



5-17-2017

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Recommended Citation

Juliana Shulman-Laniel, *A Patient's Right Not to Hear: The Public Health Case for Challenging Pre-Abortion Ultrasound Description Mandates by Refocusing on the Listener*, 6 DePaul J. Women, Gender & L. (2017)

Available at: <https://via.library.depaul.edu/jwgl/vol6/iss2/2>

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**A PATIENT'S RIGHT NOT TO HEAR:
THE PUBLIC HEALTH CASE FOR
CHALLENGING PRE-ABORTION ULTRASOUND
DESCRIPTION MANDATES BY REFOCUSING
ON THE LISTENER**

*Juliana Shulman-Laniel, MPH**

I. INTRODUCTION

On June 27, 2016, the Supreme Court ruled on its first major abortion case in nearly a decade: *Whole Woman's Health v. Hellerstedt*.¹ In *Whole Woman's Health*, the Court reiterated and expanded upon the “undue burden” standard first established by *Planned Parenthood v. Casey*.² In doing so, the Court provided further guidance on how to interpret state laws that regulate abortion access. While the Court’s decision in *Whole Woman's Health* has major implications for many state regulations concerning abortion providers, the Court’s holding left unanswered a number of critical questions. In particular, lower courts and scholars must still grapple with how to analyze the wide range of abortion-specific informed consent laws that women must face prior to obtaining abortion care,³ including state laws that require women to undergo pre-

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¹ *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

² *Id.* at 2309 (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992)).

³ See generally GUTTMACHER INST., *State Laws and Policies: An Overview of Abortion Laws* (Aug. 1, 2016), <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws> (describing the myriad of state laws that may restrict a woman’s access to abortion services).

abortion ultrasounds that further require physicians to provide descriptions of the fetus.⁴

Most of the challenges to these ultrasound description mandates, in both legal literature and in the courts, have focused on the First Amendment rights of physicians and other health professionals who must provide ultrasound descriptions to a woman seeking an abortion.⁵ Courts and scholars have consistently asked whether health professionals have a First Amendment right against compelled speech, and if so, whether informed consent ultrasound laws violate this right.⁶ Surprisingly little attention has been paid, however, to the question of whether patients who are required to hear a pre-abortion ultrasound description may have a right against “compelled listening.”⁷

This Note analyzes that question and proposes a different approach. Rather than attempting to strike down these laws by navigating the abstruse arena of compelled professional speech or by grasping to demonstrate an “undue burden” where one may not exist, public health lawyers and advocates should instead focus on the rights of the *listener*, and in particular, move towards recognition of a woman’s right *not to hear*. Part II of this Note provides background on the legal landscape of abortion-specific informed consent and the legal approaches that have been taken to challenge restrictive state laws. Part III then explores how the ever-evolving First Amendment rhetoric and doctrine around

⁴ LA. REV. STAT. ANN. § 40:1061.10(D) (2016); TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(4)(C) (West 2011); WIS. STAT. ANN. § 253.10(3g)(2) (West 2016).

⁵ See, e.g., Scott W. Gaylord & Thomas J. Maloney, *Casey and a Woman’s Right to Know: Ultrasounds, Informed Consent, and the First Amendment*, 45 CONN. L. REV. 595 (2012); Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, U. ILL. L. REV. 939 (2007); Sonia M. Suter, *The First Amendment and Physician Speech in Reproductive Decision Making*, 43 J.L. MED. & ETHICS 22 (2015); Ian Vanderwalker, *Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics*, 19 MICH. J. GENDER & L. 1 (2012).

⁶ See, e.g., Gaylord & Maloney, *supra* note 5; Post, *supra* note 5.

⁷ See, e.g., Caroline Mala Corbin, *The First Amendment Right Against Compelled Listening*, 89 BOS. U. L. REV. 939, 966 (2009); see also Suter, *supra* note 5, at 38.

professional speech may support the notion of a patient's right not to hear. This section also describes how the captive-audience doctrine can be used to bolster this right for women who are required to withstand compelled speech within the intimacy of an abortion clinic, and how the content of emotionally intrusive information affects this right. Part IV discusses how the current discourse surrounding ultrasound descriptions in the *health professional's* right against compelled speech may ultimately be dangerous for public health and for the states' continuing need to regulate the practice of medicine. Additionally, Part IV argues that re-framing the debate to focus on the patient's right not to hear and away from the physician's right not to speak is therefore critical, not only to challenging the restrictive laws that hinder women's access to abortion care, but also to protecting the vital legal mechanisms of informed consent and of public health law more broadly.

II. THE LEGAL LANDSCAPE FOR ULTRASOUND DESCRIPTION MANDATES

At present,⁸ women in thirty-eight states live in jurisdictions with abortion-specific informed consent requirements.⁹ This

⁸ This Note was published in May 2017. All research is current up to this date unless otherwise indicated.

⁹ GUTTMACHER INST., *State Policies in Brief: Counseling and Waiting Periods for Abortion* (Mar. 1, 2016), https://www.guttmacher.org/sites/default/files/pdfs/spibs/spib_MWPA.pdf [hereinafter *State Counseling Policies*]. There have also been attempts to enact similar legislation at the federal level. Most recently, on January 22, 2015, the Ultrasound Informed Consent Act was introduced to Congress. The bill has since sat in the Subcommittee on Health. Similar to many of the state laws, the bill provides that a woman may look away from the required ultrasound, but the bill is notably silent on whether a woman may refuse to listen to the explanation of the ultrasound's depictions. H.R. 492, 114th Cong. (2015). Additionally, some of these state requirements may, in effect, require the particularly intrusive procedure of a transvaginal ultrasound, particular for the vast majority of women who seek abortions in the early stages of pregnancy. See Jessica Silbey, *Picturing Moral Arguments in a Fraught Legal Arena: Fetuses, Photographic Phantoms and Ultrasounds*, 16 GEO. J. GENDER & L. 1, 6 n.10 (2015) ("The transvaginal ultrasound is a common

includes twelve states that require a woman to receive counseling about the “ability of a fetus to feel pain,” six states “that require that the woman be told that personhood begins at conception,” and five states that require a woman to receive information “inaccurately assert[ing] a link between abortion and an increased risk of breast cancer.”¹⁰

Among these abortion-specific informed consent requirements, as of March 2016, women who seek abortions in thirteen states are first required to have an ultrasound.¹¹ In ten out of thirteen of these states, the woman must be “offered” the “opportunity to view the [ultrasound] image,” and may be offered the opportunity to hear the fetal heartbeat or to hear a detailed description of the fetus, its gestational age, and more. In these ten states, while the ultrasound is mandatory for most women, the woman is not required to hear a doctor’s description of the fetus or to view the ultrasound image.¹² However, women who currently seek abortions in three states – Louisiana, Texas, and Wisconsin – are required by law to not only have an ultrasound prior to giving informed consent, but also required to *hear* a verbal description of the fetus during the ultrasound procedure.¹³

These ultrasound mandates – often called Women’s Right to Know Acts¹⁴ or “speech and display” laws¹⁵ – are passed under the

procedure for early-stage pregnancies, but like all pregnancy-related treatment, it is voluntary for women. When requesting an abortion, the mandatory nature of an ultrasound, coupled with the fact that early-stage pregnancy ultrasounds are most often conducted transvaginally, makes the requirement of the ultrasound all that more invasive.”)

¹⁰ *State Counseling Policies*, *supra* note 9.

¹¹ GUTTMACHER INST., *State Policies in Brief: Requirements for Ultrasound* (Mar. 1, 2016), http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf.

¹² *Id.* (See chart providing explanations for ultrasound requirements by state. Specifically, “[i]n Virginia and Wisconsin a woman who has been sexually assaulted is not required to undergo the ultrasound.”).

¹³ LA. REV. STAT. ANN. § 40:1061.10(D) (2016); TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(4)(c) (West 2011); WIS. STAT. ANN. § 253.10(3g)(2) (West 2016).

¹⁴ See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 171.001 (West 2003).

¹⁵ Timothy Zick, *Professional Rights Speech*, 47 *Ariz. St. L.J.* 1289, 1311 (2015).

guise of informed consent, premised on the notion that, without the description conveyed during an ultrasound, women are not fully informed about their abortion procedure.¹⁶ However, the laws in Louisiana, Texas, and Wisconsin, where a clinician is required to describe the fetus during the ultrasound, arguably represent a dangerous departure from the common law of informed consent by not allowing women to decline the description.¹⁷ In other words, women are not able to determine for themselves what information is material – or not – to their consent or to refuse information the state has deemed relevant to their decision-making.

For example, Louisiana law requires all women to have an ultrasound “at least twenty-four hours” prior to any abortion procedure.¹⁸ The law articulates that the clinician must “display the screen which depicts the active ultrasound images so that the pregnant woman may view them” and “make audible the fetal heartbeat.”¹⁹ However, the woman is not required to listen to the fetal heartbeat or to view the ultrasound image.²⁰ In contrast, the law *does* specify that women are *required* to listen to a simultaneous “oral explanation” of the fetus, including the “presence and location of the unborn child,” “the dimensions of the unborn child,” and the “presence of cardiac activity.”²¹ Prior to the ultrasound, the woman

¹⁶ See, e.g., Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 351, 351 (2008).

¹⁷ For example, in Texas and Louisiana, women *can* decline the description under limited circumstances, such as to abort a pregnancy following sexual assault or rape if the woman first reports the assault to law enforcement. LA. § 40:1061.10(D)(6)(e) (Westlaw); TEX. HEALTH & SAFETY § 171.022(d)(1) (West 2011).

¹⁸ LA. § 40:1061.10(D)(2).

¹⁹ *Id.* § 40:1061.10(D)(2)(a).

²⁰ *Id.*

²¹ *Id.* §§ 40:1061.10(D)(2)(a)-(b). The law does provide the opportunity for “[p]regnant rape survivors or victims of crime against nature . . . who have reported the act to law enforcement officials” to opt-out of this oral description. *Id.* § 40:1061.10(D)(2)(e). However, given that one must first *report* the rape or other crime to law enforcement officials, one might suspect that few women who are obtaining an abortion after having experienced rape or other trauma would be able to certify to the state that they fall within this limited exception.

must sign a state-created consent form, certifying that she understands that she is “required by law to hear an oral explanation of the ultrasound images.”²²

Notably, throughout the Louisiana statute, the law frames all of these requirements in terms of a woman’s positive rights. The informed consent form states:

During this ultrasound examination, you have the right to an oral explanation of the results. You have the option to view the images on the ultrasound screen . . . You have the right to receive answers to any questions you ask about your ultrasound examination. You have the right to receive an ultrasound photographic print, which will be provided at your request.²³

This framing of the state’s requirements as a woman’s “options” conforms to the notion that these laws enhance informed consent and patient autonomy. Certainly, this framing conforms to the rhetoric put forth by the legislature that these laws are intended to “allow the patient to evaluate her condition and render her best decision under difficult circumstances.”²⁴ Yet, this framing of a woman’s positive *right to hear* may also potentially open the door to the notion that the corollary right should also exist – a right *not* to hear – based on the same premise that a patient should be “[allowed] . . . to evaluate her condition and render her best decision,”²⁵ which may include refusing specific information during her decision-making process.²⁶

Despite a great deal of attention focused on abortion-specific informed consent laws, the constitutionality of mandatory

²² *Id.* § 40:1061.10(D)(2)(d).

²³ *Id.* § 40:1061.10(D)(2)(e).

²⁴ 2012 La. Acts 685.

²⁵ *Texas Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 579 (5th Cir. 2012).

²⁶ Corbin, *supra* note 7, at 955.

ultrasound description laws remains unclear.²⁷ The Supreme Court's decision in *Whole Woman's Health* did not touch upon a First Amendment analysis, as informed consent laws were not raised by the Texas regulations in question. What *Whole Woman's Health* does provide for this discussion, however, is additional guidance for how state abortion regulations should be interpreted by the courts under the evolving "undue burden" standard.²⁸

By striking down Texas' so-called Targeted Regulation of Abortion Provider ("TRAP") laws,²⁹ *Whole Woman's Health* marks only the second time the Supreme Court has interpreted abortion regulations that predominantly use a "woman-protective rationale."³⁰ As a result, its holding may have broad implications for how to apply the "undue burden" standard and interpret the validity of legislation that uses this type of "protective" rationale in the future. As Justice Breyer described in his opinion, "[t]he rule announced in *Casey*, . . . requires that courts consider the burdens a law imposes on abortion access together with the benefits these laws

²⁷ See *Stuart v. Camnitz*, 774 F.3d 238 (4th Cir. 2014), *cert. denied*, 135 S. Ct. 2838 (2015); *Nova Health Sys. v. Pruitt*, 292 P.3d 28 (Okla. 2012), *cert. denied*, 134 S. Ct. 617 (2013); *but see Texas Med. Providers Performing Abortion Servs.*, 667 F.3d 570, 580 (5th Cir. 2012).

²⁸ See *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016) (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992)).

²⁹ See generally Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics – And the Women They Serve – Pay the Price*, 16 No. 2 GUTTMACHER POL'Y REV. 7, (Spring 2013) (describing the rise of Targeted Regulation of Abortion Providers ("TRAP") laws that place onerous restrictions on abortion facilities and providers in the name of protecting women).

³⁰ Arguably, *Gonzales v. Carhart*, 550 U.S. 124 (2007) also analyzed a law predominantly based on "woman-protective" grounds, although the purported protective purpose at issue in *Carhart* – which focused on the potential psychological harm to women if the "partial birth abortion" ban were lifted – is not as central to the case as the protective purpose was in *Whole Woman's Health*. See *Carhart*, 550 U.S. at 29. See also Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991 (2007) (describing the development of "women-protective rationales" in abortion regulation.)

confer.”³¹ He goes on to do just that, examining not only the ample evidence that Texas’ regulations “place[d] a substantial obstacle in the path of women seeking a previability abortion,”³² but also the distinct *lack* of evidence to support Texas’ assertion that these regulations would improve women’s health.³³ Justice Breyer “conclude[d] that neither [of the law’s] provisions offers medical benefits sufficient to justify the burdens upon access that each imposes.”³⁴

Similar to the TRAP laws at issue in *Whole Woman’s Health*, there is likely little evidence to support the usefulness of ultrasound description mandates to *improve* women’s health. It is not clear that states would be able to provide evidence to demonstrate that these laws serve their purported goal of improving women’s understanding of abortion prior to undergoing the procedure. What may be less clear than with TRAP laws, however, is whether ultrasound description mandates *impede* access to abortion, thereby still constituting an undue burden in light of no beneficial evidence.³⁵ Hence, while *Whole Woman’s Health* provides a helpful basis for understanding how the Court may look to laws that espouse a woman-protective rationale in the future, it does not provide a clear answer for whether ultrasound description

³¹ *Whole Woman’s Health*, 136 S. Ct. at 2309 (citing *Casey*, 505 U.S. at 887-98).

³² *Id.* at 2296.

³³ *Id.* at 2311 (“We have found nothing in Texas’ record evidence that shows that, compared to prior law (which required a ‘working arrangement’ with a doctor with admitting privileges), the new law advanced Texas’ legitimate interest in protecting women’s health. We add that, when directly asked at oral argument whether Texas knew of a single instance in which the new requirement would have helped even one woman obtain better treatment, Texas admitted that there was no evidence in the record of such a case.”).

³⁴ *Id.* at 2300.

³⁵ Ultrasound description mandates may, in fact, impede access to abortion care, in part by, in effect, requiring an additional waiting period prior to the abortion procedure (a wait that may be a substantial obstacle for many women, particularly those who may need to travel long distances for care). The ultrasound may also provide a financial barrier to women seeking abortion care. Ultimately, there is not yet enough evidence to know whether these barriers rise to the level of the undue burden standard expanded upon by *Whole Woman’s Health*.

mandates would likely be struck down by the Court as an “undue burden” on women’s access to abortion. Moreover, the Court in *Whole Woman’s Health* provides no guidance for how the First Amendment questions implicated by ultrasound description mandates should be interpreted.

Prior to the holding in *Whole Woman’s Health*, however, several courts used the previous guidance from *Casey* to analyze the constitutionality of ultrasound description mandates.³⁶ In particular, the U.S. Court of Appeals for the Fourth Circuit enjoined the enforcement of North Carolina’s ultrasound description mandate, claiming that the compelled physician speech is “ideological in intent and in kind” and represents a violation of the First Amendment.³⁷ In Texas, however, the Fifth Circuit held that a similar law did not violate the “undue burden” standard established by *Casey*, allowing the Texas legislature to continue to require that women seeking abortions first be required to hear an oral description during their mandated pre-abortion ultrasound.³⁸ Again, the court focused on the patient’s rights as only tangential to the clinician’s, emphasizing that the Texas law does not violate a physician’s First Amendment right not to speak, but providing little analysis as to whether the law may violate an undefined right of the patient not to hear.³⁹

III. ESTABLISHING A PATIENT’S RIGHT NOT TO HEAR

Legal advocates have struggled with how to counter the wave of state legislation that regulates – and arguably restricts – abortion access by requiring pre-abortion ultrasounds.⁴⁰ While

³⁶ See, e.g., *Stuart v. Camnitz*, 774 F.3d 238, 256 (4th Cir. 2014), *cert. denied*, 135 S. Ct. 2838 (2015); *Nova Health Sys. v. Pruitt*, 292 P.3d 28, 29 (Okla. 2012), *cert. denied*, 134 S. Ct. 617 (2013). See also, *Stuart v. Loomis*, 992 F. Supp. 2d 585 (M.D.N.C. 2014).

³⁷ *Camnitz*, 774 F.3d at 242.

³⁸ *Texas Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 576 (5th Cir. 2012).

³⁹ *Id.* at 583.

⁴⁰ See generally, e.g., Silbey, *supra* note 9, at 45; and Suter, *supra* note 5, at 27.

Whole Woman's Health may open the door to new challenges of “speech and display” laws,⁴¹ prior to this case, advocates and scholars had been generally pessimistic about whether ultrasound requirements may be successfully struck down as an “undue burden” on a woman’s ability to access abortion services.⁴² In part, this pessimism arose because the *Casey* Court upheld a Pennsylvania abortion-specific informed consent requirement that compels physician speech and, in doing so, provided little guidance to lower courts about how they should analyze these types of laws.⁴³ This pessimism persists because lower courts have consistently “[reproduced] the idea [from *Casey*] that abortion has negative mental health consequences while finding mandatory speech requirements do not burden a woman’s access to abortion.”⁴⁴ In fact, *Casey* arguably was critical in opening the floodgates for a broader variety of restrictions on access to abortion services, leading scholars and advocates to re-envision how ultrasound description mandates can be struck down through means other than the “undue burden” standard,⁴⁵ and leading some to focus on whether the ever-evolving First Amendment doctrine may more effectively strike down these restrictions as violations of a health professional’s right not to speak.⁴⁶

With this notion of a professional’s right against compelled speech, though, also comes the corollary notion of the right against compelled listening.⁴⁷ As Caroline Mala Corbin notes in one of the

⁴¹ See *supra* Part II.

⁴² See, e.g., Gaylord & Maloney, *supra* note 5, at 645–46; see also Aziza Ahmed, *Informed Decision Making and Abortion: Crisis Pregnancy Centers, Informed Consent, and the First Amendment*, 43 J.L. MED. & ETHICS 51, 55 (2015) (citing Caitlin E. Borgmann, *Abortion, the Undue Burden Standard, and the Evisceration of Women’s Privacy*, 16 WM. & MARY J. WOMEN & L. 291, 291 (2009)).

⁴³ See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992) (“If the information the State requires to be made available to the woman is truthful and not misleading, the requirement may be permissible.”); see also Suter, *supra* note 5, at 22.

⁴⁴ Ahmed, *supra* note 41, at 55 (citing Borgmann, *supra* note 41, at 291).

⁴⁵ See, e.g., *id.*

⁴⁶ See, e.g., Corbin, *supra* note 7, at 941.

⁴⁷ *Id.* at 940.

few scholarly texts to explore the patient's right not to hear: "While the right to speak, the right to listen, and the right against being compelled to speak are well-established First Amendment rights, free speech jurisprudence has not yet recognized a 'right against compelled listening.'"⁴⁸ Even though there has been much more attention paid to the First Amendment rights of doctors than to the First Amendment rights of patients, Corbin asserts that the notion of a right against compelled listening is also strongly supported by the values underlying the First Amendment, including the promotion of autonomy, self-determination, self-realization, and the marketplace of ideas.⁴⁹ As Corbin writes, "without both a listener and a speaker, freedom of expression is as empty as the sound of one hand clapping."⁵⁰ Corbin's analysis focuses on some of the theoretical principles, further described below, including the applicability of the "captive audience" doctrine. What Corbin fails to do, however, is establish how the right against compelled listening would not only potentially provide a stronger foundation for striking down ultrasound description mandates, but how it would do so in a manner that bolsters informed consent law and the necessary value of the doctor-patient relationship within public health law more generally.⁵¹

How, then, might one establish this right against compelled listening for women during pre-abortion ultrasounds? Unfortunately, there is little doctrine from which to draw this right. In fact, one recent case, *McCullen v. Coakley*, indicates that the Supreme Court may, in fact, have explicitly *rejected* the notion of a First Amendment right not to hear in 2014.⁵² In *McCullen*, the Court

⁴⁸ *Id.*

⁴⁹ See, e.g., *id.* at 942; and see, Ellen Camburn, *Doctor-Patient-State Relationship: The Problem with Informed Consent and State Mandated Ultrasounds Prior to Abortions*, 10 RUTGERS J. L. & PUB. POL'Y 301, 311 (2013).

⁵⁰ Corbin, *supra* note 7, at 965 (citing Rodney A. Smolla, *Freedom of Speech for Libraries and Librarians*, 85 LAW. LIBR. J. 71, 77 (1993)).

⁵¹ See *infra* Part IV.

⁵² *McCullen v. Coakley*, 134 S. Ct. 2518, 2545–46 (2014) ("Protecting people from speech they do not want to hear is not a function that the First

struck down, on First Amendment grounds, a Massachusetts statute that prohibited individuals from “knowingly [standing] on a ‘public way or sidewalk’ within 35 feet of . . . any place, other than a hospital, where abortions are performed.”⁵³ However, the circumstances facing the patient in the context of pre-abortion ultrasound description mandates can be substantially distinguished from the circumstances in *McCullen* in two primary ways. It is within these distinct circumstances that the right against compelled listening can begin to be situated.

First, in the pre-abortion ultrasound context, the listener (i.e., the patient) is subjected to government-compelled professional speech within the context of a clinician-patient relationship, *not* the speech within a *public* forum at issue in *McCullen*. Second, the listener is exposed to the “uncomfortable message” that she may not want to hear *not* on “the public streets and sidewalks,” where one may not reasonably expect privacy (as in *McCullen*),⁵⁴ but in the intimate and confined setting of a doctor’s office. She is often held figuratively “captive” by the stirrups holding her feet or by the ultrasound wand across her torso and unable to avoid the speech in question without leaving the appointment and, should she still seek an abortion, without leaving the state where the law is enacted. The next sub-sections examine the limited, though evolving, doctrine around each of these distinctions, including a discussion of professional speech and the beginnings of case law that lay a rhetorical foundation for the recognition of a listener’s rights. As described below, the captive nature of the interaction implicated by ultrasound description mandates is sufficiently distinct from the public spaces about which Chief Justice Roberts wrote in *McCullen*. This distinction may thereby implicate the “captive audience” doctrine to establish that patients in medical settings, where there is little or no opportunity to simply avoid the speech, may have a First Amendment right not to listen.

Amendment allows the government to undertake in the public streets and sidewalks.”).

⁵³ *Id.* at 2525 (citing MASS. GEN. LAWS ch. 266, §§ 120E1/2(a), (b) (West 2012)).

⁵⁴ *Id.* at 2529.

A. Bridging the First Amendment Rights of Professionals and Patients

As mentioned, one primary way to distinguish *McCullen* is to note the identity of the speaker. The Court's holding in *McCullen*, when read narrowly, refutes a right against compelled listening when the First Amendment rights of *private* speakers outweigh the potential rights of the listener.⁵⁵ In the case of abortion informed consent, however, courts must now grapple with the simultaneous rights of the patient-as-listener and the rights of the physician-as-speaker, compelled by the state to speak.⁵⁶ Unlike in *McCullen*, these rights are not inherently at odds, but are instead often aligned in the interest of forming and promoting a physician-patient relationship in the context of medical care. The professional's rights, then, should not only be viewed as in conflict with, but rather strengthened by, the listener's right to determine what to hear.⁵⁷

⁵⁵ *Id.* at 2541.

⁵⁶ See, e.g., *Stuart v. Camnitz*, 774 F.3d 238, 246 (4th Cir. 2014), *cert. denied*, 135 S. Ct. 2838 (2015) ("Compelled speech is particularly suspect because it can directly affect listeners as well as speakers. Listeners may have difficulty discerning that the message is the state's, not the speaker's, especially where the 'speaker [is] intimately connected with the communication advanced.'") (quoting *Hurley v. Irish-Am. Gay, Lesbian & Bisexual Grp. Of Bos.*, 515 U.S. 557, 576 (1995)); see also, e.g., *Texas Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 573, 579 (5th Cir. 2012) ("... whereas *Casey* only required the physician to make certain materials about childbirth and the fetus 'available' to the woman, the physician here is required to explain the results of sonogram and fetal heart auscultation, and the woman is required to listen to the sonogram results.").

⁵⁷ This is in contrast to what Paula Berg describes as *Casey*'s understanding of a patient's right against compelled listening. Berg noted that "the Court characterized and decided [*Casey*] as if it involved a bipartite conflict between physicians' right to speak and states' right to regulate professionals, rather than a tripartite conflict among physicians' speech rights, government's power to regulate professionals, and patients' audience-based right to receive information." 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, 220 (1994).

This starting point – the rights of the physician-as-speaker – admittedly provides an unstable foundation. As numerous scholars and courts have noted, the doctrine around professional speech is “murky” at best.⁵⁸ Therefore, determining which standard of review should be applied to professional speech and how such standard should be applied is far from a settled area of law.⁵⁹

Generally, it is accepted – largely through the common law doctrine of informed consent – that “the state may freely regulate physician speech as part of its regulation of the practice of medicine.”⁶⁰ Yet, “[t]he Supreme Court has said relatively little about the First Amendment’s coverage of professional advice and communications.”⁶¹ Ultimately, the lower courts have only “cryptic guidance” on how to “make sense” of professional speech regulations.⁶² There is still uncertainty regarding whether the state exceeds its power to protect public health when it “[requires] physicians to engage in ideological speech,” and whether and when the state may “[require] physicians to communicate information that the medical profession regards as false, or prohibits physicians from communicating information that the medical professional regards as true.”⁶³ This question, while complex, is ultimately beyond the scope of this article.

Regardless of the instability of the professional speech doctrine, the professional identity of the speaker in the context of state-mandated ultrasound description provides a starting point for establishing a listener’s First Amendment rights against compelled

⁵⁸ *Wollschlaeger v. Governor of Fla.*, 814 F.3d 1159, 1186 (11th Cir. 2015), *vacated*, 2016 WL 2959373 (Feb. 3, 2016).

⁵⁹ *See, e.g.*, Post, *supra* note 5, at 944; Suter, *supra* note 5, at 23; Zick, *supra* note 15, at 1296 (“Lower courts have been left to divine a doctrine from concurrences, brief snippets in plurality opinions, and precedents in which professional speech was regulated but no doctrinal framework materialized.”). *See also, e.g.*, Claudia E. Haupt, *Professional Speech*, 125 *YALE L.J.* 1238, 1241 (2016) (“What is strikingly – and perhaps somewhat surprisingly – still absent from the case law and the legal literature is a comprehensive theory of professional speech.”).

⁶⁰ Post, *supra* note 5, at 939.

⁶¹ Zick, *supra* note 15, at 1291.

⁶² *Id.*

⁶³ Post, *supra* note 5, at 939.

listening in a context quite distinct from the context at issue in *McCullen*.⁶⁴

It is the unique character of the professional-listener relationship, and in particular, the doctor-patient relationship, that has created the need for not only an informed consent doctrine, but also for a recognition and a valuing of a patient's right not to hear. As Claudia Haupt describes in her recent article on professional speech, professional speech is of a distinct character.⁶⁵ Haupt explains how "'learned' professionals," including doctors, form "knowledge communities," "communities whose principle *raison d'être* is the generation and dissemination of knowledge."⁶⁶ These knowledge communities fundamentally re-shape how one thinks about regulating professional spaces and professional relationships. "Sometimes," Haupt writes, "regulation aligns with" the collective "professional insights" of a knowledge community, but at other times, it "contradicts them."⁶⁷ Still, the uniqueness of the learned professions as knowledge communities "informs" both how one justifies the "First Amendment protection" of professional speech, as well as "the limits of that protection, the permissibility of regulating the professions" through licensure and other mechanisms, "and the imposition and extent of tort liability for professional malpractice."⁶⁸ In particular, the existence of these knowledge communities (built around professional consensus and specialized knowledge) fundamentally reshapes how one regulates the transmission of knowledge from professional to layperson, from doctor to patient, from speaker to listener. As Haupt explains, "Professionals speak not only for themselves but also as members

⁶⁴ Haupt, *supra* note 59, at 1259 ("[T]he doctrinal basis of professional speech appears indeterminate at best. But a wide-angle view reveals that, despite the initial lack of clarity in *Casey*, the Court seems to have at least a hunch that speech communicated by professionals in a professional-client relationship for the purpose of providing professional advice is somehow distinctive.").

⁶⁵ *Id.* at 1241.

⁶⁶ *Id.*

⁶⁷ *Id.* at 1245.

⁶⁸ *Id.* at 1238.

of a learned profession: they ‘assist[] individuals in making personal choices based on the cumulative knowledge of the profession.’”⁶⁹

Building on the professional’s distinctive role, as described by Haupt, the listener – the patient – also has distinct autonomy interests; these interests are exacerbated by the inherent power imbalance within the doctor-patient relationship. Unlike the patient who may walk through the crowd of protestors in *McCullen*, the patient in a doctor’s office may *depend upon* dialogue with a professional in order to make an informed decision.⁷⁰ These “decisional autonomy interests,” as Haupt describes them,⁷¹ are unique. Professional speech – unlike lay speech – by its very nature “implicates the autonomy interests of both the speaker and the listener.”⁷² Building on the notion of knowledge communities, the professional-listener relationship or the physician-patient relationship is “characterized by an asymmetry of knowledge.”⁷³ The patient is seeking professional speech “precisely because of this asymmetry.”⁷⁴

Informed consent has long been chosen as the legal mechanism to “fix” this asymmetry.⁷⁵ But in the context of ultrasound description mandates, this asymmetry also demands something broader: the recognition of a listener’s agency and, ultimately, a listener’s rights to receive or deny information. In the context of any doctor-patient relationship, the patient is vulnerable and often disempowered.⁷⁶ Dependent on the doctor’s professional

⁶⁹ *Id.* at 1242 (citing Daniel Halberstam, *Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions*, 147 U. Pa. L. Rev. 771, 773 (1999)).

⁷⁰ Haupt, *supra* note 59, at 1243.

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.* (emphasis added).

⁷⁴ *Id.*

⁷⁵ See Zick, *supra* note 15, at 1352 (“States are rightly concerned about the asymmetries of power and information that inhere in professional client relationships. Malpractice and informed consent laws seek to account for such concerns.”).

⁷⁶ See Berg, *supra* note 57, at 227 (“Patients’ lack of power within the structure of the doctor-patient relationship leads to passivity and a reluctance to question or challenge physicians. [citation omitted] A large body of

guidance and the knowledge community's insights, the patient relies on a physician's speech to determine her choices and to come to an informed decision.⁷⁷ In the context of a doctor-patient relationship in which the state can dictate specific physician speech, the patient's vulnerabilities are deepened. Her interests "are only served if the professional communicates information that is accurate (under the knowledge community's current assessment), reliable, and personally tailored to the specific situation of the listener."⁷⁸

State-mandated professional speech, such as ultrasound abortion mandates, runs afoul of these interests, replacing the knowledge community's assessment of a listener's needs and the critical discourse between a physician and patient⁷⁹ with a specific and standardized state message, amplified through the mouthpiece of the physician and without recognition of listener agency. In so doing, it exacerbates the imbalance of the doctor-patient relationship and ignores the distinct speech rights of the listener. It replaces not only the professional's autonomy and independent judgment with the state's judgment, but with it, it replaces the patient's decisional autonomy.⁸⁰ Regardless of the professional

research has demonstrated that patients rarely ask questions during conversations with physicians or take control of topics that are discussed.").

⁷⁷ See *id.* at 224 ("Patient/clients form professional relationships because they lack the information needed to make a rational decision on their own about a problem that is within the professional's area of expertise. The goal of this relationship is to identify the patient/client's particular needs and interests and to obtain expert advice about the most appropriate course of action.").

⁷⁸ Haupt, *supra* note 59, at 1271.

⁷⁹ See Berg, *supra* note 57, at 235–36 ("When a patient . . . must decide on a course of treatment, the 'marketplace of ideas' that informs his or her decision making is provided mainly by physicians. In conversations with physicians, patients seek to discover the nature of the medical problem . . . Patients' discovery of their medical truth – that is, of the particular course of treatment that is best for them – depends on an unconstrained flow of information from physicians.").

⁸⁰ Haupt, *supra* note 59, at 1271–72 ("As Justice Stevens pointed out in his opinion in *Casey*, '[d]ecisional autonomy must limit the State's power to inject into a woman's most personal deliberations its own views of what is best.' " (Stevens, J., concurring in part and dissenting in part) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 916 (1992)).

speech rights at issue, without a recognition of a patient's right to demand information or to refuse information, both the professional's and the patient's agency are put into question.

The listener's interests are then implicated by the unique nature of professional speech and by the unique dynamics of the professional-patient relationship. "Compelling physician speech, like silencing it, implicates *both* doctors' right to speak *and* patients' right to receive information."⁸¹ Patients have an "audience-based interest in receiving information from their physicians;"⁸² by regulating physician speech, regardless of the validity of the regulation, the state inevitably impacts the rights of the listener, and these restrictions should be analyzed as such.

In recent years, in addition to the scholarly analysis, various courts have struggled with how to balance the rights of the state, of professionals, and of patients in the context of "[s]tate regulations of professional speech [that] have become more prevalent, more politically tinged, and more likely to structure and dictate the specific content of professional-client interactions."⁸³ From multiple cases that uphold restrictions on "sexual orientation change efforts" (SOCE) counseling⁸⁴ to a case that upholds restrictions on physicians' ability to discuss firearm access and safety,⁸⁵ lower courts have recently been faced with determining how and whether to recognize a patient's right to listen or to avoid listening, and what these patients' rights may mean for regulations of professional

⁸¹ Berg, *supra* note 57, at 220.

⁸² *Id.*

⁸³ Zick, *supra* note 15, at 1292.

⁸⁴ Pickup v. Brown, 740 F.3d 1208, 1222 (9th Cir. 2014) (upholding California's law restricting the provision of SOCE therapy to minors as a constitutional "regulation of professional conduct"); Doe *ex rel.* Doe v. Governor of N.J., 783 F.3d 150, 151 (3d Cir. 2015) (upholding New Jersey's law restricting the provision of SOCE therapy to minors as a constitutional regulation of professional speech).

⁸⁵ Wollschlaeger v. Governor of Florida, 814 F.3d 1159 (11th Cir. 2015), *vacated*, 2016 WL 2959373 (Feb. 3, 2016).

speech.⁸⁶ In the abortion context, too, from *Rust v. Sullivan*⁸⁷ to *Planned Parenthood v. Casey*,⁸⁸ the Supreme Court has more

⁸⁶ See *Zick*, *supra* note 15, at 1294 (arguing that “[r]ecently enacted professional speech regulations do not merely interfere with the transmission and receipt of expert knowledge, transgress patients’ and professionals’ rights to receive or impart information about medical care, or implicate the activities of ‘knowledge communities’ . . . They are troublesome for a related but distinctive reason. These regulations suppress, alter, or dictate professional rights speech—professional client communications about, concerning, or relating to the recognition, scope, or exercise of constitutional rights.”).

⁸⁷ In *Rust*, the Court ultimately found that regulations that prohibited recipients of Title X funding from “counseling, referral, and the provision of information regarding abortion as a method of family planning” did not violate physician’s First Amendment rights. *Rust v. Sullivan*, 500 U.S. 173, 193 (1991). However, the *Rust* Court also recognized that the regulations in question “d[id] not significantly impinge upon the doctor-patient relationship,” in part, because the regulations did not affect all doctors or all patients in a given jurisdiction. *Id.* at 200. In doing so, the Court quickly acknowledges that a woman may at times have a “right to receive” information about abortion. (“Under the [Title X] regulations . . . a doctor’s ability to provide, and a woman’s right to receive, information concerning abortion and abortion-related services outside the context of the Title X project remains unfettered.”) *Id.* at 203. Despite this brief nod to a patient’s potential rights, the *Rust* court largely ignores the patient’s “audience-based interests.” See *Berg*, *supra* note 57, at 219–20 (“The unconstitutional conditions doctrine, upon which the *Rust* Court based its analysis, balances the government’s need to make funding decisions against the constitutional rights of government agents and employees while performing official duties. The doctrine does not address the impact that funding restrictions may have on the First Amendment rights of listeners who depend upon publicly financed speakers for information. The *Rust* Court’s reliance on the doctrine of unconstitutional conditions, rather than on the First Amendment rights of patients, leads it to overlook the danger that restrictions on the speech of publicly funded physicians pose to patients’ audience-based interests.”).

⁸⁸ The majority in *Casey* does not discuss a patient’s right not to listen, though Justice Stevens, in his opinion concurring in part and dissenting in part, describes how “[w]henver government commands private citizens to speak or to listen, careful review of the justification for that command is particularly appropriate.” *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 921–22 (1992) (Stevens, J., concurring in part and dissenting in part). Justice Stevens goes on to describe how, for many women, the information required by Pennsylvania’s statute would be “clearly useless” and “thus constitute and

indirectly wrestled with whether patients may have a right to receive or reject information within doctor-patient relationships, though the Court has only barely touched upon this question in each of these cases.⁸⁹ Ultimately, while case law has not yet established that *listeners* have a right to hear or not to hear, a set of recent cases have begun to develop some rhetorical underpinnings for this type of analysis, a rhetoric that, if applied to the ultrasound description mandate context, may ultimately provide the critical discursive nexus through which these regulations may be successfully struck down.

For example, in a recent triad of vacated opinions named *Wollschlaeger v. Governor of Florida*, the Eleventh Circuit specifically grappled with whether patients should have a corollary right to avoid professional speech.⁹⁰ At issue in *Wollschlaeger* is a Florida law, the Firearm Owner's Privacy Act, which, in part, restricts how and when health care providers can inquire about a patient's gun ownership or discuss firearm safety.⁹¹ The court has

unnecessary – and therefore undue – burden on the women's constitutional liberty . . ." *Id.* As Paula Berg writes about *Casey*, the majority "characterized and decided the case as if it involved a bipartite conflict between physicians' right to speak and states' right to regulate professionals, rather than a tripartite conflict among physicians' speech rights, government's power to regulate professionals, and patients' audience- based right to receive information." Berg, *supra* note 57, at 220.

⁸⁹ Berg, *supra* note 57, at 219 ("[T]he Court [in *Rust* and in *Casey*] approaches its analysis of government restrictions on the content of doctor-patient discourse exclusively from the standpoint of their interference with physicians' right to speak. The Court ignores that the regulation of physician speech also impacts on patients' receipt of medical information.").

⁹⁰ In fact, the court grapples with this question again and again, as the case has been vacated and superseded on rehearing three times since the matter first came to the Eleventh Circuit in July of 2014. *Wollschlaeger v. Governor of Florida*, 814 F.3d 1159 (11th Cir. 2015), *rev'd in part, vacated in part*, 797 F. 3d 859 (11th Cir. 2014), *vacated*, 2016 WL 2959373 (Feb. 3, 2016).

⁹¹ *Wollschlaeger*, 814 F.3d at 1167–68 ("The Act seeks to protect patient privacy by restricting irrelevant inquiry and record-keeping by physicians on the sensitive issue of firearm ownership and by prohibiting harassment and discrimination on the basis of firearm ownership. The Act does not prevent physicians from speaking with patients about firearms generally. Nor does it prohibit specific inquiry or recordkeeping about a patient's firearm-

now issued three different opinions in the case, all of which rely on a different level of First Amendment scrutiny to analyze the professional speech restriction,⁹² and all of which have been vacated and superseded by the subsequent opinion. In each opinion, however, the Eleventh Circuit upholds Florida's restriction on professional speech, concluding that a patient has a right to not have to hear a doctor's warnings or inquiries about gun ownership.⁹³

Throughout its analysis, the *Wollschlaeger* court grounded aspects of its decision in a depiction of the listener's (the patient's) "powerlessness" and vulnerability.⁹⁴ At the start of the more recent opinion (decided in 2016 and since vacated), the Eleventh Circuit quoted First Amendment scholar, Paula Berg, describing the unique nature of the physician-patient relationship:

Society has traditionally accorded physicians a high degree of deference due to their superior knowledge, educational pedigree, position of prestige, and "charismatic authority," resulting from their "symbolic role as conquerors of disease and death." . . . This deference reaches its apex in the examination room where patients are in a position of relative powerlessness. Patients must place their trust in the physicians' guidance and submit to the physicians' authority.⁹⁵

ownership status when the physician determines in good faith, based on the circumstances of that patient's case, that such information is relevant to the patient's medical care or safety, or the safety of others.").

⁹² The most recent opinion, since vacated, "pass[es] no judgment on what level of scrutiny should apply here," and instead concludes that "the Act survives even strict scrutiny as the State has asserted a compelling interest and the Act is narrowly tailored to advance that interest." *Id.* at 1186.

⁹³ *Wollschlaeger v. Governor of Florida*, 814 F.3d 1159 (11th Cir. 2015), *vacated*, 2016 WL 2959373 (Feb. 3, 2016); *Wollschlaeger v. Governor of Fla.*, 797 F.3d 859 (11th Cir. 2015); *Wollschlaeger v. Governor of Fla.*, 760 F.3d 1195 (11th Cir. 2014).

⁹⁴ *Wollschlaeger*, 814 F.3d at 1168.

⁹⁵ *Id.* (quoting Berg, *supra* note 57, at 226).

Throughout its opinion, the court builds upon this rhetoric of an inherent power imbalance between physician and patient. The Act, the court noted, was an extension of the long tradition of regulating the doctor-patient relationship, with the ultimate goal of protecting patients in the context of this asymmetry.⁹⁶ In the multiple *Wollschlaeger* decisions, the court additionally centered its analyses of a physician's First Amendment rights around the patient's corollary rights, specifically focusing on the captive nature of the patient, and how this contributes to the dynamic of physician-patient speech.⁹⁷ "In such a situation," the court wrote, "the balance of power between doctor and patient will often make a patient feel as if he has no choice but to listen and answer a doctor's questions, especially when seeing another doctor may not be practicable, or even possible."⁹⁸ By building its analysis from this notion of the vulnerable patient, the *Wollschlaeger* court, despite its flaws,⁹⁹ began to provide a basis for conceptualizing how a patient's rights to listen/not to listen may be at the very foundation of analyzing regulations of professional speech.

Another set of cases analyzing the constitutionality of bans on sexual-orientation change efforts counseling ("SOCE") has also begun to grapple with the question of whether First Amendment doctrine provides for a corollary right for patients to listen or to refuse to listen. For example, in *Doe ex rel. Doe v. Governor of New*

⁹⁶ *Wollschlaeger*, 797 F.3d at 868 ("To protect patients, society has long imposed upon physicians' certain duties and restrictions that define the boundaries of good medical care. In keeping with this tradition, the State passed the Act.").

⁹⁷ See, e.g., *Wollschlaeger*, 814 F.3d at 1198 ("This [doctor-patient] relationship is not conducted in an open forum; it takes place behind the closed doors of the examination room. As such, a doctor will usually have a captive audience of one: the patient . . . In these moments of vulnerability, patients could hardly be expected to affirmatively rebuff their doctors by demanding all non-medically relevant questioning cease.").

⁹⁸ *Id.* at 1200.

⁹⁹ The court in *Wollschlaeger* fails to recognize, for example, that physicians are not necessarily able to determine the required relevance of a discussion about firearms with a patient if the inquiry itself is restricted by law. Yet, if physicians do not inquire, patients are simply never given the important opportunity to reject or to request the professional speech.

Jersey,¹⁰⁰ the Third Circuit Court of Appeals upheld a New Jersey statute that restricted state-licensed counselors from providing minors with SOCE therapy.¹⁰¹ In *Doe*, unlike in *Wollschlaeger*,¹⁰² the plaintiffs are not the potential professional speakers, but instead the potential *listeners*, the patients.¹⁰³ The *Doe* plaintiffs, a minor and his parents, challenged New Jersey's legislation, in part, by asserting that the law burdened their First Amendment right to receive information.¹⁰⁴

While the Third Circuit ultimately concluded that the legislation neither violated the “[professional’s] right to speak” nor the patient’s “right to receive information,”¹⁰⁵ it began to slightly open the door for rhetoric surrounding how the First Amendment may protect both the speaker and the listener.¹⁰⁶ In part, the court, throughout its discussion, recognized that there may be, in certain contexts, a right for patients to listen.¹⁰⁷ While the court ultimately determined that the reciprocal right to *listen*, to receive information, is not violated in the instant case, the court arguably did so clumsily.¹⁰⁸ Instead of providing an analysis for why the patient does not independently have a right to listen, the court simply found

¹⁰⁰ *Doe ex rel. Doe v. Governor of New Jersey*, 783 F.3d 150, 151 (3d Cir. 2015).

¹⁰¹ *Id.*

¹⁰² *Wollschlaeger*, 814 F.3d at 1167.

¹⁰³ *Doe*, 783 F.3d at 154.

¹⁰⁴ *Id.* at 155.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* (“Appellants are correct that the First Amendment protects both the speaker and the recipient of information.” (citing *Virginia State Bd. of Pharm. v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 756–57 (1976))).

¹⁰⁷ *Doe*, 783 F.3d at 154.

¹⁰⁸ After establishing that the *Doe* court believes that a patient’s right to listen/not to listen does exist, the only analysis provided in *Doe* about why it fails to recognize a right to listen in the legislation at-issue here is provided by the following: “We are not suggesting that Appellants do not have the right to receive the information for the reason that the legislature enacted A3371, which bars the provision of SOCE counseling to minors; rather, Appellants’ right to receive the information is not violated because *we already upheld* A3371, which bans the provision of SOCE counseling to minors, against a constitutional challenge in *King*.” *Id.* at 155–56.

that, by upholding the ban on clinician speech, the simultaneous ban on the listener's ability to receive SOCE information is also upheld. Because the professional's First Amendment rights are not violated by the statute, the court argued, neither are the patient's.¹⁰⁹

As applied to ultrasound description mandates, this myopic understanding of listener's rights as being *contingent upon* speaker's rights is problematic. As previously described, professional speech doctrine makes it unclear whether laws that compel physician "speech and display" mandates will successfully be struck down on First Amendment grounds. But what *Doe* and *Wollschlaeger* do provide is the potential beginnings for rhetorical analysis of what courts are now beginning to accept: that in the unique and, in many ways, strange contexts of professional-patient relationships, there may be a right for patients to listen or to refuse to listen.

While the courts in *Doe* and *Wollschlaeger* come out differently in their analyses of whether a patient may have a right to hear or deny information that the state has determined is harmful, both cases begin to provide a framework for re-imagining the First Amendment rights of both doctor and patient, opening the door for a patients' right against compelled listening in the case of pre-abortion ultrasound descriptions. While these opinions provide little doctrinal certainty, they can be observed as potential forays into how courts may be able to move towards incorporating an analysis of the rights of a patient into analyses of the First Amendment rights of professionals. As will later be discussed, however, these cases provide for a potentially problematic precedent for public health law more broadly, and *Wollschlaeger's* broader holding and analysis, in particular, is flawed, at best. Still, in grounding some of their discussion in listeners' rights, these cases may allow for another rhetorical avenue for advancing women's rights against compelled listening in the context of abortion informed consent.

B. The "Captive" Patient

An additional way to distinguish the *McCullen* Court's rejection of the "right not to hear" is to recognize that the context in

¹⁰⁹ *Doe*, 783 F.3d at 155-56.

which ultrasound descriptions are required may uniquely implicate the “captive audience” doctrine. As the previous section demonstrates, there is little doctrine explicitly promoting a general First Amendment right against compelled listening, and the existing analysis is fairly preliminary. For this reason, ultrasound description mandates may, in fact, be better analyzed by applying the captive audience doctrine to doctor-patient interactions.

The captive audience doctrine is one of the few ways that the law recognizes some First Amendment protection for both speakers *and* listeners.¹¹⁰ As the court in *Wollschlaeger* states, “[a]lthough the First Amendment usually requires that the burden of avoiding unwanted speech be placed on the listener, the captive-audience doctrine applies in certain instances where the listener cannot avoid being exposed to that speech.”¹¹¹ Even when speakers have a right to communicate, a listener’s legal rights may be balanced against a speaker’s rights;¹¹² in this way, the captive audience doctrine may provide an answer for how to address ultrasound description mandates even if the compelled speech does not violate the First Amendment rights of the professional. If a listener is “unwilling,” the captive-audience doctrine finds that speakers may not “foist” their speech onto the listener.¹¹³ “Instead, the government may restrict such speech if ‘substantial privacy interests are being invaded in an essentially intolerable manner.’”¹¹⁴

The setting in which the speech occurs is a central component in analyzing this doctrine.¹¹⁵ Unlike the listener in *McCullen v. Coakley*, the listener on an ultrasound table in a physician’s office is in a physically vulnerable and captive state, unable to easily escape the government’s message – as communicated through the physician – should she refuse to listen.

¹¹⁰ See, e.g., Corbin, *supra* note 7, at 941; Marcy Strauss, *Redefining the Captive Audience Doctrine*, 19 HASTING CONST. L. QUARTERLY 85, 108–09 (1992).

¹¹¹ *Wollschlaeger*, 814 F.3d at 1199 (citing *Snyder v. Phelps*, 562 U.S. 443, 459 (2011); *Erznoznik v. City of Jacksonville*, 422 U.S. 205, 210–11 (1975)).

¹¹² Corbin, *supra* note 7, at 941.

¹¹³ *Id.* at 943.

¹¹⁴ *Id.*

¹¹⁵ *McCullen v. Coakley*, 134 S. Ct. 2518, 2529 (2014).

As Chief Justice Roberts states in *McCullen*, “[on public streets and sidewalks], a listener often encounters speech he might otherwise tune out” and the captive audience doctrine need not be applied.¹¹⁶ In contrast, in labor settings or in the privacy of one’s home,¹¹⁷ the captive audience doctrine may apply if the listener “cannot readily avoid the message.”¹¹⁸

While the Supreme Court has not readily applied the captive audience doctrine to medical settings,¹¹⁹ scholars and the courts have preliminarily suggested such an application.¹²⁰ Certainly, given the expectation of privacy *within* medical facilities along with the right to make one’s own health-care decisions, the captive audience doctrine should be applied to these settings in order to protect the patient from unwanted speech. Listeners in a medical environment should not reasonably be “expected to leave in order to avoid unwanted speech”¹²¹ nor should listeners be “held ‘captive’ by medical circumstance[.]”¹²²

In addition to recognizing the nature of the setting, in applying the captive audience doctrine, courts analyze the extent to which the listener can simply avoid their “captivity.”¹²³ First, courts look to whether the listener can readily avoid the unwanted speech.¹²⁴ In other words, the listener must show “that a substantial

¹¹⁶ *Id.*

¹¹⁷ See, e.g., Strauss, *supra* note 110, at 95; Paul M. Secunda, *Toward the Viability of State-Based Legislation to Address Workplace Captive Audience Meetings in the United States*, 29 COMP. LAB. L. & POL’Y J. 209, 214 (2008).

¹¹⁸ Corbin, *supra* note 7, at 942.

¹¹⁹ *Madsen v. Women’s Health Center, Inc.*, 512 U.S. 753, 768 (1995) (citing *Operation Rescue v. Women’s Health Center, Inc.*, 626 So. 2d 664, 673 (Fla. 1993)) (discussing how a patient may be “held ‘captive’ by medical circumstances.”). The Court in *Madsen* does not, however, explicitly hold that the captive audience doctrine can or should be applied to medical settings.

¹²⁰ See, e.g., *id.* at 781; Corbin, *supra* note 7, at 947; *Wollschlaeger*, 814 F.3d at 1199 (“The captive-audience doctrine has special force in confrontational settings and in cases regarding access to medical facilities.”). *But see* *McCullen v. Coakley*, 134 S. Ct. 2518 (2014).

¹²¹ Corbin, *supra* note 7, at 946.

¹²² *Madsen*, 512 U.S. at 678 (citing *Operation Rescue*, 626 So.2d at 673).

¹²³ See Corbin, *supra* note 7, at 944.

¹²⁴ See, e.g., *Frisby v. Schultz*, 487 U.S. 474, 487 (1988).

privacy interest is ‘being invaded in an essentially intolerable’ way.”¹²⁵ Second, courts note that the listener must “not have to quit the space to avoid the message.”¹²⁶ As the Eleventh Circuit stated in one of the vacated opinions in *Wollschlaeger*, “while offensive speech cannot be curtailed just because a listener does not *wish* to hear it, that general rule does not extend so far as to include speech ‘so intrusive that the unwilling audience *cannot* avoid it’”¹²⁷

Applying these principles to ultrasound description mandates, it would be difficult for the state to demonstrate that the audience in question (i.e., the patient) would be able to “readily avoid” the physician’s speech.¹²⁸ For one, more so than in other settings where the captive audience doctrine has been recognized, the audience in question is physically required to hear the government message¹²⁹ because the ultrasound mandates require “simultaneous” descriptions. This means that while the patient is likely in a hospital gown, stirrups, or with her abdomen exposed and touched by the “speaker,” she is simultaneously listening to the doctor orally describe the ultrasound image as it appears.¹³⁰

Beyond physical captivity, a woman is additionally captive to the legal requirements that she must face prior to obtaining a procedure she has determined she needs. A woman comes to her

¹²⁵ *Wollschlaeger*, 814 F.3d at 1199 (citing *Snyder*, 562 U.S. at 459).

¹²⁶ Corbin, *supra* note 7, at 944 (citing J.M. Balkin, *Free Speech and Hostile Environments*, 99 COLUM. L. REV. 2295, 2312 (1999)); *see also* *Wollschlaeger*, 814 F.3d at 1199 (citing *Snyder*, 562 U.S. at 459).

¹²⁷ *Wollschlaeger*, 814 F.3d at 1200 (citing *Hill v. Colorado*, 530 U.S. 703, 716 (2000)) (emphasis added).

¹²⁸ *See* Berg, *supra* note 57, at 256 (describing how patients may be captive to government-mandated messages within the context of the physician-patient relationship. “Once in the presence of a physician, substantial physical and psychological barriers make government-mandated messages extremely difficult, if not impossible, to ignore. While patients can simply discard printed materials, they have ‘no choice but to sit and listen, or perhaps to sit and to try not to listen’ when the state’s message is communicated orally.”).

¹²⁹ *See* Corbin, *supra* note 7, at 943.

¹³⁰ *See* Silbey, *supra* note 9, at 25–26 (describing how “[s]ubmitting to a vaginal ultrasound and being forced to listen to and see the results of an ultrasound while physically restrained in stirrups and undressed from the waist down is degrading.”).

doctor seeking an abortion and she is first required to listen to an ultrasound description and to certify on an informed consent form that she has done so, all prior to obtaining the care that she seeks. In order to achieve her goal of obtaining an abortion, she is certainly, by law, unable to avoid the speech in question. If she is forced to “quit the space to avoid the message,”¹³¹ she also forgoes any opportunity to obtain abortion care in her state. The physical and legal circumstances in which she finds herself create captivity.

One major limitation of applying the captive-audience doctrine to the ultrasound mandate context is that this doctrine traditionally applies to private speakers.¹³² In the abortion context, while the physician may at times be the “mouthpiece” of the state,¹³³ the speaker’s identity is more analogous to a private speaker than a government speaker, particularly when viewed from the listener’s perspective. That said, even if the professional speaker in this context is seen as a government-speaker, when the “government’s message crosses over from available to required viewing,” the captive audience doctrine may still apply.¹³⁴

C. The Intrusive Nature of Troubling Information

Building on the captive audience doctrine, it is also necessary to recognize that not only are the *circumstances* of speech consequential to whether a regulation of speech survives constitutional analysis, but, as the Supreme Court made clear in *Florida Bar v. Went For It, Inc.*,¹³⁵ the particularly troubling *nature* of the message being conveyed may also factor into a First Amendment analysis of a listener’s rights.¹³⁶ In *Went For It*, the Court analyzed a set of Florida Bar rules, which prohibited lawyers from soliciting “personal injury or wrongful death” clients through

¹³¹ Corbin, *supra* note 7, at 944 (citing Balkin, *supra* note 125, at 2312).

¹³² *Id.* at 942.

¹³³ *Stuart v. Loomis*, 992 F.Supp.2d 585, 609 (M.D.N.C. 2014).

¹³⁴ Camburn, *supra* note 49, at 311.

¹³⁵ *Florida Bar v. Went For It, Inc.*, 515 U.S. 618 (1995).

¹³⁶ *Id.* at 638–39 (citing *Consolidated Edison Co. of N.Y. v. Pub. Serv. Comm’n of N.Y.*, 447 U.S. 530, 542 (1980)).

direct mail within 30 days of an “accident or disaster.”¹³⁷ The Court held that the restriction on speech was constitutionally valid.¹³⁸

While *Went for It* is distinct in many ways from the ultrasound description mandates at issue here, *Went For It's* analysis may, in part, be applicable because of the Court's emphasis on the role of the *effect* of the speech on the listener in its analysis of whether or not to uphold this speech restriction. In part, the Court looked to one of the substantial government interests asserted by the petitioners – a concern for “protecting the *privacy* and *tranquility* of personal injury victims and their loved ones against intrusive, unsolicited contact by lawyers . . .” (emphasis added).¹³⁹ In particular, the Court cited the petitioners' brief and petition for *certiorari*, which stated, “[b]ecause direct-mail solicitations in the wake of accidents are perceived by the public as intrusive . . . the reputation of the legal profession in the eyes of Floridians has suffered commensurately.”¹⁴⁰

Applying this analysis, it becomes even clearer that a right against compelled listening may exist in the pre-abortion ultrasound description context. In *Went For It*, the law at issue restricts *visual* messages conveyed through direct mail, with the notion that receiving mail at one's home while the recipient is in a vulnerable emotional state is “intrusive.”¹⁴¹ The Court even cited “empirical evidence” from a summary report, prepared by the Florida Bar, about the public's feelings of these types of direct-mail solicitations and the anger that these direct mail solicitations prompted.¹⁴² The Court noted that “the harm targeted by the Bar” (the direct mail solicitation) “cannot be eliminated by a brief journey to the trash can.”¹⁴³

While not all women seeking abortions are in a fragile emotional state at the time of a pre-abortion ultrasound, the

¹³⁷ *Id.* at 620.

¹³⁸ *Id.*

¹³⁹ *Id.* at 624 (citing Brief for Petitioner at 8, 25–27).

¹⁴⁰ *Florida Bar*, 515 U.S. at 624 (citing Petition for Writ of Certiorari at 14–15; Brief for Petitioner at 28–29).

¹⁴¹ *Id.*

¹⁴² *Id.* at 631–32, 626–27.

¹⁴³ *Id.* at 631.

circumstances and captivity in which a woman may be required to view the fetus, hear its heartbeat, etc. may render these messages emotionally intrusive.¹⁴⁴ As in *Went For It*, the act of listening to the state's message, as it is conveyed by the physician, may not simply be solved by "a brief journey to the trash can" or being forced to forget what one has just seen or been told. By the state's design, these messages are meant to impact the woman as she makes (or confirms) her decision to have an abortion. The troubling nature of these messages may have a lasting and harmful impact.

IV. SHIFTING THE DISCOURSE TOWARDS A PATIENT'S RIGHT NOT TO HEAR

The notion of a First Amendment right against *compelled listening* has not yet been established, nor is the argument for establishing this right robust enough to withstand the current Supreme Court's analysis.¹⁴⁵ Still, the discourse around ultrasound description mandates should be actively shifted away from the First Amendment rights of the *physician* and towards developing a doctrine that bolsters a *patient's* right not to hear. Further, this will have implications for the regulation of medicine and for public health. Ultimately, shifting the analysis from physician rights to patient rights is not only critical to women's rights in the context of abortion care, but also essential for upholding the common-law doctrine of informed consent and for strengthening the continued role of law in protecting public health.

A. Informed Consent and the Interplay Between Physicians' and Patients' Rights

One primary reason to shift the abortion rights discourse from a *physician's* right against government-compelled speech to a *patient's* right against compelled listening is grounded in the critical

¹⁴⁴ In fact, the setting in which a woman finds herself during an ultrasound description – in the confines of a physician's office, with the "speaker" – and not in the privacy of one's home (as is the case in *Went For It*) would arguably make the messages at-issue far more intrusive than a direct mailing.

¹⁴⁵ See, e.g., *McCullen v. Coakley*, 134 S. Ct. 2518 (2014).

importance of informed consent. Founded predominantly on notions of patient autonomy,¹⁴⁶ informed consent typically requires that doctors disclose all “material risks” to a patient, applying either a *reasonable physician* standard or a *reasonable person* standard as the mechanism by which courts determine what doctors should consider “material.”¹⁴⁷ While the doctor – guided, in part, by fears of tort liability – typically determines what specific information to share with a patient, under the doctrine, “the decision [to refuse medical interventions] belongs to the patient.”¹⁴⁸ Ideally, once armed with enough information, the patient can make an autonomous decision about his or her health care.

This view of informed consent, however, is rosy. While many scholars argue that ultrasound description mandates and other abortion-related informed consent requirements can, and should, be struck down as “fundamentally inconsistent with the doctrine of informed consent,”¹⁴⁹ other scholars, such as Nadia Sawicki, note that these laws “should [perhaps] be viewed not as anomalies, but rather as explicit manifestations of the sort of value judgments that have long been implicit in the law and doctrine of informed consent.”¹⁵⁰

For example, despite the notion that the informed consent doctrine was “driven in large part by a desire to combat the

¹⁴⁶ Vanderwalker, *supra* note 5, at 5.

¹⁴⁷ *Id.* (citing *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972)).

¹⁴⁸ Vanderwalker, *supra* note 5, at 5.

¹⁴⁹ Nadia N. Sawicki, *The Abortion Informed Consent Debate: More Light, Less Heat*, 21 CORNELL J.L. & POL’Y 1, 3 (2011) (“Scholars of law, medicine, and ethics argue that the new disclosure requirements are fundamentally inconsistent with the doctrine of informed consent, which obligates physicians to provide patients with sufficient information to make autonomous and educated decisions about their medical care.”). *See also* Sanger, *supra* note 16, at 403 (describing how seeing a fetal image on an ultrasound may “distort judgment” rather than inform it); Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL’Y 223, 226 (“Abortion law invokes and then misuses ‘informed consent’ terminology.”).

¹⁵⁰ Sawicki, *supra* note 149, at 5.

paternalism of medicine,”¹⁵¹ the doctrine is still often critiqued as “too physician-centric.”¹⁵² A patient’s autonomy interests are, arguably, more recognized as central to the informed consent doctrine today,¹⁵³ but both state- and doctor-proscribed paternalism have long impacted and still impact what information is and is not shared with patients.¹⁵⁴ By focusing solely on the physician’s rights against compelled speech, the public health rhetoric around ultrasound description mandates, while well meaning, may exacerbate this physician-centric view of informed consent.¹⁵⁵ By refocusing on patients’ rights against compelled listening in the abortion context, this concern can, in part, be addressed and ensure

¹⁵¹ Sonia M. Suter, *The Politics of Information: Informed Consent in Abortion and End-of-Life Decision Making*, 39 AM. J.L. & MED. 7, 15 (2013).

¹⁵² Haupt, *supra* note 59, at 1288 (“There is continued debate over whether the current tort paradigm [around informed consent] appropriately accounts for patients’ interests, or whether it continues to be too physician-centric.”).

¹⁵³ *See id.* at 1287–88.

¹⁵⁴ *See, e.g., id.* at 1288 (“There is a troubling history of paternalism in the medical profession that limited the amount of information shared with patients.”); *see also*, Suter, *supra* note 150, at 12 (“Historically, physicians disclosed medical information only to persuade patients to do what physicians thought was best for them or to try to offer hope and comfort. Indeed, deception in certain cases was not only acceptable, but sometimes considered necessary, to achieve those goals.”); Sawicki, *supra* note 149, at 19 (“[B]oth the ethical standard of informed consent, which looks to materiality of the information to the patient’s decision, and the legal standard, which looks to the standard of a reasonable patient or physician, necessarily are dependent on social norms and values.”).

¹⁵⁵ Recognizing a professional’s speech rights may, in fact, put patients and professionals at odds, because physicians alone will then determine what is relevant to a patient’s decision-making. *See, e.g.,* Haupt, *supra* note 59, at 1300 (“Under the knowledge community focused theory of professional speech, the professional is to decide what is relevant professional information. The knowledge community’s insights not only determine what accurate information is, but also what is relevant in any given situation according to the specific circumstances of the client.”). While this cannot always be avoided, given the asymmetry of knowledge in a doctor-patient relationship, it is worth striving for doctor-patient dialogue that is predominantly driven by the patient’s ability to ask for information and to refuse doctor-provided information.

that a patient-focused doctrine of informed consent is more able to emerge.

Moreover, despite many advocates' concerns that abortion-related informed consent requirements are too politicized or intervene too greatly in the doctor-patient relationship,¹⁵⁶ informed consent laws will never be value-neutral¹⁵⁷ and striving for a non-interventionist, value-neutral informed consent doctrine should not be the goal. In fact, by focusing the discussion of ultrasound description mandates on establishing a physician's right not to be *compelled* to be the state's mouthpiece, the public health legal community may set a dangerous precedent that greatly restricts the government's ability to compel physician speech, speech that is often essential for promoting patient autonomy in medical decision-making and in protecting informed consent.¹⁵⁸ "Ordinarily, the doctrines of free speech and informed consent coexist without much difficulty."¹⁵⁹ Yet, by putting a physician's common law duty to

¹⁵⁶ See, e.g., Zick, *supra* note 15, at 1357 (describing how "[t]he politicization of professional speech undermines not just individual client trust and confidence, but to some extent the very notion of professionalism itself.>").

¹⁵⁷ See Sawicki, *supra* note 149, at 19 ("[E]ven the normative view of informed consent as an ethical ideal recognizes that neutrality, objectivity, and impartiality are often impossible, and sometimes unwarranted.>").

¹⁵⁸ Moreover, the state sometimes does have a substantial interest in barring professional speech. In *Doe*, for example, the court found the evidence that SOCE counseling is "ineffective or harmful" compelling towards its reasoning that the state had a substantial interest in protecting potential patients. *Doe*, 783 F.3d 150 at 153(citing *King v. Governor of N.J.*, 767 F.3d 216, 235 (3d Cir. 2014)). If, then, the state itself has a right to bar speech to protect patients, why shouldn't the patient also have the same right to bar speech? Even though ultrasound description mandates are most often discussed in the context of "compelled" professional speech, ultrasound description mandates, too, can be considered as a question of when and by whom a professional's speech can be prohibited. A First Amendment right against compelled listening is, in a sense, a right for patients to themselves restrict the speech of professionals; speech that may be, at best, "ineffective" and, at worst, "harmful" to patients.

¹⁵⁹ See, e.g., David Orentlicher, *Abortion and Compelled Physician Speech 2* (Ind. Univ. Robert H. McKinney Sch. of Law Research Paper No. 2014-31, 2014).

obtain informed consent from patients and a physician's First Amendment rights in tension, we create a conflict for public health that may undermine decades of legal precedent to protect patients who, almost invariably, have less information about a procedure than their physicians.¹⁶⁰

B. The Negative Implications of Focusing on Physicians' First Amendment Rights

The "regulation of medicine has long been recognized as within the state's police powers" and medical practices are a common venue through which populations interact with a state's public health systems.¹⁶¹ From preventing gun injuries in households with children to advancing vaccination campaigns, regulating physician speech and promoting strong informed consent policies must continue to be an important tool for regulating the practice of medicine and for advancing public health. The public health community wants, at times, to require doctors to advance the state's interests in order to protect patients.¹⁶² We want, at times, for the government to dictate that a physician should offer to a patient information that may be material to her decision-making.¹⁶³ Setting

¹⁶⁰ *See id.* at 1.

¹⁶¹ Suter, *supra* note 5, at 22 (citing Post, *supra* note 5, at 950).

¹⁶² For example, in the case of promoting widespread vaccination, the public health community often argues that medical professionals should be required to provide detailed information about the risks of not vaccinating one's children to parents hesitant about or refusing the recommended vaccination schedule. *See, e.g.*, Kristin S. Hendrix, et al., *Ethics and Childhood Vaccination Policy in the United States*, 106 AMER. J. PUB. HEALTH 273, 276 (describing how "the documented difficulty of communicating with vaccine-hesitant and vaccine-opposing families" may warrant "making the informed-consent process more educationally intensive and applicable not only to parents choosing to immunize their children but also, and especially, to those refusing or declining immunizations or requesting a modified schedule.").

¹⁶³ *See, e.g.*, Truman v. Thomas, 611 P.2d 902 (1980) (holding that a physician breached his duty of care when the doctor failed to inform a patient of the potentially fatal consequences of declining a pap smear.). We also want the patient to ultimately be able to dictate when the physician's speech should stop or when the speech is no longer material to her decision-making. *See infra* notes 171, 177 and accompanying text.

a precedent that compelling physician speech is *not* within the scope of these police powers may, therefore, have dangerous implications for how the state can advance its interest in public health through its regulation of the medical profession in the future.

By refocusing on the patient's right against compelled listening, it becomes clear that the state's use of informed consent and the patient's own rights need not be at odds. In fact, the state's use of informed consent can strengthen the unique interplay of physician-patient relationship. As First Amendment scholar Paula Berg notes in an article about informed consent, "government regulation of doctor-patient speech may in some cases be necessary to increase the flow of information to patients, thereby facilitating the attainment of consent and thus advancing the First Amendment goals of self-fulfillment and autonomy."¹⁶⁴ As described in Part I of this article, by their very nature, informed consent laws can help to correct the power imbalance inherent between a physician (and their "knowledge community") and a patient.¹⁶⁵ "States are rightly concerned about the asymmetries of power and information that inhere in professional client relationships."¹⁶⁶ When the patient is central to the informed consent doctrine, informed consent laws can help to fundamentally correct for these concerns.

Ultimately, if we begin to ground the discussion around abortion-specific informed consent laws in a *patient's* right not to hear, the First Amendment can advance *in conformity* with the goals of informed consent and can, in fact, strengthen the informed consent doctrine. Even with the recognition that informed consent laws are inherently paternalistic, when looked at from the perspective of the *patient's* right not to listen, abortion-specific informed consent requirements, in general – and ultrasound description mandates, in particular – run afoul of informed consent's doctrinal goals.¹⁶⁷ As many scholars have noted, "[t]he

¹⁶⁴ Berg, *supra* note 57, at 206.

¹⁶⁵ Zick, *supra* note 15, at 1352.

¹⁶⁶ *Id.*

¹⁶⁷ See, e.g., Orentlicher, *supra* note 159, at 2. See also Sanger, *supra* note 16, at 378 ("Although couched in the protective terms of informed consent, these statutes are unabashedly meant to transform the embryo or fetus from an abstraction to a baby in the eyes of the potentially aborting mother."); Rachel

Supreme Court has allowed a *degree* of paternalism to permeate informed consent doctrine for abortions even though this is absent in traditional informed consent and prohibited in other speech cases.”¹⁶⁸ By compelling listening, ultrasound description mandates “[interfere] with the decision-making process by not allowing adults to choose what information to consider in developing their thoughts and making up their minds.”¹⁶⁹ The mandates also “[force] . . . information onto unwilling listeners . . . [potentially] unduly [influencing] the ultimate decision made.”¹⁷⁰

By refocusing on the patient’s rights as listener, the rhetoric regarding ultrasound description mandates can also acknowledge the essential importance of the physician-patient relationship,¹⁷¹ and the value that patients can bring to this relationship, while still maintaining informed consent. In recognizing a patient’s right not

Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, 10 GUTTMACHER POL’Y REV. 6, (2007) (“[T]he use of the informed consent process in this way clearly runs counter to fundamental ethical principles that have long guided the practice of medicine.”).

¹⁶⁸ Camburn, *supra* note 49, at 311–312 (citing Dale Carpenter, *The Antipaternalism Principle in the First Amendment*, 37 CREIGHTON L. REV. 579, 633 (2004) (emphasis added)). See also Suter, *supra* note 5, at 27 (noting that “[i]n fact, informed consent doctrine emerged to ensure that patients could overcome the paternalism of medicine when physicians alone decided on behalf of the patient what the patient needed to know.”).

¹⁶⁹ Corbin, *supra* note 7, at 982.

¹⁷⁰ *Id.*; see also Howard Minkoff & Mary Faith Marshall, *Government-Scripted Consent: When Medical Ethics and Law Collide*, HASTINGS CTR. REP. 21, 21 (2009) (“The twin tenets of voluntariness [on the patient’s part] and adequate disclosure [by the physician] are not independent silos, but rather mutually dependent fundamentals for the exercise of individual choice. The selection of data to be shared, the values that frame the facts, and the emotional perspective by which they are proffered all contribute to a context that either animates or degrades a person’s autonomy.”).

¹⁷¹ Zita Lazzarini, *South Dakota’s Abortion Script — Threatening the Physician–Patient Relationship*, 359 NEW ENG. J. MED. 2189, 2191 (2008) (discussing South Dakota’s informed consent abortion script, writing that the state’s “script also threatens the physician patient relationship in ways that may resonate far beyond the issue of abortion. Patients have a right to expect that physicians will provide them with accurate and complete medical information that will guide them in making medical decisions.”).

to hear, patients – guided, in part, by their doctors – can assess what information is “material” to their decision-making, without being subjected to speech that they deem harmful or immaterial.¹⁷² If the discourse is shifted to *patients*, a woman who decides that the description of an ultrasound is irrelevant to her abortion decision can autonomously choose not to hear and not be required by the

¹⁷² Following *Truman v. Thomas*, 611 P.2d 902 (1980), there is a great deal of case law discussing the implications for informed consent doctrine of a patient refusing treatment. However, I am aware of no case on-point in which a court found that informed consent explicitly *requires* that a physician tell a patient something that the physician believes is material to the patient’s decision-making even after the patient makes clear their explicit desire not to hear. Further, in the absence of law requiring specific informed consent disclosures, the American Medical Association and the American Congress of Obstetricians and Gynecologists both guide physicians with the notion that patients should be allowed to refuse material information and to determine the “quantity and specificity” of the information communicated by a physician. Amer. Med. Ass’n, *Opinion 8.08 – Informed Consent*, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.page?> (last visited Feb. 25, 2016); *see also* Amer. Cong. on Obstetrics & Gynecology, *ACOG Committee Opinion on Informed Consent* (reaffirmed 2015), available at <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Informed-Consent> (last visited Feb. 25, 2016).

state to do so.¹⁷³ Patients themselves can guide the disclosure¹⁷⁴ and be treated by the law as “capable of making their own decisions” regarding whether to undergo this medical procedure.¹⁷⁵ While the physician may need to carefully navigate the initial discussion with a patient to determine what information she considers relevant/irrelevant, women should ultimately determine for themselves what they want to hear.¹⁷⁶ In contrast, if the state continues to compel listening, the state, in effect, “removes decision-making authority from the individual” and, with it, the patient’s autonomy.¹⁷⁷ As Carol Sanger writes, “Women understand that abortion terminates pregnancy and that some form of life . . . is extinguished by virtue of the procedure; that is its very point. But .

¹⁷³ Many women may, in fact, voluntarily choose to view an ultrasound prior to making an abortion decision. See Orentlicher, *supra* note 159, at 16 (“More studies are needed to inform the question, but the data to date suggest that it makes sense for physicians to offer women the opportunity to view their ultrasounds when they are having ultrasounds performed. A substantial minority, if not a majority, of women want to view the ultrasound, the viewing is generally a positive experience, and for a small number of women who are uncertain whether to have an abortion, the ultrasound may influence their thinking.”). The same woman may still be given pamphlets or be asked to sign informed consent documents that advance the government’s message in ways that she does not want to read, but as she is less captive in this scenario and not subject to professional speech within the trusting bonds of a physician-patient relationship, these types of government messages may continue to be constitutionally valid even if a right against compelled listening is further established.

¹⁷⁴ See, e.g., Suter, *supra* note 5, at 27. These laws currently “demand[] the communication of *irrelevant* information toward an arguably nonscientific ideological end (dissuading women from obtaining an otherwise legal professional service).” Haupt, *supra* note 59, at 1299.

¹⁷⁵ Manian, *supra* note 149, at 224.

¹⁷⁶ Sawicki, *supra* note 149, at 34–35 (“The challenge is finding a way to explain to a patient what information is available to her without running afoul of her right to refuse information, but this challenge is resolvable. One way of resolving this would be to begin the informed consent discussion by asking the patient what information she considers relevant and what information she would prefer not to hear— although this approach, applied in the abortion context exclusively, again runs the risk of buying into assumptions about women’s emotional vulnerability.”).

¹⁷⁷ Strauss, *supra* note 110, at 108–09.

. . . mandatory ultrasound[s] improperly burden[] the ability of women to make decisions about abortion It is harassment masquerading as knowledge.”¹⁷⁸

By shifting to a patient-focused approach, we can better promote the continued empowerment of patients in their health care decision-making, while still holding open the door for public health law to advance population health by ensuring that patients have available to them information that may be material to their needs. Vesting the First Amendment analysis in the patient’s right against compelled listening would do precisely this. The state has a profound role in continuing to regulate and shape informed consent, “but only to the extent that it promotes, as opposed to hinders, informed decision making.”¹⁷⁹ By grounding abortion informed consent analysis in the patient’s right not to hear, the public health law community can better reach the “aspirational goal for informed consent” of “[basing] disclosure on both the physician’s expertise and knowledge of the patient’s condition and the patient’s preference for information and how it is dispensed, all of which is clarified in an individualized dialogue between the two.”¹⁸⁰ Establishing that the patient has control over what she hears and what she refuses to hear allows for strong protections concerning the principles and procedures of informed consent, while also serving the goals of promoting autonomy in medical decision-making, of preserving the integrity of the physician-patient relationship (a relationship that is strained when the government compels the physician to speak and the patient cannot refuse to

¹⁷⁸ Sanger, *supra* note 16, at 360 (describing the supposed “health” of the fetus that a woman has chosen to abort obscures the relevant medical questions relating to the procedure itself and its outcomes). If informed consent is to be driven by information that may be medically relevant, ultrasound description mandates are by their very nature, not medically relevant.

¹⁷⁹ Suter, *supra* note 5, at 31.

¹⁸⁰ *Id.* at 27.

listen),¹⁸¹ and of allowing the state to further protect and advance public health.¹⁸²

C. Limitations

As described throughout, the courts have yet to build a firm doctrine that establishes a patient's right not to hear that would both bolster patient autonomy and strengthen public health. While the rhetoric of the Eleventh Circuit in *Wollschlaeger* provides for some recognition of this right, it does so dangerously; instead of recognizing a right for the patient to refuse to listen, it prohibits the patient from ever having the opportunity to reject or request professional speech. *Wollschlaeger*'s understanding of a patient's rights, therefore, continues to undermine the ability of the state to regulate public health, while also undermining patient's autonomy and access to potentially essential information.

Moreover, applying the captive audience doctrine to abortion informed consent laws raises additional questions of how states can continue to regulate the physician-patient relationship if all patients are "captive" as soon as they don a hospital gown or close the doctor's office door. However, "[t]he right against compelled listening does not preclude the government from advocating policy positions or launching public education campaigns . . . only when there is *captivity*."¹⁸³ The government has a myriad of ways to share its message,¹⁸⁴ including through a physician, so long as the speech can readily be avoided or refused by the listener. Yet, by forcing physicians to hold the listener captive (in the ultrasound description context), the state goes above

¹⁸¹ The court in *Stuart* recognizes this by its comment: "She must endure the embarrassing spectacle of averting her eyes and covering her ears while her physician—a person to whom she should be encouraged to listen—recites information to her." *Stuart*, 774 F.3d at 253.

¹⁸² As Sawicki notes, even in the context of abortion, the state's purported interest in the health of the fetus and of the mother can still be advanced in the context of informed consent, if not within the context of the doctor-patient relationship. See *infra* note 184 and accompanying text.

¹⁸³ Corbin, *supra* note 7, at 980.

¹⁸⁴ *Id.*

and beyond the paternalism arguably inherent in public health law, violating the underpinnings of informed consent.¹⁸⁵

Similarly, as critical as it may be for patients to have the ultimate say in what is or is not material to their healthcare decision-making, there may, in fact, be instances in which a patient should not be given the opportunity to reject critical medical information. For example, if one is about to undergo an elective medical procedure that carries a high risk of death, would it suffice for the state to merely *offer* this information through pamphlets and forms, or should the state instead *require* that all patients be told by their physicians of this risk, with no opt-out provision for the speech? It is possible that there is a threshold beyond which the right against compelled listening should not exist. In establishing this threshold, anti-abortion activists may argue that the information provided in ultrasound mandates serves such a substantial state interest in the life of the fetus that the information provided to a patient should be mandatorily received. Ultimately, a doctrinal test of the listener's rights would help to distinguish between instances where patients have full autonomy in their listening and instances where the information provided is so critical as to trump the patients' right against compelled listening. As the doctrine and scholarly rhetoric on this issue develop, this will remain an essential question.

Moreover, while many of the arguments supporting a right against compelling listening come from a concern about "the state's

¹⁸⁵ As Nadia Sawicki writes, "some of the information currently required by abortion disclosure statutes need not be conveyed by the physician directly but may instead be communicated (as often occurs) in the form of a state pamphlet. To the extent that abortion disclosure laws require conveyance of non-medical information, such laws would be more consistent with informed consent doctrine if the state, rather than the physician, were to make the disclosures . . . it must be emphasized that introducing the state's communicative message at this particular time and place can only be defended as a matter of convenience—and not because state speech is relevant to, analogous to, or part of the informed consent dialogue between physician and patient."). Sawicki, *supra* note 149, at 32.

reliance on emotion to persuade,¹⁸⁶ the use of compelled emotion is often an important and effective tool that may continue to need a place in public health law and communications. From Smokey the Bear to anti-tobacco campaigns, the government often uses imagery to speak,¹⁸⁷ in many contexts, shocking images may be the most effective method to promote public health.¹⁸⁸ Reconciling the contexts in which emotional imagery may create more harm than good may be a critical part of future analysis.¹⁸⁹ A woman, in the captive setting of the exam room, should not be *required* to listen to the emotionally unsettling messages that ultrasound descriptions require,¹⁹⁰ just as a smoker encountering the emotionally startling warnings on a cigarette pack is not required to read them. While there may seem to be an inherent tension between the effectiveness of emotional public health messaging and the rights of the listener, by establishing a right to *refuse* to hear these emotional messages, this tension may also be reconciled, while still allowing the public health community to attempt to *expose* listeners to – but not *force*

¹⁸⁶ Nadia Sawicki, *Compelling Images: The Constitutionality of Emotionally Persuasive Health Campaigns*, 73 MD. L. REV. 458, 458 (2014) [hereinafter *Compelling Images*].

¹⁸⁷ *Id.* at 459.

¹⁸⁸ See, e.g., *id.* at 460 (citing Required Warnings for Cigarette Packages and Advertisements, 76 Fed. Reg. 36,628, 36,674 (June 22, 2011)) (“Notably, the FDA selected these images precisely because of their emotional impact, citing evidence that ‘messages that arouse emotional reactions’ or ‘generate an immediate emotional response’ are more likely to trigger behavioral changes.”).

¹⁸⁹ See generally, *Compelling Images*, *supra* note 186, at 460.

¹⁹⁰ Under the current First Amendment doctrine allowing for “truthful,” “non-misleading” messages, even “‘truthful’ information” such as that at-issue during an ultrasound “may nevertheless be misleading when it takes advantage of individuals’ likelihood to be inappropriately persuaded by emotional biases. That is, empirical research demonstrates that individuals tend to be more easily persuaded when in a fearful or anxious emotional state—the emotional state most likely to be elicited by the information provided.” Jeremy A. Blumenthal, *Abortion, Persuasion, and Emotion: Implications of Social Science Research on Emotion for Reading Casey*, 83 WASH. L. REV. 1, 36 (2008). *But see* *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 577–78 (5th Cir. 2012) (holding that the required disclosures associated with an ultrasound description law represented “the epitome of truthful, non-misleading information”).

upon captive listeners – emotional messages that seek to advance population health.

V. CONCLUSION

As discussed, ultrasound description mandates are at odds with the purported goal of promoting patient autonomy. However, continued attempts to dismantle these regulations by focusing on a physician's First Amendment right against compelled speech may have dangerous implications for the regulation of medicine and for public health more broadly. Instead, by establishing a patient's First Amendment right not to hear, the public health legal community can strike a balance that continues to allow for broad promotion and regulation of the physician-patient relationship, while also respecting and enhancing patient autonomy. By continuing to allow physicians to speak and to communicate the government's interests in protecting health, but also by insisting that patients be allowed to refuse to listen and to determine what information may be material to their decision-making, we can lift the "informed consent" veil that protects pre-abortion ultrasound description mandates. In its place, by establishing a patient's right not to hear, we can enhance patients' rights by re-building a patient-centric view of informed consent, giving patients the ability to avoid unwanted speech, and allowing for the continuing strength of the state's role in promoting public health.