENOME RES. INST., <https://www.genome.gov/19518854/learning-about-duchenne-muscular-dystrophy/#3> (last updated Apr. 18, 2013) (last visited Apr. 16, 2019) (describing the symptoms of DMD) (on file with the Washington and Lee Law Review).

111. See *id.* (discussing how DMD is inherited).

112. See Wanner, *supra* note 108 (explaining that genotyping focuses on “certain locations in the genome where variations often occur”).

order to conduct effective genotyping, the physician must know in advance that the DMD gene is the target.

Next-generation sequencing (NGS), however, is rapidly supplanting genotyping. If genotyping is the card catalog, NGS is the Google search. With this technology, a physician need not know in advance that the sentence is from *Pride and Prejudice* because NGS allows him to check every “book” in the library simultaneously.¹¹³ There are two distinct types of NGS. Whole-exome sequencing (WES) focuses on the known protein-coding regions of the genome (i.e., what we think of as genes), rather than on specific variants of interest.¹¹⁴ Whole-genome sequencing (WGS) focuses on both the coding and non-coding portions of the genome (i.e., all DNA).¹¹⁵ Though WES expands the frame of analysis measurably, it is but a stop on the way to WGS. WGS is the most comprehensive method of genetic analysis, allowing investigation of an individual’s entire genome.¹¹⁶ However, comprehensiveness is not necessarily a good indicator of clinical utility.¹¹⁷

113. See Olwen Reina, *A Beginner’s Guide to Next Generation Sequencing (NGS) Technology*, BITE SIZE BIO, <https://bitesizebio.com/21193/a-beginners-guide-to-next-generation-sequencing-ngs-technology/> (last visited Apr. 16, 2019) (explaining that compared to genotyping, “NGS is characterized by improved accuracy and speed, but also reduced manpower and cost”) (on file with the Washington and Lee Law Review).

114. See *What Are Whole Exome Sequencing and Whole Genome Sequencing?*, GENETICS HOME REFERENCE, <https://ghr.nlm.nih.gov/primer/testing/sequencing> (last visited Apr. 16, 2019) (describing how whole-exome sequencing works) (on file with the Washington and Lee Law Review).

115. See *id.* (describing how whole-genome sequencing works).

116. See *id.* (explaining that WGS can identify variations that WES would miss). WGS is distinguishable from a genome-wide association study (GWAS). GWAS involves rapid scans of an entire genome for variations associated with disease. However, like genotyping, GWAS only surveys an individual’s genome for strategically selected markers of variation (i.e., single nucleotide polymorphisms (SNP)). See *Genome-Wide Association Studies*, NAT. HUM. GENOME RES. INST., <https://www.genome.gov/20019523/genomewide-association-studies-fact-sheet/> (last updated Aug. 27, 2015) (last visited Apr. 16, 2019) (providing an overview of GWAS) (on file with the Washington and Lee Law Review).

117. See *What Are Whole Exome Sequencing and Whole Genome Sequencing*, *supra* note 114 (explaining that although “many more genetic changes can be identified with whole-exome and whole-genome sequencing than with select gene sequencing, the significance of much of this information is unknown”).

Despite its comparatively narrow lens, WES is currently considered more clinically valuable than WGS.¹¹⁸ The reasons are both philosophic and economic.¹¹⁹ In providing a base-by-base view of the genome, WGS generates data of unparalleled breadth, depth, and volume.¹²⁰ WGS thus differs in quantity and in kind from other types of genetic testing.¹²¹ On the one hand, it offers higher-yield returns by virtue of the simple fact that it returns more (and does so efficiently).¹²²

More information has the potential to expose disease-causing variants that would otherwise be missed and to therefore positively affect diagnosis rates.¹²³ On the other hand, WGS returns indiscriminately. In addition to information about medically-severe, early-onset conditions (i.e., the same information available via genotyping and WES), WGS also generates vast amounts of information that may be clinically irrelevant, diagnostically ambiguous, or nonmedical.¹²⁴ Perhaps most

118. See Janine Meienberg et al., *Clinical Sequencing: Is WGS the Better WES?*, 135 HUM. GENETICS 359, 359 (2016) (“Current clinical next-generation sequencing is done by using gene panels and exome analysis . . .”); Wanner, *supra* note 108 (stating that “[m]any of the institutions to first offer clinical sequencing chose to focus on the coding regions only—the exome”).

119. See Meienberg et al., *supra* note 118, at 359 (discussing how WES “have been favored because of low sequencing costs, short turnaround time, and low rate of unspecific or incidental findings”).

120. See *id.* (explaining that WGS is “more likely than WES to provide complete coverage of the entire coding region of the genome”).

121. See Wanner, *supra* note 108 (explaining that whereas WES only sequences 1.5% of the human genome and does not sequence non-coding regions, WGS sequences the entire human genome including the non-coding regions).

122. See *id.* (discussing how WES only diagnoses roughly 30% of patients and WGS may improve diagnostic rates).

123. See Jamie M. Ellingford et al., *Whole Genome Sequencing Increases Molecular Diagnostic Yield Compared with Current Diagnostic Testing for Inherited Retinal Disease*, 123 OPHTHALMOLOGY 1143, 1146 (2016) (finding that WGS could result in a 29% diagnostic increase for inherited retinal disease); Dimitri J. Stavropoulos et al., *Whole-Genome Sequencing Expands Diagnostic Utility and Improves Clinical Management in Paediatric Medicine*, 15012 NPJ GENOMIC MED. 1, 5 (2016) (finding that “WGS exceeds other technology platforms in ability to detect genetic variants involved in childhood disease”).

124. There are five categories of novel information implicated by WGS: “variants of unknown significance, nonmedical genetic markers, carrier status, susceptibility genes, and genes expressing conditions with late onset.” Greer

concerning, WGS provides unparalleled access to “variants of unknown significance” (VUS), the scientific term for nebulous genetic findings.¹²⁵ Given the volume of results and levels of uncertainty attendant to them, many clinicians consider WGS an inelegant alternative to WES.¹²⁶

Indeed, in terms of philosophy, many clinicians subscribe to a theory of elegant medicine. Edmund Pellegrino articulated the theory as one of temperance, wherein clinicians “use only as many tests and treatments as necessary—just so much as to be able to understand what could be wrong, what could be done, and what ought to be done for the patient.”¹²⁷ Pellegrino championed doing more with less, an ideal he styled variously as “diagnostic elegance” and “therapeutic parsimony.”¹²⁸ For the elegant clinician, “reflex[ive] shotgunning in the face of uncertainty”¹²⁹ is

Donley et al., *Prenatal Whole Genome Sequencing: Just Because We Can, Should We?*, 42 HASTINGS CTR. REP. 28, 29 (2012).

125. See *id.* at 31 (“Because the health-related impact of VUS cannot be stated with any degree of certainty, the variants do not yet reveal any medically important information.”).

126. See Richard R. Sharp, *Downsizing Genomic Medicine: Approaching the Ethical Complexity of Whole-Genome Sequencing by Starting Small*, 13 GENETICS MED. 191, 191 (2011) (cautioning against clinical integration of WGS “before having established the knowledge base and clinical infrastructure required to support [it]”). But not all clinicians consider WGS less viable than the alternatives. For example, Howard Jacob, former Director of the Human and Molecular Genetics Center at the Medical College of Wisconsin, argues that “one simple test [referring to WGS] is a lot easier to figure out than doing each individual test.” Ryan Cross, *Howard Jacob on Why Whole Genome Sequencing Is Best for Medicine*, BIO-IT WORLD (Apr. 13, 2016), <http://www.bio-itworld.com/2016/4/13/howard-jacob-why-whole-genome-sequencing-best-for-medicine.aspx> (last visited Apr. 16, 2019) (on file with the Washington and Lee Law Review). That said, Jacob acknowledges that he and his research team are considered “cowboys and irresponsible for using a research-only tool” by the medical establishment. *Id.*

127. Daniel P. Sulmasy, *Edmund Pellegrino’s Philosophy and Ethics of Medicine: An Overview*, 24 KENNEDY INST. ETHICS J. 105, 109–10 (2014).

128. See Edmund D. Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL’Y 23, 27 (1986) (describing therapeutic parsimony and diagnostic elegance as ethical guidelines for the practice of competent medicine).

129. Howard Brody, *Cost Containment as Professional Challenge*, 8 THEORETICAL MED. & BIOETHICS 5, 11 (1987) (discussing Pellegrino’s fundamental requirements for practicing ethical medicine).

intellectually sloppy.¹³⁰ So-called shotgun medicine¹³¹ thus stands as the inverse of elegant medicine, with its “test everybody for everything”¹³² approach representative of everything wrong in modern medicine.¹³³ At least until scientific understanding catches up with technological capability, WGS is something akin to the genetic testing equivalent of “everything but the kitchen sink.”

In terms of economy, most of our scientific understanding is currently limited to Mendelian (single-gene) disorders.¹³⁴ Though the exome only comprises between 1–2% of the human genome, approximately 85% of the nearly 4,000 Mendelian disorders with a known molecular basis are caused by gene mutations located in the exome.¹³⁵ That said, more than 90% of the human exome, and 98%

130. See Joseph S. Alpert, *Required Reading for Anyone Involved in Graduate Medical Education*, 128 AM. J. MEDICINE 441, 441 (2015) (calling an “approach of obtaining every test possible, needed or not, the results of which would be sifted through later . . . too expensive, too wasteful, too invasive, and too intellectually sloppy”).

131. Pellegrino himself was more diplomatic in his assessments of shotgun medicine. He described it as but one of many styles of practice, and used the more flattering term “diagnostic enthusiasm, which leaves no test unused.” EDMUND D. PELLEGRINO, *THE PHILOSOPHY OF MEDICINE REBORN: A PELLEGRINO READER* 34 (H. Tristram Engelhardt, Jr. & Fabrice Jotterand eds., 2008).

132. Dan Shine, *Rules for Shotgun Diagnosis*, 128 AM. J. MED. e59, e59 (2015).

133. For a thoughtful and thorough consideration of the development of modern treatment models, see generally KENNETH M. LUDMERER, *LET ME HEAL: THE OPPORTUNITY TO PRESERVE EXCELLENCE IN AMERICAN MEDICINE* 240–63 (2014) (discussing the evolution from the education-centered medical system of the pre-1980s to the economics-centered medical system of the current era and concluding that “the system [is] not designed to let [doctors] heal patients who require[] ‘slow medicine’”).

134. See *What Are the Different Ways in Which a Genetic Condition Can Be Inherited?*, GENETICS HOME REFERENCE, <https://ghr.nlm.nih.gov/primer/inheritance/inheritancepatterns> (last visited Apr. 16, 2019) (demonstrating a greater understanding of single-gene disorders compared to polygenic disorders) (on file with the Washington and Lee Law Review).

135. See Murim Choi et al., *Genetic Diagnosis by Whole Exome Capture and Massively Parallel DNA Sequencing*, 106 PROC. NAT’L ACAD. SCI. U.S. 19,096, 19,096 (2009) (describing the role that genetic mutations play in Mendelian disorders); Jessica X. Chong et al., *The Genetic Basis of Mendelian Phenotypes: Discoveries, Challenges, and Opportunities*, 97 AM. J. HUM. GENETICS 199, 199 (2015) (explaining that “2,937 genes underlying 4,163 Mendelian phenotypes have been discovered”).

of the genome, remain a question mark¹³⁶—we do not know what most genetic findings from these regions mean, or whether they mean anything at all.¹³⁷ Practically, this means that even when researchers limit the area of inquiry to the exome, upwards of 40% of patients with suspected Mendelian disorders are left with the diagnosis: We don't know.¹³⁸ Considering, then, the billions of ways that a genetic mutation might occur, it makes sense to focus on common “troublemaker genes.”¹³⁹ Or at least it did when sequencing was costly. Until recently, sequencing a whole human genome was prohibitively expensive. In 2003, it cost \$2.7 billion.¹⁴⁰

136. See Donley et al., *supra* note 124, at 30 (explaining that “it will likely take decades to gain a more comprehensive understanding of the genome” (citing Amy L. McGuire & James R. Lupski, *Personal Genome Research: What Should the Participant Be Told?*, 26 TRENDS GENETICS 199, 200 (2010))).

137. For a long time, it was assumed that the genome's non-coding regions lacked functionality. Francis Crick famously speculated that non-coding genes were “little better than junk.” Stephen S. Hall, *Hidden Treasures in Junk DNA*, SCI. AM. (Oct. 1, 2012), <https://www.scientificamerican.com/article/hidden-treasures-in-junk-dna/> (last visited Apr. 16, 2019) (on file with the Washington and Lee Law Review). In 2012, *Nature* published a series of papers based on data gathered by the ENCODE project debunking the idea of “junk DNA.” For a fascinating discussion on the evolution of thought regarding junk DNA, and the scholarly debate the ENCODE project generated, see W. Ford Doolittle, *Is Junk DNA Bunk? A Critique of ENCODE*, 110 PROC. NAT'L ACAD. SCI. U.S. 5294, 5294 (2013) (recapping the debate ENCODE's publications prompted and arguing that notwithstanding ENCODE's findings, “junk” remains an apt descriptor “for much of our genome”). See also ENCODE Project Consortium, *An Integrated Encyclopedia of DNA Elements in the Human Genome*, 489 NATURE 57, 57 (2012) (assigning “biochemical functions for 80% of the genome”).

138. See Damian Smedley et al., *A Whole-Genome Analysis Framework for Effective Identification of Pathogenic Regulatory Variants in Mendelian Disease*, 99 AM. J. HUM. GENETICS 595, 604 (2016) (estimating that when WES is used, “only about 25–40% of individuals with suspected Mendelian disease . . . actually receive a diagnosis”); Wanner, *supra* note 108 (estimating that “exome sequencing still leaves ~70% of patients without diagnoses”).

139. Whereas whole-genome sequencing identifies previously unknown genes, traditional tests would only focus on the known “troublemaker genes” such as trisomies 13, 18, and 21. See *Whole Genome Sequencing*, GENETICS GENERATION, <http://knowgenetics.org/whole-genome-sequencing/> (last visited Apr. 16, 2019) (discussing the advantages of WGS) (on file with the Washington and Lee Law Review).

140. See *The Cost of Sequencing a Human Genome*, NAT. HUM. GENOME. RES. INST., <https://www.genome.gov/27565109/the-cost-of-sequencing-a-human-genome/> (last updated July 6, 2016) (last visited Apr. 16, 2019) (detailing the price to develop the first human genome sequence) (on file with the Washington and Lee Law Review).

Since then, WGS's price tag has plummeted to under \$1,000¹⁴¹—a marked decrease that nonetheless remains above the costs of genotyping and WES.

C. . . . To Prenatal Whole-Genome Sequencing

NIPT and WGS are still transitioning into clinical care. Though there are those with philosophical reservations, cost is still a factor. For NIPT, cost-effective analyses weigh in favor of clinical adoption.¹⁴² There is also growing professional and consumer support for NIPT's implementation as a routine first-tier screening method.¹⁴³ For WGS, costs have fallen more than 99% in less than fifteen years.¹⁴⁴ What once took thirteen years and billions of dollars now takes roughly three weeks.¹⁴⁵ In January 2017, Illumina, the largest manufacturer of DNA sequencers, issued a press release promising that its latest product would “enable the \$100 genome.”¹⁴⁶ In subsequent interviews, Illumina's CEO was more pragmatic. He admitted that the \$100 genome was “more of a roadmap—something that would probably happen in more than three years and fewer than ten.”¹⁴⁷ Either way, there is no denying that sequencing costs are plummeting.

141. See *id.* (listing the price for WGS in 2016).

142. See Song et al., *supra* note 104, at 1180 (“NIPT, at a base case price of \$795, was more clinically effective and less costly (dominant) over both FTS [first trimester screening] and INT [integrated screening].”).

143. See *Global NIPT Market to Exceed USD 2.5 Bn by 2025 Led by US, China*, REUTERS (July 3, 2018, 6:45 AM), <https://www.reuters.com/brandfeatures/venture-capital/article?id=41031> (last visited Apr. 16, 2019) (discussing NIPT market growth) (on file with the Washington and Lee Law Review).

144. See *The Cost of Sequencing a Human Genome*, *supra* note 140 (demonstrating the reduced cost to produce WGS).

145. See *id.* (discussing the logistics of producing WGS).

146. *Illumina Introduces the NovaSeq Series—A New Architecture Designed to Usher in the \$100 Genome*, ILLUMINA (Jan. 9, 2017), <https://www.illumina.com/company/news-center/press-releases/press-release-details.html?newsid=2236383> (last visited Apr. 16, 2019) (on file with the Washington and Lee Law Review).

147. Matthew Herper, *Illumina Promises to Sequence Human Genome for \$100—But Not Quite Yet*, FORBES (Jan. 9, 2017, 5:30 PM),

Recent opinion pieces have described WGS as a challenge to long-considered “basic tenets of genetics,” such that “we are all mutants” now.¹⁴⁸ Tom Shakespeare rather articulately observed that “whole genome sequencing reminds us that everyone is carrying deleterious mutations” and that “[i]n the postgenomic era, everyone is potentially disabled.”¹⁴⁹ In a 2010 *Lancet* piece, Kelly Ormond et al. predicted that “an average person might need information about roughly 100 genetic risks discovered in their genome.”¹⁵⁰ And as noted previously, there is a shortage of genetic counselors to provide that information.¹⁵¹ Of course, the difficult questions raised by genetic testing in general, and by WGS in particular, apply no less in the prenatal context. If we are all mutants now, what does that mean for our unborn children—and what, if anything, should we do with this information?

The influx of genetic data, the inherent complexity and uncertainty associated with that data, and the difficulties in obtaining truly informed consent has created a perfect storm. Given the level of debate in academic and professional quarters, it is unsurprising that the storm has caught the attention of our political representatives. ABGA legislation is the clear result of that attention. The constitutionality of ABGAs has already been raised in the broader abortion debate and indeed, the Fourteenth Amendment is an obvious and appropriate lens through which to examine reason-based abortion bans. Scholars have done so at length.¹⁵² However, in the schema of our constitutional framework,

<https://www.forbes.com/sites/matthewherper/2017/01/09/illumina-promises-to-sequence-human-genome-for-100-but-not-quite-yet/> (last visited Apr. 16, 2019) (on file with the Washington and Lee Law Review).

148. Carrie Arnold, *We Are All Mutants Now: The Trouble with Genetic Testing*, *GUARDIAN* (July 18, 2017, 1:00 PM), <https://www.theguardian.com/science/2017/jul/18/we-are-all-mutants-now-the-trouble-with-genetic-testing> (last visited Apr. 16, 2019) (on file with the Washington and Lee Law Review).

149. Tom Shakespeare, *A Brave New World of Bespoke Babies?*, 17 *AM. J. BIOETHICS* 19, 19 (2017).

150. Kelly E. Ormond et al., *Challenges in the Clinical Application of Whole-Genome Sequencing*, 375 *LANCET* 1749, 1750 (2010).

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

152. See Donley, *supra* note 68, at 291 (examining the constitutionality of reason-based abortion bans in the WGS context at both the state and federal levels, under the Commerce Clause, the Necessary and Proper Clause, and Section 5 of the 14th Amendment); Jaime S. King, *Not This Child: Constitutional*

the First Amendment is no less important than the Fourteenth and, in the context of laws like North Dakota's, no less relevant.

III. The Development of Free Speech

Free speech protection is traditionally justified on intrinsic and instrumental grounds.

That is, speech is adjudged either inherently valuable as a conduit for self-expression,¹⁵³ or extrinsically valuable as a tool to

Questions in Regulating Non-Invasive Prenatal Genetic Diagnosis and Selective Abortion, 60 UCLA L. REV. 2, 2 (2012) (exploring 14th Amendment challenges to prenatal genetic testing technologies and reason-based abortion bans); Rachel Rebouché & Karen Rothenberg, *Mixed Messages: The Intersection of Prenatal Genetic Testing and Abortion*, 55 HOW. L.J. 983, 986 (2012) (arguing that “current law and practice put genetic testing and abortion on a collision course”); John A. Robertson, *Abortion and Technology: Sonograms, Fetal Pain, Viability, and Early Prenatal Diagnosis*, 14 U. PA. J. CONST. L. 327, 373–79 (2011) (speculating about the likely reaction of anti-abortion groups to prenatal sequencing and considering whether states can constitutionally restrict abortion or limit testing); Samantha von Ende, Note, *SEQUELA: Casey, Gonzales, and State Legislatures’ Unscrupulous Use of Science in Crafting Legislation to Regulate Pregnant Women and Women’s Access to Reproductive Health Care*, 4 IND. J.L. & SOC. EQUALITY 21, 49 (2016) (focusing on states’ “unscrupulous use” of advancements in reproductive technologies to restrict abortion rights).

153. Seana Valentine Shiffrin argues against conceptualizing free speech as instrumentally valuable. Rather, “[s]peech, and free speech in particular, are . . . the only precise avenues by which one can be known as the individual one is by others.” Seana Valentine Shiffrin, *A Thinker-Based Approach to Freedom of Speech*, 27 CONST. COMMENT. 283, 291 (2011). For Shiffrin, free speech facilitates the transmission of one’s thoughts and beliefs to others—a critical function “[i]f what makes one a distinctive individual *qua person* is largely a matter of the contents of one’s mind” *Id.* Shiffrin’s argument assumes that “[b]eing known by others . . . is important in itself.” *Id.* at 292. Edwin Baker’s liberty theory of the First Amendment also emphasizes inherent value, albeit on different grounds than Shiffrin’s thinker-based approach. See Elizabeth Blanks Hindman, *First Amendment Theories and Press Responsibility: The Work of Zechariah Chafee, Thomas Emerson, Vincent Blasi and Edwin Baker*, 69 JOURNALISM Q. 48, 59 (1992) (describing Baker’s theory as protective of “the speaker in the act of speaking,” “whether or not intended to communicate propositions or attitudes to others”). See also C. Edwin Baker, *The Process of Change and the Liberty Theory of the First Amendment*, 55 S. CAL. L. REV. 293, 298 (1982) (noting that instrumental theories suggest First Amendment protection would extend to “effective speech” but not to communicative or symbolic speech); Kent Greenawalt, *Free Speech Justifications*, 89 COLUM. L. REV. 119, 153 (1989) (discussing justification for free speech on dignity and equality grounds in that “suppression represents a kind of contempt

accomplish something else (though there is disagreement about what that something else may be).¹⁵⁴ Whatever the theoretical underpinnings of these value assessments, however, it is clear that not all speech is valuable. Speech that incites unlawful or violent conduct, for example, receives very minimal protection under the First Amendment.¹⁵⁵ The same is true for libel,¹⁵⁶ child

for citizens that is objectionable independent of its consequences"); Martin H. Redish, *The Value of Free Speech*, 130 U. PA. L. REV. 591, 595 (1982) (arguing against determining constitutional protection on the basis of types of speech because "all forms of expression are equally valuable for constitutional purposes"); Laurence H. Tribe, *Toward a Metatheory of Free Speech*, 10 SW. U.L. REV. 237, 241 (1978) (arguing for the analytic strength of intrinsic over instrumental claims because though controversial, "only forthright claims of intrinsic value . . . can avoid the endless chase of means after ends").

154. See, e.g., *Monitor Patriot Co. v. Roy*, 401 U.S. 265, 272 (1971) (suggesting that the First Amendment's "urgent" value lies in ensuring appropriate political campaign conduct); *N.Y. Times Co. v. Sullivan*, 376 U.S. 254, 270 (1964) (recognizing free speech as necessary to prevent "occasional tyrannies" and promote self-governance); *Abrams v. United States*, 250 U.S. 616, 630 (1919) (Holmes, J., dissenting) (establishing the canonical "marketplace of ideas" metaphor wherein free speech is instrumentally valuable as a catalyst for the discovery of truth); ALEXANDER MEIKLE JOHN, *FREE SPEECH AND ITS RELATION TO SELF GOVERNMENT* 29 (3d ed. 2004) (proposing free speech protection as instrumentally directed at preserving "the program of self-government"); Vincent Blasi, *The Checking Value in First Amendment Theory*, 1977 AM. B. FOUND RES. J. 521, 527–28 (1977) (articulating an instrumental value for free speech in checking the abuse of power by public officials and calling it "the checking value").

155. This type of speech is also called "*Brandenburg* incitement" in reference to the landmark case of the same name. See generally *Brandenburg v. Ohio*, 395 U.S. 444 (1969). The *Brandenburg* test represents the strongest free speech protection ever recognized by the Court and the current governing law in First Amendment jurisprudence.

156. See *Chaplinsky v. New Hampshire*, 315 U.S. 568, 572 (1942) (calling libel "of such slight social value as a step to truth that any benefit that may be derived from them is clearly outweighed by the societal interest in order and morality").

pornography,¹⁵⁷ obscenity,¹⁵⁸ “fighting words,”¹⁵⁹ and true threats.¹⁶⁰ It is also clear that not all valuable speech is equally valuable. For instance, commercial speech is considered less valuable than core speech and therefore enjoys limited First Amendment protection.¹⁶¹ By contrast, political speech and press publications, the paradigmatic examples of high-value core speech, receive the fullest constitutional protection.¹⁶² The question of value thus has more than just descriptive significance; value assignments prescribe levels of constitutional scrutiny.

157. See *New York v. Ferber*, 458 U.S. 747, 763 (1982) (recognizing and classifying child pornography as a category outside the protection of the First Amendment).

158. The Supreme Court has consistently held that obscenity—i.e., hardcore sexual materials (distinguishable from the broader category of pornography)—is not protected, except with respect to private possession in the home. See *Paris Adult Theater I v. Slaton*, 413 U.S. 49, 63 (1973) (concluding that legislatures may ban commercialized obscenity based on its “tendency to exert a corrupting and debasing impact leading to antisocial behavior”); *Stanley v. Georgia*, 394 U.S. 557, 565 (1969) (“If the First Amendment means anything, it means that a State has no business telling a man, sitting alone in his own house, what books he may read or films he may watch.”).

159. *Chaplinsky* defined fighting words as “those by which their very utterance inflict injury or tend to incite an immediate breach of the peace.” *Chaplinsky*, 315 U.S. at 572; see also *Cohen v. California*, 403 U.S. 15, 20 (1971) (adopting a “directed use” requirement for distinguishing fighting words from merely offensive speech).

160. See *Virginia v. Black*, 538 U.S. 343, 359 (2003) (“‘True threats’ [are] those statements where the speaker means to communicate a serious expression of an intent to commit an act of unlawful violence to a particular individual or group of individuals.”).

161. See *Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council*, 425 U.S. 748, 771 n.24 (1976) (concluding that commercial speech is not valueless but is different enough from other forms of speech such that “a different [i.e., lesser] degree of protection is necessary”).

162. See, e.g., *Connick v. Myers*, 461 U.S. 138, 145 (1983) (acknowledging the “Constitution’s special concern with threats to the right of citizens to participate in political affairs”); *NAACP v. Claiborne Hardware Co.*, 458 U.S. 886, 913 (1982) (placing political speech “on the highest rung of the hierarchy of First Amendment values” (quoting *Carey v. Brown*, 447 U.S. 455, 467 (1980))); *N.Y. Times Co. v. Sullivan*, 376 U.S. 254, 296 (1964) (explaining that the First Amendment “at the very least . . . leaves the people and the press free to criticize officials and discuss public affairs with impunity”); *Roth v. United States*, 354 U.S. 476, 484 (1957) (describing the phrasing of the First Amendment as designed “to assure unfettered interchange” of political and social ideas).

A. Legitimate, Important, and Compelling: The Levels of Judicial Scrutiny

In the earliest part of the twentieth century, judicial review came in just two flavors: rational basis and strict scrutiny. Both were, and are, generally understood to be outcome-determinative. Low-value speech triggers rational basis review. Built on a bedrock of judicial minimalism, rational basis analyses begin with a strong presumption of constitutional validity.¹⁶³ When confronted with a categorical prohibition on obscenity¹⁶⁴ or child pornography,¹⁶⁵ for instance, the Supreme Court asks only: Is the restriction rationally related to a legitimate state interest?¹⁶⁶ By the Court's own articulation, rational basis sets a low bar. It accepts as valid "any conceivable basis" for a claimed state interest, even if offered post hoc;¹⁶⁷ even if "not . . . in every respect logically consistent";¹⁶⁸ even if "unwise [or] improvident";¹⁶⁹ even if imperfect in operation.¹⁷⁰ At

163. See Frederick Schauer, *The Boundaries of the First Amendment: A Preliminary Exploration of Constitutional Salience*, 117 HARV. L. REV. 1765, 1775 (2004) (calling rational basis review so "stunningly minimal" that it allows "regulatory schemes based on highly dubious justification"); Cass R. Sunstein, *Foreword: Leaving Things Undecided*, 110 HARV. L. REV. 4, 78 (1996) (stating that "rational basis' review is rooted in a presumption of good faith, rebutted only in rare instances").

164. See, e.g., *Paris Adult Theater I v. Slaton*, 413 U.S. 49, 60–63 (1973) (upholding state regulation of adult films in public theaters even lacking "conclusive proof"); Schauer, *supra* note 163, at 1775 (noting that the Supreme Court has failed to subject obscenity regulations "to anything more than rational basis review").

165. See, e.g., *New York v. Ferber*, 458 U.S. 747, 753, 758 (1982) (applying rational basis review and finding that a State has "somewhat more freedom in proscribing works which portray sexual or lewd exhibitions of genitalia by children").

166. See Thomas B. Nachbar, *The Rationality of Rational Basis Review*, 102 VA. L. REV. 1627, 1627 ("Through the 'rational basis' test, the Supreme Court asserts the authority to assess whether laws are 'rationally related to a legitimate government interest.'").

167. See *FCC v. Beach Commc'ns*, 508 U.S. 307, 315 (noting also that "it is entirely irrelevant for constitutional purposes whether the conceived reason for the challenged [law] actually motivated the legislature"). See also Russell W. Galloway, *Basic Free Speech Analysis*, 31 SANTA CLARA L. REV. 883, 898–99 (1991) (describing rationality review as requiring only "any conceivable valid government interest").

168. *Williamson v. Lee Optical*, 348 U.S. 483, 487–88 (1955).

169. *Id.* at 488.

170. See *McGowan v. Maryland*, 366 U.S. 420, 541–42 (1961) (eschewing the

the other end of the spectrum, high-value core speech triggers strict scrutiny.

Strict scrutiny swaps “rationally related” for “narrowly tailored” and “legitimate” for “compelling.”¹⁷¹ The question thus becomes: Is the restriction narrowly tailored to serve a compelling government interest?¹⁷² Where rational basis review assumes legislative good faith, strict scrutiny analyses begin with strong skepticism. In terms of a speech restriction’s chance of surviving a legal objection, strict scrutiny is the legal equivalent of sinking a basket from half-court.¹⁷³

Beginning in the 1940s, hairline fractures began appearing in the glossy veneer of the two-tiered system of judicial review. Some cases seemed to call for “more exacting judicial scrutiny” than rational basis allows.¹⁷⁴ In those cases, the Supreme Court was at the same time hesitant to treat the claimed state interest as a foregone issue. For example, in *Kovacs v. Cooper*,¹⁷⁵ the city of Trenton, New Jersey banned the use of sound trucks (i.e., motor

idea that a legislature be required to “hew the line of logical exactness” under the rational basis standard).

171. For examples of strict scrutiny applications, see *United States v. Stevens*, 559 U.S. 460, 482 (2010) (striking down a statute banning depictions of animal cruelty for insufficient narrow tailoring); *United States v. Playboy Entm’t Grp.*, 529 U.S. 803, 813 (2000) (failing to find a compelling government interest and narrow tailoring for content-based regulations under the 1996 Telecommunications Act); *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 235–37 (1995) (articulating and applying the strict scrutiny test to racial classifications).

172. See *United States v. Marzzarella*, 614 F.3d 85, 96 n.14 (2010) (“Strict scrutiny asks whether the law is narrowly tailored to serve a compelling government interest.” (quoting *Playboy Entm’t Grp.*, 529 U.S. at 813)).

173. In 1972, Stanford Law professor Gerald Gunther described strict scrutiny under the Warren Court as “‘strict’ in theory and fatal in fact.” Gerard Gunther, *Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 48 (1972). The phrase has since become a “pithy and influential slogan” for a predetermined result. Matthew D. Bunker et al., *Strict in Theory, But Feeble in Fact? First Amendment Strict Scrutiny and the Protection of Speech*, 16 COMM. L. & POL’Y 349, 349 (2011). In core speech cases, strict scrutiny means “the speaker [will] triumph, and the government’s case (and frequently the statute on which it [is] based) [will] go down in flames.” *Id.* at 351.

174. *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 n.4 (1938).

175. 336 U.S. 77 (1949).

vehicles affixed with a loudspeaker) on public streets.¹⁷⁶ The appellant was arrested by a city patrolman for parking his truck near a municipal building and using a sound truck to broadcast political commentary about an ongoing Trenton labor dispute.¹⁷⁷ The appellant's commentary, decidedly not low-value speech, should have triggered strict scrutiny. And of course, challenged laws should not survive strict scrutiny. The analysis should have been straightforward, the outcome predetermined.¹⁷⁸ And yet, even if Trenton could not demonstrate an interest which would traditionally qualify as compelling—e.g., public health and safety, national security, and the like¹⁷⁹—the Court nonetheless felt that the city's interest in protecting residents “from the distracting noises of vehicles equipped with such sound amplifying devices” was important.¹⁸⁰ To hold otherwise would violate “the quiet and tranquility so desirable for city dwellers.”¹⁸¹ Indeed, it would put them “at the mercy of advocates of particular religious, social or political persuasions.”¹⁸² The Court was unwilling to profoundly

176. *See id.* at 78 (prohibiting “any device known as a sound truck, loud speaker, or amplifiers . . . which emits therefrom loud and raucous noises . . . upon any vehicle operated or standing upon said streets or public places aforementioned”).

177. *Id.* at 79 (recounting the record of the police officer's testimony whereby the Trenton officer heard the appellant broadcasting his voice in what the lower court believed was a commentary on the labor dispute progress).

178. *See supra* Bunker, note 173 at 349 (describing strict scrutiny as a “pithy and influential slogan” for a predetermined result).

179. *See, e.g.,* *Whitney v. California*, 274 U.S. 357, 371 (1927) (expanding *Gitlow's* list of compelling interest to include preventing “endanger[ment] of the foundations of organized government”); *Gitlow v. New York*, 268 U.S. 652, 667 (1926) (finding that the interests in preventing corruption of public morals, incitements to crime, and disturbances of the peace are sufficiently compelling to justify speech restrictions); *see also* *Jacobson v. Massachusetts*, 197 U.S. 11, 38 (1905) (concluding that the state's interest in protecting public health and public safety is sufficiently compelling to justify compulsory vaccination). Though not a speech case, *Jacobson* is relevant in that it emphasized that core constitutional rights have never been without limitation. Under our system of government, a citizen: “may be compelled, by force if need be, against his will and without regard to his personal wishes or his pecuniary interests, or even his religious or political convictions, to take his place in the ranks of the army of his country and risk the chance of being shot down in its defense.” *Id.* at 29.

180. *Kovacs v. Cooper*, 336 U.S. 77, 89 (1949).

181. *Id.* at 87.

182. *Id.*

handicap the government's ability to secure the peace.¹⁸³ Thus, in *Kovacs* and thereafter, the Supreme Court adopted a new methodology.¹⁸⁴ By the late 1980s, that methodology had coalesced under the banner of "intermediate scrutiny," a nebulous grey area that now occupies the middle of the spectrum between rational basis and strict scrutiny.¹⁸⁵

Today, speech that is neither low-value nor high-value triggers intermediate scrutiny. Though it has multiple formulations,¹⁸⁶ intermediate scrutiny refers to a "middle-tier"

183. *Cf. id.* at 88 ("To enforce freedom of speech in disregard of the rights of others would be harsh and arbitrary in itself.").

184. In truth, the new methodology existed for several decades as a set of disparate speech-specific tests. For a thorough discussion of each test, see generally Ashutosh Bhagwat, *The Test that Ate Everything: Intermediate Scrutiny in First Amendment Jurisprudence*, 2007 U. ILL. L. REV. 783, 785–800.

185. The development of intermediate scrutiny in First Amendment law has garnered mixed reviews. According to some scholars, rational basis was "an acceptable starting point," but forcing a two-tiered system to accommodate the nuances of the First Amendment "sacrifice[d] much-needed subtleties for doctrinal simplicity." Bhagwat, *supra* note 184, at 785–86. Accord Neel U. Sukhatme, *Making Sense of Hybrid Speech: A New Model for Commercial Speech and Expressive Conduct*, 118 HARV. L. REV. 2836, 2836 (2005) (noting that "not all speech fits neatly within this dichotomy"). Bhagwat argues that even three tiers is not enough. *See id.* at 831 (arguing for disaggregation as the doctrinal solution to the problem of intermediate scrutiny). Other scholars argue that it is not the two-tiered system that is deficient but rather the judicial tendency to circumvent it. By this view, intermediate scrutiny is one of the ways in which "courts manage to avoid the application of strict scrutiny." Bunker et al., *supra* note 173, at 352.

186. The Supreme Court does not consistently use the same language in its application of intermediate scrutiny. *See, e.g.*, *Ward v. Rock Against Racism*, 491 U.S. 781, 798–99 (1989) (combining "narrowly tailored" with "legitimate interest" to form intermediate hybrid analysis); *Cent. Hudson Gas & Elec. Corp. v. Public Serv. Comm'n*, 447 U.S. 557, 566 (1980) (requiring a "substantial" government interest and a means of advancing it that is "not more extensive than necessary"); *Buckley v. Valeo*, 424 U.S. 1, 25–29 (1976) (describing the standard of review as a "rigorous" weighing of the competing interests and applying something less than strict scrutiny); *United States v. O'Brien*, 391 U.S. 367, 376–77 (1968) (stating that "the Court has employed a variety of descriptive terms: compelling; substantial; subordinating; paramount; cogent; strong"—and settling on "important or substantial"); *Schneider v. State*, 308 U.S. 147, 161 (1939) (calling for a "weigh[ing of] the circumstances" and an appraisal of "the substantiality of the reasons advanced" by the government). The Supreme Court has itself acknowledged inconsistency in this area. *See Denver Area Ed. Telecomm. Consortium, Inc. v. FCC*, 518 U.S. 727, 741–42 (1996) (calling it "close scrutiny" and declaring it "unwise and unnecessary definitively to pick one analogy or one

approach that requires a “sharper focus” than “the relatively deferential ‘rational basis’ standard.”¹⁸⁷ The question is: Does the speech restriction advance a “significant/substantial/important” government interest via reasonable means?¹⁸⁸ But unlike in rational basis and strict scrutiny analyses, the Court’s asking of the question under intermediate scrutiny is not perfunctory. Whether the answer is “yes” or “no” is not predetermined. Rather, “the track record of outcomes is mixed” and “[i]nstead of winning always or never, the government may sometimes win or sometimes lose—it all depends.”¹⁸⁹ For the purposes of this Article, it is perhaps enough to understand that intermediate scrutiny is a vague balancing technique that applies to medium-value speech.

B. The Doctrinal Development of Professional Speech

specific set of words”).

187. *Craig v. Boren*, 429 U.S. 190, 211 (1976) (Powell, J., concurring). Bhagwat and others have concluded that “despite somewhat differing formulations, many of the Court’s new ‘tests’ share some basic, common characteristics.” Bhagwat, *supra* note 184, at 801. *See also* Kathleen M. Sullivan, *Post-Liberal Judging: The Role of Categorization and Balancing*, 63 U. COLO. L. REV. 293, 297 (1992) (stating that all the many formulations of intermediate scrutiny ultimately require laws to “meet the same mid-level hurdle”).

188. Bhagwat, *supra* note 184, at 801. Jay D. Wexler’s definition of intermediate scrutiny is also clarifying: “a test that requires a state interest which is greater than legitimate but less than compelling and a fit between means and end that is not necessarily narrowly tailored but has more than just an incidental connection.” Jay D. Wexler, *Defending the Middle Way: Intermediate Scrutiny as Judicial Minimalism*, 66 GEO. WASH. L. REV. 298, 300 n.15 (1998).

189. Sullivan, *supra* note 187, at 297–98.

The category of medium-value speech is expansive. Expressive/symbolic conduct,¹⁹⁰ mass media communications,¹⁹¹ and commercial speech¹⁹² all trigger intermediate scrutiny. The standard also applies—regardless of the type of speech involved—to time, place, and manner restrictions¹⁹³ (and

190. Nude dancing is an example of expressive conduct falling “within the outer ambit of the First Amendment’s protection.” See *City of Erie v. Pap’s A.M.*, 529 U.S. 277, 290, 296 (2000) (distinguishing between laws that target nudity containing an erotic message—i.e., erotic dancing—and laws that target all public nudity and applying *O’Brien* to the latter); see also *Texas v. Johnson*, 491 U.S. 397, 405–06 (1989) (holding that desecration of the American flag by burning qualifies as expressive conduct); *Tinker v. Des Moines Indep. Cnty. Sch. Dist.*, 393 U.S. 503, 505 (1969) (concluding that “the wearing of an armband for the purpose of expressing certain views . . . was . . . closely akin to ‘pure speech’”); *Brown v. Louisiana*, 383 U.S. 131, 141–43 (1966) (reiterating that free speech rights “are not confined to verbal expression” and concluding that a peaceful sit-in to protest racial segregation qualifies as expressive conduct).

191. See, e.g., *FCC v. Pacifica Found.*, 438 U.S. 726, 746–48 (1978) (stating that “of all forms of communication, it is broadcasting that has received the most limited First Amendment protection” and declining to apply strict scrutiny to a content restriction on speech that would be protected in other contexts); *Red Lion Broad. Co. v. FCC*, 395 U.S. 367, 386, 390 (1969) (weighing the rights of viewers and listeners against the rights of broadcasters and concluding that “differences in the characteristics of new media justify differences in the First Amendment standards applied to them”).

192. See *44 Liquormart, Inc. v. Rhode Island*, 517 U.S. 484, 485–86 (1996) (determining that a ban on commercial speech that is neither false nor misleading “does not satisfy even the less than strict standard that generally applies in commercial speech cases under *Central Hudson*”); see also *Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm’n*, 447 U.S. 557, 562–63 (1980) (establishing definitively that commercial speech receives lesser protection than core speech, requiring an analysis that “turns on the nature both of the expression and of the governmental interests served by its regulation”); *Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council*, 425 U.S. 748, 761, 771 (1976) (stating that “speech does not lose its First Amendment protection because money is spent to project it” and weighing the respective societal and government interests in the free flow of commercial information).

193. See, e.g., *McCullen v. Coakley*, 134 S. Ct. 2518, 2534–41 (2014) (applying intermediate scrutiny after concluding that a Massachusetts buffer zone law was a content-neutral time, place, or manner regulation); *Hill v. Colorado*, 530 U.S. 703, 719 (2000) (identifying Colorado’s buffer zone law as a time, place, manner regulation and applying *Ward*); *Ward v. Rock Against Racism*, 491 U.S. 781, 798 (1989) (stating that time, place, manner regulations “must be narrowly tailored to serve the government’s legitimate, content-neutral interests but that it need not be the least restrictive or least intrusive means of doing so”).

injunctions)¹⁹⁴ on speech, as well as to legislative attempts to mitigate secondary effects of speech.¹⁹⁵ Intermediate scrutiny undoubtedly applies to a broader swath of speech than either rational basis or strict scrutiny. In a characteristically animated dissent in 1994, the late Justice Antonin Scalia chided the Court for its assumption that intermediate scrutiny constitutes “some kind of default standard.”¹⁹⁶ The context in that case was a speech-free buffer zone around a Florida abortion clinic,¹⁹⁷ but Scalia’s sentiment was correct in a broader sense—intermediate scrutiny has become a multi-purpose staple of First Amendment jurisprudence.¹⁹⁸ Indeed, it seems intermediate scrutiny increasingly applies to any speech not readily categorizable.

Professional speech is a particularly glaring example of “not readily categorizable” speech. In 1999, Robert Post provided a succinct definition of the type of professional speech to which I am referring: “speech uttered in the course of professional practice as distinct from speech uttered by a professional.”¹⁹⁹ At various points, I refer to speech of the latter type—i.e., speech uttered by a professional—as “context-divorced speech.” If a physician comments as a private citizen on an issue of public interest, then that physician is engaging in context-divorced speech.

194. *Madsen v. Women’s Health Ctr., Inc.*, 512 U.S. 753, 765 (1994) (“[W]hen evaluating a content-neutral injunction . . . the challenged provisions of the injunction [must] burden no more speech than necessary to serve a significant government interest.”).

195. *Renton v. Playtime Theatres*, 475 U.S. 41, 56–57 (1986) (noting that a time, place, manner restriction on adult film theaters may be justified if the restriction is directed “at the secondary effects of such theaters on the surrounding community”).

196. *Madsen*, 512 U.S. at 792 (1994) (Scalia, J., dissenting).

197. *Id.* at 757–60 (describing the factual background of the case including the order prohibiting petitioners from engaging in certain activities).

198. See Bhagwat, *supra* note 184, at 784 (noting that strict scrutiny is limited to content-based speech regulations and rational basis is “rarely invoked”); see also Sullivan, *supra* note 187, at 297 (arguing that intermediate scrutiny is applied whenever “[a] set of cases comes along that just can’t be steered readily onto the strict scrutiny or rationality track”); Wexler, *supra* note 188, at 300 (“Intermediate scrutiny is one of the Court’s most frequently employed balancing techniques.”).

199. Robert C. Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 947 (2007) (quoting Daniel Halberstam, *Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions*, 147 U. PA. L. REV. 771, 834 (1999)).

However, that a practical definition of professional speech can be articulated is far from conclusive.²⁰⁰ In the legal sense, it is unclear whether there is such a thing as professional speech at all.²⁰¹ Certainly the Supreme Court has never explicitly recognized it.²⁰² Notably, the Court has taken pains to demarcate discernible lines between *other* categories of speech.

Obscenity does not include graphic violence;²⁰³ sexually explicit material is not by definition obscenity;²⁰⁴ pornography is

200. It is worth noting that there are many professionals who might qualify as “professional speakers.” However, the Court’s professional speech doctrine is not any clearer with respect to one profession over another. *See generally*, Agency for Int’l Dev. v. All. for Open Soc’y Int’l, Inc., 570 U.S. 205 (2013) (NGOs); Holder v. Humanitarian Law Project, 561 U.S. 1 (2010) (professional advocacy services); Milavetz v. United States, 559 U.S. 229 (2010) (bankruptcy attorneys); Legal Servs. Corp. v. Velasquez, 531 U.S. 533 (2001) (public interest lawyers); Gentile v. State Bar of Nev., 501 U.S. 1030 (1991) (lawyers); Riley v. Nat’l Fed’n of the Blind, 487 U.S. 781 (1988) (professional fundraisers). Given the subject matter of this Article, I have chosen to focus exclusively on physician speech qua professional speech.

201. *See, e.g.*, Claudia E. Haupt, *Professional Speech*, 125 YALE L.J. 1238, 1258 (2016) (stating that “the Supreme Court has never identified a category of ‘professional speech’ for First Amendment purposes”); Jennifer M. Keighley, *Physician Speech and Mandatory Ultrasound Laws: The First Amendment’s Limit on Compelled Ideological Speech*, 34 CARDOZO L. REV. 2347, 2353 (2013) (describing professional speech rights as doctrinally “unclear and opaque”); Post, *supra* note 130, at 944 (noting that the Supreme Court has not resolved the issue and “[s]cholars have taken widely different views about the constitutional status of physicians’ speech”); Timothy Zick, *Professional Rights Speech*, 47 ARIZ. ST. L.J. 1289, 1293 (2015) (“[I]t is unclear whether there is a category of ‘professional speech’ that is subject to minimal or no First Amendment scrutiny.”); Jacob M. Victor, Note, *Regulating Sexual Orientation Change Efforts: The California Approach, Its Limitations, and Potential Alternatives*, 123 YALE L.J. 1532, 1554–55 (2014) (exploring the blurry “line between speech that is incidental to professional conduct and protected speech”).

202. The Supreme Court has at least not addressed professional speech as a separate and distinct category from commercial speech or regulable professional conduct. Nat’l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361, slip op. at 8 (2018) (“But this Court has not recognized ‘professional speech’ as a separate category of speech.”).

203. *See, e.g.*, Brown v. Entm’t Merchants Assn., 564 U.S. 786, 793 (2011) (rejecting “a State’s attempt to shoehorn speech about violence into obscenity” and concluding that “speech about violence is not obscene”).

204. *See, e.g.*, Jenkins v. Georgia, 418 U.S. 153, 161 (1974) (finding that the film at issue showed “in a broader sense, sex . . . including [scenes wherein] ‘ultimate sexual acts’ [are] . . . taking place” but concluding it did not qualify as

legally differentiable from child pornography;²⁰⁵ “fighting words” and “true threats” are separate categories of speech.²⁰⁶ Indeed, as a general matter, the Court’s First Amendment jurisprudence is fairly nuanced. And yet to the extent that the Court has considered professional speech at all, it has until recently only done so tangentially. The abortion cases illustrate the most obvious examples of this phenomenon.

1. Planned Parenthood v. Casey

In 1992, the Supreme Court granted a re-assessment of many of the constitutional questions first raised in *Roe v. Wade*.²⁰⁷ In doing so, the Court provided arguably the most defensible statement for professional speech as a protected category for the ensuing twenty-six years. Ironically, it did so using language of such ambiguity that commentators have described the passage as “cryptic,”²⁰⁸ “puzzling,”²⁰⁹ and “limited.”²¹⁰ At least one commentator speculated that the Court did not intend to meaningfully address professional speech at all.²¹¹ Rather, the Court “simply blundered” in referencing the First Amendment in a due process analysis.²¹²

legally obscene).

205. See, e.g., *New York v. Ferber*, 458 U.S. 747, 761 (1982) (finding the *Miller* standard for obscenity an unsatisfactory solution to the problem of child pornography).

206. Though true threats are unprotected under the same rationale as fighting words, the two categories are recognized as separate. Compare *Chaplinsky v. New Hampshire*, 315 U.S. 568, 572 (1942) (defining fighting words), with *Virginia v. Black*, 538 U.S. 343, 359 (2003) (defining true threats).

207. 410 U.S. 113 (1973).

208. Haupt, *supra* note 201, at 1259.

209. Post, *supra* note 199, at 946.

210. Keighley, *supra* note 201, at 2356.

211. See Nadia N. Sawicki, *Informed Consent as Compelled Professional Speech: Fictions, Facts, and Open Questions*, 50 WASH. U. J.L. & POLY 11, 38 (2016) (hypothesizing that other commentators missed the mark in their theories and that the Court did not intend to directly address professional speech and that it was incidental in their decision in *Casey*).

212. *Id.*

At issue in *Planned Parenthood of Southeastern Pennsylvania v. Casey*²¹³ were five provisions of Pennsylvania's Abortion Control Act.²¹⁴ Much of the content outlined in the provisions mirrored content the Court had found objectionable in earlier cases.²¹⁵ Pennsylvania's Act structured abortion discussions under the auspices of informed consent. Physicians in Pennsylvania, as in the earlier cases, were required to advise pregnant women of the medical risks involved; the availability of medical assistance benefits for prenatal care, childbirth and neonatal care; and the availability of public and private agencies to provide assistance

213. 505 U.S. 833 (1992).

214. *See id.* at 844 (“At issue in these cases are five provisions of the Pennsylvania Abortion Control Act of 1982, as amended in 1988 and 1989.”).

215. *See City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 444–45 (1983) (concluding disclosures were medically inappropriate suggesting abortion was a dangerous procedure). Akron, Ohio's city ordinance required physicians to orally inform women seeking abortions that “abortion is a major surgical procedure” with physical and psychological complications. *Id.* at 445. The ordinance also mandated a verbal and detailed description of “the anatomical and physiological characteristics of the particular unborn child,” accompanied by the statement that “the unborn child is a human life from the moment of conception.” *Id.* at 444. The Court concluded that the required disclosures were not only medically inappropriate, requiring “at best speculation by the physician,” but further constituted “a parade of horrors” intended to suggest that abortion is a particularly dangerous procedure.” *Id.* at 444–45; *see also Thornburg v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 764 (1986) (determining the statute's informational requirements were facially unconstitutional). At issue in *Thornburg* were provisions of Pennsylvania's Abortion Control Act prescribing the elements of informed consent to abortion. The Court held that the required disclosures—which mandated a physician-delivered description of fetal characteristics; presentation of a list of agencies available to provide prenatal, childbirth, and neonatal care; and a statement that the father is liable for child support—were nonmedical, irrelevant, and inappropriate. *Id.* at 762–63. The Court concluded:

Forcing the physician or counselor to present the materials and the list to the woman makes him or her in effect an agent of the State in treating the woman and places his or her imprimatur upon both the materials and the list. All this is, or comes close to being, state medicine imposed upon the woman, not the professional medical guidance she seeks, and it officially structures—as it obviously was intended to do—the dialogue between the woman and her physician.

Id. at 763 (internal citations omitted). The Court found the informational requirements facially unconstitutional. *Id.* at 764.

during and after pregnancy.²¹⁶ As in earlier cases, Pennsylvania mandated a 24-hour waiting period between the patient's giving of informed consent and performance of the abortion.²¹⁷ And, finally, again as in earlier cases, the Pennsylvanian legislators mandated a statement advising pregnant women of the biological father's liability.²¹⁸

Aside from an earlier Title X case, which was limited by its facts to contexts involving federal funding,²¹⁹ the First Amendment had yet to merit independent consideration in the Court's abortion jurisprudence. In *Casey*, the Court granted it that independent consideration—in all of two sentences. “To be sure,” the Court stated in a joint opinion signed by only three Justices, “the physician's First Amendment rights not to speak are implicated, but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State.”²²⁰ We see no constitutional infirmity in the requirement that the physician provide the information mandated by the State here.”²²¹ Without directly overturning any of its earlier case law, the Court nonetheless

216. *Compare* Regulation of Abortions, Akron Codified Ordinances, ch. 1870, § 1870.06, Ordinance No. 160-1978, *invalidated by Akron*, 462 U.S. 416 (1983) (requiring attending physicians make specified statements to assure a truly informed consent), *with* 18 PA. CONS. STAT. § 3205 (1982) (providing a comprehensive list of required disclosures for doctors performing abortions with criminal penalties for violation).

217. *See* 18 PA. CONS. STAT. § 3205(a)(1) (listing a disclosure requirement twenty-four hours prior to the planned abortion).

218. *Id.* § 3205(2)(iii) (1989). The *Thornburgh* court took issue with the liability provision in 1986. Justice Blackmun observed that in some cases a liability reminder might have a destructive effect on the doctor–patient relationship. The Court determined, “a victim of rape should not have to hear gratuitous advice that an unidentified perpetrator is liable for her support . . . [u]nder the guise of informed consent.” *Thornburgh*, 476 U.S. at 763. In the amended provision at issue in *Casey*, the legislature exempted physicians from issuing a liability advisory in cases of rape. Section 3205(2)(iii) (“The father of the unborn child is liable to assist in the support of her child, even in instances where he has offered to pay for the abortion. In the case of rape, this information may be omitted.”).

219. *Rust v. Sullivan*, 500 U.S. 173, 202 (1991).

220. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992) (internal citations omitted).

221. *Id.*

“overrule[d] those parts of [earlier case law]” deemed inconsistent with the State’s legitimate interest in protecting potential life.²²²

Since *Casey*, legal scholars—and more notably, lower court judges—have spilled significant ink speculating, arguing, and ultimately disagreeing about its First Amendment import.²²³ Whatever level of importance the Court meant to ascribe to professional speech with those two “on-the-fly” sentences,²²⁴ most commentators agree that the intention was clearly not to provide a coherent framework for assessing future First Amendment claims.²²⁵ Thus, the Court’s decision in 2017 to grant certiorari in *National Institute of Family and Life Advocates v. Becerra*²²⁶ was potentially momentous. For the first time since *Casey*, the question of physicians’ free speech rights was again under Supreme Court scrutiny, and in the abortion context no less.

222. *Id.* at 870. Note that even absent explicit overturn, *Akron* and *Thornburgh* were not good law after *Casey*. See, e.g., Nat’l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361, 2384 (2018) (Breyer, J., dissenting) (“These cases [*Akron* and *Thornburgh*], however . . . are no longer good law [after *Casey*].”).

223. See, e.g., Haupt, *supra* note 201, at 1246 (“There may be less desire to protect professional speech concerned with abortion—and more tolerance for government demands to read inaccurate, legislatively drafted scripts, compelled descriptions of mandatory ultrasounds and the like—based on moral disapproval.”); Sawicki, *supra* note 211, at 14 (addressing the lower court difficulty of interpreting the precedent set by *Casey* with regard to constitutional standards for reviewing state regulations of physician speech); Jennifer M. Keighley, *supra* note 201, at 2348 (questioning the First Amendment implications of the compelled speech mandated by state laws after the decision in *Casey* specifically in the context of ultrasound procedures); Lindsey Schmidt, Note, *The Constitutional Right to an Abortion Does Not Encompass the Right to Be Uninformed: The Fourth Circuit’s Puzzling Approach to Evaluating Mandatory Ultrasound Provisions in Stuart v. Camnitz*, 774 F.3d 238 (4th Cir. 2014), 95 NEB. L. REV. 1124, 1156–57 (2017) (discussing the Fourth Circuit’s conclusions related to a North Carolina law and addressing the potential flaws with the decision in light of precedent in *Casey*).

224. Rodney A. Smolla, *Professional Speech and the First Amendment*, 119 W. VA. L. REV. 67, 81 (2016).

225. See *id.* (discussing a previous scholar’s work and how that work did not go far enough to state that *Casey* provided “virtually no guidance as to the general constitutional status of professional speech”).

226. 138 S. Ct. 2361 (2018).

2. National Institute of Family & Life Advocates v. Becerra

The specific question under consideration in *Becerra* was: “Do disclosures required by a California reproductive rights law violate protections arising from the free speech clause of the First Amendment?”²²⁷ The law in question, California’s Reproductive FACT (Freedom, Accountability, Comprehensive Care, and Transparency) Act had two core provisions. The first required licensed clinics²²⁸ in California to tell pregnant women (via posted or printed notice in no less than 22- or 14-point type, respectively) that the State provides free or low-cost access to family planning services, including abortion.²²⁹ The second provision required unlicensed clinics to post a notice disclosing their unlicensed status and to include in all their advertisements the same disclosure.²³⁰ Per the Act, the notice included in advertisements needed to be “in the same size or larger font than the surrounding text.”²³¹

In their court briefs, Petitioners, two pro-life crisis pregnancy centers—one licensed and the other unlicensed—argued that the Reproductive FACT Act violated the First Amendment. More specifically, the licensed clinic argued that compelling them to distribute a government-drafted script advertising abortion—i.e., “the very practice that petitioners are devoted to opposing”—“at the same time petitioners [are trying] to dissuade women from choosing that option” effectively transformed them into the State’s mouthpiece.²³² The unlicensed clinic argued in a similar vein.

227. National Institute of Family and Life Advocates v. Becerra, OYEZ, <https://www.oyez.org/cases/2017/16-1140> (last visited Apr. 16, 2019) (on file with the Washington and Lee Law Review).

228. The FACT Act defined such clinics as those providing obstetric ultrasounds, obstetric sonograms, prenatal care, contraception counseling, pregnancy testing and diagnosis, prenatal sonography, or abortion services. See CAL. HEALTH & SAFETY CODE § 123471(a)(1)–(6) (West, Westlaw through Ch. 4 of 2019 Reg. Sess.) (defining licensed covered facilities as those providing two or more of the listed services).

229. See *id.* § 123472(a)(2)(A) (“A public notice posted in a conspicuous place where individuals wait that may be easily read by those seeking services from the facility. The notice shall be at least 8.5 inches by 11 inches and written in no less than 22-point type.”).

230. *Id.* § 123472(b)(3)

231. *Id.*

232. Nat’l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361, 2371 (2018).

Under the Act's definition, a facility that advertised the availability of free resources to encourage childbirth (e.g., prenatal vitamins, diapers, baby clothes), would count as an "unlicensed clinic." Thus, such a facility's two-word advertisement—FREE DIAPERS—would need to be accompanied by a twenty-nine-word disclosure, in thirteen languages, with the same size font.²³³ Petitioners argued that "[w]hile the centers exist to support childbirth, the Act forces them to point the way to ending unborn babies' lives."²³⁴

With respect to licensed clinics, California's reply brief leaned heavily on an argument that had been gaining traction in many of the lower courts, including the Ninth Circuit.²³⁵ Namely, that notices of the type required by the FACT Act did not count as self-expression.²³⁶ Respondents argued that notifying patients that abortions are available as an option from other providers did not amount to either an endorsement or a referral.²³⁷ Indeed, the State noted that "although California's law leaves clinics entirely free to expressly disavow the notice, no 'disavowal' should be necessary, because the required notice does not suggest any 'avowal' in the first place."²³⁸ With respect to unlicensed clinics, Respondents argued that the disclosure served to protect pregnant women from mistaking unlicensed clinics for medical providers and was, like the disclosure for licensed clinics, neutral and non-directive.²³⁹

233. "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) (West, Westlaw through Ch. 4 of 2019 Reg. Sess.).

234. Brief for Petitioners at 1–2, Nat'l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361 (2018) (No. 16-1140), 2018 U.S. S. Ct. Briefs LEXIS 63, at *11.

235. See *infra* Part III.B.1.

236. See Brief for the State Respondents at 43, Nat'l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361 (2018) (No. 16-1140), 2018 U.S. S. Ct. Briefs LEXIS 650, at *75 ("Patients understand that a clinic's role in serving as a conduit for such notices is not self-expression.") (citation omitted).

237. See *id.* at 38 (noting that the Court is wary of government attempts to compel endorsement).

238. *Id.* at 43–44 (citations omitted).

239. See *id.* at 21–22 (discussing unlicensed facilities whose activities include "obstetric ultrasounds," "prenatal care," "pregnancy testing or diagnosis," and

In the nearly three decades since *Casey* was handed down, the Supreme Court had said little about professional speech.²⁴⁰ With respect to context-divorced speech, however, the Court's jurisprudence was considerably better developed. Several opinions had addressed context-divorced speech in the realm of commercial advertising,²⁴¹ which prompted some lower courts to apply the commercial speech case law to evaluate professional speech claims,²⁴² albeit controversially.²⁴³ Other courts interpreted *Casey* as both identifying a distinct category of speech (i.e., professional) and ascribing to it a lower, rational basis level value.²⁴⁴ And still other courts subscribed to the opposite conclusion and accordingly applied heightened—even strict—scrutiny in professional speech cases.²⁴⁵ Given the absence of guiding doctrine from the High Court, the lower courts, by necessity, actively developed their own, often divergent, lines of professional speech jurisprudence.²⁴⁶

“collect[ing] health information from clients” (quoting CAL. HEALTH & SAFETY CODE § 123471(b) (West 2015)).

240. See Eugene Volokh, *The Law of Compelled Speech*, 97 TEX. L. REV. 355, 388 (2018) (describing *Becerra* and *Casey* as key precedents in the context of compelled speech).

241. See, e.g., *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 557 (2011) (considering First Amendment protection for pharmaceutical marketers and data miners); *Zauderer v. Office of Disciplinary Counsel of Supreme Court*, 471 U.S. 626, 629 (1985) (considering attorneys' free speech rights with respect to soliciting business via advertising); *Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council*, 425 U.S. 748, 756–57 (1976) (considering professional pharmacists' free speech rights in the context of price advertising for prescription drugs).

242. See *King v. Governor of N.J.*, 767 F.3d 216, 234 (3d Cir. 2014) (“We believe that commercial and professional speech share important qualities and, thus, that intermediate scrutiny is the appropriate standard of review for prohibitions aimed at either category.”).

243. See Claudia E. Haupt, *Professional Speech*, 125 YALE L.J. 1238, 1264 (2016) (arguing that courts are mistaken in analogizing professional speech and commercial speech because the underlying speech interests are fundamentally different).

244. See *Pickup v. Brown*, 740 F.3d 1208, 1231 (9th Cir. 2014) (applying rational basis after determining that a law's effect on free speech interests was merely incidental).

245. See, e.g., *Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195, 1246 (11th Cir. 2014) (“[W]hen speech is prohibited rather than compelled, reasonableness-scrutiny is ratcheted up to intermediate scrutiny.”); *Wollschlaeger v. Governor of Fla.*, 814 F.3d 1159, 1192 (11th Cir. 2015) (applying strict scrutiny but noting that the outcome would be the same if the court applied intermediate scrutiny).

246. See Claudia E. Haupt, *Professional Speech and the Content-Neutrality*

Unsurprisingly then, analysts across the political spectrum were hopeful that *Becerra* would ameliorate the circuit split and provide the coherent framework omitted in *Casey*.²⁴⁷

In a 5–4 opinion, penned by Justice Clarence Thomas, the Court struck down both provisions of the Reproductive FACT Act.²⁴⁸ Thomas began his analysis by belying the idea that a category of speech called “professional speech,” separate and differentiable from speech qua speech, exists.²⁴⁹ “Speech is not unprotected merely because it is uttered by ‘professionals’”²⁵⁰ Justice Thomas wrote, in a statement reminiscent of Robert Post.²⁵¹ At first glance, the statement reads as definitive: professional speech as a unique category of speech does not exist.²⁵² Rather, professional speech is speech like any other; it is not, to use Thomas’s phrasing, “subject to different rules.”²⁵³ In the ensuing analysis, however, Justice Thomas was explicit not only in carving out instances in which professional speech is, in fact, subject to different rules—but also in moderating his initial statement to the point of near negation.²⁵⁴ To the first point, Justice Thomas acknowledged that both (1) compelled disclosures

Trap, 127 YALE L.J. FORUM 150, 167 (2017) (“Several competing approaches to professional speech have emerged as such cases have percolated through the federal courts.”).

247. See, e.g., *id.* at 171 (advocating for the Eleventh Circuit’s framework); Rodney A. Smolla, *Professional Speech and the First Amendment*, 119 W. VA. L. REV. 67, 112 (2016) (concluding that professional speech should receive the “highest levels of constitutional protection”).

248. See *Nat’l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2377 (2018) (“Even if California had presented a nonhypothetical justification for the unlicensed notice, the FACT Act unduly burdens protected speech.”).

249. See *id.* at 2371 (“[T]his Court has not recognized ‘professional speech’ as a separate category of speech.”).

250. *Becerra*, 138 S. Ct. at 2371–72.

251. See *supra* note 199 and accompanying text (regarding Post’s definition of “speech uttered in the course of professional practice as distinct from speech uttered by a professional”).

252. See *id.* at 2372 (noting the Court’s reluctance to add new categories to exclude from constitutional protection).

253. *Id.* at 2371.

254. See *id.* at 2372 (“This Court’s precedents have applied a lower level of scrutiny to laws that compel disclosures in certain contexts.”).

by professionals of “purely factual and uncontroversial information,” and (2) professional speech that is closely tied to professional conduct, are subject to a lesser standard of review.²⁵⁵ To the second point, Justice Thomas conceded that the type of professional speech that does not fall within one of the two approved exceptions is “a difficult category to define with precision.”²⁵⁶ He further stated that even when such a feat is accomplished—that is, even when a court is able to accurately determine that a given professional is speaking on a topic neither purely factual nor uncontroversial, and is speaking in such a way that the speech is divorced of conduct—there are nonetheless persuasive reasons for which the professional speech might still be “exempt from ordinary First Amendment principles.”²⁵⁷ At this point, a critical observer might reasonably ask: which reasons are persuasive? Justice Thomas expounded on this point with only one sentence: “We do not foreclose the possibility that some such reason exists.”²⁵⁸ Or, put another way, there might be such a thing as professional speech—sometimes.

Ultimately, *Becerra*'s outcome is perhaps best described as a loss for the pro-choice agenda and, if anything, a tepid win for free speech.²⁵⁹ Certainly, it did little to resolve the existing circuit split.²⁶⁰ For those hoping for elucidation of professional speech's First Amendment standing, the decision likely raises more questions than it answered. A coherent framework—for identifying professional speech in the first place, and for assigning

255. *Id.* at 2372–74 (citing *Zauderer v. Office of Disciplinary Counsel of Supreme Court*, 471 U.S. 626 (1985); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992)).

256. *Id.* at 2375.

257. *Id.*

258. *Id.*

259. See Emma Green, *The Supreme Court Hands a Win to the Pro-Life Movement*, ATLANTIC (June 26, 2018), <https://www.theatlantic.com/politics/archive/2018/06/the-supreme-court-hands-a-win-to-the-pro-life-movement/563738/> (last visited Apr. 16, 2019) (“Looking ahead, the Court’s decision . . . may be most consequential as a boundary line for the way the government treats pro-life groups.”) (on file with the Washington and Lee Law Review).

260. See *Nat’l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2375 (2018) (recognizing that there is the possibility that professional speech should be exempt from First Amendment principles).

it an appropriate level of judicial scrutiny in the second—remains elusive.

IV. Physician Speech: Low-, Medium-, or High-Value?

Progress is rarely value-neutral.²⁶¹ Some measure of societal distress, if not outright controversy, frequently accompanies intellectual advancement.²⁶² Within the last ten years the accumulation of medical knowledge on three diverse topics—gun violence, sexual orientation, and abortion sequelae—has triggered an amalgam of cases that have divided legal opinion on the First Amendment value of physician speech.²⁶³ For our purposes, these cases have predictive value for anticipating legal responses to restrictions on physician speech in the PWGS context.

A. Physician Gag Laws and Gun Safety

In July 2010, Amber Ullman entered the pediatrician's office in Ocala, Florida for her daughter's four-month check-up.²⁶⁴ Following a series of health-and-safety questions—for example, "Do you have a pool? Do you use a car seat?"—Dr. Chris Okonkwo asked: "Do you keep a gun in the house?"²⁶⁵ When Ms. Ullman

261. See Erwin Chemerinsky, *The Vanishing Constitution*, 103 HARV. L. REV. 43, 92 (1989) (asserting that constitutional interpretation inevitably invokes a subjective process of examining the intentions of the drafters and the ratifiers and deciding whose views are more important).

262. See Dan M. Kahan & Donald Braman, *Cultural Cognition and Public Policy*, 24 YALE L. & POL'Y REV. 149, 170–71 (2006) (reasoning that disagreements over the consequences of law stem from differences in values resulting in polarized beliefs which persist in the face of scientific advancement).

263. See *infra* Parts IV.A–C (analyzing recent cases regarding gun violence, sexual orientation, and abortion sequelae).

264. See Fred Hiers, *Family and Pediatrician Tangle Over Gun Question*, Ocala Star BANNER (July 23, 2010), <http://www.ocala.com/article/20100723/News/604191215> (last visited Apr. 16, 2019) (reporting a disagreement between a physician and a parent regarding questions about gun ownership) (on file with the Washington and Lee Law Review).

265. See *id.*

refused to answer, Dr. Okonkwo completed the exam but advised the Ullmans that they would need to find another pediatrician.²⁶⁶ He later told the local paper he would have done the same if Ms. Ullman had refused to disclose information about whether she had a pool or smoked in the house.²⁶⁷ “I don’t tell them to get rid of the guns,” Dr. Okonkwo stated, “The purpose [of the question] is to give [safety] advice.”²⁶⁸

Six months later, prompted by the “Ocala incident,”²⁶⁹ State Representative Jason Brodeur introduced House Bill 155 as “[a]n act relating to the privacy of firearm owners.”²⁷⁰ In April 2011, the Florida Senate passed the Firearms Owners’ Privacy Act (FOPA).²⁷¹ Section 790.338 of the Act reads:

A health care practitioner . . . shall respect a patient’s right to privacy and should refrain from making a written inquiry or asking questions concerning the ownership of a firearm or ammunition by the patient or by a family member of the patient, or the presence of a firearm in a private home²⁷²

The Act further stated that physicians “should refrain from unnecessarily harassing a patient about firearm ownership during an examination.”²⁷³ Finally, the Act mandated that FOPA violations were punishable by fines up to \$10,000 per offense, letters of reprimand, probation, suspension, compulsory remedial education, or permanent revocation of the offender’s medical license.²⁷⁴ Governor Rick Scott signed the Act into law on June 2,

266. *See id.* (“[Okonkwo] said he respected a patient’s right not to answer questions, but it was also his right to no longer treat them.”).

267. *See id.* (“[T]he doctor and patient have to develop a relationship of trust and that if parents won’t answer such basic safety questions, how could they trust each other about more important health issues.”).

268. *Id.*

269. Joint Statement of Undisputed Facts in Support of Cross Motions for Summary Judgment at 1, *Wollschlaeger v. Farmer*, 880 F. Supp. 2d 1251 (S.D. Fla. 2012) (No. 1:11-cv-22026-MCG).

270. H.B. 155, 2011 Leg., 113th Reg. Sess. (Fla. 2011), 2011 Bill Tracking FL H.B. 155 (LexisNexis).

271. *See id.* (reporting on the passage of the bill and its signature by the governor).

272. FLA. STAT. § 790.338(2) (Westlaw through Apr. 8, 2019).

273. *Id.* § 790.338(6).

274. *See id.* §§ 790.338(8), 456.072 (mandating disciplinary action by Florida’s Board of Medicine).

2011.²⁷⁵ At least a dozen other states introduced similar legislation thereafter.²⁷⁶

1. U.S. District Court for the Southern District of Florida

On June 24, 2011, a group of Florida physicians filed suit in federal court.²⁷⁷ The complaint alleged First Amendment violations attendant to physicians' right to "engage in open and free exchanges of information and advice with their patients."²⁷⁸ Plaintiffs filed declarations demonstrating that many physicians consider firearm inquiries routine in the practice of preventative medicine.²⁷⁹ Official guidelines issued by the American Academy of

275. See H.B. 155, 2011 Leg., 113th Reg. Sess. (Fla. 2011), 2011 Bill Tracking FL H.B. 155 (LexisNexis).

276. See Olga Khazan, *The Strange Laws that Dictate What Your Doctor Tells You*, ATLANTIC (Oct. 16, 2015), <https://www.theatlantic.com/health/archive/2015/10/the-laws-that-stand-between-you-and-your-doctor/410722/> (last visited Apr. 16, 2019) ("Fourteen states have introduced similar legislation since [FOPA], though none as restrictive as Florida's have been enacted.") (on file with the Washington and Lee Law Review); Alexis Macias, *When States Practice Medicine: Physician Gag Laws*, 97 BULL. AM. COLL. SURGEONS 39, 39–40 (Feb. 1, 2012), <http://bulletin.facs.org/2012/02/when-states-practice-medicine-physician-gag-laws/> (last visited Apr. 16, 2019) (reporting on NRA-sponsored bills in Alabama, Minnesota, North Carolina, Oklahoma, and West Virginia) (on file with the Washington and Lee Law Review); Mobeen H. Rathore, *Physician "Gag Laws" and Gun Safety*, 16 AMA J. ETHICS 235, 284 (2014) (stating that twelve other states followed Florida by introducing physician gag laws).

277. See Complaint for Declaratory and Injunctive Relief at ¶ 1, *Wollschlaeger v. Farmer* (*Wollschlaeger I*), 880 F. Supp. 2d 1251 (S.D. Fla. 2012) (No. 1:11-cv-22026) (seeking declaratory and injunctive relief declaring the law unconstitutional and preventing enforcement of FOPA).

278. First Amended Complaint for Declaratory and Injunctive Relief at ¶ 1, *Wollschlaeger I*, 880 F. Supp. 2d 1251 (No. 1:11-cv-22026).

279. See, e.g., Declaration of Judith Schaechter, MD at ¶ 13, *Wollschlaeger I*, 880 F. Supp. 2d 1251 (No. 1:11-cv-22026) ("I am afraid this law could be interpreted as allowing doctors to ask about guns only if they believe a danger to the patient is imminent—an interpretation that would preclude standard preventative care as part of my patients' care."); Declaration of Dr. Tommy Schechtman at ¶ 7, *Wollschlaeger I*, 880 F. Supp. 2d 1251 (No. 1:11-cv-22026) ("I routinely ask patients during checkups about a long list of risk factors, including whether guns are present in the home."); Declaration of Dr. Bernd Wollschlaeger at ¶ 8, *Wollschlaeger I*, 880 F. Supp. 2d 1251 (No. 1:11-cv-22026) ("As a family

Pediatrics, the American Academy of Family Physicians, and the American College of Physicians similarly validated preventative firearm inquiries.²⁸⁰

In the district court, the State argued that the Act was not a speech regulation.²⁸¹ FOPA “prohibits harassment and discrimination, not speech,” the State insisted.²⁸² District Court Judge Marcia Cross was unconvinced.²⁸³ “Under this law,” Judge Cross said, “physicians may ask a new patient complaining of a stomachache . . . questions regarding household chemicals, risky recreational activities, sexual conduct, or drugs and alcohol kept in the home, but not whether the patient owns a firearm.”²⁸⁴ She classified FOPA’s provisions as content-based speech restrictions.²⁸⁵ Acknowledging that the standard for professional speech was an “unsettled question of law,”²⁸⁶ Judge Cross nonetheless struck FOPA down as unconstitutional.²⁸⁷ “I need not decide [here] which standard applies because the State would not prevail under either test [i.e., heightened or strict],” she stated.²⁸⁸

practitioner, I consider anticipatory guidance regarding safe firearm practices to be a key part of preventative health consultations, in light of the significant health risks posed by firearms to my patients.”).

280. See, e.g., M. Denise Dowd & Robert D. Sege, *Firearm-Related Injuries Affecting the Pediatric Population*, 130 PEDIATRICS e1416, e1416 (2012) (“The absence of guns from children’s homes and communities is the most reliable and effective measure to prevent firearm-related injuries in children and adolescents.”).

281. See Defendants’ Reply to Plaintiffs’ Response to Defendants’ Motion for Summary Judgment at 1, *Wollschlaeger I*, 880 F. Supp. 2d 1251 (No. 1:11-cv-22026) (“Section 790.338 does not prohibit speech.”).

282. *Id.* (capitalization altered).

283. See *Wollschlaeger I*, 880 F. Supp. 2d 1251, 1261 (S.D. Fla. 2012) (“Despite the State’s arguments to the contrary, the anti-discrimination and anti-harassment provisions are also content-based.”).

284. *Id.*

285. *Id.* (“[FOPA] purports to regulate practitioners’ inquiries, record-keeping, discrimination, and harassment with respect to one subject matter only—firearm ownership and possession.”).

286. *Id.* at 1262–63.

287. See *id.* at 1267 (“This law chills practitioners’ speech in a way that impairs the provision of medical care and may ultimately harm the patient.”).

288. *Id.* at 1263 (citing *United States v. Alvarez*, 132 S. Ct. 2537, 2543 (2012) (plurality opinion)).

The district court granted the plaintiffs' motion for summary judgment.²⁸⁹

2. The Eleventh Circuit's Approach

On appeal, the State continued to argue that the Act's language—physicians “should refrain” from asking patients about firearms—was merely hortatory.²⁹⁰ As such, the State argued that FOPA posed (if anything) only incidental burdens on speech.²⁹¹ Like the district court, the Eleventh Circuit was unconvinced by the State's hortatory argument.²⁹² Unlike the district court, Circuit Judge Tjoflat found the State's broader defense compelling.²⁹³ The Act, as he described it, “merely reaffirm[ed] the boundaries surrounding what constitutes good medical practice.”²⁹⁴ He eschewed the idea that physicians had any type of free speech rights within the confines of the physician-patient relationship.²⁹⁵ He reasoned that conversations in the exam room were not

289. *See id.* at 1270 (enjoining enforcement of the statute).

290. *See* *Wollschlaeger v. Governor of Fla. (Wollschlaeger II)*, 760 F.3d 1195, 1207 (11th Cir. 2014) (relaying the State's argument that the statutory language does not constitute a bar on speech). At an evidentiary hearing in the district court, the defense counsel described the State's position regarding statutory construction: “It *recommends* to practitioners that they refrain from asking about firearm ownership in most cases,” the defense stated, “but it does not prohibit it.” Transcript of Evidentiary Hearing Before the Honorable Marcia G. Cooke at 29, *Wollschlaeger I*, 880 F. Supp. 2d 1251 (No. 1:11-cv-22026) (emphasis added). Defense counsel also stressed that FOPA contained a good-faith exception, allowing practitioners to discuss firearms in cases of medical necessity. *See* H.B. 155 § 790.338(2), 2011 Leg., 113th Reg. Sess. (Fla. 2011).

291. *See Wollschlaeger II*, 760 F.3d at 1207 (summarizing the State's argument that the District Court erred in its finding that FOPA was facially unconstitutional).

292. *See id.* at 1212 (“Laws—such as the Act—that provide for disciplinary action in case of violation should generally not be interpreted as hortatory.”).

293. *See id.* at 1217 (“To define the standards of good medical practice and provide for administrative enforcement of those standards is well within the State's long-established authority to regulate the professions.”).

294. *Id.* at 1215.

295. *See id.* (“Insofar as Plaintiffs claim a generalized interest in being able to speak freely to their patients, such conversation (if not relevant to medical care) is outside the boundaries of the physician–patient relationship.”).

speech—they were medicine.²⁹⁶ Writing for a divided three-judge panel, Judge Tjoflat wrote: “The Act simply informs physicians that inquiring about a private matter irrelevant to medical care is not part of the practice of good medicine, and that, as always, a physician may face discipline for not practicing good medicine.”²⁹⁷ The court concluded that FOPA regulated professional conduct, not speech, and thus did not implicate the First Amendment.²⁹⁸

Circuit Judge Wilson disagreed with the majority’s application of rational basis review.²⁹⁹ “Simply put,” Judge Wilson wrote in his excoriating dissent, “the Act is a gag order.”³⁰⁰ To his mind, labeling the speech “conduct” and the speakers “professionals” did not belie the simple fact that FOPA prohibited conversations about one topic by one group of speakers.³⁰¹ Moreover, he considered the majority’s position “based on a misreading of *Casey*.”³⁰² Indeed, contrary to the majority’s assertion that *Casey* removed the First Amendment from medical practice entirely,³⁰³ the text of that opinion explicitly said the opposite—i.e., “First Amendment rights . . . are implicated.”³⁰⁴ By Judge Wilson’s reading, *Casey* had applied some level of First Amendment scrutiny to the Pennsylvania regulation, though ascertaining *which* level from two sentences was an admittedly harder task.³⁰⁵ After considering *Casey*’s application in other circuits, and parsing the opinion itself for clues, Judge Wilson concluded that *Casey* “applied something akin to intermediate First Amendment scrutiny,” and that nothing

296. See *id.* (describing inquiries into gun ownership as “conduct outside of the bounds of good medical practice”).

297. *Id.* at 1219–20.

298. See *id.* at 1217, 1230 (reversing the district court).

299. See *id.* at 1239 (Wilson, J., dissenting) (asserting that the law would fail under strict or intermediate scrutiny).

300. *Id.* at 1230.

301. *Id.* at 1231, 1236.

302. *Id.* at 1243.

303. See *id.* at 1222 n.16 (majority opinion) (stating that the *Casey* court allowed states “to some extent regulate physician speech within the confines of the physician-patient relationship ‘as part of the practice of medicine’ without violating the First Amendment”).

304. *Id.* at 1245 (Wilson, J., dissenting) (emphasis added) (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992)).

305. *Id.* (Wilson, J., dissenting) (recognizing the Court’s lack of clarity regarding the standard applied in *Casey*).

less should be applied to FOIA.³⁰⁶ He noted, also, the legal implications of the majority's decision—namely, that every one-to-one professional relationship would now be regulable without scrutiny.³⁰⁷ “I do not so simply identify a slippery slope,” Judge Wilson wrote, “[rather,] today's decision brings us to the bottom of that slope.”³⁰⁸ He concluded, “health care in Florida [will be] worse, not better.”³⁰⁹

3. *The Eleventh Circuit Redux*

In July 2015, the same three-judge panel issued a revised opinion.³¹⁰ The tone of it suggested that in the intervening year, Judge Wilson's dissent had gained some traction. Judge Tjoflat,

306. *Id.* at 1245–46, 1256 (Wilson, J., dissenting) (“Even if Casey applied something less than intermediate scrutiny, [*Zauderer*] confirms that intermediate scrutiny applies here.”).

307. *See id.* at 1253 (Wilson, J., dissenting) (positing a hypothetical in which a state prohibits all discussions about firearm safety). In *Becerra*, the Supreme Court echoed Judge Wilson's concern, noting:

As defined by the courts of appeals, the professional speech doctrine would cover a wide array of individuals—doctors, lawyers, nurses, physical therapists, truck drivers, bartenders, barbers, and many others. . . . All that is required to make something a “profession,” according to these courts, is that it involves personalized services and requires a professional license from the State. But that gives the State unfettered power to reduce a group's First Amendment rights by simply imposing a licensing requirement.

Nat'l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361, 2375 (2018) (citations omitted).

308. *Wollschlaeger II*, 760 F.3d 1195, 1249–50 (11th Cir. 2014) (Wilson, J., dissenting).

309. *Id.* at 1257 (Wilson, J., dissenting) (noting that numerous medical associations support his conclusion regarding FOIA's detrimental effect on health care).

310. Eleventh Circuit Judges Tjoflat and Wilson, joined by Northern District of Alabama Judge Coogler, vacated their original opinion *sua sponte*, mooted Petitioners' request for rehearing en banc. *See Wollschlaeger v. Governor of Fla. (Wollschlaeger III)*, 797 F.3d 859, 868 (11th Cir. 2015); *see also* Petition for Rehearing En Banc at 3–4, *Wollschlaeger III*, 797 F.3d 859 (No. 12-14009) (“The majority erroneously held that a government may, under guise of regulating medical practice, silence physicians from providing medical advice even to squelch a perceived political viewpoint.”).

writing again for the majority, began by observing that “[t]he State’s analysis,” which the court had validated and adopted in its first opinion, “proceeds at such a high level of generality that *all* laws regulating the practice of a profession . . . would always pass muster under the First Amendment.”³¹¹ To appropriately narrow the analysis, the majority devised a four-category grid to capture the universe of physician speech: (1) speech to the public in furtherance of medicine; (2) speech to a patient in furtherance of medicine; (3) speech to a patient on a matter irrelevant to medicine; and (4) speech to the public on a matter irrelevant to medicine.³¹² The majority—retreating from its original position that FOIA regulated only professional conduct—classified firearm inquiries as category 2 speech.³¹³ Reasoning that regulation of professional practices had long been within the purview of the states’ police power, the court held that category 2 speech was subject to intermediate First Amendment scrutiny.³¹⁴ The higher level of scrutiny notwithstanding, the outcome was the same, by the same 2–1 vote.³¹⁵ Judge Wilson, again the lone dissenter, commented: “The Majority is now persuaded that the Act is subject to some level of scrutiny under the First Amendment. It is the analysis that follows where we part ways”³¹⁶ Judge Wilson’s second dissent was similar to his first.³¹⁷ It turned on his belief that the majority was devaluing professional speech “precisely because the speakers are so qualified.”³¹⁸ Put another way, a speaker’s

311. *Wollschlaeger III*, 797 F.3d at 884 (emphasis in original).

312. *See id.* at 888 n.15 (providing a visual grid to illustrate the categories). Note that Bandy Lee et al.’s *The Dangerous Case of Donald Trump* would likely fall into the court’s fourth category. *See generally* THE DANGEROUS CASE OF DONALD TRUMP (Bandy X. Lee ed. 2017) (compiling assessments from psychiatrists and mental health experts regarding Donald Trump’s mental state).

313. *See Wollschlaeger III*, 797 F.3d at 891 n.17 (concluding that FOIA regulated professional speech).

314. *See id.* at 893, 895–96 (discussing the duty of the states to protect the public against incompetent or untrustworthy professionals).

315. *See id.* at 901 (upholding FOIA but cautioning that the decision does not reflect the propriety of the law).

316. *Id.* at 901 (Wilson, J., dissenting).

317. *See id.* (Wilson, J., dissenting) (renewing his argument that the law does not survive intermediate scrutiny).

318. *Id.* at 914 (Wilson, J., dissenting).

professional status should not serve as a basis for denying her First Amendment protections.³¹⁹

Two months later, the Eleventh Circuit issued an order requesting memorandums from the *Wollschlaeger* litigants. The court asked that they address whether *Reed v. Town of Gilbert*,³²⁰ a First Amendment Supreme Court case decided in June 2015, necessitated the application of strict scrutiny in the instant case.³²¹ Then, in December 2015, the same three-judge panel issued a third, revised opinion.³²² The majority again agreed with the plaintiffs that FOPA was a content-based speech regulation.³²³ More promising, the majority accepted the plaintiffs' assertion that *Reed* required the application of strict scrutiny.³²⁴ But, in a bizarre twist,³²⁵ the majority concluded both that the State had a compelling interest (in protecting patient privacy and Second Amendment rights),³²⁶ and that FOPA was narrowly tailored to advance that interest.³²⁷ By the same 2–1 vote, the majority held

319. *See id.* (Wilson, J., dissenting) (“[D]octors were silenced because their speech was causing patients to question whether the safety concerns associated with firearm ownership outweighed the benefits.”).

320. 135 S. Ct. 2218 (2015).

321. *See* Memorandum to Counsel or Parties, *Wollschlaeger III*, 797 F.3d 859, 884 (11th Cir. 2015) (No. 12-14009) (directing submission within twenty days). *Reed* held that town ordinances restricting the size, number, duration, and location of temporary directional signs violated the First Amendment. The Court applied strict scrutiny. *See Reed v. Town of Gilbert*, 135 S. Ct. 2218, 2224 (2015).

322. *See Wollschlaeger v. Governor of Fla. (Wollschlaeger IV)*, 814 F.3d 1159, 1168 (11th Cir. 2015) (upholding FOPA).

323. *See id.* at 1186 (applying *Reed* and conceding that FOPA applies to speech based on the “topic discussed”).

324. *See id.* at 1186 n.14 (“The Court seemed to suggest that strict scrutiny applies broadly to all content-based regulations of speech.” (quoting *Reed*, 135 S. Ct. at 2224–25)).

325. Recall that challenged laws are never supposed to survive “fatal in fact” strict scrutiny. *See supra* Part III.A and note 173 (concerning the levels of scrutiny and Professor Gerald Gunther assertion that strict scrutiny is typically fatal in fact).

326. *See Wollschlaeger IV*, 814 F.3d at 1193–95 (“Florida rightfully treats the privacy of [gun ownership] as sacrosanct and acts aggressively to protect it.”).

327. *See id.* at 1199 (querying “what narrower way to advance this interest could there be than by requiring physicians to base any inquiry or record-keeping about firearm ownership on a genuine, subjective determination of medical need?”).

that “the Act survives even strict scrutiny”³²⁸ Again in lone dissent, Judge Wilson wrote: “I decline to pen another dissent responding to the Majority’s evolving rationale. I rest on my previous dissents.”³²⁹

In February 2016, the Eleventh Circuit finally granted the plaintiffs’ request for the case to be reheard, this time en banc, before a full panel of the eleven sitting judges.³³⁰ In a nod to the preceding three panel decisions—“each using a different First Amendment standard of review”³³¹—the court began by recognizing that the First Amendment is “sometimes . . . difficult to apply.”³³² But what the preceding panels had found difficult, the full court disposed of easily.³³³ Quoting one of Judge Wilson’s earlier dissents, the court intoned, “[S]aying 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.”³³⁴ The court similarly agreed with Judge Wilson’s “bottom of the slope” argument:

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 general contractors that they cannot suggest the use of cheaper foreign steel in construction projects, or accountants that they cannot discuss legal tax avoidance techniques, and so on and so on.³³⁵

After determining that the standard was not rational basis, however, the court declined to decide anything further.³³⁶ Circuit Judge Jordan, the majority’s representative on this final round, held that FOPA’s provisions could not withstand even heightened

328. *Id.* at 1186.

329. *Id.* at 1202 (Wilson, J., dissenting).

330. *See* Order Granting Petition for Rehearing at 2, *Wollschlaeger v. Governor of Fla. (Wollschlaeger V)*, 848 F.3d 1293 (11th Cir. 2017) (No. 12-14009).

331. *Wollschlaeger V*, 848 F.3d 1293, 1301 (11th Cir. 2017).

332. *Id.* at 1300.

333. *See id.* at 1301 (analyzing with heightened scrutiny under *Sorrell v. IMS Health, Inc.*, 564 U.S. 553 (2011)).

334. *Id.* at 1308.

335. *Id.* at 1311.

336. *See id.* (“Because these provisions fail to satisfy heightened scrutiny under *Sorrell*, they obviously would not withstand strict scrutiny.”).

scrutiny, obviating any need to determine whether strict scrutiny should apply.³³⁷ The court concluded that firearm inquiries—even if conducted via “blanket questioning”—would not lead to the practice of bad medicine.³³⁸ At its crux, the Eleventh Circuit’s final opinion endorsed the aphorism “knowledge is power” or, to use the court’s phrasing, “information can save lives.”³³⁹ Judge Wilson concurred, taking care to note that he would apply strict scrutiny but reach the same result.³⁴⁰ FOPA was struck down as unconstitutional under the First Amendment.³⁴¹

The Eleventh Circuit’s seesawing between levels of judicial scrutiny—from rational basis to intermediate to strict, and back again—is telling. Its four incongruous opinions highlight the marked opacity of the legal standard for professional speech.³⁴²

B. Sexual Orientation Conversion Therapy

Sexual orientation conversion efforts (SOCE) refer to psychoanalytic techniques designed to redirect same-sex sexual desires toward people of a different sex.³⁴³ More succinctly, SOCE is talk therapy meant to cure homosexuality.³⁴⁴ There is no

337. *See id.* (declining to decide whether strict scrutiny should apply).

338. *Id.* at 1316 (“There is no claim, much less any evidence, that routine questions to patients about the ownership of firearms are medically inappropriate, ethically problematic, or practically ineffective.”).

339. *Id.* at 1313 (quoting *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 566 (2011)).

340. *Id.* at 1324 (Wilson, J., concurring).

341. *Id.* at 1323 (“In this quintessential First Amendment area, the State may not hinge liability on a phrase so ambiguous in nature.”).

342. *See id.* at 1310–11 (summarizing jurisprudence regarding the standard of scrutiny for professional speech).

343. *See Healing Arts: Sexual Orientation Change Efforts: Hearing on S.B. 1172 Before the S. Comm. on Bus., Professions & Econ. Dev.*, 2012 Leg. (Cal. 2012) (defining “sexual orientation change efforts”).

344. A. Lee Beckstead, *Can We Change Sexual Orientation?*, 41 ARCHIVES SEXUAL BEHAV. 121, 123 (2012). Historically, SOCE is not limited to talk therapies. For an expanded discussion of historical methodologies, see David B. Cruz, *Controlling Desires: Sexual Orientation Conversion and the Limits of Knowledge and Law*, 72 S. CAL. L. REV. 1297, 1303–10 (1999) (describing the evolution of procedures used through history to try and “cure” homosexuality including surgery, chemicals, drugs, and therapy).

evidence that SOCE is effective,³⁴⁵ and the American Psychiatric Association (APA) has explicitly disavowed its use.³⁴⁶ In September 2012, Governor Jerry Brown signed Senate Bill 1172, making California the first state to ban state-licensed therapists from performing SOCE on any patient under eighteen years of age.³⁴⁷ A year later, Governor Chris Christie approved identical legislation, Assembly Bill 3371, in New Jersey.³⁴⁸

1. Pickup v. Brown: *The Ninth Circuit's Approach*

In 2014, two circuit courts—the Ninth Circuit, addressing the California ban, and the Third Circuit, addressing the New Jersey ban—confronted legal challenges to SOCE bans.³⁴⁹ In both cases, plaintiff-counselors alleged free speech violations.³⁵⁰ In the Ninth

345. Annie Bartlett et al., *The Response of Mental Health Professionals to Clients Seeking Help to Change or Redirect Same-Sex Sexual Orientation*, 9 BMC PSYCHIATRY 1, 7 (2009) (summarizing that no recent or earlier published literature evidences that a person's sexual orientation can be changed).

346. See JUDITH M. GLASSGOLD ET AL., AM. PSYCHOL. ASS'N, REPORT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION TASK FORCE ON APPROPRIATE THERAPEUTIC RESPONSES TO SEXUAL ORIENTATION, 3–4 (2009) (synthesizing psychological knowledge and recommending therapeutic approaches providing acceptance and support).

347. See *Jerry Brown, California Governor, Signs SB 1172, Bill Banning Gay Conversion Therapy for Minors*, HUFFINGTON POST, https://www.huffpost.com/entry/jerry-brown-sb-1172-gay-conversion-therapy-california_n_1926855 (last updated Feb. 2, 2016) (last visited Apr. 16, 2019) (summarizing the types of therapy banned under the law and the public response to the bill) (on file with the Washington and Lee Law Review).

348. See N.J. REV. STAT. § 45:1–55 (2013) (banning SOCE for minors); Martha T. Moore, *N.J. Gov. Christie Signs Ban on Gay Conversion Therapy*, USA TODAY, <https://www.usatoday.com/story/news/politics/2013/08/19/chris-christie-gay-conversion-therapy-new-jersey/2671197/> (last updated Aug. 19, 2013, 6:07 PM) (last visited Apr. 16, 2019) (summarizing the types of therapy banned under the law and the public response to the bill) (on file with the Washington and Lee Law Review).

349. See *King v. Governor of N.J.*, 767 F.3d 216, 220 (3d Cir. 2014) (challenging New Jersey law prohibiting “licensed counselors from engaging in ‘sexual orientation change efforts’ with a client under the age of 18”); *Pickup v. Brown*, 740 F.3d 1208, 1221 (9th Cir. 2014) (challenging California law prohibiting “state-licensed mental health providers from engaging in ‘sexual orientation change efforts’ with patients under 18 years of age”).

350. See *King*, 767 F.3d at 222 (summarizing the basis of plaintiffs' allegations); *Pickup*, 740 F.3d at 1224–25 (summarizing the basis of plaintiffs' allegations).

Circuit case, *Pickup v. Brown*,³⁵¹ the court adopted a framework resembling that proposed in the Eleventh Circuit's second *Wollschlaeger* opinion.³⁵² Instead of a four-category grid, the Ninth Circuit imagined a continuum.³⁵³ At one end was professional speech within a public dialogue (the Eleventh Circuit's category 1 and category 4 speech).³⁵⁴ At the continuum's midpoint was speech that occurs within a physician-patient relationship (the Eleventh Circuit's category 2 and category 3 speech), like that in *Casey*.³⁵⁵ And at the other end of the continuum was professional conduct, which is not speech at all (off the Eleventh Circuit's grid).³⁵⁶ The Ninth Circuit concluded that SB 1172 regulated talk therapy as medical conduct, not talk therapy as expressive speech.³⁵⁷ Unsurprisingly, that conclusion dictated rational basis review and SB 1172 was upheld.³⁵⁸

allegations).

351. 740 F.3d 1208 (9th Cir. 2014).

352. *See id.* at 1227 ("In determining whether SB 1172 is a regulation of speech or conduct, we find it helpful to view this issue along a continuum.").

353. *Id.*

354. *Compare Pickup*, 740 F.3d at 1227 (using a continuum to analyze the statute at issue), *with Wollschlaeger III*, 797 F.3d 859, 888 (11th Cir. 2015) (using a four-category grid to analyze the statute at issue).

355. *See Pickup*, 740 F.3d at 1228–29 (explaining the midpoint of the continuum where certain limits on speech will be tolerated such that they fall within "reasonable licensing and regulation by the State" of the practice of medicine).

356. *See id.* at 1229 (explaining that the state has great power to regulate professional conduct even though it may incidentally implicate a professional's speech).

357. *See id.* at 1229–30 (concluding California's prohibition on sexual orientation conversion therapy for minors was a Constitutional regulation of professional conduct).

358. *See id.* at 1231–32 ("Because SB 1172 regulates only treatment, while leaving mental health providers free to discuss and recommend, or recommend against, SOCE, we conclude . . . that SB 1172 is subject to only rational basis review.").

2. *King v. Governor of New Jersey: The Third Circuit's Approach*

The Third Circuit heard *King v. Governor of New Jersey*³⁵⁹ almost six months after the Ninth Circuit decided *Pickup*.³⁶⁰ The majority opinion opened similarly: “[T]he question we confront is whether verbal communications become ‘conduct’ when they are used as a vehicle for mental health treatment.”³⁶¹ The District Court had relied heavily on *Pickup*, and the Third Circuit also considered the obvious parallels on appeal.³⁶² But Circuit Judge Smith, writing for a unanimous panel of three, found greater alignment with Ninth Circuit Judge O’Scannlain, who had dissented in *Pickup*, than with the majority.³⁶³ The Ninth Circuit’s continuum was “nothing more than a ‘labeling game,’” lacking a doctrinally sound methodology for separating protected speech from unprotected conduct.³⁶⁴ Under such an approach, courts could simply label unpopular speech “conduct” and do away with First Amendment scrutiny.³⁶⁵ “Speech is speech,” Judge Smith concluded, “and it must be analyzed as such.”³⁶⁶ In terms of the level of scrutiny, however, the Third Circuit found professional speech—though undoubtedly speech—was not comparable to pure speech.³⁶⁷ It bore a greater resemblance to commercial speech.³⁶⁸ Both serve an “informational function” and both occur in traditionally highly-regulated contexts.³⁶⁹ The Third Circuit thus

359. 767 F.3d 216 (3d Cir. 2014).

360. See *id.* at 226–28 (summarizing and discussing *Pickup*).

361. See *id.* at 224.

362. See *id.* at 223–24 (summarizing the New Jersey district court’s application of *Pickup*).

363. See *id.* at 227–28 (summarizing O’Scannlain’s dissent in *Pickup*).

364. See *id.* (quoting *Pickup v. Brown*, 740 F.3d 1208, 1218 (9th Cir. 2014) (O’Scannlain, J., dissenting from denial of rehearing en banc)).

365. See *id.* at 229 (explaining that “[b]y labeling certain communications as ‘conduct,’ thereby assuring that they receive no First Amendment protection at all”).

366. *Id.*

367. See *id.* at 230–31 (explaining that appeals courts have interpreted the Supreme Court’s *Casey* decision as “establish[ing] special rules for the regulation of speech that occurs pursuant to the practice of a licensed profession”).

368. See *id.* at 234 (“We believe that commercial and professional speech share important qualities. . .”).

369. See *id.* (determining that professional speech is similar to commercial speech and thus applying intermediate scrutiny).

applied commercial speech’s intermediate scrutiny.³⁷⁰ Given the empirical evidence in the legislative record (demonstrating a dearth of credible evidence of SOCE’s efficacy), and given the special vulnerability of the population (minors) New Jersey’s ban was designed to protect, the court concluded that A3371 “directly advances New Jersey’s stated interest in protecting minor citizens from harmful professional practices,” via sufficiently tailored means.³⁷¹

Though both California’s and New Jersey’s SOCE bans were upheld, the Ninth and Third Circuits each applied different levels of judicial scrutiny.³⁷² Moreover, both circuits adopted approaches not wholly consistent with the final *Wollschlaeger* opinion.³⁷³

C. Abortion Sequelae

Ultrasound imaging has been a component of pregnancy care in the Western world for decades, and standard since at least 1978.³⁷⁴ In the early 1980s, pro-life advocates identified the technology as an opportunity for abortion deterrence.³⁷⁵ The

370. *See id.*

371. *See id.* at 239–40 (applying intermediate scrutiny analysis to the New Jersey statute banning sexual orientation conversion therapy).

372. *See King v. Governor of N.J.*, 767 F.3d 216, 234 (3d Cir. 2014) (determining that intermediate scrutiny is the proper standard of review); *Pickup v. Brown*, 740 F.3d 1208, 1231–32 (9th Cir. 2014) (determining that rational basis review is the proper standard of review).

373. In fact, the *King* court cited with approval the Eleventh Circuit’s first *Wollschlaeger* opinion, which was, of course, vacated and replaced three times. *King*, 767 F.3d at 231–32 (citing *Wollschlaeger II*, 760 F.3d 1195, 1207 (11th Cir. 2014)).

374. *See Gillian Harris et al.*, “*Seeing the Baby*”: *Pleasures and Dilemmas of Ultrasound Technologies for Primiparous Australian Women*, 18 MED. ANTHROPOLOGY Q. 23, 24 (2004) (evaluating the use of ultrasound during pregnancy) (citing Ann Oakley, *The History of Ultrasonography in Obstetrics*, 13 BIRTH 8 (1986)).

375. *See, e.g.*, Robert M. Godzeno, *The Role of Ultrasound Imaging in Informed Consent Legislation Post-Gonzales v. Carhart*, 27 QUINNIPIAC L. REV. 285, 303 & n.127 (2009) (citing *Margaret S. v. Treen*, 597 F. Supp. 636 (E.D. La. 1984) which struck down pre-abortion mandatory ultrasound law); *THE SILENT SCREAM* (American Portrait Films 1984) (depicting the abortion process via ultrasound).

strategy hinges on the contested assumption that ultrasound examinations are emotionally-laden events for all pregnant women.³⁷⁶ There is evidence to suggest that the viewing of an ultrasound does have a positive impact on maternal-fetal attachment—in wanted pregnancies.³⁷⁷ Research suggests the impact is greater the earlier the ultrasound is performed.³⁷⁸ However, there is also a substantial body of research suggesting that ultrasounds have a varied impact in the abortion context. A 2012 study indicated that in the case of unwanted pregnancy, many women do not consider an ultrasound helpful to their decision-making.³⁷⁹ In fact, a 2014 analysis of over 15,000 pregnancies showed that 98.4% of abortion-seekers proceed to termination even after viewing an ultrasound.³⁸⁰ Another study, again using a dataset of more than 15,000 abortion care visits from 2011, demonstrated that most women would decline to view the ultrasound image.³⁸¹ Of course, given a mandatory speech-and-display ultrasound law, declining is not an option.³⁸²

376. See Godzeno, *supra* note 375, at 287 (describing the three types of laws promulgated by states requiring women to receive an ultrasound “before [the] woman can give informed consent to an abortion”).

377. See Lisa M. Mitchell, *Women’s Experiences of Unexpected Ultrasound Findings*, 49 J. MIDWIFERY & WOMEN’S HEALTH 228, 232 (2004) (suggesting that seeing an image on screen “can make its existence ‘real’”); B. Sedgmen et al., *The Impact of Two-Dimensional Versus Three-Dimensional Ultrasound Exposure on Maternal-Fetal Attachment and Maternal Health Behavior in Pregnancy*, 27 ULTRASOUND OBSTETRICS & GYNECOLOGY 245, 250 (2006) (exploring the effects that viewing ultrasounds can have on a mother’s behavior during pregnancy); Claude Villeneuve et al., *Psychological Aspects of Ultrasound Imaging During Pregnancy*, 33 CAN. J. PSYCHIATRY 530, 534 (1988) (“The exam had a positive effect [on expectant parents] and seemed to enhance bonding.”).

378. See Sedgmen et al., *supra* note 377 (discussing findings consistent with a positive impact and stating that “impact is greatest earlier in pregnancy”).

379. See Katrina Kimport et al., *Women’s Perspectives on Ultrasound Viewing in the Abortion Care Context*, 22 WOMEN’S HEALTH ISSUES e513, e517 (2012) (summarizing the results of twenty interviews conducted with women who received ultrasounds when seeking an abortion).

380. See Mary Gatter et al., *Relationship Between Ultrasound Viewing and Proceeding to Abortion*, 123 OBSTETRICS & GYNECOLOGY 81, 85 (2014) (finding that viewing an ultrasound had a limited effect on a woman’s choice to seek an abortion).

381. See Katrina Kimport et al., *Patient Viewing of the Ultrasound Image Prior to Abortion*, 88 CONCEPTION 666, 668 (2013) (summarizing the results of a study investigating ultrasound usage when a woman is seeking an abortion).

382. See *Requirements for Ultrasound*, GUTTMACHER INST.,

Whatever the actual deterrent effect of such laws, more than half of the states regulate pre-abortion ultrasounds.³⁸³ Three states have passed so-called speech-and-display laws, the most aggressive form of ultrasound regulation.³⁸⁴

1. Texas Medical Providers Performing Abortion Services.
v. Lakey: *The Fifth Circuit's Approach*

In 2011, the Texas State Legislature amended its 2003 Woman's Right to Know Act (WRTK)³⁸⁵ to include a speech-and-display provision. Styled as an informed consent safeguard, House Bill 15 required physicians to:

perform[] a sonogram on the pregnant woman on whom the abortion is to be performed; display[] the sonogram images in a quality consistent with current medical practice in a manner that the pregnant woman may view them; . . . provide[], in a manner understandable to a layperson, a verbal explanation of the results of the sonogram images . . . [and to] make audible the heart auscultation for the pregnant woman to hear, if present, in a quality consistent with current medical practice and provide[], in a manner understandable to a layperson, a simultaneous verbal explanation of the heart auscultation[.]³⁸⁶

H.B. 15 did not allow pregnant women, absent incest or rape, to decline a sonogram or opt not to hear the heartbeat and explanation of the sonogram images.³⁸⁷ The Act mandated denial

<https://www.guttmacher.org/state-policy/explore/requirements-ultrasound> (last updated Apr. 1, 2019) (last visited Apr. 16, 2019) (stating that three states have mandatory ultrasound laws) (on file with the Washington and Lee Law Review).

383. *See id.* (stating that twenty-six states regulate the provision of ultrasound by abortion providers).

384. *See id.* (“[Three] states mandate that an abortion provider perform an ultrasound on each woman seeking an abortion and requires the provider to show and describe the image.”).

385. TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(4)(A)–(D) (West, Westlaw through 2017 Reg. Sess.).

386. *Id.*

387. *See id.* § 171.012(a)(5) (providing a required medical form which informs a pregnant woman that she must hear the explanation of the sonogram images).

or revocation of a physician's medical license for failure to comply.³⁸⁸

Texas physicians and abortion providers immediately challenged H.B. 15 on First Amendment grounds.³⁸⁹ The District Court granted a preliminary injunction.³⁹⁰ On the State's appeal, the Fifth Circuit ordered expedited briefing and oral argument to consider whether Texas's speech-and-display provisions were substantively different than the provisions upheld in *Casey*.³⁹¹ Like Pennsylvania's informed consent statute, H.B. 15 compelled physicians to deliver "medically accurate depictions."³⁹² Unlike Pennsylvania's law, however, H.B. 15's mode of delivery was, Appellees argued, "qualitatively different."³⁹³ In *Casey*, the Supreme Court upheld a law dictating a passive information exchange—i.e., Pennsylvania physicians were only required to make certain materials "available" to abortion-seekers.³⁹⁴ But H.B. 15 not only compelled Texas physicians to verbally deliver information themselves, but also compelled pregnant women to listen.³⁹⁵ Moreover, the law dictated the context and content of the conversation such that the information exchange amounted to advocacy, making physicians the "'mouthpiece' of the state."³⁹⁶ The Fifth Circuit disagreed.³⁹⁷ The information delivered via sonogram

388. See TEX. OCC. CODE ANN. § 164.055(a) (West, Westlaw through 2017 Reg. Sess.) (providing the punishment for failure to comply with TEX. HEALTH & SAFETY CODE § 171.012).

389. See *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 806 F. Supp. 2d 942, 947–48 (W.D. Tex. 2011) (challenging H.B. 15 for "compelling physicians and patients to engage in government-mandated speech and expression"), *vacated in part*, 667 F.3d 570 (5th Cir. 2012).

390. See *id.* at 977 (granting preliminary injunction).

391. See *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 574–75 (5th Cir. 2012) (discussing the similarities between the Pennsylvania law upheld in *Casey* with the Texas law).

392. See *id.* at 577 (describing the requirements of the Texas law).

393. See *id.* at 578–79 (summarizing the appellee's argument).

394. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 883 (1992) ("This requirement cannot be considered a substantial obstacle to obtaining an abortion, and, it follows, there is no undue burden.").

395. See TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(5) (requiring the pregnant woman to hear an explanation of the sonogram images).

396. See *Lakey*, 667 F.3d at 579 (addressing appellees' criticism of the Texas law).

397. See *id.* (articulating that *Casey* does not provide the "ceiling" of what can

was not “different in kind” from the disclosures in *Casey*.³⁹⁸ Rather, the information was of the same kind—i.e., medically accurate, inherently truthful, and non-misleading.³⁹⁹ The only difference between the Pennsylvania law and H.B. 15 was that H.B. 15 called for “more graphic and scientifically up-to-date information.”⁴⁰⁰ The Fifth Circuit concluded that in terms of constitutional analysis, the mode of delivery was immaterial.⁴⁰¹ The court applied *Casey*-level scrutiny (a standard it referred to as “the antithesis of strict scrutiny”)⁴⁰² and upheld H.B. 15.⁴⁰³ By the majority’s reasoning, then, compelled speech—so long as it is medically accurate—is not subject to heightened scrutiny.⁴⁰⁴ Indeed, as Circuit Judge Higginbotham noted in his *Lakey* concurrence, if the challenged law compels accurate speech, it need only meet a minimum threshold of rationality.⁴⁰⁵ In the Fifth Circuit, medically accurate compelled speech is closer to professional conduct than speech.⁴⁰⁶

be required of medical providers).

398. *See id.* at 578 (“They are not different in kind, although more graphic and scientifically up-to-date, than the disclosures discussed in *Casey*.”).

399. *See id.* at 578–79 (describing the required disclosures as “the epitome of truthful”).

400. *See id.* at 578 (“They are not different in kind, although more graphic and scientifically up-to-date, than the disclosures discussed in *Casey*.”).

401. *See id.* at 579 (stating that the mode of delivery did not make a “constitutionally significant” difference). Whether the “mode of delivery” matters—and more specifically, whether there is a constitutional difference between prohibited speech (as in *Wollschlaeger*, *Pickup*, and *King*) and compelled speech (as in *Lakey* and *Camnitz*) remains unclear, even after *Becerra*. *See* Nat’l Inst. of Family & Life Advocates v. *Becerra*, 138 S. Ct. 2361, 2387–88 (2018) (Breyer, J., dissenting) (decrying “the majority’s reliance on cases that prohibit rather than require speech” because compelled disclosures, even if controversial, are less likely to suppress the “marketplace of ideas” than prohibitions).

402. *See* *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 575 (5th Cir. 2012) (discussing the standard of review applied in *Casey*).

403. *See id.* at 584 (“Appellees failed to demonstrate constitutional flaws in H.B. 15.”).

404. *See id.* (determining that the appellees were unlikely to succeed on their First Amendment claims).

405. *See id.* at 585 (Higginbotham, J., concurring) (stating that H.B. 15’s validity requires only “a legislative judgment that is at least rational”).

406. *See id.* at 584 (stating that appellees failed to show a constitutional flaw in the Texas law).

2. *Stuart v. Camnitz: The Fourth Circuit's Approach*

The same year that Texas passed H.B. 15, North Carolina introduced its own speech-and-display law.⁴⁰⁷ Its provisions were near identical.⁴⁰⁸ The Real-Time View Requirement (RTV)⁴⁰⁹ of North Carolina's Woman's Right to Know Act required abortion providers to "perform an obstetric real-time view of the unborn child" and "provide a simultaneous explanation of what the display is depicting."⁴¹⁰ Interestingly, the drafters also included a caveat: "Nothing in this section shall be construed to prevent a pregnant woman from averting her eyes from the displayed images or from refusing to hear the simultaneous explanation."⁴¹¹ The certification proviso dictated that pregnant women verify compliance with the RTV in writing, and, further, that they indicate whether they had averted their eyes.⁴¹²

As in Texas, physicians and abortion providers successfully sought a permanent injunction.⁴¹³ On appeal, the Fourth Circuit assessed the District Court's application of intermediate scrutiny.⁴¹⁴ The court acknowledged that the RTV regulated both speech and conduct and even agreed with the Fifth Circuit's characterization of it as "the epitome of truthful, non-misleading information."⁴¹⁵ It did not, however, view medical accuracy as the conclusive element.⁴¹⁶ That the RTV compelled speech dealing in

407. See N.C. GEN. STAT. § 90-21.85(1)–(2) (Westlaw through S.L. 2018-145) (requiring certain steps be taken by medical providers prior to an abortion).

408. Compare *id.* (requiring medical providers to take certain steps prior to an abortion), with TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(5) (West, Westlaw through 2017 Reg. Sess.) (same).

409. N.C. GEN. STAT. § 90-21.85(1)–(2).

410. *Id.*

411. *Id.* § 90-21.85(b).

412. See *id.* § 90-21.85(a)(5) (requiring women to attest to aspects of the medical treatment before receiving an abortion).

413. See *Stuart v. Loomis (Stuart I)*, 992 F. Supp. 2d 585, 611 (M.D.N.C. 2014) (ordering a permanent injunction of N.C. GEN. STAT. § 90-21.85).

414. See *Stuart v. Camnitz (Stuart II)*, 774 F.3d 238, 245 (4th Cir. 2014) (agreeing with the lower court's choice to apply intermediate scrutiny).

415. See *id.* at 246 (determining that compelling speech requires a speaker "to change the content of his speech or even to say something where he would otherwise be silent" (quoting *Tex. Med. Providers Performing Abortion Servs. V. Lakey*, 667 F.3d 570, 577–78 (5th Cir. 2012))).

416. See *id.* (discussing the medical accuracy of the procedure).

facts versus opinions did not “divorce the speech from its moral or ideological implications.”⁴¹⁷ To the court’s mind, wholly factual information—if compelled at a time “when the intended recipient is most vulnerable,”—constitutes a “plainly [] expressive act.”⁴¹⁸

The Fourth Circuit also disagreed with the Fifth (and Ninth) Circuit’s rational basis review.⁴¹⁹ “With respect,” Circuit Judge Wilkinson intoned, “our sister circuits read too much into *Casey*.”⁴²⁰ Even if *Casey* had dictated rational basis as the standard for all informed consent provisos in the abortion context—a claim the Fourth Circuit considered dubious⁴²¹—the RTV did not resemble the *Casey* statute.⁴²² Pennsylvania had legislated only modest deviations from traditional informed consent. By contrast, North Carolina had legislated that doctors recite information, even when the recipient “has through ear and eye covering rendered herself temporarily deaf and blind.”⁴²³ Moreover, even if a woman elected against the “embarrassing spectacle” of blindfolding and ear-muffling, the Fourth Circuit felt that compelling delivery via the physician’s own voice was especially coercive.⁴²⁴ More than anything, the Fourth Circuit’s opinion stressed that “context matters.”⁴²⁵ The RTV “finds the patient half-naked or disrobed on her back on an examination table, with an ultrasound probe either on her belly or inserted into her vagina.”⁴²⁶ In such a context,

417. *Id.*

418. *See id.* at 245–46 (assessing the act of showing the pregnant woman images of her scans).

419. *Id.* at 249.

420. *Id.* Judge Wilkerson also suggested the Eighth Circuit was guilty of the same misreading in *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds*, 530 F.3d 724 (8th Cir. 2008) (en banc). *Stuart II*, 774 F.3d at 248–49 (citing *Lahey* and *Rounds* with disapproval).

421. *See id.* (stating that *Casey* “hardly announces a guiding standard of scrutiny for use in every subsequent compelled speech case involving abortion”).

422. *See id.* (discussing the differences between RTV and the *Casey* statute).

423. *Id.* at 252.

424. *See id.* at 253 (“We can perceive no benefit to state interests from walling off patients and physicians in a manner antithetical to the very communication that lies at the heart of the informed consent process.”).

425. *See id.* at 247–48 (discussing a wholistic assessment of the North Carolina statute).

426. *See id.* at 255 (describing the patient’s vulnerable position).

compelled speech could hardly be anything other than constitutionally infirm.⁴²⁷ The Fourth Circuit held that the RTV did not survive even intermediate scrutiny—let alone strict, which was arguably the more appropriate standard.⁴²⁸

D. Conclusions and Future Applications

There is nothing even approaching judicial consensus on professional speech—not in definition, not in application, and certainly not doctrinally.⁴²⁹ The Eleventh Circuit applies intermediate scrutiny (and leaves open the possibility for strict) to physician speech restrictions—at least in the context of gun violence.⁴³⁰ The Ninth Circuit applies rational basis scrutiny—but likely *only* in the context of sexual orientation conversion efforts.⁴³¹ The Third Circuit applies intermediate scrutiny—but its commercial speech analogy likely precludes the possibility of stricter applications in other contexts.⁴³² The Fifth Circuit applies rational basis with enough robust confidence to suggest it would

427. *See id.* (discussing how the context of the speech affects the informed consent assessment).

428. *See id.* at 248, 250–53 (affirming the lower court's decisions that § 90-21.85 of the North Carolina General Statutes violates the First Amendment).

429. *Compare* *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 574–75 (5th Cir. 2012) (upholding a Texas law requiring certain speech of professionals), *with* *Stuart II*, 774 F.3d 238, 245 (4th Cir. 2014) (striking a North Carolina statute compelling professional speech).

430. *See* *Wollschlaeger V*, 848 F.3d 1293, 1319 (11th Cir. 2017) (upholding a Florida statute that discouraged medical personnel from inquiring of a patient about firearms).

431. Indeed, the Ninth Circuit did *not* apply rational basis in *Becerra*. In applying intermediate scrutiny, the court responded to the Fourth Circuit's jab in *Stuart II*: “*Casey*'s short discussion of a physician's First Amendment rights in the context of abortion means only what it says—that there was no violation of the physicians' First Amendment rights given the particular facts of *Casey*. We need not ‘read too much’ into *Casey*'s statement . . .” *Nat'l Inst. of Family & Life Advocates v. Harris*, 839 F.3d 823, 838 (2016) (citations omitted). Notably, the Ninth Circuit did not retreat from its *Pickup* analysis, even as it applied higher scrutiny to abortion-specific speech restrictions. *See id.* at 839 (distinguishing from *Pickup* by stating “*Pickup*, however, never discussed the level of scrutiny appropriate for speech that fell at the midpoint”).

432. *See* *King v. Governor of N.J.*, 767 F.3d 216, 220 (3d Cir. 2014) (challenging New Jersey law prohibiting “licensed counselors from engaging in ‘sexual orientation change efforts’ with a client under the age of 18”).

do so in any context.⁴³³ Finally, the Fourth Circuit, like the Eleventh, applies intermediate scrutiny with the possibility for strict, at least in the abortion context.⁴³⁴

The absence of clear legal guidelines in an area so ideologically charged as abortion suggests that legislatures will feel, as they have historically, emboldened to take speech-restricting liberties.⁴³⁵ Further, the Supreme Court's most recent guidance prescribes "application of so broad and obscure a standard," "[it] threatens to create serious problems."⁴³⁶ With PWGS on the horizon, it is both critical to predict the foreseeable likelihood of state intervention in physician-patient conversations, and to anticipate the constitutional concerns triggered by such interventions.⁴³⁷

V. "Context Matters": Prenatal Whole Genome Sequencing

The practice of prenatal medicine is changing. Until the late 1980s, women did not begin making decisions until months into pregnancy,⁴³⁸ and their decision-making was facilitated by multiple and unfettered exchanges of information with their provider.⁴³⁹ Today, with rapid clinical uptake of new technologies, the timeline for prenatal decision-making is earlier. Obtaining fetal information is easier.⁴⁴⁰ For both mother and child, the tests

433. See *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 574–75 (5th Cir. 2012) (defending a challenge to a Texas statute for compelling physicians to engage in speech).

434. See *Stuart II*, 774 F.3d 238, 245 (4th Cir. 2014) (agreeing with the lower court's choice to apply intermediate scrutiny to a North Carolina law requiring certain speech of medical providers).

435. See *id.*

436. *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2388 (2018) (Breyer, J., dissenting).

437. See sources cited *supra* note 9 (suggesting and discussing the eventual routinization of PWGS).

438. Amniocentesis is routinely unavailable until the second trimester. ACOG, *Practice Bulletin No. 162*, *supra* note 76, at e111.

439. See discussion *supra* Part II (discussing changes in prenatal genetics as exemplifying the rapid changes in prenatal care).

440. See discussion *supra* Part II.A–C (exploring the evolution to prenatal whole-genome sequencing).

are safer.⁴⁴¹ But an evolution in medical practice has not produced an evolution in political thought. Far from moderating the abortion debate, the influx of technology has only amplified the motivation of conservative legislators.⁴⁴² In a practical sense, of course, state laws like North Dakota's are unenforceable.⁴⁴³ Under the Supreme Court's viability standard, a woman's right to choose is inviolable until at least twenty-three weeks of gestation.⁴⁴⁴ As a matter of federal law, a woman may choose to terminate for any reason—be it preference, convenience, or no reason at all.⁴⁴⁵ Certainly, she is entitled to terminate on the basis of a genetic abnormality, even in North Dakota.⁴⁴⁶ But that ABGAs are legally unenforceable says little about their symbolic power. Indeed, their most damaging effects are of two kinds: normative and precedential.

A. Existing Hardship: The Normative Effect of ABGAs

As they are written, ABGAs target specific action. They prohibit physicians only from performing abortions “with knowledge that the pregnant woman is seeking an abortion solely because the unborn child has been diagnosed with either a genetic abnormality or a potential for a genetic abnormality.”⁴⁴⁷ But the effect is not limited to circumscription of the specific action. The practical effect is a global undermining of the physician-patient relationship—subtle discouragement of frank and open communication.⁴⁴⁸ It does not take any special acuity for a

441. See Dennis, *supra* note 77, 485–86 (discussing a new method for collecting fetal DNA).

442. See discussion *supra* Part IV.C (discussing judicial challenges to various state statutes which sought to regulate physician speech in the abortion context).

443. See H.B. 1305, 63d Gen. Assemb., Reg. Sess. (N.D. 2012) (outlawing abortions “because the unborn child has been diagnosed with either a genetic abnormality or a potential for a genetic abnormality”).

444. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 837, 933 n.6 (1992) (“The joint opinion agrees with *Roe*'s conclusion that viability occurs at 23 or 24 weeks at the earliest.”).

445. See *id.* at 860–61 (discussing “that viability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions”).

446. See *id.* (discussing a woman's right to an abortion pre-viability).

447. H.B. 1305, 63d Gen. Assemb., Reg. Sess. (N.D. 2012).

448. See *Stuart II*, 774 F.3d 238, 253(4th Cir. 2014) (determining that the

physician to realize that the easiest way to avoid running afoul of North Dakota's dictate is to simply not ask questions.⁴⁴⁹ At an extreme, the legislative discouragement might manifest as a decision to selectively discuss testing options—or to abandon the genetic testing discussion altogether.⁴⁵⁰ Of course, from the patient's perspective, too, the disincentive is equally clear: "if a medical professional can 'turn her in' for wanting an abortion,"⁴⁵¹ she has no incentive whatsoever to discuss either her available options or her ultimate choice.⁴⁵² Writ large, the erosion of communication channels is sure to have damaging normative effects.⁴⁵³ ABGAs are clearly benign only insofar as they are ignored—that is, insofar as patients and physicians resist the legislative invitation to silence. But in light of physicians' pre-existing discomfort with genetic conversations, and patients' awareness that abortion is a charged issue, the invitation might prove irresistible.⁴⁵⁴

In their historical context, ABGAs might be viewed as a continuation of pro-lifers' general strategy—yet another hardship construction project. As in previous projects—mandatory waiting periods, hospital-admitting requirements, insurance restrictions, etc.—the legislative intent is clear. ABGAs target the pregnant patient. They do so indirectly, via circumscription of the physician's action, but the ultimate goal is to prevent women from making certain choices.⁴⁵⁵ ABGAs seek to limit, however unenforceable, the woman's constitutional rights. But in the modern context, against the nebulous backdrop of professional

speech required of physicians was coercive of the patient).

449. See H.B. 1305, 63d Gen. Assemb., Reg. Sess. (N.D. 2012) (regulating a physician's actions when assisting patients seeking an abortion).

450. See *id.* (setting requirements for physicians assisting patients seeking abortions).

451. See Stefanija Giric, *Strange Bedfellows: Anti-Abortion and Disability Rights Advocacy*, 3 J. LAW BIOSCIS. 736, 740 (2016) (stating that such knowledge will disincentivize the patient from discussing the abortion decision).

452. See Giric, *supra* note 451, 739–40 (discussing how certain laws discourage women from discussing medical decisions with their physicians).

453. See *id.*

454. See *id.*

455. See *id.*

speech doctrine, ABGAs might be alternatively viewed as a successful first step. If North Dakota can dictate the reasons for which an abortion can be performed, and Texas can compel physicians to make statements designed to discourage abortion-seekers,⁴⁵⁶ it is not unimaginable that state legislatures might next prohibit abortion-motivating communications altogether. If professional speech is treated as low-value—or worse, is not recognized as “speech” in the legal sense of that word—ABGAs are anything but benign. They are the precursors to laws that would regulate the content of genetic testing discussions.

B. Imagining Future Hardship: The Precedential Effect of ABGAs

It is not difficult to predict what future laws might look like. Conceivably, they might be drafted as compelled speech provisions resembling the speech-and-display laws passed in Texas and North Carolina. They might, for instance, compel physicians to tell patients that PWGS can be used to diagnose conditions X, Y, and Z. Without a scientific understanding of genetics and sequencing technology, and absent a more nuanced discussion with their doctor, a patient might reasonably believe that the technology is capable of diagnosing *only* X, Y, and Z—when the reality is that these tests are capable of assessing the entire alphabet. Alternatively, a legislature might draft speech prohibitions resembling Florida’s Firearms Owners’ Privacy Act. Such a law might prohibit physicians from offering patients certain kinds of testing (e.g., testing for adult-onset, nonmedical, or aesthetic traits), or from otherwise communicating with patients about a proscribed topic (i.e., PWGS). A third possibility might be a state initiative resembling the SOCE bans upheld in California and New Jersey.⁴⁵⁷ At this extreme, future genetic testing laws might foreclose not only the offer of PWGS, but the ordering of genetic tests during pregnancy altogether. Finally, legislatures might adopt an approach that has already proven successful. In the abortion context, TRAP laws—targeted regulations of abortion

456. See *supra* Part IV.C.1.

457. See *supra* Part IV.B.

providers—are legislative impediments intended to drive down abortion rates.⁴⁵⁸ For example, many states make the legal performance of an abortion contingent on the physical space providers occupy, requiring abortion facilities be equipped with extensive neonatal units,⁴⁵⁹ with procedure rooms of a specified size, or even with corridors of specified widths.⁴⁶⁰ Making the performance of an abortion contingent on the provider having hospital admitting privileges is an especially popular strategy. Currently, eleven states require that providers have an affiliation with a local hospital,⁴⁶¹ despite the fact that post-abortion complications requiring hospital care occur at a rate of less than one percent.⁴⁶² In the PWGS context, legislatures might similarly implement TRAP-style restrictions such that a physician's ability to order PWGS for a patient that is contingent on medically unnecessary and functionally onerous requirements. The implication of any one of these potential regulatory moves, of course, is that it is appropriate for legislatures to narrow the decision-making options for any given family. More broadly, the implication is that politicians, rather than medical professionals, are best qualified to answer medical questions. The unavoidable result if any of these laws were passed would be an unequivocal loss of patients' decision-making power and physicians' freedom of speech.

458. See sources cited *supra* note 37 (examining TRAP laws).

459. See, e.g., IND. CODE ANN. § 16-34-2-3 (LexisNexis 2018) (setting conditions for abortions post-viability); H.B. 4146, 2015 Leg. Assemb., Reg. Sess. (Mich. 2015) (proposing neonatal unit requirement).

460. Nine states regulate the size of abortion procedure rooms and seven states regulate the width of corridors in facilities where abortions are performed. *Targeted Regulation of Abortion Providers*, GUTTMACHER INSTITUTE, <https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers> (last updated Apr. 1, 2019) (last visited Apr. 16, 2019) (on file with the Washington and Lee Law Review).

461. *Id.*

462. Laura Kurtzman, *Major Complication Rate After Abortion Is Extremely Low, Study Shows*, UCSF NEWS CTR. (Dec. 8, 2014), <https://www.ucsf.edu/news/2014/12/121781/major-complication-rate-after-abortion-extremely-low-study-shows> (last visited Apr. 16, 2019) (on file with the Washington and Lee Law Review).

Predicting judicial intervention, however, is far easier than predicting legislative action. The law, for all its failings, is an iterative instrument—courts rarely approach problems, even new problems, with an entirely new methodology. For this reason, the physician speech cases recently decided in the Eleventh, Ninth, Fifth, Fourth, and Third Circuits likely represent the spectrum of possible judicial approaches with respect to future PWGS legislation. As it stands, given a speech-specific law and a responsive First Amendment challenge, the question a court will always answer is this: how valuable is physician speech? If the answer to this question is “low,” then the approaches adopted by the Fifth and Ninth Circuits are appropriate and we should expect courts to apply rational basis review.⁴⁶³ If rational basis is the appropriate test, we should expect legislatures to feel, rightly, empowered to compel, prohibit, and direct physician speech as they see fit. There is, however, good reason to suspect that physician speech is anything but low-value.

The original doctrine underlying First Amendment protection is helpful scaffolding for assigning value to physician speech in modern medicine. An argument that physician speech is not low-value suggests, doctrinally, that it must therefore be either: (1) inherently valuable as a conduit for self-expression, or (2) instrumentally valuable as a tool to accomplish something else. In the United States, medicine is not an expressive profession—at least not in the way acting, creative writing, or fashion design are. American medicine is a professional practice rather than an artistic pursuit, which makes claims of inherent value conceptually difficult. When physicians act or speak, we do not ask if what they have done is beautiful. We ask if they have met the practice guidelines for good medicine. We ask if they have helped the patient. This distinction is significant. Indeed, it seems to be the driving rationale behind, for example, the Ninth Circuit’s approach to SOCE bans.⁴⁶⁴ The court’s conclusion in *Pickup v. Brown* was that California’s SB 1172 regulated medical conduct, not expressive speech.⁴⁶⁵ By categorizing physician speech as

463. See *supra* Part IV.C.; IV.B.

464. See *supra* Part IV.B.1.

465. See *Pickup v. Brown*, 740 F.3d 1208, 1221 (9th Cir. 2014) (challenging California law prohibiting “state-licensed mental health providers from engaging

non-expressive, as conduct within a professional practice, the court rejected the inherent value of physician speech as a conduit for self-expression.⁴⁶⁶ Similarly, the Fifth Circuit's decision in *Lakey* followed from its conclusion that medically accurate speech was closer to professional conduct than expressive speech and was therefore not entitled to heightened scrutiny.⁴⁶⁷

But to conclude that physician speech is low-value because it is not inherently valuable as a conduit for self-expression ignores entirely the possibility that it might be *instrumentally* high-value as a tool to accomplish something else—namely, good medicine. Indeed, the instrumental value of physician speech seems to have been the focus of Eleventh Circuit Judge Wilson's numerous dissents in the *Wollschlaeger* litigation.⁴⁶⁸ The Eleventh Circuit's final opinion—that firearm inquiries would not lead to the practice of bad medicine—was focused entirely on instrumental value.⁴⁶⁹ The Third Circuit, too, found that physician speech has at least medium-value because it serves an “informational function” for patients.⁴⁷⁰ And the Fourth Circuit, of course, went further than both the Third and Eleventh Circuits in finding that physician speech is both instrumentally valuable and inherently valuable as a “plainly expressive act.”⁴⁷¹

American medicine may not be an expressive profession. But it is absolutely an instrumentally valuable one. In the United States, medicine is highly regulated because we are, as a nation,

in ‘sexual orientation change efforts’ with patients under 18 years of age”).

466. *See id.* at 1227 (evaluating the statute at issue's implication for physician speech).

467. *See* *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 572 (5th Cir. 2012) (challenging a Texas statute for its effect on physician speech).

468. *See Wollschlaeger V*, 848 F.3d 1293, 1300 (11th Cir. 2017) (addressing the challenge to a Florida statute regulating physician speech regarding firearms).

469. *See id.* at 1318 (addressing the challenge to a Florida statute regulating physician speech regarding firearms).

470. *See supra* notes 368–371 and accompanying text (explaining that professional speech, like commercial speech, serves as an important channel for the communication of information that might otherwise never reach the public).

471. *See supra* text accompanying notes 414–416.

concerned with empowering patients. If a surgeon performs an unnecessary surgery without the patient's consent, it is no defense for the surgeon to say that her diagnosis was elegant or that her sutures were a work of art. We believe that safeguarding patient autonomy ensures the practice of "good medicine." To that end, we have enshrined in law principles like informed consent and the right to refuse treatment.⁴⁷² If we assume, as the Third, Fourth, and Eleventh Circuits do, that open communication between patients and their doctors is integral to patient autonomy—integral, that is, to the practice of good medicine—then physician speech is at least medium-value.⁴⁷³ Indeed, insofar as it promotes informed decision-making, physician speech is high-value, and rational basis review is wholly inappropriate.⁴⁷⁴ If physician speech is valuable—possibly, *very* valuable—then intermediate scrutiny is the constitutional floor and strict scrutiny is the ceiling.

VI. Conclusion

The lower courts have repeatedly approached the problem of identifying professional speech by attempting to differentiate "medical conduct" from physician speech.⁴⁷⁵ In *Becerra*, the Supreme Court addressed the question by suggesting that physician speech should be considered speech under the First Amendment when "it is tied to a [medical] procedure."⁴⁷⁶ By that definition, the majority reasoned, disclosures of the type challenged in *Casey* withstand constitutional scrutiny because

472. See Piechan, *supra* note 12 (discussing informed consent in the context of genetic testing).

473. See, e.g., *Wollschlaeger V*, 848 F.3d 1293, 1316 (11th Cir. 2017) ("[T]he American Medical Association and the American Academy of Pediatrics each recommend that doctors and pediatricians routinely ask patients about firearm ownership, and educate them about the dangers posed to children by firearms that are not safely secured").

474. See, e.g., *id.* at 1311 ("[W]e do not think it is appropriate to subject content-based restrictions on speech by those engaged in a certain profession to mere rational basis review.").

475. See, e.g., *Pickup v. Brown*, 740 F.3d 1208, 1229–30 (9th Cir. 2014) (concluding California's prohibition on sexual orientation conversion therapy for minors was a Constitutional regulation of professional conduct).

476. *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2369 (2018).

they facilitate informed consent for a medical procedure (i.e., an abortion).⁴⁷⁷ By contrast, the notices challenged in *Becerra* were struck down for lacking a sufficient connection to a medical procedure.⁴⁷⁸ But notably, the Court did not indicate how close a connection is needed to pass constitutional muster nor did it provide a framework for identifying what counts as a “connection” in the first place. As Justice Breyer’s dissent quickly pointed out, if Pennsylvania can require disclosures about adoption to get an abortion (as in *Casey*), why can’t California require disclosures about abortion to get prenatal or reproductive care (as in *Becerra*)?⁴⁷⁹

It seems likely that the problem is in the question itself. Courts should not be asking: Is this medical conduct or “speech as speech”? Rather, the more appropriate question is: Does treating physician speech as conduct—in essence, does treating physician speech as low-value—lead to the practice of good medicine? Once that question is raised, proposing a coherent definition for professional speech is far easier. Physician speech is professional speech—not medical conduct—when treating it as such promotes patient safety, occurs within the confines of a doctor-patient relationship, and is supported by evidence-based medicine. When these three criteria are met, physician speech is high-value—and the tests designed for high-value speech apply. Of course, there remain definitional questions about how promotion of patient safety ought to be quantified, how a doctor-patient relationship ought to be recognized, and how much evidence (and of what type) demonstrates evidence-based medicine. While such questions are beyond the scope of this Article, the proposed definition nonetheless suggests the same conclusion: rational basis review is wholly inappropriate for professional speech—and for physician speech, especially.

477. See *id.* at 2373 (comparing the disclosures required in a California statute with similar disclosures required by a Pennsylvania statute in *Casey*).

478. See *id.* at 2375 (“[T]he licensed notice is not sufficiently drawn to achieve it”).

479. See *id.* at 2283 (Breyer, J., dissenting).