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 PROFESSORS OF LAW, MEDICINE, AND PUBLIC HEALTH AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

PATRICK J. HAYDEN
KATELYN KANG
COOLEY LLP
55 Hudson Yards
New York, NY 10001

RAYMOND P. TOLENTINO
JOSHUA REVESZ
ANGELINE X. CHEN
COOLEY LLP
1299 Pennsylvania Avenue NW
Washington, DC 20004

KATHLEEN R. HARTNETT
ZOË HELSTROM
Counsel of Record
COOLEY LLP
3 Embarcadero Center, 20th Floor
San Francisco, CA 94111
(415) 693-2000
khartnett@cooley.com

Counsel for Amici Curiae

131381

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

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INTEREST OF *AMICI CURIAE*

Amici curiae are professors of law, medicine, and public health who teach and write about biomedical ethics and health-related rights and discrimination.[1] Biomedical ethics, sometimes referred to as bioethics, is "the discipline of ethics dealing with moral problems arising in the practice of medicine and the pursuit of biomedical research."[2] *Amici* have a strong interest in ensuring that principles of biomedical ethics are accurately described and properly applied. They submit this brief to explain the ethical underpinnings of licensure and other regulatory regimes in the professional-medical-care context. *Amici* believe that Colorado's Minor Conversion Therapy Law, which prohibits licensed medical professionals in the State from engaging in harmful and unethical conversion "therapy,"[3] accords with bioethics principles and fits

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1. No counsel for a party authored this brief in whole or in part. No person or entity other than *amici curiae*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

2. J. R. Vevaina et al., *Issues in Biomedical Ethics*, 39 Disease-a-Month 869 (1993), https://pubmed.ncbi.nlm.nih.gov/8243220.

3. For consistency, *amici* refer to this practice as conversion "therapy," but use quotation marks to emphasize consensus in the medical and scientific community that this practice is in no way "therapeutic" and that sexual- and gender-variant people do not "need repair or conversion." *See* Department of Health and Human Services, Substance Abuse and Mental Health Services Admin., *Moving Beyond Change Efforts: Evidence and Action to Support and Affirm LGBTQI+ Youth* 8 (2023) [hereinafter SAMHSA Report], https://archive.org/details/httpsstore.samhsa.govsitesdefaultfilespep22-03-12-001/mode/2up.

comfortably within the tradition of state regulation of medical care. *Amici* also submit this brief to highlight the ethical harms that would flow from Petitioner's attempt to use the First Amendment to undermine state regulation of the medical profession, which (if accepted) would undermine all kinds of medical care, including care outside of the mental health context.

A full list of *amici* is provided in the appendix to this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

Since the Founding, state regulation of medical practice has played an important role in safeguarding the rights and wellbeing of patients, including by upholding baseline standards of care set by the medical community that help to protect patients from being subject to treatment that is unnecessarily harmful or otherwise unethical.[4] The Colorado law at issue in this appeal, the Minor Conversion Therapy Law, codified at Colorado Revised Statutes § 12-245-224(1)(t)(V) ("MCTL"), falls squarely within this long history of regulating the licensure of practitioners within States' borders to safeguard both the wellbeing of their

4. *See* Paul Starr, *The Social Transformation of American Medicine: The rise of a sovereign profession and the making of a vast industry* 12 (1982) ("Doctors . . . claim authority . . . as members of a community that has objectively validated their competence. The professional offers judgments and advice, not as a personal act based on privately revealed or idiosyncratic criteria, but as a representative of a community of shared standards[,] [t]he basis of [which] . . . is presumed to be rational inquiry and empirical evidence.").

communities and the medical profession through the ethically sound provision of care.

The Colorado law is also consistent with the precepts of biomedical ethics. Those principles require care providers to avoid harming their patients; to act in their patients' best interests; to respect their patients' autonomy; and to treat their patients justly. These ethical standards play an important role in shaping lawmaking, including by helping to guide decision-making for difficult policy questions involving public health and safety. State medical licensing regimes like Colorado's rely on these principles to shape regulations and restrictions that protect patients. Provisions like the MCTL—which prohibit the use of conversion "therapy," a form of "treatment" that has been widely recognized as ineffective and harmful to patients—do exactly that.

Petitioner claims that the First Amendment draws a distinction between her talk therapy practice and other forms of medical treatment. Her position seeks to insulate from regulation all kinds of care within the mental health sphere and grossly downplays the ethical obligations that licensed mental health practitioners have towards their patients. Petitioner's position would also set a dangerous precedent that could harm the State's ability to enforce baseline standards for broad swaths of medical treatment, even outside the mental health context. The First Amendment does not require that mistaken approach.

ARGUMENT

I. THE MCTL ADVANCES KEY TENETS OF BIOMEDICAL ETHICS.

Colorado generally prohibits psychologists, therapists, and other mental health professionals licensed in the State from engaging in conduct that "does not meet the generally accepted standards" of the mental health profession. Colo. Rev. Stat. § 12-245-224(1)(g)(I). As part of those efforts, the MCTL prohibits the usage of "conversion therapy" on clients under eighteen years of age. Colo. Rev. Stat. § 12-245-224(1)(t).

Conversion "therapy"—also referred to as "reparative therapy," "gender identity change efforts," and "sexual orientation change efforts"—describes conduct designed "to repress or change someone's sexual orientation or gender identity."[5] As a practice, conversion "therapy" is broadly recognized by medical experts and medical associations to be both harmful and ineffective.[6]

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5. *See* SAMHSA Report, *supra*, at 8.

6. *See* Jack L. Turban, *Gender Identity and Ethnoracial Disparities in Conversion Effort Exposure*, 114 Am. J. Pub. Health 455, 455 (2024); Joel R. Anderson, *Engaging Mental Health Service Providers to Recognize and Support Conversion Practice Survivors Through Their Journey to Recovery*, 31 Cognitive & Behavioral Practice 20, 21 (2024); Tural Mammadli, *Gender Identity Conversion Efforts as a Source of Minority Stress Among Transgender and Nonbinary Persons Living in the U.S.: Correlation with Wellbeing and Proximal Stressors*, 22 Sexuality Research & Social Policy 393, 393-94 (2025); *see also infra* at Sections I(B)-(D).

"Conversion therapy" is defined under the MCTL as any "practice or treatment" 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." Colo. Rev. Stat. § 12-245-202(3.5)(a). The statute does not prohibit any advocacy or other speech outside the confines of a provider-patient relationship.

Colorado's decision to restrict harmful medical practices, including conversion efforts, falls within the State's traditional prerogative to regulate the medical profession and safeguard patients from unethical procedures and practices. As the Tenth Circuit aptly noted, such "historical tradition of regulation is unsurprising, because medical treatment provided to the public must fall within the accepted standard of care for the profession." Pet. App. 41a (citations omitted). By defining that standard of care to protect minor patients from a practice that the medical and scientific community—not merely government officials—regards as harmful, ineffective, and at odds with the rights and dignity of LGBTQ+ people, the MCTL advances core tenets of bioethics and safeguards the health of Colorado's citizens.

A. The History of Medical Licensing and Ethics Supports Upholding the MCTL.

Regulation of public health in the United States is older than the Nation itself. In 1649, the Massachusetts Bay Colony enacted a statute prohibiting medical practitioners

from acting "contrary to the known approved rules of art."[7] And beginning in the early nineteenth century—before the enactment of the Fourteenth Amendment—state legislatures began implementing more specific licensing regimes to better ensure that medical practice advanced public health and safety.[8] Over and over, this Court upheld those licensing regimes as legitimate exercises of state authority, writing that since "time immemorial," governments have exercised the power "to exact in many pursuits a certain degree of skill and learning upon which the community may confidently rely" and that "[f]ew professions require more careful preparation by one who seeks to enter it than that of medicine." *Dent v. West Virginia*, 129 U.S. 114, 122 (1889).[9] By 1910, nearly every

7. Nissa M. Strottman, *Public Health and Private Medicine: Regulation in Colonial and Early National America*, 50 Hastings L.J. 383, 392 (1999) (quoting The Book of the General Lawes and Libertyes Concerning the Inhabitants of the Massachuests 18 (1660)).

8. *Id.* at 393.

9. *Reetz v. People of State of Michigan*, 188 U.S. 505, 505 (1903) ("The power of a state to make reasonable provisions for determining the qualifications of those engaging in the practice of medicine . . . and punishing those who attempt to engage therein in defiance of such statutory provisions, is not open to question."); *Watson v. State of Maryland*, 218 U.S. 173, 176 (1910) ("It is too well settled to require discussion at this day that the police power of the states extends to the regulation of certain trades and callings, particularly those which closely concern the public health."); *see also Barsky v. Bd. of Regents of Univ.*, 347 U.S. 442, 449 (1954) ("It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power. The state's discretion in that field extends naturally to the regulation of all professions concerned with health.").

State had established licensing boards in furtherance of this purpose.[10]

After the atrocities committed during World War II, it became apparent that mere declarations of medical ethics were not sufficient and that active enforcement would be required. As a result, state licensing regimes further evolved to better protect patients' rights, and to help restore the public's faith in the practice of medicine overall.[11] In furtherance of those goals, providers are now expected to comply with and support four key tenets of biomedical ethics: nonmaleficence, beneficence, autonomy, and justice.[12]

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10. *See* David Johnson & Humayun J. Chaudry, *The History of the Federal of State Medical Boards*, 98 J. Med. Reg. 20, 22 (2012); Starr, *supra*, at 22 (explaining that physicians recognized the benefits of licensing laws, as a market without such regulation "drew no sharp boundary between the educated and uneducated, blurred the lines between commerce and professionalism, and threatened to turn [doctors] into mere employees").

11. *See* Jonathan F. Will, *A Brief Historical and Theoretical Perspective on Patient Autonomy and Medical Decision Making: Part II: The Autonomy Model*, 139 Chest 1491, 1495 (2011) (noting that, after Nuremberg trials, there was "an unwillingness to trust physicians to protect the well-being of their patients"); *see* Kevin C. Chung, *Maintenance of Certification, Maintenance of Public Trust*, 127 Plast. Reconstr. Surg. 967, 968 (2011) (discussing the ways in which "significantly more accountability began to be demanded from physicians and hospitals to justify their practices and decisions" in the second half of the twentieth century).

12. *See*, *e.g.*, American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct* (2017) [hereinafter APA Code of Conduct], https://www.apa.org/ethics/code.]

Each principle plays a key role in safeguarding patient rights. Nonmaleficence requires a provider to avoid causing harm to their patients.[13] Nonmaleficence justifies prohibiting provider conduct that would cause harm, such as experimenting on patients, or conduct that would otherwise put the provider's interests before the patients' well-being.[14] Medical professionals in the United

13. *See* Jeami Nikolay, *Classification and Significance of Nonmaleficence within Medical Ethics*, 9 Advances in Med. Ethics J. 1 (2023) ("Nonmaleficence, derived from the Latin phrase 'primum non nocere,' which means 'first, do no harm,' symbolizes healthcare practitioners' ethical obligation to prioritize patient well-being and avoid inflicting damage."); *see* Jim Summers, *Principles of Healthcare Ethics*, 41 (2d ed. 2009); *see also* Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics*, 217 (8th ed. 2019) ("[M]orality requires that we treat persons autonomously and refrain from harming them").

14. *See* APA Code of Conduct, *supra*, § 3.06 ("Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to . . . expose the person or organization with whom the professional relationship exists to harm or exploitation."); American Psychiatric Association, *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* (2013) (describing the psychiatrist's "responsibility to the patient as paramount" and noting that "[w]hen the psychiatrist's outside relationships conflict with the clinical needs of the patient, the psychiatrist must always consider the impact of such relationships and strive to resolve such conflicts in a manner . . . likely to be beneficial to the patient"); APA Code of Conduct, *supra*, Principle A (describing as a "[g]eneral [p]rinciple" "[n]onmaleficence"); American Counseling Association, *Code of Ethics* § A.4 (2014) [hereinafter APA Code of Ethics], https://www.lpcboard.org/assets/docs/aca-code-of-ethics.pdf (noting that "[c]ounselors act to avoid harming their clients . . . and to minimize or to remedy unavoidable or unanticipated harm" and citing as a "fundamental principle[] of professional ethical behavior . . . nonmaleficence, or avoiding actions that cause harm").

States and around the world take oaths to "do no harm" and are held to duties that encompass this principle.[15]

Relatedly, beneficence is the duty to act in the best interest of patients.[16] The bioethical principle of autonomy seeks to ensure that patients can decide what care they wish to receive consistent with their beliefs, values, and interests.[17] Informed consent is central to autonomy, requiring providers to give accurate information that the patient would find important (such as a treatment's benefits and risks) so that patients can make decisions based on what is both medically and personally appropriate.[18]

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15. *See*, *e.g.*, APA, *The Principles of Medical Ethics* ("A physician shall, while caring for a patient, regard responsibility to the patient as paramount."); *see also* World Medical Association, WMA Declaration of Geneva, The Physician's Pledge, https://www.wma.net/policies-post/wma-declaration-of-geneva (pledging not to use medical knowledge to violate human rights and civil liberties); APA Code of Conduct, *supra*, § 3.04(a), https://www.apa.org/ethics/code ("Psychologists take reasonable steps to avoid harming their clients/patients . . . and to minimize harm where it is foreseeable and unavoidable."); ACA, Code of Ethics § A.4 (similar); *see also* APA, The Principles of Medical Ethics § 7.5 (prohibiting psychiatrists from participating in torture); Colorado Association of Psychotherapists, *Code of Ethics*, https://coloradopsychotherapists.org/code-of-ethics ("Members *shall* terminate the client/therapist relationship when it becomes clear to the member that: . . . the client is being harmed by continued counseling.") (emphasis added).

16. *See* Beauchamp & Childress, *supra*, at 13.

17. *See id.* at 105.

18. *See* Parth Shah et al., *Informed Consent*, StatPearls [Internet] (last updated Nov. 24, 2024), https://www.ncbi.nlm.nih.gov/books/NBK430827; *Cobbs v. Grant*, 8 Cal. 3d 229, 242-43 (1972).

Finally, a fourth core principle of bioethics—justice—requires providers to acknowledge inequalities in the delivery of medical care and to work toward fair, equitable, and appropriate treatment for all.[19]

By furthering each of these principles, state licensing and regulatory regimes benefit patients and medical care providers alike,[20] including by promoting public trust in the practice of medicine overall.[21] "Licensing and regulation by the state 'provide clients with the confidence they require to put their health or their livelihood in the hands of those who utilize knowledge and methods with

19. Beauchamp & Childress, *supra*, at 267–68.

20. *See* Johnson & Chaudry, *supra*, at 22 ("Where once the licensing of physicians had been equated with 'power and privilege,' the concept now became more closely linked to a genuine effort at protecting the public and the interests of independent educated professionals."); *see also* Gabriel Andrade & Maria Campo Redondo, *Is Conversion Therapy Ethical? A Renewed Discussion In The Context Of Legal Efforts To Ban It,* 20 Ethics Med. Public Health 1, 7 (2022) ("There has always been a need for State regulation of faulty practices, even if patients request them. . . . [W]ithout professional regulations enforced through the State, medicine could have never advanced as it has during the last two centuries."); *see also* Hannah B. Bayne & Kevin Doyle, *Licensure Portability Through an Ethical Lens: Considering Multiple Stakeholders*, 4 J. Mental Health Counseling 2, 100 (2019) ("The ability of each state to determine licensing requirements is therefore often seen as an important service for the protection of the public."); Starr, *supra*, at 22 ("Standardization of training and licensing became the means for realizing both the search for authority and control of the market.").

21. Starr, *supra*, at 22 ("To gain the trust that the practice of medicine requires, physicians had to assure the public of the reliability of their 'product.'").

which the clients ordinarily have little or no familiarity.'" *Stuart v. Camnitz*, 774 F.3d 238, 247 (4th Cir. 2014) (Wilkinson, J.) (quoting *King v. Gov. of N.J.*, 767 F.3d 216, 232 (3d Cir. 2014)). Clinicians benefit from the increased trust that these licensing regimes and other regulations foster.[22]

Licensure also has long helped protect the practices of qualified, ethical medical professionals, including by distinguishing qualified experts from unqualified "snake oil salesmen" who are not duty-bound to advance their clients' best interests. *See Peel v. Att'y Registration & Disciplinary Comm'n of Ill.*, 496 U.S. 91, 103 (1990) ("[B]oard certification nevertheless has 'come to be regarded as evidence of the skill and proficiency of those to whom they [have] been issued.'" (citation omitted)); *see also Pennsylvania v. Wilson*, 1897 WL 3612, at *2 (Pa. Quar. Sess. 1897) (describing how ailing patients' susceptibility to "accept the services of quacks" justifies medical regulations that ensure clinicians "possess the highest estimate of human life and the good health of society").

22. *See* Sylvia R. Cruess & Richard L. Cruess, *Professionalism and Medicine's Social Contract with Society*, 6 Virtual Mentor 185, 186 (2004) (noting that "society expects that the profession will ensure the competence of each physician by setting and maintaining standards for education, training, and practice—and by disciplining incompetent, unethical, or unprofessional conduct" and that physicians who fail to act with integrity "lose trust," which "reflect[s] upon the profession as a whole"); Starr, *supra*, at 24 ("By augmenting demand and controlling supply, greater professional authority helped physicians secure higher returns for their work.").

Contrary to Petitioner's selective view of the history of medical regulation, state regulation of medical practice has not been confined to procedural requirements like "continuing-education requirements, sufficient practice hours, and ongoing competence." Pet. Br. 10. For example, numerous States regulate the use of psychosurgery (*e.g.*, lobotomies and electroshock therapy), including by limiting or prohibiting the usage of such treatments on vulnerable populations, such as minors.[23] Each of these regulations is designed to help advance the values of nonmaleficence, beneficence, autonomy, and justice.

The MCTL is no different. In upholding the MCTL, the Tenth Circuit recognized Colorado's interests in protecting public health and the medical profession as "undeniably legitimate," and correctly concluded that the MCTL is rationally related to achieving those goals. *See* Pet. App. 63a-72a. Indeed, the MCTL establishes regulations whereby state-licensed mental health practitioners are subject to discipline for providing minor conversion "therapy"—a treatment that is demonstrably harmful, ineffective, and unethical. In doing so, the MCTL furthers the core bioethical principles that undergird modern-day licensing regimes and thereby serves the interests of patients and practitioners alike.

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23. Devan Stahl et al., *Should DBS for Psychiatric Disorders be Considered a Form of Psychosurgery? Ethical and Legal Considerations*, Science English Ethics (2017), https://philarchive.org/archive/STASDF.

B. The MCTL Safeguards Providers' Duties of Nonmaleficence and Beneficence.

The MCTL upholds the principles of nonmaleficence and beneficence by barring licensed mental health professionals from performing conversion "therapy" on minor patients, a practice that dozens of States and "every major medical, psychiatric, psychological, and professional mental health organization" have determined poses a significant risk of harm with little benefit. *Tingley v. Ferguson*, 47 F.4th 1055, 1064 (9th Cir. 2022).[24]

Petitioner and her *amici* attempt to draw a distinction between Petitioner's conduct, which she characterizes as mere "talk therapy," and other forms of "aversive" conduct. *See* Pet. Br. 5, 8-9, 21; Br. of *Amicus Curiae* American College of Pediatricians 22. But this distinction downplays the harms caused by *all* forms of conversion "therapy,"[25] harms that the Tenth Circuit recognized in upholding the MCTL. *See* Pet. App. 63a-65a (reflecting on

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24. *See* Movement Advancement Project, *LGBTQ Youth: Conversion "Therapy" Laws* (2025), at 3, https://www.lgbtmap.org/img/maps/citations-conversion-therapy.pdf (listing twenty-three states and the District of Columbia that prohibit state-licensed healthcare providers from performing conversion "therapy" on minors).

25. *See* Djordje Alempijevic et al., *Statement on Conversion Therapy*, 30 Torture 66, 70 (2020) ("All forms of conversion therapy, including talk or psychotherapy, can cause intense psychological pain and suffering."); *see also* Mallory et al., *supra*, at 2 (noting that "talk therapy is the most commonly used therapy technique" in conversion therapy).

suicide risks associated with conversion "therapy").[26] The American Psychological Association has collected recent research documenting how conversion "therapy" intended to change gender identity is associated with "increase[d] [] depression, anxiety, suicidality, loss of sexual feeling, impotence, deteriorated family relationships, a range of post-traumatic responses, and substance abuse."[27] Similarly, the United Nations Human Rights Council has concluded that conversion "therapy" practices are "by their very nature degrading, inhuman and cruel and create a significant risk of torture," calling for the practice to be banned worldwide.[28]

Research and clinical practice further establish that conversion therapy is ineffective in helping patients

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26. This reality directly contradicts with Petitioner's framing of conversion "therapy" as a form of "emotional support" that can alleviate mental health disparities among patients seeking care. *See* Pet. Br. 9.

27. American Psychological Association, *APA Resolution on Gender Identity Change Efforts* (Feb. 2021), at 3 [hereinafter *APA GICE Resolution*]; *see* American Psychological Association, *APA Resolution on Sexual Orientation Change Efforts* (Feb. 2021), at 5-6 (collecting research on the increased harms associated with conversion "therapy" intended to change sexual orientation, especially when practiced on minors, including suicidal behavior, depressive symptoms, distress, dissociation, emotional numbness, unprotected sex, substance abuse, disorientation, confusion, feelings of inauthenticity, anger, and grief); *see also* Andrade & Redondo, *supra*, at 3 ("More recent studies have documented that conversion therapy may cause depression, anxiety, suicide and general distress." (footnotes omitted)).

28. United Nations General Assembly Human Rights Council, *Practices of So-Called "Conversion Therapy"* (2020), at 21, https://docs.un.org/en/A/HRC/44/53.

overcome their distress or in altering their gender or sexuality. In 2008, psychology researchers concluded that "current literature fails to support [conversion 'therapy'] as an [empirically supported treatment]" because the practice did not show "better results than placebo or another established treatment."[29] Similarly, an expert consensus panel assembled by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services reported in 2023 that "[n]o available research supports the claim that [conversion 'therapy'] is beneficial to children, adolescents, or families" and that the practice is "not effective in altering sexual orientation . . . [or] gender identity."[30] Rather, the panel emphasized that "[a]vailable research indicates that [conversion 'therapy'] can cause significant harm."[31] In short, by prohibiting a treatment that plainly "conflicts with the principle of non-maleficence," the MCTL helps to ensure that licensed clinicians cannot harm their minor patients under the pretense of state-approved medical practice.[32]

Contrary to Petitioner's suggestion, *see* Pet. Br. 8-9, 28, not even the Cass Review, a 2024 collection of seven

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29. Robert J. Cramer et al., *Weighing the Evidence: Empirical Assessment and Ethical Implications of Conversion Therapy*, 18 Ethics Behavior 93, 102 (Mar. 31, 2008), https://doi.org/10.1080/10508420701713014.

30. SAMHSA Report, *supra*, at 9; *see also APA GICE Resolution*, *supra*, at 2 (finding that conversion "therapy" is "not supported by empirical evidence as effective practice[] for changing gender identity").

31. SAMHSA Report, *supra*, at 9.

32. *See* Andrade & Redondo, *supra*, at 7.

reviews that has been critically scrutinized by other medical professionals,[33] supports the use of conversion "therapy." In fact, the Cass Review expressly states that "no LGBTQ+ group should be subjected to conversion practice" and that "[n]o formal science-based training in psychotherapy, psychology, or psychiatry teaches or advocates conversion therapy."[34] "If an individual were to carry out such practices they would be acting outside of professional guidance."[35] In other words, even Petitioner's cited sources acknowledge the harms caused by conversion therapy. By prohibiting this harm, the MCTL helps to ensure that provider conduct remains within the boundaries of treatment that is in the patient's best interest.

C. The MCTL Does Not "Disrespect" Patients' Autonomy.

Petitioner and her *amici* wrongly claim that the MCTL "disrespects clients' autonomy," and seeks to

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33. *See*, *e.g.*, Chris Noone et al., *Critically Appraising the Cass Report: Methodological Flaws and Unsupported Claims*, 25 BMC Medical Research Methodology 128 (2025); Meredithe McNamara et al., *An Evidence-Based Critique of "The Cass Review" on Gender-affirming Care for Adolescent Gender Dysphoria*, at 2, https://law.yale.edu/sites/default/files/documents/integrity-project_cass-response.pdf (finding that the Cass Review "repeatedly misuses data and violates its own evidentiary standards by resting many conclusions on speculation" and "reveals profound misunderstandings of the evidence base and the clinical issues at hand").

34. Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People*, 150 § 11.5 (2024).

35. *Id.* at 150-151 §§ 11.5, 11.7.

"override" clients' goals. Pet. Br. 12, 54; *see also* Br. for *Amici Curiae* Christian Med. and Dental Ass'ns & Alliance For Hippocratic Med. 8 (arguing the MCTL "violates the patient's need for self-determination"). But Petitioner and her *amici* overlook the inherently coercive nature of the conduct that the MCTL prohibits.[36] States and medical associations often regulate coercive medical practices in an effort to protect patient autonomy. For example, chemical and physical restraints on patients are typically heavily regulated due to their impact on autonomy, dignity, and bodily integrity.[37] Similarly, "[a]ll forms of 'conversion therapy' share one autonomy-diminishing goal: to restrict a host of profoundly important interests in relation to sexuality and gender identity."[38] By prohibiting licensed clinicians from offering "therapy" that ultimately "suppress[es] fundamental choices that are central to personal autonomy," the MCTL actually helps to preserve a patient's autonomy rather than diminishing it.[39] Importantly, the law does not advocate

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36. *See* Timothy F. Murphy, *The Ethics of Conversion Therapy*, 5 Bioethics 123, 125 (1991) ("[T]he pursuit of conversion therapy ought to be seen as a forced choice persons would not otherwise make."); *see also* Douglas C. Haldeman, *The Practices and Ethics of Sexual Orientation Conversion Therapy*, 62 J. Consult. Clin. Psychol. 221, 226 (1994) ("[T]he concept that individuals seek [conversion 'therapy'] of their own free will may be fallacious.").

37. *See* Marie Chieze et al., *Coercive Measures in Psychiatry: A Review of Ethical Arguments*, 12 Frontiers in Psychiatry 1, 5 (2021); *see also Use of Restraints*, Opinion 1.2.7, AMA Code of Medical Ethics, available at https://code-medical-ethics.ama-assn.org/ethics-opinions/use-restraints (last visited August 19, 2025).

38. Ilias Trispitotis & Craig Purshouse, "*Conversion Therapy*" *as Degrading Treatment*, 42 Oxford J. Leg. Stud. 104, 110 (2022).

39. *See id.* at 110.

for any particular sexual orientation or gender identity; instead, it simply bars clinicians who have sought and received state licensure from expressing their personal beliefs and preferences under the guise of a proclaimed therapeutic benefit that is not empirically supported.

Thus, the MCTL's ban on conversion therapy for minors helps to protect patients from an inherently coercive and ineffective procedure, while also safeguarding their right to complete and accurate information about their care.

D. The MCTL Supports the Principle of Justice.

Medical regulations and licensing regimes uphold the bioethical principle of justice by ensuring that providers fulfill their ethical duty not to discriminate—including against LGBTQ+ people—when providing treatment.[40] Consistent with this principle, the MCTL disallows minor

40. *See* APA Code of Conduct, *supra*, § 3.01 ("In their work-related activities, psychologists do not engage in unfair discrimination based on . . . gender identity [or] sexual orientation. . . ."); American Association for Marriage and Family Therapy, Code of Ethics, at § 1.1, https://www.aamft.org/AAMFT/Legal_Ethics/Code_of_Ethics.aspx ("Marriage and family therapists provide professional assistance to persons without discrimination on the basis of . . . sexual orientation [or] gender identity."); National Association of Social Workers, Social Workers' Ethical Responsibilities to Clients, at § 1.05(d), https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English/Social-Workers-Ethical-Responsibilities-to-Clients ("Social workers should obtain education about and demonstrate understanding of the nature of social diversity and oppression with respect to . . . sexual orientation [or] gender identity. . . ."); CAP, *Code of Ethics*, ("Members shall not discriminate against or refuse professional services solely on the basis of . . . gender[] or sexual orientation.").

conversion "therapy," a practice that invalidates and pathologizes core parts of LGBTQ+ patients' identities and ultimately harms public health.[41] *See supra*, Section I(B). For example, and as the American Psychological Association has explained, conversion "therapy" to change gender identity is inherently discriminatory, because it is "founded on the notion that any gender identity that is not concordant with sex assigned at birth is disordered, and that a cisgender identity is healthier, preferable, and superior to a transgender or gender nonbinary identity."[42] Moreover, "all programs of sexual reorientation have their common origins and justifications" in an unjust moral judgment that "homoeroticism" is an "inferior" state,[43] and are similarly discriminatory and harmful to LGBTQ+ individuals. Because conversion "therapy" is "necessarily predicated on a devaluation of homosexual identity and behavior" and gender-variant identity and behavior, it fundamentally conflicts with mental health providers' duty to "promote the dignity and welfare of humankind."[44] Suggesting that a patient's identity is inferior and can be forced to change in some way—as conversion "therapy" does—"violates the principles of integrity and respect for the rights and dignity of minority individuals."[45]

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41. Andrade & Redondo, *supra*, at 4.

42. *APA GICE Resolution* at 1.

43. Murphy, *supra*, at 133.

44. Haldeman, *supra*, at 226; *see also* Andrade & Redondo, *supra*, at 4 (concluding that conversion "therapy" "practitioners engage in a form of discriminatory behavior that is not ethically warranted").

45. Cramer et al., *supra*, at 103.

Today, there is a medical consensus that variance in gender identity and sexual orientation are not disorders, but rather "normal aspects of human diversity."[46] Without laws like the MCTL, however, conversion "therapy" stands to perpetuate a long history of medical abuse—including the provision of electroconvulsive shocks, nausea-inducing drugs, and lobotomies—that dates back to a time in the nation's history when LGBTQ+ people were treated as criminals and as mentally disordered.[47] Colorado is well within its power to regulate conversion "therapy" and discipline state-licensed clinicians who inflict continued medical harm on LGBTQ+ people based on unjust and outdated misconceptions about them, thereby "disregard[ing] their commitment to social responsibility."[48]

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In sum, the MCTL furthers the principles of nonmaleficence and beneficence by prohibiting conduct that stigmatizes and harms patients (thus promoting

46. *See* SAMHSA Report, *supra*, at 51; *see also* N.J. Stat. § 45:1-54 ("Being lesbian, gay, or bisexual is not a disease, disorder, illness, deficiency, or shortcoming."); Illinois Public Act No. 099-0411 (same); *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 594 (4th Cir. 2020), *as amended* (Aug. 28, 2020) ("Being transgender is also not a psychiatric condition, and 'implies no impairment in judgment, stability, reliability, or general social or vocational capabilities.'").

47. *See* Andrade & Redondo, *supra*, at 2; Katherine Ott, *The History of Getting the Gay Out*, National Museum of American HISTORY (Nov. 15, 2018), https://americanhistory.si.edu/explore/stories/history-getting-gay-out.

48. Andrade & Redondo, *supra*, at 4.

nonmaleficence) and which is known to be ineffective (thus promoting beneficence). The MCTL also safeguards patient autonomy by barring a "treatment" that, at its core, deprives patients of their agency. Finally, the MCTL supports the principle of justice by prohibiting a treatment that inherently discriminates against LGBTQ+ individuals. The MCTL thus advances each of the bioethical values that safeguard the health and dignity of the patients within Colorado's borders.

II. TREATING TALK THERAPY LIKE ALL OTHER FORMS OF SPEECH WOULD COMPROMISE THE INTEGRITY OF MEDICAL CARE.

The ethical standards and principles discussed above are not merely aspirational. Ethics frequently shapes legal doctrine, including by assisting courts in determining how to answer questions implicating difficult policy considerations in public health and healthcare. *See*, *e.g.*, *Vacco v. Quill*, 521 U.S. 793, 800-01 & n.6 (1997) (discussing the ethical principles of nonmaleficence and beneficence in the context of assisted suicide); *Abdur'Rahman v. Bredesen*, 2004 WL 2246227, *8 & n.45 (Tenn. Ct. App. Oct. 6, 2004) (discussing bioethical principles in the context of physician participation in executions); *see also United States v. Ilayayev*, 800 F. Supp. 2d 417, 435-36 (E.D.N.Y. 2011) (detailing physicians' ethical duties to patients in evaluating sentences for opioid-related convictions).

Petitioner's arguments are a frontal assault on the role that ethical standards play not just in marking the bounds of professional conduct for medical and mental health practitioners but also in shielding society from unethical policy. Petitioner contends that, because talk

therapy "consists—entirely—of words," it is "pure speech" and should be treated the same as any other speech protected by the First Amendment. *See*, *e.g.*, Pet. Br. 11, 21-22. This argument is profoundly misguided. It trivializes a necessary form of medical care—mental health treatment—as mere "private conversation[s]" between licensed counselors and their clients. *Id.* at 15. And it embraces a position diametrically at odds with the many congressional efforts treating mental healthcare as medical care.[49] Furthermore, this view ignores the reality of medical practice and, if accepted, would threaten the integrity of care that practitioners in *all* areas of medicine provide to their patients.

State regulatory boards, professional associations, and insurance companies have long recognized talk therapy as a form of medical treatment subject to regulations and standards of best practice.[50] *See*, *e.g.*, Colo. Rev. Stat. § 12-245-202(14)(a). And talk-therapy

49. *See*, *e.g.*, 42 U.S.C. § 300gg-26 (Mental Health Parity and Addiction Equity Act) (requiring that insurance plans provide mental health and substance use disorder benefits with the same coverage restrictions as medical and surgical benefits); *see also* Centers for Medicare & Medicaid Services, *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, CMS.Gov (Sept. 10, 2024), https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity.

50. American Psychiatric Association, *What Is Psychiatry?* (Jan. 2023), https://www.psychiatry.org/patients-families/what-is-psychiatry (defining talk therapy as a "talking relationship"); APA Code of Conduct; Medicare.gov, *Mental Health & Substance Use Disorders*, https://www.medicare.gov/coverage/mental-health-substance-use-disorder (defining "counseling or psychotherapy" as a method to "help diagnose and *treat* mental health conditions" (emphasis added)).

practitioners have been subject to state regulation limiting what they can say within the confines of the provider-patient relationship. For example, Colorado prohibits licensed counselors from "exercis[ing] undue influence on the client, including . . . in such a manner as to exploit the client for financial gain of the practitioner or a third party." Colo. Rev. Stat. § 12-245-224(j). Such regulations recognize the "essentially private, highly personal, and sometimes intensely emotional nature of the relationship established" between provider and patient.[51]

Nor does it make any sense from a bioethical perspective to make the distinction Petitioner attempts to draw between care that "consists entirely of words" and care that does not. Pet Br. 19, 22. Medical care is medical care: regardless of whether a clinician's relationship with a patient is composed of "entirely speech," the provider-patient relationship is one in which a patient seeks treatment from a medical professional, and which is

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51. American Psychiatric Association, *APA Commentary on Ethics in Practice* (Dec. 2015), at § 3, https://www.psychiatry.org/file%20library/psychiatrists/practice/ethics/apa-commentary-on-ethics-in-practice.pdf (noting that a code of ethics for mental health practitioners is especially important "*because*" of these traits in the provider-patient relationship)(emphasis added); *see also* APA Code of Conduct, *supra*, Principle B (noting psychologists' "relationships of trust with those with whom they work" and their "professional and scientific responsibilities to society and to the specific communities in which they work"); ACA, Code of Ethics, *supra*, at § A & A.4.b (describing "[t]rust [as] the cornerstone of the counseling relationship" and counselors' responsibility to be "aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors . . . especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature").

grounded in trust and communication.[52] Medical providers acknowledge their ethical duty to provide care in the patient's best interest while respecting their goals and autonomy.[53] By attempting to equate talk therapy with "teaching or protesting," "[d]ebating," or "[b]ook clubs," Pet. Br. 30, Petitioner degrades the very nature of the provider-patient relationship, "which is the collaborative and trusting bond between the therapist and the client" and which "[r]esearch has consistently shown . . . is one of the most important predictors of positive treatment

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52. *See*, *e.g.*, AMA Code of Medical Ethics, Opinion 1.1.1 *Patient–Physician Relationships*, https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/1.1.1.pdf "[t]he relationship between a patient and a physician is based on trust"); APA Code of Conduct, *supra*, at Principle B ("Psychologists establish relationships of trust with those with whom they work."); ACA, Code of Ethics, *supra*, at 4 ("Trust is the cornerstone of the counseling relationship."); *see also* Faisal Abdullatif Alnaser, *Effective Communication Skills and Patient's Health*, 3(4) CPQ Neurology & Psychology 1, 7-8 (2020) (noting that improved provider-patient communication "assists in better diagnosis and management of [] problems" and "hence, improves the overall health outcome").

53. *See* AMA, Code of Medical Ethics, *Opinion 1.1.1* (describing physicians' "ethical responsibility to place patients' welfare over the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare); APA Commentary on Ethics in Practice § 3, https://www.psychiatry.org/file%20library/psychiatrists/practice/ethics/apa-commentary-on-ethics-in-practice.pdf ("The physician-patient relationship['s] goal is to promote patient health and well-being, embodying the key ethical considerations of respect for persons, fairness, and beneficence."); ACA Code of Ethics, *supra*, at § A.1.a ("The primary responsibility of counselors is to respect the dignity and promote the welfare of clients.").

outcomes and adherence to healthcare professional recommendations."[54]

Moreover, allowing the state to regulate specific medical treatments based on the level of "speaking" involved in the treatment is not only an unworkable test to apply but also disregards the realities of medical care, including outside the context of talk therapy. For example, if a doctor advises a patient to pursue an unsafe treatment course, that doctor has committed malpractice—just the same as if she herself had operated on the patient in an unsafe manner. In addition, many forms of medical care consist of "entirely speech" between a provider and a patient—*e.g.*, providing lifestyle advice, preventative care, diagnoses without specific prescriptive care, telehealth appointments, and obtaining informed consent. And each of these forms of care implicate their own set of ethical considerations, which state licensing regimes and other regulatory bodies strive to protect.[55] Yet Petitioner's

54. Caitlin Opland & Tyler J. Torrico, *Psychotherapy and Therapeutic Relationship*, StatPearls [Internet] (last updated Oct. 6, 2024), https://www.ncbi.nlm.nih.gov/books/NBK608012.

55. *See*, *e.g.*, Tsiampalis et al., *Physicians' Words, Patients' Response: The Role of Healthcare Counselling in Enhancing Beneficial Lifestyle Modifications for Patients with Cardiometabolic Disorders: The IACT Cross-Sectional Study*, 11 Healthcare (2023), at 9 (discussing ethical considerations in communicating lifestyle advice to patients); Sammie N.G. Jansen et al., *Ethic of Early Detection of Disease Risk Factors: A Scoping Review*, 25 BMC Medical Ethics 25 (2024) (evaluating ethics such as autonomy, privacy, and justice relating to preventative medicine and early disease detection); Sarah Hull et al., *Practical and Ethical Consideration in Telehealth: Pitfalls and Opportunities*, 95 Yale J. Bio. & Med. 367, 369 (2022) (considering autonomy vs. beneficence, distributive justice, and unintended consequences in telehealth).

argument, if accepted, would threaten the State's ability to regulate these practices, as well as certain forms of dangerous medical care, and would insulate providers from liability for violating their duties to their patients.

The Court should therefore respect the provider-patient context—as well as the trust the public puts in the State's protection against snake oils and magic beans—by holding that the First Amendment does not impair state regulation of that critical relationship. Regardless of whether medical treatment is provided through "words" or through deeds, the nature of that treatment is far afield from the First Amendment's command "that debate on public issues should be uninhibited, robust, and wide-open." *N.Y. Times Co. v. Sullivan*, 376 U.S. 254, 270 (1964). Again, a course of treatment, verbal or otherwise, is not a debate; it is a potentially life-altering choice that the State has regulated for centuries. And while the First Amendment guarantees that "no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion," *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943), governments have always retained the power to prescribe doctors' prescribing practices. Shoehorning First Amendment doctrine into the provider-patient relationship would destabilize that history of regulation and the patients it protects.

Despite Petitioner's sensationalist rhetoric, recognizing this difference does not mean "gagging the professionals best equipped to speak on the issues." Pet. Br. 25. Petitioner, like any citizen, is entitled to speak her mind on the issues of the day, including issues relevant to her professional practice. What she may not do,

however, is weaponize the First Amendment to jeopardize longstanding and vital state regulation of medical care and other professional services. This Court's cases have drawn that line in the past. *See NAACP v. Button*, 371 U.S. 415, 444 (1963) ("Nothing that this record shows as to the nature and purpose of NAACP activities permits an inference of any injurious intervention in or control of litigation which would constitutionally authorize the application of [the challenged law] to those activities."). The Court should not imperil biomedical ethics—and the patients those ethical precepts protect—by changing course.

CONCLUSION

This Court should affirm the judgment below.

Respectfully submitted,

PATRICK J. HAYDEN
KATELYN KANG
COOLEY LLP
55 Hudson Yards
New York, NY 10001

RAYMOND P. TOLENTINO
JOSHUA REVESZ
ANGELINE X. CHEN
COOLEY LLP
1299 Pennsylvania Avenue NW
Washington, DC 20004

KATHLEEN R. HARTNETT
ZOË HELSTROM
Counsel of Record
COOLEY LLP
3 Embarcadero Center, 20th Floor
San Francisco, CA 94111
(415) 693-2000
khartnett@cooley.com

Counsel for Amici Curiae

August 26, 2025

APPENDIX

TABLE OF APPENDICES

APPENDIX — LIST OF *AMICI CURIAE*

The *amici* listed below join this brief as individuals; institutional affiliation is noted for informational purposes only and does not indicate endorsement by institutional employers of the positions advocated in this brief.

Jamie R. Abrams
Professor of Law
American University Washington College of Law

Julia Zoë Beckerman, JD MPH
Teaching Professor and Vice Chair, Health Policy and Management
George Washington University Milken Institute School of Public Health

Barbara E Bierer, MD
Professor of Medicine
Brigham and Women's Hospital

Teneille Brown
James I. Farr Professor of Law
University of Utah

T. Desmond Brown, MD
Assistant Professor of Orthopedic Surgery (Ret.)
Boston University School of Medicine

Scott Burris
Professor of Law and Public Health
Center for Public Health Law Research, Temple University Beasley School of Law

Appendix A

Catherine Caldicott
Associate Clinical Professor of Medicine (Ret.)
SUNY Upstate Medical University

Yael Cannon
Professor of Law
Georgetown University Law Center

Kathleen Carey
Professor of Health Law, Policy and Management
Boston University School of Public Health

Jack A. Clark
Professor
Boston University School of Public Health

Carl H. Coleman
Professor of Law
Seton Hall University School of Law

William Cosgrove, MD
Adjunct Clinical Professor Emeritus (Pediatrics)
University of Utah

Emilee Coulter-Thompson, DrPH, LMSW
Managing Director, Center for History, Humanities, Arts, Social Sciences and Ethics in Medicine
University of Michigan

D. Dangaran
Assistant Professor of Law
University of Hawai'i at Mānoa William S. Richardson School of Law

Appendix A

J. Shoshanna Ehrlich
J.D., Professor Emerita, Women's, Gender, and Sexuality Studies
University of Massachusetts

Gwyneth M. Eliasson, JD, MPH
Assistant Professor
Rutgers School of Public Health

Cheryl Erwin, JD, PhD
Professor of Psychiatry and Law
Texas Tech University

David M. Frankford
Professor of Law
Rutgers Law School

Martha E. Gaines, JD, LLM
Distinguished Clinical Professor of Law Emerita
University of Wisconsin Law School

Katherine Ginsbach
Senior Associate/Adjunct Law Professor
Georgetown University Law Center

Allegra Gordon
Assistant Professor
Boston University School of Public Health

Sharona Hoffman
Edgar A. Hahn Professor of Law, Professor of Bioethics,
Co-Director of Law-Medicine Center
Case Western Reserve University School of Law

Appendix A

Kathleen Hoke
Professor
University of Maryland Carey School of Law

Dana Howard
Assistant Professor, Division of Bioethics
The Ohio State University College of Medicine

Nicole Huberfeld
Edward R. Utley Professor of Health Law
Boston University

Loren Jacobson
Associate Professor of Law
UNT Dallas College of Law

Margo Kaplan
Professor of Law
Rutgers Law School

Ben King
Clinical Assistant Professor
University of Houston

Stephen Latham
Director, Interdisciplinary Center for Bioethics
Yale University

Yvonne Lindgren
Associate Professor of Law
University of Missouri- Kansas City School of Law

Appendix A

Maya Manian
Professor of Law
American University Washington College of Law

Jessica Mantel
Professor of Law, Director Health Law & Policy Institute
University of Houston Law Center

Adam Marks
Clinical Professor of Medicine
University of Michigan

Thomas Wm. Mayo
Professor of Law
Southern Methodist University/Dedman School of Law

Karen McDonnell, PhD
Associate Professor of Prevention and Community Health
The George Washington University

Benjamin Meier
Professor of Global Health Policy
University of North Carolina at Chapel Hill

Ted Mermin
Executive Director
UC Berkeley Center for Consumer Law & Economic Justice

Seema Mohapatra
Professor of Law
SMU Law

Appendix A

Timothy F. Murphy
Professor of Philosophy in the Biomedical Sciences
University of Illinois College of Medicine

Michelle Oberman
Katharine & George Alexander Prof. of Law
Santa Clara University School of Law

Tomar Pierson-Brown
Assistant Professor of Law
University of Pittsburgh School of Law

Radhika Rao
Professor of Law and Harry & Lillian Hastings Research Chair
UC Law San Francisco

Laura Richman
Associate Professor of Law and Social Science
George Washington Law School

Sara Rosenbaum
Emerita Professor Health Law and Policy
George Washington University

David Rosenbloom
Professor Emeritus
Boston University

Amy N. Sanders
Executive Director and Instructor of Law
Saint Louis University School of Law, Center for Health Law Studies

Appendix A

Leonard A. Sandler
Clinical Professor of Law Emeritus
University of Iowa College of Law

Nadia N. Sawicki
Beazley Chair in Health Law; Georgia Reithal Professor of Law
Loyola University Chicago School of Law

Naomi Scheinerman
Assistant Professor of Bioethics
The Ohio State University

Naomi Seiler, JD
Professor
George Washington University School of Public Health

Alice Setrini
Clinical Teaching Fellow
Loyola University Chicago School of Law

Paul Shafer
Associate Professor of Health Law, Policy, and Management
Boston University

Joseph A. Singleton
Health Law & Policy Fellow
Wake Forest University School of Law

Michael S. Sinha, MD, JD, MPH
Associate Professor of Law, Center for Health Law Studies
Saint Louis University School of Law

Appendix A

Mary Slavin
Director, Education and Dissemination
Boston University

Kayte Spector-Bagdady
Associate Professor, Obstetrics & Gynecology
University of Michigan Medical School

Sonia Suter
Professor of Law
The George Washington University Law School

Lance Tibbles
Emeritus Professor of Law
Capital University Law School

Elizabeth Tobin-Tyler
Professor of Health Services, Policy and Practice
Brown University

Michael R. Ulrich
Associate Professor
Boston University School of Public Health and School of Law

Heather Walter-McCabe
Associate Professor
Saint Louis University School of Law

Richard M. Weinmeyer, JD, PhD
Assistant Professor of Law
Loyola University Chicago School of Law

Appendix A

Allison M. Whelan
Assistant Professor of Law
Georgia State University College of Law