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NOTE

Taking Physicians Out of the Straitjacket: Defending Physician Free Speech Rights by Defining the “Truthful and Nonmisleading” Standard

Kathryn E. Meyer

INTRODUCTION

There is a new frontier in the legal battle over access to abortion. Forty years after Roe v. Wade, litigation and regulation concerning abortion-related services remain hotly contested and unsettled, as parties continue to challenge and expand on the central holding of the landmark case. While historically much of the litigation in this area has focused on the undue burden that certain state and federal regulations may place on a woman’s constitutional rights, the shifting landscape of abortion legislation has presented a new issue and a new challenge in the modern era. Because many recently enacted regulations require the woman’s physician to disseminate certain information as an aspect of obtaining informed consent, opponents claim these laws violate the treating physician’s freedom of speech rights by compelling doctors to circulate and speak to information with which they may not agree. These challenges center on an area of the law left unclear by Casey, in which the Court explicitly upheld a state’s right to compel physician speech and regulate the physician-patient interaction to serve the government’s public health interest so long as the disclosures contained “truthful, nonmisleading information.”

1 Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 67 n.8 (1976) (“To ascribe more meaning [to informed consent and mandatory disclosures] than [the giving of information to the patient as to the procedure and the consequences] might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession.”).

2 J.D. Candidate, 2016, University of Kentucky College of Law; B.A., Government, 2012, Centre College. The author would like to sincerely thank Professor Nicole L. Huberfeld for her guidance throughout the writing process. The author would also like to thank her family and friends for their love, support, and advice.

3 Roe v. Wade, 410 U.S. 113 (1973). This case serves as a landmark decision in which the Supreme Court first enunciated a woman’s right to abortion services, grounded in the Due Process Clause of the Fourteenth Amendment. Id. at 153–54. While the Court’s trimester framework for understanding when and how the state could regulate these services was overturned in Planned Parenthood of Southeastern Pennsylvania v. Casey, the Court explicitly noted that “the essential holding of Roe v. Wade should be retained and once again reaffirmed.” Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 846, 869–70 (1992). These two cases form the framework of the modern jurisprudence concerning access to abortion services.


5 Casey, 505 U.S. at 882.
The Court did not speak to what further analysis underlies the determination of when compelled disclosures are truthful and nonmisleading, and federal courts have subsequently followed suit, giving this standard sparse treatment and deferring to the legislature on the fact-finding associated with the regulations.

Because this treatment can ultimately result in an infringement upon physician free speech rights, this Note seeks to give context to the "truthful and not misleading" standard implemented by the Court, arguing that by drawing on other jurisprudence from the healthcare community and compelled speech challenges, the courts can provide more appropriate guidelines for regulating physician speech and can remedy this constitutional violation. Part I of this Note explores the current state of the law on compelled speech in the context of the physician-patient relationship and the way the courts have treated the "truthful and not misleading" standard. This part will point to the potential problems and inconsistencies that have arisen from the current state of the law. Part II draws inspiration from the medical community, commercial and professional speech jurisprudence, and false advertising cases in an effort to provide a solution to issues created by the existing body of law. Part III then utilizes this information and seeks to give substance to the "truthful and not misleading" standard in this context to adequately protect physicians' fundamental right to freedom of speech.

I.legislators in the exam room: an introduction to state regulation of abortion through informed consent and compelled disclosures

While the Supreme Court upheld Roe v. Wade's central holding and affirmed the right of a woman to receive an abortion in Casey, the Court's opinion also opened the door to a new route for state regulation of the procedure by upholding the section of the Pennsylvania law requiring a woman to give her informed consent to the procedure. In doing so, the Court overturned its own standards and holdings from previous informed consent cases. Formerly, when physicians challenged informed consent mandates as violations of their freedom of speech, the

6 Id. at 846.
7 See id. at 881–82; see also 18 PA. STAT. AND CONS. STAT. ANN. § 3205 (West, Westlaw through the 2015 Reg. Sess. Acts 1 to 39). Under the statute, a physician must orally inform the woman of: "(i) [t]he nature of the proposed procedure or treatment and of those risks and alternatives to the procedure or treatment that a reasonable patient would consider material to the decision of whether or not to undergo the abortion[,] (ii) [t]he probable gestational age of the unborn child at the time the abortion is to be performed, [and] (iii) [t]he medical risks associated with carrying her child to term." § 3205(a)(1).
courts looked to whether disclosures were “directly material to any medically relevant fact” or whether the disclosure’s purpose was only to confuse or punish the woman or to heighten her anxiety. \(^9\) *Casey* explicitly overruled this standard, broadening the range of allowable information and inviting states to mandate similar disclosures, so long as the information is truthful and not misleading. \(^11\)

The Court’s decision in *Casey* thus both lays the groundwork for physicians to bring future claims by noting the free speech rights at stake (“[t]o be sure, the physician’s First Amendment rights not to speak are implicated”), \(^12\) and for future state regulations by expressing the state interest at hand (“but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State.”). \(^13\) Both physician-challengers and state-regulators have seized upon this language in subsequent years.

### A. Freedom of Speech Interests and Concepts at Play

The Supreme Court has made clear that the right not to speak is within the protection of the First and Fourteenth Amendments. \(^14\) The government generally cannot control what a person sees, reads, or says. \(^15\) Citizens have generally been protected against government-compelled speech under the theory that such compulsion would violate freedom of speech principles by requiring “an individual, as part of his daily life . . . to be an instrument for fostering public adherence to an ideological point of view he finds unacceptable.” \(^16\) In mandatory disclosure and compelled speech cases, opponents cite the negative effects such regulations can have on personal autonomy \(^17\) and liberty of thought. \(^18\) Under this reasoning, the

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\(^10\) *Thornburgh*, 476 U.S. at 762.

\(^11\) *Casey*, 505 U.S. at 882; see also *Suter*, supra note 8, at 21–22.

\(^12\) *Casey*, 505 U.S. at 884.

\(^13\) *Id.* (citation omitted).

\(^14\) U.S. CONST. amend. 1 (“Congress shall make no law . . . abridging the freedom of speech . . . .”); *Gitlow v. New York*, 268 U.S. 652, 666 (1925) (ruling that the First Amendment is incorporated against and constrains state government action via the Fourteenth Amendment); see also W. Va. State Bd. of Educ. v. *Barnette*, 319 U.S. 624, 645 (1943) (Murphy, J., concurring) (“The right of freedom of thought . . . as guaranteed by the Constitution against State action includes both the right to speak freely and the right to refrain from speaking at all . . . .”).


\(^17\) See, e.g., Caroline Mala Corbin, *Emotional Compelled Disclosures*, 127 HARV. L. REV. F. 357, 360 (2014) (“State-mandated speech implicates the individual autonomy of the compelled speaker, as the right to control your speech can be violated as much by being forced to speak as by being silenced.”).

\(^18\) *Barnette*, 319 U.S. at 642 (noting that protection against compelled speech preserves “the sphere of intellect and spirit which it is the purpose of the First Amendment to our Constitution to reserve from all official control”).
United States court system has frequently invalidated legislation that forces speakers to recite the views of a third party or the government.\(^\text{19}\)

Although the Court recognized the First Amendment implications of informed consent laws within the \textit{Casey} opinion, the last several years have seen a proliferation of cases applying this concept to regulations and disclosure requirements upon physicians.\(^\text{20}\) While lower court opinions (both pre- and post-\textit{Casey}) have dealt with these challenges using a variety of frameworks, the \textit{Casey} opinion indicates that the Supreme Court will protect physician speech as professional or commercial speech\(^\text{21}\) and thus will consider these challenges under a different analysis than other restrictions on speech.\(^\text{22}\) To pass constitutional muster, the challenged restriction must regulate lawful and not misleading speech and must be “not more extensive than is necessary” to serve a substantial government interest.\(^\text{23}\) By emphasizing a state’s important interest in regulating the medical field and “in ensuring so grave a choice is well informed,”\(^\text{24}\) \textit{Casey} and related cases indicate that the decisive prong of the \textit{Central Hudson} test in these challenges will be whether speech is “truthful and not misleading.”\(^\text{25}\) However, in reality the truthful and not misleading standard has been given little treatment. The slight consideration and nonexistent treatment of this standard originates in \textit{Casey} itself, where the Court essentially assumed that the information contained in the compelled disclosures was truthful and nonmisleading.\(^\text{26}\)

\textbf{B. The States React: Abortion Regulations and Informed Consent Statutes After the Casey Decision}

States (and the federal government) were quick to take advantage of the pathway the Court left open in the \textit{Casey} decision by moving to enact their own “informed consent” statutes. Legislation and regulations related to abortion services

\footnotesize{\begin{itemize}
\item \textsuperscript{20} See supra note 4 (listing cases dealing with compelled speech and mandated disclosures for physicians and healthcare providers).
\item \textsuperscript{22} See Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm’n of N.Y., 447 U.S. 557, 566 (1980) (discussing a court’s review analysis in commercial speech cases); see also Halberstam, supra note 21, at 779.
\item \textsuperscript{23} Cent. Hudson, 447 U.S. at 566; see also Lorillard Tobacco Co. v. Reilly, 533 U.S. 525, 553–56 (2001).
\item \textsuperscript{24} Gonzales v. Carhart, 550 U.S. 124, 159 (2007).
\item \textsuperscript{25} \textit{Casey}, 505 U.S. at 882–83.
\item \textsuperscript{26} See id. at 882, 884.
\end{itemize}}
have surged in the past several years. From 2011 to 2013, states around the
country enacted more abortion restriction laws than had been enacted in the entire
preceding decade, and in 2013 alone, seventy anti-abortion measures were
enacted in twenty-two states. Federal legislation (though unsuccessful thus far)
was introduced as early as 2004, though not voted on until 2006, with the Unborn
Child Pain Awareness Act, and as recently as 2014 and 2015. Anti-abortion
advocates see this as the new frontier for limiting abortion access—a way to shut
down some clinics and ultimately eliminate such services.

This trend has been especially pronounced in relation to regulations concerning
informed consent. As of March 1, 2016, thirty-eight states have implemented laws
mandating that physicians provide certain counseling and information to a woman
seeking an abortion as part of seeking her informed consent. Thirty of these states
mandate the specific information that must be included, while eight mandate that
the abortion-specific requirements generally follow informed consent principles.
Information contained in these disclosures varies from state to state and can include
details about the procedure, the gestational age of the fetus, and fetal
development—categories which exactly mirror the language used in the Casey
holding and the Pennsylvania law at issue in that case.

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27 Erik Eckholm, Access to Abortion Falling as States Pass Restrictions, N.Y. TIMES, Jan. 4, 2014,
at A1, http://www.nytimes.com/2014/01/04/us/women-losing-access-to-abortion-as-opponents-gain-
ground-in-state-legislatures.html.
29 Id. at 9.
vote of 250-162 in the House. Unborn Child Pain Awareness Act Loses Vote in House, CATHOLIC
see also Katherine E. Engelman, Fetal Pain Legislation: Protection Against Pain Is Not an Undue
Burden, 10 QUINNIPIAC HEALTH L.J. 279, 280 n.6 (2007).
31 Hearbeat Informed Consent Act, H.R. 5551, 113th Cong. (2014); Elise Viebeck, GOP
Relaunches Push to Ban Late-Term Abortions, THE HILL (Jan. 6, 2015, 5:34 PM),
http://thehill.com/policy/healthcare/228686-gop-relaunches-abortion-push (reporting on the GOP’s
renewed effort to introduce legislation mandating disclosure of fetal pain information to women seeking
abortions).
32 Gregory H. Wilmoth, Abortion, Public Health Policy, and Informed Consent Legislation, 48 J.
SOC. ISSUES, no. 3, 1992, at 1, 11 (quoting THOMAS A. GLESSNER, ACHIEVING AN ABORTION-
33 Counseling and Waiting Periods for Abortion, GUTTMACHER INST.: STATE POLICIES IN
34 Id.
35 Id.
36 Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 881 (1992); see also 18 PA. STAT. AND
The *Casey* decision affords states the ability to regulate and mandate informed consent provisions through their power to regulate the healthcare field," and commentators have pointed to language in the *Gonzales v. Carhart* decision as further augmenting state power in this area." In reality, state laws seem to have outgrown the broad categories of required information seen in the Pennsylvania law at issue in *Casey*, now mandating that the physician dispense much more specific and detailed "facts" to the woman as part of achieving the requisite informed consent. These laws have led to a variety of challenges from physicians on free speech grounds under the theory that legislatures have overstepped the *Casey* test and are no longer limiting mandated information to those disclosures that are truthful and not misleading disclosures. Such laws include those requiring physicians to dispense information concerning the purported link between breast cancer and abortion, the ability of the fetus to feel pain, the long-term mental health consequences to women after receiving abortion services, and those requiring that a woman be informed that "personhood begins at conception." Several lower federal courts have struck down many laws for requiring the dissemination of information that was potentially misleading or not truthful, but almost all of these laws have been subsequently upheld in federal circuit appeals courts. These lower federal court decisions are indicative of the nationwide treatment of (and confusion and disagreement on) this issue.

One of the most noteworthy examples of a physician compelled speech challenge came in response to a South Dakota informed consent statute, which, in part, required that a physician inform a woman seeking an abortion that the procedure would "terminate the life of a whole, separate, unique, living human being," and would terminate her existing relationship with that human being. The lower federal court held that these provisions went beyond the information allowable under *Casey* and contained the state's views on the "unsettled medical,

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37 See *Casey*, 505 U.S. at 884 (noting that a physician's free speech rights are only implicated as they relate to the practice of medicine, an area "subject to reasonable licensing and regulation by the State.").


39 As will be explained later in this Note, many of the "facts" contained in disclosures under these initiatives are often not based in fact at all. See infra notes 58–64 and accompanying text.

40 See, e.g., supra note 4 (listing cases challenging such laws).


43 Counseling and Waiting Periods for Abortion, supra note 33.


45 S.D. CODIFIED LAWS § 34-23A-10.1 (West, Westlaw through the 2015 Reg. Sess.).
philosophical, theological, and scientific issue" of whether a fetus constituted a human being. 46

This decision was eventually overturned by the Eight Circuit, which enunciated the familiar Casey standard in its decision by noting that the plaintiffs could only succeed in their compelled speech claim by showing that the mandatory disclosure was untruthful, misleading, or irrelevant. 47 While the Eighth Circuit recognized that, in isolation, the statute's language concerning the termination of "the life of a whole, separate, unique, living human being" could seem misleading or ideological, 48 in this particular instance the court found the mandated disclosure withstood the Casey test because "human being" was defined for purposes of the statute to include "an individual living member of the species of Homo sapiens . . . during [its] embryonic [or] fetal age[]." 49 In the court's opinion, this language made the disclosure both truthful and relevant. 50 Subsequent litigation has followed a similar pattern to that of Rounds, though the exact information in the mandated disclosures differs from state to state. 51

Until recently, there have been few successful physician free speech challenges to informed consent statutes. However, in 2014, the Fourth Circuit upheld a lower court's ruling that a North Carolina informed consent statute violated the treating physician's free speech rights. 52 Rather than invalidating the law under the Casey truthful and not misleading test, the Fourth Circuit focused on the state interest at play and the means used by the state. 53 While this decision still accorded little treatment to the truthful and nonmisleading standard and developed few guideposts for future courts to determine why and how such a statute constitutes a violation, the court did refer to the importance of considering traditional informed consent principles in these decisions and of placing some safeguards on a physician's free speech rights. 54

47 See id. at 735.
49 See id.
50 See supra note 4 (listing cases dealing with requirements placed on physicians and healthcare providers).
51 Stuart v. Camnitz, 774 F.3d 238, 255–56 (4th Cir. 2014) (holding that an informed consent requirement that the physician take, display, and explain ultrasound photographs to a woman seeking an abortion violated the physician's free speech rights by compelling ideological speech in a way that overreached the important state interests involved), cert. denied, 135 S. Ct. 2838 (mem.) (2015). In upholding the lower court's finding that certain provisions of North Carolina's informed consent statute violated the challenging physician's rights to free speech, the Fourth Circuit became the first appellate level court to recognize such a violation. See id. at 248–49 (disagreeing with approaches of the Fifth and Eighth Circuits in reviewing cases about the constitutionality of abortion regulations under the First Amendment).
52 See id. at 250.
53 See id. at 251–52.
C. The Subsequent Lack of Protection for Physician Free Speech Rights

Under the Casey standard, the government may compel disclosures in the context of the physician-patient relationship only when the information contained within the disclosures is truthful and not misleading. Since the courts generally find that these laws serve a compelling state interest and are narrowly tailored (the other two prongs of the Central Hudson test regarding commercial speech regulations), the truthful and not misleading standard is often the only defense against infringements on the doctor's free speech rights.

Ideally, this standard protects doctors from being compelled to act as ideological vehicles for the state or to say anything against their beliefs or values. However, under the current system, courts do not often look carefully at whether each compelled piece of information is in line with the Casey standard. States are thus able to mandate disclosures that distort and compel physician speech by including disclosures that are not entirely true, or are true but are also misleading.

As previously noted, there has been much activity in the lower federal court system concerning whether a law regulating physician speech violates a medical provider's freedom against government compelled speech. However, there has been little discussion regarding the considerations that should go into determining whether a regulation constitutes an impermissible intrusion on this right. By giving such cursory treatment to this issue, the courts are undervaluing, and giving little protection to, the physician's freedom of speech rights. While all of these required disclosures force physicians to become vehicles of the state, such actions only become problematic and violate a physician's freedom of speech rights when the action compels the physician to make statements that may not be truthful and may be misleading to those who hear them. The courts' failure to look underneath the legislative findings and test the factual statements required under mandatory disclosure laws puts the physician in a straitjacket and undermines his or her right to freedom of speech and to avoid being a mouthpiece for the state in practice.

The best way to see potential problems caused by an overly deferential standard in this area is to look to some of the laws and disclosures that have been upheld as truthful and nonmisleading by federal appellate courts. Of the twenty-five states that require certain disclosures regarding the risks of abortion, Guttmacher Institute has posited that four states inaccurately portray the risks to a woman's

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future fertility, five inaccurately assert a possible link between abortion and breast cancer, and nine emphasize the negative emotional responses to the procedure, rather than including the full range of potential emotional responses. Other abortion-specific informed consent provisions include a requirement that the woman seeking an abortion be told that personhood begins at conception (six states), or that require the woman be given information that details the fetus' ability to feel pain (twelve states). While the courts have upheld challenges to almost all of these provisions, research shows that such provisions are based on statements that are untrue, or for which there is no medical consensus. In response, many scientists and physicians have opposed these policies and the related mandatory dispersal of such information in an informed consent context, arguing that these disclosures work against informed consent and interfere with adequate patient-physician interactions.

II. INFORMING CONSENT: GIVING CONTEXT TO THE TRUTHFUL AND NOT MISLEADING STANDARD

To assure that physicians' free speech rights are protected against infringement, the legal system must give context to the truthful and not misleading standard. Disclosures under the *Casey* standard must be truthful—but what does truthful entail, and what should courts look to when determining if mandated disclosures meet that definition? According to Merriam-Webster's dictionary, truthful is

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59 Counseling and Waiting Periods for Abortion, supra note 33 (listing Arizona, Kansas, South Dakota, and Texas as states that inaccurately portray the risk to women's fertility).

60 Id. (listing Alaska, Kansas, Mississippi, Oklahoma, and Texas as states that inaccurately assert a link between abortion and breast cancer).

61 Id. (listing Kansas, Louisiana, Michigan, Nebraska, North Carolina, South Dakota, Texas, Utah, and West Virginia as states that misrepresent the range of emotional responses to abortion).

62 Id. (listing Indiana, Kansas, Missouri, North Dakota, Oklahoma, and South Dakota as states that tell women seeking abortion that personhood begins at conception).

63 Id. (listing Alaska, Arkansas, Georgia, Indiana, Kansas, Louisiana, Minnesota, Missouri, Oklahoma, South Dakota, Texas, and Utah as states that include information on the ability of a fetus to feel pain).


65 See, e.g., Vignettes E. Charles et al., Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence, 78 CONTRACEPTION 436, 449 (2008) ("Programs and policies based on claims derived from flawed research should be modified to reflect the most scientifically sound literature."); Gail Erlick Robinson et al., Is There an "Abortion Trauma Syndrome"? Critiquing the Evidence, 17 HARV. REV. PSYCHIATRY 268, 276 (2009) ("To date, the published studies concluding that abortion causes psychiatric illness have numerous methodological problems; since their conclusions are questionable, they should not be used as a basis for public policy.").
defined as "containing or expressing the truth," 66 while truth means "a judgment, proposition, or idea that is true or accepted as true," or "being in accord with fact or reality." 67 These definitions become complicated in the legal arena, especially in relation to scientific findings and personal beliefs. The truthful standard involves further inquiry than a look into the dictionary. The additional requirement that disclosures be "not misleading" is also not so easily defined.

Because the Casey standard plays so vital a role in preserving physicians' free speech rights, this Note will now seek to give context to this standard, and to propose a solution to the shortcomings of the current analysis. First, this Note considers the Casey precedent in an effort to understand what information the Court intended to allow in mandatory disclosures. Then, the Note discusses what determinations should underlie the truthful and not misleading standard from the Casey test by looking to the purposes and law concerning informed consent, scientific and medical principles, and jurisprudence concerning false advertising and emotional appeals. This Note will additionally discuss considerations of pre-CASEY precedent and deference to the legislature in this area.

A. Clearer Look at the Casey Precedent

Although the Casey standard has already been discussed at length, giving context to this standard in relation to modern state informed consent laws requires a deeper and clearer look at the precedent itself. First, the provisions of the law challenged in Casey are distinguishable from the informed consent provisions that states have enacted in recent years. The Pennsylvania statute at issue in Casey required the physician to speak to the gestational age of the fetus, the relevant medical risks of abortion and childbirth, and to inform the woman about state pamphlets concerning alternatives to abortion and medical benefits for prenatal care and childbirth. 68 This general information lines up with the type of information that doctors are already required to give patients under the doctrine of informed consent, 69 and providing such information does not require the physician to directly parrot the state's perspective. In fact, the only true state information being compelled is contained in a pamphlet from the state that the doctor must merely inform the woman of, and provide to her if requested.

The law that was at issue in Casey, then, differs markedly from those enacted following the Court's decision. Many laws now require the physician to inform the woman orally or in writing that human life begins at conception; 70 that the abortion

69 See infra Part II.B; see also Canterbury v. Spence, 464 F.2d 772, 782 n.27 (D.C. Cir. 1972).
70 See, e.g., IND. CODE ANN. § 16-34-2-1.1(a)(1)(E) (West, Westlaw through the 2015 First Reg. Sess.).
“will terminate the life of a whole, separate, unique, living human being’’;\textsuperscript{71} that "objective scientific information shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age;\textsuperscript{72} and that risks to her fertility,\textsuperscript{73} of breast cancer,\textsuperscript{74} and of suicide or other serious mental health issues may exist.\textsuperscript{75} When laws contain these specific, required disclosures and do not leave room for physician discretion as to what is medically accurate, they depart from Casey, go outside traditional informed consent notions,\textsuperscript{76} and compel physician speech—that is, unless the laws and disclosures are truthful and not misleading.\textsuperscript{77} Thus, these specific, mandated disclosures should be subjected to judicial oversight in relation to their impact on and potential infringement of physician free speech.\textsuperscript{78}

\textbf{B. Drawing Inspiration from Science, General Informed Consent Jurisprudence, and Other Healthcare Law Contexts}

Scientific principles, general informed consent law, and the regulation of other healthcare contexts can provide an important basis for determining when a law is both truthful and not misleading. In informing the truthful and not misleading standard, disclosures should be compared to the current scientific consensus. While the Supreme Court has made clear that the required disclosures may go outside the realm of medically necessary and can be in addition to the information traditionally required under informed consent,\textsuperscript{79} a look to medical ethics and the way the law

\begin{itemize}
\item\textsuperscript{72} IND. CODE ANN. § 16-34-2-1.1(a)(1)(G); see also KAN. STAT. ANN. § 65-6709(b)(6) (espousing a similar requirement).
\item\textsuperscript{73} See KAN. STAT. ANN. § 65-6709(a)(3); S.D. CODIFIED LAWS § 34-23A-10.1(1)(e)(iv).
\item\textsuperscript{74} KAN. STAT. ANN. § 65-6709(a)(3).
\item\textsuperscript{75} S.D. CODIFIED LAWS § 34-23A-10.1(1)(e)(i)–(ii).
\item\textsuperscript{76} Suter, supra note 8, at 28–29.
\item\textsuperscript{78} In fact, precedent and case law surrounding Casey call for this. See infra Part II.D; Thornburgh v. Am. Coll. of Obstetricians & Gynecologists, 476 U.S. 747, 761–62 (1986); City of Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416, 443–44 (1983). In Planned Parenthood Minn., N.D., S.D. v. Daugard, 799 F. Supp. 2d 1048 (D.S.D. 2011), the court applied strict scrutiny after holding that the information contained in the disclosures was false or misleading. Id. at 1072. The lower court in Rounds actually noted that Casey precedent required the district court to make preliminary determinations concerning the "objective scientific and medical accuracy of the statements" in disclosures. Planned Parenthood Minn., N.D., S.D. v. Rounds, 467 F.3d 716, 723 (8th Cir. 2006). Additionally, the Court in Gonzales v. Carhart specifically stated that the Court retained this independent constitutional duty to review the legislature's findings. Gonzales v. Carhart, 550 U.S. 124, 165 (2007).
\item\textsuperscript{79} See Carhart, 550 U.S. at 159–60 (stating that additional information can be required to "ensure so grave a choice can be informed" and to prevent women from later coming to regret their decision); Maya Manian, The Irrational Woman: Informed Consent and Abortion Decision-Making, 16 DUKE J. GENDER L. & POLY 223, 254, 256–57 (2009) ("The Court recognized that the law of informed consent generally does not require disclosure of every detail of a particular medical procedure . . . . However, it was 'precisely this lack of information . . . that is of legitimate concern to the State.'").
\end{itemize}
treats informed consent in other contexts helps to inform notions of what information is truthful and not misleading within the context of compelled physician disclosures. Additionally, because much of the information contained in mandatory informed consent laws involves unsettled science, courts must also look to the way these issues are treated in other medical contexts.

1. Informed Consent in the Medical Field—Current law and medical ethics require doctors to obtain a patient’s informed consent to any procedure. “[A] requirement that a doctor give a woman certain information as part of obtaining her consent to an abortion is, for constitutional purposes, no different from a requirement that a doctor give certain specific information about any medical procedure.” According to Casey, then, courts should begin their inquiry into whether mandated disclosures are truthful and not misleading by determining whether the information fits within the purposes and law concerning informed consent in other contexts.

The doctrine of informed consent has a long history, but its modern conception is generally expressed as a focus on patient autonomy, as seen in Canterbury v. Spence. Under this conception, the three key elements of proper informed consent are: information concerning the risks of the proposed treatment; the viable alternative treatments, if any; and the likely outcomes in the absence of treatment. Some jurisdictions have also required that patients be given information about the nature of the procedure and/or the procedure’s rate of success, though some scholars argue that such requirements are subsumed within Canterbury’s three categories. Doctors must communicate this necessary information, and the patient should comprehend all information before consenting. Thus, while the modern standard for informed consent is technically patient-centric (in that it calls not just for the delivery of information, but also the patient’s autonomous consent after understanding the risks), there is an important role for the doctor as well.

The American Medical Association (“AMA”) has issued ethics opinions that reflect the modern notion of informed consent and expand upon the physician’s role. Under the AMA’s guidelines, physicians must accurately present medical facts, must make recommendations in accordance with “good medical practice,”

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80 Casey, 505 U.S. at 884.
82 Id. at 787–88.
85 Canterbury, 464 F.2d at 780.
and must tailor the information they provide to "the preferences and needs of individual patients." This is also reflected in Canterbury:

[O]f necessity, the content of the disclosure rests in the first instance with the physician. Ordinarily, it is only he who is in the position to identify particular dangers; always he must make a judgment... as to whether and to what extent revelation to the patient is called for. 87

Casey also contemplated this formulation of informed consent. There, the law at issue contained an exemption from the required disclosures law for situations in which a physician believed the disclosure would adversely affect the patient's physical or mental state, allowing the doctor to maintain some control and some autonomy. 88

Informed consent jurisprudence and its rationale can thus provide the court with some guideposts for understanding whether information is truthful and not misleading and whether mandated disclosures violate the physician's free speech rights. Disclosures must have some relation to the three categories of information traditionally required under informed consent law and must leave to the physician some discretion to tailor information to the particular patient. While abortion disclosures should rest neatly within the general informed consent requirements of the state, they should also be complete statements of the relevant information, noting both the risks of the procedure and the risks of a choice not to undergo the procedure.

2. Help from Other Healthcare Law Contexts—Informed consent jurisprudence is not the only source of guidance concerning what information should be covered in required disclosures. It is also helpful to look to other areas of law and the regulation of healthcare. In this area, medical malpractice jurisprudence and the theory of evidence-based medicine can provide important considerations.

2(a). The Medical Field and Malpractice Law—Courts first look to the medical standard of care (a higher standard of care that considers whether the defendant acted in conformity with the common practice of his or her profession and reasonable physicians in the same or similar positions) in evaluating malpractice


87 Canterbury, 464 F.2d at 787. While the government does have some room under this model to restrict the doctor's dialogue in the context of abortion services under Rust v. Sullivan, 500 U.S. 173 (1991), this finding rested on the assumption that the regulations would not "require[] a doctor to represent as his own any opinion that he does not in fact hold." Id. at 200.

claims. However, courts give physicians additional flexibility when there are "two schools of thought" on a treatment or medical issue, or when there is no medical unanimity on the issue. This standard has been applied to issues of medical malpractice based on failure to obtain informed consent in contexts other than abortion, and could be informative in this specialized context as well.

Under the "two schools of thought" approach, unsettled or debatable information does not necessarily have to be disclosed, and the courts defer greatly to the physician's discretion in this area; oftentimes, the courts do not require any statement on the issue in either direction. Some courts and medical ethics experts actually reject the idea that the patient should be fully informed of both schools of thought or that physicians should be required to share the details of both schools of thought with the patient, finding that discussion of the controversy can be confusing and unhelpful when there is no medical certainty on which to base the disclosures. This rule also notes that when there is scientific consensus on a medical issue, the physician cannot suggest that there is uncertainty.

This treatment is important for informing the truthful and nonmisleading standard—its instruction can guide the court in considering how scientific fact is presented. When mandating disclosures, the legislature should consider whether there are two schools of thought on an issue or whether scientific consensus has been achieved to such certainty that it will not confuse or mislead the hearer. Since many of the laws recently passed by legislatures include language on scientific consensus, it is important for the courts to look to the scientific communities' opinion on the information and whether that opinion is settled consensus or is still subject to active debate.

2(b). Evidence-Based Medicine Standards and the Patient Protection and Affordable Care Act—The medical field's developing theory of "evidence-based medicine" can also lend important guidance to courts in determining what is accurate, nonmisleading information in the informed consent process for abortion services. While evidence-based medicine has been working its way into courts for years in relation to the applicable standard of care and the admissibility and credibility of expert evidence in relation to the Daubert test, it was also recently integrated into our legal system in the Patient Protection and Affordable Care Act

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89 See Robbins v. Footer, 553 F.2d 123, 126 (D.C. Cir. 1977).
90 Suter, supra note 8, at 52–53.
91 See, e.g., gala v. Hamilton, 715 A.2d 1108, 1110 (Pa. 1998) (noting that this is the standard applied in Pennsylvania) (quoting Jones v. Chidester, 610 A.2d 964, 964 (1992)).
92 Suter, supra note 8, at 53.
93 See id.
94 Id.
95 See Thomas A. Robinson, Robinson on Tension Between Evidence-Based Medicine and Clinical-Based Medicine, 2014 EMERGING ISSUES 7240 (July 29, 2014). The Daubert test aims to allow only scientific evidence that is reliable and relevant into trial court considerations. Id.; see also Daubert v. Merrell Dow Pharm., 509 U.S. 579, 589–95 (1993).
Evidence-based medicine was initially created to establish more uniform standards for physicians during medical treatment and diagnosis. Essentially, it seeks to combine the current best clinical research evidence with a doctor's clinical expertise and patient values. This includes emphasizing: (1) clinical research that discusses the safety, efficacy, and effectiveness of certain treatments; (2) the doctor's ability to apply these studies to an individual patient's care based on the doctor's prior experience and expertise; and (3) the patient's unique preferences, concerns, and expectations. While the discussion of these standards in the PPACA comes within the section of the law aimed at bettering healthcare quality by "facilitat[ing] shared decisionmaking" and concerns the federal funding requirements for materials provided to patients, these standards can also provide an important touchstone to the consideration of what is truthful and nonmisleading.

Patient decision aids are defined by the Act as tools that help patients in understanding and deciding "what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences." This definition reflects many of the same aims and principles as the truthful and not misleading standard—the difference being that this law further defines what should be included in those decisions. This deeper explanation can lend helpful context to what courts should consider in determining whether information contained in disclosures is truthful and not misleading. Under the PPACA, patient decision aids:

(B) shall present up-to-date clinical evidence about the risks and benefits of treatment options in a form and manner that is age-appropriate and can be adapted for patients, caregivers, and authorized representatives from a variety of cultural and

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98 SHARON E. STRAUS ET. AL., EVIDENCE-BASED MEDICINE: HOW TO PRACTICE AND TEACH EBM 1 (3d ed. 2005).
99 Id.
100 42 U.S.C. § 299b-36 (titled "Program to facilitate shared decisionmaking").
101 It is important to state here that this Note is not concerned with the legislative intent of this specific Act in relation to the funding or provision of abortion services, as the Patient Protection and Affordable Care Act does not allow federal funding to go to abortion services in any way. See Coverage for Abortion Services and the ACA, KAISER FAM. FOUND. (Sept. 19, 2014), http://kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-and-the-aca/. Rather, this Note merely attempts to show the potential applicability of evidence-based medicine standards to an additional and separate area of the law.
educational backgrounds to reflect the varying needs of consumers and diverse levels of health literacy; [and]

(C) shall, where appropriate, explain why there is a lack of evidence to support one treatment option over another.\(^{103}\)

This standard is incredibly instructive regarding the way in which information should be considered under the truthful and not misleading standard, as it ascribes quantifiable standards to how scientific and medical data should be treated under the law. Under this, courts should require that information contained in disclosures be in line with up-to-date clinical findings and should ensure that disclosures explain why there is a lack of evidence supporting a certain treatment option if necessary to clarify and not mislead the patient.

C. Using Commercial and Professional Speech Cases and False Advertising
Precedent

Even if a compelled statement is truthful and not misleading under scientific considerations, a court should also look to commercial or professional speech cases and false advertising precedent to determine when certain statements by abortion providers may be misleading. While this area of the law does not contain a basis in science or medical provider rights, the precedent and the doctrines it can bring to bear are directly relevant to the protection of physician free speech and the Casey standard.

In both commercial and professional speech cases and false advertising claims, the court frequently looks to the effect the specific speech has on an audience when making determinations about the potentially misleading nature of any information, speech, or disclosure concerned.\(^{104}\) Oftentimes, in commercial speech cases, the court's justification relates to protecting the free flow of information to the consumer (or the client/patient) as well as the rights of the speaker.\(^{105}\) The nature of the relationship between a professional and client or an advertiser and advertisee is one of recognized imbalance of information and sophistication, in which the listener must often rely upon and trust in the speaker.\(^{106}\) Because of this, legislatures and courts largely concern themselves with protecting and regulating areas like

\(^{103}\) § 299b-36(d)(2)(B)–(C).

\(^{104}\) See, e.g., Sandoz Pharm. Corp. v. Richardson-Vicks, Inc., 902 F.2d 222, 224 (3d Cir. 1990).


\(^{106}\) See, e.g., Opinion 10.015—The Patient-Physician Relationship, AMA CODE OF MED. ETHICS (last updated December 2001). http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.page?("The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and advocate for their patients' welfare.").
professional speech and advertising because of an interest in the transmission of truthful and not misleading information to the receiver.\textsuperscript{107}

For example, false advertisement actions under the Lanham Act require the plaintiff to establish, and the court to determine, whether the information contained in the advertisement at issue is false or misleading.\textsuperscript{108} One of the most important considerations undertaken by the court in these cases is an analysis of the surrounding context of the disclosure—specifically, the audience and listeners targeted by the advertisement.\textsuperscript{109} While the court often finds this information most relevant to its determination when the targeted audience or hearer has sophisticated or specialized knowledge concerning the advertisement or disclosure,\textsuperscript{110} this principle is still applicable in the opposite situation, when the intended audience does not have any knowledge concerning the subject matter.

In fact, it is arguable that this consideration is even more relevant and more important in determinations under abortion informed consent statutes and physician free speech rights because the speaker (here, the compelled physician) is assumed to be the party with sophisticated or specialized knowledge.\textsuperscript{111} Professional speech jurisprudence has recognized this in relation to the lawyer-client relationship, noting that "because the public lacks sophistication concerning legal services, misstatements that might be overlooked or deemed unimportant in other advertising may be found inappropriate."\textsuperscript{112} While this statement deals specifically with the legal services context, its principle is applicable to a larger professional speech context as well.

Another important takeaway from this area of the law is the court’s willingness to consider the actual misleading effect of certain advertisements or speech. Notable discussions of this occur in \textit{Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio},\textsuperscript{113} \textit{FTC v. Colgate-Palmolive Co.},\textsuperscript{114} and \textit{National Commission on Egg Nutrition v. FTC}.\textsuperscript{115} In \textit{Zauderer}, the Court upheld a

\begin{footnotesize}
\textsuperscript{107} See e.g., \textit{Va. State Bd. of Pharmacy}, 425 U.S. at 765.
\textsuperscript{110} Often, the court will be less likely to find information misleading when the audience has knowledge that would allow them to understand that the information contained in potentially deceptive statements is false. See id. at 229–30.
\textsuperscript{111} See \textit{Halberstam}, supra note 21, at 838; see also \textit{Opinion 10.015—The Patient-Physician Relationship}, supra note 104.
\textsuperscript{113} \textit{Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio}, 471 U.S. 626 (1985) (requiring private attorneys to inform their clients that they might have to pay some added costs if they lose their cases).
\textsuperscript{114} \textit{FTC v. Colgate-Palmolive Co.}, 380 U.S. 374 (1965) (holding that the undisclosed use of a prop or mock-up made of plexiglass to which sand had been applied in a television commercial, which showed the application of shaving cream to what appeared to be sandpaper and razor shaving the substance clean was a material deceptive practice).
\textsuperscript{115} \textit{Nat’l Comm’n On Egg Nutrition v. FTC}, 570 F.2d 157, 160–61 (7th
\end{footnotesize}
challenge to an attorney's advertisement concerning contingency fee arrangements that claimed clients would not be responsible for any fees unless the claim had a successful resolution, when in actuality the client would be responsible for certain court costs regardless. The Supreme Court noted that it was "commonplace" for the general public to assume that the terms "fees" and "costs" were (and are, in their ordinary usage) interchangeable, and thus the advertisement was misleading. Because the Court believed the potential to mislead was so high in Zauderer, it did not require further proof. However, physicians in informed consent cases would likely need to look to the Court's Colgate recommendation that the parties provide further proof of the misleading effect of the speech by surveying the public's opinion.

This jurisprudence gives context to and provides for a variety of considerations regarding the truthful and not misleading standard. First, it insists that the court look to the setting in which the speech occurs and the relationship between the particular parties. The more imbalanced the relationship, or the more power or responsibility held by the speaker (versus the hearer), the more likely it is that the court should look closely at whether the information involved could be seen as misleading. Additionally, this determination concerning the misleading nature of the information can be proved in court by evidence that the information itself has, in fact, misled a significant segment of the population.

D. Preventing Problematic Emotional Appeals Under the Akron, Danforth, and Thornburgh precedents

While the Court has explicitly held that a state can express its preference for childbirth over abortion through mandatory disclosures in Casey and has overruled the precedential cases that limited these disclosures to medically relevant ideas that are designed to inform rather than convince, there is still some role for these considerations in the truthful and not misleading analysis. In both Thornburgh and Akron, the Court struck down abortion informed consent statutes as violations of a woman's constitutional right to obtain an abortion, reasoning that those laws created an undue burden on the woman by intending to persuade her to choose to carry her child to term, rather than informing her about her particular procedure. In several pre-Casey cases, the Court noted that these laws implicated physician

Cir. 1977) (holding in part that egg industry should not have been required to include in any future statements information that many medical experts believe that increased consumption of cholesterol may increase the risk of heart disease).  
117 Id. at 652.  
118 Id.  
119 See id. (quoting Colgate-Palmolive Co., 380 U.S. at 391–92).  
free speech rights, and many times explicitly cited a concern that too much regulation and too much compelled speech could place the physician in an "undesired and uncomfortable straitjacket.\textsuperscript{122"

While \textit{Casey} technically overruled these cases, aspects of their analysis can be helpful when considering the truthful and not misleading standard. The legislature may be allowed to mandate disclosures that go outside the traditional informed consent and medical context, but this does not change the fact that these mandates are governed by the truthful and not misleading standard. \textit{Akron} and \textit{Thornburgh} both offer helpful insights into when persuasion by the state to forgo an abortion may become misleading. Indeed, many scholars have drawn this line where the information imposes an emotional element "that serves \textit{no purpose other than to . . . persuade}.\textsuperscript{123} Many aspects of mandatory disclosure informed consent statutes contain information that is not only medically irrelevant, but also can be misleading to a woman by arousing a certain emotional response.

This line of reasoning is applicable when considering the physician's professional role and free speech rights and should be considered under the truthful and not misleading standard. Physicians are ethically and legally bound to provide services that "hold[] the best interests of the patient as paramount.\textsuperscript{124} Thus, while the state can mandate certain disclosures and regulate aspects of the physician-patient relationship, information that has no relevance to a patient's decision other than to persuade by eliciting a negative emotional response could be considered misleading and violate the physician's free speech rights.

\textit{E. Revisiting the Issue of Deference}

While the \textit{Casey} precedent and subsequent cases seem to allow a large amount of deference to the state legislatures regarding the information that can be considered truthful, this standard of review will face challenges in light of recent Supreme Court and lower court decisions. The Supreme Court itself partially reopened this debate with its decision in \textit{Sorrell v. IMS Health Inc.}\textsuperscript{125} There, the Court renewed and restated the well known rule that "[t]he First Amendment requires heightened scrutiny whenever the government creates 'a regulation of speech because of disagreement with the message it conveys' . . . . [and] [c]ommercial speech is no exception."\textsuperscript{126} In \textit{Sorrell}, the Supreme Court made clear that even state regulations of commercial speech must be scrutinized—a court cannot just entirely defer to the legislature's judgment.\textsuperscript{127}

\textsuperscript{123} Suter, supra note 8, at 48 (emphasis added).
\textsuperscript{124} Opinion 10.015—The Patient-Physician Relationship, supra note 104.
\textsuperscript{125} Sorrell v. IMS Health Inc., 131 S. Ct. 2653 (2011).
\textsuperscript{126} Id. at 2664.
\textsuperscript{127} See id.
This is exactly what the Fourth Circuit Court of Appeals focused on in its December 2014 decision in Stuart v. Camnitz, which marked the first victory for proponents of physician free speech against state regulation of informed consent measures.129 The Fourth Circuit specifically noted that the state's interest must be only a starting point, that professionals "do not leave their [free] speech rights at the office door," and that state regulations that limit the freedom of speech must pass a level of constitutional scrutiny that requires them to be drawn to a state interest and be proportional to the burden placed upon the speech.129 The Fourth Circuit compared the state's regulation to the purposes and requirements of traditional informed consent and found that the North Carolina statute seriously deviated from these with no counterbalancing state interest to explain why.130 The state was allowed to express its preference, but once it "commandeer[ed] the doctor-patient relationship" to do so, the law moved outside of the state's interest and subverted the patient's expectations and relationship of trust with her doctor.131 The Supreme Court denied a writ of certiorari in this case in June 2015.132 The Fourth Circuit's decision in Camnitz and the Supreme Court's subsequent action could serve to revitalize the courts' important role in scrutinizing the relationship between a state's interest and a burden on speech rather than entirely deferring to the legislature's judgments on these issues.

III. REMOVING THE STRAIGHTJACKET: HOW TO DEFINE THE TRUTHFUL AND NONMISLEADING STANDARD TO RESPECT PHYSICIAN FREE SPEECH RIGHTS

In the aftermath of Casey, lower courts around the country have been faced with deciding when a state can and cannot regulate the interaction between a physician and a woman seeking an abortion. It is rather unsurprising that the Casey decision's quick disposal of the issue and statement that truthful and nonmisleading disclosures will survive constitutional scrutiny has led to some confusion among lower courts and to varying treatment of this standard across the country. However, as the laws regulating abortion-provider and patient interactions continue to become more detailed and specific, it is almost inevitable that the constitutionality of mandated informed consent provisions in abortion procedures will make their way to the Supreme Court or to lower federal courts. When the issue does arise, those deciding the case should ensure the protection of both the state's interest and the physician's free speech rights by looking into the mandated disclosures and ensuring they comply with the truthful and not misleading standard.

129 Id. at 251.
130 Id. at 252.
131 Id. at 253.
First, the court should determine whether the information contained within the mandatory disclosures fits within the framework and purposes of general informed consent law. Under this, disclosures should relate to risks of the proposed treatment, the viable alternative treatments, and the likely outcomes in the absence of treatment. Disclosures should also be complete, noting both the risks of undergoing the procedure (proceeding with the abortion) and of declining the procedure (proceeding with the pregnancy). The court should use definitions and jurisprudence from other healthcare contexts to ensure that the mandated disclosures contain information that conforms to the truthful and not misleading standard. Information should contain up-to-date clinical findings and explain why there is potentially a lack of conclusive evidence on a certain treatment option if necessary. Disclosures should also reflect scientific consensus.

Additionally, courts should draw inspiration from case law concerning false advertising and commercial and professional speech by looking to the surrounding context of both the speech and the relationship in which the speech occurs. A court should consider the actual effect the information has and whether a significant number of the affected population found the disclosure misleading. Finally, courts should consider the purpose of including the mandated information and the emotional effect the information will have on the patient. If certain information is not relevant for any reason but to upset the patient and persuade her to forego the procedure, it should be ruled misleading under the Casey standard.

While the state certainly has the power to regulate these disclosures and to ensure that a woman’s choice is informed, it should not do so by infringing on the free speech rights of physicians who provide abortions. By taking these four categories of ideas into consideration, courts will retain their constitutional duty to oversee and review the fact-finding of legislatures. Additionally, they will take the physician out of a straitjacket, protect the doctor’s fundamental right to freedom of speech, and contribute to better medical care.

CONCLUSION

Almost fifteen years after Justices O’Connor, Kennedy, and Souter announced in Casey that “[l]iberty finds no refuge in a jurisprudence of doubt,” and more than forty years after the Court’s initial recognition of a woman’s fundamental right to receive an abortion in Roe v. Wade, there has been more legislation and litigation related to abortion services than ever before. Much of this legislation relates to restrictions upon those physicians providing abortions, and new challenges to these laws in the court system assert the rights of these physicians.

135 Roe v. Wade, 410 U.S. 113, 154 (1973) (holding in part that the right to privacy under the Due Process Clause of the Fourteenth Amendment extended to a woman’s decision to have an abortion).
Specifically, as state legislatures have successfully enacted laws mandating that physicians disclose certain information to a woman seeking an abortion as a part of obtaining her informed consent, these doctors have begun to challenge the laws as infringing upon their freedom of speech as guaranteed by the First and Fourteenth Amendments. 137

While the Supreme Court disposed of one of these free speech infringement challenges in Casey, it did so in a manner that provided future courts with little guidance. 138 All the Court afforded to the matter was the following:

[t]o be sure, the physician’s First Amendment rights not to speak are implicated, but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State. We see no constitutional infirmity in the requirement that the physician provide the information mandated by the State here. 139

The only limit the Court placed on the state’s power was the requirement that information involved be both truthful and not misleading. 140 Since this decision, numerous states have enacted a variety of informed consent statutes requiring the dispersal of a wide-range of information to patients seeking abortions, some requiring more specific information than others. 141

While many of these statutes have come under fire as violating physician’s free speech rights because information they contain is either not truthful or is misleading, physicians have seen very little success pursuing these claims in court. This is largely due to the fact that Casey and many subsequent courts have been hesitant, or unable, to look within the information contained in the mandatory disclosures and determine what meets the truthful and not misleading standard. However, in the wake of Camnitz, 142 the issue of adequately protecting physician free speech rights under the Casey standard has become more important than ever. This Note has attempted to provide context and criteria to aid the courts in these determinations by looking to traditional informed consent principles, other areas of health law and healthcare, and the jurisprudence surrounding other areas of compelled speech and false advertising. By taking these factors into consideration, courts will be better able to protect both a state’s interest in adequately and accurately informing patients and promoting life and a physician’s constitutional right to freedom of speech.

137 See supra note 4.
138 See Casey, 505 U.S. at 884.
139 Id. (citations omitted).
140 See id. at 882, 884.
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