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As states increasingly impose informed consent mandates on abortion providers, the required disclosures bring two well-established legal doctrines into conflict — the First Amendment's freedom of speech and the physician's duty to obtain informed consent.

On one hand, the First Amendment provides for a broad freedom of speech, under which government may neither prevent people from voicing their own views, nor compel individuals to voice the government's views. As the Supreme Court observed in *Wooley v. Maynard,*[1] the First Amendment protects "both the right to speak freely and the right to refrain from speaking at all."[2] When legislatures tell physicians what they must disclose to their patients, the physicians lose their right not to speak.

On the other hand, legislatures and courts can insist that physicians properly explain to patients about their medical conditions and potential treatments so patients can make informed decisions about their health care. Patients lack the medical expertise necessary to make informed decisions on their own; hence, the law requires physicians to disclose material information to patients as part of the decision making process. Physicians are free to speak or not to speak outside of their professional roles. But when taking care of patients, doctors assume a duty to speak, as well as a duty to speak responsibly.[3]

The duty of physicians to speak to their patients has unique features, but it also has much in common with the duties of other professionals to speak to those with whom they have a fiduciary relationship. For example, under Model Rule of Professional Conduct 1.4, lawyers must "promptly inform" clients of decisions for which client consent is required,[4] they must keep clients "reasonably informed" about the status of their representation,[5] and they must explain matters "to the extent reasonably necessary" for clients "to make informed decisions regarding the representation."[6] Similarly, the Uniform Trust Code requires trustees to keep beneficiaries "reasonably informed about the administration of the trust and of the material facts necessary for them to protect their interests."[7] Trustees also must provide to the beneficiaries at least once a year "a report of the trust property, liabilities, receipts, and disbursements, including the source and amount of the trustee's compensation, a listing of the trust assets and, if feasible, the market value of the trust's assets."[8]

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Ordinarily, the doctrines of free speech and informed consent coexist without much difficulty. Courts rarely feel the need to discuss the First Amendment implications of informed consent mandates.[9]

But as states have expanded the kinds of information that abortion providers must disclose to pregnant women, First Amendment concerns have become increasingly salient. Indeed, in 2011, a three-judge panel on the U.S. Court of Appeals for the Eighth Circuit struck down part of an informed consent mandate from the South Dakota legislature on the ground that it violated the free speech rights of physicians.[10] Under the South Dakota law, physicians are required to disclose "all known medical risks" of abortion, including the existence of an "[i]ncreased risk of suicide ideation and suicide."[11] Because studies have not found that having an abortion increases the risk for suicide, the court concluded that the provision "violates doctors' First Amendment right to be free from compelled speech that is untruthful, misleading, or irrelevant."[12] While the court's decision was reversed by an *en banc* decision of the Eighth Circuit,[13] the mandate raises serious concerns. In this article, I will use several examples of informational mandates or other required physician speech to identify principles for distinguishing between legitimate regulation of the informed consent process and illegitimate interference with the freedom of speech.[14]

Courts and other scholars have suggested a number of bases for distinguishing between permissible and impermissible health mandates. For example, as the Eighth Circuit observed, physicians should not be compelled to deliver untruthful speech.[15] Courts and commentators also have worried about speech that is too graphic[16] or that is designed to manipulate the patient's decision making.[17]

Perhaps, the best way to conceptualize the problem is to view the doctrine of informed consent as a carve-out from standard First Amendment doctrine.[18] As long as the state is mandating speech that serves the goals of informed consent, the requirements should not raise First Amendment concerns. However, when the mandates deviate from informed consent principles, they should receive the usual "strict scrutiny" for laws that compel speech by individuals and ordinarily be struck down.[19]

In practice, this conceptualization results in two rules that typify much of the analysis in judicial decisions and academic commentary. First, abortion speech mandates should be permissible when they provide material information to patients about the abortion decision. If the state is trying to ensure that patients are fully informed, the mandates should be allowed. As a corollary, the information must be truthful and not be misleading.[20] The goal is to inform not to misinform. Second, speech mandates that pertain to the morality of abortion should not be permitted. Rather than informing the patient's decision, these mandates force the physician or other health professional to espouse the state's ideology.[21]

As indicated, courts and legal scholars have proposed other ways to distinguish permissible from impermissible mandates. However, these additional distinctions raise their own concerns and should not be needed. If courts strictly apply the requirements that compelled speech pertain to medical facts about abortion and its alternatives rather than abortion ideology and that the compelled speech be truthful and not misleading, then the interests of pregnant women and their physicians should be protected.

Informed Consent Mandates in Health Care

While many of the legislative mandates for abortion informed consent are problematic, some concerns about "abortion exceptionalism" are misplaced. Critics often worry that abortion is singled out for special treatment,[22] but informed consent statutes in health care are not unique to abortion. Legislatures have imposed disclosure requirements for several other medical decisions.

In the late 1970s and 1980s, concern about breast cancer treatment led a number of states to impose informed consent mandates on physicians.[23] The concern arose over the extent to which surgeons were recommending radical mastectomy for early stage cancers without suggesting that their patients consider the breast-conserving alternative of a lumpectomy, typically followed by radiation.[24] In other words, if the cancer were still small and localized, the surgeon could remove the tumor and a small amount of surrounding tissue rather than removing the entire breast. To ensure that women understand their treatment options, many state legislatures adopted statutes requiring greater disclosure of information to patients about the alternative treatments.[25]

These mandates do not raise meaningful First Amendment concerns. It is reasonable for the state to ensure that patients are fully informed about their treatment options, especially when patients are dealing with a treatment that can be disfiguring and a disease that could be lethal.

Supporters of abortion speech mandates make a similar argument. Before women undergo abortion, it is important that they truly understand their reproductive options, especially since the choice of abortion means that the fetus will not survive.[26]

But are there important differences between the breast cancer mandates and the abortion mandates?

For example, the abortion speech mandates seem much more specific than the breast cancer mandates about the information that should be disclosed. At one time, the Supreme Court worried that rigid requirements to disclose a specific body of information would impose an "uncomfortable straitjacket" on physicians performing abortions.[27] If one looks just at the statutory text for the mandates, it appears that legislatures mandate a much greater degree of specificity for abortion than for breast cancer treatment. While the abortion mandates often prescribe a detailed "script" for physicians,[28] breast cancer statutes typically reiterate the basic doctrine of informed consent. For example, a California statute simply requires that patients be informed about "the advantages, disadvantages, risks, and descriptions of the procedures with regard to medically viable and efficacious alternative methods of treatment for breast cancer."[29] However, the statute also requires physicians to satisfy their disclosure requirements by giving patients a brochure developed by the California Department of Public Health.[30] The current version of the brochure provides 35 pages of information to patients.[31] Other states have even longer informational brochures for breast cancer patients,[32] although these states may not require physicians to use the brochure but instead may state that the brochure satisfies the physician's duty of disclosure.[33]

There is an important way in which the breast cancer statutes differ from the abortion mandates. Although the breast cancer statutes were enacted to encourage greater use of breast-conserving treatment, they generally represent less of an effort to push the patient's decision in one direction or another.[34] While the breast cancer laws require disclosure of information regarding all of the treatment options, the abortion statutes typically emphasize information about the risks of abortion and the benefits of childbirth.[35]

Still, abortion speech mandates are not the only speech mandates that promote one decision over another. For example, most states in the 1980s enacted provisions for "required request" to increase the number of organ transplants. Required request laws applied to patients who died in a hospital, were suitable candidates for organ donation, and did not decide about posthumous organ donation while alive. For these patients, a hospital representative[36] was required to inform family members about their option to authorize donation and also to request the family to consent to donation. So speech was compelled, and it was compelled with a bias. Hospital personnel not only would inform family members about organ donation, they also would push for a decision to donate.[37]

For an example of another kind of informed consent mandate that gets fairly specific and that evinces a bias (in this case against the proposed treatment), consider requirements for consent to electroconvulsive treatment (ECT) for major depression or other psychiatric disorders. About 40 percent of states have such mandates.[38] Under Colorado's statute, physicians must notify patients about

> The nature, degree, duration, and probability of the side effects and significant risks of [ECT] commonly known by the medical profession, especially noting the possible degree and duration of memory loss, the possibility of permanent irrevocable memory loss, and the remote possibility of death.[39]

Patients also must be told about "reasonable alternative treatments and why the physician is recommending electroconvulsive treatment" and that "there is a difference of opinion within the medical profession on the use of electroconvulsive treatment."[40] On the other hand, the Colorado statute does not require physicians to discuss the nature, degree, duration, and probability of the side effects and significant risks of alternative treatments.

While abortion mandates are not as exceptional as some writers suggest, abortion exceptionalism makes sense to a certain extent — abortion entails an action that will end the life of a fetus and the potential life of a child.[41] When a potential life is ended, greater care should be taken than for medical decisions that have less serious implications. Consider in this regard that when state legislatures have authorized physician "aid in dying,"[42] they have imposed a number of requirements that can make it difficult for patients to exercise their aid-in-dying right. For example, patients must endure a two-week waiting period between the time of their first request for aid in dying and their ability to receive a prescription for a lethal dose of drug.[43] They also must see a second physician for confirmation of their eligibility for aid in dying. In addition, the statutes impose special disclosure requirements that are not seen for other medical decisions.[44] For example, Oregon requires physicians to "inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15-day waiting period."[45]

Similarly, in states that allow mature minors to make health care decisions, courts may impose stricter standards for decisions whether to forgo life-sustaining medical treatment than for other decisions. According to the Illinois Supreme Court, for example, the govern-

ment's interest in imposing its judgment on the minor "will vary depending upon the nature of the medical treatment involved. Where the health care issues are potentially life threatening, the State's *parens patriae* interest is greater than if the health care matter is less consequential."[46] Or consider the U.S. Supreme Court's decision in *Jacobson v. Massachusetts*[47] for another example of greater deference to the state's interests when a health care decision can result in death. In that case, Henning Jacobson refused to be immunized against small pox, despite a local public health regulation requiring vaccination.[48] The Supreme Court upheld mandatory immunization, and it did so without giving any special weight to Mr. Jacobson's autonomy interests. Rather than employing strict scrutiny or another form of heightened scrutiny, the Court analyzed the ordinance through rational basis review. According to the Court, the regulation was not so arbitrary or unreasonable that it should be invalidated.[49]

In other words, while abortion speech mandates seem to violate principles of equality when they impose disclosure requirements that are not typically seen elsewhere, the equality argument runs into the fact that abortion really is different in a very meaningful way from other medical procedures. It would be surprising if the rules for abortion were the same as the rules for an appendectomy.[50]

As the different examples of health care speech mandates indicate, there often are good reasons for legislatures to require specific disclosures of information by physicians. Common law principles of informed consent generally work well to protect patients, but not always. And this is particularly the case in the many states that rely on professional standards to define the scope of the physician's duty to disclose information to their patients.[51] Doctors are very much devoted to the welfare of their patients, but their own interests may interfere with their duty to serve their patients' interests.[52] Accordingly, we should expect that at times, the common law may not compel adequate disclosures by physicians to their patients.[53]

Of course, legislative mandates for informed consent will not always reflect a genuine effort to insure that physicians disclose all material information to their patients. At times, as is the case with some of the abortion mandates, legislators will be trying to prevent patients from making a disfavored decision. Accordingly, courts need standards by which to distinguish legitimate speech mandates from illegitimate speech mandates.

The Supreme Court has required that mandated speech be truthful and not misleading. Are there speech mandates that are truthful and not misleading, but nevertheless are problematic? We can turn to some examples of mandated abortion speech to answer this question.

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Speech Mandates for Abortion

At one time, speech mandates for abortion were limited and covered ground that was quite consistent with principles of informed consent. For example, in the law challenged in *Planned Parenthood of Southeastern Pennsylvania v. Casey,* Pennsylvania required physicians to provide material medical information about abortion and the alternative of childbirth.[55] Before an abortion, pregnant women were to be told about the nature of the proposed abortion procedure and its risks, the risks with carrying the fetus to term, and the probable gestational age of the fetus.[56] All of these requirements would make for a more informed decision about the woman's choice. Patients typically want to know about benefits and risks of a proposed procedure, as well as the benefits and risks of alternative treatments. The gestational age of the fetus would affect the risks from abortion, and it also might influence a woman's choice about abortion. For some women, it may be easier to abort a very young fetus than an older fetus.[57]

Under the Pennsylvania law, women also were to be told that information was available about agencies that offered alternatives to abortion, that medical assistance benefits might be available to defray the costs of pregnancy and childbirth, and that the father might be responsible for child support payments.[58] In other words, to the extent that financial considerations were relevant to the woman's decision, she was able to better understand the economic trade-offs between abortion and childbirth.

The *Casey* Court upheld the disclosure requirements on the grounds that they mandated information

that was truthful and non-misleading and that would make for a fully informed decision by the woman.[59] Although the holding represented a departure from the Court's past rejection of speech mandates for abortion,[60] the *Casey* Court's approach fits well under the doctrine of informed consent.

In the past few years, however, some states have adopted speech mandates that are not based on traditional principles of informed consent. As discussed above, a number of legislatures have required physicians to disclose information that is inaccurate. For example, when women are told that having an abortion will increase their risk of suicide, they are being misled. Accordingly, a suicide risk mandate cannot be justified under principles of informed consent and should be found to violate the First Amendment.[61] Other misleading mandates include information that abortion is linked with an increased risk of breast cancer.[62]

In addition to misleading speech, many states require ideological speech. South Dakota and some other states require physicians to tell patients that an abortion will "terminate the life of a whole, separate, unique, living human being."[63] This mandate forces the physician to take sides on moral questions that are very much disputed. For example, there is much debate on the question whether the fetus is a "separate" entity or is part of the woman. Similarly, there is considerable controversy on the question whether the fetus has the status of a "human being" or is morally different from an infant.

Ideological speech mandates should fall outside the informed consent carve out for compelled speech.[64] They do not serve the goals of ensuring that patients understand the benefits and risks of abortion or the alternative of childbirth. Rather, they require physicians to promote the state's views on the propriety of a controversial public policy. As the Supreme Court wrote in *West Virginia State Board of Education v. Barnette*,[65] no government official may try to "prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein."[66] Accordingly, the New Jersey Supreme Court rejected a woman's informed consent claim that her physician should have told her before her abortion that her embryo "was a complete, separate, unique and irreplaceable human being," or that abortion involves "killing an existing human being."[67]

Moreover, with ideological speech mandates, the government can exploit the trust of patients in their physicians to lend credibility to its message.[68] And that corrupts the fiduciary relationship between patient and physician. Patients rely on physicians for their expertise and judgment with the understanding that physicians will use their expertise and judgment to promote the interests of their patients.[69] With ideological speech mandates, the government forces physicians to use their expertise and judgment to promote the interests of the state. We would not want Congress or the Obama administration to compel physicians to advocate on behalf of the right to health care under the Affordable Care Act when informing their patients. Similarly, legislatures should not require physicians to advocate against a right to abortion. In other words, the ideological speech mandates for abortion are akin to the compelled speech struck down by the Supreme Court in *Wooley v. Maynard.*[70]

To be sure, as the Casey Court indicated, the state need not remain silent about the woman's decision whether to abort or carry her fetus to term. The state is entitled to try to persuade pregnant women to choose childbirth. But when it tries to do so with ideological speech, it must do so without forcing physicians — or other individuals — to deliver its message.

Interpretive Issues

While the principles of truthful speech mandates and non-ideological mandates provide good standards, they suffer from the usual imprecision of legal standards. Judges can come to different conclusions about the application of speech mandate standards, and indeed they have applied the standards in different ways.

Consider, for example, the contrast between the U.S. Court of Appeals for the Eight Circuit's 2008 opinion in *Planned Parenthood of Minnesota, North Dakota, South Dakota v. Rounds*[71] and the 2014 opinion in *National Association of Manufacturers v. SEC*[72] by the U.S. Court of Appeals for the D.C. Circuit. In both cases, plaintiffs challenged speech mandates on grounds that the mandates compelled ideological speech. The D.C. Circuit gave the government much less leeway than did the Eighth Circuit on the ideological speech question.

The D.C. Circuit issued its decision in the context of disclosures to consumers by sellers of goods. In *National Association of Manufacturers,* the court rejected a speech mandate for producers of goods that use the kinds of minerals that are mined in the Democratic Republic of the Congo. Congress was concerned about the extent to which armed groups fighting each other in the Congo war were financing their operations with gold and other minerals from eastern Congo.[73] Accordingly, users of minerals that could have come from the Congo were required to determine whether their minerals did in fact come from the Congo. If so, they were required to disclose on their websites that

their products were not free from minerals mined in the Democratic Republic of Congo.[74] In the government's view, it was simply requiring companies to make a factual disclosure about the components of their goods — were the minerals from the Congo, or were they from other countries? Indeed, country of origin disclosures are common for other businesses. For example, federal law requires groceries to disclose the country of origin of the meats, fish, fruits, vegetables, and nuts that they sell.[75] Nevertheless, the D.C. Circuit viewed the mandate as demanding ideological speech and therefore found the disclosure requirement unconstitutional under the First Amendment. In effect, wrote the court, a company subject to the requirement had "to tell consumers that its products are ethically tainted." The mandate required a business to assume "moral responsibility for the Congo war" even in the case of a company that "condemns the atrocities of the Congo war in the strongest terms" and "may disagree with that assessment of its moral responsibility."[76]

If manufacturers cannot be forced to weigh in on the morality of Congo minerals, one would expect that physicians cannot be forced to weigh in on the morality of abortion. Yet the Eighth Circuit permitted South Dakota's ideological mandate in *Rounds*. South Dakota requires physicians to tell their abortion patients that the abortion "will terminate the life of a whole, separate, unique, living human being."[77] In the court's view, this mandate entailed factual rather than ideological speech because the statute included a definition of "human being" in the definitions section of the law, according to which human being means an "individual living member of the species of Homo sapiens, including the unborn human being during the entire embryonic and fetal ages from fertilization to full gestation."[78] Of course, South Dakota does not require physicians to include the statutory definition of human being in their disclosures, and even if physicians discuss the statutory definition, it still represents ideological speech — that a fetus is a human being.[79] If the Congo minerals mandate was ideological, surely the human being mandate is ideological.[80]

Just as courts differ on the meaning of ideological speech, they differ on the meaning of misleading speech. Consider an internal disagreement in the Eight Circuit in a challenge to South Dakota's mandate regarding the risks of suicide from abortion. As mentioned earlier, South Dakota requires physicians to disclose "all known medical risks" of abortion, including the existence of an "[i]ncreased risk of suicide ideation and suicide."[81] Because studies have not found that having an abortion increases the risk for suicide, a three-judge panel of the Eighth Circuit concluded that the provision "violates doctors' First Amendment right to be free from compelled speech that is untruthful, misleading, or irrelevant."[82] However, sitting *en banc*, the Eighth Circuit reversed the panel and upheld the suicide risk mandate. According to the *en banc* majority, stating that there is an "increased risk" of suicide among women who have had an abortion does not mean that there is a causal relationship between abortion and suicide. Rather, wrote the majority, an increased risk is an appropriate way to characterize an association, and there was evidence to support the claim that there is a statistically significant correlation between having an abortion and having an increased risk of suicide.[83]

It is difficult to square the *en banc* court's opinion with the requirement that speech mandates not mislead. Women told that there is an increased risk of suicide with abortion are likely to incorrectly conclude that having an abortion will increase their risk of suicide rather than correctly concluding that women who choose an abortion have a higher risk of suicide for other reasons.

Sufficient Standards for Permissible Abortion Speech Mandates

If the requirements for truthful speech mandates and non-ideological mandates can be manipulated, should other standards be added to limit the ability of legislatures to violate principles of informed consent and freedom of speech? Additional distinctions raise their own concerns. Moreover, they would be subject to the same problem of judicial manipulation.

What other standards might be invoked to reject speech mandates for abortion? For example, is it a problem if the state takes sides on a matter that is controversial?[84] Is it a problem if the state tries to manipulate a woman's decision making process by appealing to emotion? Is it a problem if the government requires health care providers to show graphic images to pregnant women before an abortion?[85]

That information takes sides, is designed to appeal to emotion, or is presented in a graphic fashion should not automatically disqualify a speech mandate. In many cases, such information can promote better decision making. Some mandates for biased, emotion-laden, or graphic information are problematic, but they usually are problematic because they require untruthful or misleading speech or because they require ideological speech.[86] There may be some limits on the degree to which a speech mandate takes sides, appeals to emotions, or is graphic, but a mandate should not be rejected simply because it takes sides, may appeal to emotion rather than reason, or is graphic.

Taking Sides

Perhaps it is wrong for the government to favor one choice over another. If the government tries to influence the woman's decision, it does not seem respectful of the woman's autonomy. Under *Roe v. Wade*,[87] the Supreme Court required the government to remain neutral about a woman's decision whether to abort her fetus. The Court therefore rejected many informed consent mandates on the ground that the state was trying to influence the woman's decision in favor of childbirth.[88] In *Casey*, the Court concluded that the state need not remain neutral, but was free to promote an interest in the preservation of fetal life, as long as its speech mandates were truthful and not misleading.[89] Did the *Casey* Court wrongly reverse course on this question?

If the Court returned to its pre-*Casey* doctrine and prohibited speech mandates that reflect an effort by government to influence individual decision making, most health-related speech mandates would be suspect.[90] Governments often pass speech mandates precisely because they worry about the decisions that people make. Nutritional labeling mandates have been adopted because lawmakers think that many people make poor choices about their diet. Tobacco warnings have been required for cigarette manufacturers because lawmakers think that many people make poor choices about smoking. Lawmakers adopt speech mandates because they believe that consumers would make better choices if they had more information about their decisions.

Of course, what it means to make a "better" choice is an important question. Let us assume it means a choice that the person would want to make if the person truly understood all that was at stake with the decision.[91] For example, a consumer would forgo a food option once the person realized how much fat, how many calories, or how much salt the food contained. Or a consumer would abstain from smoking once the person realized that tobacco causes cancer. With health-related speech mandates, the government can help people make decisions that better reflect their preferences. And one can make the same argument about abortion speech mandates. A woman worried about her finances may not feel that she cannot afford to raise a child. But when informed about the father's obligation to provide support, she might decide she could afford childrearing.

It should not be a problem simply because the government tries to influence people's decisions by requiring that they be given more information by companies or physicians. For example, it should not be a problem if a state requires physicians to provide truthful information about support services for new mothers in the hope that more women will choose childbirth over abortion. Nor should it be a problem if a state requires cigarette manufacturers to provide truthful information about the health risks of tobacco in the hope that fewer people will smoke.

If the doctrine of informed consent is designed to ensure that patients make their decisions after carefully considering the advantages and disadvantages of their options, we might worry if decisions are driven by emotion rather than reason. Emotional factors might result in a patient forgoing the choice that best reflects the patient's genuine preferences. Should speech mandates therefore be prohibited if they would exploit the emotions of the listeners or viewers?

Rather, it is a problem if the government misleads the public in its efforts to influence personal decision making or compels others to deliver speech that is ideological in nature. Thus, for example, the Constitution should prevent states from trying to discourage abortion by forcing physicians to provide inaccurate information, such as claims that an abortion will increase the woman's risk of suicide or breast cancer. The Constitution also should prevent states from trying to discourage abortion by forcing physicians to voice the government's view about the moral status of a fetus. In other words, concerns about the government taking sides are already addressed by the standards that speech mandates may require only truthful and nonmisleading information and that the mandates not require ideological speech.[92]

Manipulating Emotions

If the doctrine of informed consent is designed to ensure that patients make their decisions after carefully considering the advantages and disadvantages of their options, we might worry if decisions are driven by emotion rather than reason.[93] Emotional factors might result in a patient forgoing the choice that best reflects the patient's genuine preferences. Should

speech mandates therefore be prohibited if they would exploit the emotions of the listeners or viewers?

In the context of abortion, Carol Sanger has criticized mandates to show ultrasound images to pregnant women. According to Sanger, these mandates try to overpower the woman's reason by "triggering something like a primitive maternal instinct."[94] Ultrasound images are more likely, argues Sanger, to distort judgment than to inform it.[95] Caroline Corbin also worries that ultrasound images can distort the decision making process. For both Sanger and Corbin, the social significance of a fetal ultrasound image in the United States is the image of an infant — of the pregnant woman's child.[96] As a result, the decision to abort one's fetus may feel more like a decision to kill one's baby.[97]

Appeals to emotion cannot be categorically rejected.[98] All decision making reflects the intersection of reason and emotion.[99] Indeed, emotion and reason are both required to make decisions — "the ability to decide depends upon the ability to feel."[100] This is because

> emotions help us to interpret, organize, and prioritize the information that bombards us.... We cannot function without creating markers of saliency and value, and our emotions aid us in identifying which information is especially salient, valuable, or urgent....In short, emotions help shape the...cognitive tools that are essential to the continuing task of information processing.[101]

Moreover, objections based on appeals to emotion can have the undesirable effect of suggesting that women are untrustworthy decision makers because of their emotional vulnerability.[102]

While there are few studies on the question, published data suggest that the viewing of ultrasound images can actually play a positive role for women undergoing abortion. In a Canadian study, for example, women were given the option of viewing the ultrasound images as the procedure was being performed, and more than 70 percent of the women chose to view.[103] Among those who viewed the ultrasound, viewing did not make the abortion more difficult emotionally for more than 83 percent of the women.[104] Indeed, typical comments from the women indicated that viewing the ultrasound made it easier for them to undergo the abortion.[105] In another study that was conducted in South Africa, half of the women that participated were offered the opportunity to view the ultrasound while it was being performed.[106] Among those who viewed the ultrasound, nearly three-fourths said they would want to view the ultrasound if they needed an abortion in the future.[107] These positive data may reflect the fact that the overwhelming percentage of abortions are performed in the first trimester. Women may expect to see a miniature baby on the ultrasound, but all that may be present is a gestational sac.[108]

In another study, with a much larger number of participants[109] and that was conducted in the United States (Planned Parenthood in Los Angeles), researchers examined whether viewing an ultrasound would change women's minds about abortion.[110] At the clinics studied, ultrasounds were routinely performed, and patients were offered the opportunity to view the ultrasound. More than 40 percent of the women chose to view the ultrasound, and for the most part, viewing did not affect the decision whether to abort.[111] However, for the 7 percent of women who came to the clinic with a low to medium level of certainty about having an abortion, there appeared to be a small effect on their decision making in the direction of carrying the fetus to term.[112]

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.[113]

If we cannot reject appeals to emotion as a general matter, or even the specific appeal of an ultrasound image, can we reject some appeals to emotion because they are too extreme? Once again, we come back to the standard that speech mandates must be truthful and non-misleading. Emotional appeals that rely on deception are not acceptable.[114]

Graphic Images

Related to the concern about appeals to emotion is the concern about the use of graphic images. We might worry that powerful images can be overly persuasive by leading viewers to ignore important factual information.

It is difficult to see why legal doctrine should distinguish between dry text and graphic images. The goal of informed consent doctrine is to ensure that patients develop a meaningful understanding of their options before making a decision. And many people will more readily understand information that is delivered graphically — sometimes a picture really is worth a thousand words. Hence, Congress passed legislation in 2009 requiring the traditional textual warnings on cigarette packages to be paired with images that illustrate the harms of smoking,[115] and many states require physicians to offer women the opportunity to view pic-

tures of fetuses or images from their own fetal ultrasound before an abortion.[116]

Whether in the context of smoking or abortion, graphic images can provide a better understanding of the considerations important to the person's decision. For abortion, it will be relevant for many women whether the fetus is still a blob of tissue or has developed many of the features of a person. An abortion at six weeks can be a very different decision than an abortion at eighteen weeks. As discussed in the preceding section, ultrasound images often can serve the purposes of informed consent.[117]

graphic images of people with the illness the immunization protects against. Suppose in particular that the images included cases in which an immunocompromised individual dies from chicken pox or measles. If the images would more effectively communicate to the parents the importance of immunization, then it is difficult to see why the images should be prohibited.

To be sure, some graphic images may be problematic. In particular, graphic images can mislead patients. For example, if an ultrasound image of a woman's fetus is magnified so that it appears to be larger than its actual size, as is often the case with first-trimester

As I have discussed, courts can draw a good balance between principles of informed consent and the First Amendment by ensuring that abortion speech mandates are truthful, not misleading, and not ideological. Some courts have not employed these standards with sufficient bite, as when the Eighth Circuit permitted misleading statements about the risk of suicide from abortion, but the answer to that problem is for the Supreme Court to insist that the standards be applied more rigorously.

But is there a problem if images are too graphic? Should women really be confronted with ultrasounds of their fetuses before an abortion? After all, we do not expect patients to view videotapes of heart surgery before they undergo their own operations.[118] Perhaps an image mandate would be designed for its shock value rather than for its ability to convey factual information.[119]

On the other hand, we can imagine some very graphic images that would be desirable. Consider a hypothetical informed consent statute for immunization. In recent years, the United States has seen a significant increase in the incidence of childhood diseases that are preventable with vaccines (e.g., measles and chicken pox). These increases reflect the fact that parents are more likely than in the past to refuse immunizations for their children. To some extent, the willingness to reject immunization reflects the success of immunization in nearly eliminating once-common childhood communicable diseases. Because parents today are far less familiar than were generations past with the impact of these infections,[120] they may discount the benefits of vaccination. Moreover, they may discount the benefits not only for their own children but also for individuals who cannot be vaccinated because of compromised immune function or other medical conditions.[121] Suppose, then, that a state wanted to address the declining rate of immunization by requiring pediatricians to show parents pregnancies, the pregnant woman would be given an inaccurate sense of the fetus' nature.[122] One can generally protect against inappropriate graphic images by requiring that they be truthful and not misleading.

It is possible to imagine graphic images that would be accurate but unacceptable. For example, suppose a legislature required women to watch a video of a physician dismembering a fetus during an abortion. But images that extreme have not been mandated. If such a mandate were enacted, then it would be necessary to establish a standard for identifying images that are too graphic.

Conclusion

As I have discussed, courts can draw a good balance between principles of informed consent and the First Amendment by ensuring that abortion speech mandates are truthful, not misleading, and not ideological. Some courts have not employed these standards with sufficient bite, as when the Eighth Circuit permitted misleading statements about the risk of suicide from abortion, but the answer to that problem is for the Supreme Court to insist that the standards be applied more rigorously.

In that regard, a number of scholars have criticized courts for their differential treatment of speech mandates for companies and speech mandates for abortion providers.[123] For example, the U.S. Court of Appeals for the D.C. Circuit struck down the Food and Drug Administration's proposed graphic warnings for ciga-

rette packages[124] while the U.S. Court of Appeals for the Fifth Circuit upheld Texas' ultrasound image viewing statute.[125] There were good reasons for the tobacco warnings, and they should have been upheld.[126]

As the examples from corporate speech and physician speech illustrate, there are problems with both overenforcement and underenforcement of the requirements that speech mandates be truthful, not misleading, and not ideological. Unfortunately, in its approach to speech mandates for tobacco companies — or its approach on the Congo minerals disclosure[127] — the D.C. Circuit did not give the government sufficient leeway to require informational disclosures (the overenforcement problem). On the other hand, the Fifth Circuit (and the Eighth Circuit[128]) have given government too much authority to impose disclosures in the context of abortion speech mandates (the underenforcement problem). Accordingly, when it next addresses the question of speech mandates that are designed to better inform the public, the Supreme Court needs to provide sufficient guidance to avoid problems of both overenforcement and underenforcement.

But adding new standards to supplement the standards regarding truth and ideology will not be useful. Additional standards would give weight to the wrong factors, and in any event, would be the subject to the same problems of overenforcement and underenforcement that currently exist with appropriate standards for judging speech mandates.[129]

Acknowledgements

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References

1. 430 U.S. 705 (1977) (recognizing right of individuals to cover up the New Hampshire state motto, "Live Free or Die" on their automobile license plates).
2. *Id.*, at 714.
3. R. C. Post, "Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech," *University of Illinois Law Review* 2007, no. 3 (2007): 939-990, at 949-951.
4. Model Rules of Professional Conduct R. 1.4(a)(1). Versions of the Model Rules have been adopted in many states. In Indiana, Model Rule of Professional Conduct 1.4(a)(1) is codified as Indiana Rule of Professional Conduct 1.4(a)(1).
5. Model Rule of Professional Conduct R. 1.4(a)(3).
6. Model Rule of Professional Conduct R. 1.4(b).
7. Unif. Trust Code § 813(a). Versions of the Uniform Trust Code have been enacted in more than half of the states. In Michigan, § 813(a) is codified as Mich. Comp. Laws § 700.7814(1).
8. Unif Trust Code § 813(c). The trustee's duties differ depending on the type of beneficiary (e.g., current beneficiary or qualified beneficiary). For more discussion, see W. M. McGovern, S. F. Kurtz, and D. M. English, *Wills, Trusts and Estates: Including Taxation and Future Interests*, 4th ed. (St. Paul: Thomson Reuters, 2010): at section 12.3.
9. Or they may dismiss First Amendment concerns with little discussion. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 884 (1992). The Casey Court also observed that misleading or non-truthful speech runs afoul of the liberty clause of the 14th Amendment. *Id.*, at 882.
10. *Planned Parenthood of Minnesota, North Dakota, South Dakota v. Rounds*, 653 F.3d 662, 670-672 (8th Cir. 2011) (with one judge dissenting). The Court also struck down the mandate as a violation of due process. *Id.*, at 672.
11. S.D. Cod. Laws § 34-23A-10.1(1)(e) and (1)(e)(2).
12. *Rounds*, 653 F.3d at 673.
13. *Planned Parenthood of Minnesota, North Dakota, South Dakota v. Rounds*, 686 F.3d 889 (8th Cir. 2012) (en banc).
14. In addition to first amendment challenges to regulations that mandate physician speech, there have been first amendment challenges to regulations that restrict physician speech. See, e.g., *Rust v. Sullivan*, 500 U.S. 173 (1991) (permitting the U.S. Department of Health and Human Services to prevent recipients of federal funding for family planning services from counseling patients about abortion or making referrals for abortion); *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002) (invalidating a federal prohibition on the recommending of marijuana to patients for medical reasons); *Final Exit Network, Inc. v. State*, 722 S.E.2d 722 (Ga. 2012) (striking down a Georgia statute that made it a criminal offense to publicly offer assistance to persons who wish to commit suicide, but not punishing the private provision of assistance).

    Censored speech can raise more concerns than required speech, since more speech generally is preferable to less speech, but as with compelled speech, the nature of the patient-physician relationship may provide justification for restrictions on speech that would not be allowed in other settings. For example, legislatures might want to prevent physicians from exploiting their treatment relationships to invade their patients' privacy or to subject their patients to practices that may cause harm without providing any offsetting benefit. For relevant cases, see *Wollschlaeger v. Governor of Florida*, 760 F.3d 1195 (11th Cir. 2014) (permitting Florida to limit questioning of patients about gun ownership "when doing so is not necessary to providing the patient with good medical care"); *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2013) (permitting California to prohibit "mental health providers from engaging in 'sexual orientation change efforts' ('SOCE') with patients under 18 years of age"). Pennsylvania apparently has prohibited physicians from discussing some of the risks to health from fracking in order to protect proprietary information of energy companies that use fracking to extract natural gas. J. L. Dolgin, "Physician Speech and State Control: Furthering Partisan Interests at the Expense of Good Health," *New England Law Review* 48, no. 2 (2014): 293-342, at 308-313.

    Whether courts have drawn the right balance between the First Amendment and the state's power to regulate professional conduct in the context of restrictions on physician speech is an important question that is beyond the scope of this article.
15. *Rounds*, 653 F.3d at 673.
16. R. Dresser, "From Double Standard to Double Bind: Informed Choice in Abortion Law," *George Washington Law Review* 76, no. 6 (2008): 1599-1622, at 1622.
17. C. Mala Corbin, "Compelled Disclosures," *Alabama Law Review* 65, no. 5 (2014): 1277-1351, at 1338.
18. Post, *supra* note 3, at 950-951.
19. Under strict scrutiny, courts will not uphold a regulation of speech unless it is narrowly tailored to serve a compelling state interest. The government has more leeway to compel speech by businesses than speech by individuals, as when it imposes mandates to prevent consumers from being misled. Milavetz, *Gallop & Milavetz v. United States*, 559 U.S. 229 (2010).
20. Corbin, *supra* note 17, at 1294-1295.
21. *Planned Parenthood of Minnesota, North Dakota, South Dakota v. Rounds*, 530 F.3d 724, 734-735 (8th Cir. 2008) (discussing the distinction between compelling doctors "to speak the State's ideological message" and requiring disclosure of "truthful, non-misleading information relevant to a patient's decision to have an abortion"); P. Berg, "Toward a

First Amendment Theory of Doctor-Patient Discourse and the Right to Receive Unbiased Information," *Boston University Law Review* 74, no. 2 (1994): 201-266, at 260-261.

22. I. Vandewalker, "Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics," *Michigan Journal of Law and Gender* 19, no. 1 (2012): 1-70, at 1.
23. S. G. Nayfield et al., "Statutory Requirements for Disclosure of Breast Cancer Treatment Alternatives," *Journal of the National Cancer Institute* 86, no. 16 (1994): 1202-1208. For a critical discussion of these statutes, see R. Andersen-Watts, "The Failure of Breast Cancer Informed Consent Statutes," *Michigan Journal of Gender and Law* 14, no. 2 (2008):201-222.
24. B. Fisher, "Role of Science in the Treatment of Breast Cancer When Tumor Multicentricity is Present," *Journal of National Cancer Institute* 103, no. 17 (2011): 1292-1298, at 1292-1293.
25. According to a 2008 article, 22 states have enacted such statutes. Andersen-Watts, *supra* note 23, at 211.
26. Casey, 505 U.S. at 852; M. P. Vargo, "The Right to Informed Choice: A Defense of the Texas Sonogram Law," *Michigan State University Journal of Medicine & Law* 16, no. 3 (2012): 457-501, at 475.
27. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 762 (1986).
28. See, e.g., S. D. Cod. Laws § 34-23A-10.1 (requiring disclosure of more than a dozen pieces of information); Mo. Rev. Stat. § 188.027 (requiring an even longer list of information).
29. Cal. Health & Saf. Code § 109275(c)(1).
30. Cal. Health & Saf. Code § 109275(a).
31. Cancer Detection Section, California Department of Public Health, A Woman's Guide to Breast Cancer Treatment (January 2010), *available at* <http://www.mbc.ca.gov/Publications/Brochures/breast_cancer_english.pdf> (last visited February 11, 2015).
32. Michigan's brochure runs about 65 pages. See Michigan Department of Community Health, *What You Need to Know Before Treatment About: Breast Cancer* (September 2008), *available at* <http://www.michigan.gov/documents/BCIC_final_110303_169314_7.pdf> (last visited February 11, 2015).
33. See, e.g., Mich. Comp. Laws 333.17013(3).
34. However, it was common for states to recommend separate procedures for biopsy and treatment rather than combining biopsy and treatment into a single procedure. Nayfield, *supra* note 23, at 1204. With separate procedures, patients would have time between the biopsy and the initiation of treatment to carefully explore their treatment options.
35. Corbin, *supra* note 17, at 1288. One could view the bias in the type of information required as reflecting misleading speech. If patients hear more about the disadvantages of childbirth and the disadvantages of abortion, they may not get an accurate picture of their options. However, the abortion mandates do not preclude other speech by physicians during the informed consent process. Hence, the mandates permit physicians to supplement the required information with other information, and the doctrine of informed consent would require physicians to provide information that is balanced overall.
36. Compelled speech mandates may be less troublesome when imposed on health care workers who do not have the same fiduciary relationship with patients as do treating physicians, but that should not affect the First Amendment analysis. All individuals have First Amendment rights not to speak, so freedom of speech applies to both non-physician health care providers and physicians. And while states typically impose greater duties of informed consent on physicians than on other health care providers, states may extend the duty of informed consent to non-physician providers. *Blotner v. Doreika*, 678 S.E. 2d 80, 82 (Ga. 2009) (discussing Georgia's application of informed consent to acupuncturists, psychologists, and social workers, but not to chiropractors).
37. K. S. Andersen and D. M. Fox, "The Impact of Routine Inquiry Laws on Organ Donation," *Health Affairs* 7, no. 5 (1988): 65-78, at 68-69. Among the states without required request laws, a majority required hospitals to inform family members about the option for donation. A provision for required request was included in the Uniform Anatomical Gift Act of 1987. Unif. Anat. Gift Act § 5(b). After Congress required hospitals to inform family members about donation, 42 U.S.C. § 1320b-8, and the Department of Health and Human Services issues regulations governing the process for informing families and requesting donation, 42 C.F.R. § 482.35(a)(3), the 2006 revision of the Uniform Anatomical Gift Act eliminated the required request provision. Most states have amended their anatomical gift acts to follow the 2006 model. M. A. Hall, M. A. Bobinski and D. Orentlicher, *Health Care Law and Ethics*, 8th ed. (New York: Wolters Kluwer Law & Business, 2013): at 649. Required request laws therefore may be less common now.
38. V. Harris, "Electroconvulsive Therapy: Administrative Codes, Legislation, and Professional Recommendations," *Journal of the American Academy of Psychiatry and the Law* 34, no. 3 (2006): 406-411.
39. Colo. Rev. Stat. § 13-20-401(4)(d).
40. *Id.*, at (4)(e) and (4)(g).
41. Dresser, *supra* note 16, at 1600, 1622.
42. Physician aid in dying also is characterized as physician-assisted suicide.
43. Or. Rev. Stat. § 127.840. This waiting period is considerably longer than the typical 24-hour waiting period for abortion.
44. Dresser, *supra* note 16, at 1622 n. 138.
45. Or. Rev. Stat. § 127.815(1)(h). For another kind of informed consent mandate regarding end-of-life care, a New York statute "requires physicians and other health care practitioners to offer terminally ill patients 'information and counseling regarding palliative care and end-of-life options appropriate to the patient, including…prognosis, risks and benefits of the various options; and the patient's legal rights to comprehensive pain and symptom management.'" S. E. Weinberger, et al., "Legislative Interference with the Patient–Physician Relationship," *New England Journal of Medicine* 367, no. 16 (2012): 1557-1559, at 1557.
46. In re E.G., 549 N.E.2d 322, 327 (Ill. 1989).
47. 197 U.S. 11 (1905).
48. *Id.*, at 12-13.
49. *Id.*, at 27-28. To be sure, Jacobson was decided well before the Supreme Court began to develop its fundamental rights doctrine in the 1960s and 1970s. But that does not explain the Court's reasoning. Just fourteen years before *Jacobson*, the Court wrote that "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person." *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).
50. Of course, abortion is very different from an appendectomy not only in terms of the state's interests, but also in terms of the patient's interests. Abortion legislation implicates a woman's fundamental interests not only in health care decision making but also in reproductive choice. Nevertheless, by setting proper limits on the state's power to mandate physician speech, women's fundamental interests can be safeguarded. In particular, the requirements for truthful and non-ideological speech discussed in this paper should provide the needed protection.
51. About half the states rely on a professional standard for disclosure while the other states require physicians to disclose information that would be material to a reasonable patient. Hall et al., *supra* note 37, at 212-213.
52. Physicians may overprescribe medications or recommend surgeries because of the financial remuneration that they realize. C. T. Robertson, S. L. Rose, and A. S. Kesselheim, "Effect of Financial Relationships on the Behavior of Healthcare Professionals," *Journal of Law, Medicine & Ethics* 40, no. 3 (2012): 452-466. See also Post, *supra* note 3, at 982 (discussing the controversy over the risk of mercury poisoning from tooth amalgams (fillings) and whether the financial interests of dentists cloud their judgment).
53. For example, courts have been slow to require physicians to disclose information about their surgery success rates, conflicts of interest, or other personal information that might affect the qual-

ity of care. D. Orentlicher, "A Restatement of Health Care Law," *Brooklyn Law Review* 79, no. 2 (2014): 435-456, at 439-440.
54. Casey, 505 U.S. at 882.
55. *Id*., at 844.
56. 18 Pa. Cons. Stat. 3205(a)(1).
57. According to a December 2012 Gallup poll, 61 percent of Americans support a right to abortion during the first three months of pregnancy, while only 27 percent support a right to abortion during the second three months of pregnancy, *available at* <http://www.gallup.com/poll/160058/majority-americans-support-roe-wade-decision.aspx> (last visited February 11, 2015).
58. 18 Pa. Cons. Stat. 3205(a)(2). In the case of rape, health care providers could omit information about paternal support. *Id*.
59. Casey, 505 U.S. at 881-883.
60. The Court did not reject all speech mandates between its decisions in Roe and Casey. In some cases, states passed statutes that required a mix of permissible and impermissible disclosures. In those cases, the Court struck down the entire mandate, on the ground that it could not sever the impermissible provisions from the permissible ones but had to decide the constitutionality of the mandates in their entirety. Thornburgh, 476 U.S. at 759-766; *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 442-445 & n.37 (1983).
61. R. Tushnet, "More than a Feeling: Emotion and the First Amendment," *Harvard Law Review* 127, no. 8 (2014): 2392-2433, at 2415-2416.
62. Dresser, *supra* note 16, at 1609.
63. S. D. Cod. Laws § 34–23A-10.1(1)(b); N.D. Cent. Code § 14-02.1-02; Mo. Rev. Stat. § 188.027.
64. Dresser, *supra* note 16, at 1622; Dolgin, *supra* note 14, at 340.
65. 319 U.S. 624 (1943).
66. *Id*., at 642.
67. *Acuna v. Turkish*, 930 A.2d 416, 418 (N.J. 2007). The court's informed consent analysis arose in the context of a medical malpractice lawsuit brought by the woman after the abortion.
68. Corbin, *supra* note 17, at 1297.
69. D. Orentlicher, "The Commercial Speech Doctrine in Health Regulation: The Clash Between the Public Interest in a Robust First Amendment and the Public Interest in Effective Protection from Harm," *American Journal of Law & Medicine* 37, nos. 2 & 3 (2011): 299-314, at 311.
70. Indeed, the Wooley Court specifically observed that "where the State's interest is to disseminate an ideology, no matter how acceptable to some, such interest cannot outweigh an individual's First Amendment right to avoid becoming the courier for such a message." 430 U.S. at 717. Wooley arose when George Maynard was cited for covering up the "Live Free or Die" motto on the New Hampshire license plate. He objected because the motto was "repugnant to [his] moral, religious, and political beliefs." Id. at 707.
71. 530 F.3d 724 (8th Cir. 2008).
72. 748 F.3d 359 (D.C. Cir. 2014). I am grateful to Thomas Joo for pointing me to this case.
73. *Id*., at 362-363.
74. *Id*., at 363-364, 370.
75. 7 C.F.R. § 65.300.
76. National Assn., 748 F.3d at 371. In a more recent decision upholding country-of-origin disclosure regulations for meat products, the U.S. Court of Appeals for the D.C. Circuit sitting en banc repudiated part of the reasoning of the three-judge panel in the Congo minerals case (without commenting on the panel's discussion about the ideological nature of the minerals mandate). *American Meat Institute v. U.S. Dept. of Agriculture*, 760 F.3d 18 (D.C. Cir. 2014). It is possible that the court will override the rest of the Congo minerals reasoning in a future opinion.
77. S.D. Cod. Laws § 34-23A-10.1(1)(b).
78. Rounds, 530 F.3d at 735 (citing S.D. Cod. Laws § 34-23A-1(4)).
79. The Eighth Circuit relied on a dubious reading of a U.S. Supreme Court precedent, *Meese v. Keene*, 481 U.S. 465 (1987), to reach its result. In that case, the Court upheld a requirement that domestic exhibitors of films produced by foreign countries register the films as "political propaganda" with the Department of Justice. The Court rejected a claim of unconstitutional compelled ideological speech, in part because the statute defined political propaganda in a broad, non-pejorative way. *Id*., at 477-478. Hence, the Eighth Circuit relied on the definitional section of the South Dakota statute to mitigate the ideological nature of the mandated speech in its case. But there were some important differences between the political propaganda case and the Eighth Circuit case. The required disclosure to viewers of the films stated that the film was registered under the Foreign Agents Registration Act but did not include the words "political propaganda," and the registration requirement had existed for more than four decades with no record of problems for exhibitors. *Id*., at 471, 483-484.
80. One would not have expected greater protection for the First Amendment rights of manufacturers than for abortion providers for another reason – abortion speech mandates interfere with the autonomy of people, while the Congo minerals mandate interfered with the autonomy of corporations. However, with the invigoration of the "commercial speech" doctrine in recent decades, differences between regulation of corporate speech and regulation of individual speech have greatly narrowed. D. Orentlicher, "The FDA's Graphic Tobacco Warnings and the First Amendment," *New England Journal of Medicine* 369, no. 3 (2013): 204-206, at 204.
81. S.D. Cod. Laws § 34-23A-10.1(1)(e) and (1)(e)(2).
82. *Rounds*, 653 F.3d at 673 (with one judge dissenting).
83. *Rounds*, 686 F.3d at 898-899. The correlation reflects the fact that women choosing an abortion are already at an increased risk for depression, not that having an abortion increases their risk.
84. Corbin, *supra* note 17, at 1302-1303.
85. Dresser, *supra* note 16, at 1617-1618, 1622 (arguing that graphic descriptions or images are not justified under principles of informed consent).
86. Tushnet, *supra* note 61, at 2415, 2425-2432.
87. 410 U.S. 113 (1973).
88. *Thornburgh*, 476 U.S. at 759-763.
89. *Casey*, 505 U.S. at 882.
90. Tushnet, *supra* note 61, at 2424, 2430.
91. In other words, the quality of a decision is judged from the perspective of the individual making the decision rather than according to the values of the state.
92. The U.S. Court of Appeals for the Fourth Circuit has drawn a distinction between requiring physicians to provide informational material that takes sides and requiring physicians to deliver the information directly by speaking to the patient. According to the court, the state should not force physicians to become mouthpieces for its message. *Stuart v. Camnitz*, 774 F.3d 238, 253-254 (4th Cir. 2014). But the legal doctrine of informed consent necessarily requires physicians to become mouthpieces for the state. Requiring physicians to speak the state's message becomes a problem when the message is ideological, misleading, or not truthful.
93. *R.J. Reynolds Tobacco Co. v. FDA*, 696 F.3d 1205, 1216-1217 (D.C. Cir. 2012)
94. C. Sanger, "Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice," *UCLA Law Review* 56, no. 2 (2008): 351-408, at 396-397.
95. *Id*., at 403.
96. *Id*., at 378, 401; Corbin, *supra* note 17, at 1332.
97. Corbin, *supra* note 17, at 1338-1339; Sanger, *supra* note 94, at 402.
98. Corbin acknowledges this point explicitly. Corbin, *supra* note 17, at 1304-1307.
99. Tushnet, *supra* note 61, at 2422.
100. Corbin, *supra* note 17, at 1306.
101. S. A. Bandes, "Emotions, Values, and the Construction of Risk," *University of Pennsylvania Law Review PENNumbra* 156 (2008): 421-434, at 422-423. Corbin tries to distinguish ultrasound images from other speech that appeals to emotion with the argument that creating an association between a fetus and a child is illegitimate because it conflates the wom-

an's view of a child with her view of a fetus. Corbin, *supra* note 17, at 1338-1339. In Corbin's view, this is like an advertiser using an attractive woman to sell a coffee maker and hoping that potential purchasers will conflate their views about the woman with their views of the coffee maker. *Id.* However, associating a fetus with a child is very different from associating a coffee maker with an attractive woman. Tushnet, *supra* note 61, at 2419-2420. Moreover, the ultrasound mandates apply to images of the fetus itself, not to images of a child.

102. N. N. Sawicki, "The Abortion Informed Consent Debate: More Light, Less Heat," *Cornell Journal of Law and Public Policy* 21, no. 1 (2011): 1-38, at 34.
103. E. R. Wiebe and L. Adams, "Women's Perceptions about Seeing the Ultrasound Picture before an Abortion," *European Journal of Contraception & Reproductive Health Care* 14, no. 2 (2009): 97-102, at 99.
104. *Id.*, at 99.
105. *Id.*, at 99-100 (reporting the following comments: "'Oh God, I do not know, but I said "bye" ', It's very helpful, glad to have this option', 'It actually made me feel better', 'It was neat', 'It made it more real', 'It made it easier for me', 'It was a bit sad', 'Very interesting and educational', and 'Thanks'").
106. A. A. Bamigboye et al., "Should Women View the Ultrasound Image Before First-Trimester Termination of Pregnancy?" *South African Medical Journal* 92, no. 6 (2002): 430-432. It was randomly decided whether or not the woman was offered the opportunity to view the ultrasound images. *Id.* at 430-431.
107. *Id.*, at 432.
108. Wiebe and Adams, *supra* note 103, at 101.
109. This study included more than 15,000 women compared to 500 in the South African study and 350 in the Canadian study. M. Gatter et al., "Relationship Between Ultrasound Viewing and Proceeding to Abortion," *Obstetrics & Gynecology* 123, no. 1 (2014): 81-87, at 81.
110. *Id.*, at 81.
111. *Id.*, at 83-85.
112. *Id.*, at 85.
113. Statutes that require physicians to do more than simply offer women the opportunity to view the ultrasound raise additional concerns. The U.S. Court of Appeals for the Fourth Circuit struck North Carolina's ultrasound statute down because physicians were required to display the ultrasound image and describe it even for women who did not want to receive the mandated information. *Stuart*, 774 F.3d at 242, 251-254.
114. Tushnet, *supra* note 61, at 2424-2425.
115. While the U.S. Court of Appeals for the 6th Circuit upheld the authority of Congress to require *some* graphic images, Disc. Tobacco City & Lottery, Inc. v. United States, 674 F.3d 509 (6th Cir. 2012), the U.S. Court of Appeals for the D.C. Circuit rejected the specific graphic images adopted by the Food and Drug Administration. *R.J. Reynolds*, 696 F.3d at 1208 (D.C. Cir. 2012). I think the D.C. Circuit erred when it blocked the images. They were designed to enhance consumer understanding of the risks of smoking; in other words, they were designed to better inform rather than misinform. *Id.* at 1231-1233 (Rogers, J., dissenting). Rather than appealing the decision, the FDA decided to revise its images. Orentlicher, *supra* note 80, at 205.

    Two years after the D.C. Circuit's decision (which was by a three-judge panel), the *en banc* court rejected the *Reynolds* decision's logic in a case involving a requirement that meat products include information about their countries of origin. *American Meat Institute*, 760 F.3d at 22-23.
116. Sanger, *supra* note 94, at 351, 397. About one-third of states have enacted some form of ultrasound legislation. *Id.* at 375. Requiring that women undergo an ultrasound raises different questions than requiring physicians to offer women the opportunity to view their ultrasound images. That said, ultrasounds are commonly performed before an abortion for medical reasons. According to a national survey of abortion providers in the United States, more than 90 percent of the facilities perform ultrasounds as a routine matter for first-trimester abortions, and the other facilities often will perform ultrasounds for medical reasons. K. O'Connell et al., "First-Trimester Surgical Abortion Practices: A Survey of National Abortion Federation Members," *Contraception* 79, no. 5 (2009): 385-392, at 388.
117. See, *supra*, at p. 9. See also Texas Medical Providers Performing Abortion Services v. Lakey, 667 F.3d 570, 577-578 (5th Cir. 2012). To be justified under the doctrine of informed consent, graphic image mandates should adhere to the principle that patients may refuse to hear or view information that is offered to them. Sawicki, *supra* note 102, at 34-35.
118. Vandewalker, *supra* note 22, at 20.
119. *R.J. Reynolds*, 696 F.3d at 1216 (discussing the FDA's graphic images for cigarette packages).
120. S. B. Omer, W. A. Orenstein and J. P. Koplan, "Go Big and Go Fast – Vaccine Refusal and Disease Eradication," *New England Journal of Medicine* 368, no. 15 (2013): 1374-1376, at 1374.
121. Ordinarily, people who cannot be immunized themselves are protected by the "herd immunity" that develops when a high enough percentage of the community is vaccinated. Herd immunity protects against the spread of the disease. If too many parents refuse immunization for their children, then herd immunity is compromised. Herd immunity also protects immunized children, since vaccines are not 100 percent effective. A. Buttenheim, M. Jones, and Y. Baras, "Exposure of California Kindergartners to Students with Personal Belief Exemptions from Mandated School Entry Vaccinations," *American Journal of Public Health* 102, no. 8 (2012): e59-e67, at e59.
122. Corbin, *supra* note 17, at 1328.
123. *Id.*, at 1309-1339; Tushnet, *supra* note 61, at 2404.
124. See, *supra*, note 115.
125. *Lakey*, 667 F.3d at 577-580. It may make sense to have different standards for compelled speech by corporations and professionals. On one hand, individuals have traditionally enjoyed greater free speech rights than have corporations, which suggests greater freedom for the government to impose disclosure mandates on companies than on physicians. On the other hand, as the discussion of informed consent indicated, physicians and other professionals assume duties to speak to their patients and clients from their fiduciary relationships with their patients and clients. See, *supra*, at p. 1. Because corporations do not have fiduciary relationships with their customers, one can argue that the government has a weaker basis for imposing disclosure requirements on companies. In addition, the strengthening of the commercial speech doctrine's protection for corporate speech in recent years has brought first amendment doctrine for corporate speech closer to that for individual speech.
126. *R.J. Reynolds*, 696 F.3d at 1230-1232 (Rogers, J., dissenting). One of the proposed textual warnings – an 800-QUIT-NOW number to help smokers with their tobacco cessation efforts – was not designed to inform consumers about the health risks from cigarettes, but to promote the government's anti-smoking ideology. Accordingly, it did raise substantial first amendment concerns. *Id.*, at 1236-1237. In *American Meat Institute*, 760 F.3d at 22-23, the *en banc* D.C. Circuit overruled the reasoning in *R.J. Reynolds*, so the graphic warnings may be revived after all.
127. See, *supra*, at p. 6-7.
128. See, *supra*, at p. 7.