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ARTICLE

# Listening to the Listeners: A Patient's Right to Receive Information via Telehealth

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## Introduction

Patients have a right to listen. When a medical professional speaks with a patient, the First Amendment protects both the speaker and the listener. But courts have tended to uphold regulations regulating doctor-patient speech on theories that disregard the patient's right to receive information.

This neglect of listeners' rights hurts patients. In the telehealth context, for instance, patients in states with onerous telehealth rules may have to travel great distances or relocate to reach life-saving care from out-of-state specialists. Or a patient moving to a new state may have to abandon a lasting relationship with a beloved doctor because the new state will not allow the out-of-state physician to maintain a remote doctor-patient relationship.

Telehealth visits merit First Amendment protection. Courts that have held otherwise have often focused only on the rights of the practitioner. They fail to consider the other side of the coin. There is a curious blind spot toward the rights of the patient to hear their chosen physician's speech, whether in person or online.

Listeners' rights in general are an undeveloped area of First Amendment law. Such rights exist, but little else is known about them. This Article aims to explore listeners' rights in the telehealth context of virtual doctor-patient communication. Listeners' rights should push courts to impose a higher level of scrutiny when analyzing laws restricting telehealth.

This Article proceeds in five parts: Part I discusses what telehealth is, how states regulate it, and current litigation over that regulation. Part II analyzes how courts have addressed First Amendment challenges to regulations restricting doctor-patient speech. Part III reviews the scant doctrine regarding listeners' rights under the First Amendment. Part IV argues that viewing telehealth restrictions through the lens of the listener should prompt courts to employ a tougher standard of First Amendment scrutiny. Finally, Part V briefly addresses potential counterarguments.

## I. Telehealth's Friends and Foes

### A. *A Lifeline*

Telehealth can be a lifeline. It certainly was for a baby boy in New York. At eighteen months old, Jun Abell was diagnosed with a rare brain tumor.[1] Time was short. His parents arranged for treatment, and Jun's dad

[1] *See Cancer Doctors and Patients Fight for Right to Telehealth*, PAC. LEGAL FOUND., https://perma.cc/DAA7-6YJJ. The rest of Jun's story will rely on this citation.

waged a multi-day war to save his son's life by calling every pediatric oncologist in the country he could find.

Chemotherapy and multiple surgeries failed to kill the tumor. But then Jun's parents found Dr. Shannon MacDonald, who worked in Massachusetts. Dr. MacDonald specializes in proton therapy, an innovative treatment that could save Jun, but was unavailable in New York.

Jun's parents consulted with Dr. MacDonald remotely, and the family decided to start treatment under her care in Massachusetts. That decision saved Jun's life.

But Jun's fight is not over. He needs monitoring for the rest of his life to guard against relapse. But he now lives with his family in New Jersey, a state that forbids virtual doctor-patient visits with out-of-state practitioners.

If Jun and his family had lived in New Jersey when he'd first been diagnosed, the telehealth campaign that saved his life might not have happened. Yet even now New Jersey makes it harder for Jun to consult with the specialists most suited to watch over him.

Dr. MacDonald and Jun's family are now both plaintiffs in a lawsuit challenging New Jersey's telehealth law as unconstitutional under the First Amendment, among other theories.[2]

In May 2025, a federal district court granted New Jersey's motion to dismiss Jun's case, holding that the telehealth restriction was content-neutral and survived deferential rational basis review.[3] Likewise, a similar telehealth restriction in California was upheld in *McBride v. Lawson*[4] in November 2024, holding that telehealth restrictions regulate conduct with only incidental effects on speech.[5]

### B. *Telehealth Laws*

Telehealth can be many things. It can involve remote examination of imaging, the prescription of medication by virtual means, remote patient monitoring, or the transmission of medical information without real-time interaction.[6] But most fundamentally, it means a doctor and patient

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[2] *See* Complaint for Declaratory and Injunctive Relief at 27, MacDonald v. Sabando, No. 1:23-cv-23044 (D.N.J. Dec. 13, 2023).

[3] *See* MacDonald v. Sabando, No. 23-cv-23044, 2025 WL 1367443, at *1, *13 (D.N.J. May 12, 2025), *appeal docketed*, No. 25-2090 (3d Cir. June 10, 2025).

[4] No. 2:24-cv-01394, 2024 WL 4826378 (E.D. Cal. Nov. 19, 2024), *appeal docketed*, No. 25-963 (9th Cir. Feb. 13, 2025).

[5] *See* Order Granting Motion to Dismiss at 13, *McBride*, No. 2:24-cv-01394, 2024 WL 4826378, at *7–8 (E.D. Cal. Nov. 18, 2024), *appeal docketed*, No. 25-963 (9th Cir. Feb. 13, 2025).

[6] *See What Can Be Treated Through Telehealth?*, DEP'T OF HEALTH & HUM. SERVS. (Aug. 16, 2024), https://perma.cc/95AV-T7SC.

communicating with one another via real-time audio-visual technology or recording.[7]

California, for example, defines telehealth as "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care."[8] It includes "synchronous interactions and asynchronous store and forward transfers," which encompasses both real-time and recorded communication.[9]

New Jersey's definition is similar: "[T]he use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration," and so on.[10] It defines "telemedicine" generally to refer to "the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care provider who is located at a distant site and a patient who is located at an originating site."[11]

While this Article's argument may apply to many forms of telehealth, it focuses on telehealth that involves real-time virtual communication between doctor and patient about symptoms, diagnoses, and treatments. This is what the Article refers to when it uses the term "telehealth" unless stated otherwise.

As technology often does, telehealth has stirred up both great hopes and great anxieties. Its supporters praise its potential to expand health care access and improve patient care, and its detractors raise fears of fraud, misinformation, malpractice, data breaches, and so forth.[12]

All fifty states regulate telehealth in some fashion, with regulations ranging from permissive to restrictive.[13] California and New Jersey, for instance, fall on the restrictive side. Both demand a full medical license

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[7] *See Why Use Telehealth?*, DEP'T OF HEALTH & HUM. SERVS. (Feb. 2024), https://perma.cc/SF3U-EN32.

[8] *Medicine: Telehealth* (*medne tele*), CAL. DEP'T OF HEALTH CARE SERVS., (2023), https://perma.cc/GQ85-593U.

[9] *Id.*

[10] N.J. STAT. ANN. § 45:1-61 (West, Westlaw through L.2025, c. 100 and J.R. No. 10).

[11] *Id.*

[12] *See* David Pratt, *Telehealth and Telemedicine in 2015*, 25 ALB. L.J. SCI. & TECH. 495, 508, 538 (2015); Barbara J. Tyler, *Cyberdoctors: The Virtual Housecall—The Actual Practice of Medicine on the Internet Is Here; Is it a Telemedical Accident Waiting to Happen?*, 31 IND. L. REV. 259, 271 (1998) (raising concerns about fraud and misinformation through online health providers).

[13] The Center for Connected Health Policy's website is a useful resource for reviewing the telehealth laws for all fifty states and the District of Columbia. *See Nat'l Telehealth Pol'y Res. Ctr.*, CTR. FOR CONNECTED HEALTH POL'Y, https://perma.cc/B5NM-H6LD.

from the state for any telehealth visit where the patient is located in the regulating state.[14]

Some states, like New York, offer a little more leeway by providing an alternative to full licensure. A physician interested in telehealth relationships with New York patients can apply for a limited permit to practice telemedicine in the state, which is, at least in theory, less burdensome than getting a full-fledged license.[15]

States may offer various general exceptions to licensed care that affect the telehealth context. Utah, for instance, allows an out-of-state doctor to consult with a Utah-based patient without a license if the care is offered as an unpaid public service.[16] And some states, like Virginia, allow for telemedicine if the out-of-state physician practices telemedicine under the direction of an in-state-licensed physician.[17]

At the more permissive end of the spectrum are states that simply require out-of-state doctors engaged in telehealth to hold a medical license with a state and register with the regulating state's health department.[18] Even registration procedures, however, may still impose burdens sufficient to dissuade out-of-state physicians from going through the trouble or may result in delay that prevents out-of-state physicians from offering timely care.

## II. Doctor-Patient Communication in the Courts

Courts have struggled with applying the First Amendment in the context of communication between a client and a professional. On the whole, though, First Amendment challenges to the regulation of professional-client speech have tended to fail.[19] This would change for the better if courts and litigants turn more attention to clients' or patients' First Amendment rights to receive information along with professionals' rights to provide it.

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14 *See* CAL. BUS. & PROF. CODE § 2290.5(3)(A) (West, Westlaw through ch. 79 of 2025 Reg. Sess.); N.J. STAT. ANN. § 45:1-62(b) (West, Westlaw through L.2025, c. 100 and J.R. No. 10).

15 *See* N.Y. COMP. CODES R. & REGS. tit. 14, § 596.6(a)(1)(i) (2022).

16 UTAH CODE ANN. § 58-67-305(7) (LexisNexis, LEXIS through 2025 Gen. Sess.).

17 VA. CODE ANN. § 54.1-2901(A)(7) (LexisNexis, LEXIS through 2025 Reg. and Reconvened Sess.).

18 *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-3606(A) (West, Westlaw through 1st Reg. Sess. of the 75th Leg. (2025)).

19 *See, e.g.*, Chiles v. Salazar, 116 F.4th 1178, 1191 (10th Cir. 2024) (rejecting a First Amendment challenge to regulation of therapist-patient communication); Brokamp v. James, 66 F.4th 374, 380–81 (2d Cir. 2023) (same). *But see* Otto v. City of Boca Raton, 981 F.3d 854, 859 (11th Cir. 2020) (holding a regulation of therapist-client communication violated the First Amendment); Conant v. Walters, 309 F.3d 629, 632 (9th Cir. 2002) (holding that federal law prohibiting physicians from recommending marijuana to patients violated the First Amendment).

Courts addressing these cases have tended to resolve the issues along several threads of reasoning: (1) the mostly defunct professional-speech doctrine; (2) the speech-conduct distinction; and (3) content neutrality. An understanding of all three demonstrates how a focus on listeners' rights will make this area of First Amendment law more protective and more coherent.

### A. *Professional Speech*

While the professional-speech doctrine has fallen into disrepute following the 2018 Supreme Court case *National Institute of Family and Life Advocates v. Becerra*[20] ("*NIFLA*"), it still provides helpful background for understanding the legal landscape. And courts continue to employ reasoning rooted in the same flawed rationale as the debunked professional-speech doctrine.[21]

Prior to *NIFLA* in 2018, many courts exempted doctor-patient speech and similar "professional speech" from the First Amendment.[22] "Professional" here refers to "individuals who provide personalized services to clients and who are subject to 'a generally applicable licensing and regulatory regime.'"[23] When such professionals speak based on "expert knowledge and judgment" or "within the confines of [the] professional relationship," some courts argued that such speech did not merit special First Amendment protection.[24]

This professional-speech doctrine rested on the notion that "the First Amendment tolerates a substantial amount of speech regulation within the professional-client relationship that it would not tolerate outside of it."[25] Courts adopting this doctrine reasoned that "[w]hen professionals, by means of their state-issued licenses, form relationships with clients, the purpose of those relationships is to advance the welfare of the clients, rather than to contribute to public debate."[26] The courts that embraced this doctrine distinguished between professionals advocating in the public square—where their First Amendment rights are at their zenith—and professionals engaged in expression with clients, where professionals are beholden to state licensing regimes.[27]

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20 (*NIFLA*), 585 U.S. 755 (2018).

21 *See infra* Section II.B.

22 *See, e.g.*, King v. Governor of N.J., 767 F.3d 216, 232 (3d Cir. 2014); Pickup v. Brown, 740 F.3d 1208, 1225–27 (9th Cir. 2014), *abrogated by NIFLA*, 585 U.S. 755 (2018); Moore-King v. Cnty. of Chesterfield, 708 F.3d 560, 568–70 (4th Cir. 2013).

23 *NIFLA*, 585 U.S. at 767.

24 *Id.*

25 *Pickup*, 740 F.3d at 1228; *see also King*, 767 F.3d at 232; *Moore-King*, 708 F.3d at 569.

26 *Pickup*, 740 F.3d at 1228.

27 *See, e.g.*, *King*, 767 F.3d at 226; *Pickup*, 740 F.3d at 1227–29.

The Supreme Court rejected this doctrine, holding that the degree of First Amendment protection offered to professionals does not "turn[] on the fact that professionals were speaking."[28]

While *NIFLA* was a win for free speech, it missed an opportunity to note listeners' rights as another rationale for rejecting the professional-speech doctrine. After all, it seems odd that a physician, for instance, should enjoy full First Amendment protection when he is speaking in the role of a soapbox orator addressing the world at large, but the physician receives less protection when he is speaking to a specific patient who has sought out the physician's counsel. Listeners' rights and interests are more heightened in the doctor-patient setting than when the doctor is simply speaking to the public and no one has specifically solicited the physician's advice. Without question, the doctor's speech should be protected in the soapbox context, but courts violate listeners' rights when they treat the doctor's speech as less protected when a specific listener has sought out that speech.[29]

In any case, despite *NIFLA*, the professional-speech doctrine lingers on, though disguised in different doctrinal trappings.

### B. *Speech as Conduct*

A common rationale among courts confronting free-speech challenges to regulation of the doctor-patient relationship—and similar professional-client arrangements—is to hold that such regulations govern conduct and any impact on speech is incidental. This strategy allows courts to dial down the level of scrutiny to an anemic rational basis standard.

Consider, for example, the Court of Appeals for the Ninth Circuit's approach to a challenge to a conversion-therapy ban in Washington State. In *Tingley v. Ferguson*,[30] a therapist plaintiff challenged the ban on First Amendment grounds, claiming his "talk therapy" methodology was protected speech.[31]

But the court held that this talk therapy was a form of treatment, and the law at issue was directed at treatment (i.e., conduct) rather than speech.[32] Key to the court's holding was the fact that the therapist was a professional wielding expertise in service of a client.[33] In other words, the same rationale that had undergirded the discredited professional-speech

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28 *NIFLA*, 585 U.S. at 768.

29 *See infra* Section IV.A.

30 47 F.4th 1055 (9th Cir. 2022).

31 *Id.* at 1082.

32 *Id.* at 1077–78.

33 *Id.* at 1082.

doctrine was retrofitted as the basis for the speech-conduct distinction in *Tingley*.

The Court of Appeals for the Ninth Circuit is not the only court to perpetuate this error.[34] Most relevant for this Article is a federal district court ruling in a case challenging California's telehealth law, *McBride v. Lawson*.[35] The *McBride* court, relying on *Tingley*, held that doctors speaking with patients in virtual settings are engaged in "treatment, and not protected speech."[36] The trial court accepted the argument that consulting with patients on medical matters "is a core component of medical practice" that "can pose substantial risks of harm," so the speech is analogous to "hands-on treatment" and therefore conduct just like other direct treatment.[37] Because the trial court labeled doctor-patient communication as conduct, it employed rational basis and upheld the telehealth law.

Some circuits, however, have rejected this approach. The Fifth Circuit, in *Hines v. Pardue*,[38] recently held that a law requiring a physical exam prior to consultation violated the speech rights of a veterinarian who gave advice to pet owners by email.[39] The court dismissed the argument that the physical exam requirement only regulated conduct, reasoning that the requirement did not have a merely incidental effect on speech because "the regulation *only* kicked in when Dr. Hines began to share his opinion with his patient's owner."[40] And the Eleventh Circuit in *Otto v. City of Boca Raton*[41] rejected the speech-as-conduct reasoning in the same conversion-therapy context as *Tingley*, warning that "the enterprise of labeling certain verbal or written communications 'speech' and others 'conduct' is unprincipled and susceptible to manipulation."[42]

Yet none of the dissenters in cases like *Tingley*,[43] nor the majority opinion authors in cases like *Otto*, bring up listeners' right to hear the professional's opinion. This Article discusses how a listener focus offers a simpler way to resolve this sticky speech-conduct dichotomy.

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34 *See, e.g.*, Chiles v. Salazar, 116 F.4th 1178, 1204 (10th Cir. 2024).

35 Order Granting Motion to Dismiss at 1, McBride v. Lawson, No. 2:24-cv-01394, 2024 WL 4826378 (E.D. Cal. Nov. 18, 2024), *appeal docketed*, No. 25-963 (9th Cir. Feb. 13, 2025).

36 *Id.* at 13, 2024 WL 4826378, at *8.

37 *Id.* at 14, 2024 WL 4826378, at *8.

38 117 F.4th 769 (5th Cir. 2024).

39 *Id.* at 771.

40 *Id.* at 778.

41 981 F.3d 854 (11th Cir. 2020).

42 *Id.* at 861.

43 *See generally* Tingley v. Ferguson, 57 F.4th 1072, 1073 (9th Cir. 2023) (O'Scannlain, J., respecting the denial of rehearing en banc); *id.* at 1083 (Bumatay, J., dissenting from the denial of rehearing en banc).

### C. *Content Neutrality*

Sometimes courts have upheld professional-client speech restrictions on the grounds that they are content-neutral. This is, for example, how the New Jersey federal district court resolved Jun Abell's and Dr. MacDonald's First Amendment claim.[44] A speech restriction that does not target specific content, speakers, or viewpoints need only satisfy intermediate scrutiny.[45] Common examples include noise ordinances and laws limiting where or when protests can take place.[46] By contrast, a content-based law—to which strict scrutiny applies—is one where the speech restriction "depends on what they say."[47] Finding the line between content-neutral and content-based regulations, however, is often not so simple.[48]

In the professional-client speech context, some courts have emphasized that the professional setting triggers the speech restriction, not the content of the speech itself. For example, in *Brokamp v. James*,[49] the Second Circuit held that New York's mental-health-counselor licensing regulations were content-neutral.[50] Elizabeth Brokamp, a Virginia-licensed counselor, wanted to treat New York patients online with talk therapy, but New York regulation required that she hold a New York license.[51] The Second Circuit reviewed the licensing rule under intermediate scrutiny, holding it to be content-neutral because the licensing requirement "applies—regardless of what is said—only to speech having a particular purpose, focus, and circumstance."[52] The Court upheld the licensing regime.[53]

Likewise, in *MacDonald*, the New Jersey district court rejected Jun Abell's First Amendment argument on the grounds that New Jersey's telehealth rules were content-neutral and rationally related to New

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44 *See* MacDonald v. Sabando, No. 23-cv-23044, 2025 WL 1367443, at *3–4 (D.N.J. May 12, 2025), *appeal docketed*, No. 25-2090 (3d Cir. June 10, 2025).

45 *See* TBS v. FCC, 512 U.S. 622, 642 (1994).

46 *See* Forsyth Cnty. v. Nationalist Movement, 505 U.S. 123, 130 (1992) ("Although there is a 'heavy presumption' against the validity of a prior restraint, the Court has recognized that government, in order to regulate competing uses of public forums, may impose a permit requirement on those wishing to hold a march, parade, or rally." (citation omitted)); *see also* S. New England Tel. Co. v. United States, 886 F. Supp. 211, 218 (D. Conn. 1995) ("Laws that restrict noisy speeches near a hospital, ban billboards in residential communities, limit campaign contributions, or prohibit the mutilation of draft cards are examples of content-neutral restrictions.").

47 Holder v. Humanitarian L. Project, 561 U.S. 1, 27 (2010).

48 Hines v. Pardue, 117 F.4th 769, 778–79 (5th Cir. 2024).

49 66 F.4th 374 (2d Cir. 2023).

50 *Id.* at 393.

51 *Id.* at 381–82.

52 *Id.* at 393.

53 *Id.* at 406.

Jersey's interest in physicians' fitness and capacity to practice.[54] The rule did not restrict speech based on content, the court reasoned, because the rule "does not inquire as to the identity of a physician or what they might say."[55]

Once again, neither *Brokamp* nor *MacDonald* said anything about the rights of the patients to meet with their chosen therapist or physician. If these courts had considered the right to receive information, they may not have held these regulation to be content-neutral.[56]

## III. Listeners' Rights

"[T]he right to hear and the right to speak are flip sides of the same coin."[57] An emphasis on the lesser-known side of this coin can help resolve some of the tangled First Amendment problems that arise in challenges to doctor-patient regulation. The Supreme Court has not said much about listeners' rights aside from asserting their existence,[58] but a brief review of what it has said offers at least an outline of the doctrine.

Often, the Court has invoked listeners' rights without much explanation. It has clarified, however, that the right to receive information is active and justiciable even when the speaker lacks a First Amendment right to speak. For example, in *Lamont v. Postmaster General*,[59] the Supreme Court addressed a statute requiring that incoming foreign mail deemed "communist political propaganda" be detained and released only upon the addressee's request.[60] The postal service had intercepted a copy of the "Peking Review #12," addressed to Mr. Lamont.[61] Rather than reply with a

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54 *See* MacDonald v. Sabando, No. 23-cv-23044, 2025 WL 1367443, at *10–11 (D.N.J. May 12, 2025), *appeal docketed*, No. 25-2090 (3d Cir. June 10, 2025).

55 *Id.*

56 *See infra* Section IV.B.

57 Conant v. Walters, 309 F.3d 629, 643 (9th Cir. 2002) (Kozinski, J., concurring).

58 *See, e.g.*, TikTok Inc. v Garland, No. 24-656, slip op. at 7–8 (U.S. Jan. 17, 2025) (per curiam) (recognizing a right to "receipt of information and ideas"); Bd. of Educ., Island Trees Union Free Sch. Dist. No. 26 v. Pico *ex rel.* Pico, 457 U.S. 853, 867 (1982) ("[T]he right to receive ideas is a necessary predicate to the *recipient's* meaningful exercise of his own rights of speech, press, and political freedom."); First Nat. Bank of Bos. v. Bellotti, 435 U.S. 765, 783 (1978) (discussing the First Amendment's "role in affording the public access to discussion, debate, and the dissemination of information and ideas"); Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc., 425 U.S. 748, 756 (1976) ("But where a speaker exists . . . the protection afforded is to the communication, to its source and to its recipients both."); Stanley v. Georgia, 394 U.S. 557, 564 (1969) ("It is now well established that the Constitution protects the right to receive information and ideas."); Red Lion Broad. Co. v. FCC, 395 U.S. 367, 390 (1969) ("It is the right of the public to receive suitable access to social, political, esthetic, moral, and other ideas and experiences which is crucial here.").

59 381 U.S. 301 (1965).

60 *Id.* at 302.

61 *Id.* at 304.

request to release his mail, he sued, claiming a First Amendment injury, and the Supreme Court agreed.[62] Even though the foreign correspondent did not enjoy First Amendment protection, the *Lamont* majority assumed that Lamont had a right at the receiving end of the communication that the First Amendment protected.[63]

The concurrence went into greater depth. "The dissemination of ideas," the concurrence said, "can accomplish nothing if otherwise willing addressees are not free to receive and consider them. It would be a barren marketplace of ideas that had only sellers and no buyers."[64] *Lamont* and cases like it indicate that listeners' rights stand independently from speakers' rights. In other words, it is not a conditional right that exists only when there is an actionable right to speak.

The right to receive information has appeared in the medical context. In *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.*,[65] a group of consumers of prescription drugs challenged a rule forbidding licensed pharmacists from advertising drug prices.[66] Even though the lawsuit was not made "by one directly subject to its prohibition," the consumers could defend their own rights to receive information, since "the protection afforded is to the communication, to its source and to its recipients both."[67] The Court struck down the advertising ban.[68]

Likewise, the right to receive information arose in a Ninth Circuit case involving an issue analogous to the topic of this Article—recommendations by doctors to patients that they consume medical marijuana, which at the time was unlawful under federal marijuana policy.[69] While the majority only mentioned in passing the patients' First Amendment rights, Judge Kozinski's concurrence focused on the right to receive information. Judge Kozinski felt the greater First Amendment injury was to the patients' rights:

> [I]t is perfectly clear that the harm to patients from being denied the right to receive candid medical advice is far greater than the harm to doctors from being unable to deliver such advice. While denial of the right to speak is never trivial, the simple fact is that if the

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62 *Id.* at 304, 307.

63 *Id.* at 305 ("We conclude that the Act as construed and applied is unconstitutional because it requires an official act (*viz.*, returning the reply card) as a limitation on the unfettered exercise of the addressee's First Amendment rights.").

64 *Id.* at 308 (Brennan, J., concurring); *see also* Kleindienst v. Mandel, 408 U.S. 753, 765 (1972) (recognizing that denial of visas to a foreign academic to speak in the United States implicated listeners' rights); Thunder Studios, Inc. v. Kazal, 13 F.4th 736, 743–44 (9th Cir. 2021) (holding the stalking statute applied against foreign nationals implicated the listeners' First Amendment rights).

65 425 U.S. 748 (1976).

66 *Id.* at 749–50, 753.

67 *Id.* at 753, 756.

68 *Id.* at 773.

69 Conant v. Walters, 309 F.3d 629, 632 (9th Cir. 2002).

> injunction were denied, the doctors would be able to continue practicing medicine and go on with their lives more or less as before. It is far different for patients . . . .[70]

Ironically, the Ninth Circuit would later rely on *Conant v. Walters*[71] in *Tingley*, but the court ignored *Conant*'s lesson about the poignant—and sometimes life-saving—need for patients to exercise their right to receive information.

Yet, while the Court has recognized this right on many occasions, it invokes the right haphazardly. Consider, for instance, another pharmaceuticals case in which the right to receive information was at play but went unmentioned. In *Sorrell v. IMS Health Inc.*,[72] the Supreme Court entertained a lawsuit by another group of listeners: data miners and pharmaceutical marketers who wanted to receive data on doctors' prescription practices but could not due to a ban on pharmacies sharing this information with them.

Vermont defended the law as a restriction on access to information rather than a restriction on speech.[73] The simplest response to this would have been that the marketers and data miners enjoyed an independent right to receive information, regardless of whether the Vermont law was a speech restriction. Instead, the Court took the circuitous route of arguing that the marketers and data miners were speakers themselves, and their inability to access information impacted their right to pass on that information through their own speech.[74] While not wrong, the Court left a simpler tool for the job in the toolbelt. Oddly, the Court cited to *Virginia State Board of Pharmacy* for other propositions, but not to hold that the Vermont law violated marketers' right to receive information.[75]

Perhaps because listeners' rights rarely come up, courts have not yet defined the contours of those rights. One open question is whether listeners' rights strengthen or weaken depending on the speech context. For instance, returning to Mr. Lamont and his communist propaganda mail: Would the strength of his right to receive communist propaganda vary based on whether he'd requested the Peking Review or had just received it passively as part of a mass mailing? Does a listener's right change depending on whether he is an accidental recipient of the speech versus an earnest seeker? Does it matter if the information is tailored for and directed to the listener specifically, such as a therapy session, as opposed to a general book on therapy? This Article explores these questions in the telehealth context.

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70 *Id.* at 643–44 (Kozinski, J., concurring) (footnote omitted).

71 309 F.3d 629 (9th Cir. 2002).

72 564 U.S. 552 (2011).

73 *Id.* at 566–67.

74 *Id.* at 568–69.

75 *Id.* at 577.

## IV. Telehealth: A Case Study for Listeners' Rights

This Article examines telehealth regulations through the lens of listeners' rights with two aims: to strengthen First Amendment rights to telehealth and to explore a more robust vision of listeners' rights. Specifically, this Part addresses how listeners' rights help resolve three common hurdles to First Amendment challenges to professional-client speech regulation: (1) the speech-conduct distinction, (2) the content-neutrality problem, and (3) the deference given to the state's asserted interests when applying scrutiny.

### A. *Conduct or Speech? Let the Listener Weigh in*

Telehealth restrictions, like many other regulations of professional-client relationships, determine whether and what doctors may communicate to patients. Nonetheless, courts have often said that restrictions on professional-client communication deserve only mild scrutiny because any impact on speech is incidental to the regulation's true focus: conduct.[76]

The trial court in *McBride* took this route when resolving the First Amendment challenge to California's telehealth law.[77] Not once did the *McBride* court engage with the First Amendment rights of the patient to receive information vital to their welfare, perhaps even their survival.

The patient-plaintiff, Shellye Horowitz, has a rare blood disorder that requires all medical treatment she receives to be done in consultation with a hemophilia specialist.[78] The specialist closest to her lives in Oregon, and California telehealth regulations prevent the specialist's remote involvement in her care. If the court had considered Ms. Horowitz's rights, its erroneous holding regarding the speech-conduct distinction would have been harder to justify.

To be sure, cases like *Hines* and *Otto* present strong arguments against *McBride*'s speech-conduct holding under a more traditional First Amendment analysis. But a more robust and principled understanding of listeners' rights can strengthen the arguments made in *Hines*, *Otto*, and the dissent in *Tingley*.

First, a focus on the right to receive information reveals a paradox behind the speech-as-conduct approach taken by cases like *Tingley*: The listener receives *less* protection when the information is targeted at the

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[76] *See, e.g.*, Chiles v. Salazar, 116 F.4th 1178, 1208–09 (10th Cir. 2024); Tingley v. Ferguson, 57 F.4th 1072, 1074 (9th Cir. 2023); Order Granting Motion to Dismiss at 13, McBride v. Lawson, No. 2:24-cv-01394, 2024 WL 4826378, at *7–8 (E.D. Cal. Nov. 18, 2024).

[77] Order Granting Motion to Dismiss at 13, *McBride*, No. 2:24-cv-01394, 2024 WL 4826378, at *8 (E.D. Cal. Nov. 18, 2024).

[78] *Id.* at 2, 2024 WL 4826378, at *1.

listener, and *more* protection when the speech is addressed to the public at large. *Tingley* adopted a "continuum approach," where "'public dialogue' by a professional is at one end of the continuum and receives the greatest First Amendment protection," and speech that arises in the context of medical treatment is at the other end of the continuum where protections weaken.[79] Hence, a doctor who publicly advocates against COVID-19 vaccines for children under ten is fully protected, but if that doctor advises a pediatric patient to forgo a COVID-19 vaccine, he is not as protected.

The puzzling paradox of the Ninth Circuit's approach is that the strength of the *listeners'* interests moves in an opposite direction along this continuum. The Ninth Circuit, applying its continuum in *Tingley*, gave no thought for the rights of Tingley's patients, who had sought out Tingley's conversion-therapy methods.[80] Such patients who have approached a specific therapist regarding a deeply personal matter have, to say the least, a stronger interest than a random social media user who scrolls across Tingley's viewpoints on a feed.

To return to the vaccine example: If Dr. Smith advocates, on her personal X account, that children under ten shouldn't be vaccinated, listeners' interests in that viewpoint are diffuse and abstract. To be sure, X users have a right to see what Dr. Smith has to say, but the speech is not tailored and targeted toward a particular person. Yet the Ninth Circuit would give the physician speaker the most protection at this end of the continuum.

On the other end of the continuum, where the doctor's speech is least protected, the patient's right to receive information is most heightened. Imagine Dr. Smith posts her view on X that healthy children under ten shouldn't be vaccinated. She then holds a telehealth visit with a long-time pediatric patient and the patient's parents, who have just moved from Dr. Smith's state of Wyoming to California but want to stay with their pediatrician. Dr. Smith advises her patient's parents not to get their child a COVID-19 vaccine because the child is young and healthy.

Now imagine two California laws: one that forbids physicians from advising the public not to get vaccinated, and one forbidding physicians from consulting with California patients online without a California medical license. According to the Ninth Circuit, the first law would face strict scrutiny because it restricts Dr. Smith's speech at the most protective end of the continuum—public advocacy. The second law would face mere rational basis scrutiny, as it restricts Dr. Smith's speech at the opposite end of the continuum, where speech is considered treatment and therefore conduct.

But the continuum reverses flow when viewed from the listeners' perspective. Any given X user has a right to hear Dr. Smith's viewpoint, but

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[79] Tingley v. Ferguson, 47 F.4th 1055, 1072–73 (9th Cir. 2022) (quoting Pickup v. Brown, 740 F.3d 1208, 1227 (9th Cir. 2014)).

[80] *See id.* at 1067–68.

their interest is abstract and generalized. Compared to the X user's right to listen, however, the right of Dr. Smith's patient to receive information is more impacted by Dr. Smith's telehealth consultation, which is concrete, specific, targeted to the patient's circumstances and needs, and specifically sought after by the patient.[81] Perhaps most importantly, this direct, personalized communication is connected to the patient's individual welfare and even, in cases like Jun Abell's and Shellye Horowitz's, their survival. No X user's survival is likely to turn on Dr. Smith's 280-character posts to the general public about vaccination.[82]

In short, viewing the telehealth restriction at issue in *McBride* from the patient's right to receive information, the *Tingley* continuum reverses its flow—the First Amendment rights and interests of the patient have an inverse relationship to the First Amendment rights of the physician. Thus, because of *Tingley* and *McBride*'s failure to consider listeners' rights, the First Amendment protects least the speech that affects listeners' rights the most.

To be clear, this Article does not argue that Dr. Smith's X post about vaccines should receive the weak and perfunctory protections that *McBride* applied to telehealth visits. Rather, this Article argues that the continuum approach does not adequately protect the right to receive information, particularly when that right should be at its zenith, such as in private settings far from the public speech marketplace. Courts should at least apply a level of scrutiny higher than rational basis to telehealth restrictions to protect listeners' rights, even assuming that speakers' rights are less compelling in the professional-client context.

The *Tingley* continuum is also a poor fit with how patients use information technology. Patients can and do rely on AI tools and algorithmic search engines to seek and receive medical information. Indeed, laws like California's likely drive more patients to this brand of DIY health care.[83] As of 2013, 80% of internet users had searched for health information online.[84] Two-thirds of these users began by using a search

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81 *See* Transcript of Oral Argument at 97–104, TikTok Inc. v. Garland, No. 24-656 (U.S. Jan. 17, 2025) (Justice Barrett reasoning that a listener's interests are greater when "[they] have to specifically request this information" as opposed to coming across the information on social media).

82 *See* Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc., 425 U.S. 748, 763 (1976) ("As to the particular [pharmaceutical] consumer's interest in the free flow of commercial information, that interest may be as keen, if not keener by far, than his interest in the day's most urgent political debate.").

83 *See* Conant v. Walters, 309 F.3d 629, 643–44 (9th Cir. 2002) (Kozinski, J., concurring) (stating that legal restrictions on advising medical marijuana would drive patients to "poor substitutes for a medical doctor" like the internet).

84 *See* Peter J. Schulz & Kent Nakamoto, *Patient Behavior and the Benefits of Artificial Intelligence: The Perils of "Dangerous" Literacy and Illusory Patient Empowerment*, 92 PATIENT EDUC. & COUNSELING 223, 226 (2013).

engine.[85] Likewise, internet users can turn to artificial intelligence ("AI") tools for medical advice. If a patient uploads an x-ray image, blood test results, or a urinalysis into ChatGPT or a similar bot, the AI will eagerly offer its interpretation. If a patient describes symptoms, these bots will give a diagnosis (though it will likely also warn that it is not providing real medical advice, whatever good that does).

Whether search engine results and AI responses enjoy First Amendment protection is unclear.[86] Assume AI responses do not enjoy First Amendment protection and that the California Medical Board adopts a rule stating AI bots like ChatGPT that interpret medical images or test results are engaging in unlicensed medical practice. Cases like *Lamont* show that even if the speech does not itself enjoy First Amendment protection, the First Amendment independently protects the listeners' rights to receive that speech.[87] Hence, such a rule would likely violate the right to receive information.

Thus, the *Tingley* continuum results in *less* First Amendment protection for a patient in a telehealth visit with a real out-of-state practitioner—who also has free-speech rights—than for a patient in a medical conversation with an AI tool that may lack any free-speech right. This outcome is not only senseless, but also detrimental to patient welfare. The *Tingley* continuum fails to give listeners' rights their due course, and *McBride* and similar decisions err by holding that doctor-patient speech is less protected than a doctor's public advocacy.

The *McBride* court's argument that a doctor-patient consultation is no different than "hands-on treatment" and is therefore conduct also appears weaker when viewed through the eyes of the listener. From the listener's perspective, what courts label "conduct" is clearly speech. It does not alter or affect the patient's body—it simply arms the listener with information and is thus distinct from hands-on treatment.

In *McBride*, the court reasoned that both hands-on treatment and doctor-patient speech can cause substantial harm.[88] While true, of course, the Supreme Court has often declined to withdraw First Amendment

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85 *Id.*

86 *See generally* Eugene Volokh & Donald M. Falk, *Google: First Amendment Protection for Search Engine Search Results*, 8 J.L. ECON. & POL'Y 883 (2012) (concluding that Google and other search engines exercise editorial judgment, much like a newspaper or book publisher, about what information is relevant to a user's search, meaning First Amendment protections apply); Moody v. NetChoice, LLC, 144 S. Ct. 2383, 2394 (2024) (accepting that editorial choices made through algorithms are protected by the First Amendment).

87 *See* Lamont v. Postmaster Gen., 381 U.S. 301, 305 (1965).

88 *See* Order Granting Motion to Dismiss at 14–15, McBride v. Lawson, No. 2:24-cv-01394, 2024 WL 4826378, at *8.

protection just because—contrary to the children's rhyme—words can indeed hurt us.[89]

But consider these risks of harm from the perspective of listeners' rights. Unlike hands-on treatment, harm caused by doctor-patient speech is indirect and depends on the listener's agency.[90] Any harm from faulty advice turns on whether the listener accedes to the practitioner's judgment after engaging in their own information-seeking behavior, including seeking second opinions, AI tools, internet research, and so on. This speech marketplace is the First Amendment's primary answer to the harmful effects of faulty information.[91]

Recognizing a right often means deferring to the agency and assumptions of risk made by the right-holder. This is especially true of the First Amendment, where courts' long-standing tradition is to allow the free spread of information and let listeners do with that information what they will.[92] This does not leave the state helpless to deal with harmful information; the state can respond to speech it deems harmful with the storied instrument of its own counter-speech.[93] This is a vital distinction between hands-on treatment and information about treatment: The state cannot easily interject itself into ongoing hands-on treatment, but it can influence the health information marketplace with its own public information campaigns, informed-consent requirements, and disclosure. This approach has the triple virtue of respecting the listeners' right to receive information, enhancing listeners' interests by spoiling them with more information, and promoting the state's interest in public health and safety.

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89 *See* Snyder v. Phelps, 562 U.S. 443, 460–61 (2011) ("Speech is powerful. It can stir people to action, move them to tears of both joy and sorrow, and—as it did here—inflict great pain. On the facts before us, we cannot react to that pain by punishing the speaker. As a Nation we have chosen a different course—to protect even hurtful speech on public issues to ensure that we do not stifle public debate.").

90 Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc., 425 U.S. 748, 770 (1976) ("[I]nformation is not itself harmful . . . ."). This could be a meaningful distinction between talk therapy, which is often an end in itself that might harm a patient of its own accord, and doctor-patient consultation, which depends on the agency of the listener. *See* Tingley v. Ferguson, 47 F.4th 1055, 1063–64 (9th Cir. 2022).

91 Citizens United v. FEC, 558 U.S. 310, 361 (2010) ("[I]t is our law and our tradition that more speech, not less, is the governing rule.").

92 *See Va. State Bd. of Pharmacy*, 425 U.S. at 773.

93 *See* Whitney v. California, 274 U.S. 357, 377 (1927) (Brandeis, J., concurring) ("If there be time to expose through discussion the falsehood and fallacies, to avert the evil by the processes of education, the remedy to be applied is more speech, not enforced silence."), *overruled on other grounds by* Brandenburg v. Ohio, 395 U.S. 444 (1969).

### B. *Content Neutrality and Listeners*

A law is content-based if it "target[s] speech based on its communicative content."[94] Yet, under prevailing First Amendment doctrine, the test for what is content-based is murky. Laws that target speech based on its "function or purpose" may be content-based, but not always.[95] And if courts must examine speech to determine whether a given law applies to that speech, that indicates—but does not prove—that the law is content-based.[96]

As mentioned above, courts that do not reject challenges to doctor-patient speech restrictions through the speech-as-conduct rationale have sometimes done so instead through content neutrality.[97] *Brokamp*, for instance, held that a restriction on out-of-state online talk therapy was content-neutral because the speech restriction was triggered by "speech having a particular purpose, focus, and circumstance," not what was said.[98]

As with the speech-as-conduct conundrum, analyzing listeners' rights and interests in the telehealth context can help resolve the content-neutrality question. Courts apply strict scrutiny to content-based laws to prevent laws from driving certain subjects or topics from the marketplace.[99] A focus on the patient's rights and interests as a listener shows that laws restricting online professional-client communication drive out certain speech content from the market and thus warrant strict scrutiny.

Patients meet with physicians for content-based reasons. Jun Abell's father did not call every oncologist in the country to hear them expound on any topic of the physician's choosing. Shellye Horowitz is not spending time and money to travel and disclosing private information to hear whatever her hemophilia specialist may have to say about the issues of the day. The patient's purpose is to seek out specific content. Restrictions on that effort are therefore content-based.

The online-counseling law in *Brokamp* and the telehealth laws in states like New Jersey apply in a specific scenario—where the professional, such as a doctor or therapist, is offering targeted and personalized advice or expert knowledge to a specific patient unique to that patient's circumstance and needs.[100] By its nature, such speech is unique—tailored

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94 Reed v. Town of Gilbert, 576 U.S. 155, 163 (2015).

95 City of Austin v. Reagan Nat'l Advert. of Austin, LLC, 596 U.S. 61, 74 (2022).

96 *Id.* at 75–76.

97 *See supra* Section II.C.

98 Brokamp v. James, 66 F.4th 374, 393 (2d Cir. 2023).

99 R.A.V. v. City of St. Paul, 505 U.S. 377, 387 (1992).

100 *See Brokamp*, 66 F.4th at 383 (acknowledging that mental health counseling, which triggers the in-state license requirement, is based on the individual circumstances of the patient); Order Granting Motion to Dismiss at 14, McBride v. Lawson, No. 2:24-cv-01394, 2024 WL 4826378, at *8

and designed to the needs of the client. Indeed, the client has selected the particular professional for this personalized content, not to hear the professional talk in generalized terms or pontificate on any topic of their choosing.

If a physician and patient cannot meet virtually because the physician lacks an in-state license, then unique speech content related to the patient and their needs is driven from the speech marketplace. Doctors can still meet with in-state patients, but the advice given will not contain the same content because other patients have other needs. And patients can seek in-state doctors, but—once again—the specific content that the patient had a right to receive will not be the same, because other doctors do not have the identical perspective, training, and experience as the out-of-state doctor the patient would have otherwise chosen. Shellye Horowitz's hemophilia specialist has unique content to share that other California physicians do not, which is a key reason she sought out-of-state medical care. The heightened scrutiny for content-based laws exists to prevent the exclusion of certain speech content from the marketplace, which is just what telehealth restrictions like New Jersey's do.[101]

In short, a focus on listeners' rights in a doctor-patient context clarifies in two related ways how regulating that relationship is content-based: (1) the patient wants to hear this speech for its specific content, and (2) the telehealth law drives specific content from the speech marketplace because the speech is unique to the circumstances of the patient.

### C. *Listeners' Rights and Application of Scrutiny*

The focus on listeners' rights confirms that telehealth laws like those in *McBride*—and similar laws regulating professional-client speech—must satisfy strict scrutiny. And a focus on listeners' rights also helps to reveal that telehealth restrictions and laws like them are unlikely to survive intermediate or strict scrutiny.

Laws governing telehealth and similar professional-client interactions tend to be defended as necessary to protect the patient or client. In *Tingley*, *Brokamp*, and similar cases, states restricted therapists' speech to protect the public against psychological harms.[102] California likewise defended its telehealth restriction in *McBride* as preventing harm to patients that may result from telehealth advice given in "a

(the discussion of symptoms and diagnoses, which are unique to each patient, is a "core component of medical practice" and therefore triggers the telehealth restriction).

101 *See* Transcript of Oral Argument at 138, TikTok Inc. v. Garland, No. 24-656 (U.S. Jan. 17, 2025) (Justice Alito arguing that a law preventing a specific person from speaking is necessarily either content-based or viewpoint-based even if the content of that speech is unknown).

102 Tingley v. Ferguson, 47 F.4th 1055, 1065 (9th Cir. 2022); *Brokamp*, 66 F.4th at 398; Otto v. City of Boca Raton, 981 F.3d 854, 859 (11th Cir. 2020).

professionally incompetent manner because they lack sufficient qualifications."[103]

While understandable, the concerns for patient welfare look less compelling as rationales for restricting speech when viewed through the lens of a patient's right to receive information. Consider, for example, how the focus on listeners and patients in *Virginia State Board of Pharmacy* affected the Supreme Court's analysis of the law banning the advertising of drug prices. The only plaintiffs in that case were patients asserting their right to receive information. The Court adapted its application of scrutiny to that specific right. The Court noted the "highly paternalistic" treatment of listeners who are barred from accessing information.[104] When focused on listeners' rights, the Court rejected the state's approach of keeping people in the dark for their own good, reasoning that a more narrowly tailored law would "assume that this information is not in itself harmful, that people will perceive their own best interests if only they are well enough informed, and that the best means to that end is to open the channels of communication rather than to close them."[105]

By contrast, viewed from the speaker's perspective—the pharmacist who wants to advertise drug prices—the case looks like a speech right pitted against the welfare of the consumer. But viewed from the listener's perspective, laws barring access to information become more suspect.

Telehealth restrictions like California's suffer from the same paternalism. Indeed, in the telehealth context the listener's right against such enforced blindness seems even more compelling. Unlike the pharmaceutical customers in *Virginia State Board of Pharmacy*, telehealth patients specifically seek out speech from a particular practitioner who addresses their unique circumstances. Indeed, as in the case of Jun Abell's parents, a patient's effort to find an out-of-state practitioner likely indicates a determined attempt to communicate with a specific physician regarding a matter vital to the patient's welfare or survival. By contrast, drug prices are communicated to the public at large, not tailored to any particular listener, and accessible to listeners without significant effort. Telling a patient who has invested effort to connect with a specific doctor about a specific problem that the state is stopping them for their own good is an even more overweening exercise of control than a law banning access to drug price information.

The state can still protect against fraud, predatory behavior, and quackery without infringing listeners' rights. Direct solicitation and general advertising by telehealth providers, for example, may be a possible

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103 Order Granting Motion to Dismiss at 14–15, *McBride*, No. 2:24-cv-01394, 2024 WL 4826378, at *8.

104 Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc., 425 U.S. 748, 770 (1976).

105 *Id.*; *see also* 44 Liquormart, Inc. v. Rhode Island, 517 U.S. 484, 503 (1996) ("The First Amendment directs us to be especially skeptical of regulations that seek to keep people in the dark for what the government perceives to be their own good.").

source of concern for either fraud or other malfeasance. The listeners' rights theory proposed here argues that listeners' rights are stronger where the listener has initiated the relationship. While listeners' rights are still implicated in general advertising,[106] the theory proposed here would not upset the longstanding intermediate scrutiny standard applied against solicitation and advertising.

Disclosure requirements can also satisfy state interests in protecting patients who meet with telehealth practitioners. Indeed, medical profession regulations often require disclosures that ensure informed consent and are "firmly entrenched in American tort law."[107] States might require disclosure regarding where a telehealth practitioner is licensed, any enforcement actions against the practitioner, medical education, and so on.

Of course, not all telehealth interactions are the same. The state's case for paternalistic control over information may shift depending on the type of care that might be occurring via telehealth—such as analysis of imaging, diagnosis, or consultation.

This Article does not address all these situations individually, but to offer one example: A state might make a stronger case for demanding in-state licensing or a direct physical examination requirement when a physician offers a diagnosis, rather than advises a patient on treatment options post-diagnosis. A diagnosis, after all, carries with it a wide array of direct consequences, such as insurance eligibility, medical prescriptions, and access to specialized care. It may also be more difficult for the state to use disclosures and information campaigns to guard against incorrect diagnoses.

Meanwhile, consultations where a patient and physician explore treatment options may be tougher to justify. The state may have more opportunities to inject its own views about the viability or safety of certain forms of treatment, and any harm caused by bad information is less direct, contingent upon the patient's agency.

Such nuances demonstrate some need for as-applied adjudication of First Amendment challenges to doctor-patient speech restrictions. Regardless, it should be the state's burden to demonstrate that hindering a patient's right to receive information staves off a serious harm in a narrowly tailored manner. For good reason, that would not be an easy burden to carry.

## V. The Right to Listen Is Not a Regulatory Death Knell

The listeners' rights theory proposed here might raise the concern that it will handcuff states pursuing their police powers to address public

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106 *See, e.g.*, *Va. State Bd. of Pharmacy*, 425 U.S. at 756–57.

107 *See* Cruzan *ex rel.* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 269 (1990).

health and safety. While this Article cannot anticipate or address every counterargument or concern, it will attempt to address two here: (1) Do robust listeners' rights undermine medical licensing by allowing patients to select any medical professional, licensed or not? and (2) How does this rule apply to other licensed professions?

### A. *Will Listeners' Rights Destroy the States' Power to Limit Medical Practice to Licensed Professionals?*

Granting patients a right to receive medical advice via telehealth from out-of-state practitioners would not render medical boards helpless to prevent any unlicensed quack from offering medical advice.

A recognition of a listener's right to receive information does not deny entirely the state's interest in protecting patients from bad information. It does, however, place the onus on the state to demonstrate that its burden on listeners' rights alleviates a substantial risk of harm in a tailored way. In the case of a wholly unlicensed medical practitioner, the state can demonstrate with some ease that it has a compelling interest in ensuring medical practitioners meet a minimum standard of competency, and that preventing wholly unlicensed care is tailored to achieve that end.

The state might have greater difficulty, however, in demonstrating that preventing a patient from consulting with a physician licensed in another state satisfies First Amendment scrutiny. If a patient meets with a physician licensed in a different state, then the state might carry its burden under the First Amendment with evidence that the other state's licensing standards are not adequate to protect the patient. Other factors that could affect this analysis might include: Are there specialists licensed in the state qualified to treat the patient? Is the doctor-patient relationship long-lasting or unique in some respect (such as a familial relationship or cultural or linguistic connection)? Does the out-of-state physician enjoy admitting privileges at an accredited hospital? Is the physician insured? How long have they been practicing? Are there pending disciplinary actions taken by a licensing board against the physician? Such questions could bear on whether the state has satisfied its First Amendment burden.

This assumes that the First Amendment applies, but there are also possible exceptions to the right to listen, just as there are exceptions to the right to speak. Such exceptions could apply in some licensing contexts. The right to speak is qualified by exceptions such as speech that is likely to provoke an immediate violent response or that is designed and likely to incite imminent lawless action.[108] True threats, obscenity, fraud, defamation, and an assortment of other brands of speech either enjoy no

[108] Chaplinsky v. New Hampshire, 315 U.S. 568, 573–74 (1942); Brandenburg v. Ohio, 395 U.S. 444, 448–49 (1969).

First Amendment protection or far less than core protected expression. Granted, these exceptions are all quite narrow.

Given the underdeveloped state of the right to receive information, the existence of similar exceptions to the right to listen is unclear. However, some possible exceptions could allow the state to play a regulatory role. For instance, some recognized exceptions to the freedom to speak likely have a mirrored counterpart regarding the right to receive information. There is probably no right to receive defamatory information, for instance. Similar exceptions could exist to prevent fraud or coercion. The exceptions meant to forestall serious violence could also hint at a corollary exception for the right to receive information that limits some speech that, if heard, could cause direct, serious harm. That exception, though, should be quite narrow, like the narrow exceptions for incitement and threats in the context of the right to speak.

Finally, listeners' rights do not inhibit the state's licensing and regulatory apparatus regarding conduct. Just as with the right to speak, a constitutional distinction remains between "'treatments . . . implemented through speech' and those implemented 'through scalpel.'"[109] While this Article advocates for removing pure speech from the category of treatment, some regulations do genuinely regulate conduct with incidental effects on speech, and such regulations would not face heightened scrutiny under a robust right to listen. Requiring an in-state license to perform a colonoscopy, for instance, might have an incidental effect on speech because that procedure involves some communication, such as instructing the patient to refrain from eating solid food before the procedure. But a patient cannot call upon the right to receive such instructions (speech) as a justification for seeking a colonoscopy (conduct) from a practitioner licensed in another state.[110]

Nor would the right to receive information foreclose states from regulating online prescription practices, even if writing a prescription is a speech act. Prescribing medication is an act of independent legal effect, and the exercise of that authority can be conditioned by the state without affecting First Amendment rights.[111]

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[109] Tingley v. Ferguson, 57 F.4th 1072, 1075 (9th Cir. 2023) (O'Scannlain, J., respecting the denial of rehearing en banc) (ellipsis in original) (quoting Tingley v. Ferguson, 47 F.4th 1055, 1064 (9th Cir. 2022)).

[110] Giboney v. Empire Storage & Ice Co., 336 U.S. 490, 502 (1949) ("[I]t has never been deemed an abridgment of freedom of speech or press to make a course of conduct illegal merely because the conduct was in part initiated, evidenced, or carried out by means of language, either spoken, written, or printed.").

[111] *See* Conant v. Walters, 309 F.3d 629, 635–36 (9th Cir. 2002) (distinguishing between recommending a drug—speech protected by the First Amendment—and prescribing a medication, a legally significant act outside of First Amendment protection).

### B. *Application of Listeners' Rights Outside the Medical Context*

A strong indication of a sound theory is whether it stands up when exported to a different context. The model of listeners' rights explored here would not upend longstanding regulations of other "talking professions" such as attorney-client communication.

If a patient has a First Amendment right to meet with an out-of-state physician via telehealth, that does not mean a party has a right to receive legal advice from an out-of-state attorney. The speech-conduct dichotomy and the content-neutrality analyses discussed above would seem to apply to attorney-client communication.[112] Just as with a doctor-patient communication, the listener does not experience the interaction as conduct, but as speech. And the tailored, content-specific nature of the conversation renders regulation of that communication content-based.

Thus, this Article's theory of listeners' rights would likely mean that First Amendment scrutiny applies to regulation of attorney-client speech. That scrutiny might be more deferential than in the doctor-patient context because—right or wrong—attorney speech has been deemed a unique area of state concern "since lawyers are essential to the primary governmental function of administering justice, and have historically been 'officers of the courts.'"[113]

And, whatever the level of scrutiny, there seems to be a more compelling rationale for distinguishing between in-state and out-of-state practitioners in the attorney-client speech context. State jurisdictions, after all, are distinct, prompting the need for state-specific expertise. The distinction between out-of-state and in-state physicians, on the other hand, seems less justified: Illness does not vary by state.

Further, listeners' rights would not imperil state bar requirements that only state-barred attorneys may carry out the actual practice of law in the state. Filing motions and appearing in court are, much like prescribing medicine, actions endowed with a special legal significance, and they extend beyond a listener simply gathering information.

But the legal and medical professions are not the only licensed professions that might be affected by the theory proposed here. Some other licensed professions, such as therapy, have a strong speaker-listener dynamic. As discussed above, the theory proposed here would apply to talk therapy.[114] While I am skeptical of regulation of talk therapy, the state might be able to make a stronger case to satisfy strict scrutiny in the context of therapy, since in this setting the talk *is* the treatment—and the state's theory, at least in the conversion therapy context, is that the harm

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112 *See supra* Sections IV.A, IV.B.

113 Goldfarb v. Va. State Bar, 421 U.S. 773, 792 (1975) (citing Sperry v. Florida *ex rel.* Fla. Bar, 373 U.S. 379, 383 (1963)).

114 *See supra* notes 50–53, 79–80 and accompanying text.

flows directly from the speech. Thus, just as the state may be able to carry its burden of showing direct harm from therapeutic practices, it may be able to override listeners' rights where other speech content causes direct harm, as opposed to harms caused when listeners act on faulty information.

Other licensed professions that consist mostly of speech could also include jobs like tour guides, for which some major cities require a license.[115] Here, the right to speak is likely satisfactory to strike down such laws, without a need to resort to the right to receive information.[116] But if courts were to resort to that right, the state would lack a compelling rationale for preventing someone from listening to the tour guide of their choice.

## Conclusion

The First Amendment is about more than the public's interest in free discourse. It is also about protecting the right to intensely private and personal speech—speech that could save the listener's life. Patients thus have a right to seek out information vital to their own welfare, whether that information comes from a doctor on a screen or a doctor in person. The time has come to honor listeners' rights.

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115 *See* Angela C. Erickson, *Putting Licensing to the Test: How Licenses for Tour Guides Fail Consumers—and Guides*, INST. FOR JUST., at 3 (2016), https://perma.cc/BL7M-ADPZ.

116 *See* Billups v. City of Charleston, 961 F.3d 673, 676–77 (4th Cir. 2020) (striking down a local ordinance requiring paid tour guides to obtain a license).