

SEX AND THE FIRST AMENDMENT THROUGH THE LENS OF PROFESSIONAL SPEECH

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First Amendment theory and doctrine apply in distinctive ways in the context of professional speech. Within the professional-client relationship, the law constrains professionals in various ways. Professionals are subject to licensing and malpractice regimes. They have fiduciary duties to their clients or patients. Because clients and patients seek professional advice in order to access knowledge they lack but need to make important decisions, professional advice must be comprehensive and accurate according to the insights of the relevant professional knowledge community. And dispensing professional advice within the professional-client relationship ought to remain free from state interference that seeks to prescribe its content in a way that contradicts professional knowledge.

Implicit in the professional speech story are themes of sex, gender, sexual orientation, and religion. Much of professional speech doctrine in the courts has most recently developed around conversion therapy laws and legislation concerning reproductive rights. In part due to continued contestation surrounding these issues, the development of professional speech doctrine has been uneven and still lacks theoretical coherence. This Article charts the sites of conflict that typically arise in the professional context, and further unpacks how professional speech theory and doctrine apply in likely future conflicts around reproductive rights and transgender healthcare.

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INTRODUCTION

Navigating the First Amendment universe through a lens of professional speech yields a perspective in which standard theory and doctrine apply in distinctive ways.¹ When professionals speak to their clients to give professional advice within the confines of a professional-client relationship, the law in many ways constrains what they may say. Professionals who give bad advice are subject to malpractice liability, and the First Amendment provides no defense; this creates liability for some forms of “false speech,” unknown in other areas of speech protected by the First Amendment.² Professionals have fiduciary duties to their clients; such duties between speakers do not exist elsewhere in First Amendment doctrine.³ And the state may require professionals to obtain a license before they dispense advice; a similar requirement outside the context of a professional-client relationship would likely be an impermissible prior restraint.⁴

Clients and patients seek professional advice in order to access knowledge they lack but need to make important decisions. To that end, professional advice must be comprehensive and accurate, and must reflect the insights of the relevant professional knowledge community.⁵ Moreover,

¹ See generally Claudia E. Haupt, *Professional Speech*, 125 YALE L.J. 1238 (2016) [hereinafter Haupt, *Professional Speech*].

² Claudia E. Haupt, *Unprofessional Advice*, 19 U. PA. J. CONST. L. 671, 682 (2017) [hereinafter Haupt, *Unprofessional Advice*]; Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 949 (2007). Cf. *United States v. Alvarez*, 567 U.S. 709 (2012) (holding that false ideas are not unprotected under the First Amendment).

³ See Claudia E. Haupt, *The Limits of Professional Speech*, 128 YALE L.J. F. 185, 191 (2018) [hereinafter Haupt, *The Limits of Professional Speech*].

⁴ See generally Claudia E. Haupt, *Licensing Knowledge*, 72 VAND. L. REV. (forthcoming 2019), <https://ssrn.com/abstract=3151985> [hereinafter Haupt, *Licensing Knowledge*].

⁵ Haupt, *Unprofessional Advice*, *supra* note 2, at 676 (discussing “the range of valid professional knowledge for First Amendment purposes”).

dispensing professional advice within the professional-client relationship ought to remain free from state interference that seeks to prescribe its content in a way that contradicts professional knowledge, and I have previously argued that the First Amendment provides a shield against such state interference.⁶

Implicit in the development of professional speech theory and doctrine are themes of sex, gender, sexual orientation, and religion. This Article aims to foreground these themes, chart the sites of conflict that typically arise in the professional context, and further unpack how professional speech theory and doctrine cash out in likely future conflicts around reproductive rights and transgender healthcare. Much of professional speech doctrine in the courts has most recently developed around conversion therapy laws⁷ and legislation concerning reproductive rights.⁸ Because these issues remain contested, the development of professional speech doctrine in the courts has been uneven and still lacks a coherent theoretical basis. I have suggested elsewhere that the professions are best conceptualized as knowledge communities and have proposed a theory of First Amendment protection of professional speech based on this understanding.⁹ This discussion builds on that theory.

This Article proceeds in four parts. Part I traces the emergence of professional speech—implicitly in the jurisprudence of the Supreme Court and explicitly in the federal appellate courts—drawing out the themes of sex, gender, sexual orientation, and religion as they have surfaced in these cases.

Part II examines the tensions arising in the professional context from the perspective of the profession. I first illustrate the dynamic of outward resistance against state interference with professional insights. Such interference is likely based on justifications that are not part of the profession's shared knowledge basis, as most prominently displayed in the reproductive health context. Then, I turn to internal contestation within the professions and consider which role—if any—the

⁶ *Id.* at 673.

⁷ See *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014) and *King v. Governor of N.J.*, 767 F.3d 216 (3d Cir. 2014) (both upholding laws prohibiting sexual orientation change efforts by licensed mental health providers for minors).

⁸ See, e.g., *Stuart v. Camnitz*, 774 F.3d 238, 248 (4th Cir. 2015); *Planned Parenthood of Minn., N.D., S.D. v. Rounds*, 686 F.3d 889 (8th Cir. 2012). See also *Nat'l Inst. of Family and Life Advocates v. Harris*, 839 F.3d 823 (9th Cir. 2016), *rev'd sub nom.* *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018). For greater clarity and readability, *Nat'l Inst. of Family and Life Advocates v. Harris* is hereinafter shortened as “Harris” in citations, and *Nat'l Inst. of Family & Life Advocates v. Becerra* is shortened as “Becerra.”

⁹ Haupt, *Professional Speech*, *supra* note 1, at 1241–42.

state should play in resolving contested matters. Finally, the discussion shifts to the client's or patient's perspective to illustrate how professional knowledge is ultimately conveyed, and what tensions in the professional-client (or doctor-patient) relationship result from state interference.

Part III takes the view of the individual professional seeking to depart from the consensus of the knowledge community. I have suggested that these individual professionals can be divided into internal and external outliers.¹⁰ First, I describe the different ways in which professional outliers depart from the knowledge community's consensus. The key distinction is between those professionals who depart from professional consensus but base their advice on a shared methodology of the profession and those who depart from professional knowledge due to exogeneous—most likely religious, philosophical, or political—disagreement. Then, I examine ways in which the state endorses or reinforces professionals' outlier status. Finally, here, too, I shift to the client's or patient's perspective, illustrating how the individual professional's outlier status affects advice-giving.

Part IV identifies two likely sites of future conflict, namely the continuing struggle over access to comprehensive reproductive health services and the emergent contestation surrounding transgender healthcare. It then maps the application of professional speech theory and doctrine in those areas.

“For more than two centuries,” as Geoffrey Stone explains, “Americans have fought divisive social, political, and constitutional battles over laws regulating sex, obscenity, contraception, abortion, homosexuality, and same-sex marriage. These conflicts have been divisive in no small part because of the central role religion has played in shaping our laws governing sex.”¹¹ Several of these themes, and the tensions they contain, converge in professional speech, resulting in questions as to the appropriate basis for giving professional advice, and the

¹⁰ See Haupt, *Unprofessional Advice*, *supra* note 2, at 676.

¹¹ GEOFFREY R. STONE, *SEX AND THE CONSTITUTION* 4 (2017).

availability of professional services¹²—including, crucially, healthcare services—to the public.¹³

I. PROFESSIONAL SPEECH DOCTRINE AND THEORY

Landmark cases in the doctrinal history of professional speech are *Rust v. Sullivan*,¹⁴ *Planned Parenthood of Southeastern Pennsylvania v. Casey*,¹⁵ and *National Institute of Family & Life Advocates (NIFLA) v. Becerra*¹⁶ in the Supreme Court, as well as several reproductive rights and conversion therapy cases in the federal appellate courts.¹⁷ This Part examines those cases, and their role in the development of professional speech, more closely.

A. Reproductive Rights Cases

The starting point in the professional speech canon involving access to reproductive healthcare is the Supreme Court's 1991 decision in *Rust v. Sullivan*.¹⁸ Under federal regulations, recipients of certain government funding were prohibited from giving advice on abortion, and providers were further prohibited from referring patients to abortion providers. The Court upheld these limits upon professionals as consistent with the First Amendment. The majority opinion's framing of *Rust* as a case about selective government funding, however, concealed the true nature of the issue as one of professional speech.¹⁹ Justice Blackmun's dissent makes the professional dimension clear in its reference not only to "the legitimate expectations of the patient," but also "the ethical responsibilities

¹² In the legal context, see, e.g., Bill Piatt, *Opting Out in the Name of God: Will Lawyers Be Compelled to Handle Same-Sex Divorces?*, 79 ALB. L. REV. 683 (2016). See also Claudia E. Haupt, *Antidiscrimination in the Legal Profession and the First Amendment: A Partial Defense of Model Rule 8.4(g)*, 19 U. PA. J. CONST. L. ONLINE (2016).

¹³ See Haupt, *Unprofessional Advice*, *supra* note 2, at 678; Claudia E. Haupt, *Religious Outliers: Professional Knowledge Communities, Individual Conscience Claims, and the Availability of Professional Services to the Public*, in LAW, RELIGION, AND HEALTH IN THE UNITED STATES 173 (Holly Fernandez Lynch, I. Glenn Cohen & Elizabeth Sepper eds., 2017) [hereinafter Haupt, *Religious Outliers*]; Claudia E. Haupt, *Professional Ethics, Personal Conscience, and Public Expectations*, 27 J. CLINICAL ETHICS 233 (2016).

¹⁴ 500 U.S. 173 (1991).

¹⁵ 505 U.S. 833 (1992).

¹⁶ 138 S. Ct. 2361 (2018).

¹⁷ See *Stuart v. Camnitz*, 774 F.3d 238, 248 (4th Cir. 2015); *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014); *King v. Governor of N.J.*, 767 F.3d 216 (3d Cir. 2014); *Planned Parenthood of Minn., N.D., S.D. v. Rounds*, 686 F.3d 889 (8th Cir. 2012). See also *Nat'l Inst. of Family and Life Advocates v. Harris*, 839 F.3d 823 (9th Cir. 2016), *rev'd sub nom. Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018).

¹⁸ 500 U.S. 173 (1991).

¹⁹ Haupt, *Unprofessional Advice*, *supra* note 2, at 683; Haupt, *Professional Speech*, *supra* note 1, at 1260.

of the medical profession.”²⁰ Irrespective of funding, the argument goes, the patient and the profession demand that the professional provide comprehensive advice.²¹

It is instructive to read *Rust* alongside *Legal Services Corporation v. Velazquez*:²² whereas the Court held the government funding scheme’s limits on abortion counseling to be constitutional under the First Amendment, it held unconstitutional restrictions placed on providing legal advice.²³ The opposite outcomes are noteworthy because, as Justice Scalia observed, the two cases equally concern government funding of professional services: “the normal work of doctors” and “the normal work of lawyers.”²⁴ Ultimately, the important takeaway for the development of professional speech doctrine from *Rust* is that the “Court did acknowledge the possibility of First Amendment protection in this professional context.”²⁵

A year after *Rust*, the Court offered another glimpse at its doctrinal understanding of professional speech in a famously opaque paragraph in *Casey* addressing the First Amendment:

All that is left of petitioners’ argument is an asserted First Amendment right of a physician not to provide information about the risks of abortion, and childbirth, in a manner mandated by the State. To be sure, the physician’s First Amendment rights not to speak are implicated . . . 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

²⁰ *Rust*, 500 U.S. at 213–14 (Blackmun, J., dissenting).

²¹ Haupt, *Professional Speech*, *supra* note 1, at 1261.

²² 531 U.S. 533 (2001) (holding unconstitutional restrictions on challenging existing welfare laws).

²³ See Haupt, *Unprofessional Advice*, *supra* note 2, at 683–85 (offering a parallel analysis of *Rust* and *Velazquez*). See also PAUL HORWITZ, FIRST AMENDMENT INSTITUTIONS 253 (2013) (“The Court in *Rust* and *Velazquez* has the right idea about professional speech, but it lacks proper language with which to express it.”).

²⁴ *Velazquez*, 531 U.S. at 562 (Scalia, J., dissenting).

²⁵ Haupt, *Professional Speech*, *supra* note 1, at 1261.

provide the information mandated by the State here.²⁶

The federal appellate courts are markedly split as to the meaning of this statement. The Fourth Circuit, per Judge Wilkinson, rejected the Fifth and Eighth Circuits' interpretations regarding the constitutionality of abortion regulations under the First Amendment.²⁷ With respect to the paragraph in *Casey*, Judge Wilkinson noted that it “does not assert that physicians forfeit their First Amendment rights in the procedures surrounding abortions, nor does it announce the proper level of scrutiny to be applied to abortion regulations that compel speech”²⁸ By contrast, the Fifth and Eighth Circuits had held that *Casey* as well as *Gonzales v. Carhart* permit significant regulation of physician speech on the topic of abortion,²⁹ an interpretation that Judge Wilkinson criticized as “read[ing] too much into *Casey* and *Gonzales*.”³⁰

Another site of conflict involved deceptive practices at Crisis Pregnancy Centers (CPCs), facilities which dispense anti-abortion counseling under the guise of reproductive healthcare. In response, California enacted the Reproductive Freedom, Accountability, Comprehensive Care and Transparency Act (FACT Act).³¹ The statute, which applied to both licensed and unlicensed facilities, required CPCs to post certain disclosures. Licensed facilities had to post “a notice stating the existence of publicly-funded family-planning services, including contraception and abortion.”³² Unlicensed facilities had to “disseminate a notice stating that they are not licensed by the State of California.”³³ Upon First Amendment challenge, the Ninth Circuit upheld the FACT Act, holding the disclosures were professional speech and properly regulated as such by the Act.³⁴ The Supreme Court, however, reversed and remanded the

²⁶ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992) (plurality opinion) (citations omitted).

²⁷ *See* *Stuart v. Camnitz*, 774 F.3d 238, 248 (4th Cir. 2014) (rejecting compelled ultrasounds as violating the First Amendment). *See also supra* Part II.A.

²⁸ *Id.* at 249.

²⁹ *Id.* at 248–49 (citing *Planned Parenthood Minn., N.D., S.D., v. Rounds*, 686 F.3d 889 (8th Cir. 2012); *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570 (5th Cir. 2012); *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724 (8th Cir. 2008)).

³⁰ *Stuart*, 774 F.3d at 249.

³¹ CAL. HEALTH & SAFETY CODE § 123470 (West 2018).

³² *Nat'l Inst. of Family & Life Advocates v. Harris*, 839 F.3d 823, 828–29 (9th Cir. 2016), *rev'd sub nom.* *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018).

³³ *Harris*, 839 F.3d at 829.

³⁴ *Id.* at 845.

decision, striking down the disclosure requirements as unconstitutional under the First Amendment.³⁵ Both the Ninth Circuit's decision upholding the FACT Act and the Supreme Court's majority opinion, authored by Justice Thomas, contain extensive discussions of professional speech doctrine. While the Ninth Circuit explicitly relied on an—as I have argued, overly expansive³⁶—theory of professional speech,³⁷ the Supreme Court's *NIFLA* majority rejected the analysis, insisting that the Court had never recognized professional speech as a distinct category of speech.³⁸

The doctrinal development of professional speech has suffered as a result of the *NIFLA* litigation in at least two respects. First, the Ninth Circuit's broad concept of professional speech uncoupled doctrine from theory, because “[t]he content of the disclosures in *NIFLA* was too far removed from expert knowledge to be properly attributed to the realm of professional expertise.”³⁹ But professional speech must be linked to expertise in order to achieve its distinctive goal, namely, to ensure that the client or patient receives accurate and comprehensive advice from the professional in accordance with the insights of the relevant professional knowledge community.⁴⁰ Second, the Supreme Court's opinion may very well have been influenced by the topic of abortion, potentially making it difficult to apply its rationale to other areas of professional advice-giving.⁴¹

B. Conversion Therapy Cases

Another area in which federal appellate courts have addressed professional speech is conversion therapy. Conversion therapy laws “prohibit licensed mental health professionals, such as psychiatrists, psychologists, social workers, psychoanalysts, and counselors, from engaging in conversion therapy with minors, with conversion therapy defined as practices or treatments that seek to eliminate or reduce sexual or romantic

³⁵ *Becerra*, 138 S. Ct. 2361.

³⁶ Haupt, *The Limits of Professional Speech*, *supra* note 3, at 189 (“In classifying the CPC disclosures as professional speech, the Ninth Circuit defined professional speech too broadly.”).

³⁷ *Harris*, 839 F.3d at 840.

³⁸ *Becerra*, 138 S. Ct. at 2372 (“This Court’s precedents do not recognize such a tradition for a category called ‘professional speech.’”).

³⁹ Haupt, *The Limits of Professional Speech*, *supra* note 3, at 189.

⁴⁰ *Id.* at 195 (suggesting that “professional speech should be defined . . . as speech that communicates a knowledge community’s insights from a professional to a client, within a professional-client relationship, for the purpose of giving professional advice. If speech does not fall within that definition, it should not be considered professional speech”).

⁴¹ See *infra* Part IV.A.

attractions or feelings towards individuals of the same sex.”⁴² Notably, “[i]t was not until the late nineteenth century that persons drawn to same-sex sex came for the first time to be seen as having a distinctive psychological identity.”⁴³ Reflecting prevailing societal attitudes “in which the dominant religion deemed homosexuality a heinous sin, the law branded homosexuals as criminals, and the medical profession diagnosed homosexuals as ‘strange freaks of nature,’ . . .”⁴⁴ The medical profession, however, has since dramatically changed its assessment.⁴⁵

In 1973, the American Psychiatric Association declassified homosexuality as a mental illness, but it took the medical mainstream until the 1980s to distance itself from conversion therapy.⁴⁶ Since then, proponents of conversion therapy have progressively migrated from the professional mainstream to the fringe. In the end, “[f]rom the perspective of mental health professionals, advising minors to subject themselves to conversion therapy has become unprofessional advice.”⁴⁷ California was the first state to prohibit conversion therapy by licensed mental health providers for minors in 2012.⁴⁸ Several states, the District of Columbia, and a number of cities followed.⁴⁹ Several of these laws were subsequently challenged on the theory that they violated the First Amendment’s speech or religion clauses.

In the development of professional speech doctrine, the Ninth Circuit’s decision in *Pickup v. Brown*⁵⁰ and the Third Circuit’s decision in *King v. Governor of New Jersey*,⁵¹ upholding respectively the California and New Jersey conversion therapy laws, stand out. The Ninth Circuit in *Pickup* articulated as an analytical framework a speech continuum that locates a professional’s speech in public discourse at one end, professional speech in the professional-client relationship at the mid-point, and professional conduct at the other end.⁵² The standard of scrutiny tracks along the continuum, highest in public discourse,

⁴² Marie-Amélie George, *Expressive Ends: Understanding Conversion Therapy Bans*, 68 ALA. L. REV. 793, 795–96 (2017).

⁴³ STONE, *supra* note 11, at xxx.

⁴⁴ *Id.*

⁴⁵ George, *supra* note 42, at 801–10.

⁴⁶ *Id.* at 801.

⁴⁷ Haupt, *Unprofessional Advice*, *supra* note 2, at 717.

⁴⁸ George, *supra* note 42, at 795.

⁴⁹ See *Born Perfect: Laws & Legislation by State*, NAT’L CTR. FOR LESBIAN RTS., <http://www.nclrights.org/bornperfect-laws-legislation-by-state/> (last visited Mar. 1, 2019) (providing a current list of conversion therapy laws).

⁵⁰ *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014).

⁵¹ *King v. Governor of New Jersey*, 767 F.3d 216 (3d Cir. 2014).

⁵² *Pickup*, 740 F.3d at 1227–29.

lower at the midpoint within the professional-client relationship, and lowest when regulation governs conduct.⁵³ Ultimately, the *Pickup* court upheld the conversion therapy law as a regulation of professional conduct.⁵⁴

By contrast, the Third Circuit in *King* considered the New Jersey conversion therapy law to govern “speech that enjoys some degree of protection under the First Amendment.”⁵⁵ Analogizing professional speech to commercial speech, the court noted that the “level of protection is diminished” for individuals “speaking as state-licensed professionals within the confines of a professional relationship.”⁵⁶ While the analogy of professional and commercial speech for the purpose of establishing the level of scrutiny is problematic,⁵⁷ the important takeaway here is that the Third Circuit considered professional speech to be a category of speech separate from commercial speech.

The Ninth Circuit in subsequent litigation also confronted the challenge of drawing the line between professional and religious advice in the context of conversion therapy.⁵⁸ As conversion therapy moved out of the mainstream, it found its way “into evangelical politics, further reinforcing the relationship between conversion therapy and religion.”⁵⁹ But the Ninth Circuit upheld California’s conversion therapy law against challenges under the Free Exercise and Establishment clauses, reasoning that the law only concerns speech within “the confines of the counselor-client relationship.”⁶⁰ The court explained that “[t]he law regulates the conduct of state-licensed mental health providers only; the conduct of all other persons, such as religious leaders not acting as state-licensed mental health providers, is unaffected.”⁶¹ Further, “even the conduct of state-licensed mental health providers is regulated only within the confines of the counselor-client relationship; in all other areas of life, such as religious practices, the law simply does not apply.”⁶² In short, the Ninth Circuit considered the speech within a professional-client relationship to be subject to a different set of rules than speech outside of that relationship, including religious speech.

⁵³ *Id.*

⁵⁴ *Id.* at 1222.

⁵⁵ *King*, 767 F.3d at 224.

⁵⁶ *Id.*

⁵⁷ See Haupt, *Professional Speech*, *supra* note 1, at 1264–68.

⁵⁸ See *Welch v. Brown*, 834 F.3d 1041 (9th Cir. 2016), *cert. denied*, 137 S. Ct. 2093 (2017).

⁵⁹ George, *supra* note 42, at 801.

⁶⁰ *Welch*, 834 F.3d at 1045.

⁶¹ *Id.*

⁶² *Id.*

These doctrinal developments reflect both the courts' awareness that speech within the confines of the professional-client relationship is somehow distinctive, and the absence of a theoretical basis to account for this distinctiveness. Indeed, some scholars suggest that professional speech ought to be regarded as ordinary speech.⁶³ The Ninth Circuit in *Pickup* offers perhaps the most thoughtful theoretical discussion, though I ultimately disagree with the court's speech continuum theory.⁶⁴ The *NIFLA* majority, by contrast, leaves largely unexplained why speech within the professional-client relationship can be governed by a separate doctrinal framework that includes malpractice liability and informed consent, among other features. The lack of theoretical engagement makes the *NIFLA* decision of only limited use for lower courts grappling with questions surrounding First Amendment protection for professional speech. One such question concerns the conversion therapy laws just discussed. As a doctrinal matter, commentators on *NIFLA* have noted that it is now "uncertain . . . whether laws restricting speech in order to enforce professional standards, such as previously upheld bans on 'conversion therapy' for lesbian, gay, bisexual, and transgender people, will now be subjected to strict scrutiny."⁶⁵ The important question in the professional speech context ought to be "what professional speech is scrutinized for."⁶⁶ If the goal of professional advice-giving is to convey expertise, restrictions on what a professional may say—whether or not the courts want to identify a separate category of speech—must be measured against the knowledge community's insights.⁶⁷ Since the conversion therapy laws enshrine the professional standard, they should survive any type of inquiry that scrutinizes speech within the professional-client relationship in light of its underlying purpose.

The current status of professional speech remains contested. Most recently, the Supreme Court in *NIFLA* expressed doubt as to whether professional speech is a distinctive

⁶³ See, e.g., Rodney A. Smolla, *Professional Speech and the First Amendment*, 119 W. VA. L. REV. 67 (2016).

⁶⁴ See Claudia E. Haupt, *Professional Speech and the Content-Neutrality Trap*, 127 YALE L.J. F. 150, 168 (2017) (criticizing the *Pickup* continuum).

⁶⁵ Wendy E. Parmet et al., *The Supreme Court's Crisis Pregnancy Center Case—Implications for Health Law*, 379 N. ENGL. J. MED. 1489, 1490 (2018).

⁶⁶ Haupt, *supra* note 64, at 171.

⁶⁷ *Id.*

category of speech,⁶⁸ though the decision left open that possibility.⁶⁹ Yet a review of the doctrinal basis of professional speech illustrates that the very question of whether it is a new category of speech may be misguided.⁷⁰ Rather, descriptively identifying the phenomenon is simply an acknowledgement of the traditionally distinct doctrinal nature of professional speech that has been implicit in the Court's decisions at least since Justice White's concurrence in *Lowe v. SEC*.⁷¹ Among these unique doctrinal features are the imposition of malpractice liability for bad advice as well as informed consent, both of which the *NIFLA* majority explicitly, and without further analysis, recognized as consistent with the First Amendment.⁷² This makes the majority opinion in *NIFLA* theoretically incoherent because "professional speech cannot logically be the same as other speech, yet be governed by a different doctrinal framework."⁷³ Throughout the remainder of this Article, I will highlight the potential implications of the *NIFLA* decision.

II. PROFESSIONAL PERSPECTIVE: PROFESSION VERSUS OUTSIDE INTERFERENCE

Historically, state involvement with the professions emerged alongside processes of professionalization. As disciplinary knowledge developed, states, under their police powers, started navigating the line between regulating the

⁶⁸ Nat'l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361, 2372 (2018) ("This Court's precedents do not recognize such a tradition for a category called 'professional speech.'").

⁶⁹ *Becerra*, 138 S. Ct. at 2375 ("In sum, neither California nor the Ninth Circuit has identified a persuasive reason for treating professional speech as a unique category that is exempt from ordinary First Amendment principles. We do not foreclose the possibility that some such reason exists.").

⁷⁰ Cf. Haupt, *Professional Speech*, *supra* note 1, at 1258 ("Although the Supreme Court has never identified a category of 'professional speech' for First Amendment purposes, its existence is implicit in a number of cases.").

⁷¹ 472 U.S. 181, 211–36 (1985) (White, J., concurring in the judgment) ("Where the personal nexus between professional and client does not exist, and a speaker does not purport to be exercising judgment on behalf of any particular individual with whose circumstances he is directly acquainted, government regulation ceases to function as legitimate regulation of professional practice with only incidental impact on speech; it becomes regulation of speaking or publishing as such, subject to the First Amendment's command that 'Congress shall make no law . . . abridging the freedom of speech, or of the press.'"). Others go back even further in identifying the origins of professional speech doctrine. See, e.g., *Moore-King v. County of Chesterfield*, 708 F.3d 560, 568 (4th Cir. 2013) (citing *Thomas v. Collins*, 323 U.S. 516 (1945) (Jackson, J., concurring)).

⁷² *Becerra*, 138 S. Ct. at 2373 (discussing "[l]ongstanding torts for professional malpractice" and characterizing informed consent as "firmly entrenched in American tort law").

⁷³ Haupt, *The Limits of Professional Speech*, *supra* note 3, at 189.

profession and regulating professional speech.⁷⁴ Licensing regimes, for example, frequently emerged in cooperation with the professions.⁷⁵ But sometimes, the dissemination of emergent disciplinary knowledge was quashed by state interference before it could fully develop.

During the Second Great Awakening, “Charles Knowlton, a Massachusetts physician, published *Fruits of Philosophy; or, The Private Companion of Young Married People*, a path-breaking work that ‘attempted to apply science to sexual relations.’ Knowlton argued that people’s understanding of sex and sexuality must move into the realm of medicine.”⁷⁶ This effort, however, was cut short by state intervention. “Knowlton was sentenced to hard labor by a Massachusetts court, which took the evangelical line and officially declared all books discussing contraception, even those written by physicians in a medical manner, morally unacceptable.”⁷⁷ Indeed, “the Commonwealth of Massachusetts, invoking the still-nascent doctrine of obscenity, repeatedly prosecuted Knowlton for *The Fruits of Philosophy*, even though the text was clearly intended to convey health information about birth control in a responsible and thoughtful manner.”⁷⁸

The federal Comstock Act equally functioned to restrict the dissemination of emergent expert knowledge, as illustrated by the prosecution in 1876 of public health advocate Dr. Edward Bliss Foote. His “popular home guide, *Plain Home Talk About the Human System*, served a large and eager medical-advice market by providing clear and practical information about sex and contraception. . . .”⁷⁹ Nonetheless, “Foote was prosecuted and convicted for distributing information about contraception. The presiding judge ruled that medical advice was not exempt from the statutory prohibition.”⁸⁰

Today, external interference—primarily by state legislatures—equally occurs in the reproductive health context, and it tends to largely contradict professional knowledge.⁸¹ This

⁷⁴ See, e.g., *Lowe v. SEC*, 472 U.S. 181, 228–29 (1985) (White, J., concurring in the result).

⁷⁵ Haupt, *Licensing Knowledge*, *supra* note 4, at 8 (discussing emergent professions’ “calls for state intervention to establish admissions regulations, or licensing regimes”).

⁷⁶ STONE, *supra* note 11, at 146–47.

⁷⁷ *Id.* at 147.

⁷⁸ *Id.* at 182–83.

⁷⁹ *Id.* at 160.

⁸⁰ *Id.*

⁸¹ See, e.g., *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016); *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889, 906 (8th Cir. 2012) (upholding a state law requiring doctors to inform patients seeking an abortion of an increased risk of suicide to obtain informed consent). See also Rick Rojas, *Arizona*

Part discusses those laws that contradict an existing professional standard before turning to contestation of professional knowledge within the profession and its relation to state interference. The key question is how the state should account for internal professional disagreement around expert knowledge.

A. External Interference

Perhaps the most prominent examples of government interference at odds with professional insights come from the reproductive rights context. State legislatures are increasingly chipping away at the fundamental right to choose articulated in *Roe v. Wade*⁸² and reaffirmed in *Casey*.⁸³ As part of this process, various states have passed laws requiring professionals to advise patients in a manner inconsistent with professional insights.

The Eighth Circuit, for example, upheld a South Dakota informed consent statute that requires abortion providers to warn against an alleged increased risk of suicide ideation and suicide, inconsistent with medical knowledge.⁸⁴ A panel of the Eighth Circuit held the suicide advisory unconstitutional under the First Amendment as “compelling untruthful and misleading speech,” and thereby “violat[ing] doctors’ First Amendment right to be free from compelled speech that is untruthful, misleading, or irrelevant.”⁸⁵ Upon en banc review limited to the issue of the suicide advisory, the Eighth Circuit reversed. Relying on *Gonzales v. Carhart*,⁸⁶ the plurality emphasized the state’s ability to compel the disclosure even in the face of “medical and scientific uncertainty.”⁸⁷ Two separate concurrences, however, indicate that the physician may still exercise individual professional judgment in either tailoring the disclosure itself⁸⁸ or supplementing the disclosure,⁸⁹ thereby granting “somewhat more weight to professional knowledge and deference to the

Orders Doctors to Say Abortions with Drugs May Be Reversible, N.Y. TIMES (Mar. 31, 2015), <http://nyti.ms/1DpDo0Q> (“Arizona . . . became the first state to pass a law requiring doctors who perform drug-induced abortions to tell women that the procedure may be reversible, an assertion that most doctors say is wrong.”).

⁸² 410 U.S. 113 (1973).

⁸³ 505 U.S. 833 (1992).

⁸⁴ *Planned Parenthood of Minn., N.D., S.D. v. Rounds (Rounds II)*, 686 F.3d 889, 892 (8th Cir. 2012) (en banc) (quoting S.D. CODIFIED LAWS § 34-23A-10.1(1)(e)(ii) (2015)).

⁸⁵ *Planned Parenthood of Minn., N.D., S.D. v. Rounds (Rounds I)*, 653 F.3d 662, 673 (8th Cir. 2011).

⁸⁶ 550 U.S. 124 (2007).

⁸⁷ *Rounds II*, 686 F.3d at 904.

⁸⁸ *Id.* at 906 (Loken, J., concurring) (interpreting the decision to “require only a disclosure as to relative risk that the physician can adapt to fit his or her professional opinion of the conflicting medical research on this contentious subject”).

⁸⁹ *Id.* at 907 (Colloton, J., concurring) (suggesting that “the physician [is] free to augment that description based on his or her professional judgment”).

individual professional.”⁹⁰ Critics suggest that “a more robust First Amendment inquiry” in this case would have focused on “ensuring clinically and professionally appropriate speech within the doctor-patient relationship.”⁹¹ Indeed, such an inquiry would have required “the judge . . . to determine whether the knowledge community’s insights are being communicated.”⁹²

The Fourth Circuit struck down a North Carolina statute that required mandatory sonograms as unconstitutional under the First Amendment—on the reasoning that, while truthful, it is up to the professional to decide whether or when the information conveyed is relevant⁹³—whereas the Fifth Circuit upheld a similar Texas law.⁹⁴ Other examples from the reproductive rights context include an ultimately unsuccessful effort by Arizona to require advice that medication abortion is reversible.⁹⁵

Taken together, these opinions show that, when confronted with legislative interference into professional advice that contradicts professional knowledge, courts have a mixed record. Especially in the reproductive rights arena, outcomes are inconsistent. In the context of conversion therapy legislation, by contrast, courts have signaled more willingness to defer to professional consensus.⁹⁶

B. Internal Contestation

Conversion therapy and reproductive health provide useful illustrations of internal contestation in light of emergent

⁹⁰ Haupt, *Professional Speech*, *supra* note 1, at 1298.

⁹¹ Recent Case, *First Amendment—Compelled Speech—Eighth Circuit Applies Planned Parenthood of Southeastern Pennsylvania v. Casey to South Dakota “Suicide Advisory”*—Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds, 686 F.3d 889 (8th Cir. 2012) (en banc), 126 HARV. L. REV. 1438, 1438 (2013).

⁹² Haupt, *Professional Speech*, *supra* note 1, at 1299.

⁹³ *Stuart v. Camnitz*, 774 F.3d 238, 254 (4th Cir. 2014).

⁹⁴ *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570 (5th Cir. 2012).

⁹⁵ *Federal District Court Ends Legal Challenge to Unconstitutional Arizona Law Forcing Doctors to Lie to Women, Ensuring Law Will Never Take Effect*, CTR. FOR REPRODUCTIVE RTS., (Aug. 23, 2016), <https://www.reproductiverights.org/press-room/federal-district-court-ends-legal-challenge-to-unconstitutional-arizona-law-forcing-doctors-to-lie-to-women>; *Planned Parenthood Arizona, Inc. et al. v. Brnovich, Christ, et al.*, CTR. FOR REPRODUCTIVE RTS., <https://www.reproductiverights.org/case/planned-parenthood-arizona-inc-et-al-v-brnovich-christ-et-al> (last revised July 20, 2018).

⁹⁶ The Eleventh Circuit likewise signaled deference to the professional standard when it held a Florida statute prohibiting doctors to inquire about gun ownership as a matter of course unconstitutional under the First Amendment. *Wollschlaeger v. Governor of Fla.* 848 F.3d 1293, 1301 (11th Cir. 2017). In this case, however, the court displayed considerable ambiguity when choosing its ultimate rationale. Haupt, *supra* note 64, at 151 (noting that “a three-judge panel of the Eleventh Circuit issued three consecutive, contradictory decisions” before “the court handed down an en banc decision that offers yet another analysis. . .”).

or changing knowledge upon which professionals base their advice. Here, too, historical antecedents exist. Professional knowledge is neither static nor monolithic, and professional insights change over time. This is true both for scientific insights as well as professional groups' positions on individual issues. Contrast the role of the American Psychiatric Association and its declassification of homosexuality as a mental disorder⁹⁷ with the American Medical Association's early anti-abortion advocacy.⁹⁸ Both areas also have an additional challenge in their religious salience that may at times be difficult to separate out from matters of expertise.

The internal professional developments that form the backdrop of contemporary conversion therapy legislation illustrate how professional knowledge leaves the mainstream, becoming so discredited that a professional consensus forms against it. This trend within the profession has been reflected in the courts. Consider, for example, the exclusion of expert testimony in a conversion therapy case, *Ferguson et al. v. JONAH*, Jews Offering New Alternatives for Healing ("JONAH" f/k/a Jews Offering New Alternatives to Homosexuality) where "a New Jersey court, after jury trial, found conversion therapy providers to be engaged in consumer fraud."⁹⁹ During the trial, the court excluded a number of expert witnesses who were to testify on the benefits of conversion therapy.¹⁰⁰ Plaintiffs in that case relied on the American Psychiatric Association's 1973 removal of homosexuality as a mental disorder from the Diagnostic and Statistical Manual of Mental Disorders (DSM) and argued "because the belief that homosexuality is a mental disorder is false and lacks any basis in science, any expert opinion derived from that false initial premise is unreliable and should be excluded."¹⁰¹ JONAH, however, argued that "reliance on the DSM is misplaced because the removal of homosexuality was a political, rather than scientific, decision."¹⁰² The judge, excluding the pro-conversion therapy witnesses, noted "[t]he overwhelming weight of scientific authority concludes that homosexuality is not a disorder or abnormal. The universal acceptance of that scientific conclusion—save for outliers such

⁹⁷ See discussion *supra* Part I.B.; George, *supra* note 42.

⁹⁸ STONE, *supra* note 11, at 187–89. See also Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 280–318 (1992).

⁹⁹ Haupt, *Unprofessional Advice*, *supra* note 2, at 718.

¹⁰⁰ *Ferguson v. JONAH*, No. HUD-L-5473-12, 2015 WL 609436, at *9 (N.J. Super. Ct. Law Div. Feb. 5, 2015) (granting plaintiffs' motion to bar five of JONAH's experts and partially granting their motion to bar the sixth).

¹⁰¹ *Id.* at *4.

¹⁰² *Id.* at *5.

as JONAH—requires that any expert opinions to the contrary must be barred.”¹⁰³ Whether the reasons for changing the DSM were scientific or political, moreover, is not for the court to decide.¹⁰⁴ Likewise, it is not for the court to decide on the accuracy of the professional community’s assessment.¹⁰⁵ In short, the court’s assessment of internal contestation follows the profession.

By contrast, in the reproductive rights context the courts’ response to internal contestation is instructive because at times it seems to take the opposite approach. Take the “partial birth” abortion cases, *Stenberg v. Carhart*¹⁰⁶ and *Gonzales v. Carhart*,¹⁰⁷ as an example. Aziza Ahmed has carefully charted the shifts in the jurisprudential treatment of expertise in the abortion context.¹⁰⁸ Comparing the *Stenberg* and *Gonzales* decisions, Ahmed notes that both concerned “nearly identical evidence and expertise,” but resulted in opposing outcomes.¹⁰⁹ This raises questions about “how medical experts with conflicting opinions legitimate themselves through participating in adjudication, and how medical expertise and evidence constrains judicial decision-making.”¹¹⁰ The Court in *Stenberg* was faced with medical questions that were unresolved as a matter of professional knowledge regarding certain procedures and their associated risks. Thus, the Court confronted “numerous competing sources of opinion, each deemed to be medically and scientifically authoritative, but providing differing advice, guidance, and

¹⁰³ *Id.* at *6.

¹⁰⁴ *Id.* at *8 (quoting *Landrigan v. Celotex Corp.*, 127 N.J. 404, 414 (1992)) (noting that “a trial court should not substitute its judgment for that of the relevant scientific community.”).

¹⁰⁵ *Id.* (“It is not a proper inquiry for a court to determine the correctness of the APA’s decision to generally accept that homosexuality is not a disorder, and no proper basis has been advanced on which a court may reassess the scientific accuracy of the psychiatric categorization of homosexuality.”).

¹⁰⁶ 530 U.S. 914 (2000) (striking down Nebraska statute prohibiting “partial birth abortion”).

¹⁰⁷ 550 U.S. 124 (2007) (upholding the federal Partial Birth Abortion Act).

¹⁰⁸ See Aziza Ahmed, *Medical Evidence and Expertise in Abortion Jurisprudence*, 41 AM. J. L. & MED. 85 (2015). Outlining a shift over time, Ahmed notes: “In *Roe* and *Casey*, where the Court portrayed the medical establishment as objective and neutral, the Justices were able to defer to medical expertise and evidence. In the post-*Stenberg* context, however . . . judges must now arbitrate medical evidence and expertise.” *Id.* at 106.

¹⁰⁹ *Id.* at 88.

¹¹⁰ *Id.* There are several larger themes at issue—especially the question of objectivity of scientific insights looms large. For purposes of this discussion, however, I will focus on the distinct problem of indeterminacy or contestation within the professional knowledge community and the state’s role (here embodied by the courts) to resolve the issue. *Id.* at 88–89. See also Haupt, *Licensing Knowledge*, *supra* note 4, at 28–35 (discussing epistemology of scientific knowledge in the sociology of the professions literature).

knowledge on the actual procedure.”¹¹¹ As Ahmed puts it, “[i]n the face of conflicting data, the Court became an arbiter of medical and health knowledge.”¹¹² Importantly, the Court explicitly acknowledged that expert opinion was divided; “[t]his explicit acknowledgement of a divided body of literature is important as we approach *Gonzales v. Carhart*, in which the Court cited to non-medical anecdotal evidence partly due to a perceived lack of clarity amongst medical experts.”¹¹³

Stone explains this dynamic with respect to the justices’ reasoning in *Gonzales v. Carhart*. Justice Kennedy’s majority opinion acknowledged “that *medical opinion was divided* on whether intact D&E abortions might be safer for some women in some circumstances,” but “Kennedy noted that Congress had made a finding in enacting the challenged legislation that partial-birth abortion ‘is never medically necessary.’”¹¹⁴ Thus, the majority deferred to Congress regarding the internal conflict, rather than the profession. In other words, the Court here intervened in an internal dispute of the relevant professional knowledge community, picking winners and losers by deferring to congressional judgment which did the same.

The dissent by Justice Ginsburg, joined by Justices Stevens, Souter, and Breyer, criticized this deference to Congress on a contested professional matter. Reliance on congressional findings inconsistent with professional knowledge, she noted, was inappropriate. Stone recounts “Ginsburg insisted that the congressional finding relied upon by the majority could not ‘withstand inspection.’ To the contrary, she . . . concluded, Congress’s bare assertion that ‘there was a medical consensus that the banned procedure is never necessary’ was completely inconsistent with the . . . facts.”¹¹⁵ In the end, the case thus not only disregards contestation within the knowledge community, but also enshrines an erroneous interpretation of medical knowledge into legal doctrine.

The Court’s differential treatment of expertise raises several larger questions relevant to professional speech. Among them are: deference to whom and deference for what?¹¹⁶ Stone’s discussion of *Gonzales v. Carhart* highlights the misguided

¹¹¹ Ahmed, *supra* note 108, at 99.

¹¹² *Id.* at 99–100

¹¹³ *Id.* at 101.

¹¹⁴ STONE, *supra* note 11, at 426 (emphasis added) (quoting *Gonzales v. Carhart*, 550 U.S. 124, 161, 164 (2007)).

¹¹⁵ *Id.* (quoting *Gonzales*, 550 U.S. at 171–76 (Ginsberg, J., dissenting)).

¹¹⁶ *Cf.* Mary-Rose Papandrea, *Sex and Religion: Unholy Bedfellows*, 116 MICH. L. REV. 859, 876 (2018) (noting the importance of deference for the outcome of the cases Stone discusses).

deference to medical expertise as interpreted by Congress; the Court appropriately should have deferred to the knowledge community's expertise as interpreted by the profession. And, as illustrated in the discussion of *Rounds*, the suicide advisory case, the Eighth Circuit has taken the misguided approach in *Gonzales v. Carhart* as permission to uphold a statute that disregards even broader consensus in the medical community.¹¹⁷ In order to ensure the accuracy of professional expertise, however, other experts—rather than legislators or judges—should be the arbiters of its content.

C. Client/Patient Perspective

From the perspective of the client or patient, the importance of safeguarding professional knowledge against outside interference that contradicts professional insights comes into sharp relief. The client or patient must rely on professional advice. The premise of the professional-client or doctor-patient relationship is that the professional has knowledge that the client or patient lacks. The fiduciary relationship between them demands that the professional gives comprehensive and accurate advice.

By interfering, the state injects its authority into this relationship. When legislation aligns with professional insights, as in the conversion therapy example, state involvement is relatively unproblematic, though even here it is important to reiterate that professional insights are neither monolithic nor static.¹¹⁸ The state ought not choose one approach if the professional consensus allows several. Nor should the state halt innovation.¹¹⁹ But much more serious problems arise when state interference contradicts professional insights, as in the reproductive health examples. Here, the fundamental premise of the professional relationship—based on giving comprehensive and accurate advice—is in jeopardy.¹²⁰

To be sure, the states have an interest in regulating citizens' health and welfare via the police powers. But the site of expertise lies with the profession, so the content of accurate and comprehensive advice must be determined by the profession, as the malpractice liability regime has traditionally recognized.

¹¹⁷ See *supra* Part II.A.

¹¹⁸ Haupt, *Professional Speech*, *supra* note 1, at 1294–95.

¹¹⁹ Haupt, *Unprofessional Advice*, *supra* note 2, at 721.

¹²⁰ *Id.* at 691. The same applies to the Florida gun case, discussed *supra* note 96. See *Wollschlaeger v. Governor of Fla.* 848 F.3d 1293.

III. INDIVIDUAL PERSPECTIVE: PROFESSIONAL VERSUS PROFESSION

Another site of potential conflict lies in the relationship between the individual professional who departs from the professional consensus on the one hand, and the profession on the other hand.¹²¹ This could be the pro-conversion therapy therapist, the anti-vaccine doctor, or the pharmacist who refuses to dispense birth control medication they believe to be abortifacients. But this could also be the doctor who believes marijuana is medically beneficial, or the doctor who finds mammograms useless.¹²²

A. Professional Outliers

When considering professional outliers, that is, individual professionals who depart from the professional consensus, it is useful to identify the basis upon which they justify their departure.¹²³ Outliers who use the shared methodology of the profession to justify their departure (internal outliers) should be considered part of the discourse of the profession. These professionals, in fact, could be the particularly innovative individuals ahead of the curve whose insights subsequently are embraced by a wider professional consensus.¹²⁴ The shifting views regarding the benefits of medical marijuana serve as a prime example.¹²⁵ Alternatively, these outliers' views could be tested and refuted by the profession; here, the refuted link between certain childhood vaccines and autism is a useful example.¹²⁶ Outliers who use exogenous justifications for departure (external outliers), however, place themselves outside of the professional discourse that assumes shared ways of

¹²¹ I use the term "consensus" to mean "agreement relative to the relevant knowledge community." See Haupt, *Unprofessional Advice*, *supra* note 2, at 675 n.14. See also Sheila Jasanoff, *Serviceable Truths: Science for Action in Law and Policy*, 93 TEX. L. REV. 1723, 1741 (2015) ("[T]he argument is not that science has been able to access unvarnished truth, but rather that relevant scientific communities have been able to set aside all theoretical and methodological disagreements to come together on a shared position. If most or all members of the relevant thought collective are in agreement, then that collective judgment surely demands a high degree of respect from society in general and the law more particularly.").

¹²² See Haupt, *Unprofessional Advice*, *supra* note 2, at 672–73.

¹²³ Haupt, *Unprofessional Advice*, *supra* note 2, at 676; Haupt, *Religious Outliers*, *supra* note 13, at 179–85.

¹²⁴ Haupt, *Unprofessional Advice*, *supra* note 2, at 690 ("To the extent that a professional's outlier status is grounded in disagreement based on shared notions of validity, departure from the knowledge community's insights must be permissible. Indeed, dynamic development and refinement of professional insights will often depend on such divergent assessments.").

¹²⁵ *Id.* at 721–24.

¹²⁶ *Id.* at 715–16.

knowing and reasoning.¹²⁷ Typically, religious, philosophical, or political disagreement with the profession creates external outliers.¹²⁸ Most prominently among them are healthcare professionals who invoke religious disagreement with professional standards and justify their departure from the professional standard accordingly.

Importantly, however, there is a line between expertise and moral or value judgments where no special claim to expertise exists.¹²⁹ As I have explained elsewhere, “professional determinations based on medical expertise can be made regarding the total and irreversible cessation of all brain functions (‘brain death’) and its diagnostic criteria.”¹³⁰ But “it is a value judgment whether this medical diagnosis constitutes the end of life of the individual; this is a matter with ethical, philosophical, and religious dimensions beyond medical expertise.”¹³¹ Similar questions regarding the limits of professional expertise may arise in the abortion context. To be sure, this line between expertise and moral or value judgment can be quite elusive at times. Some emergent reproductive rights controversies will likely fall in this area where the underlying science is evolving, but moral disagreement persists.¹³²

B. Government Endorsement of Outlier Status

There are various ways in which the state can endorse or reinforce professional outlier status of individual professionals against the profession. Most notably, such endorsement may

¹²⁷ *Id.* at 690 (explaining that “outlier status based on exogenous reasons undermines the status of the professional as a member of the knowledge community founded in shared notions of validity and common ways of knowing and reasoning”).

¹²⁸ *Id.* at 672.

¹²⁹ Haupt, *Religious Outliers*, *supra* note 13, at 177 (“The knowledge community has a superior understanding of issues directly related to its core knowledge. But no amount of specialized training, for instance, by itself makes a professional more competent to render general value judgments on moral issues unrelated or only tangentially related to professional insights.”).

¹³⁰ Haupt, *Religious Outliers*, *supra* note 13, at 177.

¹³¹ *Id.*

¹³² See, e.g., Chelsea Conaboy, *The Abortion Debate Doesn't Change, But the Science of Abortion Does*, BOS. GLOBE (Aug. 31, 2018), <https://www.bostonglobe.com/ideas/2018/08/31/the-abortion-debate-doesn-change-but-science-abortion-does/smHRPvw5XDkTXzMUrADawK/story.html>; Emma Green, *Science Is Giving the Pro-Life Movement a Boost*, ATLANTIC (Jan. 18, 2018), <https://www.theatlantic.com/politics/archive/2018/01/pro-life-pro-science/549308/>.

come in the form of religious exemptions.¹³³ Another way to frame the issue is to consider how the government may insulate dissenters.¹³⁴

The Department of Health and Human Services (HHS) has created a “Conscience and Religious Freedom Division” that “was established to hear complaints from medical professionals . . . who feel they have been pressured into providing medical services that conflict with their religious beliefs.”¹³⁵ Based on newly issued regulations, HHS can “enforce protections for religious medical providers.”¹³⁶ In effect, this results in state enforcement of individual professionals’ outlier status against the profession. Whether such government involvement in the profession’s arguably internal affairs is justified depends on the extent to which departure from the professional consensus for personal reasons ought to be permissible. Importantly, the profession typically will accommodate its members to a certain extent. The American Medical Association, for instance, in Opinion 1.1.7 addresses “Physician Exercise of Conscience.”¹³⁷ It is worth considering whether the fundamental decision in favor of certain self-regulating professions—justified on the idea of respecting the locus of expertise within the profession—warrants granting a large degree of autonomy to the profession in deciding to what extent departure from professional knowledge ought to be permissible. The perspective of the client or patient to whom the professional owes a fiduciary duty should guide the appropriate answer.

C. Client/Patient Perspective

From the client’s or patient’s perspective, receiving limited advice constricts the otherwise available range of options among which to choose. Indeed, the client or patient has a strong

¹³³ Here, I do not use “endorsement” in the technical sense of the Establishment Clause. *See, e.g.*, *Capitol Square Review & Advisory Bd. v. Pinette*, 515 U.S. 753, 772 (1995) (O’Connor, J., concurring) (discussing the endorsement test); *Lynch v. Donnelly*, 465 U.S. 668, 688–89 (1984) (O’Connor, J., concurring) (same). However, some forms of religious exemptions might raise Establishment Clause questions. *See* Douglas NeJaime & Reva Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 *YALE L.J.* 2516, 2529 (2015) (“Under the Establishment Clause, the Court has invalidated accommodations that impose ‘significant burdens’ on third parties.”).

¹³⁴ Robin Fretwell Wilson, *When Governments Insulate Dissenters from Social Change: What Hobby Lobby and Abortion Conscience Clauses Teach About Specific Exemptions*, 48 *U.C. DAVIS L. REV.* 703 (2014).

¹³⁵ Olga Khazan, *When The Religious Doctor Refuses to Treat You*, *ATLANTIC* (Jan. 23, 2018), <https://www.theatlantic.com/health/archive/2018/01/when-the-religious-doctor-refuses-to-treat-you/551231/>.

¹³⁶ *Id.*

¹³⁷ *CODE OF MEDICAL ETHICS* § 1.1.7 (AMA 2016).

autonomy interest that the professional's fiduciary obligations, as well as the imposition of informed consent requirements, protect. The ultimate decision, in short, has to remain with the client or patient. In order to make a fully informed choice, however, the patient should know what is being withheld. To achieve this, scholars offer various solutions. Nadia Sawicki has proposed a common law duty to disclose limitations.¹³⁸ Similarly, I have suggested that full advice also means advising on what is left out.¹³⁹ These approaches acknowledge that the client or patient has an important interest in receiving comprehensive professional advice.

IV. FUTURE SITES OF CONFLICT

To illustrate how themes of sex, gender, sexual orientation and religion continue to play a role in the professional speech context, this Part focuses on two likely future sites of conflict. The first concerns the continuing contestation over reproductive rights. Between the Supreme Court decisions in *NIFLA*¹⁴⁰ and *Whole Women's Health v. Hellerstedt*,¹⁴¹ new fault lines emerge that implicate the interaction between professional advice and state activities in seeking to limit access to abortion. The second area of likely future conflict involves transgender healthcare. Here, professional standards are beginning to emerge. At the same time, however, state interference is becoming increasingly probable.

A. Reproductive Rights

With respect to the content of advice, a shift has taken place between the "partial birth" abortion decisions¹⁴² and *Whole Women's Health*.¹⁴³ Whereas the Court relied on questionable assumptions in the former set of cases, it deferred much more clearly to scientific evidence in the latter. States increasingly moved to protecting women's health as a justification for imposing limits on access to abortion.¹⁴⁴ In *Whole Women's*

¹³⁸ See, e.g., Nadia N. Sawicki, *A Common Law Duty to Disclose Conscience-Based Limitations on Medical Practice*, in *LAW, RELIGION, AND HEALTH IN THE UNITED STATES* 187 (Holly F. Lynch, I. Glenn Cohen & Elizabeth Sepper eds., 2017).

¹³⁹ Haupt, *Religious Outliers*, *supra* note 13.

¹⁴⁰ 138 S. Ct. 2361 (2018).

¹⁴¹ 136 S. Ct. 2292 (2016).

¹⁴² *Gonzales v. Carhart*, 550 U.S. 124 (2007); *Gonzales v. Stenberg*, 530 U.S. 914 (2000).

¹⁴³ 136 S. Ct. 2292 (2016).

¹⁴⁴ See generally Linda Greenhouse & Reva B. Siegel, *Casey and the Clinic Closings: When "Protecting Health" Obstructs Choice*, 125 *YALE L.J.* 1428 (2016).

Health, however, the Court closely hewed to scientific insights in evaluating these justifications.¹⁴⁵

Linda Greenhouse and Reva Siegel explain that the Court's approach in *Whole Woman's Health* "closely scrutinizes scientific evidence marshaled by opposing parties." The type of "[e]vidence-based balancing" displayed in the decision has significant impact on the lower courts' approaches to a range of "health-justified restrictions on abortion," including "scientifically inaccurate warnings that abortion causes breast cancer," state laws that, contrary to scientific insights, "requir[e] abortion providers to inform women that they are more likely to experience psychological harm if they obtain abortions than if they carry their unplanned pregnancies to term," and "abortion restrictions that rest on contested factual claims—for example, claims that abortion before viability inflicts fetal pain."¹⁴⁶

The *NIFLA* decision, however, has arguably unsettled the regulation of abortion-related speech more generally. As commentators note, the decision "raises the troubling possibility that the courts may be more apt to apply the informed-consent exception to laws that regulate the speech of abortion providers than to those that regulate the speech of abortion opponents."¹⁴⁷ In light of the unequal treatment for abortion-related speech that had been found to exist prior to *NIFLA*,¹⁴⁸ one question is "whether this unequal application of the First Amendment will continue after *NIFLA* or whether the courts will now apply strict scrutiny more broadly to all regulations of abortion-related speech, including state laws that require abortion providers to give patients medically inaccurate information."¹⁴⁹

With respect to controversy around the "domestic gag rule,"¹⁵⁰ the problem is giving comprehensive professional advice. As such, the contestation is similar to that surrounding *Rust v. Sullivan* and, in the legal context, *Legal Services Corp. v. Velazquez*.¹⁵¹ In response to the HHS announcement of the final

¹⁴⁵ See Linda Greenhouse & Reva B. Siegel, *The Difference a Whole Woman Makes: Protection for the Abortion Right After Whole Woman's Health*, 126 YALE L.J. F. 149 (2016).

¹⁴⁶ *Id.* at 159–61.

¹⁴⁷ Parmet et al., *supra* note 65, at 1490.

¹⁴⁸ See generally Caroline Mala Corbin, *Abortion Distortions*, 71 WASH. & LEE L. REV. 1175 (2014).

¹⁴⁹ Parmet et al., *supra* note 65, at 1490.

¹⁵⁰ Julie H. Davis & Maggie Haberman, *Trump Administration to Tie Health Facilities' Funding to Abortion Restrictions*, N.Y. TIMES (May 17, 2018), <https://www.nytimes.com/2018/05/17/us/politics/trump-funding-abortion-restrictions.html>.

¹⁵¹ See *Rust v. Sullivan*, 500 U.S. 173 (1991); *Legal Servs. Corp. v. Velazquez*, 531 U.S. 533 (2001). See also *supra* Part I–I.A.

rule limiting Title X funding,¹⁵² the AMA has expressed deep concern regarding the new regulation's impact on access to comprehensive healthcare. The AMA's position is that the regulation "would limit women's access to care and force doctors to withhold information about all of their health care options."¹⁵³ In addition to interfering with the doctor-patient advice-giving relationship, the AMA argues that the new rule will force physicians into a conflict with the professional code of ethics.¹⁵⁴

B. Transgender Healthcare

As transgender healthcare moves into the mainstream of healthcare service delivery,¹⁵⁵ the dynamics of internal contestation and outside interference will likely become more apparent in this area. Standards of care are in the process of development; the content of good professional advice is still in its formation stages.¹⁵⁶ Moreover, medical education is only starting to incorporate trans healthcare into the curriculum.¹⁵⁷ The American Academy of Pediatrics, for example, released a new policy statement regarding healthcare for transgender and gender diverse children and adolescents in September 2018.¹⁵⁸

At the same time, state involvement in this area is becoming more likely. According to news reports, the Trump administration is in the process of redefining "gender" under federal civil rights law. HHS in particular is reportedly drafting a memo arguing that "[s]ex means a person's status as male or female based on immutable biological traits identifiable by or

¹⁵² Pam Belluck, *Trump Administration Blocks Funds for Planned Parenthood and Others Over Abortion Referrals*, N.Y. TIMES (Feb. 22, 2019), <https://nyti.ms/2BOeX21> For the final rule, see <https://www.hhs.gov/opa/sites/default/files/title-x-notice-of-final-rule.pdf>.

¹⁵³ Andis Robeznieks, *New Federal Regulations Impose Gag Rule on Physicians, Restrict Access to Critical Services*, AMA (Feb. 22, 2019), <https://www.ama-assn.org/delivering-care/physician-patient-relationship/new-federal-regulations-impose-gag-rule-physicians>.

¹⁵⁴ *Id.* ("Protecting the integrity of the patient-physician relationship and defending the freedom of communication between patients and their physicians is a fundamental priority for the AMA," Dr. McAneny added. "With this action, the administration wants to block physicians from counseling patients about all of their healthcare options and from providing appropriate referrals for care. This is a clear violation of patients' rights in the Code of Medical Ethics.").

¹⁵⁵ See generally Laura Buchholz, *Transgender Care Moves into the Mainstream*, 314 JAMA 1785 (2015).

¹⁵⁶ *Id.* at 1786 (discussing emergent standard of care). See also Jessica A. Clarke, *They, Them, and Theirs*, 132 HARV. L. REV. 894, 987 (2019) ("Health care providers are beginning to recognize the unique needs of nonbinary patients, and finding ways to provide more support and affirming care.").

¹⁵⁷ Buchholz, *supra* note 155, at 1786–87; Kevin L. Ard & Alex S. Keuroghlian, *Training in Sexual and Gender Minority Health—Expanding Education to Reach All Clinicians*, 379 N. ENGL. J. MED. 2388 (2018).

¹⁵⁸ Jason Rafferty, Policy Statement, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 PEDIATRICS 1, 15 (2018).

before birth. . . The sex listed on a person's birth certificate, as originally issued, shall constitute definitive proof of a person's sex unless rebutted by reliable genetic evidence."¹⁵⁹ One area acutely affected by such a change is the Affordable Care Act's prohibition of sex discrimination by providers, which courts have interpreted to include gender-identity discrimination.¹⁶⁰ Commentators note that the contemplated change "would be tragic not just for patients, but for the health care profession as well."¹⁶¹ The ACA provision, they suggest, provides guidance to patients and providers, "and it has been welcomed by physician groups such as the American Medical Association."¹⁶² The HHS memo, by contrast, not only contradicts court decisions on gender-identity discrimination but also takes away important legal guidance for providers.¹⁶³ Moreover, the HHS memo's definitional interference contradicts expert knowledge—or at the very least obscures internal contestation.¹⁶⁴

In addition, the HHS conscience and religious freedom directive¹⁶⁵ may permit providers to opt out of educational requirements concerning sexual and gender minority healthcare.¹⁶⁶ Notably, educators have found "[a]ppeals to professional competence—the ability to care for any person who walks through the practice's doors" to be successful when confronted with providers who were ambivalent based on "personal, cultural, or religious views about sexual orientation or gender identity."¹⁶⁷ Thus, it seems that as professional knowledge in this area develops, conflicts along the lines of profession versus outside interference as well as professional versus profession are likely.

¹⁵⁹ Erica L. Green et al., *'Transgender' Could Be Defined Out of Existence Under Trump Administration*, N.Y. TIMES (Oct. 21, 2018), <https://www.nytimes.com/2018/10/21/us/politics/transgender-trump-administration-sex-definition.html>.

¹⁶⁰ Clarke, *supra* note 156, at 988; Jocelyn Samuels & Mara Keisling, *The Anti-Trans Memo—Abandoning Doctors and Patients*, 380 N. ENGL. J. MED. 111, 112 (2019), https://www.nejm.org/doi/full/10.1056/NEJMp1814406?query=main_nav_lg

¹⁶¹ *Id.* at 112–13

¹⁶² *Id.* at 112.

¹⁶³ *Id.*

¹⁶⁴ See, e.g., Denise Grady, *Anatomy Does Not Determine Gender, Experts Say*, N.Y. TIMES (Oct. 22, 2018), <https://www.nytimes.com/2018/10/22/health/transgender-trump-biology.html>.

¹⁶⁵ See discussion *supra* Part IV.A.

¹⁶⁶ Ard & Keuroghlian, *supra* note 157, at 2391.

¹⁶⁷ *Id.* at 2390–91.

V. CONCLUSION

For the most part, the advice clients and patients receive from their professionals is uncontroversial. Thus, state legislatures will not likely find reason to intervene when the subject of advice-giving concerns broken bones, damaged joints, or torn ligaments. The expertise clients and patients seek will be provided within a regulatory framework that ensures professionals are qualified and provide accurate and comprehensive advice according to the insights of the profession. Of course, Justice Thomas in *NIFLA* is right to note that professional malpractice liability and informed consent are firmly entrenched in American law.¹⁶⁸ Nonetheless, this does not negate the need for a theoretical basis. Yet, the underlying contestation over sex, gender, sexual orientation, and religion explains why professional speech doctrine itself may sometimes be controversial.

¹⁶⁸ See discussion *supra* Part I.A.