No. 16-1140

In the Supreme Court of the United States

NATIONAL INSTITUTE OF FAMILY AND LIFE ADVOCATES, dba NIFLA, *et al.*,
Petitioners,

v.

XAVIER BECERRA,
Attorney General of California, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF AMERICAN MEDICAL ASSOCIATION, *AMICUS CURIAE*, IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

The certified question is whether the disclosures required by the California Reproductive FACT Act violate the protections set forth in the Free Speech Clause of the First Amendment, applicable to the States through the Fourteenth Amendment.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

CONSTITUTIONAL PROVISIONS

STATUTES

OTHER AUTHORITIES

IDENTIFICATION AND INTEREST OF *AMICUS CURIAE*[1]

The AMA is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all US physicians, residents and medical students are represented in the AMA's policy making process. AMA members practice in every state and in every medical specialty. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes.

The interests of the AMA in this case are three-fold. First, the AMA has an interest in ensuring that physicians can care for their patients to the best of their abilities, without undue interference from governmental bodies. In this regard, the AMA seeks to impose a judicial barrier against laws which, under the pretext of patient protection, seek to advance the government's political objectives at the expense of unfettered communications between physicians and patients. Second, the AMA has an interest in ensuring that physicians, like all Americans, can enjoy the right to speak—or not to speak—without government constraints arising from partisan objectives. Third, the AMA has an interest in ensuring that physicians

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[1] The parties have consented to the filing of this brief. No party's counsel authored this brief in whole or in part. No party or counsel for a party made a monetary contribution intended to fund the preparation or submission of the brief. No person other than the AMA made a monetary contribution.

practice ethically, without misleading their patients as to their medical conditions in order to satisfy what the physicians profess to be their personal moral or religious beliefs.

SUMMARY OF ARGUMENT

Most free speech cases start, as did the courts below and does the brief of petitioners at pp. 20-46, with a determination of the level of scrutiny to be applied to the speech in question. One of the petitioners in this case, Pregnancy Care Clinic (PCC), a licensed medical facility, utilizes physicians to provide medical services. Brief for Petitioners at 5-6. In somewhat perfunctory fashion, this brief begins by agreeing with petitioners that PCC is entitled to strict scrutiny of the Reproductive FACT Act.

Then the brief moves to the heart of the matter. The Court's decision should not be cabined within the confines of these specific parties and this specific statute. Too much is at stake – for legislatures and the lower courts, for physicians, and most importantly for patients. This Court should adopt a " rule of thumb" to clarify the law for the cases (at least the most difficult cases) involving physician speech: *viz*., any law that restricts or compels physician speech and is targeted toward a matter of general public debate should be subjected to strict scrutiny. This proposed rule will protect Freedom of Speech without unduly infringing on governments' interest in properly regulating health care. Laws that regulate physician speech but do not target matters of general public debate would simply fall outside the rule of thumb and would be addressed by other aspects of Free Speech jurisprudence.

Finally, the brief concludes, based on the statements made on the PCC website and in its Brief to this Court, that the physicians at PCC appear to be practicing medicine unethically – thus establishing a compelling reason for the State of California to require PCC's adherence to the Reproductive FACT Act.

Accordingly, the lower courts here should be affirmed, albeit that the AMA believes some of their reasoning was faulty and should be disapproved.

As for the petitioners other than PCC, this brief takes no position.

ARGUMENT

I. As Applied to Pregnancy Care Clinic, the Reproductive FACT Act Should be Subjected to Strict Scrutiny.

At pp. 20-46 of their brief, petitioners, including PCC, argue that, as applied to them, the Reproductive FACT Act should be subjected to strict scrutiny. The AMA does not necessarily agree with petitioners' full chain of reasoning, but the AMA does agree with the conclusion. Nothing would be gained by a detailed critique of that reasoning, as it would not change the end result.

II. Any Law that Restricts or Compels Physician Speech and is Targeted Toward a Matter of General Public Debate Should be Subjected to Strict Scrutiny.

The AMA now moves to the heart of the matter – from the AMA viewpoint. We urge this Court to adopt the following rule: any law that restricts or compels

physician speech and is targeted toward a matter of general public debate should be subjected to strict scrutiny.

As used here, a matter of general public debate is one in which members of the general public commonly take positions. The prime example of a publicly debated issue leading to regulation of physician speech is whether abortions should be legal and, since they are, to what extent should the state weigh in to support either "right to life" or "freedom of choice." But government laws and policies have affected (and may in the future affect) physician speech in publicly debated areas that are divorced from the abortion context.

Thus, laws have restricted physicians from advising patients about the use of contraceptives, *Poe v. Ullman*, 367 U.S. 497 (1961), penalized physicians if they have discussed possible medicinal benefits of marijuana with their patients, *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002), and restricted pediatricians from making routine inquiries of parents about possession of unsecured firearms in their homes, *Wollschlaeger v. Governor of the State of Florida*, 848 F.3d 1293 (11th Cir. 2017) (*en banc*) (*Wollschlaeger IV*).[2] It is

[2] An Eleventh Circuit panel issued multiple decisions in the same case and on the same issue. *Wollschlaeger v. Governor, Florida*, 760 F.3d 1165 (11th Cir. 2014) (vacated and superseded) ("*Wollschlaeger I*"), *Wollschlaeger v. Governor, Florida*, 797 F.3d 859 (11th Cir. 2015) (vacated and superseded) ("*Wollschlaeger II*"), and *Wollschlaeger v. Governor, Florida*, 814 F.3d 1159 (11th Cir. 2015) ("*Wollschlaeger III*"), before the court, sitting *en banc*, finally held three provisions of the Florida Firearm Owners' Privacy Act to be a violation of physicians' Free Speech. *Wollschlaeger v.*

conceivable, too, that a law might require or forbid physicians who examine junior high school students to expound or refrain from expounding on the advantages and disadvantages of playing football. *See Wollschlaeger IV*, 848 F.3d at 1329 (Pryor, J., concurring) (commenting on "the number of highly controversial topics that doctors [might] discuss as a direct part of their medical responsibilities").

By contrast, the general public, as a rule, would be unlikely to take a position regarding a law that requires an emergency room physician to notify the police department (or forbids such notification) if a patient presented with a gunshot wound. Likewise, the general public would be unlikely to take a position on a law that requires physicians to maintain the confidentiality of patients' medical records, 38 U.S.C. § 7332, or that fines physicians who neglect to notify their patients if a mammogram has been performed improperly, 42 U.S.C.A. § 263b(h)(2). While it is certainly possible that such matters could, in some unusual circumstance, rise to the level of a public debate, in general they would not. These run-of-the-mill laws might or might not, depending on the specifics, violate Freedom of Speech. At least superficially, though, these laws would not suggest government co-opting of physician/patient communications, and they would fall outside this proposed rule of decision.

Governor, Florida, 848 F.3d 1293 (11th Cir. 2017) (*en banc*) ("*Wollschlaeger IV*").

A. The Present Judicial Standards Employed to Protect Physician Speech are Confused and Often at Odds with the Values of a Free Society.

This Court has never established a general standard for First Amendment scrutiny of physician speech. *Wollschlaeger IV*, 848 F.3d at 1325 (Wilson, J., concurring). However, in *Thornburgh v. American College of Obstetricians and Gynecologists*, Justice White and Chief Justice Rehnquist opined that laws regulating physician speech should be accorded rational basis deference. 476 U.S. 747, 800-804 (1986) (White, J., dissenting). They argued that state governments, as part of their general police power, may impose such regulations on the medical profession as the legislatures may deem appropriate for the protection of the public, including restrictions on or compulsion of physician speech with patients. *Id.* To drive the point home, they stated: "[N]othing in the constitution indicates a preference for the liberty of doctors over that of lawyers, accountants, bakers, or brickmakers." *Id*. at 803.

The cases cited at pp. 10a – 12a of *Scharpen Foundation, Inc. v. Harris*, the California Superior Court opinion appended to Petitioners' Brief, illustrate the conflicting standards the courts have used to scrutinize laws that regulate physician speech, specifically on the topic of abortions. Thus, *Texas Medical Providers v. Lakey*, 667 F.3d 570 (5th Cir. 2012), and *Planned Parenthood of Minnesota, North Dakota, South Dakota v. Rounds*, 530 F.3d 724 (8th Cir. 2008), approved laws that compelled speech by abortion providers, based on a rational basis standard of review.

However, *Stuart v. Camnitz*, 774 F.3d 238 (4th Cir. 2014), invalidated a state law that compelled speech by abortion providers, based on intermediate scrutiny, and *Evergreen Association v. City of New York,* 740 F.3d 233 (2d Cir. 2014), invalidated a municipal ordinance that compelled speech by pro-life pregnancy service centers, based on either intermediate or strict scrutiny. And of course, the district court and the court of appeals disagreed on the proper level of scrutiny for this case. *See Nat'l Inst. of Family & Life Advocates v. Harris,* No. 15CV2277 JAH(DHB), 2016 WL 3627327 at *7 (S.D. Cal. Feb. 9, 2016); *Nat'l Inst. of Family & Life Advocates v. Harris,* 839 F.3d 823, 839 (9th Cir. 2016). This was not because of a misconstruction of a definitive ruling of this Court. Rather, it was because a definitive ruling does not exist.

The confusion does not end, though, with abortion cases. *Wollschlaeger I* applied rational basis scrutiny and *Wollschlaeger II-IV* applied intermediate scrutiny to evaluate the Florida Firearm Owners' Privacy Act. In a concurrence to *Wollschlaeger IV*, Judge Wilson opined that the Florida law should be examined under strict scrutiny. 848 F.3d at 1323-1325 (Wilson, J., concurring). As another example, *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002), applied strict scrutiny to invalidate a Justice Department policy that would have penalized physicians for educating their patients about the medicinal values of marijuana.

The laws at issue in these cases had a common theme: governmental bodies attempted to restrict physician speech in order to further a thinly disguised political or non-medical social agenda. These laws claim justification under a veneer that the government

– not physicians – knows what is best for patients. But such paternalism stands against the virtues of free discourse, as embodied in the First Amendment. *Riley v. Nat'l Fed'n of the Blind of N.C., Inc.,* 487 U.S. 781,791 (1988). Physicians should not lose their right to communicate freely with their patients because the physicians may explicitly or implicitly converse with their patients on matters contrary to a political position preferred by the government. "A society that tells its doctors under pain of criminal penalty what they may not tell their patients is not a free society. Only free exchange of ideas and information is consistent with a 'civilization of the dialogue.'" *Poe v. Ullman*, 367 U.S. 497, 515 (1961) (Douglas, J., dissenting).

B. Rather than Approach the Issue Incrementally, the Court Should Articulate a Rationale for its Decision that will Extend Beyond the Facts of this Case.

This Courts' efforts to balance individuals' abortion rights against governments' interest in protecting and encouraging potential human life have created a rich body of judicial precedent. It would serve no purpose to enumerate the extensive case law in this area, and the AMA will not attempt it. The case at bar, however decided, will add another link to this long chain.

Obviously, medical care extends far beyond the provenance of abortions. If the decision in this case is framed narrowly, then abortion jurisprudence will gain yet more weight, but broader concerns of personal liberty will go unaddressed. It is appropriate that physician communications to patients, whether or not centered on the right to obtain an abortion or on the

fetal development of potential human life, be accorded the highest level of First Amendment scrutiny when such communications concern matters of general public debate.

Communications between physicians and patients should receive "robust First Amendment protection." Rodney A. Smolla, *Professional Speech and the First Amendment,* 119 W. VA. L. REV. 67, 68 (2016). The doctor-patient relationship inherently requires complete confidence and trust. American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics, *Current Opinions* (2017): Opinion 1.1.1—Patient-Physician Relationships, *available at* https://goo.gl/qKXwA6 ("Successful communication in the patient-physician relationship fosters trust and supports shared decision making") and Opinion 2.1.3—Withholding Information from Patients, *available at* https://goo.gl/q1bpt8 ("Truthful and open communication between physician and patient is essential for trust in the relationship and for respect for autonomy").[3] The role of physicians is not

[3] The *AMA Code of Medical Ethics* is the most widely respected standard for ethical medical conduct in the United States. It has been frequently cited in this Court. *E.g. Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S.Ct. 2566, 2611 (2012) (Ginsburg, J., concurring in part and dissenting in part); *Baze v. Rees*, 553 U.S. 35, 64 (2008) (Alito, J., concurring); *Gonzales v. Oregon*, 546 U.S. 243, 286 (2003) (Thomas, J., dissenting); *Ferguson v. City of Charleston*, 532 U.S. 67 (2001); *Vacco v. Quill*, 521 U.S. 793, 801 (1997); *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997); *Cruzan v. Dir., Missouri Dep't. of Health,* 497 U.S. 261 (1990); *Bates v. State Bar of Ariz.*, 433 U.S. 350, 369-370, n. 20 (1977); *Roe v. Wade*, 410 U.S. 113, 144 n. 9 (1973).

only to treat ailments; it is also to educate patients so they can be proactive in their own healthcare.

If physicians must tailor their speech to accommodate a political restriction, patients will know their doctors are no longer candid and the quality of medical care will erode, potentially with dire consequences. "[I]n the fields of medicine and public health, information can save lives." *Sorrell v. IMS Health Inc*., 564 U.S. 552, 556 (2011).

Moreover, patients might simply forego necessary medical treatment on account of distrust of their physician. Doctor visits can be stressful and uncomfortable. Regardless of their objective needs, many people will, perhaps unconsciously, rationalize their avoidance of medical care. Government imposed barriers to an effective physician-patient relationship stifle public health. If those barriers arise from the government's political purposes, they can be just as pernicious to the social fabric as the classic Free Speech violation – a law restricting a challenge to government policy at a public forum.

The AMA recognizes that judicial restraint usually commands that the Court's rulings be limited to the facts before it. In most circumstances, the courts can develop their jurisprudence on a case by case basis, without extraordinary repercussions. This situation, though, is different, because it concerns speech between patients and physicians, a critical element of health care. As stated in *Trammel v. United States*, "a physician must know all that a patient can articulate in order to identify and to treat disease; barriers to full disclosure would temper diagnosis and treatment." 445 U.S. 40, 51 (1980). The confused legal doctrine in this

area will almost certainly disrupt necessary care, and its consequences could be even more pernicious. Physicians' jobs are hard enough without laws that force them to think twice about providing – or not providing – information that may save lives. *Wollschlaeger II*, 797 F.3d at 933 (Wilson, J., concurring).

In the viewpoint of the AMA, speech between patients and physicians fills a different role in American society than does the discourse between brickmakers and their customers.

C. The Proposed Rule of Decision is the Right One.

This Court should balance the principles of First Amendment freedoms against the state's interest in enacting routine regulations to protect public health. The "right" rule of decision should prevent governments from imposing censorship under claims of beneficence. The objective is not to suppose that government restrictions on physicians will always be used for invidious, thought-control purposes. Rather, the objective should be to root out laws that lend themselves to such purposes. *Reed v. Town of Gilbert*, 135 S. Ct. 2218, 2229 (2015). At the same time, the rule should distinguish those laws that ought not to trigger First Amendment concerns.

To illustrate why the AMA believes its proposed rule of decision[4] is the right one, it may help to consider

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[4] Again, the proposed rule would be that any law which restricts or compels physician speech and is targeted toward a matter of general public debate should be subjected to strict scrutiny.

a specific issue – the need for informed consent. The general legal requirement that physicians explain the likely benefits and hazards of any significant medical procedure to their patients before providing treatment has been long recognized as a basic element of medical practice. Code of Medical Ethics *supra*, at Opinion 2.1.1—Informed Consent, *available at* https://goo.gl/i4kWwB ("Informed consent to medical treatment is fundamental in both ethics and law"). No special justification should be required for a law that articulates the basic standard for informed consent.

Furthermore, a medical board regulation that might adopt informed consent guidelines of a specialty medical society for a procedure in which that society has established expertise should, in general, raise no judicial eyebrows. Even if there were debate confined to the medical community as to whether that regulation was wise, it should not affect the constitutional analysis. The likelihood of government coopting of physician speech for partisan purposes in such a situation would be minimal, and the legal system should not be burdened by such a slim likelihood of a Free Speech encroachment.

However, a law that would require an extraordinary discussion – beyond normal medical practice – of the possible side effects associated with a measles vaccination should require strict scrutiny. What is the compelling interest in requiring such a detailed explanation to the patient? Whatever that compelling interest may be, could it be accomplished through some less intrusive means? What should send up a red flag in such a situation is that, wisely or unwisely,

vaccinations of children have become a matter of public debate.

While this Court should do nothing to stifle public debate, the proponents of a particular side in the debate should not be allowed to advance their position by burdening the communications between physicians and those patients who seek only competent medical care according to established professional standards. It is not that a law restricting physician speech in an area of general public debate is necessarily unconstitutional; it is that the likelihood of censorship is high. Speech on matters of public concern is at the heart of the First Amendment's protection, *Snyder v. Phelps*, 562 U.S. 443, 452 (2011), and in such matters patients should enjoy the full and unvarnished benefit of whatever information their physician may be able to provide them.

But what about intermediate scrutiny or some other, lower level of judicial analysis—would that do the trick? The answer is maybe, sometimes. Ultimately, the resolution depends on this Court's judgment as to the importance of protecting physician-patient speech from political hijacking. The AMA's position on this issue is clear and so, we think, is the position of Justice Douglas:

> The right of the doctor to advise his patients according to his best lights seems so obviously within First Amendment rights as to need no extended discussion … Leveling the discourse of medical men to the morality of a particular community is a deadening influence ... These are [the doctor's] professional domains into which

the State may not intrude. *Poe*, 367 U.S. at 513-515 (Douglas, J., dissenting).

III. The State of California has a Compelling Interest in Mitigating PCC's *Prima Facie* Unethical Medical Conduct.

Even if the Reproductive FACT Act is subjected to strict scrutiny analysis, it still passes muster against PCC. While strict scrutiny erects a high barrier to validity, it does not raise an impossible obstacle. *Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 237 (1995) ("[W]e wish to dispel the notion that strict scrutiny is "strict in theory, but fatal in fact"); *Johnson v. California*, 543 U.S. 499, 515 (2005) ("[t]he fact that strict scrutiny applies says nothing about the ultimate validity of any particular law; that determination is the job of the court applying strict scrutiny").

In order to survive strict scrutiny, the government must demonstrate that the law is narrowly tailored to serve a compelling interest. *Reed*, 135 S. Ct. at 2218. Other briefs, the AMA assumes, will discuss narrow tailoring, as well as the State's compelling interest in providing public health information to patients. Here, the AMA will focus on California's compelling interest in mitigating the *prima facie* unethical practices of PCC's physicians.

The foundations for an ethical physician-patient relationship are trust and honesty. At the core of responsible medical practice is respect for patients' ability to make informed and autonomous decisions about their own healthcare. The obligations to patients sit above the physician's own self-interest. Code of Medical Ethics, *supra*, at Opinion 1.1.1—Patient-

Physician Relationships. Whether to give birth is a critical, time sensitive healthcare decision. Pregnant women are entitled to information about their medical condition when they seek care. Code of Medical Ethics, *supra*, at Opinion 1.1.3—Patient Rights, *available at* https://goo.gl/ytrxvZ. If patients are delayed in receiving this information, they may lose the right to make a decision at all.

Thus, a physician's own moral beliefs must be balanced against the ethical duties owed to patients. Before entering into a treating relationship, the physician must have an honest conversation with the patient about limitations to the care the physician can provide. Code of Medical Ethics, *supra*, at Opinion 1.1.7—Physician Exercise of Conscience, *available at* https://goo.gl/oYFCXc; *see also* American Medical Association, Council on Ethical and Judicial Affairs, *Report of the Council on Ethical and Judicial Affairs: Physician Exercise of Conscience*, (2014), https://goo.gl/hC7dAR. If a physician is unable to provide care, the physician should refer the patient to another physician or institution that can meet the patient's needs. *Id*. When a "deeply held, well-considered personal belief" leads a physician to decline to refer a patient for services the physician will not provide, "the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services." *Id*. PCC makes no bones about its failure to do this.

At nn. 1-5 of their Brief, PCC and the other Petitioners invite a search of their websites. The AMA has accepted that invitation.

The PCC publication *Letting the Light In: The True Value of Pregnancy Care Clinic* makes the following statements, which, to a trained lawyer, might seem fair enough, but to a conflicted patient in an examination room, are likely to prove misleading:

> "Consider the following as you make your decision:
>
> …Abortion & Breast Cancer
>
> Medical experts continue to debate the association between abortion and breast cancer. Research has shown the following:
>
> - Carrying a pregnancy to full term gives a measure of protection against breast cancer, especially a woman's first pregnancy. Terminating a pregnancy results in loss of that protection.
> - The hormones of pregnancy cause breast tissue to grow rapidly in the first 3 months, but it is not until after 32 weeks of pregnancy that breasts are relatively more cancer resistant due to the maturation that occurs."

Pregnancy Care Clinic, *Letting the Light In: The True Value of Pregnancy Care Clinic*, MOUNTAIN PRINTERS (2015), http://www.supportpcc.com/wp-content/uploads/2015/11/letting-the-light-in.pdf.

Ninety-nine people out of one hundred will read this statement and conclude, as intended, that the medical research shows that women who abort their fetus are significantly more likely to develop breast cancer than those who give birth. The meticulous lawyer, after

reading the statement several times, will focus on the disclaimer, "experts continue to debate the association" and conclude, more correctly, that the link between abortion and breast cancer is debatable, tenuous, and dependent on multiple extraneous factors. *See Reproductive History and Cancer Risk*, NAT'L CANCER INST. (Nov. 9, 2016) https://www.cancer.gov/about-cancer/causes-prevention/risk/hormones/reproductive-history-fact-sheet.

Furthermore, not only does the readers' setting matter, but the information itself is problematic. Other studies have shown that women who have recently given birth may actually have a temporary increase in breast-cancer risk, which declines after about ten years. *See* Robert B. Dickson & Marc E. Lippman, *Cancer of the breast*, *in* 1, 2 CANCER: PRINCIPLES AND PRACTICE OF ONCOLOGY 37.1 (Vincent T. Devita et al. eds., 7th ed. 2004). The reason for this temporary increase is not known, but some researchers believe it may be due to the effect of high levels of hormones on the development of cancers or to the rapid growth of breast cells during pregnancy. *Id.*

PCC's materials also state:

- "We want to demonstrate our commitment to medical professionalism, excellence, honesty, conscience and exceeding client expectations.
- At PCC, we believe a woman can and should have all options presented and discussed in a coercive-free environment.
- All services are provided with standards above and beyond regulations, best practices, and the expectations of our clients.

- It is not the mission of PCC to talk women into keeping their baby, but rather to educate them in their options so they can come to an informed choice." *Id*.

However, PCC's brief in this Court states: "Petitioners [have] the sole mission of encouraging expectant mothers to give their children the opportunity for life. … All of their speech is designed to encourage childbirth." Brief for Petitioners at 1.

The issue is not whether these statements are out-and-out fraudulent or whether there might be some sources, somewhere, which in some measure support PCC's statements. Physicians can violate the profession's ethical standards through half-truths. The question is whether these statements are likely to mislead emotionally vulnerable and relatively uninformed pregnant women about their medical care.

PCC, of course, deserves a full hearing on whether it has, in fact, conducted itself unethically. At this stage of the case, though, it sure looks that way, at least to the AMA.

CONCLUSION

The AMA agrees with petitioners that the Reproductive FACT Act should be measured, for PCC, under a strict scrutiny standard. The AMA further believes that the Court should articulate a rationale for its decision that encompasses more than the narrow facts of this case. The AMA urges this Court to determine that any law which restricts or compels physician speech and is targeted toward a matter of general public debate should be subjected to strict scrutiny.

Finally, the AMA believes that, even under a strict scrutiny standard, the trial court properly denied the PCC motion for preliminary injunction.

Respectfully submitted,

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