No. 24-539

IN THE

Supreme Court of the United States

KALEY CHILES,

Petitioner,

v.

PATTY SALAZAR, IN HER OFFICIAL CAPACITY AS EXECUTIVE DIRECTOR OF THE COLORADO DEPARTMENT OF REGULATORY AGENCIES, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

AMICI CURIAE BRIEF ON BEHALF OF MEDICAL HISTORY SCHOLARS AND HISTORIANS IN SUPPORT OF RESPONDENTS

KENDRA N. BECKWITH
Counsel of Record
WOMBLE BOND DICKINSON (US) LLP
1601 19th Street, Suite 1000
Denver, CO 80202
(303) 623-9000
kendra.beckwith@wbd-us.com

Counsel for Amici Curiae

384427

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

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INTEREST OF THE AMICI CURIAE[1]

The following professors and historians of medicine, together with their counsel, undertook the research for, and writing of, this brief: Nancy Tomes, PhD, SUNY Distinguished Professor, Stony Brook University; Susan Lawrence, PhD, History of Medicine Professor and Department Head, University of Tennessee Knoxville; and Lara Freidenfelds, PhD, independent historian.

Joining them as signatories (collectively, "Amici") are the following distinguished professors:

- Allan M. Brandt, PhD, Professor, History of Science and Amalie Moses Kass Professor of the History of Medicine, Harvard University

- Christopher Crenner, PhD, MD, Professor, History and Philosophy of Medicine, University of Kansas Medical Center

- Mary Fissell, PhD, Inaugural J. Mario Molina Professor of the History of Medicine, Johns Hopkins School of Medicine, and Professor, Johns Hopkins Krieger School of Arts & Science

- Laura Hirshbein, MD, PhD, George E. Wantz, M.D. Distinguished Professor of the History of Medicine, University of Michigan Departments of Psychiatry and History

1. No counsel for a party authored this brief in whole or part, nor did any person or entity, other than Amici or their counsel, make a monetary contribution to the preparation or submission of this brief.

• John Warner, PhD, Avalon Professor in the History of Medicine and Professor of American Studies and History, Yale School of Medicine

These Amici are well-credentialed and well-respected scholars in their field and leading historians of American medicine. Collectively, they have published sixteen books, thirteen co-edited volumes, and over one hundred peer-reviewed articles on the history of American medicine, medical regulation, medical training, medical innovations, and psychiatry. Four Amici are past, current, or immediate future presidents of the American Association for the History of Medicine, the field's preeminent professional organization.[2] Two Amici are awardees of the coveted Bancroft Prize for distinguished work in history, and one is a member of Institute of Medicine National Academy of Sciences and American Academy of Arts and Sciences.

In addition to producing groundbreaking research in this field over the last forty years, Amici train aspiring historians and medical professionals. Several have or are presently leading educational programs at preeminent medical schools and universities across the country. Six Amici hold endowed chairs, and two are practicing physicians and historians. One Amicus served as editor of the *Bulletin of the History of Medicine*[3], the leading

2. *See* American Association for the History of Medicine, https://histmed.org/ (last visited Aug. 24, 2025).

3. *See* Bulletin of the History of Medicine, Johns Hopkins Univ. Press, https://www.press.jhu.edu/journals/bulletin-history-medicine?srsltid=AfmBOooPxivVIDO1InCKfV2E98Kqj1RGzIeNktpO4RJe2hYOwTzGvMRG (last visited Aug. 24, 2025).

journal of medical history in America, for fifteen years, and another is currently editor of the *Journal of the History of Medicine and Allied Sciences*.[4]

Petitioner's assertion that Colorado's ban on conversion therapy is both unprecedented and unconstitutional is wrong as a matter of fact and history. Amici participate through counsel here because as professional historians and scholars of medicine, they are committed to the principle that the past is a key to understanding the present. Amici, as knowledgeable and dedicated stewards of history, wish to ensure that the Court is presented with an accurate portrayal of American history and tradition as it applies to this case.

Over the past four hundred years, the United States, initially as colonies under English common law and then, as an independent nation, has enjoyed a rich framework and longstanding tradition of licensing and regulating medical doctors and mental health professionals. Talk therapy is among the modalities states' duly-elected legislators have regulated. Amici therefore urge this Court to consider this historical tradition as resolving this case and affirm the decision below.

INTRODUCTION AND SUMMARY OF ARGUMENT

Colorado law establishes state licensing boards for professional counselors, including psychologists, social

4. *See* Journal of the History of Medicine and Allied Sciences, Oxford Academic, https://academic.oup.com/jhmas (last visited Aug. 24, 2025).

workers, psychotherapists, marriage and family therapists, and addiction counselors. *See* Colo. Rev. Stat. § 12-245-101(2). These boards "safeguard the public health, safety, and welfare of" Coloradans and protect them "against the unauthorized, unqualified, and improper application" of professional counseling. *Id.* § 12-245-101(1). To fulfill this purpose, these boards establish requirements for obtaining and retaining professional licenses in the state, set the scope of permitted activities, establish professional standards, and administer disciplinary actions and penalties for violations of these standards. *See generally* Colo. Rev. Stat. § 12-245-101 *et seq.* (the "Act").

As relevant here, effective August 2, 2019, Colorado's General Assembly—a legislative body consisting of 100 senators and representatives duly elected by the citizens of Colorado—banned conversion therapy for minors ("Conversion Therapy Ban"). § 12-245-224(1)(t)(V). Conversion therapy is a defined term in the Act. It means "any practice or treatment by a licensee, registrant, or certificate holder that attempts or purports to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attraction or feelings toward individuals of the same sex." § 12-245-202(3.5)(a). Excluded from this definition are "practices or treatments that provide" "[a]cceptance, support, and understanding for the facilitation of an individual's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as the counseling does not seek to change sexual orientation or gender identity"; or "[a]ssistance to a person undergoing gender transition." § 12-245-202(3.5)(b).

Petitioner is a licensed professional counselor. She contends these regulations "censor" conversations she is entitled to have with her patients, improperly regulating her speech in violation of the Free Speech clause of the First Amendment. Pet. Br. ii. In support of Petitioner's efforts to bypass Colorado's Conversion Therapy Ban, her amici posit to this Court that bans or regulations like the Conversion Therapy Ban are a historical anomaly. These bans, they argue, should be rejected to allow professionals, like Petitioner, free reign to employ whatever treatment modality they desire. *See, e.g.*, Br. of Anthony M. Joseph as *Amicus Curiae* in Support of Petitioner. Amici strongly disagree, as history belies these arguments.

Specifically, the historical record demonstrates four realities pertinent to this case. First, state regulation of medical practitioners dates back to the colonies. Second, these regulations, from the eighteenth century through the present, are steeped in the state's power to prevent licensed medical practitioners from providing therapies deemed unsafe, harmful, and ineffective to patients. Third, this regulatory power has always included the authority to regulate speech, which in the context of talk therapy, as this case concerns, is inextricable from conduct. Finally, state regulation of medicine has historically been for the purpose of protecting patients and ensuring licensed medical professionals follow professional standards.

ARGUMENT

This Court has explained that its "precedents do not permit governments to impose content-based restrictions on speech without 'persuasive evidence . . . of a long (if heretofore unrecognized) tradition' to that effect." *Nat'l*

Inst. of Fam. & Life Advocs. v. Becerra, 585 U.S. 755, 767 (2011) (quoting *United States v. Alvarez*, 567 U.S. 709, 722 (2012)). Amici disagree that talk-based treatments are exclusively speech.

Yet if this Court does so find, Amici provide this brief to explain, in historical context, the longstanding, widespread history of state medical licensure laws that restrict medical professionals' speech in the context of the fiduciary patient-provider relationship. Centuries of medical care have recognized that medical providers' speech and conduct cannot be separated from each other, and both have long been regulated. These laws have always extended to both speech and conduct and are appropriately limited to only that speech and conduct which falls below the applicable standard of care. While the more modern designation of "licensed professional counselor" was not present centuries ago, the nation's early medical care was almost entirely talk-based, and states passed their earliest medical licensure laws with this context in mind. Accordingly, state licensure laws for licensed professional counselors engaging in exclusively talk therapies fall squarely within the nation's longstanding tradition of regulating medical care. To conclude otherwise would entirely upend this long-settled, crucial form of protection for the public.

I. States Have Regulated Medical Providers' Treatment of Patients, Via Both Speech and Conduct, for Centuries.

State regulation of medical practitioners has always existed in the United States. This regulation includes the power to prevent licensed physicians from providing

therapies deemed unsafe, ineffective, or harmful to patients.

The principle of medical regulation by the state was widely recognized by the time of the American Revolution. Colonial Americans inherited a robust legal tradition from England in which governmental bodies had taken on the duty of licensing medical personnel to protect the public from poorly trained practitioners. The crown first gave this authority to the Royal College of Physicians (1518), and the courts confirmed their right to license all medical practitioners in London in 1602 and 1607 to protect citizens' health. Harold J. Cook, *Policing the Health of London: The College of Physicians and the Early Stuart Monarchy*, 2 Social History of Medicine 8, no. 1 (April 1989), https://doi.org/10.1093/shm/2.1.1.

Britain's North American colonies continued this English tradition. Very early in their operation, colonial legislatures passed laws regulating the practice of medicine and allied professions. The earliest such law was adopted in the Massachusetts Colony in 1649. Its purpose was to ensure that medical care came from skilled, rather than unskilled, providers. Richard Shryock, *Medical Licensing in America, 1650-1965* vii, Johns Hopkins Univ. Press (1967) (hereafter "Shryock 1967"). This early law was difficult to enforce at a time when few educated physicians existed in the colonies. But as the colonies grew in population and developed their distinctive systems of representative government, colonial legislators sought to improve systems of medical licensure. New York, New Jersey, and Connecticut all passed medical licensing laws starting in 1760. *Id.* at 17-19.

In both England and its North American colonies, licensure covered speech and conduct. The two were inseparable due to the integral connection between the doctor's discussions with each patient and their care. At that time, medicine was primarily performed via speech, i.e., without any manipulation or touching of the patient. This included taking a history, communicating a diagnosis and prognosis, and giving herbal and behavioral prescriptions. Doctors routinely inquired into the patient's state of mind and feelings as part of treatment. To the extent the practice of medicine and counseling was regulated, this sort of speech was squarely within its ambit. Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* 9-10, 59, 257-58, W. W. Norton & Co. (1st ed. 1997); Dorothy Porter & Roy Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth Century England* 74-85, Stanford Univ. Press (1st. ed. 1989). The purpose of these regulations was to protect patients. Licensing laws were intended to help patients distinguish between skilled and unskilled practitioners at a time when the former was in short supply and the general population lacked the expertise or ability to discern a quack from a professional. Shryock 1967, *supra* at 13-14.

While medical licensing was recognized as a valuable, legitimate service of colonial governments, it remained of limited application due to the scarcity of trained physicians in the early colonies. Richard Shryock, *Medicine and Society in America: 1660-1860* 9, Cornell Univ. Press (1960) (hereafter "Shryock 1960"). To correct this problem, medical leaders first needed to build up the colonies' educational and professional resources. Physicians formed their own societies for the pursuit of useful knowledge. These included the Medical Society of

New Jersey (1766), the Massachusetts Medical Society (1781), and the College of Physicians of Philadelphia (1787). Shryock 1967, *supra* at 17, 23; Shryock 1960, *supra* at 30.

Perhaps most importantly, the desire for improvement in the quality of care manifested in the founding of the first hospitals in the colonies, starting with the Pennsylvania Hospital in Philadelphia (1755) and then New York Hospital (1771) in New York City. The trend continued in the new republic with the founding of the Massachusetts General Hospital (1811) in Boston. Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* 150, Basic Books (1982 & 2d. ed. 2017).

The last link in the engine that would drive medical improvement was the formation of the first American medical schools, which meant aspiring doctors would not need to go to Edinburgh or London for scientific training. These included the College of Philadelphia's Medical School (now the University of Pennsylvania's School of Medicine) in 1765, (Shryock 1967, *supra* at 16); Kings College (now Columbia University) in 1767 (Columbia University Irving Medical Center, *VP&S: The Early Years* (1767-1928), https://www.giving.cuimc.columbia.edu/news/vp-s-early-years-1767-1928 (last visited Aug. 25, 2025)); the Harvard Medical College in 1783 (Shryock 1967, *supra* at 25); and the Dartmouth Medical College in 1797 (Dartmouth Geisel School of Medicine, *Dartmouth Medical Milestones*, https://geiselmed.dartmouth.edu/about/milestones/ (last visited Aug. 25, 2025)). Each of these medical institutions aligned with what was then called "regular" medicine, the same tradition that dominated the British schools and hospitals that Americans adopted as role models.

These new institutions promoted the development of professional standards of practice. These standards required the individual practitioner to subordinate their opinion and values to the standards of the collective profession, or whole, while providing treatment. This did not mean physicians ceased to debate ideas and treatments or accept that different approaches may work for different patients. It meant simply that the medical profession had the responsibility, after rigorous analysis, to designate some therapies as harmful medicine and discourage (if not altogether prohibit) their use.

This process of excluding treatments the profession determined to be outside acceptable practice has existed at least since the 1700s. For example, seventeenth century physicians accepted supernatural explanations for ill-health. But after the Salem witchcraft trials of 1692, the colonial medical profession rejected these supernatural explanations for disease. This shift mirrored the growing influence of the Enlightenment, with its emphasis on the role of natural law, not supernatural forces, in explaining everyday life. Owen Davies, *Troubled by Faith: Insanity and the Supernatural in the Age of the Asylum* 3-8, 46-48, Oxford Univ. Press (July 20, 2023), https://doi.org/10.1093/oso/9780198873006.001.0001.

In 1721, when smallpox broke out in Boston, Cotton Mather, a prominent minister, and Dr. Boylston, a physician colleague, promoted smallpox inoculation to keep the disease under control. John B. Blake, *The Inoculation Controversy in Boston: 1721-1722*, 25 New England Quarterly, no. 4 (1952). This new and, to most, risky and untried procedure, required infecting healthy people who had never had smallpox with the disease.

William Buchan, *Domestic Medicine Or, A Treatise on the Prevention and Cure of Diseases* 255-56 (11th ed. 1789). Upon hearing that Dr. Boylston had inoculated some children and enslaved people, Boston's Selectmen and Justices consulted with senior physicians in the city and decided it was too dangerous to employ. They forbade Dr. Boylston from continuing the practice. Blake, *supra* at 493. The Selectmen had no doubts that they held the authority to regulate this prophylactic technique. Blake, *supra*. The ensuing controversy was bitter, and the state had trouble enforcing its decree—but the regulatory principle existed.

Likewise, when decades of experience with smallpox inoculation in other localities confirmed that its benefits for the population outweighed the risks to individuals, the procedure became a standard medical intervention. Blake, *supra*; Buchan, *supra* at 265. This example underscores the ability of both the profession and its regulators to change when presented with sufficient scientific evidence.

From their personal papers and public statements, it is evident that the educated, thoughtful group of leaders who came together to write the U.S. Constitution and Bill of Rights were aware of these efforts to improve the scientific basis of medical practice. John Adams and George Washington were strong advocates of inoculation, for example. Jeanne E. Abrams, *Revolutionary Medicine: The Founding Fathers and Mothers in Sickness and in Health* 1-2, New York Univ. Press (2013). They knew firsthand the scarcity of carefully trained physicians in the British colonies; one observer wrote in the 1750s, "the quacks abound here like locusts in Egypt." Abrams, *supra* at 20. In their writings and careers, leaders such

as Benjamin Franklin, John Adams, and James Madison supported the idea that the success of the new nation depended upon improving the people's health, which in turn required adopting science-based treatments and supporting improvements in medical education. Abrams, *supra* at 2-3, 231-232. For this reason, the regulation of medicine fell naturally to the states under the scope of the Tenth Amendment. As the eminent historian of medicine and law James Mohr states, "With few exceptions through the middle of the twentieth century, policies involving medicine and public health remained among those reserved powers and hence were hammered out on a state-by-state basis." James C. Mohr, *Licensed to Practice; the Supreme Court Defines the American Medical Profession* 9, Johns Hopkins Univ. Press (2013).

II. Medical and Scientific Advances Resulted in Stronger Licensing Requirements to Prevent Harmful Practices.

The nature and extent of state regulation of medical practice became more restrictive in the late 1800s as new scientific discoveries improved the credibility and efficacy of mainstream medicine. These new, scientific methods and findings eventually led to a more rigorous form of medical licensing reflecting the evolving intent of eighteenth century medical leaders to keep the practice of medicine safe. The scope of this regulation has always included speech as an aspect of medical practice inseparable from conduct.

For the first two-thirds of the nineteenth century, it proved difficult to arrive at consensus on what knowledge a physician must have to be a skilled practitioner. In the

early years of the new republic, physicians attempted to set standards for themselves using methods of scientific inquiry that did not produce easily replicable results or consistent success from the chosen therapeutics. Mohr, *supra* at 11-16; Starr, *supra* at 54-59.

In addition, physicians had little authority outside of large cities. In frontier and later rural areas, trained physicians were very rare; American households had to learn to "self-doctor." In the era of Jacksonian democracy, all experts were distrusted, the medical profession included. As a result, licensing laws remained weak or non-existent in many locales until after the U.S. Civil War. Starr, *supra* at 57-59; Mohr, *supra* at 11-16.

Changes in the fundamental science of medicine helped bring licensing laws back into favor. Two waves of change transformed the understanding of medical science in the United States. The first wave was associated with the so-called "Paris School," which integrated statistics, clinical observation, and pathology to track the course of specific diseases. *See generally* John Harley Warner, *Against the Spirit of System: The French Impulse in Nineteenth-Century American Medicine*, Johns Hopkins Univ. Press (2003) ("Warner 2003"). The second wave came with the adoption of experimental, laboratory-based inquiry, most famously associated with the proof of the germ theory of disease. Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life* 27-38, Harvard Univ. Press (1999). These waves of scientific change applied to both physical and mental illnesses. Psychiatry was fully part of these developments; in fact, it emerged as one of the earliest medical specialties in the United States. The American Psychiatric Association, originally known as the

Association of Medical Superintendents of Asylums for the Insane, was founded in 1844, three years before the American Medical Association. Gerald N. Grob, *Mental Institutions in America: Social Policy to 1875* 138, Free Press (1973) ("Grob 1973").

Medical therapeutics changed slowly but decisively because of these new influences. A case in point is the regular profession's abandonment of excessive bleeding and purging. Within medical schools and medical societies, the influence of the Paris School led to critiques of excessive bleeding and purging as early as the 1820s. This internal "therapeutic revolution" led to the slow, steady abandonment of these therapies by the late 1800s. John Harley Warner, *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820-1885* 207-226, Harvard Univ. Press (1987). Certainly, these changes were encouraged by competition from alternative medical sects opposed to bleeding and purging. But the shift primarily occurred because regular physicians adopted the more scientific methods of assessing therapies inspired by the Paris School, and these methods were then taught in regular medical schools. *See generally* Warner 2003, *supra*.

Following their own professional methods, physicians committed to the principles of the "new" scientific medicine gradually arrived at key breakthroughs in both public health and surgery. Public health measures to combat epidemic diseases raised popular appreciation for preventive medicine. *See generally* Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System,* 143-150, Basic Books (1987). The medical and surgical experience gained during the U.S. Civil War also

contributed to advances in the regular profession. *See generally* Margaret Humphreys, *Marrow of Tragedy: The Health Crisis of the American Civil War*, Johns Hopkins Univ. Press (2013). With innovations in anesthesia, then acceptance of germ theory and adoption of antiseptic methods, surgery gained new respect in the late 1800s. Starr, *supra* at 135-136.

Respect for these scientific innovations increased the scope and scale of medical regulation in the late 1800s. Many homeopathic and eclectic physicians also had an interest in scientific improvement. But in terms of public opinion, it was the regular profession that more successfully laid claim to the new scientific medicine. At a time of rising respect for science, that association helped physicians persuade state legislatures to pass more restrictive licensing laws. Susan Lawrence, *Iowa Physicians: Legitimacy, Institutions, and the Practice of Medicine. Part Two: Putting Science into Practice, 1887-1928* 9-16, 63 Annals of Iowa (Winter 2004).

Physicians with a personal stake in alternate modes of treatment, however, vigorously opposed the renewed licensing laws. This opposition led to an important case before this Court: *Dent v. West Virginia*, 129 U.S. 114 (1889). *See generally* Mohr, *supra*. Dent was an eclectic physician who objected to an 1882 law passed by the West Virginia legislature requiring any doctor wanting a license to have one of the following qualifications: be a graduate of a "reputable medical college," have practiced medicine in West Virginia for at least ten years, or have passed an exam given by the State Board of Health showing him to be qualified to practice medicine. 129 U.S. at 124. The Court explained,

> We perceive nothing in the statute which indicates an intention of the legislature to deprive one of any of his rights. No one has a right to practice medicine without having the necessary qualifications of learning and skill; and the statute only requires that whoever assumes, by offering to the community his services as a physician, that he possesses such learning and skill, shall present evidence of it by a certificate or license from a body designated by the state as competent to judge of his qualifications.

Id. at 123. The Court ruled unanimously in the state of West Virginia's favor, stating that it was within the state's power to pass a law "intended to secure such skill and learning in the profession of medicine that the community might trust with confidence those receiving a license under authority of the state." *Id.* at 128.

As state legislatures started to pass more stringent licensing laws in the late 1800s, regular physicians' association with the new scientific medicine gave them an edge over their alternative competitors. By the 1880s, it was not just bacteriology, asepsis, and anesthesia that were transforming basic understandings of disease and its treatment, but also advances in physiology, pathology, pharmacology, and biochemistry. Some laboratory discoveries did not have immediate clinical applications, but there was growing faith among younger physicians that they soon would. Bert Hansen, *America's First Medical Breakthrough: How Popular Excitement About a French Rabies Cure in 1885 Raised New Expectations of Medical Progress*, 103 Amer. Hist. Rev. 373-418, no. 2 (Apr. 1998), https://doi.org/10.2307/2649773.

Again, the process of change was slow and considered, unfolding state by state through the actions of state medical boards endowed with licensing authority by their state legislatures. David A. Johnson & Humayun J. Chaudhry, *Medical Licensing and Discipline in America: A History of the Federation of State Medical Boards* 35-54, Lexington Books (2012). Some state boards chose to accommodate alternative traditions such as homeopathy by setting up separate tracks for licensing homeopathic practitioners. But that accommodation required those sects to adopt essential features of regular medical education and practice. For example, if a homeopathic medical school was going to teach surgery, it needed to be aseptic surgery. Homeopathic medical schools became more like regular medical schools, not the other way around. Naomi Rogers, *An Alternative Path: The Making and Remaking of Hahnemann Medical College and Hospital of Philadelphia* 83-103, Rutgers Univ. Press (1998). The same pattern would follow with osteopathy: its distinctive medical approach had to be subordinated to the larger profession's standards before osteopathy was fully integrated into medicine. Today's Doctors of Osteopathy are trained almost identically to Doctors of Medicine. *See, e.g.*, *Crane v. Johnson*, 242 U.S. 339, 343-44 (1917) (upholding state medical licensing requirement challenged by Christian Science "drugless practitioner").

This pace of scientific change has been slow and deliberate. Historically, medical regulation and licensure have not changed overnight. Rather change comes about over decades; it grows from the inside out, as physicians dedicated to the pursuit of science test theories with new information. Within this culture of scientific debate, physicians have retained considerable freedom to make

decisions about which treatments to offer their patients. But this freedom has never been absolute. There have always been instances in which the profession determined that some ideas and practices were so unscientific, ineffective, or dangerous that they should be forbidden. A physician who continued to practice such therapies would be at risk of a malpractice suit, a disciplinary action, or loss of their license to practice medicine.

A case in point is germ theory and surgery. Germ theory in general and the role of germs in wound infection were for decades matters of debate. Nancy Tomes, *American Attitudes Toward the Germ Theory of Disease: Phyllis Allen Richmond Revisited*, 52 J. Hist. Med. Allied Sci. 1, 17-50 (Jan. 1997). Physicians could and did disagree about the need for antisepsis and asepsis in wound care and surgery. But in time, the experience of leading surgeons led to the closure of that debate. Rosenberg, *supra* at 143-150.

In the United States, the controversy surrounding the death of President Garfield in 1881 was such a turning point: the autopsy results showing that he died because of the unsanitary handling of his gunshot wounds resolved doubts among surgeons about the role of bacteria in wound care. Candace Millard, *Destiny of the Republic: A Tale of Madness, Medicine and the Murder of a President* 253-254, Doubleday (2011). After 1890, failure to observe asepsis in surgery would be grounds for a malpractice suit. An individual surgeon might still doubt the role of germs. But if he practiced according to his skepticism, rather than this standard of care, he would be liable in a malpractice suit on the grounds that he had departed from the "customary and expected" knowledge of his fellow

physicians. Kenneth De Ville, *Medical Malpractice in Nineteenth Century America: Origins and Legacy* 220, New York Univ. Press (1990).

Psychiatry was subject to the same kinds of regulation. For example, standards for the physical restraint of patients changed dramatically over the nineteenth century. Under the influence of "moral treatment," physicians stopped using manacles on mental patients in the early 1800s and did away with the "Utica crib," a wooden enclosure used to confine agitated patients, in the late 1800s. Nancy Tomes, *The Great Restraint Controversy: A Comparative Perspective on Anglo-American Psychiatry in the 19th century* 190-225, *in* 3 *Anatomy of Madness* (W.R. Bynum, et al. eds., 1988) (hereafter "Tomes 1988"); Ellen Dwyer, *Homes for the Mad; Life Inside Two Nineteenth-Century Asylums* 124, Rutgers Univ. Press (1987).

At a time when effective psychoactive drugs did not yet exist, the specialty worked steadily to set standards aimed at employing the minimum amount of restraint needed to prevent patients from harming themselves or others. *See generally* Tomes 1988, *supra.* State boards of visitors were established in the late 1800s to ensure that physicians presiding over institutions adhered to these standards and that those who did not could be dismissed. Gerald N. Grob, *Mental Illness and American Society, 1875-1940* 203-07, Princeton Univ. Press (1983), https://doi.org/10.2307/j.ctvct00bz ("Grob 1983").

III. State Regulation of Medicine and Psychological Treatment, Including Talk Therapy, Developed in Tandem.

In both medicine and psychiatry, this process of standard-setting through education, licensing, and other forms of regulation continued to make no distinction between speech and conduct. With the rise of psychodynamic psychiatry in the interwar period, "talk therapy" emerged as a specialized practice. Under the National Mental Health Act of 1946, medical schools and graduate psychology programs instituted rigorous training in psychotherapeutic methodologies, with techniques refined by clinical research. Eva S. Moskowitz, *In Therapy We Trust: America's Obsession with Self-Fulfillment* 154, Johns Hopkins Univ. Press (2001).

In the United States, psychodynamic treatment in its most specialized form, psychoanalysis, remained the exclusive domain of physicians until after World War II, when non-Doctors of Medicine were finally allowed to practice psychoanalysis following a long course of training. That restriction reflected the conviction that only practitioners with the Doctors of Medicine degree or its equivalent should offer the most intensive forms of interpersonal therapy. *See generally* Nathan G. Hale, Jr., *The Rise and Crisis of Psychoanalysis in America: Freud and the Americans, 1917-1985*, Oxford Univ. Press (1995).

Talk-based therapies continued to develop as formal therapeutic practices and were measured against the standards of scientific evidence. Cognitive behavioral therapy, for instance, was developed in the 1960s as a means of making more rapid behavioral change than typically occurred in other psychotherapeutic approaches,

and its effectiveness has been demonstrated in clinical trials. Suma P. Chand, et al., *Cognitive Behavioral Therapy*, StatPearls (May 23, 2023), https://www.ncbi.nlm.nih.gov/books/NBK470241/. Since its introduction, this therapy has further developed and become widely available from licensed mental health professionals and endorsed by professional organizations.

In a contrasting example, Recovered Memory therapy, developed in the 1980s, soon proved dangerous and damaging. Its practitioners faced successful malpractice suits from patients and cautionary warnings from professional organizations. As a result of these legal and professional actions it fell into disuse by the mid-1990s. Allan V. Horwitz, *PTSD: A Short History* 107-34, Johns Hopkins Univ. Press (2018); American Psychiatric Association, *Position Statement on Therapies Focused on Memories of Childhood Physical and Sexual Abuse* (March 2000), https://www.psychiatry.org/getattachment/930fb215-2147-40e9-9d44-f06d84fc64de/Position-2013-Memories-Child-Abuse.pdf.

Similarly, talk therapies intended to change a person's sexual orientation or gender identity were increasingly rejected beginning in the mid-1970s, as mental health professionals came to understand homosexuality as a natural and acceptable variant of human sexuality, and as the lack of efficacy of these therapies was demonstrated. American Psychological Association, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* 11 (August 2009), https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf ("Task Force Report").

By the late 1990s, the American Counseling Association ("ACA")–the professional organization for licensed counselors–had rejected these types of therapies from legitimate practice. Task Force Report, *supra* at 12. States provided legal force to the ACA's decision and other professional associations beginning in the 2010s. Jack Drescher, et al., *The Growing Regulation of Conversion Therapy*, 102 J Med. Regul. 7-12, no. 2 (June 1, 2016), https://doi.org/10.30770/2572-1852-102.2.7.

Since the late nineteenth century, then, state governments have acted as guarantors of the profession's standards through their support of licensure. The states did so not to impose their own views but to put the force of law behind the collective judgment of those best equipped to set those standards: leaders of the medical profession. As the scientific consensus regarding best practices has changed, so too have the responsibilities of licensed health care practitioners to adhere to them.

IV. Licensing Requirements Restricting Professionals' Talk Therapy Practices Have Long Been Recognized as Necessary to Ensure Patient Safety and Do Not Implicate Free Speech Concerns.

The purpose of state regulation of medicine has always been to protect the patient by guaranteeing that the practitioner abides by the professional standards necessary to receive and maintain a license. As this Court has recognized, "In addition to its general interest in protecting consumers and regulating commercial transactions, the State bears a special responsibility for maintaining standards among members of the licensed professions." *Ohralik v. Ohio State Bar Ass'n*, 436 U.S.

447, 460 (1978) (affirming state's application of discipline to attorney's conduct); *Semler v. Oregon State Bd. of Dental Exam'rs*, 294 U.S. 608, 611 (1935) (affirming state restrictions on dentists' advertising).

As a fiduciary relationship, the doctor-patient bond is subject to special expectations: that physicians place patients' well-being above their own rights and interests. Those fiduciary obligations have always applied to both speech and conduct.

The fiduciary duty of a doctor to their patient has been recognized since ancient times. This duty was first articulated by the School of Hippocrates sometime between the fifth and third centuries BCE. The famous Hippocratic oath included the injunction, "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous." *Hippocratic oath | Definition, Summary, & Facts*, Britannica (July 17, 2025), https://www.britannica.com/topic/Hippocratic-oath.

As medical ethics evolved in the nineteenth century onward, the values of beneficence and non-maleficence (providing benefit and avoiding harm), as well as the protection of vulnerable individuals, remained paramount. Tom L. Beauchamp & James F. Childress, *Principles of Bioethics* 97-101, 135-36, Oxford Univ. Press (1st ed. 1979). As part of those principles, doctors understood that they had a duty to deny patients a dangerous treatment even when the patient requested it. Historical examples of this duty include: assisting in euthanasia (Albert R. Jonsen, *The Birth of Bioethics* 233-34, Oxford Univ.

Press (1998)); prescribing narcotic drugs to sustain an addiction (U.S. Drug Enforcement Administration, *DEA-led Operation Pill Nation Targets Rogue Pain Clinics in South Florida*, February 24, 2011, https://www.dea.gov/press-releases/2011/02/24/dea-led-operation-pill-nation-targets-rogue-pain-clinics-south-florida); and prescribing steroids for bodybuilding (Carlos R. Hamilton, *Medical Ethics and Performance-Enhancing Drugs*, AMA J. Ethics (November 2005), http://doi.org/10.1001/virtualmentor.2005.7.11.oped1-0511).

Since the mid-twentieth century, the medical profession has revised its legal and ethical standards to take more account of patient autonomy. Beauchamp & Childress, *supra* at 56. This includes a greater effort to listen to patients and align treatments to their goals. But patients' requests must be measured against practitioners' medical expertise and constrained by their obligation to provide benefit and avoid ineffective and harmful therapies. As they were in 1790, physicians remain duty-bound to turn down patient requests for treatments that have been judged by their profession to be ineffective, unsafe, or potentially dangerous. D. Porter & R. Porter, *supra* at 85-92.

Medicine's fiduciary standards have been the model for licensure of other professional groups working in the medical field, including nurses, physicians' assistants, psychologists, and social workers. Although the specifics of what these non-M.D. professionals are expected to know and do is different from physicians, they share an understanding and commitment to abide by the highest professional standards set for their field. This medical model of professional regulation did not recognize a

distinction between talking to and treating a patient—they were one and the same. Until the late nineteenth century, most medical care primarily involved talking to the patient; taking a history, communicating a diagnosis and prognosis, and giving directions about diet and lifestyle all were essential features of medical practice. Roy Porter, *supra* at 9-10, 59, 257-58; D. Porter & R. Porter, *supra* at 74-76.

Even as medicine became more procedure-oriented in the twentieth century, talking to the patient remained an integral part of treatment. As historian David Rothman wrote, "In the 1930s, conversations with patients were inseparable from diagnosis and treatment, and thus it was not necessary to emphasize the need to talk with them." David J. Rothman, *Strangers at the Bedside: A History of How Law And Bioethics Transformed Medical Decision Making* 132, Basic Books (1992). The idea that a physician's speech could be conceptually separated from his therapeutic practice did not exist.

The fiduciary duty to the patient, and the centrality of speech to treatment, applied equally to the medical specialty of psychiatry, which focused on the diagnosis and treatment of mental illness. Psychiatric treatments included somatic interventions, such as psychoactive drugs, electroshock therapy, and occupational therapy; in the 1940s the more modern concept of psychoanalysis and other forms of "talk therapy" gained widespread use. Grob 1983, *supra* at 291-305; *see generally* John Burnham, "The Influence of Psychoanalysis on American Culture" in *American Psychoanalysis: Origins and Development* 52-72 (Jacques M. Quen and Eric T. Carlson, eds., Brunner/Mazel 1978); *see also* Hale, *supra*.

The decision of which modality to use remained in the physician's hands. But as psychiatry moved from an exclusive focus on severe mental illness to a broader conception of mental health, it began to recognize the contributions of non-medical professional groups. To a far greater extent than other medical fields, psychiatry adopted an interdisciplinary approach, bringing allied practices under the psychotherapy umbrella and imbuing them with the standards of care developed in medicine. Nancy Tomes, *The Development of Clinical Psychology, Social Work, and Psychiatric Nursing, 1900s-1980s*, in *History of Psychiatry and Medical Psychology* 657-82 (Edwin R. Wallace & John Gach eds., 2008) ("Tomes 2008").

The impulse to extend the reach of psychiatry originated in the child guidance movement of the early 1900s, when psychologists and social workers were recruited to work with troubled youth and their families. During World War II, a multidisciplinary team approach proved useful as a response to soldiers' wartime traumas. In the 1950s, psychology, psychiatric nursing, and psychiatric social work were expanded to address not only concerns about deteriorating conditions in mental hospitals but also the prevention of mental problems in the larger communities. As non-Doctor of Medicine professionals came into the mental health field, they followed the medical model of professionalism, in which expert practitioners set collective practice standards and licensed practitioners were bound to observe them. *See generally* Tomes 2008, *supra*.

For example, the ACA, the professional organization for counselors such as Petitioner, follows medical ethics

established by the medical profession in its code of conduct. It describes nonmaleficence and beneficence as "fundamental principles of professional ethical behavior." ACA, 2014 ACA Code of Ethics 3, https://www.counseling.org/docs/default-source/default-document-library/ethics/2014-aca-code-of-ethics.pdf. It requires that "[w]hen providing services, counselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation" and that "[c]ounselors do not use techniques/procedures/modalities when substantial evidence suggests harm, even if such services are requested." *Id.* at 10.

In both hospital and community settings, psychiatry remained the undisputed head of the expanding mental health "team." Because psychiatrists were physicians, they retained control over the most powerful forms of treatment: medication, electroconvulsive therapy, and psychoanalysis, the most intensive form of psychotherapy. Psychologists, originally recruited to the mental health team to administer IQ and personality tests, sought and won more independence to solo practice as therapists, but only having completed a long course of study and practice similar to that of their psychiatrist colleagues. They also could not prescribe prescription drugs. Psychiatric nursing and psychiatric social work carved out similar areas of restricted practice, under a psychiatrist's supervision.

Finally, starting in the 1960s, there was a proliferation of professional degrees in counseling that required fewer years of education and supervised training. Their role was to provide counseling in schools and other non-medical settings. As a rule, the more serious the illness

and the more potentially risky the treatment, the more psychiatric supervision remained a requirement. Tomes 2008, *supra*. With the diversity of training in the mental health professional field, it became necessary for each of these professions to have its standards set by those experts who have the most training. For psychiatrists, certification standards came to be set by the American Board of Psychiatry and Neurology ("ABPN"), which was founded in 1934. Those standards were set after careful consultation with specialists in both psychiatry and neurology. The ABPN also aligned its credentialing with the standards advocated for by the American Psychiatric Association, the first national medical organization founded in the United States (1844). Grob 1973, *supra* at 137-138; Rosemary Stevens, *American Medicine and the Public Interest: A History of Specialization* 222-225, Univ. of California Press (updated 1st ed. 1998).

As psychology expanded, a similar credentialing structure arose in that field. The American Psychology Association, founded in 1892, created the Association of State and Provincial Psychology Boards ("ASPPB") in 1961 to ensure consistent licensure requirements in both the U.S. and Canada. ASPPB, *History*, https://asppb.net/about/history/ (last visited Aug. 25, 2025). This same pattern was followed in psychiatric nursing, psychiatric social work, and mental health counseling degrees. These mental health fields developed degree programs, professional societies, peer-reviewed journals that published research meant to inform therapeutic practice, and licensing overseen by the state.

The purpose of standard setting through regulation was and remains the protection of patients. Ensuring that

patients know that the individual practitioners who treat them are properly trained and supervised professionals is the foundation of successful health care. The need for regulation, first acknowledged in the colonial era, returned to favor in the late nineteenth century as the profession better aligned its goals with medical science, and continues to be a critical part of our medical system. At no point in American history has medicine's system of regulation been more carefully constructed and thorough, encompassing a uniform medical education and board exams, professional associations with peer-reviewed journals to provide evidence for therapeutic modalities, state licensing and regulation, and malpractice laws as a remedy when preventative regulation fails.

CONCLUSION

The "persuasive evidence" of this country's "long tradition" (*Becerra*, 585 U.S. at 767) of regulating the practice of medicine—including talk therapy, or speech—is irrefutable. State regulation of medical practitioners through licensure has existed in the United States since its founding. State regulation has long recognized the right of the collective medical profession to restrict practitioners from offering certain therapies it deems inappropriate on scientific grounds and forbid licensed physicians to practice them. The medical model of professional regulation has historically made no distinction between speech and conduct because speech has consistently been integral and central to doctors' interactions with patients in the therapeutic encounter.

While the basic principles of licensing have long been accepted, the process by which licenses are granted and

the scientific knowledge on which they are based has evolved over the past two centuries. This pace of scientific and professional change has been slow and deliberate. Historically, medical regulation and licensure have not changed overnight. Rather, change has come over decades; it grew from the inside out, as physicians used science to test their ideas and practices and discarded those that failed to meet scientific standards.

Within this culture of scientific debate, physicians have retained considerable freedom to make decisions about what information and treatments to share with their patients. But this freedom has never been absolute. There have always been instances in which the profession determined that some ideas and practices were so unscientific, ineffective, or dangerous that they should be forbidden. A physician who continued to practice such therapies would be at risk of a malpractice suit, disciplinary action, or loss of their license to practice medicine.

As non-physician professionals entered the mental health care field in the post-World War II period, they did so as part of a mental health "team" led by physicians. Licensure for non-Doctors of Medicine followed the medical model, one that expected individual practitioners to be bound by the collective standards of their profession. Those shared standards were adopted for the protection of patients, and, like Colorado's Conversion Therapy Ban at issue in this case, they continue in the same longstanding tradition today.

For these reasons, Amici respectfully urge this Court to affirm the judgment below.

Respectfully submitted,

KENDRA N. BECKWITH
Counsel of Record
WOMBLE BOND DICKINSON (US) LLP
1601 19th Street, Suite 1000
Denver, CO 80202
(303) 623-9000
kendra.beckwith@wbd-us.com

Counsel for Amici Curiae