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

BRIEF OF EXPERTS IN HEALTH CARE PRACTICE, HEALTH LAW, AND BIOETHICS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

INTEREST OF THE AMICI CURIAE 1

SUMMARY OF ARGUMENT.....1

ARGUMENT 4

I. MENTAL HEALTH CARE IS AN INTEGRAL PART OF CLINICAL CARE 4

A. Science confirms that mental health is integral to overall health 4

B. Legal frameworks treat mental health care as part of the broader practice of health care delivery 7

II. SINCE THE BIRTH OF MODERN MEDICAL PRACTICE, THE STATE HAS REGULATED HEALTH CARE PROFESSIONALS' SPEECH AS PART OF ITS OVERSIGHT OF CLINICAL STANDARDS OF CARE.....8

A. Clinical encounters frequently consist only of speech.....9

B. The government has long regulated medical speech, including advice, as part of the standard of care 14

C. The regulation of clinical advice is distinguishable from non-clinical speech 26

III. DISTURBING COLORADO'S REGULATORY SCHEME WILL PLACE THE COURT IN THE POSITION OF DECIDING THE CONTENT OF CLINICAL STANDARDS ACROSS HEALTH CARE.....30

CONCLUSION 31

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374 P.3d 812 (Okla. 2016)..... 13, 16

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INTEREST OF THE AMICI CURIAE

Amici are experts in health care practice, health care law, and bioethics.[1] *Amici* bring expertise in health care, which integrates mental health care as an essential component, and which is often carried out purely through speech. *Amici* also have expertise in health care regulation, through which the state has maintained standards of clinical practice—even when such practice is carried out through speech. A list of *amici* is appended to this brief.

SUMMARY OF ARGUMENT

Since the beginning of modern medical practice,[2] states have regulated standards of clinical care—including care concerning mental health and care delivered through speech. Such regulation has taken many forms. Tort law has enforced prevailing standards of care, even when the care was delivered solely through speech. Licensing and other regulatory regimes have disciplined unlicensed individuals holding themselves out as professionals, who often

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[1] No counsel for a party authored this brief in whole or part, and no party other than *amici* or their counsel made a monetary contribution to the preparation or submission of the brief. *See* Supreme Court Rule 37.6.

[2] Medical historians date the birth of modern medical practice to the late nineteenth century, when empirical methods and germ theory were developed and incorporated into clinical care. Until then, medical practice relied on many approaches, including the belief that "illness … was … caused by an imbalance of the four humors" and ameliorated through techniques such as "bleeding" using leeches, among other approaches. Paul Starr, *The Social Transformation of American Medicine* 38, 95 (Basic Books 1982). *See* Br. of Medical History Scholars and Historians as Amici Curiae in Support of Respondents 13-17 [hereinafter *Historians' Br.*].

offered dubious scientific theories, as well as licensed professionals who engaged in clinical speech that was inaccurate or deviated from then-prevailing standards of care. And governments have created and standardized the very vocabulary of health care—diagnostic codes, procedural codes, and data standards—without which clinical communication would be impossible. These frameworks apply equally to mental health care. And for more than a century, such regulation of clinical communication has never been understood to infringe the First Amendment, because it governs the delivery of health care, not speech as speech.

These regulatory efforts reflect the realities of clinical practice. In the pre-antibiotic era, when effective procedures were scarce, physicians primarily advised patients through speech: how to prevent illness through hygiene; when to let an ailment run its course; how to prepare for death. Despite scientific advances, that remains true today. Pediatricians, primary care physicians, and mental health professionals then—and now—spend much of their practice counseling patients and families in encounters that consist only of speech. Licensing standards have long helped consolidate clinical practice into a discernible profession, and standardized vocabularies ensure that those standards are applied consistently.

State courts and legislatures have long recognized mental health as critical to the delivery of health care. Modern statutes confirm this parity: the Affordable Care Act treats mental health services as "essential health benefits," Health Insurance Portability and Accountability Act of 1996 (HIPAA) applies stringent

protections to psychotherapy notes, and state mental health licensing boards regulate counseling under frameworks parallel to those that govern medicine. For example, in Colorado, while licensed professional counselors may not "engage in the practice of medicine," [3] they are nevertheless subject to comprehensive state oversight, including licensure, discipline, and scope-of-practice rules that regulate their clinical speech in the same way that medical boards regulate physicians. This reflects clinical reality: mental health directly affects physical health, and biological factors strongly influence mental health.

The regulation of clinical practice, including care delivered primarily or exclusively through speech, relies heavily on professional expertise. Malpractice standards are defined in part by professional custom and the testimony of experts regarding the standard of care. Licensing boards rely on their licensees' expertise when imposing disciplinary sanctions. And regulatory agencies incorporate evidence-based guidelines developed by professional associations. This ensures that clinical practice of all kinds is held to the same standards, whether carried out through conduct, speech, or both.

These regulatory efforts are distinct from other speech regimes that do not set standards of care and may apply even outside clinical practice. *See Nat'l Inst. of Fam. & Life Advocs. v. Becerra*, 585 U.S. 755, 756 (2018) (where speech regime did not pertain to clinical standard of care) [hereinafter *NIFLA*]. For example, privacy laws restrict disclosure of a patient's

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[3] Colo. Rev. Stat. § 12-245-210(1).

visit whether or not clinical care is rendered. Such situations present different First Amendment questions and standards that do not apply to this case.

The Colorado law at issue here plainly regulates clinical care by prohibiting a form of counseling treatment deemed harmful by every major professional association: medical sexual orientation and gender identity change efforts. Applying strict scrutiny to such a law under the First Amendment would displace professional judgment, destabilize longstanding regulatory traditions, and force courts around the nation into the business of defining clinical care standards. The Constitution does not compel that result.

ARGUMENT

I. MENTAL HEALTH CARE IS AN INTEGRAL PART OF CLINICAL CARE

Although Petitioner seeks to divorce the regulation of "healthcare professions as a whole" from that of mental health care, Pet'r's Br. at 43, both clinically and legally, psychological treatment is inseparable from the broader practice of clinical care. Traditional approaches to health care regulation more generally should guide the Court.

A. Science confirms that mental health is integral to overall health

Mental health care—including psychology and counseling services—is not distinct from clinical care but is part of its core. Chronic stress contributes to cardiovascular disease, immune dysfunction, hypertension, digestive problems, ulcers, and genetic

damage.[4] Mental illness itself often has biological origins, including genetic and neurobiological bases.[5]

In recent decades, psychological interventions, such as cognitive behavioral therapy, problem-solving therapy, and interpersonal therapy, have been validated through randomized clinical trials and meta-analyses.[6] These treatments address depression, anxiety, post-traumatic stress disorder, obsessive-compulsive disorder, and eating disorders, among other conditions.[7] Data from routine practice settings have yielded similar treatment outcomes.[8]

Given the demonstrated effectiveness of many psychological interventions, prominent professional medical associations, including the American Academies of Pediatrics and Family Physicians, and the American College of Physicians recommend psychological treatment, including in clinical

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[4] Habib Yaribeygi et al., *The Impact of Stress on Body Function: A Review*, 16 EXCLI J. 1057, 1062-66 (2017); Jue Lin & Elissa Epel, *Stress and Telomere Shortening: Insights from Cellular Mechanisms*, AGEING RSCH. REV., Jan. 2022, at 1.

[5] *See generally* NEUROBIOLOGY OF MENTAL ILLNESS (Dennis S. Charney et al. eds., 4th ed. 2013).

[6] *See* Wolfgang Lutz et al., *Measurement-Based and Data-Informed Psychological Therapy*, 18 ANN. REV. CLINICAL PSYCH. 71, 72 (2021).

[7] *See, e.g.*, Chris Gaskell et al., *The Effectiveness of Psychological Interventions Delivered in Routine Practice: Systematic Review and Meta-Analysis,* 50 ADMIN. & POL. IN MENTAL HEALTH 43 (2023).

[8] *See, e.g.*, Wolfgang Lutz et al., *Clinical Effectiveness of Cognitive Behavioral Therapy for Depression in Routine Care: A Propensity Score Based Comparison Between Randomized Controlled Trials and Clinical Practice*, 189 J. AFFECTIVE DISORDERS 150 (2016).

guidelines, for several disorders including those with primarily physical manifestations (e.g., chronic musculoskeletal pain in adults and childhood obesity). [9] Medical professionals also routinely integrate mental health care into treatment plans.[10] The use of psychological assessments and interventions to assess or prepare a patient is also recommended before many procedures are performed, including some surgeries.[11] And primary care doctors

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[9] *See, e.g.*, Heather J. Walter et al., *Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders*, 59 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1107 (2020); Rachel A. Zuckerbrot et al., *Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management*, PEDIATRICS, Mar. 2018, at 1.

[10] Nirmita Panchal & Justin Lo, *Exploring the Rise in Mental Health Care Use by Demographics and Insurance Status*, KAISER FAM. FOUND. (Aug. 1, 2024), https://www.kff.org/mental-health/exploring-the-rise-in-mental-health-care-use-by-demographics-and-insurance-status/ (last visited Aug. 26, 2025) (finding 23% of U.S. adults received mental health treatment in 2022).

[11] *See, e.g.*, Paula C. Zimbrean et al., *ACLP Best Practice Guidance: Evaluation and Treatment of Depression in Solid Organ Transplant Recipients*, 64 J. ACAD. CONSULTATION-LIAISON PSYCHIATRY 357 (2023). Relatedly, Petitioner suggests that Colorado's law promotes gender-affirming care through medication and surgery rather than counseling. *See* Pet'r's Br. at 16-17. That is misleading. In many cases, transgender or gender expansive youth seek, and receive, only mental health care; youth seeking medication also often receive mental health care, and surgery, which is rarely performed on minors, also typically involve a mental health assessment. *See, e.g.*, FENWAY HEALTH, MEDICAL CARE OF GENDER DIVERSE CHILDREN AND ADOLESCENTS 1-3 (2019); Dannie Dai et al., *Prevalence of Gender-Affirming Surgical Procedures Among Minors and Adults in the US*, 7 JAMA NETWORK OPEN, June 27, 2024, at 2. Colorado's law does nothing

frequently screen and treat patients for mental health conditions like depression and anxiety.[12]

B. Legal frameworks treat mental health care as part of the broader practice of health care delivery

Mental health care and its providers are regulated by state and federal law as part of the broader framework of health care regulation. For example, the Privacy Rule, which implements HIPAA, applies with equal force to practitioners who provide mental health services as practitioners who address physical health needs.[13] In fact, the Privacy Rule imposes heightened protections for psychotherapy notes.[14] The Affordable Care Act classifies mental health care among its Essential Health Benefits (EHBs).[15] Mental health-related diagnostic codes are fully integrated into the standardized diagnostic code set maintained by the federal government, see infra Section II.B.3.[16] And oversight of the licensed practice of mental health care (e.g., psychology or professional counseling) is usually performed by divisions of the same state agencies responsible for general health care oversight or professional licensing, using similar regulatory,

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to disturb this status quo.

[12] Anuradha Jetty et al., *Assessing Primary Care Contributions to Behavioral Health: A Cross-sectional Study Using Medical Expenditure Panel Survey*, 13 J. PRIMARY CARE & CMTY. HEALTH 1 (2021).

[13] *See* 45 C.F.R. § 160.103.

[14] 45 C.F.R. § 164.508(a)(2).

[15] 42 U.S.C. § 18022(b)(1)(E).

[16] 45 C.F.R. §§ 162.1000(a), (c)(2).

licensing, and disciplinary frameworks.[17] Accord Historians' Br. at 28 ("As psychology expanded, a similar credentialing structure arose in that field.").

Courts have likewise recognized, since the birth of modern medical practice, that treatment of the mind, like treatment of the body, is clinical practice subject to state oversight. See Resp'ts' Br. at 25 (collecting cases). And states and the federal government require insurers to treat mental health on equal footing with other forms of care.[18]

Petitioner argues that examining the regulation of "healthcare professions as a whole . . . frame[s] the historical inquiry at too high a level of generality." Pet'r's Br. at 42. But given the longstanding clinical and legal integration of mental health care within health care regulation, the regulation of standards of care in the health care profession as a whole must guide the Court's inquiry.

II. SINCE THE BIRTH OF MODERN MEDICAL PRACTICE, THE STATE HAS REGULATED HEALTH CARE PROFESSIONALS' SPEECH AS PART OF ITS OVERSIGHT OF CLINICAL STANDARDS OF CARE

Since the birth of modern medical practice, the

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[17] For example, Colorado's professional boards with responsibility for licensing are housed within the Department of Regulatory Agencies. Colo. Rev. Stat. §§ 12-20-102, 12-20-103(3); *see also Division History* under *Division of Professions and Occupations: General Information*, Colo. Dep't Regul. Agencies, https://dpo.colorado.gov/FAQ (last visited Aug. 25, 2025).

[18] Richard Cauchi & Karmen Hanson, *Mental Health Benefits: State Laws Mandating or Regulating*, National Conference of State Legislatures (Dec. 30, 2015), https://www.ncsl.org/health/mental-health-benefits (last visited Aug. 26, 2025).

government has reasonably regulated standards of clinical care.[19] Such regulation has extended to all kinds of clinical interactions, including those concerning mental health—many of which involved nothing but speech.

Indeed, unlike most other areas of communication, the state's historical regulation of such standards extends to the development of medical vocabulary itself, that enables clinical speech in the first place. Such regulation enables the maintenance of standards of clinical care even when such care is delivered exclusively through speech.

A. Clinical encounters frequently consist only of speech

Clinical communication between doctor and patient through counseling, reassurance, and advice, often with the goal of changing patient behavior, is a core element of the treatment relationship. Mental health counselors like Chiles seek to achieve these goals—but so do primary care providers and pediatricians. Popular portrayals of medical professionals and dramatic depictions of emergency rooms where patients' lives rely on heroic procedures by doctors belie the routine practice of medicine, which primarily involves conversations between doctors and patients, to which procedures are often simply incidental or last resorts.[20]

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[19] While Petitioner offers hypothetical legislation regarding clinical care standards, Pet'r's Br. at 24, any such regulations—like Colorado's law at issue here—must still survive rationality review.

[20] Tanya Stivers & Alexandra Tate, *The Role of Health Care Communication in Treatment Outcomes*, 9 ANN. REV.

Among pediatric patients in particular, communication forms the lion's share of care. Well-child visits are "the most common type of physician visit for children, and it typically involves guidance from a physician." [21] Indeed, Medicaid and CHIP require coverage of well-child visits, underscoring that counseling is a core component of pediatric care.[22] Well-child treatment and diagnostics often take a wait-and-see approach when "discerning subtle signs of emotional or psychological challenges that might warrant attention." [23] When intervention is appropriate, physicians routinely advise patients or caregivers on injury prevention behaviors such as car-seat use, smoke detector maintenance, safe hot water temperatures, maintenance of stair gates, safe storage of medication and poisonous substances, and supervised access to tubs and pools.[24] Advice tailored to the specific patient measurably results in improved

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LINGUISTICS 233 (2023).

[21] Okelue E. Okobi et al., *Analyzing Best Practices for Pediatric Well-Child Clinic Visits in the United States for Children Aged Three to Five Years: A Review*, CUREUS J. MED. SCI., Sept. 13, 2023, at 9.

[22] *See, e.g.*, Ctrs. for Medicare & Medicaid Servs., *Well-Child Care*, https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care (last visited Aug. 24, 2025).

[23] Okobi, *supra* note 21, at 2.

[24] *See* Tonja R. Nansel et al., *Baby, Be Safe: The Effect of Tailored Communications for Pediatric Injury Prevention Provided in a Primary Care Setting*, 46 PATIENT EDUC. & COUNS. 175 (2002); Paula Stehr et al., *Effective Communication with Caregivers to Prevent Unintentional Injuries in Children Under Seven Years*, 105 PATIENT EDUC. & COUNS. 2721 (2022).

family behavior and child safety.[25]

For older children, guidelines recommend an annual confidential visit, where primary care providers provide counseling addressing "several biomedical, emotional, and sociobehavioral areas currently threatening adolescent health." [26] Such counseling includes discussions regarding "use of smokeless tobacco, sexual orientation, sexual and physical abuse, . . . alcohol use while riding a bike or swimming . . . sexual intercourse, . . . consistency of seat belt and helmet use . . . , depression, eating disorders, suicide, access to handguns, and close friends' and families' risk behavior."[27] Studies suggest that even 25 years ago, 80% of pediatric adolescent patients received counseling regarding certain risk behavior, and that that number may have increased with changes to medical school curricula. [28] The interaction between adolescents and their pediatricians frequently involves *only* speech—where physiological testing is required (for example, for sexually transmitted infections), pediatricians often refer patients to other clinics.

Beyond the pediatric context, advice promoting "[i]mproved nutrition, appropriate eating behaviors,

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[25] *Id.*

[26] Bonnie L. Halpern-Felsher, *Preventive Services in a Health Maintenance Organization: How Well Do Pediatricians Screen and Educate Adolescent Patients?*, 154 JAMA PEDIATRICS 173 (2000).

[27] *Id.*

[28] *Id.* ("The significant relation between years since graduation and provision of preventive services likely reflects greater emphasis on prevention in more recent medical school curricula[.]").

and increased physical activity," *National Federation of Independent Business v. Sebelius*, 567 U.S. 519, 554 (2012) (quoting federally issued dietary guidelines) [hereinafter *NFIB*], is essential to medical practice,[29] and likewise frequently involves only speech-based medical care. Physicians routinely provide information regarding "diet related comorbidities, wh[ich] . . . require safe, evidence-based information and consultation to prevent harm, which in some situations may include death."[30] Other studies focus on communications around weight loss.[31]

More broadly, communications with general practitioners and specialists alike often consist entirely of speech. These include situations where the patient is mistaken that there is anything the matter, where the best intervention is no intervention at all.[32]

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[29] *See* James M. Rippe, *Lifestyle Medicine: The Health Promoting Power of Daily Habits and Practices*, 12 AM. J. LIFESTYLE MED. 499 (2018).

[30] Taylor J. Newman & Angela E. Surrett, *A "License to Kale"—Free Speech Challenges to Occupational Licensing of Nutrition and Dietetics*, 52 ST. MARY'S L.J. 1181, 1184 (2021). Petitioner analogizes the treatment she seeks to provide to treatments for "eating disorders." Pet'r's Br. at 12. Even if being gay or transgender could be analogized to a disorder (it cannot), just as the state may regulate inappropriate talk therapy or advice regarding eating disorders, so too may the state regulate the standard of care for therapy relating to sexuality or gender identity.

[31] Charlotte Albury et al., *Patient-Clinician Communication About Weight Loss*, 333 JAMA 900, 900-01 (2025).

[32] Naomi C. A. van der Velden et al., *The Effect of Prognostic Communication on Patient Outcomes in Palliative Cancer Care: A Systematic Review*, 21 CURRENT TREATMENT OPTIONS ONCOLOGY 40 (2020); Jeffrey L. Jackson, *Communication About Symptoms in Primary Care: Impact on Patient Outcomes*, 11 J. ALT. & COMPLEMENTARY MED. S-51 (2005).

For example, pediatricians often recommend "watchful waiting" for ear infections or minor viral illnesses; internists may advise that rest and hydration are sufficient treatment for mild gastrointestinal or respiratory symptoms, and pediatricians might advise that certain blunt foreign bodies, when accidentally ingested, can be allowed to pass through a child's digestive system without intervention.[33]

Other problems might go even beyond modern medical abilities, such as where physicians can only advise leaving matters to fate. Oncologists thus have the task of advising patients that they "can do nothing for the patient any longer" because no further medical procedures exist. [34] Geriatricians might counsel families about dementia by engaging the patient and care partners in shared decision-making and offering emotional support. [35] In other situations, doctors advise against initiating futile care, especially when do not resuscitate orders are involved.[36]

In all such situations, medical professionals engage in "speech," which effectuates the "practice of

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[33] Monte C. Uyemura, *Foreign Body Ingestion in Children*, 72 AM. FAM. PHYSICIAN 287 (2005), https://www.aafp.org/pubs/afp/issues/2005/0715/p287.html. *But see Allen v. Harrison*, 374 P.3d 812, 817 (Okla. 2016) (advise might be different when foreign body is a nail).

[34] *See* AMA, *Code of Medical Ethics: Withholding or Withdrawing Life-Sustaining Treatment, Opinion 5.3*, https://code-medical-ethics.ama-assn.org/ethics-opinions/withholding-or-withdrawing-life-sustaining-treatment (last visited Aug. 26, 2025).

[35] Meghan K. Mattos et al., *Shared Decision-Making in Dementia: A Scoping Review*, 22 DEMENTIA 875 (2022).

[36] *See* AMA, *supra* note 34.

medicine," even though they do not engage in any further medical conduct. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992), *overruled in part by Dobbs v. Jackson Women's Health Org.,* 597 U.S. 215 (2022).

B. The government has long regulated medical speech, including advice, as part of the standard of care

1. Given that speech often constitutes the entirety of a clinical encounter, states have long applied laws maintaining standards of care to clinical speech. To be sure, this Court has explicitly approved much of this regulation to "facilitate informed consent to a medical procedure." *NIFLA*, 585 U.S. at 770 (citing *Casey,* 505 U.S. at 899–900 (upholding a law requiring physicians to obtain informed consent before they could perform an abortion)); *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.); *see also Canterbury v. Spence*, 464 F.2d 772, 778 (D.C. Cir. 1972) (evaluating the failure to inform a patient of risks of operation). Other duties to speak, such as obtaining a patient's history or identifying allergies may also be "tied to a [medical] procedure." *See NIFLA*, 585 U.S. at 770; *Stokes v. Dailey*, 85 N.W.2d 745, 752 (N.D. 1957); *Yorston v. Pennell*, 153 A.2d 255, 260 (Pa. 1959).

2. But clinical speech *unrelated* to any procedure—as the previous Section describes—goes back more than 100 years. For example, after dieticians provided advice during World War I and the Spanish American War, the first major national association of dietitians was formed in 1917.[37] During the same era, parents

[37] Newman & Surrett, *supra* note 30, at 1188.

sought pediatricians' advice on issues from appropriate baby food to disciplinary measures.[38] Indeed, the limits of medical technology during this era often meant that doctors could primarily offer only speech-based counsel rather than "procedures" to effectuate clinical goals. *See also* Historians' Br. at 8 (even before the birth of modern practice, "medicine was primarily performed via speech, i.e., without any manipulation or touching of the patient"). For example, while medical professionals were familiar with germ theory by the turn of the century, it would be another 50 years before antibiotics were discovered.[39] Doctors therefore could only advise their patients on various hygiene measures.[40] The fact that mere advice was involved, however, did not allow doctors to escape liability. "Longstanding torts for professional malpractice" applied in various situations where arguably, only speech was involved. *NIFLA*, 585 U.S. at 769.

a. *Speech cases*: Throughout the course of historic medical practice, incorrect advice, unrelated to any procedure, had established liability. For example, in *Edwards v. Lamb*, 45 A. 480, 480-81 (N.H. 1899), a doctor informed a patient's wife that she could not become infected from her husband's wound. The doctor only made a statement to the wife about her own risks of infection. *Id.* Despite the doctor's argument that he had not engaged in any *conduct* per se, the court held that "[t]he fact that his duty, as to

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[38] Nancy Tomes, THE GOSPEL OF GERMS: MEN, WOMEN, AND THE MICROBE IN AMERICAN LIFE (1998).

[39] *Id.*

[40] *Id.*

her, was merely to advise, and not to administer treatment, is immaterial." *Id.* at 480. The doctor's "mere[]…advi[c]e" was subject to regulation: by "inform[ing]" the patient's wife "that there was no danger of infection…he voluntarily assumed certain obligations." *Id.* Other cases have similarly held liability when "advice was given negligently," resulting in infection. *Skillings v. Allen*, 173 N.W. 663, 664 (Minn. 1919).

Such torts were particularly relevant in situations before antibiotics were discovered, when physicians' most effective assistance was providing information.[41] *See id.* (collecting cases); *Harriott v. Plimpton*, 44 N.E. 992, 993 (Mass. 1896) (holding that "the fact that the purpose of the examination was information, and not medical treatment is immaterial"). But even today, doctors can be held liable for incorrect advice—even when no procedure is involved. *See Lininger v. Eisenbaum*, 764 P.2d 1202, 1204 (Colo. 1988) (holding that a physician's failure to diagnose the hereditary nature of a child's blindness which led his parents to conceive a second blind child provided a cause of action); *Hofmann v. Blackmon*, 241 So. 2d 752, 753 (Fla. Dist. Ct. App. 1970) (recognizing a physician's independent duty of accurately communicating information to a patient, separate from a duty to diagnose).

Additional duties like informed consent apply even when a physician's recommendation is to forgo medical intervention. *Allen v. Harrison*, 374 P.3d 812, 817 (Okla. 2016) (discussing that a patient must be

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[41] Indeed, standardized language for diagnoses were developed long before "medical *procedures*," many of which arrived later in the history of clinical care. *See infra* Subsection II.C.2.

provided information regarding risks relating to letting a nail pass through their digestive system); *Matthies v. Mastromonaco*, 733 A.2d 456, 464 (N.J. 1999) (considering whether a doctor should inform a patient of the risks and benefits of bed rest for treating a hip fracture).

b. *Diagnosis:* In yet another important category of cases, courts have recognized malpractice liability even based on a physician's *failure* to make and communicate an accurate diagnosis. *See Harris v. Gallaher*, 407 A.2d 531, 532 (Del. 1979) (addressing negligence when a patient was told not to worry about a mass in her breast that later proved to be malignant); *Colozzo v. LoVece*, 534 N.Y.S.2d 701, 701 (N.Y. App. Div. 1988) (evaluating malpractice when a pediatrician discharged an infant after assuring parents of good health, despite the infant having developed sepsis); *Molloy v. Meier*, 679 N.W.2d 711, 719 (Minn. 2004) (holding that physicians acted negligently by communicating test results as normal when in reality, the physicians had failed to perform sufficient genetic tests). These instances illustrate how a doctor's *failure* to act, and therefore convey relevant information to the patient, can give rise to liability.

To be sure, "drawing the line between speech and conduct can be difficult," and it might be argued that the failure to diagnose is inherently tied to the act of diagnosis itself. *NIFLA*, 585 U.S. at 769; *but see NFIB*, 567 U.S. at 555 (recognizing a "difference between activity and inactivity"). Nonetheless, cases make clear that even when the task of diagnosis is complete (and accurate), the failure to *communicate* that diagnosis can create liability. *See Betesh v. United States*, 400 F. Supp. 238, 246 (D.D.C. 1974) (failing to

inform a person of a possible cancer diagnosis creates liability since an "examinee generally assumes that 'no news is good news' and relies on the assumption that any serious condition will be revealed [when a doctor conducts a physical examination]"); *Oliver v. Sutton*, 540 S.E.2d 645, 648 (Ga. Ct. App. 2000) (finding that "[a]lthough determining the correct diagnosis after allegedly misdiagnosing the problem is certainly not negligence, failing to communicate the proper diagnosis can be"). Such duties may also require a physician to communicate a relevant diagnosis to a third party. *See Pate v. Threlkel*, 661 So.2d 278, 282 (Fla. 1995) (concluding that a physician's duty runs to certain third parties, including children, when the children are of a patient with a genetically transferable nature of a condition).

c. *Referral and Gatekeeping:* Speech also creates liability when physicians mishandle referrals or gatekeeping responsibilities, which are generally carried out solely through the written or spoken word. *See Scott v. Brookdale Hosp. Ctr.*, 400 N.Y.S.2d 552, 553 (N.Y. App. Div. 1977) (finding that a failure to admit a patient, when the patient presents signs of emergency, is actionable); *see also Warren v. Dinter*, 926 N.W.2d 370, 379 (Minn. 2019) (finding that a hospitalist's role as a "gatekeeper" for hospital admissions can establish a duty of care in professional negligence even if a physician-patient relationship does not exist). Similarly, although the patient's interactions with a primary care physician and a specialist may "involve different transactions, entered into at different times, with different providers," *NFIB*, 567 U.S. at 554, the failure to initiate a referral to a specialist can still breach the duty of care. *Id.*; *see King v. Flamm*, 442 S.W.2d 679, 681 (Tex. 1969)

(recognizing that "there is a duty to seek consultation with, and refer the patient to, a specialist"); *cf. Larsen v. Yelle*, 246 N.W.2d 841, 844 (Minn. 1976) (holding that a general practitioner's failure to refer a patient to a specialist does not automatically establish negligence, but may do so depending on the circumstances); *Davis v. Mercy Med. Ctr.*, 994 N.W.2d 380, 387 (N.D. 2023) (finding that a physician's failure to refer a patient to a nephrologist was the proximate cause of patient's injuries).

d. *Counseling:* Given the regulatory integration of mental health care into clinical care more generally, speech-only counseling is routinely regulated under malpractice standards. *See, e.g.*, *Roberts v. Salmi*, 866 N.W.2d 460, 474 (Mich. Ct. App. 2014) (recognizing therapist misconduct if they use inappropriate treatment techniques); *Mower v. Baird*, 422 P.3d 837, 844 (Utah 2018) (finding that therapists have a duty to refrain from recklessly giving rise to false memories or allegations of sexual abuse); *Lovelace v. Urbano*, 37 Va. Cir. 114 (Va. Cir. 1995) (upholding a malpractice verdict against a licensed clinical social worker who breached the standard of care by failing to intervene when confronted with information that patient was in imminent danger of suicide). Psychologists and other mental health professionals are also subject to liability for abusive, harassing, or otherwise harmful speech. *See, e.g., Harris v. Kreutzer*, 624 S.E.2d 24, 32-33 (Va. 2006) (holding that a psychologist's verbally abusive conduct could support a malpractice claim). As in other areas of medicine, liability in the mental health context may arise when care is delivered solely through speech.

3. In addition to tort liability, states have historically overseen clinical practice—some of which

includes only speech—through licensing and regulatory regimes. Licensure serves two purposes: it prevents untrained individuals from offering spurious information under a medical mantle, and it ensures quality of practice among licensed individuals. Respondent and its amici explain how state licensing regimes pre-date modern medical practice and have consistently been upheld against free speech challenges by unlicensed individuals. *See* Resp'ts' Br. at 32 (collecting cases).

Licensure regimes also maintain quality of practice among licensed individuals, again, even only when speech is involved. For example, the North Carolina Board of Chiropractic Examiners disciplined a chiropractor who advised a patient to deliver her own baby at home, a sanction upheld on appeal. *See Federowicz v. N.C. Bd. of Chiropractic Exam'rs*, 905 S.E.2d 788, 792 (N.C. Ct. App. 2024). Similarly, Pennsylvania disciplined a chiropractor who discouraged a patient from seeking needed medical treatment. *Commonwealth of Pa., Bureau of Prof'l & Occupational Affs. v. Gallagher,* No. 99-43-06018 (Pa. State Bd. of Chiropractic Mar. 28, 2005) (final adjudication and order) (treating chiropractor discouraged their patient from seeking additional medical treatment).

Beyond licensing, other regulations mandate forms of medical advice tailored to patient safety. For example, Nevada law obligates physicians to educate patients about the dangers of operating a motor vehicle with certain medical conditions.[42] Other states require providers or health information exchanges to

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[42] Nev. Rev. Stat. § 629.047(1)(a).

provide certain disclosures before transmitting patient data. *E.g.,* Md. Code Regs. 10.25.18.03.B; 740 Ill. Comp. Stat. § 110/9.6. And some states also regulate how diagnoses are communicated once made, requiring prior informed consent for certain test results. *E.g.,* Mass. Gen. Laws ch. 111, § 70F (requiring written informed consent from the test subject for the HIV test and the disclosure of its results or identity); N.J. Stat. Ann. §§ 10:5-45, 47 (genetic tests).

Finally, while states generally regulate standards of care, the federal government also sometimes plays a role at the margin, encouraging certain forms of indicated care, even if such care primarily involves speech. For example, federal reimbursement can be tied to certain forms of care. As noted above, pediatric well-visits are "a mandatory covered service for Medicaid and CHIP."[43] Similarly, the Centers for Medicare and Medicaid Services (CMS) provides reimbursement for face-to-face conversations with a patient or their surrogate when they involve the explanation and discussion of advance directives.[44]

4. Additionally, the government has regulated the development and standardization of medical vocabulary since the birth of modern medical practice. This ensures that consistent nomenclature can be applied to diagnoses covering a specific set of

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[43] Cntrs. for Medicare & Medicaid Servs., *Using Data to Monitor Well-Child Visits: Medicaid and CHIP Enrollees Who Received a Well-Child Visit in 2020* (Dec. 2023), https://www.medicaid.gov/medicaid/data-and-systems/downloads/macbis/well-chld-visit-data-brf.pdf.

[44] Ctrs. for Medicare & Medicaid Servs., *Advance Care Planning*, MEDICARE LEARNING NETWORK (2024).

symptoms and procedures, allowing physicians, patients, and payors to communicate reliably. Such regulation affects how medical diagnoses are created and expressed, how medical procedures are named, and how health information is prepared, stored, and transmitted. The government's development of the very vocabulary that makes communication regarding clinical care possible distinguishes this area of speech from nearly any other area of human interaction.

a. Examples of state involvement in standardizing diagnostic codes date back more than a century. In 1898, the United States government adopted the "International List of Causes of Death" created by the International Statistical Institute, a first step for a universal language for medical diagnoses.[45] Over the next century, the World Health Organization (WHO) assumed responsibility for what became the International Classification of Diseases (ICD).[46] The United States Public Health Service adapted the ICD based "on the unique needs of the United States."[47] Today, the CDC's National Center for Health Statistics (NCHS) publishes ICD-10-CM. [48] *See* Centers for Disease Control & Prevention, National Center for Health Statistics, International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM)* (2025). While the WHO's preparation has 10,607 leaf codes, the CDC's

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[45] J.A. Hirsch, et al., *ICD-10: History and Context*, 37 AM. J. NEURORADIOLOGY 596 (2016); M. Gersenovic, *The ICD Family of Classifications*, 34 METHODS INF. MED. 172 (1995).

[46] Hirsch, *supra* note 45, at 596.

[47] *Id.* at 597.

[48] *Id.*

modification expands the set to more than 71,000.[49] CMS also created ICD-10-PCS, a separate code set not based on any WHO ICD standard to classify procedures performed in inpatient hospital settings.[50]

Governmental action has also helped develop and standardize procedure codes. The *Current Procedural Terminology* (CPT) system was developed through a "a complex interplay between the American Medical Association and the Centers for Medicare and Medicaid Services (CMS)."[51] CMS has also developed the Healthcare Common Procedure Coding System which incorporates the CPT system and expands on it to provide codes for procedures not addressed by the CPT code set. Federal regulations mandate the use of these code sets by HIPAA covered entities when conducting certain electronic data transactions involving health information.[52] Furthermore, CMS maintains Medicare and Medicaid billing and coding policies through the National Correct Coding Initiative.[53]

Notably, talk therapy itself is recognized as a medical procedure in these code sets by CPT code

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[49] Kin Wah Fung, et al., *The New International Classification of Diseases 11th Edition: A Comparative Analysis with ICD-10 and ICD-10-CM*, 27 J. AM. MED. INFORMATICS ASS'N 738 (2020).

[50] Nat'l Ctr. for Health Statistics, *ICD-10-CM/PCS Transition – Background*, CDC Archive, https://archive.cdc.gov/www_cdc_gov/nchs/icd/icd10cm_pcs_background.htm (last visited Aug. 22, 2025).

[51] Hirsch, *supra* note 45, at 597.

[52] 45 C.F.R. §§ 162.1000(a), 162.1002(c).

[53] Medicare NCCI, https://www.cms.gov/medicare/coding-billing/ncci-medicare (last visited Aug. 23, 2025).

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Government regulation and standardization has more recently extended to medical records. While states once dictated standards for billing claims and creating and storing data, the federal government now plays an essential role in promoting the formats in how providers collect, store, and transmit data. For example, the certified electronic health records (EHR) technology (CEHRT) program sets standards for EHRs that change yearly based on both law and regulation.[54] These standards determine the formats that medical professionals use to enter data into their EHR systems. Craig Konnoth, *Health Data Federalism*, 101 B.U. L. REV. 2169, 2194 (2021). Providers are incentivized or penalized financially based on compliance with these standards.[55]

b. Finally, regulation reaches research and education at both the state and federal levels.[56] For example, the Common Rule governs federally funded research involving human subjects, including surveys and studies using existing identifiable data—activities that may involve only speech. [57] The

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[54] Craig Konnoth, *Regulatory De-Arbitrage in Twenty-First Century Cures Act's Health Information Regulation, Annals Health L. & Life Sci.*, 29 ANNALS OF HEALTH L. & LIFE SCI. 135 (2020).

[55] *Id.* For a small subset of 2025 requirements, see Quality Payment Program, *Quality: Traditional MIPS Requirements* https://qpp.cms.gov/mips/quality-requirements (last visited Aug. 23, 2025).

[56] Kathy Irwin et al., *Open Access Legislation and Regulation in the United States: Implications for Higher Education*, 4 J. COPYRIGHT IN EDUC. & LIBRARIANSHIP 1 (2020), https://doi.org/10.17161/jcel.v4i1.13637.

[57] 45 C.F.R. § 46.102(e)(1)(i); 45 C.F.R. § 46.102(e)(1)(ii).

government also regulates *how* the delivery of health care services is taught, with numerous requirements at both the state[58] and federal level, including tying licensing and funding to curricular standards. *See, e.g.,* Embracing Anti-Discrimination, Unbiased Curricula, and Advancing Truth in Education Act, S. 1811, 119th Cong. (2025) (seeking to eliminate diversity training from clinical programs).

4. Colorado's statute is part and parcel of the panoply of the state oversight of standards of care that has long been memorialized through common law torts, regulation, and licensing. The law defines and identifies a specific procedure or modality—"conversion therapy"—as outside the standard of care. Colo. Rev. Stat. § 12-245-202(3.5). At the same time, the statute specifically permits other modalities that include "acceptance, support, and understanding for the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions." *Id.*

In so doing, Colorado follows the same model that states have long used: identifying unsafe or ineffective practices, prohibiting them, and endorsing evidence-based alternatives rooted in the best available clinical expertise. The counseling and advice Colorado seeks to regulate falls into the category of guidance that physicians provide daily, seeking to change patient

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[58] ACLS Medical Training, *Continuing Medical Education Requirements by State*, https://www.aclsmedicaltraining.com/continuing-medical-education-requirements-state/ (last visited Aug. 23, 2025); Fed'n of State Med. Bds., *State Specific Requirements for Initial Medical Licensure*, https://www.fsmb.org/step-3/state-licensure/ (last visited Aug. 23, 2025).

behavior and improve health—and which is already regulated through licensing boards, malpractice standards, and scope-of-practice laws. This is especially true of pediatric care, where counseling has a major role in clinical care and has long been subject to oversight. Subjecting such regulation to strict First Amendment scrutiny would endanger states' ability to regulate clinical standards of care, a role they have exercised for more than a century.

C. The regulation of clinical advice is distinguishable from non-clinical speech

While the regulation of medical speech in the course of maintaining standards of care has an extended legacy, other forms of regulation of professional speech have also developed over time. These regimes are broader in scope: some apply to "all interactions between" providers and patient "regardless of whether a medical procedure is ever sought, offered, or performed." *NIFLA*, 585 U.S. at 756. Such laws might invite other kinds of First Amendment scrutiny, depending on the circumstances. *See id.*[59] But the speech at issue in this case constitutes clinical care, and is subject to a tradition of standards of care regulation.

1. All states maintain various types of mandatory and permissive reporting laws that require medical professionals, among others, to disclose information to the government—even when no clinical care is

[59] It bears noting that in the vast majority of cases, these regulations *may* pertain to medical procedures or practice are involved, for example, when the information protected relates to clinical advice or procedures. This renders it distinguishable from the regulation at issue in *NIFLA*. The *regulation*, however, applies even in the absence of any clinical need.

provided—often to protect an individual, the public and/or other third parties.[60] Examples include laws mandating the reporting of gunshot wounds or other injuries from a suspected violent crime. *E.g.,* Ariz. Rev. Stat. § 13-3806; Ark. Code Ann. § 2-12-602; Colo. Rev. Stat. § 12-240-139. States also require reporting of communicable disease. *See, e.g.*, 28 Pa. Code § 27.21a; Va. Code Ann. § 32.1-36. State mandatory reporter laws may require health care providers to report instances of child abuse or neglect they know or suspect to proper state authorities. *E.g.,* Colo. Rev. Stat. § 19-3-304. And many jurisdictions require physicians to report conditions that may impair driving, such as epilepsy, vision problems, memory loss, and suicidal ideation. *E.g.,* Cal. Health & Safety Code § 103900; Del. Code Ann. tit. 24, § 1763; Nev. Rev. Stat. § 483.330; N.J. Stat. Ann. § 39:3-10.4.

Some states require health care providers to disclose information to guardians, partners, and other third parties.[61] Such reporting generally purports to serve the interests of families or the public. For example, in *Casey*, this Court held "that a State may require a minor seeking an abortion to obtain the consent of a parent or guardian" in most

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[60] Joel M. Geiderman & Catherine A. Marco, *Mandatory and Permissive Reporting Laws: Obligations, Challenges, Moral Dilemmas, and Opportunities*, J. AM. COLL. EMERG. PHYSICIANS OPEN (Jan. 21, 2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7493571/. State laws require disclosure of information regarding changes in ownership, and for audits and reviews. Such speech does not pertain to clinical care. *See, e.g.*, Ariz. Rev. Stat. Ann. § 36-422(D); Conn. Gen. Stat. § 19a-493. Federal law imposes similar requirements. *See, e.g.,* 42 C.F.R. § 493.39(b) (reporting for clinical laboratories).

[61] 45 C.F.R. § 164.502(g)(2).

circumstances. 505 U.S. at 899–900. Many states also permit or require providers to inform parents when minors seek access to contraception.[62] Still others impose partner notification obligations and duties to warn if a patient tests positive for HIV.[63]

2. Federal and state governments also impose strict privacy-related limits on the use, disclosure, and collection of individually identifiable health information and other types of personal information. These laws generally apply whenever information is collected in a doctor-patient interaction, regardless of whether clinical advice is dispensed.[64] For example, HIPAA restricts when physicians may share identifiable information about a patient, including information that is not inherently medical in nature, such as names, addresses, or other contact information.[65] State privacy laws often layer additional requirements or restrictions.[66] HIPAA also compels disclosures, again, even if no clinical advice is given, such as providing patients with a notice of privacy practice and notifying patients of a breach of

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[62] *See, e.g.*, Del. Code Ann. tit. 13, § 710(c); Ky. Rev. Stat. Ann. § 214.185(8).

[63] *See* HIV.gov, *Limits on Confidentiality: HIV Disclosure Policies and Procedures* (Sept. 16, 2024), https://www.hiv.gov/hiv-basics/living-well-with-hiv/your-legal-rights/limits-on-confidentiality.

[64] *See, e.g.,* 45 C.F.R. § 160.103 (HIPAA definitions of individually identifiable information and protected health information).

[65] *See* 45 C.F.R. § 164.502(a), *et seq.*

[66] *See generally* McDermott, Will & Emery, *Mapping Consumer Privacy* (last updated July 2, 2025), https://www.mwe.com/pdf/mapping-consumer-privacy/ (outlining state privacy laws in various areas including health care).

PHI.[67]

3. To be sure, in some situations, violations of privacy rules, recordkeeping, and even reporting requirements have implications for clinical care, and adherence to these provisions helps ensure that clinical standards are maintained. *See, e.g.*, *DeValk v. Health Partners, Inc.*, No. A11-377, 2011 WL 5026346, at *1-2 (Minn. Ct. App. Oct. 24, 2011) (denying nurse unemployment because she was fired for misconduct that included, inter alia, disclosing private health information and making incorrect claims on patient's medical records); *Catena v. Commonwealth, State Bd. of Med. Educ. & Licensure*, 411 A.2d 869, 870 (Pa. Commw. Ct. 1980) (considering a violation of Medicare fraud when physician failed to maintain records of treatment); *Federowicz*, 905 S.E.2d at 792 (recognizing a physician's failure to keep medical records that reflected patient's previous attempted childbirth). But as a whole, these laws serve different purposes than the historical regulations that define and enforce the standard of clinical care.

The activity at issue here is the delivery of a specific counseling treatment that is recognized by procedure codes (such as CPT 90832 for talk therapy) and then billed as clinical care. Such treatments fall squarely within states' traditional authority to regulate the professional practice and is categorically different from non-clinical speech regimes.

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[67] *See* 45 C.F.R. §§ 164.520 & 164.404, *et seq*.

III. DISTURBING COLORADO'S REGULATORY SCHEME WILL PLACE THE COURT IN THE POSITION OF DECIDING THE CONTENT OF CLINICAL STANDARDS ACROSS HEALTH CARE

This Court's precedents foreclose Petitioner's challenge. Colorado's statute is just one of many state laws that, whether or not speech is involved, regulate professional conduct and standards of care. Such regulation is "subject to reasonable licensing and regulation by the State." *Casey,* 505 U.S. at 884. This legal framework, which includes "state regulation[s] of professional conduct," *NIFLA*, 585 U.S. at 769 (quoting *NAACP v. Button*, 371 U.S. 415, 438 (1963)), to ensure the safety of its residents and to maintain consistent standards and expectations for practitioners, dates back to the birth of modern medical practice. Few forms of legal oversight are more longstanding or "traditional." *Id.* Colorado's "restriction . . . is part of [this] long . . . tradition of proscription." *Brown v. Ent. Merchs. Ass'n*, 564 U.S. 786, 792 (2011). Applying strict First Amendment scrutiny here would depart from the Court's doctrinal framework.

Deference to such regulation is also well advised as a practical matter. Unlike laws unrelated to standards of care, such as those mandating reporting for public safety purposes, laws regulating professional conduct and standards of care defer to clinical expertise. Tort law, for example, relies on expert testimony and licensing boards are made up of practitioners with expertise in their fields.

Strict scrutiny would render this Court—and the numerous lower courts in the first instance—arbiters

of clinical standards of care, embodied in professional speech, clinical vocabulary, and ultimately medical knowledge. That danger is evident from Petitioner's and her amici's own arguments: many focus not simply on whether counseling is "speech," but on whether the clinical content reflects appropriate science. If courts step into this domain, they will be drawn into questions they are ill-suited to answer: "Is the cessation of treatment itself a procedure?" "What about the refusal to provide treatment?" "How far removed must speech be from a procedure before it is treated differently?" "Who bears responsibility when counseling and procedures are provided by different professionals?" These are not constitutional questions; rather, they are professional health care ones, best answered by clinicians, licensing boards, and state regulators.

Petitioner asks this Court to transform the judiciary into a national medical board. Such a radical departure would abandon longstanding state authority, erode patient protections, and destabilize health care by forcing courts to substitute their judgment for clinical consensus. The First Amendment authorizes no such oversight.

CONCLUSION

This Court should affirm the decision below.

Respectfully submitted.

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