INFORMED CONSENT TO ABORTION: A FIRST AMENDMENT ANALYSIS OF COMPELLED PHYSICIAN SPEECH†

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Although most are familiar with South Dakota's recently repealed abortion ban, few are aware that South Dakota previously enacted an informed consent statute that prohibits physicians from performing abortions without first obtaining the voluntary and informed written consent of the pregnant woman seeking an abortion. The law is most unusual, because it provides that an abortion may be performed only after a physician informs a patient that she is terminating the life of "a whole, separate, unique, living human being," and only after a physician informs a patient that abortion may cause a significant risk of psychological trauma, a risk that accepted medical knowledge does not believe exists.

This lecture analyzes the First Amendment principles that should apply to compelled physician speech of this kind. It argues that although the state may freely regulate physician speech as part of its regulation of the practice of medicine, First Amendment questions are raised by (at least) two forms of such regulation. The first is when the state requires physicians to engage in ideological speech. The second is when the state either requires physicians to communicate information that the medical profession regards as false, or prohibits physicians from communicating information that the medical profession regards as true. The lecture analyzes the First Amendment stakes in determining the constitutionality of such regulations, with particular attention to the necessity of protecting structures of profes-

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* David Boies Professor of Law, Yale Law School. Much of the material in this Lecture draws upon the pathbreaking research of Reva Siegel's Spring 2006 Baum Lecture. I am deeply indebted to Reva for bringing this fascinating material to light, for provoking me to consider the topic of this Fall's 2006 Baum Lecture, and for endless illuminating and clarifying discussion on the subject matter of this lecture. I am also grateful for the incisive advice of good colleagues and friends: Ken Abraham, Bruce Ackerman, Ed Baker, Nicole Berner, Dick Fallon, Charles Fried, Robert Goldstein, Daniel Halberstam, Don Herzog, Dawn Johnsen, Amy Kapczynski, Greg Magarian, Rick Pildes, Nancy Russo, Fred Schauer, Alan Schwartz, Geoff Stone, Jim Weinstein, and Elizabeth Zoller. The research and comments of David Tannenbaum have been of enormous assistance.

sional practice that define expert knowledge. The lecture argues that there is a First Amendment interest in protecting the integrity of physician-patient communications as a channel for the communication of accurate medical information.

> The question is asked in one of the notes handed to me, "What is the attitude of the Central Committee of the Party to my report?" I answer: The Central Committee of the Party has examined my report and approved it. [*Stormy applause. Ovation. All rise*].
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> —Trofim D. Lysenko, "The Situation in Biological Science," address delivered at the 1948 Lenin Academy of Agricultural Sciences[1]

> The right of the doctor to advise his patients according to his best lights seems so obviously within First Amendment rights as to need no extended discussion. . . . Leveling the discourse of medical men to the morality of a particular community is a deadening influence. . . . These are [the doctor's] professional domains into which the State may not intrude.
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> —Justice William O. Douglas[2]

The abortion wars continue to reshape the face of American constitutional law. Blocked from flatly prohibiting abortion by *Roe v. Wade*[3] and *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[4] anti-abortion advocates in the past two decades have pushed for the enactment of ever more stringent "'informed consent' statutes," which they regard as "'temporary tactics' on the march to the 'ultimate goal . . . to completely end abortion in America.'"[5] They have by now so thoroughly instrumentalized the institution of informed consent that the question is raised whether the First Amendment limits political control over the dispensation of expert, medical knowledge.

The *nec plus ultra* has apparently been reached by the redoubtable state of South Dakota. Most everyone is aware of the 2006 South Dakota statute banning virtually all abortions in South Dakota[6] that was re-

1. Quoted in STEPHEN JAY GOULD, HEN'S TEETH AND HORSE'S TOES 135 (1983). Gould observes that this "may well be the most chilling passage in all the literature of twentieth-century science." *Id.*

2. Poe v. Ullman, 367 U.S. 497, 513–15 (1961) (Douglas, J., dissenting).

3. 410 U.S. 113 (1973).

4. 505 U.S. 833 (1992).

5. Gregory Wilmoth, *Abortion, Public Health Safety, and Informed Consent Legislation*, J. SOC. ISSUES, Fall 1992, at 11 (quoting THOMAS A. GLESSNER, ACHIEVING AN ABORTION-FREE AMERICA BY 2001 136 (1990)).

6. H.B. 1215, 2006 Leg., 81st Sess. § 2 (S.D. 2006) (repealed 2006) ("No person may knowingly use or employ any instrument or procedure upon a pregnant woman with the specific intent of causing or abetting the termination of the life of an unborn human being.").

cently repealed by a voter referendum.[7] But few are aware that during the previous year South Dakota had enacted a statute designed "to revise the physician disclosure requirements to be made to a woman contemplating submitting to an abortion."[8] The Act, which was hailed as creating "a roadblock for the abortion industry,"[9] prohibits a physician (except in emergency conditions) from performing an abortion unless the physician first obtains "a voluntary and informed written consent of the pregnant woman upon whom the physician intends to perform the abortion."[10] The obvious objective of the Act, however, is to use the concept of "informed consent" to eliminate abortions.[11]

The doctrine of informed consent is ordinarily understood as integral to the humane practice of medicine. It requires a physician to explain to a "patient in nontechnical terms . . . what is at stake: the therapy alternatives open to him, the goals expectably to be achieved, and the risks that may ensue from particular treatment and no treatment."[12] The South Dakota statute, however, does not require the provision of such information. It compels a physician to spell out in intimidating detail the risks of undergoing an abortion, but it does not require a physician to articulate the equivalent risks of "no treatment," which is to say the risks of carrying a child to term.[13] The statute provides that "voluntary and in-

7. Judy Peres & Jodi Cohen, *S. Dakota Repeals Tough Abortion Ban*, CHI. TRIB., Nov. 8, 2006, at 10.

8. H.B. 1166, 2005 Leg., 80th Sess. (S.D. 2005).

9. *South Dakota Law Acknowledges that Abortion Ends a 'Whole, Unique Human Life*,' CATHOLIC NEWS AGENCY, Mar. 28, 2005, http://www.catholicnewsagency.com/new.php?n=3459.

10. S.D. CODIFIED LAWS § 34-23A-10.1 (2006).

11. In 2004, the South Dakota legislature had actually passed a bill banning abortions, but the bill was vetoed by the Governor. *See* H.B. 1191, 2004 Leg., 79th Sess. (S.D. 2004) (vetoed Mar. 9, 2004; passed again by House, but failed by Senate, on Mar. 15, 2004), *available at* http://legis.state.sd.us/sessions/2004/bills/HB1191enr.htm. That bill contains many of the same findings as the Legislature's subsequent informed consent statute. For example, the bill found that "the life of a human being begins when the ovum is fertilized by male sperm." *Id.* § 2. It found "that abortion procedures impose significant risks to the health and life of the pregnant mother, including subjecting women to significant risk of severe depression, suicidal ideation, suicide, attempted suicide, post traumatic stress disorders, adverse impact in the lives of women, physical injury, and a greater risk of death than risks associated with carrying the unborn child to full term and childbirth." *Id.* § 4. It found "that abortions terminate the constitutionally protected fundamental interest of the pregnant mother in her relationship with her child and abortions are performed without a truly informed or voluntary consent or knowing waiver of the woman's rights and interests. The Legislature finds that the state has a duty to protect the pregnant mother's fundamental interest in her relationship with her unborn child." *Id.* § 3.

12. Canterbury v. Spence, 464 F.2d 772, 782 n.27 (D.C. Cir. 1972); *see also* Crain v. Allison, 443 A.2d 558, 562 (D.C. 1982) ("[A]t a minimum, a physician must disclose the nature of the condition, the nature of the proposed treatment, any alternate treatment procedures, and the nature and degree of risks and benefits inherent in undergoing and in abstaining from the proposed treatment."); McKinney v. Nash, 174 Cal. Rptr. 642, 648 (Ct. App. 1981).

13. "An uninterrupted pregnancy eventuates in labor and delivery. Therefore, any physical and psychological sequelae of legal abortion can only be meaningfully understood in contrast with those of illegal abortion or unwanted childbirth. After undesired childbirth, a woman must face either the stresses of relinquishing a child for adoption or those of rearing a child." Nada L. Stotland, *The Myth of the Abortion Trauma Syndrome*, 268 JAMA 2078, 2078 (1992). The deployment of "informed consent statutes" to provide one-sided information seems to be part of the general program of antiabortion activists.

formed consent" to an abortion can occur only if, "in addition to any other information that must be disclosed under the common law doctrine, the physician provides that pregnant woman with . . . a statement in writing" that includes "the following information":

> (b) That the abortion will terminate the life of a whole, separate, unique, living human being;[14]
>
> (c) That the pregnant woman has an existing relationship with that unborn human being and that the relationship enjoys protection under the United States Constitution and under the laws of South Dakota;
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> (d) That by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated;
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> (e) A description of all known medical risks of the procedure and statistically significant risk factors to which the pregnant woman would be subjected, including:
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> (i) Depression and related psychological distress;
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> (ii) Increased risk of suicide ideation and suicide;
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> (iii) A statement setting forth an accurate rate of deaths due to abortions, including all deaths in which the abortion procedure was a substantial contributing factor;
>
> (iv) All other known medical risks to the physical health of the woman, including the risk of infection, hemorrhage, danger to subsequent pregnancies, and infertility . . . .[15]

> Pro-life advocates claim they are assuring that women have the opportunity to make medical decisions that are informed and that the woman has consented to the procedure with its attendant risks. Failing to require the physician also to inform the woman about the consequences of her alternatives, however, results in the woman making a decision that is neither informed nor based on her informed consent. . . .
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> Although pro-life advocates promote "informed consent" and "right to know" legislation that emphasizes risks of abortion, they have also fought to prevent family planning clinics that receive federal funds from informing women who have unwanted pregnancies that abortion is one of their legal options. In medicine and psychology, "informed consent" requires being advised of all legal, medically approved options. Pro-life advocates are promoting only those aspects of informed consent that further their campaign to restrict abortion.

Wilmoth, *supra* note 5, at 11; *see also* Rust v. Sullivan, 500 U.S. 173 (1991). Because the risks of "giving birth . . . can also be described as 'substantial, serious, and long-lasting,'" Wilmoth, *supra* note 5, at 12, many states explicitly require that physicians articulate the risks of carrying a pregnancy to term. *See, e.g.*, ARK. CODE ANN. § 20-16-903 (West 2006); FLA. STAT. ANN. § 390.0111 (West 2006); IND. CODE ANN. § 16-34-2-1.1 (West 2006); KAN. STAT. ANN. § 65-6709 (2005); KY. REV. STAT. ANN. § 311.725 (West 2006); MICH. COMP. LAWS ANN. § 333.17015 (West 2006); MISS. CODE ANN. § 41-41-33 (West 2006); MONT. CODE ANN. § 50-20-104 (2005); NEB. REV. STAT. § 28-327 (2006); N.D. CENT. CODE § 14-02.1-02 (2006); OHIO REV. CODE ANN. § 2317.56 (West 2006); 18 PA. CONS. STAT. ANN. § 3205 (West 2006); TENN. CODE ANN. § 39-15-202 (West 2006); UTAH CODE ANN. § 76-7-305 (West 2006).

14. The Act defines "human being" "as an individual living member of the species of Homo sapiens, including the unborn human being during the entire embryonic and fetal ages from fertilization to full gestation." S.D. CODIFIED LAWS § 34-23A-1 (2006).

The Act specifies that if after receiving this information in writing and certifying that "she has read and understands all of the disclosures," "the pregnant woman asks for a clarification or explanation of any particular disclosure, or asks any other question about a matter of significance to her, the explanation or answer shall be made in writing and be given to the pregnant woman before signing a consent for the procedure and shall be made part of the permanent medical record of the patient."[16] The physician must also "certify in writing" that he is "satisfied that the pregnant woman has read the materials which are required to be disclosed, and that the physician believes she understands the information imparted."[17] Failure to comply with the Act is a class 2 misdemeanor.[18]

Plainly this informed consent statute pushes the constitutional envelope in numerous directions, most especially with regard to the question of whether it is an "unnecessary health regulation[]" that has "the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion" and hence imposes "an undue burden on the right."[19] But in

15. *Id*. § 34-23A-10.1(b)–(e). The mandatory disclosures are supported by legislative findings:

> 1.2. The Legislature finds that all abortions, whether surgically or chemically induced, terminate the life of a whole, separate, unique, living human being.
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> 1.3 The Legislature finds that there is an existing relationship between a pregnant woman and her unborn child during the entire period of gestation.
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> 1.4. The Legislature finds that procedures terminating the life of an unborn child impose risks to the life and health of the pregnant woman. 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. The Legislature therefore finds that great care should be taken to provide a woman seeking to terminate the life of her unborn child and her own constitutionally protected interest in her relationship with her child with complete and accurate information and adequate time to understand and consider that information in order to make a fully informed and voluntary consent to the termination of either or both.
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> 1.5. The Legislature finds that pregnant women contemplating the termination of their right to their relationship with their unborn children, including women contemplating such termination by an abortion procedure, are faced with making a profound decision most often under stress and pressures from circumstances and from other persons, and that there exists a need for special protection of the rights of such pregnant women, and that the State of South Dakota has a compelling interest in providing such protection.
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> 1.6. The Legislature finds that, through the common law, the courts of the State of South Dakota have imposed a standard of practice in the health care profession that, except in exceptional circumstances, requires physicians and other health care practitioners to provide patients with such facts about the nature of any proposed course of treatment, the risks of the proposed course of treatment, the alternatives to the proposed course, including any risks that would be applicable to any alternatives, as a reasonable patient would consider significant to the decision of whether to undergo the proposed course of treatment.

Id. §§ 34-23A-1.2 to 1.6.

16. *Id*. § 34-23A-10.1(g).

17. *Id.*

18. *Id*. § 34-23A-10.2.

19. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 837 (1992). The statute's difficulties in this regard are legion. Particularly salient are its intimidating procedures for written answers to questions; its requirement that a physician attest that a patient "understands" disclosures whose meanings are plainly obscure; its required disclosure of information that would seem to be neither "truthful" nor "not misleading," *id*. at 882; and its seeming requirement that a physician comply with its provisions even "if he or she can demonstrate by a preponderance of the evidence, that he or she reasonably believed that furnishing the information would have resulted in a severely adverse effect on the physical or mental health of the patient." *Id.* at 883–84 (citation omitted). There may also be significant equal

this lecture I shall not discuss that question. I am here concerned less with obstacles that obstruct access to abortion, than with state interference with the distribution of accurate professional medical information. I shall therefore ask whether the 2005 South Dakota statute runs afoul of the First Amendment. I should note that in 2005 a federal district court enjoined the statute from going into effect on the ground that it likely violated "the First Amendment protection against compelled speech" by requiring doctors "to espouse the State's ideology."[20] The injunction was affirmed by a panel of the Eighth Circuit, whose decision was recently vacated when the Eighth Circuit granted a petition for rehearing en banc.[21]

Analyzing the First Amendment issues posed by the South Dakota statute requires some account of the complex and difficult relationship between the First Amendment and the regulation of professional speech of doctors. The nature of this relationship is unfortunately obscure and controversial. Although the Court has decided a number of cases about professional advertising,[22] "the Supreme Court and lower courts have rarely addressed the First Amendment contours of a professional's freedom to speak to a client."[23] Scholars have taken widely different views about the constitutional status of physicians' speech. Some hold "that doctor-patient discourse about medical treatment is fully protected, noncommercial speech"[24] because "freedom of expression . . . supports a ma-

protection problems with the statute. As the Minority Report of the South Dakota Task Force to Study Abortion found, "the legislative findings supporting South Dakota 34-23A-10.1, specifically 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,' are a sexist, insulting, condescending, and inaccurate stereotype of women." SOUTH DAKOTA TASK FORCE TO STUDY ABORTION, REPORT OF MINORITY (2006), *available at* http://www.argusleader.com/assets/pdf/DF34116714.PDF. For a full and illuminating discussion, see Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991.

20. Planned Parenthood Minn. v. Rounds, 375 F. Supp. 2d 881, 887 (D.S.D. 2005). The court issued a preliminary injunction based on the statute's requirement that doctors "enunciate the State's viewpoint on an unsettled medical, philosophical, theological, and scientific issue, that is, whether a fetus is a human being." *Id.* The court did not address the constitutionality of subsections (e)(i) and (e)(ii). *Id*.

21. 467 F.3d 716 (8th Cir. 2006) (affirming district court's grant of a preliminary injunction in a two-to-one panel decision). *But see* Planned Parenthood Minn. v. Alpha Ctr., No. 06-3142, 2007 U.S. App. LEXIS 1775, at *3 (8th Cir. Jan. 25, 2007) (noting that the en banc court vacated the panel's opinion on January 9, 2007).

22. *See, e.g.*, Edenfield v. Fane, 507 U.S. 761 (1993); *In re* R.M.J., 455 U.S. 191 (1982); Ohralik v. Ohio State Bar Ass'n, 436 U.S. 447 (1978); *In re* Primus, 436 U.S. 412 (1978); Bates v. State Bar of Ariz., 433 U.S. 350 (1977); Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc., 425 U.S. 748 (1976).

23. Daniel Halberstam, *Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions*, 147 U. PA. L. REV. 771, 834 (1999). For a study of First Amendment protections for the professional speech of attorneys, see Kathleen M. Sullivan, *The Intersection of Free Speech and The Legal Profession: Constraints on Lawyers' First Amendment Rights*, 67 FORDHAM L. REV. 569 (1998).

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

ture individual's sovereign autonomy in deciding how to communicate with others."[25] Other commentators advance the opposite view, that "the First Amendment applies" only "in limited circumstances within the doctor-patient relationship," because "the state retains the power to regulate the professional conduct of physicians, even when speech may be used to carry the conduct out."[26]

Each of these distinct views is paradoxically present in the Court's most recent pronouncement concerning the regulation of physicians' speech. Given the tidal force of recent pro-life mobilization, that pronouncement came, not surprisingly, in the context of an informed consent statute that applied exclusively to abortion. Plaintiffs in *Planned Parenthood of Southeastern Pennsylvania v. Casey*[27] had challenged under the Due Process Clause and the First Amendment provisions of a Pennsylvania statute requiring a physician before performing an abortion to inform her patient about

> the nature of the procedure, the health risks of the abortion and of childbirth, and the "probable gestational age of the unborn child." The physician or a qualified nonphysician must inform the woman of the availability of printed materials published by the State describing the fetus and providing information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion. An abortion may not be performed unless the woman certifies in writing that she has been informed of the availability of these printed materials and has been provided them if she chooses to view them.[28]

Addressing the question first from the perspective of a Due Process challenge, the plurality in *Casey* held that Pennsylvania could require doctors to provide patients with "truthful, nonmisleading information about the nature of the procedure, the attendant health risks and those of childbirth, and the 'probable gestational age' of the fetus,"[29] because there was "a substantial government interest justifying a requirement

Counseling as Vice Activity: The Free Speech Implications of Rust v. Sullivan *and* Planned Parenthood v. Casey, 95 COLUM. L. REV. 1724 (1995) (discussing the court's treatments of speech and conduct).

25. Paula E. Berg, *Lost in a Doctrinal Wasteland: The Exceptionalism of Doctor-Patient Speech Within the Rehnquist Court's First Amendment Jurisprudence*, 8 HEALTH MATRIX 153, 174 (1998) (quoting David A. J. Richards, *Free Speech and Obscenity Law: Toward a Moral Theory of the First Amendment*, 123 U. PA. L. REV. 45, 62 (1974)).

26. Katharine McCarthy, Conant v. Walters: *A Misapplication of Free Speech Rights in the Doctor-Patient Relationship*, 56 ME. L. REV. 447, 464–65 (2004). For the view that "Courts . . . need to answer some First Amendment questions" in the context of the regulation of "professional-client speech," see Eugene Volokh, *Speech as Conduct: Generally Applicable Laws, Illegal Courses of Conduct, "Situation-Altering Utterances," and the Uncharted Zones,* 90 CORNELL L. REV. 1277, 1345, 1343 (2005).

27. 505 U.S. 833 (1992).

28. *Id.* at 881.

29. *Id.* at 882. "If the information the State requires to be made available to the woman is truthful and not misleading, the requirement may be permissible." *Id.*

that a woman be apprised of the health risks of abortion and childbirth."[30] The plurality also saw no reason "why the State may not require doctors to inform a woman seeking an abortion of the availability of materials relating to the consequences to the fetus, even when those consequences have no direct relation to her health,"[31] because "informed choice need not be defined in such narrow terms that all considerations of the effect on the fetus are made irrelevant."[32]

It was only after reaching these conclusions that the plurality turned to the plaintiffs' First Amendment arguments.

> All that is left of petitioners' argument is an asserted First Amendment right of a physician not to provide information about the risks of abortion, and childbirth, in a manner mandated by the State. To be sure, the physician's First Amendment rights not to speak are implicated, see *Wooley v. Maynard*, 430 U.S. 705 (1977), but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State, cf. *Whalen v. Roe*, 429 U.S. 589, 603 (1977). We see no constitutional infirmity in the requirement that the physician provide the information mandated by the State here.[33]

The passage is puzzling because *Wooley* is a precedent in which the Court applied strict First Amendment scrutiny to a state statute that compelled ideological speech,[34] whereas *Whalen* upheld a New York statute requiring physicians to disclose prescriptions for certain drugs, holding in the page cited that "[i]t is, of course, well settled that the State has broad police powers in regulating the administration of drugs by the health professions."[35] Exactly how the strict First Amendment standards of *Wooley* are meant to qualify the broad police power discretion of *Whalen* is left entirely obscure.[36]

30. *Id.*

31. *Id.*

32. *Id.* at 883. The plurality added that "we permit a State to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion." *Id.* The plurality stressed, however, that "the statute now before us does not require a physician to comply with the informed consent provisions 'if he or she can demonstrate by a preponderance of the evidence, that he or she reasonably believed that furnishing the information would have resulted in a severely adverse effect on the physical or mental health of the patient.' In this respect, the statute does not prevent the physician from exercising his or her medical judgment." *Id.* at 883–84.

33. *Id.* at 884.

34. Wooley v. Maynard, 430 U.S. 705, 713 (1977).

35. Whalen v. Roe, 429 U.S. 589, 603 n.30 (1977).

36. Daniel Halberstam, in his excellent article, tells us as much as can be deduced from the passage:

> The passage tells us that physicians enjoy First Amendment rights, but provides little guidance about the weight given to the First Amendment interests involved. The application of *Wooley* would demand a compelling governmental interest to overcome the physician's First Amendment rights, or at least a substantial interest that was unrelated to the content of the speech. It would require that the regulation be narrowly tailored to that interest as well. The passage cited from *Whalen*, on the other hand, would appear to import only the basic due process limitations on nonspeech regulations of professionals. To fuse these two models in a shorthand formulation

My objective in this lecture is to throw some light on this obscurity. I shall not attempt to offer a comprehensive account of the constitutional status of professional speech, nor even of physicians' speech, but I shall attempt to elucidate so much of the subject as is necessary to illuminate the constitutional stakes in far-reaching legislation like South Dakota's informed consent statute.

I.

At the outset we should be clear about the forms of speech we are considering. South Dakota's informed consent statute regulates communication between a doctor and a patient that occurs in the course of ongoing medical treatment. It thus regulates what, following Daniel Halberstam, I shall call "professional speech," which, roughly speaking, is "speech . . . uttered in the course of professional practice," as distinct from "speech . . . uttered by a professional."[37]

For constitutional purposes the difference is fundamental. It can be illustrated by recent cases involving controversy over the safety of dental amalgams, which are a mixture of silver and mercury used to fill cavities in teeth. Amalgams apparently emit mercury vapors that can be absorbed by the body.[38] Although "the vast majority of dentists are adamant in insisting that the use of amalgams is completely safe. . . . a very small minority of dentists are equally insistent that the vapors emitted by the amalgams can result in muscular deficiencies, causing the patient to exhibit symptoms similar to muscular dystrophy . . . ."[39] Doctors[40] and dentists[41] have been disciplined for "telling patients their amalgam fillings were toxic and should be replaced,"[42] because such statements fail "to maintain a reasonable standard of competency."[43] They are "inconsistent with the standards adopted by the American Dental Association, and otherwise at odds with the overwhelming weight of scientific evidence," and unnecessarily expose patients to "risk for other dental problems."[44]

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provides little indication of how to resolve any professional's First Amendment claim other than the precise one at issue in *Casey*.

Halberstam, *supra* note 23, at 773–74.

37. *Id*. at 843.

38. Bailey v. Huggins Diagnostic & Rehab. Ctr., Inc., 952 P.2d 768, 769 (Colo. Ct. App. 1997).

39. *Id.* at 770. For a discussion of the controversy, see *Consumer Cause, Inc. v. Smilecare*, 110 Cal. Rptr. 2d 627, 630–33 (Ct. App. 2001).

40. Iowa Bd. of Med. Exam'rs, *In re* V. Thomas Riley, M.D., Final Order of the Bd., Mar. 20, 1998, *quoted in* Op. Iowa Att'y Gen., Opinion No. 02-12-1, 2002 WL 31952794, at *4 (Dec. 10, 2002).

41. Breiner v. State, 23 Conn. L. Rptr. 110 (Super. Ct. 1998) (unpublished opinion); Bd. of Dental Exam'rs v. Hufford, 461 N.W. 2d 194 (Iowa 1990); Iowa Bd. of Dental Exam'rs, *In re* Larry J. Hanus, Findings of Fact, Conclusions of Law, Decision and Order, Sept. 1, 1994, *quoted in* Op. Iowa Att'y Gen., *supra* note 40, at *4.

42. Op. Iowa Att'y Gen., *supra* note 40, at *4.

43. *Id.*

44. *Id.*

Typical is the case of Dr. Mark Breiner, a Connecticut dentist who in 2001 "agreed to stop recommending that his patients replace their amalgam fillings, as part of a consent decree he entered into with the state health department to keep his license."[45] But Breiner's story has an additional twist, one which well illuminates the distinction between professional speech and speech by a professional. Six months after the entry of his consent decree, a small mercury spill in a local high school prompted Breiner to write an editorial in *The Connecticut Post* reaffirming his belief in the danger of amalgam fillings and endorsing proposed federal legislation that would ban them from interstate commerce.[46] The Connecticut Department of Public Health (DPH) believed that the editorial "violated the consent order"[47] and sent Breiner a letter advising him "to refrain from submitting any more editorials concerning your opinion of amalgam fillings and/or legislation regarding such."[48]

Breiner, however, would have none of it. He sued the DPH for violation of his First Amendment rights. The executive director of the Connecticut Civil Liberties Union, which represented Breiner, announced that "[t]he DPH may be able to regulate what a practitioner says in his office or to his patients . . . . But the bottom line is, no public agency is able to ever squelch the First Amendment when dealing with the general public."[49] The DPH backed off, agreeing to alter the consent decree so that nothing in it "shall be construed as prohibiting [Breiner] from communicating to others, including members of the press or private individuals . . . or writing or publishing op-ed pieces or articles, or speaking at a public forum or not-for-profit educational seminar about his opinions relating to amalgam fillings."[50] But the modified consent decree still bars Breiner "from recommending that patients have amalgam fillings removed."[51]

The divide that bifurcates Breiner's new consent decree is exactly the distinction between speech by a professional and professional speech.

45. Lynne Tuohy, *Citing Free Speech, Dentist Sues; Says State Won't Allow Him to Express His Concerns About Amalgam Fillings*, HARTFORD COURANT, Nov. 13, 2003, at A19. The consent decree allowed Breiner to "tell his patients about the possible dangers of the fillings. But according to the decree, he isn't allowed to say that removal of the fillings will make a patient feel better." Avi Salzman, *Dentist Told to Shut His Mouth. Really.*, N.Y. TIMES, Nov. 16, 2003, at 14CN. "The decree also makes new patients in Dr. Breiner's office sign a sheet that contains opinions from other health professionals on the safety of amalgam fillings." *Id.* The decree also required Breiner "to pay a $5,000 civil penalty, to agree to his license being placed on probation for five years and to hire a professional monitor to observe him performing several dental procedures and evaluate his skill in doing so." Tuohy, *supra.*

46. Lynne Tuohy, *Dentist Can Criticize Fillings with Mercury*, HARTFORD COURANT, July 14, 2005, at B1 (referencing Mercury in Dental Filling Disclosure and Prohibition Act, H.R. 1680, 108th Cong. (2003)).

47. Michael P. Mayko, *Dentist Pained by State Cutting His Right to Talk*, CONN. POST, Nov. 13, 2003.

48. Salzman, *supra* note 45.

49. Mayko, *supra* note 47 (quoting Teresea Younger).

50. Tuohy, *supra* note 46.

51. *Id.*

When a physician speaks to the public, his opinions cannot be censored and suppressed, even if they are at odds with preponderant opinion within the medical establishment. But when a physician speaks to a patient in the course of medical treatment, his opinions are normally regulated on the theory that they are inseparable from the practice of medicine.[52] Even so feisty a character as Breiner is reported to have acknowledged after his legal victory, "I do not have free speech within the confines of my office."[53]

The difference between professional speech and speech by a professional is constitutionally profound. The contrast is illustrated by *Bailey v. Huggins Diagnostic & Rehabilitation Center, Inc.*,[54] which approves a plaintiff's malpractice action against a dentist for recommending the removal of amalgams in the course of dental treatment even as it invalidates a plaintiff's action for negligent misrepresentation against a dentist who recommended removal of amalgams to "the general public"[55] in a book and TV interview. The Court reasons that even though the dentist's public remarks might have caused the plaintiff to undergo medically inappropriate treatment and so might have caused foreseeable harm,

> The expression of opinions upon matters of public concern is the core value protected by the First Amendment. To subject authors of such opinions to the risk of multiple claims for personal injuries, at least in those instances, as here, in which the opinions do not address or impugn any specific individual, based solely upon the majoritarian view that the opinion is "false," would impose an intolerable burden upon the author of such opinions. And, the imposition of such a burden would have a ruinous and unjustifiable chilling effect upon free speech. *See Gertz v. Robert Welch, Inc.*, 418 U.S. 323 (1974).[56]

Bailey seems plainly correct. When persons address the public about matters of public concern, we say that the "the First Amendment recognizes no such thing as a 'false idea.'"[57] We say that "[d]iscrimination against speech because of its message is presumed to be unconstitutional,"[58] and that "viewpoint discrimination . . . is presumed

52. Although professional speech is sometimes confused with commercial speech, *see, e.g.*, Op. Iowa Att'y Gen., *supra* note 40, at *6–8, the distinct and intermediate position of commercial speech is well illustrated by the modified Breiner consent decree, which provides that "Breiner may state his views in advertisements for his practice, but the consent decree mandates that he add the caveat that his opinions 'are not shared by traditional dentists and physicians, the Connecticut Department of Public Health, the Connecticut State Dental Commission or the American Dental Association, all of whom have concluded that there is insufficient scientific evidence to establish that the removal of amalgam fillings cures and/or alleviates symptoms of any disease or condition.'" Tuohy, *supra* note 46.

53. Tuohy, *supra* note 46.

54. 952 P.2d 768 (Colo. Ct. App. 1997).

55. *Id.* at 772.

56. *Id.* at 773.

57. Hustler Magazine, Inc. v. Falwell, 485 U.S. 46, 51 (1988) (quoting Gertz v. Robert Welch, Inc., 418 U.S. 323, 339 (1974)).

58. Rosenberger v. Rector & Visitors of Univ. of Va., 515 U.S. 819, 828 (1995).

impermissible."[59] We do this in order to encourage public dialogue and discussion, so that we can promote that "robust exchange of ideas which discovers truth 'out of a multitude of tongues, [rather] than through any kind of authoritative selection.'"[60] It is precisely through public discussion, provoked in part by professionals like Breiner, that we hope eventually to reach firm and justifiable agreement about the safety of amalgams. But in the context of medical practice we insist upon competence, not debate, and so we subject professional speech to an entirely different regulatory regime. We closely monitor the messages conveyed by professional speech, and we sanction viewpoints that are false when measured by the "knowledge . . . ordinarily possessed and exercised by physicians in good standing."[61]

We are thus brought face to face with the central puzzle addressed by this lecture: so long as our society believes that the state ought to have broad discretion to regulate the practice of medicine to ensure the safety and health of patients, in what sense can professional speech claim the protection of the First Amendment? The practice of medicine, like all human behavior, transpires through the medium of speech. In regulating the practice, therefore, the state must necessarily also regulate professional speech. Without so much as a nod to the First Amendment, doctors are routinely held liable for malpractice for speaking[62] or for failing to speak.[63] Doctors commit malpractice for failing to inform patients in a

59. *Id.* at 830.

60. Keyishian v. Bd. of Regents, 385 U.S. 589, 603 (1967) (quoting United States v. Associated Press, 52 F. Supp. 362, 372 (S.D.N.Y. 1943)).

61. Larsen v. Yelle, 246 N.W.2d 841, 844 (Minn. 1976).

62. *See, e.g.*, Shea v. Bd. of Med. Exam'rs, 146 Cal. Rptr. 653, 661 (Ct. App. 1978) (citations omitted). In *Shea*, the court held that:

> The Legislature has the power to enact laws, within constitutional limits, to protect the safety, health, morals, and general welfare of society. It has the right to require that those licensed to practice medicine be of good moral character, reliable, trustworthy, and not given to deception of the public or to the practice of imposing upon credulous or ignorant persons. The constitutional protection accorded to speech applies here only insofar as the speech used does not impair the patient-physician relationship. Dr. Shea's conduct violated the trust reposed in him by his patients. Those patients were not prepared for what occurred while Dr. Shea believed them hypnotized; they were repulsed by the language used and the subject matter covered. Under such circumstances, the challenged speech is outside the ambit of constitutional protection, and the argument that a finding of Dr. Shea's unprofessional conduct will have a "chilling effect upon the right to freedom of speech and the right to practice medicine" is completely unfounded.

Id. at 661.

63. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), where the court stated:

> The cases demonstrate that the physician is under an obligation to communicate specific information to the patient when the exigencies of reasonable care call for it. Due care may require a physician perceiving symptoms of bodily abnormality to alert the patient to the condition. It may call upon the physician confronting an ailment which does not respond to his ministrations to inform the patient thereof. It may command the physician to instruct the patient as to any limitations to be presently observed for his own welfare, and as to any precautionary therapy he should seek in the future. It may oblige the physician to advise the patient of the need for or desirability of any alternative treatment promising greater benefit than that being pursued. Just as plainly, due care normally demands that the physician warn the patient of any risks to his well-being which contemplated therapy may involve.

Id. at 781 (citations omitted); *see also* Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 340 (Cal. 1976) ("When a therapist determines, or pursuant to the standards of his profession should determine,

timely way of an accurate diagnosis,[64] for failing to give patients proper instructions,[65] for failing to ask patients necessary questions,[66] or for failing to refer a patient to an appropriate specialist.[67] In all these contexts the regulation of professional speech is theoretically and practically inseparable from the regulation of medicine.

Traditional First Amendment values would seem to carry very little force in the context of professional speech. We would be puzzled by a physician who sought to preserve his constitutionally protected "'individual freedom of mind'"[68] by refusing to provide his patients necessary and accurate diagnoses, citing for his justification *Wooley's* conclusion that "the right of freedom 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."[69] Professional speech appears to leave little room for the "mature individual's sovereign autonomy in deciding how to communicate with others."[70]

Nor do basic First Amendment commitments to the marketplace of ideas seem to carry much purchase in the context of professional speech. Although physicians can, without censorship, provoke general debate by voicing misleading opinions, we routinely sanction doctors who deviate from professional standards in the course of their professional speech because we believe that in professional practice the safety and health of patients ought to trump the long-run benefits of debate.

The question, then, is whether First Amendment concerns are at all relevant to the South Dakota informed consent statute, which purports to regulate only the professional speech of physicians. In the remainder of this lecture I shall consider two alternative arguments for the applicability of First Amendment values. The first, the "Ideological Speech" argument, concerns the boundary between professional speech and ideological speech. I discuss the Ideological Speech argument in Part II. The second, the "Professional Knowledge" argument, concerns the First

that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."); Skillings v. Allen, 173 N.W. 663, 664 (Minn. 1919) ("The state board of health is charged with the duty of prescribing regulations for the disinfection and quarantine of persons and places as an incident in the treatment of all infectious diseases, and physicians are required to report all infectious cases to their local boards of health."); Jackson v. Okla. Mem'l Hosp., 909 P.2d 765, 774 (Okla. 1995) ("A physician should not leave a patient at a critical stage without giving reasonable notice or making suitable arrangements for the attendance of another equally competent substitute.").

64. *See* Smith v. Walker, 708 So. 2d 797, 803–04 (La. Ct. App. 1998).

65. Malone v. Louisiana, 569 So. 2d 1098 (La. Ct. App. 1990).

66. Axelrad v. Jackson, 142 S.W.3d 418 (Tex. App. 2004).

67. Morgan v. Engles, 127 N.W.2d 382, 383 (Mich. 1964).

68. Wooley v. Maynard, 430 U.S. 705, 714 (1977) (quoting W. Va. State Bd. of Educ. v. Barnette, 319 U.S. 624, 637 (1943)).

69. *Id.*

70. Berg, *supra* note 25, at 174 (quoting Richards, *supra* note 25, at 16).

Amendment values created by physicians' speech that seeks to secure the informed consent of patients. I discuss the Professional Knowledge argument in Part III. I conclude the lecture by briefly considering the constitutional stakes raised by First Amendment restrictions on informed consent legislation regulating the disclosure of professional knowledge.

II.

Our definition of professional speech is undoubtedly incomplete. Not all speech uttered by doctors during the course of practicing medicine qualifies as professional speech. If a physician while examining a patient should stumble, twist his ankle, and spontaneously curse, his exclamations would not constitute professional speech. They would be best characterized as personal utterances intruding into the space of professional speech. The same would be true if a surgeon were to utter a prayer before operating. If state control over professional speech depends upon state power to regulate the practice of medicine, the constitutional category of professional speech extends only so far as the practice of medicine. Physician speech, even physician speech in the presence of a client during the course of medical practice, is not professional speech if it forms no part of the practice of medicine.

The First Amendment may apply differently to state regulation of professional speech than to state regulation of physicians' speech that does not form part of the practice of medicine. This conclusion should merely restate common sense. A state statute requiring physicians to praise George Bush to their patients during the course of medical examinations would apply to the speech of physicians in the course of their professional practice. But it would not constitutionally be categorized as regulating professional speech, because it would compel speech that is not understood as included within the practice of medicine. No doubt the statute would easily be struck down as violating *Wooley*'s prohibition against compelled speech.[71]

The implications of this conclusion are significant. State regulations of medicine are ordinarily subject merely to rational basis review, which means that the state can exercise political control over the practice of medicine in ways that are for all practical purposes beyond judicial su-

71. Constitutional analysis of this example should actually proceed in two distinct steps: (1) the required speech is not professional, and (2) the required speech is ideological. Strictly speaking, *Wooley* would apply only to speech that meets both criteria. It is possible for legislation to require speech that meets criterion (1) but not criterion (2). For example, a Michigan statute might mandate that doctors endorse American-made automobiles. If requiring such speech were to be held unconstitutional, it would not be because of the considerations advanced in *Wooley*, but rather because of the principles implicit in a decision like *United States v. United Foods, Inc.*, 533 U.S. 405 (2001), which concern compelled commercial speech. I am grateful to Geoff Stone for this clarification. For my own views on the principles of *United Foods*, see Robert Post, *Transparent and Efficient Markets: Compelled Commercial Speech and Coerced Commercial Association in* United Foods, Zauderer*, and* Abood, 40 VAL. U. L. REV. 555 (2006).

pervision.[72] Courts do not confine state regulation to what judges consider to be the legitimate practice of medicine. But the hypothetical statute we have just analyzed illustrates that a different issue is presented when the state seeks to regulate the *speech* of physicians. This is because the constitutional protections accorded to professional speech differ from the constitutional protections accorded to other forms of speech,[73] and the category of professional speech can be determined only by reference to the legitimate practice of medicine. Whether the object of statutory regulation is professional speech, or some other form of more highly protected speech, is a question of constitutional law that must be independently determined by a court.[74]

We may thus ask whether subsections (b), (c), and (d) of the South Dakota informed consent statute compel professional speech or whether they compel a different and more constitutionally protected form of speech.[75] These subsections provide that under pain of criminal sanction physicians must inform their patients in writing:

> (b) That the abortion will terminate the life of a whole, separate, unique, living human being;
>
> (c) That the pregnant woman has an existing relationship with that unborn human being and that the relationship enjoys protection under the United States Constitution and under the laws of South Dakota;
>
> (d) That by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated;[76]

It is clear from the explicit language and structure of the statute that physicians must endorse the substance of these disclosures. The statute itself announces that its central purpose is to ensure that "great care" be "taken to provide a woman seeking to terminate the life of her unborn

72. *See* Barsky v. Bd. of Regents, 347 U.S. 442, 449 (1954) ("It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power. The state's discretion in that field extends naturally to the regulation of all professions concerned with health."); England v. La. State Bd. of Med. Exam'rs, 263 F.2d 661, 663 (5th Cir. 1959) (noting that in evaluating state action with respect to health and welfare, courts must decide "whether state action is so arbitrary and unreasonable as to be unconstitutional").

73. *See, e.g.*, *supra* note 71.

74. Connick v. Myers, 461 U.S. 138, 148 n.7 (1983) ("The inquiry into the protected status of speech is one of law, not fact."); Llano v. Berglund, 282 F.3d 1031, 1036 (8th Cir. 2002) (noting that characterization of speech as about a matter of public concern "is a question of law for the court to decide"); Herceg v. Hustler Magazine, Inc., 814 F.2d 1017, 1021 (5th Cir. 1987) (finding that the court must decide whether the speech in question falls into an unprotected category and may not "accept the jury's mixed finding of fact and law").

75. "[I]nformed-consent provisions may . . . violate the First Amendment rights of the physician if the State requires him or her to communicate its ideology." Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416, 472 n.16 (1983) (O'Connor, J., dissenting) (citing Wooley v. Maynard, 430 U.S. 705 (1977)).

76. S.D. CODIFIED LAWS § 34-23A-10.1.

child and her own constitutionally protected interest in her relationship with her child with complete and accurate information and adequate time to understand and consider that information in order to make a fully informed and voluntary consent to the termination of either or both."[77] Because the statute mandates the disclosure of the "accurate information" specified in subsections (b), (c), and (d) in the interests of ensuring a fully informed and voluntary consent, physician disagreement with this information would necessarily sow confusion and produce a consent that is, from the perspective of the statute, less than fully informed and voluntary. Moreover the statute requires that physicians certify in writing that they believe their patients understand the "information" conveyed by these sections,[78] and it is hard to understand how physicians can comply with this requirement if they express disagreement with the "information" disclosed.[79]

If we consider first subsection (b), we must ask whether compelling a physician to inform a patient that a medical procedure "will terminate the life of a whole, separate, unique, living human being" forms part of legitimate medical practice.[80] The statute defines "human being" "as an individual living member of the species of Homo sapiens, including the unborn human being during the entire embryonic and fetal ages from fertilization to full gestation."[81] Defined in this way, the requirement that a physician inform a woman seeking an abortion that the procedure will terminate the life of a "human being" seems trivially true. But defined in this way it is also unclear why the disclosure is necessary for informed consent, which in its standard formulation does not require the disclosure of a risk that "is either known to the patient or is so obvious as to justify presumption of such knowledge."[82] It hardly seems plausible that a woman could be confused about whether she is carrying the biological fetus of a zebra, a raccoon, or a bat.

If it is obvious that a fetus is a "human being" in the sense that it is a biological entity that belongs to the species Homo sapiens, it is not at all obvious that the fetus is a "human being" in a second and distinct sense, which is whether the fetus is a member of the community of human per-

77. *Id.* § 34-23A-1.4.

78. *Id.* § 34-23A-10.1(g).

79. In the district court case enjoining the South Dakota statute, the court noted that "[i]f a doctor disassociates himself or herself from the materials or disagrees with the materials while reviewing the materials with the patient, the doctor may have a difficult time certifying that the patient understands the materials." Planned Parenthood Minn. v. Rounds, 375 F. Supp. 2d 881, 887 (D.S.D. 2005); *see* Planned Parenthood Minn. v. Rounds, 467 F.3d. 716, 725 (8th Cir. 2006).

80. S.D. CODIFIED LAWS § 34-23A-1.

81. *Id.*

82. Sard v. Hardy, 379 A.2d 1014, 1022 (Md. 1977); *see* Canterbury v. Spence, 464 F.2d 772, 788 (D.C. Cir. 1972) ("[T]here is no obligation to communicate those [dangers] of which persons of average sophistication are aware."); Crain v. Allison, 443 A.2d 558, 562 (D.C. 1982); Mroczkowski v. Straub Clinic & Hosp., Inc., 732 P.2d 1255, 1258 (Haw. Ct. App. 1987); Crowman v. Hornada, 329 N.W.2d 422, 426 (Iowa 1983); Harnish v. Children's Hosp. Med. Ctr., 439 N.E.2d 240, 243 (Mass. 1982).

sons whose life possesses dignity and warrants respect. It is this second sense of the term "human being" that is controversial in the context of abortion.[83] It is commonly said that "the fundamental issue in settling the morality of abortion is whether a fetus is a person[,] is a human being."[84]

The abortion controversy presently turns on a debate whether the fetus enjoys the moral status of "a human person who is not yet a baby but still a fully human person,"[85] or instead whether "there is a vast moral gulf between a fetus and a child."[86] The arguments are so familiar that they enjoy formulaic status: "The liberal asks, 'What has a zygote got that is valuable?' and the conservative answers, 'Nothing, but it's a human being, so it is wrong to abort it.' Then the conservative asks, 'What does a fetus lack that an infant has that is so valuable?' and the liberal answers, 'Nothing, but it's a fetus, not a human being, so it's all right to abort it.'"[87]

"Most opposition to abortion relies on the premise that the fetus is a human being, a person, from the moment of conception."[88] Sophisti-

83. The statute thus plays on an ambiguity that has long been central to the abortion controversy.

> The central argument against abortion may be put like this:
> • It is wrong to kill an innocent human being.
> • A human foetus is an innocent human being.
> • Therefore it is wrong to kill a human foetus. . . .
> To describe a being as "human" is to use a term that straddles two distinct notions: membership of the species *Homo sapiens*, and being a person, in the sense of a rational or self-conscious being. If "human" is taken as equivalent to "person", the second premise of the argument, which asserts that the foetus is a human being, is clearly false; for one cannot plausibly argue that a foetus is either rational or self-conscious. If, on the other hand, "human" is taken to mean no more than "member of the species *Homo sapiens*", then it needs to be shown why mere membership of a given biological species should be a sufficient basis for a right to life.

Peter Singer, *Abortion*, *in* THE OXFORD COMPANION TO PHILOSOPHY 2–3 (Ted Honderich ed., 1995).

84. Norman C. Gillespie, *Abortion and Human Rights*, 87 ETHICS 237, 237 (1977). "The dispute about abortion . . . becomes a dispute about whether a foetus is a human being . . . ." Singer, *supra* note 83, at 2.

85. Francis J. Beckwith, *Taking Abortion Seriously: A Philosophical Critique of the New Anti-Abortion Rhetorical Shift*, 17 ETHICS & MED. 155, 159 (2001).

86. Thomas Nagel, Letter, N.Y. REV. BOOKS, Oct. 5, 2006, at 57.

87. Roger Wertheimer, *Understanding the Abortion Argument*, 1 PHIL. & PUB. AFF. 67, 85 (1971).

88. Judith Jarvis Thomson, *A Defense of Abortion*, 1 PHIL. & PUB. AFF. 47, 47 (1971); *see, e.g.*, CATECHISM OF THE CATHOLIC CHURCH § 2270 (2d ed. 2000), *available at* http://www.scborromeo.org/ccc/p3s2c2a5.htm#III ("Human life must be respected and protected absolutely from the moment of conception. From the first moment of his existence, a human being must be recognized as having the rights of a person—among which is the inviolable right of every innocent being to life."); Ellie Lee, *Reinventing Abortion as a Social Problem: 'Postabortion Syndrome' in the United States and Britain*, *in* HOW CLAIMS SPREAD: CROSS-NATIONAL DIFFUSION OF SOCIAL PROBLEMS 39, 40 (Joel Best ed., 2001); David C. Reardon, *A Defense of the Neglected Rhetorical Strategy*, 18 ETHICS & MED. 23, 23 (2002) ("[T]he traditional pro-life strategy . . . center[s] on the moral argument against the unjust killing of innocent humans [sic] beings."); Abort 73.com, Medical Testimony, http://abort73.com/HTML/I-A-1-medical.html (last visited Feb. 6, 2007) ("As surprising as this may be to some people, there is no debate within the medical community as to when life begins. Life begins at conception. Therefore, every 'succesful' [sic] abortion ends the life of a living human being . . . ."); Abortion Makes a Mockery of The Bible, http://www.123helpme.com/view.asp?id=16901 (last visited Feb. 6, 2007) ("'Abortion is not merely the removal of some tissue from a woman's body. . . . Abortion is the destruction of an un-

cated opponents of abortion recognize that this premise involves moral, not merely biological, reasoning:

> Since its genesis in the mid-1960s, the movement against abortion rights . . . has made its case in the public square as well as the courts by emphasizing the humanity of the fetus. Its leaders . . . have maintained that if the fetus is a member of the human community, then all the moral obligations and rights that apply to other members of the human community apply to the fetus as well. In order to establish the first half of this conditional premise, pro-lifers have made a case for the fetus's humanity, arguing that the insights of science *combined with philosophical reflection* lead inexorably to the conclusion that the fetus is a human person.[89]

Because advocates for the rights of the unborn understand full well that the controversy over whether the fetus is a "human being" turns on a normative meaning of the term, pro-life Web sites offer explicit instructions on useful forms of argument for countering the pro-choice belief that "[t]he fetus is not a human being!"[90] The construction of "the Fetus as a Human Person" is in fact a recognized and studied goal of the "social movement rhetoric" of those who oppose abortion.[91]

Whether the fetus is a "human being" is thus understood by all sides to the abortion controversy to be an essentially contested moral proposition. For South Dakota to require a physician to "inform" his patient that she will be terminating the life of a "human being" is consequently not innocent. It deliberately and provocatively incorporates the language of ideological controversy and forces physicians to affirm the side of those who oppose abortion.[92] Far from mandating professional

born baby.' . . . According to John C. Willke, president of the National Right to Life Committee, 'At the union of sperm and ovum there exists a living, single-celled, complete human being.' Therefore, according to what John C. Willke says, abortion at ANY stage of pregnancy is the immoral taking of human life and should be illegal." (citation omitted)); ProLife Alliance, Key Issues: Abortion, http://www.prolife.org.uk/about/keyabortion.htm (last visited Apr. 27, 2006) ("It is scientifically established that from the moment of conception when a single-cell embryo is created, a new human being or organism exists. To terminate the life of this individual is fundamentally unjust and discriminatory.").

89. Beckwith, *supra* note 85, at 155 (emphasis added).

90. American Life League, *Countering Pro-Abortion Arguments 4*, http://www.all.org/article.php?id=10232 (last visited Mar. 4, 2007); *see* Peter Saunders, *Deadly Questions—on Abortion*, NUCLEUS, Jan. 1998, at 31, *available at* http://www.ethicsforschools.org/abortion/deadly1.htm; Olivia Gans & Mary Spaulding Balch, Nat'l Right to Life Comm., *"When They Say . . . , You Say . . ."*, http://www.nrlc.org/abortion/facts/responseargument1.html (last visited Feb. 6, 2007) (offering advice on how to counter the argument "that the unborn child is not a human being, from the moment of fertilization").

91. Nick Hopkins & Steve Reicher, *Social Movement Rhetoric and the Social Psychology of Collective Action: A Case Study of Anti-Abortion Mobilization*, 50 HUM. REL. 261, 261, 273 (1997).

92. At the same time the South Dakota Legislature passed its informed consent law, it also created the South Dakota Task Force to Study Abortion. H.B. 1233, 2005 Leg., 80th Sess. (S.D. 2005). In passing its prohibition on abortion, H.B. 1215, 2006 Leg., 81st Sess. § 2 (S.D. 2006) (repealed 2006), the South Dakota Legislature explicitly provided that it "accepts and concurs with the conclusion of the South Dakota Task Force to Study Abortion," and the Legislature made findings based upon the conclusions of the Task Force. *Id.* § 1. The *Task Force Report* made findings about the need for informed consent. It explicitly stated:

speech, it would, in particular cases, appear to compel a physician to proclaim "adherence to an ideological point of view he finds unacceptable,"[93] and in that way to justify rigorous and almost certainly fatal First Amendment scrutiny.[94]

It was no doubt in anticipation of this conclusion that the South Dakota statute explicitly defined "human being" in purely scientific, nonideological terms, as "an individual living member of the species of Homo sapiens, including the unborn human being during the entire embryonic and fetal ages from fertilization to full gestation."[95] But constitutional liability cannot be so easily escaped. If South Dakota were to enact a statute requiring physicians to inform abortion patients that they were destroying the "soul" of their unborn progeny, and if it were explicitly to provide in the statute that "soul" is defined as "human DNA," the evasion would be obvious. For purposes of determining the constitutionality of a compelled disclosure, the meaning of the disclosure must be ascertained in light of how it would be understood by a reasonable person, not in terms of how a state legislature might arbitrarily stipulate its meaning.[96]

> Dr. Ball [a doctor who performs abortions at the facility of Planned Parenthood of South Dakota] was asked what she would tell a woman who asked her "Is this a human life?" or "At what point in the process does human life begin?" or similar questions. Dr. Ball testified that she would refuse to answer these questions. When pressed on this point, Dr. Ball stated that it is a subjective matter for the woman to decide, and an answer from her is nothing but her subjective personal opinion.
>
> Thus, a woman who goes to Planned Parenthood in Sioux Falls is not given scientific and factual information necessary for her to understand that the procedure will terminate the life of a human being, *even when the woman asks precisely if the abortion is killing their baby*.

REPORT OF THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION 17 (2005), *available at* http://www.dakotavoice.com/Docs/South%20Dakota%20Abortion%20Task%20Force%20Report.pdf [hereinafter TASK FORCE REPORT] (emphasis added). This suggests that the language of "human being" mandated by the South Dakota informed consent statute is designed to provide an answer to the ideological question of whether abortion kills a baby.

93. Wooley v. Maynard, 430 U.S. 705, 715 (1977).

94. "The Supreme Court has consistently invalidated schemes which compel ideological speech." Eubanks v. Schmidt, 126 F. Supp. 2d 451, 458 (W.D. Ky. 2000).

95. S.D. CODIFIED LAWS § 34-23A-1(4).

96. *Cf.* Planned Parenthood Minn. v. Rounds, 467 F.3d 716, 723 (8th Cir. 2006). The opinion of the panel of the Eight Circuit that upheld the district court seemed to hold both that "the district court" was not "bound by the legislature's definition of human being" because "our task is to evaluate the message South Dakota would actually compel doctors to give in the disclosures," *id.*, and that the question of whether an abortion terminates the life of a "whole, separate, unique, living human being" is "a matter of objective science," so that South Dakota should be given "the opportunity to try to establish that its terminology is supported by a firm medical consensus due to new scientific and technological developments." *Id.* at 724. This seems fundamentally confused. If South Dakota has in fact required doctors to inform patients that they are killing a member of the human community who otherwise deserves life—and no other interpretation of the disclosure would seem possible in light of the statute's purpose and legislative history, as well as in light of the audience to whom the disclosure is directed—then South Dakota has required doctors to affirm an ideological position and the findings of "objective science" are accordingly immaterial. Although the opinion of the Eighth Circuit panel referred to the possibility of further "legislative factfinding," *id.* at 723, this possibility is irrelevant because the constitutional infirmity of the statutory disclosure does not inhere in its falsity. It inheres in the constitutional prohibition against state conscription of persons to affirm ideological beliefs, whatever the findings of "objective science."

A reasonable patient, upon being informed that she is terminating the life of a "human being," would not understand her doctor to be informing her that she is ending the life of a biological member of the species Homo sapiens. She would understand her doctor to be informing her that she is ending the life of a member of the human community who otherwise deserves life.[97] Because this is the meaning that the term "human being" carries in debates about abortion, this is the way that the doctor's speech will be received and understood.

This conclusion is confirmed by the findings adopted by the South Dakota Legislature. The Legislature explicitly states that it is enacting the informed consent statute in order to counteract "pressures" that might cause a woman to choose abortion with "undue reliance on the advice of others, clouded judgment, and a willingness to violate conscience."[98] If the disclosure mandated by subsection (b) is meant to bolster the weak conscience of a patient, it is plainly addressed to the moral rather than to the biological meaning of "human being."[99]

97. *See, e.g.*, Peter Kreeft, *Human Personhood Begins at Conception*, 4 J. BIBLICAL ETHICS IN MED. 9, 14, *available at* http://bmei.org/jbem/volume4/num1/kreeft_human_personhood_begins_at_conception.pdf ("[A] 'human being' is *not* a merely biological term because the reality it designates is not a *merely* biological reality, though it is a biological reality. To identify human beings and persons is not biologism; in fact, it is just the opposite: it is the implicit claim that persons, i.e., human beings, have a human biological body and a human spiritual soul; that human souls inhabit human bodies.").

98. H.B. 1166, 2005 Leg., 80th Sess. (S.D. 2006).

99. The *Task Force Report* makes very clear that the mandated disclosure is meant to address the moral meaning of the term "human being":

> [T]he pregnant mother is not told prior to her abortion that the procedure will terminate the life of a human being. The psychological consequences can be devastating when that woman learns, subsequent to the abortion, that this information was withheld—information that would have resulted in her declining to submit to an abortion. Her anger at being deceived and being prevented from making an informed decision for herself is exacerbated by her realization that she was implicated in the killing of her own child in utero. Aside from the injustice of her being deprived of making her own informed decision . . ., the psychological harm of knowing she killed her child is often devastating.

TASK FORCE REPORT, *supra* note 92, at 47. A pregnant woman could hardly be surprised to know that she is carrying the biological fetus of the species Homo sapiens. The point of the disclosure that the fetus is a "human being," therefore, is to convey the new "information" that the fetus is a "human being" that carries the moral status of a "child" whose "killing" would be "devastating." The *Task Force Report* later makes this point explicit:

> It is now clear that the mother's unborn child is a whole human being throughout gestation and that she has an existing relationship with her child.
>
> Our nation was founded both on the proposition that human life is a gift of immeasurable worth and on the precept of equal rights for all human beings. . . .
>
> The fact that the unborn child is a whole separate unique living human being is not without significance for our culture and our state. The right to live does not derive from government. If it is truly, as we know it to be, an intrinsic natural right, it is enjoyed by every single human being, no matter how poor or wealthy, strong or weak, age of maturity, or state of dependence. We find that the unborn child possesses intrinsic rights that are in perfect harmony with and equal to the intrinsic rights of that child's mother.
>
> As for the sovereign state of South Dakota, we recognize that the State has both the right and the unqualified duty to protect every human being and their personal intrinsic rights, including the pregnant mother's natural intrinsic right to her relationship with her child, and the child's intrinsic right to life. These cherished rights are compatible and harmonious, regardless of the unfortunate circumstances that sadly invoke thoughts that she may not be able to avail herself of her great rights.

It seems apparent, then, that subsection (b) does not regulate professional speech, but instead mandates that physicians affirm ideological truths to which they might well object. Precedents like *Wooley* hold that this is constitutionally suspect under the First Amendment. This conclusion is reinforced by subsection (b)'s use of the adjectives "whole, separate, unique" to modify the noun "human being." These adjectives do not even purport to have biological or scientific content.[100] Their meaning comes entirely from the moral debate that surrounds abortion, because they emphasize the status of the fetus as a distinct and independent member of the human community. To the extent that they might be given medical meaning, they would seem obviously false. From a biological perspective, a nonviable fetus is neither "whole" nor "separate," because it cannot survive outside its relationship with its mother.[101]

A similar analysis would apply to subsections (c) and (d) of the informed consent statute, which require a physician to inform "the pregnant woman" that she "has an existing relationship with that unborn human being and that the relationship enjoys protection under the United States Constitution and under the laws of South Dakota," and that "by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated."[102]

> It is the law, as it represents the collective interests of the individuals for whom the law exists, that must protect life. Long ago, our law protected life and the mother's beautiful interest in her child's life. It protected innocent children over the misguided philosophies and trends in social thought, which come and go.
>
> If there are any self-evident and universal truths that can act for the human race as a guide or light in which social and human justice can be grounded, they are these: that life has intrinsic value; that each individual human being is unique and irreplaceable; that the cherished role of a mother and her relationship with her child, at every moment of life, has intrinsic worth and beauty; that the intrinsic beauty of womanhood is inseparable from the beauty of motherhood; and that this relationship, in its unselfish nature, and, in its role in the survival of the human race, is the touchstone and core of all civilized society. This relationship, its beauty, its survival, its benefits to the mother and child, and its benefits to the State of South Dakota, and society as a whole, all rest in the self-evident truth that a mother is not the owner of her child's life, she is the trustee of it.

Id. at 67.

100. "[B]iological occurrences are processes rather than events. Nature rarely, if ever, presents definitive transitions from one state to another." Ronald M. Green, *Determining Moral Status*, 2 AM. J. BIOETHICS 20, 20 (2002).

101. Although it has been said that a fetus is "whole" because its genetic material is fully formed, Patrick Lee, *A Christian Philosopher's View of Recent Directions in the Abortion Debate*, 10 CHRISTIAN BIOETHICS 7, 9 (2004), this view is not a biological one, and, from a scientific perspective, it is plainly false. Discarded human cells contain complete and "whole" genetic material, yet they plainly do not comprise a "whole . . . human being," if by that is meant a whole "individual living member of the species of Homo sapiens." For a fascinating discussion of the scientific evidence bearing on the unique biological status of the fetus, see Paul Copland & Grant Gillett, *The Bioethical Structure of a Human Being*, 20 J. APPLIED PHIL. 123 (2003).

102. S.D. CODIFIED LAWS § 34-23A-10.1(c)–(d) (2006). The nature of the "existing relationship" to which subsections (c) and (d) refer is entirely unclear. It is most likely that the concept originates with Harold J. Cassidy, a New Jersey antiabortion activist lawyer who was present and influential during the drafting of the South Dakota statue. *See* Siegel, *supra* note 19, at 1025 n.139. Cassidy, an Associate Counsel with the Thomas More Law Center, Press Release by Harold Cassidy, Thomas More Law Center, South Dakota House Passes Bill Criminalizing Abortions; Challenge to Roe v. Wade (Feb. 11, 2004), *available at* http://www.thomasmore.org/news.html?NewsID=172, was also promi-

These subsections do not even purport to concern medical facts or risks. They instead compel physicians to reaffirm the fetus's status as a "human being," an affirmation that we have seen constitutes compelled ideological speech in the context of subsection (b). By stressing the patient's "relationship" to the "human being" that is the fetus, these sections emphasize the moral rather than biological dimensions of the fetus's humanity,[103] and they thus force physicians to become even more entangled in antiabortion moral ideology.[104]

III.

On its face, subsection (e) of the South Dakota Informed Consent Statute does not seem to compel ideological speech. It mandates that physicians provide their patients in writing with:

> (e) A description of all known medical risks of the procedure and statistically significant risk factors to which the pregnant woman would be subjected, including:
>
> (i) Depression and related psychological distress;
>
> (ii) Increased risk of suicide ideation and suicide;
>
> (iii) A statement setting forth an accurate rate of deaths due to abortions, including all deaths in which the abortion procedure was a substantial contributing factor;

nently involved in South Dakota's passage of a 2004 bill banning abortion, which contained language referring to the "pregnant mother's fundamental interest in her relationship with her unborn child." *See supra* note 11; *Editorial Letters, Futile Legislation*, ARGUS LEADER (Sioux Falls, S.D.), Feb. 23, 2004, at 5B. In 2002 Cassidy had pressed a claim in the Third Circuit that New Jersey violated the Constitution by allowing doctors regularly to perform abortions with "inadequate consent," meaning that New Jersey did not require doctors to inform "the pregnant woman that 'her child is already in existence,' that her fetus is a 'complete, separate . . . unique' human being; and that her child, if eight weeks or older, may feel pain." Marie v. McGreevey, 314 F.3d 136, 142–43 (3d Cir. 2002). Underlying the claim was the idea that "the parent/child relationship is protected by strict scrutiny under the Equal Protection Clause." *Id*. at 141 n.4. The Third Circuit rejected the argument. *Id*. Cassidy pressed similar claims in *Acuna v. Turkish*, 808 A.2d 149, 151 (N.J. Super. Ct. App. Div. 2002). The *Task Force Report* offers a virtually identical explanation of "the already existing relationship the mother has with her child." TASK FORCE REPORT, *supra* note 92, at 35–36 & n.14.

103. "Informed consent disclosures about the existence of the child are key because they not only establish the right of the pregnant mother in her relationship with her child, but also her right to protect the child's welfare." TASK FORCE REPORT, *supra* note 92, at 36. "The Task Force . . . finds that the deliberate avoidance of a candid understandable disclosure that the child already exists and that the procedure will terminate the child's life, precludes an informed decision with regard to the woman's right to a relationship with her child and right to protect her child's life." *Id.* at 39; *see also supra* note 99.

104. I put aside the vagueness questions sharply posed by these sections because of the obscurity of the "relationship" to which they refer. The vagueness questions are especially troubling because the statute requires physicians to certify that they believe that their patients "understand[] the information imparted." I also put aside the point that these sections require physicians to affirm facts about the U.S. Constitution that are arguably false. *See supra* note 102.

> (iv) All other known medical risks to the physical health of the woman, including the risk of infection, hemorrhage, danger to subsequent pregnancies, and infertility . . . .[105]

Subsection (e) seems merely to require the disclosure of facts relating to the secular consequences of a medical intervention.[106] Because such disclosure is commonly understood to be included within "a physician's overall obligation to the patient"[107] and hence to form a necessary dimension of the legitimate practice of medicine, subsection (e) appears to compel only professional speech. I shall, in the remainder of this Part, analyze subsection (e) on the assumption that it does in fact regulate only professional speech.

Professional medical speech is continuously regulated without seeming to run afoul of First Amendment constraints. Doctors are sanctioned for engaging in certain communicative acts and they are compelled to engage in others.[108] The question that I shall consider in this Part is whether the extreme ways in which the South Dakota statute instrumentalizes informed consent doctrine to serve the antiabortion agenda exposes First Amendment limitations on the regulation of professional speech that have not heretofore been apparent.

I shall focus my inquiry on the disclosures mandated by subsections (e)(i) and (e)(ii) of the statute, which require physicians to inform their patients that "depression and related psychological distress" and "increased risk of suicide ideation and suicide" are "statistically *significant* risk factors to which" they will be vulnerable should they choose to have an abortion. I focus on these sections of the statute because it is very likely that they require physicians to disclose information that is false.[109]

105. S.D. CODIFIED LAWS § 34-23A-10.1(e).

106. I should note that although there are many state statutes that specifically address the issue of informed consent for abortion, subsection (e) is unique because it specifies the particular information that doctors must convey to their patients. A number of informed consent statutes delegate to the professional judgment of the physician the question of the "medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, and breast cancer, and the danger to subsequent pregnancies and infertility." MISS. CODE ANN. § 41-41-33(1)(a)(ii) (West 2006); *see also* MONT. CODE ANN. § 50-20-104(5)(a)(i) (2007); NEB. REV. STAT. § 28-327(1)(a) (2007); N.D. CENT. CODE § 14-02.1-02(5)(a)(2) (2007). Several states give even broader discretion to professional judgment. For example, Maine's statute requires that the physician inform the woman of "[t]he particular risks associated with her own pregnancy and the abortion technique to be performed," "in a manner that in the physician's professional judgment is not misleading and that will be understood by the patient." ME. REV. STAT. ANN. tit. 22, § 1599-A(2) (2005); *see also* ALASKA ADMIN. CODE tit. 12, § 40.070 (2007); ARK. CODE ANN. § 20-16-903 (West 2006); CONN. AGENCIES REGS. § 19a-116-1(c) (2006); DEL. CODE ANN. tit. 18, § 6852(b) (2007); IND. CODE ANN. § 16-34-2-1.1 (West 2007); MINN. STAT. ANN. § 145.412(4) (West 2007); NEV. REV. STAT. ANN. § 442.253 (West 2007); OH. REV. CODE ANN. § 2317.56 (West 2007); VA. CODE ANN. § 18.2-76 (West 2007).

107. Canterbury v. Spence, 464 F.2d 772, 782 (D.C. Cir. 1972).

108. *See supra* notes 62–67.

109. Of course, if the disclosures required by subsections (e)(i) and (e)(ii) are false, these subsections of the statute would presently violate the Due Process Clause because *Casey* holds that it is an undue burden on the abortion right to mandate the disclosure of information that is not "truthful and not misleading." *See supra* note 29. In this lecture, however, I am concerned with the constraints of

The state of the evidence is nicely summarized in a recent report prepared at the direction of U.S. Representative Henry A. Waxman:

> Pro-life advocates assert the existence of a condition called "Post-Abortion Syndrome," characterized as severe long-term emotional harm caused by abortion, and claim that this condition occurs frequently. Neither the American Psychological Association nor the American Psychiatric Association recognizes this syndrome, however. In fact, there is considerable scientific consensus that having an abortion rarely causes significant psychological harm. An expert panel of the American Psychological Association convened to "review the best scientific studies of abortion outcome" found:
>
> > The best studies available on psychological responses to unwanted pregnancy terminated by abortion in the United States suggest that severe negative reactions are rare, and they parallel those following other normal life stresses. Despite methodological shortcomings of individual studies, the fact that studies using diverse samples, different measures of postabortion response, and different times of assessment come to very similar conclusions is persuasive evidence that abortion is usually psychologically benign.
>
> Other studies have reached similar results. A subsequent analysis based on a longitudinal study of women one hour before, one hour after, one month after, and two years after abortion found: "Reports support prior conclusions that severe psychological distress after an abortion is rare." A study based on data from the National Longitudinal Survey of Youth, with respondents initially aged 14 to 21, found: "Although women may experience some distress immediately after having an abortion, the experience has no independent effect on their psychological well-being over time." Similarly, a review of multiple studies of teens and abortion reported: "data do not suggest that legal minors are at heightened risk of serious adverse psychological responses compared with adult abortion patients or with peers who have not undergone abortion." Yet another longitudinal study followed 13,000 women in Britain over a period of eleven years and found that women who continued the pregnancy and gave birth experienced the same rate of need for psychological treatment as women who had abortions.[110]

the First Amendment, not with those of the Due Process Clause. The constraints of the First Amendment will presumably remain intact, even if the Roberts Court eventually decides to overrule *Casey*. I also do not analyze subsections (e)(iii) and (e)(iv) of the statute because it is too early to know the exact content of the disclosures that they will require. Much will depend upon how these subsections are interpreted and applied. If the "findings" of the *Task Force Report* are any indication, these subsections of the Act are likely to be applied in ways that are also false. *See* TASK FORCE REPORT, *supra* note 92, at 48–52.

110. MINORITY STAFF, SPECIAL INVESTIGATIONS DIV., COMM. ON GOV'T REFORM, FALSE AND MISLEADING HEALTH INFORMATION PROVIDED BY FEDERALLY FUNDED PREGNANCY RESOURCE CENTERS (2006) [hereinafter WAXMAN REPORT] (citations omitted), *available at* http://www.democrats.reform.house.gov/Documents/20060717101140-30092.pdf. I should note that the independ-

A major recent study found that

> [t]he percent of women experiencing clinical depression within 2 years after abortion (20%) equals the rate of depression nationally among all women 15 to 35 years of age (20%). Mental health did not decline postabortion. The rate of PSTD [posttraumatic stress syndrome] associated with abortion (1%) was substantially lower than the rate of PSTD in the general population of women in this age group (10.75%) and than the rate following traumas such as childhood physical abuse (48.5%) or rape (46%). Most women were satisfied with their decision, believed they had benefited more than had been harmed by their abortion, and would have the abortion again. These findings refute claims that women typically regret an abortion.[111]

ent variable assessed in the study summarized by the *Waxman Report* as having following 13,000 women in Britain was not in fact the rate of need for psychological treatment, but instead the rate of receiving a psychiatric diagnosis. The study was one of very few to compare women who had abortions with women who had continued an unintended pregnancy. This is significant because many studies do not control for whether a pregnancy is unintended or unwanted, and the fact of a pregnancy being unintended or unwanted may account for some of the outcomes that advocates of postabortion syndrome attribute to abortion. Finally, the study found that women who had no previous history of psychosis or psychiatric illness were significantly less likely to have a psychotic episode if they had an abortion than if they delivered. *See* Anne C. Gilchrist et al., *Termination of Pregnancy and Psychiatric Morbidity*, 167 BRITISH J. PSYCHIATRY 243 (1995).

The *Waxman Report* also found:

> Despite the scientific evidence that abortion does not cause significant long-term psychological harm, thirteen pregnancy resource centers told callers the exact opposite, asserting that having an abortion would cause a wide range of damaging and long-lasting psychological impacts.
>
> According to one center, "the rate of suicide in the year following an abortion goes up by seven times."
>
> . . . .
>
> The pregnancy resource centers indicated that these emotional effects are extremely common, telling the caller: over 75% of women experience mild to severe post-abortion stress syndrome; "[j]ust about over 90% of women have some type of emotional or psychological effects of abortion"; post-abortion syndrome and other problems happen to everyone "in varying degrees"; and the "majority" of women who choose abortion have post abortion syndrome in "various degrees." The center that asserted that suicide rates increase seven times following an abortion also said that "60–70% of women have emotional complications from an abortion."
>
> The idea that abortion is likely to lead to long-term psychological harm was also present on many of the centers' websites. For example, the following descriptions appeared on these websites:
>
> - **"What is Post Abortion Syndrome?** Nine out of every ten women who have undergone an abortion suffer deep seated anxiety and regret called post-abortion syndrome. Sometimes it appears many years later." [Quoting Women's Care Center, *Facts You Should Know About Abortion*, http://www.womenscarecenter.org/faq_abortion.html (last visited Mar. 4, 2007).]
> - "**Psychological/Emotional Trauma:** 50% of post-abortive women report experiencing emotional and psychological disturbances lasting for months or years. This includes acute feeling of grief, depression, anger, fear of disclosure, preoccupation with babies or getting pregnant again, nightmares, sexual dysfunction, termination of relationships, emotional coldness, increased alcohol and drug abuse, eating disorders, anxiety, flashbacks, anniversary syndrome, repeat abortions, and suicide." [Quoting A Woman's Concern Pregnancy Resource Clinic, *Considering Abortion?*, http://www.awomansconcern.com/considering_abortion.htm (last visited Mar. 4, 2007).]

WAXMAN REPORT, *supra*, at 12–14. The Pregnancy Resource Centers discussed in the *Waxman Report* receive millions of dollars in federal funding. *Id.* at i.

111. Brenda Major et al., *Psychological Responses of Women After First-Trimester Abortion*, 57 ARCHIVES GEN. PSYCHIATRY 777, 780–81 (2000); *see* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND

To understand why South Dakota might wish to compel physicians to affirm false information to their patients, it is necessary to recall that in the late 1980s antiabortion advocates began to realize that the political future of the movement was limited so long as the public had "the impression that arguments on behalf of the unborn child's right to life trump all concerns for the woman."[112] They concluded "that antiabortionists will only be successful in stopping abortion when we truly become both pro-woman and pro-life."[113] They began to adopt a "pro-woman" stance by arguing that abortion was harmful to women. In the words of David Reardon, a major proponent of this new rhetorical strategy,

> Christians rightly anticipate . . . that any advantage gained through violation of the moral law is always temporary; it will invariably be supplanted by alienation and suffering. This insight gives us an alternative way of evangelizing. Whenever we cannot convince others to acknowledge a moral truth for the love of God, our second-best option is to appeal to their self-interest. If an act is indeed against God's moral law, it will be found to be injurious to our happiness. Thus, if our faith is true, we would expect to find compelling evidence which demonstrates that such acts as abortion, fornication,

STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV) (4th ed. 1994) (not recognizing postabortion syndrome); ELLIE LEE, ABORTION, MOTHERHOOD, AND MENTAL HEALTH: MEDICALIZING REPRODUCTION IN THE UNITED STATES AND GREAT BRITAIN 120 (2003) (discussing government and professional organizations that refute claims of a "post abortion syndrome"); Gilchrist et al., *supra* note 110, at 243 ("Rates of total reported psychiatric disorder were no higher after termination of pregnancy than after childbirth."); Nancy F. Russo & Jean E. Denious, *Violence in the Lives of Women Having Abortions: Implications for Practice and Public Policy*, 32 PROF. PSYCHOL. 142, 142 (2001) ("When history of abuse, partner characteristics, and background variables were controlled, abortion was not related to poorer mental health."); Carolyn Westhoff et al., *Quality of Life Following Early Medical or Surgical Abortion*, 67 CONTRACEPTION 41 (2003); Alexi A. Wright & Ingrid T. Katz, *Roe versus Reality—Abortion and Women's Health*, 355 NEW ENG. J. MED. 1, 3 (2006). Articles finding contrary conclusions generally suffer from obvious methodological problems. For example, studies by Reardon et al. have been severely critiqued for miscoding data or failing to control for critical variables. *Compare* Sarah Schmiege & Nancy Felipe Russo, *Depression and Unwanted First Pregnancy: Longitudinal Cohort Study*, 331 BRIT. MED. J. 1303 (2005) (showing that Reardon and Cougle's study of postabortion syndrome used miscoded data, and that when data was properly coded and analyzed, abortion was not related to depression risk), *and* British Medical Journal, Rapid Responses, http://bmj.bmjjournals.com/cgi/eletters/331/7528/1303 (presenting a debate between Schmiege and Russo and Coleman, Reardon, and others), *with* David C. Reardon et al., *Psychiatric Admissions of Low-Income Women Following Abortion and Childbirth*, 168 CAN. MED. ASS'N J. 1253 (2003), *and* David C. Reardon & Jesse R. Cougle, *Depression and Unintended Pregnancy in the National Longitudinal Survey of Youth: A Cohort Study*, 324 BRIT. MED. J. 151 (2002). The nature of David Reardon's scientific involvement in this issue is discussed in detail *infra* notes 112–14, 123, 132–34, 210 and accompanying text. A recent literature review by Bradshaw and Slade concludes that there is some anxiety linked to abortion, but includes studies showing that the stress is so minor that it could not be characterized as severe or clinically significant. Zoë Bradshaw & Pauline Slade, *The Effects of Induced Abortion on Emotional Experiences and Relationships: A Critical Review of the Literature*, 23 CLINICAL PSYCHOL. REV. 929 (2003) (concluding that "[w]omen due to have an abortion are more anxious and distressed than other pregnant women or women whose pregnancy is threatened by miscarriage, but in the long term they do no worse psychologically than women who give birth").

112. Reardon, *supra* note 88, at 24.

113. *Id.*

> and pornography lead, in the end, not to happiness and freedom, but to sorrow and enslavement.[114]

Antiabortion advocates were confident "that the negative health effects of abortion on women were so overwhelming that the evidence would force the reversal of Roe vs. Wade."[115] They pushed the Reagan Administration for official recognition of "a heretofore unrecognized post-abortion stress syndrome, similar to that suffered by some Vietnam veterans after the war," which "can cause major emotional problems for women 5 or 10 years after their abortions, and should be recognized as a significant problem."[116] To their disappointment, even Reagan's staunchly antiabortion Surgeon General C. Everett Koop regarded the effort as "a silly idea touted by one of the neophyte right-wingers on the White House staff," because "[a]bortion was more a moral issue than a medical issue."[117]

Koop tactfully reported that "the available scientific evidence . . . cannot support either the preconceived beliefs of those pro-life or of those pro-choice."[118] For this agnostic conclusion he was promptly hammered by the medical establishment:

> "The data are not only good, they are great," said Dr. David A. Grimes, a professor of obstetrics and gynecology at the University of Southern California and a former member of the Federal Centers for Disease Control. "We know more today about the safety of abortion than any other operation in the world. To say differently is to ignore hundreds of studies done over the years, including many conducted by the Government itself."[119]

The *Journal of the American Medical Association* responded to the controversy by publishing an article about postabortion syndrome that famously began: "This is . . . about a medical syndrome that does not exist."[120] The article continued: "Our patients look to us, their physicians, to provide sound scientific information to help them make informed decisions about health issues. The allegation that legal abortions, performed under safe medical conditions, cause severe and lasting psycho-

114. *Id.* at 29. Reardon writes that "I . . . argue that because abortion is evil, we can expect, and can even know, that it will harm those who participate in it. Nothing good comes from evil." *Id.* at 26.

115. Warren E. Leary, *Koop Says Abortion Report Couldn't Survive Challenge*, N.Y. TIMES, Mar. 17, 1989, at A12 (quoting Surgeon General C. Everett Koop).

116. *Id.* President Reagan, "persuaded by right-to-life supporters that it would help efforts to overturn *Roe v. Wade*," ordered Surgeon General C. Everett Koop to study the health effects of abortion. Constance Holden, *Koop Finds Abortion Evidence "Inconclusive,"* 243 SCI. 730, 730 (1989). "White House advisers had concluded that it would be impossible to muster an anti-abortion consensus on moral grounds, so they decided to follow the model supplied by the antismoking campaign and develop a case on public health grounds." *Id.*; *see also* Wilmoth, *supra* note 5, at 2.

117. C. EVERETT KOOP, THE MEMOIRS OF AMERICA'S FAMILY DOCTOR 274 (1991).

118. Holden, *supra* note 116, at 730. Koop also testified to Congress "that, from a public health perspective, the psychological risks following abortion were 'minuscule.'" Wilmoth, *supra* note 5, at 3.

119. Warren E. Leary, *Koop Challenged on Abortion Data*, N.Y. TIMES, Jan. 15, 1989, at 1; *see* Michael Specter, *Psychiatric Panel Condemns Abortions Restrictions: APA Annual Meeting Told Limits on Right to Choose Do More Harm Than Procedure Itself*, WASH. POST, May 16, 1990, at A3.

120. Stotland, *supra* note 13, at 2078.

logical damage is not borne out by the facts."[121] Those pressing the case for postabortion syndrome, the article concluded, could refer only to a "small number of papers and books based on anecdotal evidence and stressing negative effects" that "have been presented and published under religious auspices and in the nonspecialty literature."[122]

South Dakota's requirement that physicians inform their patients that abortion creates a "significant" risk of "depression and related psychological distress" and of "suicide ideation and suicide" is thus the most recent chapter in a long struggle by antiabortionists to argue, in the face of much scientific evidence to the contrary,[123] that abortion causes dire psychological consequences.[124] The same South Dakota Legislature that enacted the state's informed consent statute also created a Task Force to Study Abortion, and the South Dakota Legislature explicitly adopted the

121. *Id.*; *see also id.* at 2079 ("Significant psychiatric sequelae after abortion are rare, as documented in numerous methodologically sound prospective studies in the United States and in European countries. Comprehensive reviews of this literature have recently been performed and confirm this conclusion. The incidence of diagnosed psychiatric illness and hospitalization is considerably lower following abortion than following childbirth. In one large prospective British population study, psychosis occurred after delivery in an average of 1.7 cases per 1000 and after abortion in 0.3 of 1000."); *id.* ("Scientific studies indicate that legal abortion results in fewer deleterious sequelae for women compared with other possible outcomes of unwanted pregnancy. There is no evidence of an abortion trauma syndrome.").

122. *Id.* at 2079; *see* Amanda Vogt, *Doubt Cast on Trauma in Abortions*, CHI. TRIB., Oct. 23, 1992, at 5:

> Claims that women who undergo legal abortions suffer severe and lasting psychological damage are not supported by scientific evidence, according to a University of Chicago psychiatrist.
>
> As recently as last week's vice presidential debate, Vice President Dan Quayle referred to the hazards of "abortion trauma" as an argument against abortion.
>
> But after an extensive search of the psychiatric and psychological literature, Dr. Nada Stotland concluded that such trauma may be fictional.
>
> "I could not find a single methodologically sound study that supported such a claim," Stotland said. "It's up to us as physicians to provide sound scientific information to patients to help them make informed decisions about health issues."
>
> . . . .
>
> The University of Chicago researcher said she is concerned that value judgments masquerading as scientific truth are being conveyed to patients.

123. *See, e.g.*, Chris Mooney, *Research and Destroy: How the Religious Right Promotes Its Own 'Experts' to Combat Mainstream Science*, WASH. MONTHLY, Oct. 2004, at 36–37 (discussing Reardon's efforts to establish that "women who undergo abortions end up being admitted for psychiatric care more frequently than those who do not"). The former Chair of the South Dakota Task Force has recently written:

> Instead of the two sides (Pro-Life and Pro-Choice) working together to gather and study objective, scientific, factual information regarding abortion and its related issue (which was the assignment laid out in HB 1233), some members of the Task Force gathered only information that fit an extreme Pro-Life view. That subjective, biased information, which was not reflective of all of the information gathered, was then submitted to the Governor and Legislature in the form of the Final Report. That Final Report is unfortunately not based on sound scientific research, as a matter of fact, the same people who wrote the final report also voted down a motion to only accept data that is consistent with current medical science and based on findings obtained through the most rigorous and objective scientific studies. The Final Report contains information that was not discussed or even part of the task force proceedings, in addition to misleading, and in some areas, completely false information.

Marty L. Allison, South Dakota Medicine: My View (July 2006), http://www.sdhealthyfamilies.org/statementma101606.php.

124. For excellent brief histories of this struggle, see Lee, *supra* note 88; Siegel, *supra* note 19, at 1011 n.92.

findings of this Task Force when it chose to prohibit abortion altogether.[125] These findings draw heavily on the "empirical" work of David Reardon and his coauthors.[126] The Task Force concludes that "[w]omen with a history of induced abortion are at a significantly higher risk for . . . inpatient and outpatient psychiatric claims, particularly adjustment disorders, bipolar disorder, depressive psychosis, neurotic depression, and schizophrenia . . . and . . . clinically significant levels of depression, anxiety, and parenting difficulties."[127]

Like Reardon, the Task Force is explicit about the moral foundation of these "findings":

> The Task Force finds that it is simply unrealistic to expect that a pregnant mother is capable of being involved in the termination of the life of her own child without risk of suffering significant psychological trauma and distress. To do so is beyond the normal, natural, and healthy capability of a woman whose natural instincts are to protect and nurture her child.[128]

The Task Force evidently regards "significant psychological trauma and distress" as the necessary consequence of women breaking from their "normal, natural, and healthy . . . instincts to protect and nurture" their children.[129] The essentially moral thrust of this reasoning is illustrated by the Task Force's conclusion that "the abortion procedure is *inherently* dangerous to the psychological and physical health of the pregnant mother."[130]

Medical risks are *contingent*; whether or not they materialize is the result of complex chains of interactive causes. When the Task Force characterizes the psychological and physical harm produced by abortion as inherent, it suggests that this harm is an inevitable consequence of the

125. *See supra* note 92.

126. TASK FORCE REPORT, *supra* note 92, at 41–48. Reardon has coauthored papers with at least three witnesses who appeared before the Task Force: Priscilla Coleman, Vincent Rue, and Martha Shuping. Two other witnesses who appeared before the Task Force, Elizabeth Shadigian and Joel Brind, are leading advocates of the view that women who have abortions are more likely to develop breast cancer. Although numerous studies and a workshop of over one hundred experts conducted by the National Cancer Institute in February 2003 have concluded that the theory has no merit, *see* NAT'L CANCER INST., SUMMARY REPORT: EARLY REPRODUCTIVE EVENTS AND BREAST CANCER WORKSHOP (Mar. 25, 2003), http://www.cancer.gov/cancerinfo/ere-workshop-report; Collaborative Group on Hormonal Factors in Breast Cancer, *Breast Cancer and Abortion: Collaborative Reanalysis of Data from 53 Epidemiological Studies, Including 83,000 Women with Breast Cancer from 16 Countries*, 363 LANCET 1007 (2004), the Task Force nevertheless concluded that "[t]he question concerning whether abortion causes an increased risk for breast cancer cannot be answered by this Task Force based on the record. However, the subject is of vital importance and the reasons to suspect such a connection sufficiently sound. We conclude that further study of this topic is justified and needed." TASK FORCE REPORT, *supra* note 92, at 52.

127. TASK FORCE REPORT, *supra* note 92, at 42–43. The Task Force also specifically found that Posttraumatic Stress Disorder and "suicidal ideation" were negative effects of abortion. *Id.*

128. *Id.* at 47. "The pro-life side believes the consequences are the inevitable result of the trauma produced by a woman murdering her unborn child." Wilmoth, *supra* note 5, at 6.

129. On the implications of this reasoning for Equal Protection analysis, see Siegel, *supra* note 19, at 1037–38.

130. TASK FORCE REPORT, *supra* note 92, at 66 (emphasis added).

immoral nature of abortion, which the Task Force characterizes as requiring a "mother to implicate herself in the killing of her own child."[131] The adjective "inherent" thus indicates that the Task Force was not concerned with findings of contingent scientific fact, but instead with normative reasoning about the implacable operation of a natural moral law.[132]

Particularly when read in conjunction with the overtly ideological disclosures required by subsections (b), (c), and (d), subsections (e)(i) and (e)(ii) of the South Dakota statute are most naturally interpreted as requiring physicians to disclose to patients harms that refer to the "alienation and suffering"[133] necessarily caused by violations of moral law.[134] On this reading, of course, these sections do not compel professional speech, for they require physicians to convey to patients "value judgments masquerading as scientific truth."[135] Because it is no part of the legitimate practice of medicine for doctors to instruct their patients on the sanctions of natural moral law, subsections (e)(i) and (e)(ii) would on this interpretation mandate ideological speech. They would be constitutionally suspect in the same manner as are subsections (b), (c), and (d).

My present question, however, is not the boundary between professional and ideological speech, but instead whether there are First Amendment constraints on the regulation of professional speech. I shall therefore proceed on the assumption that subsections (e)(i) and (e)(ii) merely require the disclosure of secular *medical* risks of a kind that the legitimate practice of medicine ordinarily requires to be disclosed. It may seem odd to ask whether First Amendment restrictions apply to mandated disclosures of this kind because, as we have seen, states routinely and without constitutional constraint require doctors to disclose such information. To explain why the First Amendment might bear any

131. *Id.* at 56. Abortion "expects far too much of the mother. It is so far outside the normal conduct of a mother to implicate herself in the killing of her own child." *Id.*

132. Thus David Reardon writes:

> God has created a connection between a mother and her children that is so deeply personal and intimate that the welfare of each is dependent on the other. . . . This is why, from a natural law perspective, we can know in advance that abortion is inherently harmful to women. It is simply impossible to rip a child from the womb of a mother without tearing out a part of the woman herself—a part of her heart, a part of her joy, a part of her maternity.

DAVID C. REARDON, MAKING ABORTION RARE: A HEALING STRATEGY FOR A DIVIDED NATION 4–5 (1996).

133. *Supra* note 114 and accompanying text.

134. In the words of David Reardon:

> [W]e must remember that the interests of a mother and her child are permanently intertwined. This means that the morality of abortion is built right into the psychological effects of abortion. Everyone knows that there is no psychological trauma associated with the discarding of menses. But the discarding of an unborn child's life? *That*, as Dr. Fogel reminds us, is inherently traumatic.
>
> Therefore, when we are talking about the psychological complications of abortion, we are implicitly talking about the physical and behavioral symptoms of a moral problem. By focusing public attention on the symptoms of post-abortion trauma we will inevitably draw the middle majority back to an understanding of the causes of the problem: the injustice of killing unborn children and the guilt of weakness and betrayal which haunts the mother's heart.

REARDON, *supra* note 132, at 10.

135. Vogt, *supra* note 122.

relevance to the disclosures mandated by subsections (e)(i) and (e)(ii), we must first understand the basic purposes of informed consent doctrine.

"[T]he doctrine of informed consent imposes a duty upon a doctor which is completely separate and distinct from his responsibility to skillfully diagnose and treat the patient's ills."[136] The duty is "to make a reasonable explanation and disclosure to [a] patient of the risks and hazards involved in a proposed course of treatment to the end that whatever consent given by the patient to the prescribed treatment may be an informed and intelligent consent."[137] Informed consent doctrine rests on the premise that "[i]t is the prerogative of the patient to choose his treatment," and that "a doctor may not withhold from the patient the knowledge necessary for the exercise of that right."[138] "The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision."[139] It follows that "the duty to inform the patient presupposes another duty namely, that a physician possess the knowledge of a reasonably well-trained and knowledgeable physician practicing under the circumstances."[140]

Jurisdictions are roughly split in defining the scope of a physician's obligation to convey accurate medical information to the patient.[141] Some adopt the "professional standard," under which "'a physician is required to make such disclosure as comports with the prevailing medical standard in the community—that is, the disclosure of those risks that a reasonable physician in the community, of like training, would customarily make in similar circumstances.'"[142] Others adopt the "prudent patient" standard, which "requires disclosure by the physician of all risks which would materially affect the patient's decision to undergo the medical procedure."[143]

Under either standard, physicians are obligated to disclose only those risks "of which the physician should have been aware," which is to

136. Wilkinson v. Vesey, 295 A.2d 607, 620 (R.I. 1972).

137. *Id.* at 622; *see* 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 176 (2006) ("A physician retains a qualified privilege to withhold information on therapeutic grounds if a complete and candid disclosure of possible alternatives and consequences might have a detrimental effect on the physical or psychological well-being of the patient. Also, a physician need not disclose the hazards of treatment if the patient has specifically requested that he not be told. Similarly, a physician's duty to disclose is suspended if an emergency of such gravity and urgency exists that it is impractical to obtain the patient's consent, in which case consent is implied.").

138. Miller v. Kennedy, 522 P.2d 852, 861 (Wash. Ct. App. 1974).

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

140. Cornfeldt v. Tongen, 262 N.W.2d 684, 699 (Minn. 1977) (citation omitted).

141. Crain v. Allison, 443 A.2d 558, 561 (D.C. 1982).

142. Febus v. Barot, 616 A.2d 933, 935 (N.J. Super. Ct. App. Div. 1992) (quoting Largey v. Rothman, 540 A.2d 504, 507 (N.J. 1988)).

143. *Id. See generally Crain*, 443 A.2d at 562 ("The information is material if the reasonable person in what the physician knows or should know to be the patient's position would be likely to attach significance to the risks in deciding to accept or forego the proposed treatment.").

say only those risks that are "recognized within the medical community."[144] "[T]he existence of the risks and alternatives which were present in the particular physical condition would be beyond the knowledge of the layman and would have to be established by medical testimony."[145] The doctrine of informed consent compels physician speech only insofar as the content of that speech is consistent with the knowledge of "the medical community."[146]

Subsections (e)(i) and (e)(ii) of the South Dakota informed consent statute, which require physicians to inform patients that "depression and related psychological distress" and "increased risk of suicide ideation and suicide" are "statistically significant risk factors" of abortion, are unique in this regard, because they seem to mandate disclosures that *contradict*

144. *Febus*, 616 A.2d at 936. "Thus expert testimony ordinarily will be required, to identify, among other things, the risks of the therapy, the frequency of their occurrence, the consequence of leaving existing maladies untreated, the existence of emergencies, and proximate cause." Cowman v. Hornaday, 329 N.W.2d 422, 426 (Iowa 1983). Courts adopting the prudent patient standard "recognize the necessity, in the usual case, of medical evidence to identify the known risks of treatment, the nature of available alternatives and the cause of any injury or disability suffered by the plaintiff." Woolley v. Henderson, 418 A.2d 1123, 1130 (Me. 1980); *see Cornfeldt*, 262 N.W.2d at 702; Wilkinson v. Vesey, 295 A.2d 676, 688 (R.I. 1972). David Reardon has argued that patients in the context of abortion should be informed of any risk that *they* consider relevant, even if the risk has no basis in medical knowledge. P. K. Coleman, D. C. Reardon, M. B. Lee, *Women's Preferences for Information and Complication Seriousness Ratings Related to Elective Medical Procedures*, 32 J. MED. ETHICS 435, 437 (2006) ("Doctors should anticipate that most women desire information on every potential risk, even risks that doctors may judge to be less serious or inconsequentially rare, and they will generally consider this information to be relevant to their decisions regarding elective procedures."). *Compare* K.A.C. v. Benson, 527 N.W.2d 553, 561 (Minn. 1995), *with* Sard v. Hardy, 379 A.2d 1014, 1023 (Md. 1977). Reardon contends that women view the risk of psychological trauma as especially relevant in the context of abortion. Harold Cassidy, *see supra* note 102, has made the distinct and more far-reaching argument that women seeking an abortion have a right to be informed by their physicians that "the life of an existing family member will be terminated" if patients consider this characterization of the procedure psychologically relevant. Acuna v. Turkish, 894 A.2d 1208, 1214 (N.J. Super. Ct. App. Div. 2006).

145. Miller v. Kennedy, 522 P.2d 852, 861 (Wash. Ct. App. 1974); *see* Korman v. Mallin, 858 P.2d 1145, 1149 (Alaska 1993). The *Korman* court observed that:

> Under the reasonable patient rule, a physician must disclose those risks which are "material" to a reasonable patient's decision concerning treatment. "The determination of materiality is a two-step process. The first step is to define the existence and nature of the risk and the likelihood of its occurrence. 'Some' expert testimony is necessary to establish this aspect of materiality because only a physician or other qualified expert is capable of judging what risk exists and the likelihood of its occurrence. The second prong of the materiality test is for the trier of fact to decide whether the probability of that type of harm is a risk which a reasonable patient would consider in deciding on treatment. The focus is on whether a reasonable person in the patient's position would attach significance to the specific risk. This determination does not require expert testimony."

Id. (quoting Hondroulis v. Schuhmacher, 553 So. 2d 398, 412 (La. 1989)).

146. *See* 3 J. D. LEE & BARRY LINDAHL, MODERN TORT LAW: LIABILITY AND LITIGATION § 25:46 (2d ed. 2006) ("Expert testimony may be necessary under the lay standard, at least to establish the existence of a risk, its likelihood of occurrence, and the type of harm in question; after that, however, expert evidence may not be required."); *see also* Jamison v. Kilgore, 903 So. 2d 45, 50 (Miss. 2005) ("[W]here a plaintiff charges that a doctor performed a procedure without first obtaining informed consent, the plaintiff's first task is to establish what are known risks of the procedure. This requires an expert opinion.").

the knowledge of the "medical community."[147] They mandate that these warnings be extended to all abortion patients, not merely to those discrete subgroups of patients who might scientifically be demonstrated to be at actual risk for dire psychological consequences.[148] The sections thus conscript the speech of physicians in order to communicate propositions that, from the perspective of the medical profession, are false.[149]

It seems clear that subsections (e)(i) and (e)(ii) are inconsistent with the basic purpose of informed consent doctrine, which is to provide patients with accurate medical information so as intelligently to select a medical course of treatment. But the question before us is whether these sections are unconstitutional under the First Amendment, not whether they are wise policy. If the disclosures required by subsections (e)(i) and (e)(ii) are false, South Dakota can have no legitimate interest in mandating them, and they are unconstitutional because irrational. The difficulty, however, is that in the context of an ordinary informed consent statute—although not in the context of an informed consent statute that specifically regulates abortion[150]—state regulation is scrutinized under the same rational basis standard that applies to all regulations of medi-

147. I am no medical expert, and I cannot pretend definitively to assess the relevant evidence and studies. For purposes of elucidating relevant First Amendment principles, however, I shall *assume* that subsections (e)(i) and (e)(ii) require disclosures that deviate from accepted expert medical knowledge. The obligatory form of subsections (e)(i) and (e)(ii) is most unusual, *see supra* note 106, and in particular the South Dakota statute should be contrasted to the Wisconsin informed consent statute, which requires that physicians inform abortion patients about "[t]he medical risks associated with the particular abortion procedure that would be used, including the risks of . . . psychological trauma . . . ." WIS. STAT. § 253.10(3)(c)(1)(f) (2006). The statute has been explicitly interpreted to require a physician to use her "best medical judgment based on the physician's training and experience" to determine "the exact nature or content" of information about the risk of psychological trauma that should be disclosed. Karlin v. Foust, 188 F.3d 446, 473 (7th Cir. 1999). "This means that if a physician believes that no psychological trauma is associated with the abortion procedure to be used, that is what the statute requires him or her to tell the patient. The legislature did not specify the exact details of the risks to be discussed." *Id.* at 472 (quoting Karlin v. Foust, 975 F. Supp. 1177, 1227 (W.D. Wis. 1997)); *see also* Reprod. Health Servs. of Planned Parenthood of the St. Louis Region v. Nixon, 185 S.W.3d 685, 690–91 (Mo. 2006) (Missouri informed consent statute places "no further duty upon Missouri physicians than was already imposed at common law. . . . In particular, a physician's duty to warn of 'psychological' or 'situational' risk factors cannot extend beyond the physician's actual expertise. For purposes of criminal or license liability under this statute, a physician has a duty to warn about only those factors that he or she knows may affect the patient's medical condition. There is no meaningful difference between the clinical and medical judgment language utilized in [the statute] and the traditional duty of a physician 'to use that degree of skill and learning ordinarily used under the same or similar circumstances by the members of defendant's profession.'").

148. For intimations about the possible identity of such subgroups, see, for example, Major et al., *supra* note 111, at 781–82 ("As in prior research, preabortion mental health emerged as the best predictor of postabortion mental health and feelings about an abortion. Women with a prior history of depression may be predisposed to subsequent depression and regret, regardless of whether or not they have an unintended pregnancy and how they choose to resolve that pregnancy.").

149. It is not implausible, for example, that in jurisdictions outside of South Dakota patients could prevail in malpractice suits against physicians if they chose not to have an abortion based upon physicians' advice that abortion would carry a significant risk of psychological trauma.

150. *See supra* note 109.

cine.[151] This standard is so extremely deferential that proving falsity is exceedingly difficult, if not impossible.

As a practical matter, therefore, courts will find the disclosures required by subsections (e)(i) and (e)(ii) to be false only if the disclosures can be shown to infringe some constitutional right that shifts the level of judicial scrutiny up from rational basis review. When we inquire into the relevance of the First Amendment to informed consent legislation, we are thus effectively asking whether the First Amendment will shift to the state the burden of justifying or defending mandated disclosures.

It is useful to begin our consideration of this issue by noting that informed consent doctrine raises First Amendment questions that are quite distinct from the ordinary regulation of physician speech. When the state imposes liability on physicians for communicative acts like diagnoses, referrals, patient directions, patient interviews, and the like,[152] the regulation of physician speech is integrally connected to the regulation of medical treatment.[153] The question is the quality of medical care that physicians are obligated to provide. This is not the primary question raised by informed consent doctrine, which focuses on the quality of a patient's decision making rather than on the treatment offered by a physician.[154] Informed consent doctrine mandates the communication of medical knowledge to the end that a lay patient can receive the expert information necessary to make an autonomous, intelligent and accurate selection of what medical treatment to receive.[155] Regulation of informed consent thus controls the dissemination of knowledge, rather than the dispensation of medical care.

151. Eady v. Lansford, 92 S.W.3d 57 (Ark. 2002) (finding that rational basis existed for statute requiring that informed consent claim be supported by expert testimony); Clinic for Women, Inc. v. Brizzi, 814 N.E.2d 1042, 1056 (Ind. Ct. App. 2004) ("[T]he speech requirement of the informed consent statute falls within the regulatory ambit of the state's police power and, as such, must satisfy only a rationality or reasonableness review."), *rev'd on other grounds*, 837 N.E.2d 973 (Ind. 2005); Dixon v. Peters, 306 S.E.2d 477 (N.C. Ct. App. 1983) (upholding constitutionality of a statutory objective standard to evaluate informed consent claims because, *inter alia*, the statute was rationally related to the state's goal of responding to medical malpractice costs).

152. *See supra* notes 64–67.

153. *See, e.g.*, Nat'l Ass'n for the Advancement of Psychoanalysis v. California Bd. of Psychology, 228 F.3d 1043, 1054 (9th Cir. 2000).

154. "[T]he doctrine of informed consent focuses upon the reasonableness of a physician's disclosures to the patient, rather than the reasonableness of the physician's treatment of that patient. . . . This duty is completely separate and distinct from the duty to skillfully diagnose and treat a patient's illness." 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 152 (2006).

155. I do not mean to deny that when patients confer with their doctors and receive the advice required by informed consent doctrine, they are not, as a practical matter, heavily dependent upon their physicians and frequently regressed, looking for the guidance of a trustworthy authority. That is in part why the disclosures required by informed consent doctrine form part of the professional speech of the physician, because they are necessarily integrated into the larger dynamics of the physician-patient relationship. The entire doctrine of informed consent seeks to mollify the dependency of this relationship by facilitating the possibility, if not the fact, of patient autonomy. As I argue later, however, the dependency that actually characterizes the physician-patient relationship is one reason for constitutionally safeguarding the professional integrity of informed consent disclosures. *See infra* text accompanying notes 174–84.

Whether this regulation raises a constitutional question depends upon whether physician communication of medical knowledge possesses First Amendment value. We should approach this question cautiously, wary of any theory of First Amendment value that too greatly disturbs existing legal arrangements.[156] It would not be credible to advance an account of First Amendment value that would render ordinary informed consent doctrine constitutionally questionable, so that every malpractice case involving informed consent would suddenly entail large constitutional questions. We should also recognize that in the context of ascertaining the presence of First Amendment value, the distinction between compelling speech and restricting speech is not especially salient. If a particular communicative form possesses First Amendment value, its restriction or compulsion can potentially raise constitutional questions; conversely, if the communicative form does not possess First Amendment value, it can typically be prohibited or mandated without raising constitutional concerns.[157]

How First Amendment value arises is of course a highly contested question. There are many who argue that First Amendment value arises whenever state regulation compromises the individual "autonomy" of a speaker.[158] In the context of subsections (e)(i) and (e)(ii), this autonomy would presumably refer to that of the physician, who may not desire to communicate the information mandated by the statute. I find this view implausible because the individual autonomy of physicians is compromised by informed consent doctrine itself, which imposes mandatory obligations on physician speech. Any physician who has been held liable for failure to obtain the informed consent of his patient could argue that the law impairs his autonomy because it requires him to speak in ways that he would prefer not to. In the context of informed consent doctrine, therefore, locating First Amendment value in the autonomy of the physician-speaker proves far too much.[159]

There are also many who argue that First Amendment value arises whenever the state regulates communication in a way that restricts the "marketplace of ideas." The Court has often announced that "'[i]t is the purpose of the First Amendment to preserve an uninhibited marketplace

156. We might understand this caution as a legal version of Rawls's theory of "reflective equilibrium." JOHN RAWLS, A THEORY OF JUSTICE 20–22, 48–53 (1971); *see also* Richard H. Fallon, Jr., *A Constructivist Coherence Theory of Constitutional Interpretation*, 100 HARV. L. REV. 1189, 1240 (1987) (describing a search for reflective equilibrium among considerations pertinent to constitutional analysis).

157. I discuss these points at length in Robert Post, *Compelled Subsidization of Speech:* Johanns v. Livestock Marketing Association, 2005 SUP. CT. REV. 195, 213–15, 220–24.

158. *See, e.g.*, C. EDWIN BAKER, HUMAN LIBERTY AND FREEDOM OF SPEECH (1989); Martin H. Redish, *The Value of Free Speech*, 130 U. PA. L. REV. 591, 593 (1982).

159. In my view, autonomy theory typically proves too much. For a discussion of the difficulty the Court has encountered in attempting to apply autonomy theory in the context of commercial speech, see Post, *supra* note 71.

of ideas in which truth will ultimately prevail.'"[160] A marketplace of ideas theory of First Amendment value would suggest that subsections (e)(i) and (e)(ii) raise constitutional questions because they compel physicians to affirm a particular truth and do not allow this truth to be contested by a "free trade in ideas."[161] But I find this account of First Amendment value to be equally implausible because the very premise of informed consent doctrine is that the state can compel physicians to communicate accurate and truthful information. The radical skepticism of the marketplace of ideas theory would undermine informed consent doctrine itself, and it thus also proves far too much.

I have argued many times that the single most useful theory of First Amendment value is the concept of democratic self-governance.[162] I shall not repeat those arguments here, but the general idea is that the First Amendment protects the ability of persons to participate in the formation of public opinion, in the hope that this freedom will sustain the democratic legitimacy of our government. The essence of democratic legitimacy lies in the belief that the conduct of government should be responsive to public opinion and that all persons should be free to influence the content of that opinion. At first blush, this theory also does not appear very promising for analyzing subsections (e)(i) and (e)(ii). If we use the term "public discourse" to refer to the speech by which we participate in the formation of public opinion,[163] private, professional communications between doctors and their patients plainly do not count as public discourse.

This ought not to conclude our analysis, however, for there is an important and influential line of cases in which the Court has held that speech which is not itself public discourse, but which disseminates information to the public sphere that is useful for the conduct of public discourse, can receive a "subordinate" form of First Amendment protection.[164] I am referring, of course, to "commercial speech," which paradigmatically consists of commercial advertisements.[165] The First Amendment protects commercial speech insofar as such speech dissemi-

160. Turner Broad. Sys., Inc. v. FCC, 507 U.S. 1301, 1304 (1993) (quoting Red Lion Broad. Co. v. FCC, 395 U.S. 367, 390 (1969)); *see also* McIntyre v. Ohio Elections Comm'n, 514 U.S. 334, 341 (1995); Hustler Magazine, Inc. v. Falwell, 485 U.S. 46, 52, 56 (1988).

161. Abrams v. United States, 250 U.S. 616, 630 (1919) (Holmes, J., dissenting); *see* Robert Kry, *The "Watchman for Truth": Professional Licensing and the First Amendment*, 23 SEATTLE U. L. REV. 885, 967–68, 974–75 (2000).

162. *See, e.g.*, Robert Post, *Reconciling Theory and Doctrine in First Amendment Jurisprudence*, 88 CAL. L. REV. 2353 (2000).

163. *See, e.g.*, Rosenberger v. Univ. of Va., 515 U.S. 819, 831 (1995); *Falwell*, 485 U.S. at 55.

164. Bd. of Trs. v. Fox, 492 U.S. 469, 477 (1989).

165. For a full explication of the reasoning in this and the subsequent two paragraphs, see Robert Post, *The Constitutional Status of Commercial Speech*, 48 UCLA L. REV. 1 (2000).

nates information "indispensable to the formation of intelligent opinions as to how" the economy "ought to be regulated or altered."[166]

Three aspects of commercial speech doctrine are particularly relevant to our analysis of subsections (e)(i) and (e)(ii). First, whereas ordinary First Amendment doctrine preserves the freedom of a speaker to participate in public discourse in the manner of her choosing, commercial speech doctrine focuses instead on preserving the flow of commercial information to the public. "[T]he extension of First Amendment protection to commercial speech is justified principally by the value to consumers of the information such speech provides . . . ."[167] "[T]he First Amendment goes beyond protection of . . . the self-expression of individuals to prohibit government from limiting the stock of information from which members of the public may draw. A commercial advertisement is constitutionally protected not so much because it pertains to the seller's business as because it furthers the societal interest in the 'free flow of commercial information.'"[168]

Second, because the object of commercial speech doctrine is to insure the flow of information necessary for an educated public opinion, commercial speech does not possess constitutional value if it is "misleading."[169] First Amendment protection is triggered only by truthful, nonmisleading commercial speech. "'The First Amendment . . . does not prohibit the State from insuring that the stream of commercial information flow[s] cleanly as well as freely.'"[170] Content-based and even viewpoint-based regulations, which are strictly disfavored in the context of public discourse, are thus routinely applied to commercial advertising. Third, because commercial speech doctrine does not protect the autonomy of the commercial speaker, but instead the right of the public to receive information, regulations of commercial speech routinely require commercial speakers to disclose accurate information in the interests of promoting more educated consumers.[171]

166. Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc., 425 U.S. 748, 765 (1976). This decision also offers additional, less convincing explanations for commercial speech doctrine, including notions of market efficiency. *See* Post, *supra* note 165, at 8–11.

167. Zauderer v. Office of Disciplinary Counsel of the Supreme Court of Ohio, 471 U.S. 626, 651 (1985).

168. First Nat'l Bank of Boston v. Bellotti, 435 U.S. 765, 783 (1978) (quoting *Va. State Bd. of Pharmacy*, 425 U.S. at 764).

169. The *Central Hudson* test provides:

> In commercial speech cases, then, a four-part analysis has developed. At the outset, we must determine whether the expression is protected by the First Amendment. For commercial speech to come within that provision, it at least must concern lawful activity and not be misleading. Next, we ask whether the asserted governmental interest is substantial. If both inquiries yield positive answers, we must determine whether the regulation directly advances the governmental interest asserted, and whether it is not more extensive than is necessary to serve that interest.

Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n, 447 U.S. 557, 566 (1980).

170. Edenfield v. Fane, 507 U.S. 761, 768 (1993) (quoting *Va. State Bd. of Pharmacy*, 425 U.S. at 771–72).

171. For a discussion, see Post, *supra* note 71, at 559–63, 584–85.

There is significant precedent, therefore, for the extension of First Amendment value to speech that is not itself public discourse, but that is nevertheless constitutionally understood as communicating information necessary "to enlighten public decisionmaking in a democracy."[172] Because the First Amendment value of such speech is different from that of public discourse, it receives a "subordinate" kind of constitutional protection that is structurally distinct from the protections accorded to public discourse. In recent years these protections have nevertheless proved quite important.[173]

We can now more precisely focus our question about whether subsections (e)(i) and (e)(ii) might raise First Amendment questions, even if these sections are understood to regulate only the professional speech of physicians. The question is whether First Amendment value inheres in communications between physicians and their patients that serve the primary purpose of providing patients with medical information necessary to make informed and intelligent decisions about their choice of medical treatment, because such communications are deemed necessary to inform public decision making. Our inquiry is whether physician-patient communications of this kind possess the same constitutional value as commercial speech, and consequently whether they should receive roughly analogous constitutional protection.

Of course this is not the kind of question that can be answered by looking more closely at the text of the Constitution. The answer will instead depend upon how we as a society choose to regard the practical sociological significance of physician-patient communications. Because questions of constitutional value do not especially turn on the distinction between proscriptions and compulsions, we can test our intuitions in this matter by asking whether we believe that First Amendment concerns would arise if South Dakota were to *prohibit* physicians from communicating truthful, accurate information necessary for intelligent patient decision making.

Take, for example, the question of contraception. Many antiabortion advocates are also opposed to contraception because they believe that it leads to immoral promiscuous sex.[174] One antiabortion Web site, which embraces David Reardon's "empirical" work demonstrating the existence of postabortion syndrome,[175] also asserts that "the reality is that condoms fail one third of the time" and that condoms are ineffective in preventing the transmission of the HIV virus.[176] Suppose antiabortion

172. *Va. State Bd. of Pharmacy*, 425 U.S. at 765.

173. *See, e.g.*, Thompson v. W. States Med. Ctr., 535 U.S. 357 (2002).

174. *See* Siegel, *supra* note 19, at 1004.

175. Abortion*facts*.com, Abortion Information You Can Use, Post Abortion Syndrome, http://www.abortionfacts.com/PAS/PAS.asp (last visited Feb. 6, 2007).

176. Abortion*facts*.com, Abortion Information You Can Use, Condoms—Do They Really Work?, http://www.abortionfacts.com/literature/literature_9593co.asp (last visited Feb. 6, 2007). A report prepared for Rep. Henry A. Waxman, U.S. H.R., COMM. ON GOV'T REFORM—MINORITY

activists caused South Dakota to enact a statute *prohibiting* physicians from communicating to their patients that "Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV," which the medical profession believes to be true.[177] Would such a statute present a First Amendment issue?

It is child's play to imagine analogous examples: Would a First Amendment issue arise if the food industry were to cause the enactment of a statute prohibiting doctors from advising their obese and cardiologically damaged patients that *trans* fats are unhealthy whenever patients seek advice about cholesterol-lowering drugs?[178] What if the chemical industry were to secure legislation prohibiting doctors from informing patients exposed to benzene, in conversations about potential treatment, that the chemical can cause health problems?[179]

I suspect that most would view these hypothetical statutes with constitutional alarm. No doubt the First Amendment would invalidate any statute that sought to prevent doctors from addressing the general public about the effectiveness of condoms, the dangers of *trans* fats, or the risks of benzene. But the question is whether, despite this secure freedom, the hypothetical statutes I have postulated would nevertheless unacceptably choke off an important channel by which reliable medical information is actually communicated to the public.

I suggest that the constitutional consternation aroused by these statutes indicates that we regard private, professional communication between doctors and patients as a significant source of expert, dependable information. This may be because we tend to trust the information we receive in this way, precisely because it is embedded in a physician-patient relationship.[180] We know that when physicians address the general public, they are, like Dr. Mark Breiner, free to express themselves as they wish, without the constraints of ordinary professional responsibility. But when physicians speak to us as our personal doctors, they must assume a fiduciary obligation faithfully and expertly to communicate the considered knowledge of the "medical community."[181] We would therefore be concerned if the state could freely, without First Amendment

STAFF, SPECIAL INVESTIGATIONS DIV., THE CONTENT OF FEDERALLY FUNDED ABSTINENCE-ONLY EDUCATION PROGRAMS 8–12 (2004), *available at* http://oversight.house.gov/Documents/20041201102153-50247.pdf, documents that federally funded abstinence-only educational programs routinely affirm similarly inaccurate facts about condom effectiveness.

177. CTRS. FOR DISEASE CONTROL & PREVENTION, FACT SHEET FOR PUBLIC HEALTH PERSONNEL, MALE LATEX CONDOMS AND SEXUALLY TRANSMITTED DISEASES 3 (2002), *available at* http://www.cdc.gov/nchstp/od/condoms.pdf.

178. The medical profession currently believes the contrary. *See, e.g.*, FDA, Revealing Trans Fats, http://www.fda.gov/fdac/features/2003/503_fats.html (last visited Feb. 6, 2007).

179. *See, e.g.*, Daniel Krewski et al., *Assessing the Health Risks of Benzene: A Report on the Benzene State-of-the-Science Workshop*, 61 J. TOXICOLOGY & ENVTL. HEALTH: PART A, 307 (2000).

180. Halberstam, *supra* note 23, at 772, 844.

181. John A. Balint & Wayne N. Shelton, *Understanding the Dynamics of the Patient-Physician Relationship: Balancing the Fiduciary and Stewardship Roles of Physicians*, 62 AM. J. PSYCHOANALYSIS 337, 338 (2002).

constraint, manipulate the trustworthy information that we were able to receive from our physicians.

This concern does not reflect anxiety only about the quality of our medical care, for we endow the state with virtually unlimited discretion to regulate the nature of that care. It instead reflects our wish to receive knowledge that our doctors can uniquely provide, so that we can decide for ourselves what our medical care ought to be. This knowledge, once received, is pertinent to much more than our personal decisions about receiving medical care. It is relevant to how we think about the provision of medical care generally, including our views about whether and how the medical system ought to be regulated by the government. In this way, information communicated by physicians in private doctor-patient relationships can be become important for enlightened "public decision-making in a democracy."[182]

Certainly the content of physician-patient communications can be as important for the formation of public opinion as the commercial information we receive from the advertisements that presently merit the protection of commercial speech doctrine. It would follow that the same First Amendment value that underlies commercial speech doctrine is also present in professional physician speech designed to convey the knowledge necessary for informed consent.[183] It is desirable for the First Amendment to protect the circulation of accurate information to the public in respect to both kinds of speech.[184]

Subsections (e)(i) and (e)(ii) do not prohibit the circulation of accurate information, but they do *compel* the circulation of misleading information. As we have seen, however, the distinction between compulsion and prohibition does not especially matter when we are considering questions of First Amendment value. If First Amendment concerns arise whenever the state proscribes physician speech in ways that prevent physician-patient relationships from serving as a source of accurate, reliable, professional knowledge, constitutional questions should also arise if the

182. *See* Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc., 425 U.S. 748, 765 (1976).

183. Robert Goldstein has powerfully argued that the First Amendment ought to protect physician speech as part of a more general aspiration to protect all "the different *institutions of knowledge* that have developed in our society." Robert D. Goldstein, *Reading* Casey*: Structuring the Woman's Decisionmaking Process*, 4 WM. & MARY BILL RTS. J. 787, 856 (1996). Goldstein regards the learned professions as institutions that create and disseminate knowledge. *Id.* at 860–74. Also relevant in this context is Jonathan Varat's recent observation that First Amendment value attaches to the integrity of "professional advice that the patient or client has reason to expect," such that the government cannot "misrepresent the real views of the doctor or lawyer and mislead the patient or client." Jonathan D. Varat, *Deception and the First Amendment: A Central, Complex, and Somewhat Curious Relationship*, 53 UCLA L. REV. 1107, 1140 (2006).

184. It is apparently on something like this ground that the Ninth Circuit recently struck down as inconsistent with the First Amendment the federal government's efforts to sanction physicians who recommended, as distinct from prescribed, the use of medical marijuana. Conant v. Walters, 309 F.3d 629 (9th Cir. 2002). The Ninth Circuit, however, protected the physicians' speech as though it were public discourse, and so failed to apply the more "subordinate" forms of protection that are accorded to commercial speech. *Id.* at 636.

state corrupts physician speech by requiring doctors to transmit misleading information in the context of informed consent.[185] "[T]he stream of . . . information"[186] necessary for enlightened decision making in a democracy is equally damaged whether doctors are compelled to contribute misleading information or instead prevented from contributing true information.

If the analogy to commercial speech holds true, First Amendment constraints on the regulation of professional physician speech in the context of communications involving informed consent should display certain predictable characteristics. First, they should focus on the right of the patient to receive information, rather than on the right of the doctor to speak as she wishes.[187] Second, First Amendment protections should be consistent with compelling the professional speech of physicians. Individual doctors should not retain autonomy rights against mandated professional speech. Third, First Amendment protections should not be triggered unless the state prohibits doctors from disclosing accurate, nonmisleading information, or unless the state requires physicians to disclose inaccurate, misleading information. Content-based and even viewpoint-based regulation should thus be perfectly permissible. The state can require doctors to disclose accurate information, and it can equally prohibit doctors from providing misleading information.

This suggests that as a practical matter First Amendment concerns will not be raised by ordinary tort actions involving informed consent, for in such actions physicians are held responsible for disclosing only accurate medical information. First Amendment questions will chiefly arise in the context of *legislation* that mandates physician disclosures, because such legislation carries the implicit danger of conscripting physicians to speak falsehoods in the service of political, rather than medical, purposes. Ordinary tort litigation actually enhances the capacity of the medical profession to serve as a source of reliable and expert knowledge for the formation of public opinion, because it functions to insure that professional physician speech designed to facilitate the informed consent of patients satisfies the expert standards of the "medical community."

Legislation like subsections (e)(i) and (e)(ii), by contrast, endangers the integrity of physician-patient communications because it threatens to transform physicians into mouthpieces for political majorities. From the constitutional point of view, such legislation does not merely compromise the ability of individual members of the public to receive accurate information; it also undermines public trust that professional physician speech will reflect the expertise of the "medical community." It thus strips phy-

185. The question is whether the state "distorts" physician speech "as a medium for information exchange." Goldstein, *supra* note 183 at 866.

186. Va. State Bd. of Pharmacy v. Va. Consumer Council, Inc., 425 U.S. 748, 772 (1976); *see* Edenfield v. Fane, 507 U.S. 761, 768 (1993).

187. Burt Neuborne, *The First Amendment and Government Regulation of Capital Markets*, 55 BROOK. L. REV. 5, 26–27 (1989).

sician-patient communications of their unique authority and dependability, and in this way jeopardizes the capacity of the medical profession to serve as a reservoir of expert knowledge that can reliably be communicated to the public through physician-patient disclosures.

I suspect that the First Amendment value of physician speech that we have identified attaches to doctor communications that transcend the narrow confines of informed consent disclosures. We would most probably be concerned if the state were to prevent doctors from imparting information about condom safety, *trans* fats, or benzene, even if these disclosures did not technically occur within the four corners of a discussion about informed consent. The difficulty, of course, is that the more broadly First Amendment value attaches to physician speech, the more it threatens to restrict the state's ability freely to regulate the provision of medical treatment.

Outside the confined context of informed consent, there is no surgically precise way to distinguish the provision of information from the provision of medical care. Fortunately, this is not an issue we need to face in the context of subsections (e)(i) and (e)(ii), which on their face apply only to communications required for informed consent. It is foreseeable, however, that if First Amendment protection for physician speech expands, very hard cases will arise, such that courts will be forced to make murky, commonsense determinations about whether a statute has the primary purpose or effect of constraining physician-patient communication, or instead of regulating the ongoing practice of medical care.

IV.

The analogy to commercial speech should not be pressed too far. Commercial speech has its own tormented doctrinal history, with far too many confusions and imprecisions.[188] It would be disheartening to see these imported wholesale into the context of professional speech.[189] It is enough to note that certain aspects of professional speech, namely those regulated by informed consent doctrine, implicate the same First Amendment value as that protected by commercial speech doctrine, which is the right of the public to receive accurate information.

At present there is heated debate about the constitutional test that should be applied to compelled commercial speech. Some courts have held that state regulation that compels commercial speech, as distinct from state regulation that prohibits such speech, "tends to [be] less objectionable under the First Amendment."[190] Others believe the reverse, that

188. *See* Post, *supra* note 165.

189. There is a tendency for this to happen. *See, e.g.*, Op. Iowa Att'y Gen, *supra* note 40.

190. Walker v. Bd. of Prof'l Responsibility of the Supreme Court of Tenn., 38 S.W.3d 540, 545 (Tenn. 2001); *see* Zauderer v. Office of Disciplinary Counsel, 471 U.S. 626, 651 n.14 (1985); Bellsouth Adver. & Publ'g Corp. v. Tenn. Regulatory Auth., 79 S.W.3d 506, 519 (Tenn. 2002).

"the relaxed scrutiny of commercial speech" ought to be "inapplicable" "to speech—commercial or otherwise—that is compelled. . . . It is one thing to force someone to close her mouth; it is quite another to force her to become a mouthpiece."[191] The Supreme Court has been deliberately noncommittal on the point.[192] This debate occurs in the context of compelled commercial speech that is assumed to be accurate and nonmisleading.

Whatever the outcome of this debate, it ought not to control constitutional doctrine applied to professional medical speech in the context of informed consent. The history and importance of mandated medical disclosures is so entrenched that it cannot be called into constitutional question. The trigger for First Amendment involvement ought to be, as I have argued, compelled disclosures that are misleading. This lecture is not the place to specify in full detail the constitutional test that should be applied to such disclosures, but I can conclude by sketching, in a general way, the sociological stakes that any such test will have to negotiate.

I can best do so by returning to the subject with which I began in Part I: the contested issue of dental amalgams. There is a small, but intense political controversy surrounding the safety of these dental fillings. There are consumer groups who fiercely oppose dental amalgams. They have Web sites, organize nationwide campaigns, solicit assistance, and push the message that mercury vapors emitted by dental amalgams harm the health of patients.[193] Citing scientific studies and policy decisions by major government agencies, established dental groups defend the safety of amalgams.[194] The American Dental Association has even issued an

191. Mich. Pork Producers Ass'n, Inc. v. Veneman, 348 F.3d 157, 163 (6th Cir. 2003), *vacated sub nom.* Mich. Pork Producers Ass'n, Inc. v. Campaign for Family Farms, 544 U.S. 1058 (2005); *see also* Cochran v. Veneman, 359 F.3d 263, 280 n.15 (3d Cir. 2004) (Rendell, J., concurring), *vacated sub nom.* Lovell v. Cochran, 544 U.S. 1058 (2005); Cal-Almond, Inc. v. U.S. Dep't of Agric., 14 F.3d 429, 436 (9th Cir. 1993). For the "relaxed scrutiny" of the *Central Hudson* test that is applied to restrictions of commercial speech, see *supra* note 169.

192. United States v. United Foods, Inc., 533 U.S. 405, 410 (2001). In 1997, Justice Souter explicitly argued that the same *Central Hudson* test that measured the constitutionality of restrictions on commercial speech should be employed to assess affirmative state requirements that persons engage in commercial speech. Glickman v. Wileman Bros. & Elliott, Inc., 521 U.S. 457, 491–92 (1997) (Souter, J., dissenting). In 2005, however, he seemed to suggest "that Central Hudson scrutiny is not appropriate in a case involving compelled speech rather than restrictions on speech." Johanns v. Livestock Mktg. Ass'n, 544 U.S. 550, 580 n.10 (2005) (Souter, J., dissenting). For my own ruminations on the question, see Post, *supra* note 71.

193. *See, e.g.*, Consumers for Dental Choice, Working to Abolish Mercury Dental Fillings, http://www.toxicteeth.org/about_Us.cfm (last visited Feb. 6, 2007); Mercury Policy Project, http://www.mercurypolicy.org/ (last visited Feb. 6, 2007).

194. *See, e.g.*, FDI WORLD DENTAL FED'N & WORLD HEALTH ORG., WHO CONSENSUS STATEMENT ON DENTAL AMALGAM (1997), *available at* http://www.fdiworldental.org/federation/assets/statements/ENGLISH/Amalgam/Dental_Amalgam.pdf ("The current weight of evidence is that contemporary dental restorative materials, including dental amalgam, are considered to be safe and effective."); FDA, Questions and Answers on Dental Amalgam (Oct. 31, 2006), http://www.fda.gov/cdrh/consumer/amalgams.html ("Since the 1990s, FDA and other government agencies (CDC, NIH) have reviewed the scientific literature looking for links between dental amalgams and health problems. To date, the agencies have found no scientific studies that demonstrate dental amalgams harm children or adults."). For a recent study, see also David C. Bellinger et al., *Neuropsychological and Renal*

advisory opinion to the effect that "removal of amalgam restorations from the non-allergic patient for the alleged purpose of removing toxic substances from the body, when such treatment is performed solely at the recommendation or suggestion of the dentist, is improper and unethical."[195] Mobilized advocates angrily counter that the medical establishment conceals the dangers of amalgams for its own financial benefit and that "amalgam fillings represent nothing more than a con on the U.S. population, orchestrated by the American Dental Association and its web of constituent associations and component societies."[196]

The form of this controversy is analogous to the abortion debates that we have considered. It pits highly motivated lay constituencies against medical professionals. In South Dakota antiabortion advocates bypassed professional self-regulation by seizing the political initiative and enacting legislation. Anti-amalgamists are aspiring to achieve the same result. They have caused Maine,[197] New Hampshire,[198] and Califor-

Effects of Dental Amalgam in Children, 295 JAMA 1775 (2006) ("[T]here were no statistically significant differences in adverse neuropsychological or renal effects observed over the 5-year period in children whose caries were restored using dental amalgam or composite materials.").

195. AM. DENTAL ASS'N, PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT 8 (2005), *available at* http://www.ada.org/prof/prac/law/code/ada_code.pdf; *see* Kids Against Pollution v. Cal. Dental Ass'n, 134 Cal. Rptr. 2d 373, 378–79 (Ct. App. 2003).

196. Am. Dental Ass'n v. Khorrami, No. CV 02-3853 DT(RZX), 2004 WL 3486524, at *1 (C.D. Cal. Aug. 16, 2004).

197. Maine has enacted a statute that provides:

> 1. Display. Beginning July 1, 2002, a dentist who uses mercury or a mercury amalgam in any dental procedure shall display the poster adopted by the Department of Human Services, Bureau of Health under this section in the public waiting area of that dentist's office and must provide each patient with a copy of the brochure adopted by the bureau under this section. The Department of Human Services shall also post on its publicly accessible site on the Internet a copy of the brochure that is suitable for downloading and printing by dentists, patients and other interested parties.
>
> 2. Rules. The Director of the Bureau of Health within the Department of Human Services shall develop a brochure that explains the potential advantages and disadvantages to oral health, overall human health and the environment of using mercury or mercury amalgam in dental procedures. The brochure must describe what alternatives are available to mercury amalgam in various dental procedures and what potential advantages and disadvantages are posed by the use of those alternatives. The brochure may also include other information that contributes to the patient's ability to make an informed decision when choosing between the use of mercury amalgam or an alternative material in a dental procedure, including, but not limited to, information on the durability, cost, aesthetic quality or other characteristics of the mercury amalgam and alternative materials. The director shall also develop a poster that informs patients of the availability of the brochure.

ME. REV. STAT. ANN. tit. 32 § 1094-C (2006).

198. N.H. REV. STAT. ANN. § 317-A:38 (2006) ("A dentist shall present patients having dental restorative procedures with a standardized pamphlet developed by the board in consultation with the department of health and human services regarding the risks and benefits of dental materials, including mercury amalgam, and shall discuss with the patient the choices of restorative dental materials prior to their use.").

The Connecticut Department of Environmental Protection has achieved this same result through administrative action. Its Web site provides a list of best management practices:

> a. Amalgam substitutes should be used in dental practices in cases where they are appropriate as determined by the dental professional when determining the best treatment option for the patient.
> b. Each dental office shall make available to patients information about mercury-amalgam fillings and possible alternatives. At a minimum, the brochure *Fillings: The Choices You*

nia[199] to pass statutes that require disclosure of the risks and benefits of various dental restorative materials.[200] These statutes, in contrast to subsections (e)(i) and (e)(ii) of the South Dakota informed consent statute, seem to leave the precise determination of what risks and benefits must be disclosed to the informed discretion of medical professionals.[201]

Have, Mercury Amalgam and Other Filling Materials shall be displayed and remain prominently displayed in each office.

CONN. DEP'T ENVTL. PROT., BEST MANAGEMENT PRACTICES FOR MERCURY AMALGAM (Jan. 11, 2006), *available at* http://www.ct.gov/dep/cwp/view.asp?a=2708&q=323996&depNav_GID=1638.

199. California has enacted a statute that provides:

> (a) The Board of Dental Examiners of California shall develop and distribute a fact sheet describing and comparing the risks and efficacy of the various types of dental restorative materials that may be used to repair a dental patient's oral condition or defect. The fact sheet shall include:
>
> (1) A description of the groups of materials that are available to the profession for restoration of an oral condition or defect.
>
> (2) A comparison of the relative benefits and detriments of each group of materials.
>
> (3) A comparison of the cost considerations associated with each group of materials.
>
> (4) A reference to encourage discussion between patient and dentist regarding materials and to inform the patient of his or her options.
>
> (b) The fact sheet shall be made available by the Board of Dental Examiners of California to all licensed dentists.

CAL. BUS. & PROF. CODE § 1648.10 (West 2006).

The statute was enacted in 1992, and, embroiled in endless controversy over the substance of the mandated fact sheet, the Board of Dental Examiners did not issue the required fact sheet until 2001. The Board then issued a second "consumer friendly" pamphlet in 2004 after being sued by a consumer group claiming that the original fact sheet was too confusing. Lisa Muñoz, *Mercury Foes Sue State Dental Board*, ORANGE COUNTY REG., Dec. 10, 2003; Lisa Richardson, *The State: Dental Board Sued Over Fillings*, L.A. TIMES, Dec. 9, 2003, at B-6; *see also* DENTAL BD. OF CAL., THE FACTS ABOUT FILLINGS (2004), *available at* http://www.dbc.ca.gov/pdf/dmfs2004.pdf; DENTAL BD. OF CAL., DENTAL MATERIAL FACT SHEET INSTRUCTIONS (2004), *available at* http://www.dbc.ca.gov/pdf/dmfs2004.pdf; DENTAL BD. OF CAL., DENTAL MATERIALS FACT SHEET (2001), *available at* http://uclasod.dent.ucla.edu/PatientCare/DentalMaterialsFactSheet.pdf. For a brief recitation of the Board's political woes, see *Dental Board of California*, CAL. REG. L. REP., Winter 2001, at 10, 15–17.

200. In California anti-amalgamists have also succeeded in requiring dentists to post a notification under Proposition 65, California's Safe Drinking Water and Toxic Enforcement Act of 1986, CAL. HEALTH & SAFETY CODE §§ 25249.5–25249.13 (West 2007), which requires disclosure of the presence of toxic chemicals like mercury. *See* Sabin Russell, *Dentists to Post Health Warning; State's Patients Advised of Office Chemicals, Mercury Risk in Fillings*, S.F. CHRON., Dec. 13, 2002, at A27:

> Californians who fear a visit to the dentist will soon have something new to worry about: a posted warning that they are exposed to mercury in their cavity fillings . . . .
>
> In the latest twist of a long-running battle between organized dentistry and critics of mercury-containing fillings, the California Dental Association [CDA] has agreed to post the warnings to settle a lawsuit filed by an environmental group called As You Sow. . . .
>
> . . . .
>
> Jim Dufor, an attorney for the CDA, insists that the settlement does not conceded that amalgam is unsafe. "Proposition 65 is not about warning of adverse health effects," he explained. "It is a consumer warning based on any detectable amount of chemicals known to cause cancer or reproductive harm."

201. *See supra* notes 197–99. Informed consent statutes generally defer to the informed judgment of medical professionals. *See, e.g.*, DEL. CODE ANN. tit. 18, § 6852 (West 2007) ("No recovery of damages based upon a lack of informed consent shall be allowed in any action for medical negligence unless . . . (2) The injured party proved by a preponderance of evidence that the health care provider did not supply information regarding such treatment, procedure or surgery to the extent customarily given to patients, or other persons authorized to give consent for patients by other licensed health care providers in the same or similar field of medicine as the defendant."); IND. CODE ANN. § 16-41-6-

Nothing in the Constitution would prevent legislation that altogether prohibits the use of dental amalgams. Medical speech acts associated with the provision of amalgams, for example, prescribing their use, can thus also be regulated without constitutional constraint. Imagine, however, that anti-amalgamists were to draw inspiration from subsections (e)(i) and (e)(ii) of the South Dakota informed consent statute and cause legislation to be enacted that requires dentists to affirm to their patients that the use of dental amalgams carries significant health risks, and imagine that the dental profession continues to deny that this is true. I have argued in Part III that such a statute would raise First Amendment concerns, but what exactly are the competing considerations that a constitutional standard must balance?

For reasons I have suggested earlier, I do not think that the constitutional autonomy of the individual dentist to speak her mind carries much weight in this context. That autonomy was long ago compromised by the doctrine of informed consent. The relevant constitutional value concerns instead the maintenance of dentist-patient communications as a

2(a)(1) (West 2007) (informed consent for court-ordered tests for communicable diseases must come after physician gives "[a] fair explanation of the examination"); NEB. REV. STAT. § 44-2816 (2006) ("Informed consent shall mean consent to a procedure based on information which would ordinarily be provided to the patient under like circumstances by health care providers engaged in a similar practice in the locality or in similar localities."). This is true even in the controversial area of abortion. *See supra* notes 106 and 147.

Texas delegates the questions of what risks must be disclosed and the general form and substance of the disclosures to a medical panel comprised of six doctors and three lawyers selected by the commissioner of health. TEX. CIV. PRAC. & REM. CODE ANN. § 74.102 (Vernon 2007). A physician who follows the panel's guidelines enjoys a rebuttable presumption that she has fulfilled her legal duties. A physician who does not follow the guidelines creates a rebuttable presumption of negligent failure to meet her duty of disclosure, barring special circumstances. TEX. CIV. PRAC. & REM. CODE ANN. § 74.106(a) (Vernon 2007). If the panel has not made a determination with respect to the procedure at issue, the physicians must "disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent." TEX. CIV. PRAC. & REM. CODE ANN. § 74.101, 74.106(b) (Vernon 2007).

It is worth noting that in 2004 the Texas panel rejected requests to require disclosure of a link between abortion and breast cancer, and between abortion and adverse psychological consequences. It was reported in the *Texas Register* that "[t]he panel disagrees that conclusive evidence exists to link surgical abortion to breast cancer and pre-term birth. . . . The panel disagrees that conclusive evidence exists to link surgical abortion to adverse psychological consequences, damage, and injury." 29 TEX. REG. 2646–47 (Mar. 12, 2004), *available at* http://texinfo.library.unt.edu/texasregister/html/2004/mar-12/adopted/25.HEALTH%20SERVICES.html#384. The required disclosures had been requested by, among other groups, the Justice Foundation, *id*. at 2647, which had originated "Operation Outcry" that had supplied the South Dakota Task Force with nearly two thousand testimonies from women who had abortions and reported negative experiences. TASK FORCE REPORT, *supra* note 92, at 7. The Web site of the Justice Foundation explains that the project is meant

> to end legal abortion by exposing the truth about its devastating impact on women and families. We believe that this will be accomplished through prayer and with the testimonies of mothers who have taken the life of their own unborn babies and of others who have suffered harm from abortion. We are working to restore justice and to protect women, men, and children from the destruction that abortion causes.

The Justice Foundation, http://www.txjf.org (last visited Feb. 6, 2007). Another group that had sought the disclosures was Living the Redeemed Life Ministries, Inc., which has recently advised pro-life groups on how they could defeat a pending referendum to repeal South Dakota's abortion ban. *See* Emergency South Dakota Briefing—For Pro-Life Leaders, http://www.emergencysouthdakotabriefing.com (last visited Feb. 6, 2007).

channel for the dissemination of accurate expert knowledge to the public. We would allow individual dentists to sue in order to vindicate this value, and in this sense we could say that individual dentists retain a First Amendment "right" not to be forced to communicate misleading information to their patients. But the content of this right must be determined by the public's interest in the receipt of unbiased, expert, medical information.[202]

In deciding whether this right has been violated, a court may have to choose between two competing paradigmatic scenarios. In scenario (1) active and alert citizens have identified a serious danger to which the dental profession, lulled by over a century of familiarity with amalgams, has grown complacent. Political mobilization has caused the public to realize that disclosures made by dentists about the safety of amalgams do not convey knowledge, but instead merely advance the self-interests of a rich and self-serving profession. In scenario (2), by contrast, highly motivated but ignorant citizens have used the political system to override scientific expertise. They have forced dentists to affirm false information, and they have therefore corrupted the capacity of dentist-patient dialogue to educate public opinion.

Either scenario is possible, which means that a court cannot know in the abstract which scenario is true. Professions have in the past been known to resist change out of inertia and self-interest;[203] political groups have been known to override medical knowledge in the name of popular hysteria and Luddite insecurity.[204] In deciding whether the informed consent legislation I have postulated is constitutional, however, a court

202. On the important distinction between the nature of the interests protected by a right, and the nature of the entity that holds or asserts a right, see Robert Post, *Democratic Constitutionalism and Cultural Heterogeneity*, 25 AUSTRALIAN J. LEGAL PHIL. 185, 192–93 (2000).

203. Milton and Rose Friedman, for example, famously argued in 1962 that

> licensure is the key to the medical profession's . . . ability to restrict technological and organizational changes in the way medicine is conducted. The American Medical Association has been consistently against the practice of group medicine, and against prepaid medical plans. . . . [T]he medical association is against only one type of group practice, namely, prepaid group practice. The economic reason seems to be that this eliminates the possibility of engaging in discriminatory pricing.

MILTON FRIEDMAN & ROSE D. FRIEDMAN, CAPITALISM AND FREEDOM 154–55 (2d ed. 1982). Contemporary critics of the healthcare system have argued that new technology for determining eyeglass prescriptions has been stymied because it threatens eye doctors, and that physicians' assistants have not been granted responsibility commensurate with their ability because of "the predictable desire of physicians to preserve their traditional market hegemony." Clayton M. Christensen et al., *Will Disruptive Innovations Cure Health Care?*, HARV. BUS. REV., Sept.–Oct. 2000, at 107–08.

204. Consider, for example, popular resistance to fluoridation. *See, e.g.*, ROBIN MARANTZ HENIG, THE PEOPLE'S HEALTH: A MEMOIR OF PUBLIC HEALTH AND ITS EVOLUTION AT HARVARD 85 (1997) ("Fluoride referenda were voted down in more than half of the 2,000 [U.S.] communities that considered them in the 1950s and 1960s. Opponents were rabid in their belief—and their organized dissemination of that belief—that water fluoridation was a Communist plot to deplete the brainpower and sap the strength of a generation of American children."); CHRISTOPHER P. TOUMEY, CONJURING SCIENCE 63–80 (1996) (using the example of opposition to fluoridation in the United States to argue that the value of science is subject to cultural meaning); Maurice Charland, *Postmodern Rhetorics of Technology: The Montreal Fluoridation Controversy*, 17 CANADIAN J. COMM. (1992), *available at* http://www.cjc-online.ca/viewarticle.php?id=83&layout=html.

must decide whether to believe scenario (1) or scenario (2). This decision must turn on whether a court believes that dental amalgams are in fact harmful. It is difficult to see how a court can decide this question without recourse to the very professional expert medical opinion that anti-amalgamists seek to discredit. It is impossible to know anything systematic about the safety of amalgams without reliance on professional medical expertise, which illustrates that such expertise has for us become constitutive of the relevant forms of knowledge.

This quandary has deep implications. It suggests that insofar as the First Amendment seeks to protect public access to expert knowledge, it must in some sense also protect the integrity of the professional community that defines such knowledge.[205] This protection is implicit in any First Amendment standard that safeguards dentists against restrictions on the disclosure of truthful information, or against requirements that they disclose misleading information, because the application of such a standard forces a court to ascertain and constitutionally to privilege professional knowledge.

It follows from this analysis that if reputable professional opinion is uniform and consistent, it would not be possible for a court to opt for scenario (1) except under the most abject of deferential standards, like rational basis review. But adopting such a deferential standard of review would grant the political system virtually unchecked discretion to prevent the dentist-patient relationship from serving as a channel for the communication of professional knowledge, and this would be inconsistent with the premise that there is First Amendment value in this channel of communication.

Courts must accordingly adopt a more elevated form of scrutiny, which implies that they must choose between scenarios (1) and (2) on the

205. There is an important analogy here to the structure of academic freedom, which does not protect the autonomy of individual scholars so much as the independence of the scholarly profession. For a full discussion, see Robert Post, *The Structure of Academic Freedom*, *in* ACADEMIC FREEDOM AFTER SEPTEMBER 11, at 61 (Beshara Doumani ed., 2006). The First Amendment would offer no recourse to a junior professor in the chemistry department of a state university who was denied tenure because he taught the truth of the phlogiston theory of heat. Academic freedom implies that the profession of chemistry must ultimately decide for itself what ought to count as competent chemistry scholarship. As Thomas Haskell has remarked, "the heart and soul of academic freedom lie not in free speech but in professional autonomy and collegial self-governance." Thomas L. Haskell, *Justifying the Rights of Academic Freedom in the Era of "Power/Knowledge," in* THE FUTURE OF ACADEMIC FREEDOM 43, 54 (Louis Menand ed., 1996); *see* Robert Post, *Constitutionally Interpreting the FSM Controversy*, *in* THE FREE SPEECH MOVEMENT: REFLECTIONS ON BERKELEY IN THE 1960S, at 401 (Robert Cohen & Reginald E. Zelnick eds., 2002). This is the inner meaning of Frankfurter's famous account of academic freedom as requiring "'the four essential freedoms' of a university—to determine for itself on academic grounds who may teach, what may be taught, how it shall be taught, and who may be admitted to study." Sweezy v. New Hampshire, 354 U.S. 234, 263 (1957) (Frankfurter, J., concurring). Needless to say, Frankfurter justified extending First Amendment protection to university scholarship because of the importance of such scholarship in communicating essential knowledge to public opinion. *Id*. at 261–62. This is exactly the rationale which the Court has used in the context of commercial speech, and which I suggest ought to be applied to professional medical speech designed to illuminate the informed consent of patients. *See* Goldstein, *supra* note 183, at 859–60.

basis of credible evidence. This suggests that no court could opt for scenario (1) unless it was able to support its decision on the basis of reputable professional opinion. As a practical matter, therefore, courts will inevitably be drawn to scenario (2) unless expert opinion is itself divided. It is reasonable that if reputable experts disagree about whether amalgams are dangerous, the state should retain flexibility to decide which experts to credit. The stakes in formulating a precise First Amendment standard are the nature and extent of this flexibility. On the one side is the need to preserve the integrity of professional knowledge; on the other side is the fact that professional knowledge sometimes reflects sociological prerogatives of class and power that should be disciplined by democratic political purposes.

It does appear that expert opinion is in fact divided on the safety of dental amalgams. Thus, when the *Journal of the American Medical Association* recently published an article concluding that "children who received dental restorative treatment with amalgam did not, on average, have statistically significant differences in neurobehavioral assessments or in nerve conduction velocity when compared with children who received resin composite materials without amalgam,"[206] it simultaneously published an editorial by a leading toxicologist who cautioned that other studies have found that "dentists and dental assistants have deficits in motor function and cognitive scores in relation to their number of fillings" and that the question should remain open to "the application of better epidemiological designs and more robust statistical methods to investigate toxicity."[207] In September 2006, an advisory panel to the FDA "generally agreed that there is no evidence that dental amalgams cause health problems in the majority of the population," but it raised "concerns about the lack of knowledge concerning the effects of dental amalgam on specific groups, including pregnant women, small children, and people who are especially sensitive to mercury."[208] When we confront

206. *See, e.g.*, Timothy A. DeRouen et al., *Neurobehavioral Effects of Dental Amalgam in Children: A Randomized Clinical Trial*, 295 JAMA 1784 (2006).

207. Herbert L. Needleman, *Mercury in Dental Amalgam—A Neurotoxic Risk?*, 295 JAMA 1835, 1835 (2006); *cf.* Michael N. Bates, *Mercury Amalgam Dental Fillings: An Epidemiologic Assessment*, 209 INT'L J. HYGIENE & MENTAL HEALTH 309 (2005) (finding that preponderance of evidence suggests amalgams are safe, but recommending better designed studies).

208. FDA, *supra* note 194. Canada's official position on this question is that

> [c]urrent evidence does not indicate that dental amalgam is causing illness in the general population. However, it is generally a good idea to reduce mercury if this can be achieved at a reasonable cost and with [sic] other adverse effects. Health Canada recommends non-mercury filling materials be considered for restoring the primary teeth in children where the mechanical properties of the material are suitable. Pregnant women and people [who] have allergic hypersensitivity to mercury or who have impaired kidney function should avoid the use of dental amalgam fillings.
>
> . . . Health Canada does not support removal of sound amalgam fillings in patients who have no indication of adverse health effects. Patients who have developed hypersensitivity to amalgam should replace existing mercury amalgam fillings with another material if their physician recommends this.

DEP'T OF HEALTH & HUMAN SERV., FDA, JOINT MEETING OF DENTAL PRODUCTS PANEL AND CENTRAL NERVOUS SYSTEM DRUGS ADVISORY COMMITTEE 73–74 (Sept. 6, 2006) (statement of Dr.

the question of formulating a precise First Amendment standard to determine the constitutionality of regulations of professional medical speech designed to create informed consent, we are in essence facing the issue of exactly how divided expert opinion must be before the Constitution will permit the political system to override otherwise dominant or officially endorsed professional beliefs.[209]

From an admittedly lay perspective, this suggests that subsections (e)(i) and (e)(ii) pose a relatively easy First Amendment case. As distinct from the controversy surrounding the safety of dental amalgams, reputable and disinterested experts seem unanimously to deny the existence of postabortion syndrome. Those who push for the recognition of postabortion syndrome, by contrast, seem to be passionately committed antiabortion activists who are heavily influenced by religious preconceptions.[210] The South Dakota statute would thus appear to pose a textbook

Arthur Conn, Dental Adviser, Health Canada), *available at* http://www.fda.gov/ohrms/dockets/ac/06/transcripts/2006-4218t1-01.pdf.

209. In the context of academic freedom, courts have held that the scholarly profession must be its own final judge of professional knowledge. *See supra* note 205. But that may be because all that is at stake in university scholarship is the production of knowledge. At stake in the context of informed consent is the selection of effective medical care, which would no doubt argue for a greater public interest in the regulation of medical professional speech.

210. These activists, of course, seek to convince the public that it is the professional establishment whose judgment has been corrupted by ideological preconceptions. In a recent book, for example, Theresa Burke and David Reardon have specifically attacked Stotland, *supra* note 13, as a fine "example of how the medical discussion of abortion risks has been deeply politicized." THERESA BURKE WITH DAVID C. REARDON, FORBIDDEN GRIEF: THE UNSPOKEN PAIN OF ABORTION 282 (2002). In their view, "[e]fforts to scientifically measure psychological problems after abortion are very difficult, highly politicized, and frequently distorted in reports . . . ." *Id.* at 277. They believe that the academic community, including the American Psychological Association, the American Medical Association, and the American Psychiatric Association, have "closed ranks" by refusing to recognize postabortion syndrome. *Id.* at 272–75. "The effort to gain recognition for the traumatic nature of abortion has only been sustained because (1) post-abortive women have banded together in peer support groups, (2) a social and political movement exists in which the post-abortion moment has at least received acknowledgement, and (3) there have been consistent minority voices in the professional mental health communities asserting these various and serious post-abortion injuries." *Id.* at 275.

The credibility of this attack on established science can be assessed by the fact that it is published by the same press, Acorn Books, that in 2000 released another Reardon book, DAVID C. REARDON, JULIE MAKIMAA & AMY SOBIE, VICTIMS AND VICTORS: SPEAKING OUT ABOUT THEIR PREGNANCIES, ABORTIONS, AND CHILDREN RESULTING FROM SEXUAL ASSAULT (2000), which reveals the "little known fact that the vast majority of sexual assault victims do not want abortions," and that "when sexual assault victims *do* have abortions, the long term, and even short term, psychological effects are devastating." *Id.* at ix. Although *Victims and Victors* purports to be empirical, Reardon is explicit that abortion in the case of rape and incest is "the proverbial 'camel's nose' in the tent," because once abortion is allowed in these cases, there is "no rational basis for banning abortion in other cases where pregnancy might impose hardship on women." *Id.* He therefore advocates that "pro-life Christians must address the question of abortion for rape and incest with both honesty and cunning. There are times and places when one might be able to fully explain why abortion in sexual assault cases is never right, both for moral reasons and because it will only hurt the women we want to help." *Id.* at 172. Abortion "is inherently dangerous," *id.* at 182, Reardon explains to his audience, because it is a violation "of God's moral law (which is an expression of love and unchanging absolute truths)." *Id.* at 171.

> The mother's body is designed to protect and nurture her child. Abortion breaches these defenses to destroy the child, and so must do violence to the woman's body that can result in permanent injury. Likewise, the woman's mind and spirit are designed to develop a maternal bond of love with her child. While the child's body may be ripped from her womb, there is no way to

example of the need for First Amendment intervention to preserve the independence of physician communications designed to enlighten patient decision making. It appears that the abortion controversy has spawned an egregious effort to undermine the integrity of independent medical expertise.

First Amendment solicitude for this integrity expresses a fundamentally distinct constitutional focus than *Casey*'s seemingly analogous ruling that the state cannot require the disclosure of information to abortion patients unless the information is "truthful and not misleading."[211] The holding of *Casey* interprets the "undue burden" standard of the Due Process Clause. It is concerned with protecting a woman's "personal liberty"[212] to end her pregnancy; the measure of constitutionality is thus the impact of governmental regulation on this liberty. The "truthful and not misleading" test applies to *all* information given by the state to a woman seeking an abortion. In *Casey* itself, the State of Pennsylvania had required physicians to "inform" patients about "the availability of printed materials published by the State describing the fetus and providing information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion."[213]

The First Amendment, by contrast, is not primarily concerned to protect the autonomy of those trying to decide whether to seek an abortion, but instead to preserve the integrity of physician-patient communications as a channel for the dissemination of expert knowledge. For this reason, the First Amendment does not apply to information that the state provides to patients *in propria persona*. If the state requires the state's own views on abortion to be delivered to patients, as happened in *Casey*, the integrity of physician-patient communication is not necessarily compromised. So long as the physician is not forced to express views that contradict and undermine the authority of medical knowledge, so

> rip the memory of her child out of her mind or the unfulfilled love for her child out of her heart. This is why the psychological, emotional, and spiritual aftereffects of abortion can never be controlled or erased. The bond between mother and child is simply too intertwined. When ever one hurts a child, born or unborn, one will also be hurting the child's mother.

Id. at 182. Reardon believes that laws prohibiting abortion in cases of rape and incest operate to

> protect the mothers and fathers who would, in a moment of despair, otherwise consent to the slaying of their children. . . . Good laws are sincerely meant to guide and protect people from making errors of judgment which are objectively wrong. Laws that prohibit abortion are just such laws. They protect women and children from a deadly mistake that is usually committed in the darkness of despair, the confusion of uncertainty, and the allure of the shallow, seductive "quick-fix" mentality.

Id. at 181.

It is noteworthy in this regard that "every woman, who was the victim of rape or incest and who testified before the [South Dakota] Task Force, advocated for a choice in such circumstances." Allison, *supra* note 123. "However, that is not reflected, in any way, in the Final Report" of the Task Force. *Id.*

211. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 882 (1992).

212. *Id.* at 847.

213. *Id.* at 881.

long as the physician retains the liberty to disagree with or to undermine messages that the state may wish to communicate, the independent medical expertise of the physician is not debased.[214] As a general matter, the First Amendment does not require the speech of the state to be truthful and not misleading, nor does it require the speech of the state to conform to medically expert knowledge.[215]

The First Amendment argument I have developed in this lecture, in other words, attributes constitutional value to a particular structure of communication, not to the autonomy of patients.

214. After *Casey*, for example, "a Pennsylvania Planned Parenthood clinic in Allentown distributed, as required, a state-prepared brochure on fetal development. The clinic, however, stamped on each pamphlet: 'This material was prepared by the Pennsylvania Department of Health. It contains some biased and inaccurate information and is not endorsed by the Allentown Women's Center.'" Goldstein, *supra* note 183, at 852 (quoting *Abortion Clinics Struggle with New Pennsylvania Law*, BOSTON GLOBE, Mar. 26., 1994, at 7).

215. I do not consider here whether other First Amendment arguments might be developed that would limit misleading state disclosures to abortion patients.