Reproductive Technologies and Free Speech

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Abstract: The Supreme Court and lower courts have not articulated a clear or consistent framework for First Amendment analysis of speech restrictions in health care and with respect to abortion. After offering a coherent doctrine for analysis of speech restrictions in the doctor-patient relationship, this piece demonstrates how potential legislation restricting patient access to information from reproductive testing intended to limit "undesirable" reproductive choices would violate the First Amendment.

The nature of First Amendment protection for speech in the context of the doctor-patient relationship has been the subject of inquiry for several decades. The Supreme Court has only addressed this issue three times — and each instance involved the regulation of speech regarding reproductive care. Unfortunately, the Court been less than clear about the role of the First Amendment in this context. In *Planned Parenthood of Southeastern Penn. v. Casey,* it held that mandated speech with respect to doctors performing abortions is consistent with the First Amendment.[1] Twenty-six years later, it held in *Nat'l Inst. of Family Life & Life Advocates (NIFLA) v. Becerra* that mandated speech for crisis pregnancy centers that try to discourage women from seeking abortions is not.[2] To achieve these divergent outcomes, the Court has had to thread the needle by making fine distinctions between speech in very similar contexts.

While some argue that the Court has carved a path that will make it difficult to uphold further state regulations of speech concerning abortion,[3] others suggest these holdings reflect a form of "constitutional gerrymandering against abortion rights" by twisting First Amendment jurisprudence to achieve a desired outcome.[4] This piece examines what these Supreme Court cases mean for regulations of speech in reproductive care. Specifically, it explores whether states can prohibit doctors from providing certain information obtained through prenatal testing or preimplantation testing of embryos created through in vitro fertilization (IVF).

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While that scenario is currently hypothetical, it does not seem far-fetched. For decades, legislatures have been whittling away at reproductive rights through abortion regulations[5] and limits on access to contraception.[6] Often the measures are wrapped in the guise of uncontroversial goals, such as protecting maternal health or improving informed consent. But the ulterior motive is clear: to restrict reproductive rights.

One area of growing focus is reason-based abortion (RBA) bans — prohibitions of abortions based on particular reasons — first sex,[7] then race,[8] and more recently, Down syndrome and other genetic anomalies.[9] As of July, 2021, nearly every state has proposed, and 17 states have enacted, such bans.[10] Like other laws intended to chip away at reproductive rights, these laws draw on values that transcend the anti-choice movement, in this case, concerns about equality, disability rights, and preventing "eugenics." Indeed, when the Court denied certiorari after the Seventh Circuit invalidated an Indiana law banning reason-based abortions, Justice Thomas wrote an impassioned concurrence describing such laws as remedies to the scourge of eugenics.[11] Because Justice Thomas has long adamantly opposed constitutional protections of abortion, it is easy to dismiss his diatribe as simply rooted in animosity toward abortion rights.

But concerns about equality, disability rights, and eugenics exist on both sides of the political spectrum, not just among the antichoice camps. They are frequently cited in discussions about the societal and ethical implications of the expansion of reproductive testing. It therefore seems plausible, as some scholars have suggested, that reason-based abortion (RBA) bans could be just the first step down a path toward prohibiting the disclosure of some or all information from prenatal testing during pregnancy[12] and preimplantation testing of embryos. Such laws would clearly raise First Amendment issues. Whether they would survive First Amendment challenges is the subject of this piece.

Part I describes current and future forms of reproductive testing. It then briefly delineates the concerns these technologies raise and how legislatures might use them to justify prohibiting disclosures of certain types of information from prenatal testing and preimplantation testing. Part II turns to the confusing Supreme Court jurisprudence on speech in health care as well as the lower courts' struggles to develop coherent First Amendment principles in this area. Part III attempts to make sense of the contradictory case law to describe the level of scrutiny that should apply to regulations of speech in health care. Finally, Part IV analyzes how potential future laws prohibiting disclosure of reproductive testing results would fare under those approaches. It concludes that they would not survive First Amendment attacks.

While some argue that the Court has carved a path that will make it difficult to uphold further state regulations of speech with respect to abortion, others suggest these holdings reflect a form of "constitutional gerrymandering against abortion rights" by twisting First Amendment jurisprudence to achieve a desired outcome. This piece examines what these Supreme Court cases mean for regulations of speech in reproductive care. Specifically, it explores whether states can prohibit doctors from providing certain information obtained through prenatal testing or preimplantation testing of embryos created through in vitro fertilization.

I. Reproductive Testing

To set the stage for a discussion of the concerns that might prompt legislative action in this arena, I begin with a brief overview of prenatal and preimplantation genetic testing today and the direction it might go in the future.

A. Reproductive Technologies and Testing

Many forms of prenatal testing, including ultrasound, amniocentesis, chorionic villus sampling (CVS), and the increasingly routine non-invasive prenatal testing (NIPT), are available to pregnant people today. Amniocentesis and CVS involve obtaining fetal or placental cells for genetic analysis to determine whether the fetus has a genetic condition, like cystic fibrosis, or a chromosome anomaly, like Down syndrome (trisomy 21).[13] While some individuals seek prenatal test-

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ing to avoid having a child with a particular genetic or chromosomal disorder, to prepare for their future child, or to help physicians plan for possible complications during delivery, others are unsure how they might use the information.[14]

The newest prenatal test is NIPT, which analyzes fragments of cell-free fetal DNA circulating in maternal blood. It can identify chromosomal abnormalities like trisomy 21, 13, and 18, as well as fetal sex.[15] NIPT is not yet truly diagnostic. If, as some anticipate, this noninvasive test ultimately provides the same information as amniocentesis and CVS, but without their risks, it could significantly increase the interest in prenatal testing.[16]

Reproductive testing can also occur through preimplantation genetic testing (PGT), which involves genetic analysis of an embryo created through in vitro fertilization (IVF). Like amniocentesis and CVS, PGT provides information about chromosomal anomalies and single-gene disorders.[17] The results can be used to select embryos to avoid having a child with a genetic disease. While abortion would not be involved, it might result in embryo destruction.

The scope of information available through prenatal testing and PGT will likely expand as our understanding of genetics grows. Scientists are identifying ever more genetic variants associated with several complex diseases and even nonmedical traits. While many such variants may have limited predictive value because they have only a small effect on disease or traits, analysis of the aggregate effect of several variants can be calculated to determine polygenic risk scores for particular diseases or traits.[18] Polygenic risk scores are not yet part of prenatal testing. So far, only one company, Genomic Predictions, offers analysis of several hundred thousand genetic variants to help parents "prioritize embryos for transfer" based on risks for several polygenic diseases, including diabetes, coronary artery disease, some cancers, and schizophrenia.[19] Some, however, question whether the science is good enough at this point to offer meaningful polygenic scores.[20]

Polygenic risk scores could also potentially be used in reproductive testing for nonmedical traits, like skin, eye, and hair color; height; or maybe even intelligence.[21] Fertility Institutes in California, for example, advertises itself as "the first and only genetics-based fertility program … anywhere worldwide" that can "offer high level genetic screening of parents seeking to have a voice in determining the eye color of planned children."[22] In addition, two of the founders of Genomic Prediction are searching for genetic variants associated with intelligence and height. One of them recently suggested that "[a]ccurate IQ predictors will be possible" within five to ten years to help couples select the "smartest" embryo for implantation.[23] One study, however, showed PRS has limited predictive value for complex traits like height and intelligence.[24]

It is crucial to emphasize that most diseases and traits are the result of a complex combination of genes and environmental factors; that is, genes are often not fully determinative. Even so, some traits, like height, have a strong genetic component, even though environment (diet, health, activity, etc.) can impact their expression.[25] Whether PRS will ever meaningfully predict complex traits is uncertain. But as we better understand the relationship between genes and traits, it may well become a part of PGT, even if the results are only probabilistic.

Finally, genome sequencing (identifying all of the base pairs of the genome) might be used with reproductive testing in the future.[26] Although not yet a routine part of clinical care, its decreasing costs might change that.[27] Interpreting the sequence is the real challenge, however, because our understanding of the entire genome is still incomplete. Nevertheless, with more time and research, our knowledge will undoubtedly grow.

For all these reasons, future reproductive testing will provide more information about the fetus and embryo, potentially even information about minor medical traits, like myopia, and nonmedical traits beyond sex, like height, athleticism, intelligence, etc.

B. Concerns about Selecting Offspring

For some, the concerns about prenatal testing and PGT are rooted in anti-choice views that oppose pregnancy termination or embryo destruction regardless of the reason. But various other concerns have been raised about this technology. One is its potential harm to people with disabilities. Some fear it can lead to fewer births of people with disabilities as well as reduced social support for, negative societal attitudes towards, and heightened discrimination against them.[28]

Testing for nonmedical traits raises additional concerns. Sex selection, which is currently possible through prenatal testing and PGT, has altered the normal male to female birth ratio in some countries, although not in the United States.[29] Scholars and professional societies worry it reflects "prejudice against female children" or might take us down "a 'slippery slope' toward selection of many other traits" that some find "ethically problematic."[30]

Several arguments against nonmedical sex selection apply to other forms of nonmedical trait selection. Some fear it denies children a "right to an open future" by imposing expectations associated with a particular

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trait, which might cause psychological harm or disrupt the parent-child relationship.[31] A related fear is that reproductive selection commodifies reproduction, challenging parents' ability to "appreciate children as gifts" and "not as objects of our design or products of our will."[32] Finally, some worry that such reproductive selection will exacerbate societal inequities because insurance is unlikely to cover testing for nonmedical traits. They fear the wealthy will be most likely to select for traits, such as height or intelligence, that will increase the societal advantages of their children.[33]

C. Legislation that Goes Beyond Reason-Based Abortion (RBA) Legislation

While counter-arguments can be made in response to the concerns described above, including their speculative nature,[34] legislatures might draw upon those concerns to justify limiting patient access to information from prenatal testing and PGT. With the growing focus on RBA bans, anti-choice efforts might commandeer these concerns, as they have done with respect to other values, to limit reproductive rights.[35] Legislatures could prohibit the disclosure of information accessible through prenatal testing entirely or before the point of viability to discourage reason-based abortions, particularly because it is difficult to establish a person's reasons for an abortion.[36] Laws might also proscribe disclosure of information from PGT to discourage destruction of embryos.

Another possibility might be to ban disclosure of certain information, like information about nonmedical traits or minor medical conditions. States might adopt approaches used by countries like Germany, Austria, France, and Italy, which only allow PGT to prevent serious diseases, or the UK, which bans nonmedical sex selection.[37] Such laws would align with public attitudes. While polls find majority support for using PGT to select against lethal, early childhood diseases (72.9%) or diseases that cause life-long disability (66.7%), only a minority support using it to select for sex (21.1%); traits like intelligence (18.9%); characteristics like height, eye color, or athleticism (14.5%); traits like intelligence (18.9%); and sexual orientation (13.3%).[38]

Legislatures could not be faulted for viewing the Supreme Court's First Amendment jurisprudence in the reproductive realm as condoning such laws. After all, it has shown deference to speech restrictions disfavoring abortion, while applying strict scrutiny to those that don't. As Part IV argues, however, such restrictions would violate the First Amendment. But before we turn to that analysis, we must first review the judicial landscape in this area.

II. Judicial Treatment of Speech in the Health-Care Context

Courts have tried to decipher the appropriate degree of First Amendment protection for speech in health care given the tension between the states' power to regulate health care and the First Amendment interests of providers. The Supreme Court has done little to unravel these conceptual knots. In fact, it has spawned continued confusion for the lower courts regarding the extent to which the state may restrict speech in this context.

A. The Supreme Court

The Supreme Court has only examined First Amendment issues related to the speech of health-care professionals in three instances.[39] The first was *Rust v. Sullivan*,[40] which addressed federal regulations restricting recipients of Title X family planning funds from offering abortion counseling, referrals, or advocacy of abortion as a method of family planning. The Court rejected the Title X recipients' First Amendment challenge of the regulations. It first observed that the government may make "'a value judgment favoring childbirth over abortion, and ... implement that judgment by the allocation of public funds.'"[41] Because the speech restriction was tied to Title X's goals to "encourage family planning," this was not government suppression of "'a dangerous idea.'" Instead, the government was simply prohibiting grantees from "engaging in activities outside of the project's scope."[42] Because the regulation did not prohibit health care providers from engaging in abortion counseling or referrals through other programs "separate and independent" from Title-X funded programs, it found no First Amendment issue.[43]

Despite hinting that speech regulations in the doctor-patient relationship may be unique,[44] the Court refused to address the argument that speech within those relationships "should enjoy projection under the First Amendment," even when the government subsidizes those relationships. Instead, it unpersuasively asserted that "the regulations did not "significantly impinge upon the doctor-patient relationship"[45] because physicians were not required to represent views they did not hold. Moreover, the Title X doctor-patient relationship was limited to preconception care, so patients would not expect "comprehensive medical advice." Because the provider could explain that advice about abortion "is simply beyond the scope of the program," clients could not interpret "silence" as an indication the physician "does not consider abortion an appropriate option."[46] This was the Court's first hint that speech restrictions intended to promote

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childbirth and discourage abortion could survive First Amendment challenges.

Just a year later, in *Planned Parenthood v. Casey*, the Court addressed several abortion regulations, including an informed consent requirement that physicians performing abortions describe the risks of the procedure, the risks of childbirth, and the probable age of the fetus, and inform patients of the availability of state-provided information about adoption and child support.[47] In upholding the informed consent mandate, the *Casey* plurality focused primarily on whether the regulation violated the Due Process Clause. Relying on its newly crafted undue-burden test, it found the law did not impose a substantial obstacle because the mandated language was "truthful and not misleading."[48]

While acknowledging that the statute raised First Amendment issues, the plurality devoted only a paragraph to conclude that the mandated disclosures presented "no constitutional infirmity." The heart of its argument can be found in one sentence and two citations:[49]

> 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).[50]

In failing to explain the applicable standard of review, this brief and opaque discussion functions like a Rorschach test.[51] Some read it as using a rational basis test, and certainly not strict scrutiny.[52] Others see it as employing some kind of intermediate or heightened scrutiny.[53]

Many hoped the Court would clarify its position on speech in health care in *NIFLA v. Becerra*.[54] In that 2018 case, the Court considered the constitutionality of a California statute requiring licensed clinics that offer services to pregnant people to provide specific notices about the availability of "free or low-cost access to comprehensive family planning services … prenatal care, and abortion."[55] The National Institute of Family and Life Advocates (NIFLA), an organization of crisis pregnancy centers, challenged the notice requirements as violating their First Amendment rights to free speech (and free exercise of religion). The Ninth Circuit affirmed the denial of a motion for a preliminary injunction,[56] concluding that the notice was a form of professional speech subject to, and likely to survive, intermediate scrutiny.[57]

Describing the law as intended to regulate crisis pregnancy centers, which "'aim to discourage and prevent women from seeking abortions'" and are commonly associated with groups that oppose abortion,[58] the Supreme Court disagreed. It first noted that content-based regulations of speech are generally "presumptively unconstitutional" and subject to strict scrutiny.[59] And it insisted that the mere fact that speech "is uttered by 'professionals'" does not mean it is not protected.[60] In fact, it emphasized that the Court's precedents have not recognized "a category for 'professional speech.'"[61]

Writing for the majority, Justice Thomas had to acknowledge that the Court had, in fact, "afforded less protection for professional speech" before. One exception he pointed to involved the mandated disclosure upheld in *Casey*.[62] Despite the strong parallels between the speech regulations in *Casey* and *NIFLA*, both of which compelled statements about reproductive options, Justice Thomas made a tortured attempt to treat them as distinct. *Casey*, he stated, involved State regulation of "professional *conduct*" that "incidentally involves speech" and was consistent with "firmly entrenched" informed consent requirements for operations.[63] Allegedly in contrast, *NIFLA*'s notice requirement applied "whether a medical procedure [was] ever sought, offered, or performed."[64] Thus, it did not "facilitate informed consent to a medical *procedure*."[65]

As Justice Breyer noted in his dissent, this distinction "lacks moral, practical, and legal force."[66] While abortion is "a medical procedure that involves certain health risks," he emphasized, "carrying a child to term and giving birth" also poses risks. Thus, health "considerations do not favor disclosure of alternatives and risks associated with the latter but not those associated with the former."[67] Further, even if the majority believes that "speech about abortion is special" because it involves "views based on deeply held religious and moral beliefs about the nature of the practice," Justice Breyer argued, the Court should treat "like cases alike," especially given the "strong, and differing, views" American hold regarding abortion.[68]

Justice Thomas did not disguise the Court's view that speech concerning abortion is special when he distinguished *NIFLA* from *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*,[69] the other instance where he noted the Court applied lesser scrutiny to a law regulating the speech of professionals.[70] Thomas observed that *Zauderer* upheld the state's discipline of an attorney for failing to disclose the terms of contingent fees in his advertising[71] because it involved "'purely factual and *uncontroversial* information" about payment for services, and it was not

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"'unjustified or unduly burdensome.'"[72] Even though the *NIFLA* notice was also purely factual, the Court remarkably found the compelled disclosures distinct because it mentioned abortion, which the Court described as "anything but …'uncontroversial.'"[73]

The Court implied that requiring mention of the "controversial" word abortion raised the "the danger of content-based regulations 'in the fields of medicine and public health, where information can save lives.'"[74] It devoted a full 41.8% of the opinion's words to describe the threats of regulating speech in health care "to increase state power and suppress minorities,"[75] to suppress "'unpopular ideas or information,'"[76] and to "'maniuplate[] the content of doctor-patient discourse' to advance … iniquitous interests.'"[77] But the Court never explained why compelled disclosures of reproductive options, including prenatal care, contraception, and abortion, impose such a threat, while compelled disclosures of nonmedical options, such as adoption and child support, do not. The implication is that compelled speech that treats abortion as acceptable is dangerous, whereas compelled speech that discourages it is not.

Despite the Court's strong rhetoric that professional speech should be treated like all other speech for First Amendment purposes, it did not "foreclose the possibility" that there may be a "persuasive reason for treating professional speech as a unique category, exempt from ordinary First Amendment principles."[78] What constitutes a "persuasive reason" is the million-dollar question, making *NIFLA* the Court's latest Rorschach test in this area.

B. Lower Courts

The Supreme Court's opaqueness has left the lower courts struggling to discern the proper standard of review for speech regulations in the doctor-patient relationship. Not surprisingly, "nothing even approaching judicial consensus" exists among the circuit courts.[79] Further confusing matters, most of lower court decisions arose before *NIFLA*, creating uncertainty about the reach of their holdings.[80] We turn first to decisions concerning prohibitions of speech, and then to compelled speech.

1. PROHIBITIONS OF SPEECH

The Ninth Circuit was the first to address prohibitions of speech in health care, which it handled differently in two cases by drawing on a speech/conduct distinction. In *Conant v. Walters*, it found unconstitutional the government's threat to revoke controlled substance registrations from physicians who recommended marijuana use for medical purposes.[81] A decade later, in *Pickup v. Brown*, however, it upheld a law banning mental health care providers from using sexual orientation change efforts (SOCE) to try to alter minors' sexual orientations.[82] The rationale for more "deferential review" in the latter case was that, unlike the regulations in *Conant*, which targeted "doctor-patient communications *about* medical treatment,"[83] the restriction in *Pickup* was a "regulation of the practice of medicine" because it applied to a form of therapy that was not, itself, "an act of communication."[84]

The Third Circuit rejected this speech/conduct distinction when it upheld a ban on SOCE in *King v. Governor of New Jersey*.[85] Although it considered SOCE "'speech' for purposes of the First Amendment,"[86] it reasoned that "speech that occurs as part of the practice of a licensed profession" is not "fully protected by the First Amendment."[87] The court also emphasized that patients "have no choice but to place their trust in" these highly trained and educated professionals.[88] To strike a balance between allowing legislatures to prohibit "harmful or ineffective professional services" and preventing legislatures from "too easily suppress[ing] disfavored ideas under the guise of professional regulation,"[89] it applied intermediate

Finally, in an unusual series of decisions that were vacated and replaced by new ones, the Eleventh Circuit addressed a Florida law prohibiting physicians from asking patients whether anyone in their family owned firearms or ammunition. After three decisions upheld the law under different approaches, the Eleventh Circuit en banc invalidated it. Despite the state's "substantial interest in regulating professions like medicine," it found the state does not have "carte blanche to restrict the speech of doctors and medical professionals."

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scrutiny. Because SOCE could harm patients, the ban survived such scrutiny.[90]

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Most recently, in a post-*NIFLA* decision, *Otto v. City of Boca Raton*, the Eleventh Circuit found unconstitutional an ordinance prohibiting therapists from practicing SOCE on minors.[95] Unlike the Ninth and Third Circuits, it applied strict scrutiny. Pointing to the speech/conduct used in *NIFLA*,[96] it concluded that the banned therapy is not conduct or a procedure because it is based entirely on speech.[97] Further the regulation was a content-based restriction of speech, prohibiting therapists "from communicating a particular message."[98] Quoting *NIFLA*, it spoke of the "'inherent risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas or information.'"[99] Finally, it emphasized *NIFLA*'s and its own refusal "to recognize professional speech as a new speech category deserving less protection."[100]

The court found that the law didn't survive strict scrutiny. First, the state's compelling interest in protecting minors did not allow it to "'restrict the ideas to which children may be exposed.'"[101] Second, unpersuaded by the government's assertions of the risks of SOCE, it found the law was not narrowly tailored. Demonstrating a remarkable lack of deference to voluminous research, it concluded that relying on "professional societies' opposition to speech," would simply allow "majority preference" to justify speech restrictions.[102] Finally, it argued, if the SOCE ban could stand, so could laws prohibiting therapists from validating clients' same-sex attraction or gender identity,[103] completely ignoring that such laws would deviate wildly from professional standards.

The dissent argued for intermediate scrutiny, but believed the law would survive strict scrutiny. Not only did it find compelling the state interests in "protecting minors from harmful professional practices" and regulating the practice of medicine, but it also found the law was narrowly tailored to that goal based on the "mountain of rigorous evidence" that SOCE was harmful and inefficacious in changing sexual orientation.[104] Notable for our purposes is the test it advocated for the standard of review. Rejecting the speech/conduct distinction, it proposed that lesser scrutiny should apply when a speech restriction is "auxiliary to" the practice of medicine.[105]

2. COMPELLED SPEECH

The inconsistency courts have shown regarding speech restrictions applies equally to compelled speech, including laws requiring ultrasounds to be performed on and displayed to people seeking abortions. The Fifth Circuit, in *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, found such compelled expression "more graphic" than that in Casey, but not "different in kind" because both provide truthful and not misleading information.[106] Describing *Casey*'s standard of review as the "antithesis of strict scrutiny," the court seemed to apply rational basis in easily finding the law constitutional.

The Fourth Circuit applied decidedly more stringent scrutiny in *Stuart v. Camnitz*.[107] While finding the ultrasound information to be "the epitome of truthful [and] nonmisleading,"[108] it found the regulation "ideological."[109] By requiring the disclosure of "facts that all fall on one side of the abortion debate," it essentially compelled a "pro-life message."[110] Moreover, the law deviated from informed consent by forcing the display and description of the ultrasound to a pregnant person when she was "most vulnerable."[111] The patient could only avoid it by covering her eyes and ears, thus threatening her psychological wellbeing and undermining her trust in her doctor by making the physician "the mouthpiece of the state."[112]

In a post-*NIFLA* decision, the Sixth Circuit, in *EMW Women's Surgical Center, P.S.C. v. Beshear*, upheld a Kentucky mandatory speech-and-display ultrasound law.[113] Reasoning much like the Eleventh Circuit, it found no material difference between the mandates in *Casey* and the Kentucky law. Drawing heavily from *NIFLA,* the Sixth Circuit concluded that heightened scrutiny should not apply because the ultrasound law regulated "professional conduct that only incidentally burdens professional speech."[114] Moreover, it rejected a "'sliding scale' test" for professional speech, which, it noted, *NIFLA* expressly refused to adopt.[115] It also rejected the Fourth Circuit's pre-*NIFLA* argument that heightened scrutiny was appropriate because the compelled message was ideological.[116]

Like the Eleventh Circuit, the Sixth Circuit ignored professional norms in evaluating the speech restrictions. It reasoned that informed consent "may be created by law, as opposed to merely medical custom,"[117] and it observed that both *Casey* and *Gonzales v. Carhart*[118] upheld medical requirements "directly contrary to alleged medical-professional custom."[119] Thus, the key inquiry was whether the law provided

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"truthful, non-misleading, and relevant information aimed at informing a patient about her decision to abort unborn life,"[120] not "necessarily whether the law is consistent with medical-profession custom or views of certain medical groups."[121] It found that in offering more specific information about the pregnancy than the *Casey* disclosures, the Kentucky law was "the epitome of ensuring informed consent."[122]

The dissent countered that the guiding First Amendment principle in *Casey* was that the "'physician's First Amendment rights not to speak are implicated, but *only as part of the practice of medicine,* subject to reasonable licensing and regulation by the State.'"[123] Thus, together, *Casey* and *NIFLA* established "that reasonable regulations that facilitate informed consent to a medical procedure are excepted from heightened scrutiny."[124]

In the spirit of the Otto dissent, the EMW dissent pointed to overwhelming evidence that the mandate requires "physicians to violate their professional and ethical obligations" by imposing a "one-size-fits all approach" for informed consent,[125] potentially harming patients by forcing them to see images that could cause distress.[126] The dissent feared that upholding the mandate would "open floodgates ... to manipulate doctor-patient discourse solely for ideological reasons,[127] which, it reasoned, violates NIFLA's admonition that "the state 'cannot co-opt [physicians] to deliver its message for it.'"[128]

As we have seen, the courts have offered contradictory and inconsistent approaches to First Amendment doctrine in the context of health care both with respect to prohibited and compelled speech regulations. We turn now to scholarly interpretations of the doctrine.

III. Making Sense of the Cases

A. Scholarly Views of Speech in Health Care

Given the confusion created by the Supreme Court and lower courts regarding the level of scrutiny for regulations of doctor-patient communications, it is not surprising that scholars interpret this body of law in various ways. Some suggest strict scrutiny should apply,[129] which seems consistent with *NIFLA*'s reluctance to afford less First Amendment protection to professional speech. Indeed, the Court cited one of these scholars to argue that strict scrutiny applies to virtually all content-based restrictions, even in healthcare.[130] But that standard cannot be the uniform rule given *NIFLA's* recognition of the *Casey* exception.

Many scholars carve out areas of speech in health care that deserve more or less First Amendment protection. Claudia Haupt, for example, argues for "robust First Amendment protection" for speech that would be "acceptable as good professional advice," whereas speech that falls outside that" acceptable range" should have no First Amendment protection."[131] Others argue that compelled "ideological" messages should be subject to "rigorous and almost certainly fatal First Amendment scrutiny"[132] or that laws regulating professional-client communications about constitutional rights, like abortion rights or the right to bear arms, should be subject to strict scrutiny because they "are, and ought generally to be treated as, regulations of political expression based on content."[133] I have argued that heightened scrutiny should apply to laws regulating informed consent because such speech is central to helping patients exercise their autonomy in making informed medical decisions.[134]

It is difficult, however, to square these positions with *NIFLA*'s interpretation of *Casey* as deferential to an informed consent mandate that 1) dealt with abortion rights; 2) was ideological in discouraging abortion, as the Casey Court itself acknowledged; and 3) required disclosure of nonmedical information, which deviates from typical informed consent doctrine.

Writing after *NIFLA*, Carl Coleman suggests the level of scrutiny depends on the governmental purpose of the law. If the restriction is "substantially related to ... professional quality,"[135] it should survive intermediate scrutiny. But if the justification is based on "*other* governmental interests," strict scrutiny applies.[136] He emphasizes that "the primary justification for regulating professional speech is to counterbalance the inherent knowledge disparity between professional and clients, which makes individuals vulnerable to exploitation by incompetent or unscrupulous practitioners."[137] He does not find *Casey* inconsistent because it dealt with "factual information that a reasonable patient would arguably want to know."[138] Moreover, although regulations must be "informed by those who have specialized knowledge and experience that laypersons lack,"[139] "nontechnical dimensions, including materiality of information to patients," are also relevant in assessing professional quality.[140]

Coleman's view raises questions about what to do when states justify speech regulations in the *guise* of protecting professional quality. Even more challenging, it does not help courts decide how much laws can deviate from professional norms in regulating professional quality and how much deference should be accorded such norms. It risks inviting the kind of blithe dismissal of professional standards that the Sixth and the Eleventh Circuits demonstrated in dismissing comprehensive research and established medical customs.

Miller and Berkman, also writing after *NIFLA*, argue that physician speech is "*instrumentally* high value" speech because of its role in achieving "good

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medicine,"[141] therefore "rational basis is wholly inappropriate."[142] They criticize *NIFLA* for trying to distinguish physician speech based on whether or not it is tied to a medical procedure. Instead, they suggest, physician speech, should be treated as high value speech or "professional speech — not medical conduct — when it promotes patient safety, occurs within the confines of a doctor-patient relationship, and is supported by evidence-based medicine."[143] While entirely sensible, this doesn't accord with *NIFLA*'s implication that the speech in *Casey* should be accorded less First Amendment protection. Informed consent, after all, falls within their category of high value speech[144] — it "promotes patient-safety, occurs within the confines of a doctor-patient relationship," and is largely supported by evidence-based medicine (to determine material risks).

Another view is that *NIFLA* did not concern professional speech in the context of a doctor-patient relationship. As Haupt points out, someone could enter a clinic, receive the mandated notice, and leave before any relationship was created between a patient and health care provider.[145] The Court, however, never made such a distinction; in fact, it took great pains to emphasize why the speech of professionals generally should not be less protected than other speech. It also spent a great deal of time discussing the dangers of the state controlling communications between doctor and patient,[146] suggesting that *any* regulation of physician speech in the doctor-patient relationship should be subject to strict scrutiny, as long as it is not incidental to regulation of conduct. The Eleventh Circuit certainly adopted that view in applying strict scrutiny to and overturning the SOCE ban.[147]

Finally, Professors Chemerinsky and Goodwin simply avoid seeking doctrinal consistency between *Casey* and *NIFLA*. Instead, they attribute the Court's different treatment of speech in the context of abortion and speech within a licensed pregnancy clinic to a form of "constitutional gerrymandering against abortion rights" that twists First Amendment jurisprudence to achieve a desired outcome.[148] Under this view, speech regulations aimed at discouraging abortion are subject to deferential review, whereas most other speech regulations are subject to strict scrutiny. Thus, a statute that goes against informed consent norms in mandating the disclosure of nonmedical information to discourage abortion can stand. But mandated disclosures about access to reproductive options (including abortion) that are consistent with medical norms cannot.

In fact, the gerrymandering in *NIFLA* and the two post-*NIFLA* cases goes beyond reproductive rights and is intertwined with concerns about religious liberties. Thus, strict scrutiny applies to restrictions of speech that conflict with a group's religious beliefs (such as mandating statements with the word "abortion" or prohibiting SOCE), even if they are informed by and consistent with professional standards. Yet laws that promote a particular perspective, such as an anti-abortion stance, are subject to less scrutiny, potentially even rational basis, no matter how much they deviate from medical customs and professional norms. The Court, it seems, is using the First Amendment to protect and promote certain perspectives, which as Chermerinsky and Goodwin argue, is unconstitutional.

As Chemerinsky and Goodwin point out, this inconsistency reflects "not simply a content-based restriction on speech," but a viewpoint restriction, which is "never allowed."[149] In fact, the gerrymandering in *NIFLA* and the two post-*NIFLA* cases goes beyond reproductive rights and is intertwined with concerns about religious liberties. Thus, strict scrutiny applies to restrictions of speech that conflict with a group's religious beliefs (such as mandating statements with the word "abortion" or prohibiting SOCE), even if they are informed by and consistent with professional standards. Yet laws that promote a particular perspective, such as an anti-abortion stance, are subject to less scrutiny, potentially even rational basis, no matter how much they deviate from medical customs and professional norms. The Court, it seems, is using the First Amendment to protect and promote certain perspectives, which as Chermerinsky and Goodwin argue, is unconstitutional.

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B. Attempting to Reconcile the Various Views

In many ways, I am most sympathetic to Chermerinsky and Goodwin. Yet I fear that succumbing to their position allows for continued gerrymandering that could undermine reproductive and other rights and run roughshod over professional custom and medical expertise, as occurred in *EMW* and *Otto*. Instead, we must try to find a coherent doctrinal position that balances the First Amendment interests of physicians and patients with the state interest in regulating health care, without allowing the state to use regulations to promote ideologies contrary to medical practice. Trying to thread that needle, given *NIFLA*, is challenging.

On the one hand, speech within the doctor-patient relationship is of great importance. It is "*instrumentally* high value" speech because it promotes health,[150] and its "[u]ndue regulation" could undermine the "well-being of patients."[151] But the State also has authority to regulate the "practice of medicine," as Coleman suggests, to protect patients who are "vulnerable to exploitation by incompetent or unscrupulous practitioners" given the knowledge disparity.[152] Thus, some form of intermediate scrutiny should apply.

The line *NIFLA* draws between speech and conduct, however, challenges this view as do the two post-*NIFLA* appellate decisions — one, applying strict scrutiny to speech qua speech,[153] and the other, applying something like rational basis to speech incidental to a procedure.[154] The *NIFLA* Court, however, never offered a persuasive rationale to explain why the level of scrutiny depends on whether the regulated speech is tied to a medical procedure.[155] It pointed to precedents that "have long drawn" a "line between speech and conduct," even though none of them distinguished speech incidental to conduct and speech as speech in health care. It also noted the state's authority to regulate professional conduct, as exemplified by malpractice torts.[156] But of course, the state's interest in regulating speech in the doctor-patient relationship exists whether or not a procedure is involved.[157]

The dissenting opinions in *Otto* and *EMW* offer a potential framework for deciding when a less stringent standard of review applies to speech restrictions like that in *Casey*. The *EMW* dissent identified the "'practice of medicine'" as "the driving term" in *Casey*.[158] Building on this idea, the *Otto* dissent looks to whether the "affected speech is 'auxiliary to' or 'inconsistent with' the practice of medicine."[159] When a law regulates speech "auxiliary to a medical practice," it should receive more deferential review, but when it is "inconsistent with the practice of medicine," heightened scrutiny should apply.[160]

While the speech mandate in *Casey* is not consistent with informed consent norms in requiring disclosure of nonmedical information intended to discourage abortion, it only required the doctor to mention the *availability* of a state-created document with nonmedical information about adoption and child support. It did not require physicians to actually make statements inconsistent with informed consent or to conduct procedures that were not medically indicated. Thus, under the law, physicians could speak in a manner consistent with the professional and ethical norms of informed consent. Reading the law as mandating mention of the *availability* of such information, but not as mandating actual disclosure of non-medical information, offers a way to find it consistent with informed consent norms.

I readily concede that this distinction is somewhat forced, but it offers a way to understand the doctrine that does not allow states to profoundly distort medical practice "solely for ideological reasons."[161] Wholesale acceptance of legislative disregard for the standard of care when regulating speech is problematic, particularly when driven by ideological concerns. Under the approach I advocate, speech restrictions wholly inconsistent with medical practice should be subject to heightened scrutiny. This approach thus avoids the troubling lack of deference to professional expertise demonstrated in *Otto* and *EMW*.

With respect to regulations of speech auxiliary to the practice of medicine, intermediate scrutiny is appropriate. As discussed above, it accommodates the tension between important First Amendment values and the States' interest in regulating medicine. Some have even suggested that *NIFLA* implied that intermediate scrutiny applies to regulations like those challenged in *Casey* when it emphasized that the notice requirement did not even survive such scrutiny.[162] While one might argue that the Court's terse support of the informed consent statute in *Casey* hinted at a rational basis test, it is also possible the plurality thought the law easily satisfied intermediate scrutiny, believing (as it seemed to) that the mandated disclosure was consistent with informed consent practices.[163] Thus, intermediate scrutiny in this context can be reconciled with *Casey* and *NIFLA*.

Although the speech/conduct distinction articulated in *NIFLA* and two circuit courts is problematic, it may nevertheless become binding. Thus, I also consider how that distinction might play out with respect to laws banning disclosure of information from reproductive testing. But even if that line holds, one question remains. Are there only two relevant categories of speech in health care — speech incidental to conduct and speech qua speech — or is the second category really two categories — speech qua speech within the doctor-patient relationship and speech qua speech

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outside the doctor-patient relationship? If three categories exist, intermediate scrutiny would apply to speech incidental to conduct because the state has wider authority to regulate medical conduct than speech,[164] heightened intermediate scrutiny would apply to speech as speech in the doctor-patient relationship, while strict scrutiny would apply to the last category. Under these different theories, therefore, speech regulations within the doctor-patient relationship should receive at least intermediate scrutiny.

IV. Evaluating Prohibitions of Disclosures of Prenatal and PGT Information

A. Standard of Review

As noted in Part I, legislatures might commandeer concerns about disability rights, equality, commodification, and eugenics to prohibit the disclosure of certain information that could be obtained through prenatal testing or PGT. To assess whether such laws would survive First Amendment challenges, the first question is the level of scrutiny.

If the *NIFLA* Court's distinction between speech incidental to procedures and speech as speech is binding, the outcome is not immediately clear. Are laws that prohibit the disclosure of or analysis of certain types of genetic information restrictions on speech qua speech or speech incidental to a medical procedure? These potential speech regulations are clearly distinct from laws prohibiting SOCE therapy or restricting health care providers from making inquiries about gun ownership, neither of which centers around a particular medical procedure.

One might argue they are very much "tied to a procedure" because medical procedures — amniocentesis, CVS, drawing blood for NIPT, or retrieving eggs for IVF/PGT — are necessary to obtain the information. Viewed that way, intermediate scrutiny would apply. However, the information is not *incidental* to the procedure; it is *derived* from a procedure. Obtaining that information is the *very purpose* of the procedure. Thus, information gleaned from prenatal testing and PGT is speech qua speech, not speech incidental to a procedure. Under a theory that does not distinguish between speech within the doctor patient relationship and other speech, strict scrutiny should apply because these laws are content-based regulations. Even if *NIFLA* does allow some lesser protection of professional speech, as opposed to other speech, heightened scrutiny should apply because this is speech qua speech.

If a court were instead to determine the level of scrutiny by asking whether the regulation is auxiliary to the practice of medicine, à la the *Otto* and *EMW* dissents, the analysis would be different. Under this test, laws prohibiting access to information about genetic risks from prenatal testing or PGT would violate clearly established standards of care. The very purpose of these procedures is to provide information so individuals can make reproductive decisions — e.g., whether to terminate or continue the pregnancy or to select embryos to prevent disease in a future child. Prohibiting disclosure of this information would render the procedures worthless. Indeed, the standard of care is so clearly established here that most jurisdictions allow wrongful birth claims when providers negligently fail to deliver correct information from reproductive testing.[165] Laws banning disclosure of this information would therefore be highly inconsistent with medical practice and should fail under First Amendment scrutiny.

But what about information that is not directly related to medical risks, such as sex or nonmedical traits?[166] While information about fetal sex from prenatal testing is routinely disclosed, the purpose is not to facilitate decisions regarding prenatal care, whether to continue a pregnancy, or decisions regarding delivery.[167] Instead, the information is provided because of its personal and social value to some parents. Failing to provide such information would likely not be the basis for a wrongful birth claim. After all, what would the damages be?[168]

In the context of PGT, only a slight majority of clinics offer nonmedical sex selection,[169] and very few offer other kinds of nonmedical trait selection.[170] Even though information about sex (and potentially other nonmedical traits) is far more likely to influence embryo selection than decisions about pregnancy termination, at least in the United States, no clear standard of care exists regarding nonmedical trait selection through PGT. Indeed, professional organizations seem ambivalent about the ethics of nonmedical sex selection.[171] Thus bans on disclosure of nonmedical information about fetuses and embryos are not "inconsistent with the practice of medicine," suggesting they should be subject only to intermediate scrutiny.[172]

B. Applying the Standards

As we saw above, the level of scrutiny for these laws ranges from intermediate to strict. We begin by analyzing them under intermediate scrutiny, which requires a showing that a "statute directly advances a governmental interest and that the measure is drawn to achieve that interest."[173] The regulations need not be perfectly tailored to the important state interests, but if the restrictions do not sufficiently advance those interests, they cannot survive.[174]

To evaluate the laws, we must first articulate the state interests. The state would likely assert three, the first being the promotion of fetal and embryonic life.[175]

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The Supreme Court has described the interest in fetal life as "legitimate and substantial."[176] While it focused on the state's interest in life from the outset of *pregnancy*,[177] courts would likely also find a legitimate and maybe even substantial interest in *ex vivo* embryos given their potentiality for life.

Second, the state might assert interests in promoting social values and preventing "morally repugnant" acts,[178] in this case, what Thomas calls "eugenic-like" practices.[179] It might also assert an interest in preventing negative social effects, including discrimination based on sex, disability, or disfavored traits. A related goal might be preventing a reduction in the number of children born with disabilities or less desirable traits[180] and the exacerbation of inequalities if those with more resources are better able to select for traits that confer social advantages.[181] Finally, the State might want to discourage parents from treating their children as products whose quality must be controlled.[182]

Courts would likely view the state's interests in addressing troubling social values and societal effects such as alleged eugenic uses, discrimination, prejudice, and commodification of reproduction as legitimate, and perhaps substantial, interests, particularly when considered in the aggregate. Even if those state interests are substantial, however, preventing physicians from disclosing information they would otherwise disclose to patients under the medical standard of care is not sufficiently related to these interests to satisfy a heightened or even intermediate standard of scrutiny for several reasons.

First, such legislation would be overly broad, at least with respect to prenatal testing. Not all people seeking such testing would terminate based on prenatal information. Patients may want information to prepare for having a child with certain traits (including gender) or a disability.[183] In addition, some prenatal information is central to prenatal care and birthing.[184] Thus, these laws would restrict access to information that can be of great personal and medical value to patients, without protecting fetal life when the patient wasn't considering termination. In addition, sometimes such laws might result in fetal loss. A couple at risk for a serious genetic condition, for example, might terminate the pregnancy, rather than risk passing on a serious disease gene. Thus, they could potentially end a pregnancy with an unaffected fetus they would not have terminated if they had had access to the prenatal information.

While information from PGT almost always influences which embryo is implanted (that is, after all, why people seek PGT), a ban on disclosure of information may not actually spare many embryos. Because IVF often results in more embryos than can be implanted, information from PGT usually affects *which* embryos are implanted, but not how many; it is not likely to influence decisions about whether to destroy embryos or donate them to infertile couples.

Bans on disclosure of this reproductive information would also be too broad to address the state interest in social values and effects, particularly in the context of prenatal testing. Even if the information were used to decide whether to terminate a pregnancy, not all (and perhaps not most) choices to terminate pregnancies based on prenatal information are rooted in prejudice or commodification of children. A pregnant person may decide, for example, to terminate a pregnancy based on a condition like Tay Sachs, not because of prejudice or because she views her child as a product. Instead, she may want to prevent suffering or have concerns about her emotional and/or financial capacity to care for a child with a disability.

One might defend the laws by pointing to the dramatic decline of children born with Down syndrome in Scandinavian countries.[185] Although not nearly so stark, the numbers in the United States are not insignificant.[186] Even so, prohibiting disclosure of prenatal information normally disclosed as part of the standard of care is not a useful way to address these behaviors. First, under the approach I advocate, the law would be subject to strict scrutiny because it would deviate from the standard of care. Second, far less intrusive and more effective measures exist. States could educate the public about Down syndrome (or other disabilities) or provide relevant information about the condition when prenatal testing identifies it.[187] Most important, they could offer adequate educational and other support for children with disabilities so that having such children would feel like a viable option to parents.

Nor do worries about the aggregate effect of embryo selection based on disease, sex, or other nonmedical traits support such bans. Given IVF's high cost, PGT is not likely to become widespread. And although wealthier people could more easily access PGT, potentially exacerbating social inequities, the physical burdens of egg retrieval would likely discourage many of them from using PGT, especially for minor diseases or mere traits. Indeed, polls suggest only a minority support embryo selection for purposes other than avoiding serious disease. Moreover, societal inequities due to wealth disparities may be more profound than those based on genetics. Studies have shown that household income is far more predictive of future success than genetics.[188] Thus, addressing income inequality through something like child tax credits would do far more to prevent exacerbation of inequities than banning information from PGT.[189]

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For all these reasons, even if the state interests motivating such bans are deemed substantial, these potential laws would not advance those interests in a meaningful way. Because the laws would struggle under intermediate scrutiny, they would surely fail under strict scrutiny. As a starting point, the state interests are not compelling. Preserving fetal life only becomes compelling at viability,[190] but prenatal testing usually occurs before viability and PGT before a pregnancy is even established. Further, the Supreme Court has not expressly described a state interest in the social values and effects legislatures might point to, suggesting they too are not compelling. Finally, because the laws are not closely enough drawn to the state interests for intermediate scrutiny, they clearly are not narrowly tailored to those interests.

V. Conclusion

Given the increase in reason-based abortion bans, it seems entirely possible that some legislatures may restrict physicians from disclosing information obtained through prenatal testing and PGT based on concerns about eugenics, disability rights, commodification, and equality. While cognizant of the First Amendment doctrinal morass regarding speech in health care, I nevertheless attempt to offer a consistent and coherent interpretation of *NIFLA* and *Casey*. Under that approach, such laws would violate the First Amendment.

I end by noting a few key issues left unexplored in this piece, given space constraints. First, should the law treat compelled speech differently from restricted speech? Courts rarely raise this issue and the "Supreme Court has been deliberately noncommittal"[191] about it, despite suggesting the distinction is not constitutionally significant.[192] Second, how should legislatures and courts grapple with the challenges and normative elements of drawing lines between medical and nonmedical conditions — a line that informs the analysis? Nor do I fully grapple with the political elements that may shape understandings of the standard of care or what constitutes a medical condition. Finally, I do not address the variations of intermediate scrutiny that courts have deployed. I hope to address these issues in a future project that will propose a theory of First Amendment analysis for speech regulations in health care generally and that avoids potential constitutional gerrymandering of the First Amendment.

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52. *See* C.H. Coleman, "Regulating Physician Speech," *North Carolina Law Review* 97, no. 4 (2019): 843-898, at 852 ("The most that can be said about *Casey* is that the plurality was clearly not applying strict scrutiny in its First Amendment analysis as it made no effort to determine whether the statute was 'narrowly tailored' or based on a 'compelling state interest.'"); B. Jessie Hill, "Sex, Lies, and Ultrasound," *University of Colorado Law Review* 89 (2018): 421-452; S.W. Gaylord, "A Matter of Context: Casey and the Constitutionality of Compelled Physicians Speech," *Journal of Law Medicine & Ethics* 43, no. 1

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(2015): 35-50 at 36; *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570 (5th Cir. 2012).
53. Suter, *supra* note 51; *Stuart v. Camnitz*, 774 F. 3d 238, 248-49 (4th Cir. 2014); M. Dunlap, "Challenging Abortion Informed Consent Regulations through the First Amendment: The Case for Protecting Physicians' Speech," *University of Chicago Legal Forum*, 2019 (2019): 443-471.
54. 138 S. Ct. 2361 (2018).
55. Cal. Health & Safety Code Ann. § 123472(a)(1). It also required unlicensed clinics to provide notices stating they are "not licensed as a medical facility." *Id.* at § 123472(b)(1).
56. *Nat'l Inst. of Family Life & Life Advocates v. Harr*is, 839 F.3d 823, 845 (9th Cir. 2016).
57. *Id.* at 833-842. It also found that the unlicensed notice would survive any level of scrutiny. *Id.* at 843-844.
58. 138 S. Ct. at 2368.
59. *Id.* at 2371.
60. *Id.* at 2371-2372.
61. *Id.* at 2372.
62. *Id.*
63. *Id.* (emphasis added).
64. *Id.* at 2373.
65. *Id.* at 2373.
66. *Id.* at 2385 (Breyer, J., dissenting).
67. *Id.* at 2386.
68. *Id.* at 2388.
69. 471 U.S. 626, 651 (1985).
70. 138 S. Ct at 2372. Some scholars question the characterization of speech in *Zauderer* as professional speech, arguing that "*Zauderer* ... involved speech directed to prospective clients as opposed to speech occurring within an established professional relationship." L. Noah, "Censorship Is So Last Century: Therapeutic Products, Propaganda, and Compelled Speech," *St. Louis University Law Journal* 66 (forthcoming 2021), at 7 n.32.
71. *Id.* at 638.
72. 138 S. Ct at 2372 (citing to *Zauderer*, 471 U.S. at 651) (emphasis added).
73. *Id.* at 2372. In addition, it found that the notice requirements concerned information that "in no way related to the services that licensed clinics provide" because it concerned services sponsored by the state. *Id.*
74. *Id.* at 2374 (quoting *Sorrell*, *supra* at 566).
75. *Id.*
76. *Id.* (internal citations omitted).
77. *EMW Women's Surgical Ctr., P.S.C. v. Beshear*, 920 F.3d 421, 453 (6th Cir. 2019) (Donald, J., dissenting) (quoting *NIFLA*, 138 S. Ct at 2374) (citations omitted)).
78. 138 S. Ct at 2375.
79. Miller and Berkman, *supra* note 12, at 645.
80. *See Harris*, 839 F.3d at 838-39 (2016); *see also King v. Governors of N.J.*, 767 F.3d 216, 232 (3d Cir. 2014); *Pickup v. Brown*, 740 F.3d 1208, 1227-29 (9th Cir. 2014); *Moore-King v. County of Chesterfield*, 708 F.3d 560, 568-570 (4th Cir. 2014); *see also* D. Halberstam, "Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions," *University of Pennsylvania Law Review* 147, no. 4 (1999): 771-874 at 843; R. Post, "Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech," *University of Illinois Law Review* 2007, no. 3 (2007): 939-990 at 947; M. Swartz, "Physician-Patient Communication and the First Amendment After *Sorrell*," *Michigan State University Journal of Medicine and Law* 17, no. 2 (2012): 101–140 at 110; C.E. Haupt, "Professional Speech," *Yale Law Journal* 125, no. 5 (2016): 1238-1303.
81. 309 F.3d 629 (9th Cir. 2002).
82. 740 F. 3d 1208 (9th Cir. 2014).
83. *Id.* at 1227.
84. *Id.* at 1230-31.
85. 767 F. 3d 216 (3d Cir. 2014).
86. *Id.* at 225-26.
87. *Id.* at 229.
88. *Id.* at 232-234.
89. *Id.* at 236.
90. *Id.* at 238.
91. Fla. Stat. Ann. §§ 381.026, 456.072, 790.338.
92. *Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195 (11th Cir. 2014), vacated on reh'g. 797 F.3d 859 (11th Cir. 2015) (reversing the lower court's use of heightened scrutiny to enjoin the statute on the grounds that the law regulated conduct and therefore did not implicate the First Amendment); *Wollschlaeger v. Governor of Fla.*, 797 F.3d 859 (11th Cir.), vacated on reh'g, 814 F.3d 1159 (11th Cir. 2015) (finding that the law did in fact regulate speech and therefore *was* subject to First Amendment analysis, but because the law regulated speech within a fiduciary relationship, intermediate scrutiny applied); *Wollschlaeger v. Governor of Fla.*, 814 F.3d 1159, 1186 (11th Cir. 2015), aff'd in part and rev'd in part en banc, 848 F.3d 1293 (11th Cir. 2017) (hinting that strict scrutiny might apply to all content-based restrictions on speech, but avoiding the "difficult question" as to whether strict scrutiny was appropriate, because the law survived strict scrutiny, and therefore would survive "any less demanding level of scrutiny").
93. *Wollschlaeger v. Governor of Fla.*, 848 F.3d 1293 (11th Cir. 2017) (en banc).
94. *Id.* at 1316. It didn't decide whether strict scrutiny applied finding the law failed intermediate scrutiny. *Id.* at 1311.
95. 981 F. 3d 854 (11th Cir. 2020).
96. *Id.* at 865 ("'States may regulate professional conduct, even though that conduct incidentally involves speech.'").
97. *Id.*
98. *Id.* at 863.
99. *Id.* at 861 (quoting *NIFLA v. Becerra*, 138 S. Ct. 2361, 2374 (2014)).
100. *Id.* at 867 (quoting *NIFLA v. Becerra*, 138 S. Ct. 2361. 2374 (2018)); *id.* at 866 (*Wollschlaeger* "already rejected the suggestion that government's ability to regulate entry into a profession entitles it to regulate the speech of professionals").
101. *Id.* at 868.
102. *Id.* at 869 (concluding that an American Psychological Association report found "'no clear indication of the prevalence of harmful outcomes among people who have undergone'" SOCE).
103. *Id.* at 871.
104. *Id.* at 878.
105. *Id.* at 880, n.1 (Martin, J, dissenting).
106. 667 F.3d 570, 578-79 (5th Cir. 2012) (describing the mandated message as the "epitome of truthful").
107. 774 F.3d 238 (4th Cir. 2014).
108. *Id.* at 246.
109. *Id.* at 242.
110. *Id.* at 246.
111. *Id. See also id.* at 255 (describing the patient's vulnerable posture in finding herself "half-naked or disrobed on her back on an examination table, with an ultrasound probe either on her belly or inserted into her vagina").
112. *Id.* at 251-253.
113. 920 F.3d 421 (6th Cir. 2019).
114. *Id.* at 429.
115. *Id.* at 436.
116. *Id.* at 435.
117. *Id.* at 436-37.
118. 550 U.S. 124 (2007).
119. *Beshear*, 920 F.3d at 438 (The Court upheld the statute in *Casey* despite the lower court's finding that the informed consent requirements "'represent a substantial departure from the ordinary medical requirements of informed consent'" and *Gonzales* upheld a ban on a late-term abortion procedure despite the lower court's finding that "the law was contrary to certain medical-profession views").
120. *Id.* at 432.
121. *Id.* at 439.
122. *Id.* at 444.

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123. *Id.* at 450 (quoting *Planned Parenthood of Southeastern Penn. v. Casey*, 505 U.S. 833, 884 (1992)) (emphasis added).
124. *Id.* at 453.
125. *Id.* at 456.
126. It noted the lack of evidence that the mandate accords with "the medically-accepted standard of care," *id.* at 459, or benefits the informed consent process, *id.* at 458.
127. *Id.* at 460.
128. *Id.* at 453 (citing *NIFLA v. Becerra*, 138 S. Ct. 2361, 2376 (2018)).
129. P. Berg, "Toward a First Amendment Theory of Doctor-Patient Discourse and the Right to Receive Unbiased Medical Advice," *Boston University Law Review* 74, no. 2 (1994): 201-266, at 201, 235; M. Swartz, "Physician-Patient Communication and the First Amendment After *Sorrell*," *Michigan State University Journal of Medicine & Law* 17, no. 1 (2012): 101-126, at 101, 107; P. Sherman, Commentary, "Occupational Speech and the First Amendment," *Harvard Law Review Forum* 128 (2015): 183-205, at 183, 199, *available at* <http://harvardlawreview.org/wp-content/uploads/2015/03/vol128_Sherman.pdf> (last visited July 28, 2021).
130. *NIFLA*, 138 S. Ct. at 2374 (citing Berg, *supra* note 129, at 201-02).
131. C.E. Haupt, "Unprofessional Advice," *University of Pennsylvania Journal of Constitutional Law* 19, no. 3 (2017): 671-729, at 671, 675 (2017). She also argues that because the professional community should decide "what is good professional advice," the "further state regulation diverges from professional consensus … the more skeptical courts ought to be." C.E. Haupt, "Professional Speech and the Content-Neutrality Trap," *Yale Law Journal Forum* 127 (2017): 150-172, at 150, 167, *available at* <https://www.yalelawjournal.org/pdf/Haupt_xv7cdx9m.pdf> (last visited July 28. 2021).
132. Post, *supra* note 80, at 957. *See also* D. Orentlicher, "Abortion and Compelled Physician Speech," *Journal of Law, Medicine & Ethics* 43, no. 1 (2015): 9-21, at 9, 13; J.L. Dolgin, "Physician Speech and State Control: Furthering Partisan Interests at the Expense of Good Health," *New England Law Review* 48, no. 2 (2014): 293-342, at 293, 342; Suter, *supra* note 51.
133. T. Zick, "Professional Rights Speech," *Arizona State Law Journal* 47, no. 4 (2015): 1290-1360, at 1289, 1294, 1327-29, 1359.
134. Suter, *supra* note 51, at 22; See also Post, *supra* note 80, at 978.
135 Coleman, *supra* note 53, at 88.
136. *Id.* at 884.
137. *Id.* at 872.
138. *Id.* at 892.
139. *Id.* at 887.
140. *Id.* at 889-890.
141. Miller and Berkman, *supra* note 12, at 652.
142. *Id.* at 654.
143. *Id.* at 654.
144. I have argued similarly. Suter, *supra* note 51.
145. C.E. Haupt, "The Limits of Professional Speech," *Yale Law Journal Forum*, September 5, 2018, *available at* <https://www.yalelawjournal.org/pdf/Haupt_e652yj62.pdf> (last visited August 1, 2021). *See also* Noah, *supra* note 70, at 6-7.
146. *See supra* text accompanying notes 77-80.
147. *Otto*, 981 F.3d at 861.
148. E. Chemerinsky and M. Goodwin, "Constitutional Gerrymandering Against Abortion Rights*: NIFLA v. Becerra*," *New York University Law Review* 94, no. 1 (2019): 61-124.
149. *Id.* at 111.
150. Miller and Berkman, *supra* note 12, at 652.
151. Suter, *supra* note 51, at 26.
152. Coleman, *supra* note 52, at 887.
153. *See supra* text accompanying notes 96-103.
154. *See supra* text accompanying notes 113-119.
155. Miller and Berkman, *supra* note 12.
156. 138 S. Ct at 2373.
157. *Id.* at 2386 (Breyer, J., dissenting).
158. *Beshear*, 920 F.3d at, 447 (Donald, J., dissenting) (quoting *NIFLA*, 138 S. Ct. at 2373)).
159. *Otto*, 981 F.3d at 880, n.1 (Martin, J., dissenting) (quoting *Beshear*, 920 F.3d at 447 (Donald, J., dissenting) (citing *NIFLA*, 138 S. Ct. at 2372)).
160. *Beshear*, 920 F.3d at 447 (Donald, J., dissenting).
161. *Id.* at 460.
162. *Otto*, 981 F.3d at 874 (Martin, J., dissenting).
163. *Casey*, 505 U.S. at 882-83 (comparing the requirement that women seeking abortion be informed of "the availability of materials relating to the consequences to the fetus, even when those consequences have no direct relation to her health," with requiring the recipient of a kidney transplant operation to "be supplied with information about risks to the donor as well as risks to himself or herself").
164. Coleman, *supra* note 52.
165. *See* Mehlman et al., *supra* note 15, at 172-82.
166. I concede that the between medical and nonmedical information is decidedly blurry, an issue I save for future work.
167. The exception would be in cases where there is a family history of sex-linked diseases.
168. While termination of pregnancies in many countries are not uncommon because of sex, usually female sex, most people in the United States have preferences for family balancing, not because one sex is deemed superior to another. *See* Guttmacher, *supra* note 10.
169. One survey found that 59% of ART clinics offer sex selection through PGT for any non-specific elective reason to infertile couples (81.2% of the 72.7% that offer sex selection) and 54% to couples without infertility (74.6% of 72.7%). *See* S.M. Capelouto et al., "Sex Selection for Non-Medical Indications: A Survey of Current Pre-Implantation Genetic Screening Practices Among U.S. ART Clinics," *Journal of Assisted Reproduction and Genetics* 35, no. 3 (2018): 409-416.
170. *See supra* text accompanying notes 22-23.
171. The Ethics Committee of the American Society for Reproductive Medicine "does not have a consensus on the Permissibility" of nonmedical sex selection selection. See Ethics Committee, *supra* note 30. In contrast, the American College of Obstetricians and Gynecologists Committee on Ethics "opposes all forms of sex selection not related to the diagnosis of sex-linked conditions." American College of Obstetricians and Gynecologists, "ACOG Committee Opinion No. 410: Ethical Issues in Genetic Testing," *Obstetrics & Gynecology* 111, no. 6 (2008): 1495-1502.
172. *See* R.L. Weaver and D.E. Lively, *Understanding the First Amendment* (2d ed. LexisNexis, 2003): at 14 (describing potentially different calibrations of intermediate levels of scrutiny with a balancing of "the competing constitutional and regulatory interests").
173. *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 572 (2011).
174. *See McCutcheon v. Federal Election Comm'n*, 572 U.S. 185, 218 (2014).
175. *Gonzales v. Carhart*, 550 U.S. 124, 145 (2007).
176. *Id.* at 145 (noting it is a "legitimate and substantial interest").
177. *Casey,* 505 U.S. at 834.
178. S.M. Suter, "The 'Repugnance' Lens of *Gonzales v. Carhart* and Other Theories of Reproductive Rights: Evaluating Advanced Reproductive Technologies," *George Washington Law Review* 76, no. 6 (2008): 1514-1598, at 1580-1583; D. Fox, "Interest Creep," *George Washington Law Review* 82, no. 2 (2014): 273-357, at 303-312, (describing such concerns as a state interest in social values).
179. *Supra* text accompanying note 11.
180. *Supra* text accompanying note 27.
181. *Supra* text accompanying note 33.
182. *Supra* text accompanying note 32.
183. Suter, *supra* note 14.
184. *Id.*
185. W. Christian, "Down Syndrome Heading for Extinction in Denmark," *CPH Postonline*, Oct. 20, 2015, *available at* <http://cphpost.dk/?p=30968#:~:text=The%20number%20

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of%20children%20born,the%20past%20in%2030%20years> (finding that, in Denmark, 98% of pregnant women found to be carrying an unborn child with Down syndrome terminated their pregnancy); D. McLean, "Iceland Close to Becoming First Country Where No Down's Syndrome Children Are Born," *Independent*, Aug. 16, 2017, *available at* <https://www.independent.co.uk/life-style/health-and-families/iceland-downs-syndrome-no-children-born-first-country-world-screening-a7895996.html> (reporting that "just one or two children with Down's syndrome are born in Iceland each year," sometimes because of inaccurate test results, and stating that 85% of pregnant women in Iceland were undergoing prenatal testing or screening and most terminated pregnancies positive for Down syndrome).

186. G. de Graaf et al., "Estimation of Live Birth and Population Prevalence of Down Syndrome in Nine U.S. States," *American Journal of Medical Genetics* 173, no. 10 (2017): 2710-2719 (finding that selective termination reduced the number of children born with Down syndrome by 39% overall in nine states, but that because people with Down syndrome now live longer than ever. There is currently a plateau in population levels of individuals with trisomy 21).
187. There has been some legislation at the state and federal level "to ensure that prospective parents receive balanced information about … conditions identified in the fetus." Mehlman et al., *supra* note 15, at 168.
188. A.V. Dam, "It is Better to Be Born Rich than Gifted," *Washington Post*, Oct. 9, 2018, *available at* <https://www.washingtonpost.com/business/2018/10/09/its-better-be-born-rich-than-talented/> (last visited July 31, 2021).
189. C. Pulliam and R.V. Reeves, "New Child Tax Credit Could Slash Poverty Now and Boost Social Mobility Later," *Brookings*, March 11, 2011, *available at* <https://www.brookings.edu/blog/up-front/2021/03/11/new-child-tax-credit-could-slash-poverty-now-and-boost-social-mobility-later/> (last viewed July 31, 2021).
190. *Dobbs v. Jackson Women's Health Organization*, 141 S. Ct. 2619 (2021). The Supreme Court granted Mississippi's petition for certiorari, after its 15-week ban of abortions was deemed unconstitutional by the lower courts for violating well-established precedent. The Supreme Court's willingness to address the question as to whether a 15-week abortion ban may sometimes be constitutional suggests this line is on shaky ground.
191. Post, *supra* note 80, at 980.
192. **Riley v. Nat'l Fed'n of the Blind of N. Carolina, Inc.*, 487 U.S. 781, 796 (1988) ("There is certainly some difference between compelled speech and compelled silence, but in the context of protected speech, the difference is without constitutional significance."). Some courts have found that regulations that compel commercial speech "'tend[] to [be] less objectionable under the First Amendment'" than regulations that prohibit such speech. Post, *supra* note 80, at 980 (quoting *Walker v. Bd of Prof'l Responsibility of the Supreme Court of Tenn.*, 38 S.W.3d 540, 545 (Tenn. 2001)). "[O]thers believe the reverse." *Id.* at 980-981.

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