NOS. 22-56220, 23-55069

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

MARK MCDONALD, *et al.*,
Plaintiffs-Appellants,
v.
KRISTINA D. LAWSON, *et al.*,
Defendants-Appellees.

MICHAEL COURIS and MICHAEL FITZGIBBONS,
Plaintiffs-Appellants,
v.
KRISTINA D. LAWSON, *et al.*,
Defendants-Appellees.

On Appeals from the United States District Court for the Central District of California, No. 8:22-cv-01805-FWS-ADS; and the United States District Court for the Southern District of California, No. 3:22-cv-01922-RSH-JLB

Reply Brief of Appellants Michael Couris and Michael Fitzgibbons

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Introduction

Lawson's brief spends most of its time defending a different statute than the one the legislature passed. Much of Defendants' argument is based on the false premise that the word "advice" can be read out of the statute by interpreting "treatment or advice" to mean simply "treatment." One understands why Defendants would rather defend a statute that doesn't cross the line from regulating medical professionals' conduct to their speech, that doesn't cross the line from treatment to advice. But that is not the statute that the legislature passed and the governor signed; and neither Defendants, nor this Court have the authority to rewrite it. *See* Section I.A.

Because AB 2098 does cross this line, it can find no solace in the *NIFLA* exception for "a traditional regulation of medical practice," as such traditional regulations have never stepped on the doctor-patient relationship this way. *Nat'l Inst. of Fam. & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018) ("*NIFLA*"). The government's interpretation of *NIFLA*'s exception would swallow the rule. *See* Section I.B.

Just as the policy in *Conant v. Walters* did, AB 2098 drives disfavored views from the marketplace of ideas. 309 F.3d 629 (9th Cir. 2002). AB 2098 thus unconstitutionally discriminates on the basis of viewpoint. *See* Section I.C. And because AB 2098 is both overinclusive and underinclusive, it is not narrowly tailored to serve cognizable interests, and must be rejected on that ground as well. *See* Section I.D.

The Court should decline the government's belated and forfeited attempt to redefine the statute, and hold it impermissibly vague. *See* Section II.

AB 2098 invades the doctor-patient relationship in a radical way that damages not only the foundations of the relationship (honesty, openness, trust, and independence), but also impedes the quest for medical and scientific advancement. Thankfully, the First Amendment repels this invasion. OB23-OB39.[1]

The government concedes (DB2-DB3) that Couris has properly invoked this Court's jurisdiction under the relevant Ninth Circuit test. The Court should hold Couris entitled to a preliminary injunction.

Argument

I. AB 2098 violates the First Amendment.

The parties agree (OB23-OB24; DB58-DB59) that Couris's entitlement to a preliminary injunction against enforcement of AB 2098 turns on the likelihood of success on the merits. But the government misstates the standard when it tries to shift and increase the burden. DB 20; *Reilly v. City of Harrisburg*, 858 F.3d 173, 180 (3d Cir. 2017) (reversing for this reason). In free speech cases, it is the "Government [that] bears the burden of proof on the ultimate question of [the law's] constitutionality." *Ashcroft v. ACLU*, 542 U.S. 656, 666 (2004). Once plaintiffs raise "a colorable claim that [their] First Amendment rights have been infringed, or are threatened with infringement…the burden shifts to the government to justify the restriction." *Thalheimer v. City of San Diego*, 645 F.3d 1109, 1116 (9th Cir. 2011); *accord Am. Bev. Ass'n v. City & Cty. of San Francisco*, 916 F.3d 749, 757-58 (9th Cir. 2019) (*en banc*). Thus, Couris "must

[1] "DB" and "OB" refer to Defendants' Brief and Couris's Opening Brief respectively. Other designations remain the same. OB1 n.1

be deemed likely to prevail unless the Government has shown that [Couris's] proposed less restrictive alternatives are less effective than [the law]." *Ashcroft*, 542 U.S. at 666.

A. Defendants elide the distinction between advice and treatment. Because AB 2098 crosses that line, it regulates speech not merely conduct.

The text of AB 2098 prohibits "disseminat[ing] misinformation or disinformation related to COVID-19" and it defines dissemination as "the conveyance of information from the licensee to a patient under the licensee's care in the form of treatment **or** advice." (emphasis added). Despite that straightforward disjunctive structure, Defendants persistently reduce the statute's application to just medical treatment, melding the advice prong into treatment or erasing it entirely. DB1, DB21, DB25, DB27, DB28, DB33, DB38. For example, defendants assert that the definition of dissemination "makes clear that AB 2098 governs *only* how doctors care for and treat their patients." DB27. That reading is atextual. AB 2098 does not restrict conveying information "in the form of treatment or care," it restricts conveying information "in the form of treatment or advice." "The replace-some-words canon of construction has never caught on in the courts." *United States v. Perkins*, 887 F.3d 272, 276 (6th Cir. 2018).

When the government is not replacing "advice" with "care" wholesale, it is whittling "advice" down to just another form of treatment. And that reading violates "one of the most basic interpretive canons": "a statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void, or insignificant." *Rubin v. Islamic Republic of Iran*, 138 S. Ct. 816, 817 (2018); *accord* Antonin Scalia & Bryan A. Garner, Reading Law: The Interpretation of Legal Texts 174 (2012) (No provision should "be given an interpretation that causes it…to have no

consequence”). The anti-surplusage canon is “strongest when an interpretation would render superfluous another part of the same statutory scheme.” *Marx v. Gen. Revenue Corp.*, 568 U.S. 371, 385 (2013).

From *Conant* through *Pickup* to *Tingley*, this Circuit unreservedly declares that advice from medical professions to patients is fully protected by the First Amendment; this ends the inquiry. *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014); *Tingley v. Ferguson*, 47 F.4th 1055 (9th Cir. 2022). Fairly read, AB 2098 oversteps the bounds established by the *Conant* trilogy. OB25, 28-32. Defendants latch onto language from *Pickup* about the regulation of “negligent advice.” DB25 (*quoting Pickup*, 740 F.3d at 1228). But that language described “the midpoint of the [speech/conduct] continuum,” a description of the doctrine that *NIFLA* “abrogated.” *Tingley*, 47 F.4th at 1073. In any event, *Pickup* follows the recommendation/treatment dichotomy laid out in *Conant*. It explicitly relies on the fact that the Washington law “regulate[d] only treatment, while leaving mental health providers free to discuss and recommend, or recommend against, SOCE.” 740 F.3d at 1231; *id.* at 1223 (cataloging bullet point list of speech, including recommendation, not covered by Washington law). That facet of the law—that it “did not restrict what the practitioner could say or recommend to a patient or client” was instrumental to the holding in *Pickup*. *Wollschlaeger v. Governor*, 849 F.3d 1293, 1309 (11th Cir. 2017) (*en banc*).

Defendants incorrectly assert that AB 2098 coheres with *Tingley*. DB38. *Tingley* was unequivocal: This Circuit distinguishes “prohibiting doctors from *treating* patients with marijuana—which the government could do—from prohibiting doctors from simply *recommending* marijuana. A prohibition on the latter is based on the content and

viewpoint of speech, while the former is a regulation based on conduct." 47 F.4th at 1072 (emphasis in original; citations omitted). *Tingley* mentions the word "treatment(s)" thirty-five times. It mentions the word "advice" only once, to describe the portion of the *Pickup* opinion abrogated by *NIFLA*. *Id.* at 1073.

Lastly, Defendants falsely accuse Couris of "overreading" *Conant*. DB30. They would limit *Conant* to recommendations that comply with accepted medical procedures and standards. DB31. Analytically though, whether advice is speech or conduct does not depend on whether it conforms to existing medical consensus. Such a limit is entirely absent in *Conant*'s majority opinion, despite the federal government's position that marijuana has "no currently accepted medical use in treatment in the United States." Petition for Certiorari, *Walters v. Conant*, No. 03-40 at 3-4 (Jul. 7, 2003) (internal quotations omitted). In *Wollschlaeger* too, the state unsuccessfully argued that the law only prohibited questions about guns that were "not relevant to patient medical care or safety," leaving room for any speech that was "consistent with medical standards." Brief for Appellants, *Wollschlaeger v. Governor*, No. 12-14009, at 1, 38 (11th Cir. Sept. 17, 2012). The reason professional consensus cannot control is that "the truth is served by allowing that consensus to be challenged without fear of reprisal. Today's accepted wisdom sometimes turns out to be mistaken." *United States v. Alvarez*, 567 U.S. 709, 752 (2012) (Alito, J., dissenting) (taking narrower view of First Amendment than majority opinion, but contrasting hypothetical laws prohibiting false statements about science with Stolen Valor Act at issue).

Conant, *Pickup*, and *Tingley* are correct to draw the line where they do. "Treatment" need not be limited to physical intervention; it can be a verbal diagnosis

or a written prescription, but it cannot be stretched to cover all advice or recommendations. "When patients seek physicians' advice for medical problems, the ensuing discourse consists of expressions of fact, opinion, and persuasion." Paula Berg, *Toward a First Amendment Theory of Doctor-Patient Discourse and the Right to Receive Unbiased Medical Advice*, 74 B.U. L. Rev. 201, 237 (1994) (citing *Thomas v. Collins*, 323 U.S. 516, 537 (1945)). Treatment often occurs through the medium of speech: "When a doctor writes a prescription for a patient, she is doing more than simply recommending a remedy… Even though the prescription physically consists of nothing more than written words, it has a nonexpressive aspect that the government may regulate." Robert Kry, *The "Watchman for Truth" Professional Licensing and the First Amendment*, 23 Seattle U. L. Rev. 885, 894-95 (2000).[2] By contrast, "[w]hen a professional does no more than render advice to a client, the government's interest in protecting the public from fraudulent or incompetent practice is quite obviously directed at the expressive component of the professional's practice rather than the nonexpressive component (if such a component even exists)." Eugene Volokh, *Speech as Conduct: Generally Applicable Law, Illegal Courses of Conduct, "Situation-Altering Utterances" and the Uncharted Zones*, 90 Cornell L. Rev. 1277, 1343 n.340 (2005) (quoting Kry, *supra*, at 893).

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[2] Informed consent requirements may also fall into this box as speech incidental to treatment. *NIFLA*, 138 S. Ct. at 2373; *see generally* Compassion & Choices Amicus Br. (explaining need for informed consent laws). But again, "[n]othing in AB 2098 obliges doctors to provide any information that would enhance consent." OB29; *contrast* Cal. Bus. & Prof. Code § 2234.1(a)(1)-(2). Indeed, it does the exact opposite, hindering the operation of an informed consent model by preventing the sharing of medical information and advice. *See* Section I.B below; OB44.

Couris has already provided examples of advice from doctor to patient that "are neither incidental speech nor conduct in the form of a treatment." OB31. Additional examples are easy to come by. Imagine if AB 2098 were operative in 2020, and a doctor conveyed her belief that cloth masks have limited effect on transmission, advising her patients to "act accordingly." Imagine it were operative in 2021, and a doctor had conveyed his belief that breakthrough cases are actually very common and had advised a high risk patient to avoid prolonged exposure in crowded areas even after getting vaccinated. Because those doctors conveyed information contradicting the contemporaneous scientific consensus on the nature and prevention of the virus in the form of advice, they could be found professionally liable under AB 2098. Yesterday's "misinformation" has become today's truth.

Simply put, professional advice is speech. *NIFLA*; *Holder v. Humanitarian Law Project*, 561 U.S. 1, 26-27 (2010); *Conant*; *see also In re Primus*, 436 U.S. 412, 426 n.17 (1977) (citing with approval concession that lawyer's meeting with prospective client to give advice concerning legal rights was fully protected speech). Defendants protest that the government must have the authority to sanction negligent professional advice. DB31-DB33. And it does! The government **does** have authority to regulate that speech, but only using generally applicable law—malpractice, breach of contract, negligence, and so on—that does not target speech on its face. This was the remedy for negligent advice Judge Kozinski's *Conant* concurrence referenced. 309 F.3d at 647. Historically-rooted, generally-applicable rules are not subject to facial attacks for failing to meet strict scrutiny. *See, e.g., Cohen v. Cowles Media Co.*, 501 U.S. 668, 669-70 (1991).

On the other hand, novel *ex ante* restrictions on the expression of particular views, like AB 2098 or the policy in *Conant*, cast a pall over the doctor/patient relationship. They interfere with the "proper functioning" of the medical system by impeding "frank[] and open" "communication between a doctor and a patient" and eroding "confidence and trust." *Conant*, 309 F.3d at 636, 638 (internal quotation omitted). These laws depend on whether patients or enforcement authorities construe a doctor's speech as a recommendation or advice. *Id.* at 639. How are doctors supposed to navigate the dividing line between opinions and general advice (both permitted according to Defendants, DB28, 38); and the forbidden advice connected to care? Does a doctor have to preface every remark about COVID saying, "now, this is my personal opinion and should not be taken as advice to you, patient?" Such a system is unworkable and "not permissible under the First Amendment" because it "leaves doctors and patients 'no security for free discussion.'" *Id.* (*quoting Thomas*, 323 U.S. at 535).

Ultimately, AB 2098 regulates the conveyance of information in the form of advice—speech *qua* speech. OB26. Amici agree. Institute for Justice Amicus Br. 4-12; ACLU Amicus Br. 5-9; New Civil Liberties Alliance Amicus Br. 18-20. *NIFLA*'s speech/conduct distinction doesn't "leave patients vulnerable to harm" (DB2) in other areas, it prevents the slippery slope to government domination of the marketplace of ideas, while still allowing legitimate regulations of professional conduct.

B. AB 2098 does not resemble a traditional regulation of medical practice.

NIFLA carves out two areas of professional speech as more amenable to state regulation: disclosures in advertising and regulations of speech incidental to

professional conduct "long familiar to the bar." *NIFLA*, 138 S. Ct. at 2373 (internal quotation omitted). Defendants attempt to shoehorn AB 2098 into the latter box of "time-hallowed" (DB21), "long-standing" (DB1, 7, 12, 18, 21, 24, 35-39), "long-running" (DB27), "historical" (DB46), "centuries-old" (DB36), "tradition of regulation" (DB5) of medical practice. Of course states can license medical professionals. DB5 n.1, DB36-DB37, DB41-DB42. Of course they can impose "longstanding tort[]" liability for "professional malpractice." *NIFLA*, 138 S. Ct. at 2373; *see also* DB6 & n.2. Of course they can regulate advertising for medical treatments or procedures, or hold medical professionals to the standard of care for speech attendant to patient treatment. DB7-DB11. But just as California's law in *NIFLA* failed to resemble traditional regulation of professional conduct, so too does AB 2098 for two major reasons.

First, AB 2098 ignores the deeply-rooted distinction between medical practice and advice, the very distinction *Tingley* and *Conant* recognize. Historically, the regulable practice of medicine consisted of "the discovery of the cause and nature of disease, and the administration of remedies or the prescribing of treatment therefor." *State v. Mylod*, 40 A. 753, 756 (R.I. 1898). It consisted "[f]irst, in adjudging the nature, character and symptoms of the disease; second, in determining the proper remedy for it; third, in giving or prescribing the application of the remedy to the disease." *Frank v. South*, 194 S.W. 375, 378 (Ky. 1917) (internal quotation omitted). It amounted to "the art of preventing, curing, or alleviating diseases, and remedying as far as possible the results of violence and accident." *Stewart v. Raab*, 56 N.W. 256, 256 (Minn. 1893). So too in California. *Harlan v. Alderson*, 203 P. 1014, 1015 (Cal. App. 1921) (discussing licensing

for those who wished to "treat diseases, injuries, deformities, or other physical or mental conditions").

But separate from diagnosis and treatment, "the right of the doctor to advise his patients according to his best lights seems so obviously within First Amendment rights as to need no extended discussion." *Poe v. Ullman*, 367 U.S. 497, 513 (1961) (Douglas, J., dissenting). The state "may not intrude" into the "domains" of a doctor's "views or beliefs" or "advice he renders." *Id.* at 515. For example, in *State v. Liffring*, the court refused to apply the state medical regulation to recommending osteopathy, concluding that legislative determination on "a question of science" "would be an astonishing denial of the commonly accepted views touching the right to personal opinion and conduct which does not invade the rights of others." 55 N.E. 168, 169 (Ohio. 1899); *see also Rubin v. United States*, 37 F.2d 991, 993 (D.C. Cir. 1930) (distinguishing "an expression of opinion" from a "diagnosis" that forms part of medical practice); *State v. Biggs*, 133 N.C. 729, 742 (1903) ("Medicine is an experimental, not an exact science. All the law can do is to regulate and safeguard the use of powerful and dangerous remedies, like the knife and drugs, but it cannot forbid dispensing with them."). AB 2098 targets doctor expression about one politically-charged disease; such a regulation is ahistorical and Defendants cite nothing that suggests otherwise.

Second, AB 2098 discards the traditional limitation of harm as a precondition to liability. This objective harm component supplies some of the "breathing space" that "First Amendment freedoms need … to survive" *NAACP v. Button*, 371 U.S. 415, 433 (1963); *see Alvarez*, 567 U.S. 709. Defendants quote *Nash v. Royer*: "departure from approved methods in general use…will render him liable, however good his intentions."

DB10 (quoting 127 S.E. 356, 360 (N.C. 1925)). The ellipsis elides *Nash's* limitation: "if ***it injures the patient***." 127 S.E. at 360 (emphasis added). California malpractice law likewise requires appreciable harm, not merely "speculative harm" or "threat of future harm." *Budd v. Nixen*, 491 P.2d 433, 436 (Cal. 1971); *Larcher v. Wanless*, 557 P.2d 507, 512 n.11 (Cal. 1976).

Defendants are incorrect to downplay AB 2098 as a "slight expansion" of and a "narrow change" to the regulatory framework. DB23. AB 2098's assertion of power to control "misinformation" absent harm is unprecedented. Today it is misinformation related to COVID-19. Tomorrow it is any "fraudulent medical theory" published on social media. *See* N.Y Senate Bill S577, 2023-24 Legislative Session, available at https://www.nysenate.gov/legislation/bills/2023/S577 (Jan. 5, 2023). The next day, it is anything deemed "misinformation" about homeland security by the putative Federal Disinformation Government Board. Roger Koppl and Abigail Devereaux, *Biden Establishes a Ministry of Truth*, Wall St. J. (May 1, 2022). Or anything deemed "misinformation" related to federal monetary and banking policy. Michael Shellenberger, *EXCLUSIVE: Senator Mark Kelly Called for Social Media Censorship to Prevent Bank Runs*, Public (Mar. 13, 2023), available at https://public.substack.com/p/exclusive-senator-mark-kelly-called.

"Were this law to be sustained, there could be an endless list of subjects the National Government or the States could single out." *Alvarez*, 567 U.S. at 723. "Were the Court to hold that the interest in truthful discourse alone is sufficient…, it would give government a broad censorial power unprecedented in this Court's cases or in our constitutional tradition." *Id.* "A society that tells its doctors…what they may not tell

their patients is not a free society." *Poe*, 367 U.S. at 515 (Douglas, J., dissenting). A society that turns the act of disseminating heterodox advice into the equivalent of gross negligence or incompetence is not a free society.

The unprecedented nature of AB 2098 has rattled public medical commentators. *See* Robert M. Kaplan, Patrick Whelan & Peter Doshi, *Yes, we need to stop COVID misinformation, but not at the expense of scientific inquiry*, S.F. Chron. (Oct. 25, 2022) ("dangerous precedent" that stifles physician speech and thus the scientific process); Leana S. Wean, *California's anti-misinformation bill is well intentioned. But it's a bad idea.*, Wash. Post (Sept. 12, 2022) ("set[s] a precedent with downstream ramifications" and "a recipe for medical practice to be subject to the whims of partisan politics"; comparing AB 2098 to Trump-era abortion gag rule); Paul Hsieh, *The Unsettled Science of COVID-19*, Forbes (Feb. 28, 2023) ("when government officials attempt to compel doctors to adhere to a false or non-existent consensus, they do a grave disservice to physicians and patients alike…").

Invoking the "standard of care" gets Defendants no further, because, like other traditional frameworks of medical regulation, the standard of care question arises in a fact-bound *ex post* posture. *Arato v. Avedon*, 858 P.2d 598, 605-07 (Cal. 1993). In fact, AB 2098 contradicts the very essence of informed consent under California law. OB44; OB29. Informed consent recognizes the patient as a decisionmaker who requires "all information relevant to a meaningful decisional process," including "therapeutic alternatives and their hazards." *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972). Although practicalities preclude it, the "ideal" is unreserved "full disclosure." *Arato*, 858 P.2d at 606; *see also Truman v. Thomas*, 611 P.2d 902, 906 (Cal. 1980) (duty to disclose can exist

even where a risk is "remote and commonly appreciated to be remote"). "The doctrine of informed consent, in effect in most states, was developed to counteract the phenomenon of professional dominance and institutionalized deference by increasing the flow of information to patients to both decrease the imbalance in knowledge and power and protect patients from physician coercion." Berg, *supra*, 74 B.U. L. Rev. at 230. AB 2098 shuts off the flow.

Defendants cite (DB37) Professor Berg's article, but contradict its thesis that "content restrictions on physician speech…enable the government to promote its partisan views by stifling the availability of medical information and distorting patients' decision-making process." 74 B.U. L. Rev. at 231; *see also NIFLA*, 138 S. Ct. at 2374 (quoting Berg on the historical dangers of allowing states to "manipulate the content of doctor-patient discourse"). Berg's observation about the asymmetry in medical knowledge between doctor and patient (DB37) supported the idea that a state-imposed message was *especially* dangerous in the doctor-patient relationship context. 74 B.U. L. Rev. at 225-30, 243.

Ultimately, Berg recognizes that "Doctor-patient speech is essential to maintaining patients' autonomy, self-determination, and dignity in the face of illness. In addition to determining treatment, another objective of doctor-patient discourse is to democratize the medical decision-making process and empower patients to participate actively in determining what happens to their bodies." 74 B.U. L. Rev. at 237. "[R]egulations that prevent physicians from informing patients about particular treatments subvert patient autonomy by, in effect, making government a silent partner in medical decision making." *Id.* at 244

Defendants rely on the drastic consequences of health decisions (DB36), but ignore the flip side: free and candid communication about potentially lifesaving information is paramount. *Sorrell v. IMS Health, Inc.*, 564 U.S. 552, 566 (2011). Patients seek open and independent advice and information and depend on a doctor with the training, expertise, and knowledge to provide it without fear or hesitation. "To hold that physicians are barred from communicating to patients sincere medical judgments would disable patients from understanding their own situations well enough to participate in the debate." *Conant*, 309 F.3d at 635 (quoting district court). Indeed, "the harm to patients from being denied the right to receive candid medical advice" can be "far greater than the harm to doctors from being unable to deliver such advice." *Conant*, 309 F.3d at 643 (Kozinski, J., concurring).

Patients need full information "to perceive their own best interests." *Sorrell*, 564 U.S. at 578. That is especially so if the patients disagree with the unorthodox views of their doctor, for in that case their interest may be getting a second opinion or finding a new doctor entirely. "It is a matter of public interest that [private economic] decisions, in the aggregate, be intelligent and well informed." *Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council*, 425 U.S. 748, 765 (1976). "Paternalistic[] interfere[nce] with the ability of physicians and patients to receive potentially relevant treatment information…could inhibit, to the public's detriment, informed and intelligent treatment decisions." *United States v. Caronia*, 703 F.3d 149, 166 (2d Cir. 2012). The First Amendment will not countenance "regulations that seek to keep people in the dark for what the government perceives to be their own good." *Sorrell*, 564 U.S. at 577 (quoting *44 Liquormart, Inc. v. Rhode Island*, 517 U.S. 484, 503 (1996) (opinion of Stevens, J.)).

Perhaps some patients would prefer to remain blissfully ignorant of their doctors' real views; that they "must endure speech they do not like … is a necessary cost of freedom." *Sorrell*, 564 U.S. at 575.

Because AB 2098's regulation of conveying information and advice is not a regulation of professional conduct, much less a traditional one, it cannot escape First Amendment scrutiny. California may not "add[] to the list" of categories of unprotected speech based on its legislative judgment that speech that contradicted the scientific consensus on COVID-19 is of "such minimal redeeming value as to render [it] unworthy of First Amendment protection." *United States v. Stevens*, 559 U.S. 460, 469-70 (2010); *accord NIFLA*, 138 S. Ct. at 2372.

C. AB 2098 unconstitutionally discriminates against disfavored viewpoints.

Couris has explained why AB 2098 is, and was designed to be, a restriction on the expression of disfavored viewpoints. OB32-OB39. Defendants say virtually nothing about this other than suggesting that viewpoint-based laws are reviewed under the same strict-scrutiny standard afforded less-problematic content-based rules. DB39 n.14. More than once, the Supreme Court has suggested a *per se* prohibition on viewpoint discrimination. OB32 (citing cases); *see also Speech First v. Cartwright*, 32 F.4th 1110, 1126 (11th Cir. 2022) ("prohibited, seemingly as a per se matter" (internal quotation omitted)). *Waln* applied strict scrutiny, which the policy at issue could not pass. *Waln v. Dysart School Dist.*, 54 F.4th 1152, 1162 (9th Cir. 2022); *but see also id.* (quoting the *per se* rule of *Nurre v. Whitehead*, 580 F.3d 1087, 1095 n.6 (9th Cir. 2009)).

Couris preserves the issue for further review if this Court determines the *Waln* standard controls.

The legislature is entitled to express its strong views about COVID-19 (OB5) in myriad ways: government speech or spending, or speech-neutral regulations of conduct; but what it cannot do is "impose its own message in place of individual speech, thought, and expression." *NIFLA*, 138 S. Ct. at 2379 (Kennedy, J., concurring).

California's legitimate interest in competent medical practice and more generally public health and safety is an interest equivalent for all ailments and all conditions. AB 2098 allows medical professionals to "lie with impunity" about anything but COVID-19. *Grimmett v. Freeman*, 56 F.4th 689, 2023 U.S. App. LEXIS 3076, at *11 (4th Cir. 2023) (following *R.A.V. v. St. Paul*, 505 U.S. 377 (1992)) (derogatory remarks about political candidates). Singling out COVID-19 betrays the legislature's real aim: imposing a COVID-19 orthodoxy on private citizens. *See* OB27 (citing *R.A.V.* and *Brown v. Entm't Merchs. Ass'n.*, 564 U.S. 786 (2011)). "[T]he history of the Act's passage and its underinclusive application suggest a real possibility" of viewpoint targeting. *NIFLA*, 138 S. Ct. at 2379 (Kennedy, J., concurring). So does the unfortunate politicization of the COVID-19 pandemic itself. "[T]aking sides in a politically charged debate about [COVID-19 treatments'] efficacy...is viewpoint discrimination, which is fatal to the statute's constitutionality." *Stock v. Gray*, No. 22-cv-4104, 2023 U.S. Dist. LEXIS 48300, at *18-*19 (W.D. Mo. Mar. 22, 2023) (statute prohibiting pharmacists from disputing efficacy of Ivermectin and hydroxychloroquine).

But AB 2098 constitutes viewpoint discrimination even without all the political baggage attached to COVID-19. Just as the policy in *Conant* did, AB 2098 drives

disfavored views from the marketplace of ideas. Though California may distrust the open marketplace as a method of truth discovery and scientific advancement, the choice whether to open or close the channels of communication is not the California Legislature's choice to make: "the First Amendment makes [it] for us." *Va. Bd. of Pharmacy*, 425 U.S. at 770. Otherwise, the state would possess the intolerable authority to grind the processes of scientific and medical advancement to a halt. What if the government had used its regulatory heft to entrench phrenology, physiognomy, bloodletting, lobotomization, or any of various forms of eugenics by prohibiting advice that departed from such accepted scientific wisdom? That is a "grave and unacceptable danger." *Alvarez*, 567 U.S. at 751 (2012) (Alito, J., dissenting); *accord id.* at 731 (Breyer, J., concurring in the judgment). "[T]he suppression of physician speech about unproven therapies may actually interfere with the discovery of truth. Many therapies are effective for some people and not others, or they may prove effective over time through clinical use. This is particularly true in the case of new diseases." *Berg*, *supra*, 74 B.U. L. Rev. at 249.

Defendants' argument (DB43) that "AB 2098 leaves practitioners free to express themselves in innumerable other fora outside of patient care" is irrelevant: the same was true in *Conant*, and in *Wollschlaeger*. Viewpoint discrimination is unacceptable even where alternative channels for communication exist. *Christian Legal Soc'y Chapter of the Univ. of Cal. v. Martinez*, 561 U.S. 661, 690 (2010). Speakers have the right to express views within the confines of the professional relationship. *NIFLA*. And, again, patients have the right to hear the views and expertise of licensed professionals. OB47; section I.B above.

Our Constitution does not permit states to act as "Oceania's Ministry of Truth" and quash dissenting viewpoints as "misinformation." *Alvarez*, 567 U.S. at 723.

D. AB 2098 is not narrowly tailored to serve any of California's cognizable interests.

Defendants assert (DB40-DB42) the need to regulate professional practice, but a free-floating interest in regulating the profession is simply too undifferentiated to qualify as compelling after *NIFLA*. Even assuming the other two putative interests—competent medical care and ensuring patients have accurate information—are compelling, AB 2098 "is not sufficiently drawn to achieve [them]." *NIFLA*, 138 S. Ct. at 2375.

The notion that regulating the profession is itself compelling collides with Supreme Court precedent on professional speech: "it is no answer…to say…that the purpose of these regulations was merely to insure high professional standards and not to curtail free expression." *Button*, 371 U.S. at 438-39. The government's argument proves too much: if states had free rein to pursue such an interest then there would be no breathing space for professionals' First Amendment rights. *NIFLA*, 138 S. Ct. at 2375. *Goldfarb v. Virginia State Bar* is merely a case about whether antitrust law applies to regulation of attorneys; it says nothing about the First Amendment, and cannot support the notion that an undifferentiated interest in the regulation of the profession can satisfy strict scrutiny. 421 U.S. 773 (1975) (antitrust claims).

AB 2098 is not narrowly tailored to the other two posited interests. With respect to competent care, it is overinclusive because it restricts advice and information that does not harm, and may even benefit, the patient. Although Defendants claim the

legislature used the "narrowest possible way" to serve its aims (DB43), it rejected a suggested amendment that would have refocused AB 2098 on "harm to patient health." OB13. The legislature also rejected the sort of "gross negligence" precondition that Governor Newsom's signing statement extra-textually reads into the statute. *Compare* OB14, *with* CER-60. And the prohibition on disseminating misinformation contains no *mens rea* requirement at all, thus "creat[ing] massive chilling effects on those wishing to speak" about COVID-19. David S. Han, *Categorizing Lies*, 89 U. Colo L. Rev. 613, 626 (2018). "*[M]ens rea* requirements…provide 'breathing room' for more valuable speech by reducing an honest speaker's fear that he may incur liability for speaking." *Alvarez*, 567 U.S. at 733 (Breyer, J., concurring in the judgment). Again, at the same time, AB 2098 is underinclusive because the interest in competent care does not distinguish between COVID-19 and other diseases.

With respect to combatting misinformation, the legislative concern centered on mass communications by doctors on social media. *See* OB38-OB39; MER-91-92 ("the White House reported in 2021 that much of the COVID-19 vaccine information began with a number of online social media users"); MER-92 (quoting NPR reporting that "even though the number of doctors involved in spreading this sort of bad information is tiny, they're having an outsized influence"); MER-72 ("False information can easily be spread to millions within days or even hours of it being created"); MER-82 (same). The legislative record displays little to no concern with one-on-one communication. AB 2098 thus fundamentally misfits the problem identified. *Contra* DB44 n.15

The narrow tailoring inquiry takes the harm as conceived by the legislating body and asks whether the law matches that harm. When the law is underinclusive because it

neglects to address the major aspect of the conceived harm, courts consistently hold that fails narrow tailoring review. *E.g., IMDB.com, Inc. v. Becerra*, 962 F.3d 1111, 1127 (9th Cir. 2020); *Victory Processing LLC v. Fox*, 937 F.3d 1218, 1229 (9th Cir. 2019); *Animal Legal Def. Fund v. Wasden*, 878 F.3d 1184, 1205 (9th Cir. 2018). Defendants' claim (DB45) that this argument "flips the narrow tailoring inquiry on its head" is thus a complaint about binding precedent. No one suggests that California should have "extend[ed]" AB 2098's censorship into still more "constitutionally suspect realms." DB45. The problem is simply that AB 2098 does nothing to alleviate the ill-identified, public-facing misinformation from doctor influencers on social media. It also does nothing to eliminate COVID-19 disinformation or misinformation from any medical professional other than physicians and surgeons. OB37. For a similar reason, *NIFLA* called the statute at issue there "wildly underinclusive." *NIFLA*, 108 S. Ct. at 2375.

The vagueness of the law also prevents narrow tailoring. Liability hinges on whether patients and enforcement authorities construe a doctor's speech as advice or simply as "statements about COVID-19." *Compare* DB38 *with Conant*, 309 F.3d at 639. That "leaves doctors and patients 'no security for free discussion.'" 309 F.3d at 639 (internal quotation omitted). And the legislative history focuses on the conveyance of "accurate information" separate from recommendations. MER-92. Defendants acknowledge this. DB43. If AB 2098 has "no effect at all on statements…such as speculation about the virus's origin or assertions about its political aspects" (DB45), then why does the law itself specifically declare that "disseminat[ing] misinformation or disinformation related to COVID-19" "includ[es] false or misleading information regarding the nature…of the virus"? OB5. That fairly includes its origins and political

aspects. And the legislative history itself singles out assertions about COVID's political aspects as the very misinformation that the law targets: "Other related conspiracy theories frequently involve the United States government, which has been accused of everything from inventing or exaggerating the pandemic to suppressing natural remedies…." MER-73, 83.

Perhaps most importantly, AB 2098 fails narrow tailoring because it is not the least restrictive means of accomplishing its aims. OB37-38. Malpractice tort liability and the regulatory authority's power to pursue incompetent doctors under Cal. Bus. & Prof. Code § 2234 ensures competent medical care. Indeed, Defendants repeatedly describe AB 2098 as "clarif[ying]" that disseminating misinformation or disinformation can constitute unprofessional conduct. DB3, DB44, DB60; *see also* DB14 (acknowledging that existing law would have covered some dissemination of misinformation). The legislature also acknowledged as much. MER-74. True, AB 2098 only requires a single dissemination for liability. But section 2234 can punish incompetence or gross negligence in the same manner. Malpractice liability too requires only a "single specific act." *Ashworth v. Mem'l Hosp.*, 206 Cal. App. 3d 1046, 1060 (1988); *see also Truman*, 611 P.2d at 907 (malpractice remedy available when patient declined pap smear test due to failure to advise and later died of cervical cancer). Malpractice and § 2234 provide an equivalent guarantee of competent care. AB 2098 only ensures that doctors will not feel free to discuss topics related to COVID-19 with their patients, thus depriving patients of the unfiltered views of a trusted confidante. The government's extreme microchip hypothetical doesn't change this. If a doctor refuses to prescribe a vaccine because of

putative microchips, then the state already has the means—§ 2234—to discipline doctors for such grossly negligent or incompetent conduct.

Even if the state would say the risk of harm demands an *ex ante* restraint on dangerous speech, "[b]road prophylactic rules in the area of free expression are suspect." *Button*, 371 U.S. at 438 (citations omitted); *Edenfield v. Fane*, 507 U.S. 761, 770-77 (1993) (rejecting, even under intermediate scrutiny, a regulation that amounted to an unsupported "prophylactic" rule). The distinction between *ex ante* and *ex post* regulation is why prior restraints constitute "the most serious and the least tolerable infringement" on our freedoms of speech and press. *Nebraska Press Ass'n v. Stuart*, 427 U.S. 539, 559 (1976). "[A] free society prefers to punish the few who abuse rights of speech after they break the law than to throttle them and all others beforehand." *Se. Promotions, Ltd. v. Conrad*, 420 U.S. 546, 559 (1975).

As *NIFLA* suggests, the "obvious[]" solution to a problem of educating the public is "a public information campaign." 108 S. Ct. at 2376; *accord* OB38. Defendants complain that misinformation has persisted (DB47), but that results from living in a free society. Some people "do not want" the state's advice. *Id.* "Either way, California cannot co-opt [medical professionals] to deliver its message for it." *Id.*

AB 2098 does not narrowly serve California's legitimate ends.

II. AB is void for vagueness; this Court should decline the government's belated invitation to rewrite the statutory definition.

Without addressing the Eastern District's decision in *Høeg* or this Court's most analogous decision in *Forbes* (OB40-OB46), Defendants assert that there is "adequate context" helping to define the relevant statutory terms, and that any uncertainty

regarding "scientific consensus" is cured by the reference to "standard of care." DB49-DB50.

Defendants seek a more forgiving review for vagueness because health providers have "specialized knowledge." "Scientific consensus," however, is "widely variable"; it's not a "medical term[] of art." *Tucson Woman's Clinic v. Eden,* 379 F.3d 531, 555 (9th Cir. 2004). It has no "settled usage or tradition" *Gentile v. State Bar of Nev.*, 501 U.S. 1030, 1049 (1991). Just as in *Forbes*, the law is vague as to medical professionals.[3]

When Defendants attempt to define "scientific consensus" as "information that the scientific community generally repudiates at the time treatment is rendered" (DB52), they simply put old wine in a new bottle. Which community? "Generally" repudiates? *Gentile* holds that "general" is a "classic term[] of degree" and thus unconstitutionally vague when setting the boundaries of an ethics rule. 501 U.S. at 548-49. So too here. The government's supposed solution merely compounds the problem.

Even if there is little or no scientific consensus, the shadow of AB 2098 enforcement "leaves doctors and patients 'no security for free discussion.'" *Conant*, 309 F.3d at 639 (internal quotation omitted). Defendants' attempt to soothe doctors by saying the lack of consensus means doctors should have no fear of liability provides no comfort for doctors advising patients on COVID-19 topics. The problem is not merely that it's nigh impossible to determine the "contemporary scientific consensus." It is that

[3] Defendants invoke the practice of narrowing construction. DB50 n.17. But when confronted with a facially vague law and the absence of a state judicial construction, this Court does not presume a narrow construction. *United States v. Wunsch*, 84 F.3d 1110, 1119 (9th Cir. 1996).

we have already seen the established "consensus" on COVID-19 be proven wrong. OB41 n.2; CER-52-54. Reasonable doctors disagree with the consensus in both directions. OB9; OB30-OB31. (The government does not dispute that recommending a booster vaccine to a 49-year-old in the summer of 2022 in contravention of contemporaneous CDC guidelines would have violated AB 2098 had it existed then.) These are not "hypothetical cases" or "hypothetical situations" (DB55), they are our actual experience with the novel coronavirus. The many about-faces of the scientific consensus are one major "reason why a State should be prohibited from protecting patients" from "information that is disavowed by the scientific community." DB53-DB54.

AB 2098's reference to the familiar "standard of care" does not alleviate the vagueness either. OB45. Standard of care itself is fluid and fact bound, particularly with respect to a new disease such as COVID-19 about which much is still being learned. At least two members of the Board acknowledged this, noting that medicinal standards are not static. OB14. The difference with malpractice is the threshold of a *harm* requirement absent from AB 2098.

Again, if false information translates into harm, incompetence, or gross negligence, there already exist remedies. *See* section I.D, above. AB 2098 lacks the requisite degree of "specificity and clarity" for a law that implicates First Amendment freedoms. *Cal. Teachers Ass'n v. Bd. of Educ.*, 271 F.3d 1141, 1150 (9th Cir. 2001).

Severance doesn't rescue AB 2098 either. To begin, as they acknowledge, Defendants did not raise this claim below. DB56 n.19. By only now making the argument "for the first time on appeal," they have forfeited it. *Orr v. Plumb*, 884

F.3d 923, 932 (9th Cir. 2018). This principle applies equally to a request for a severance remedy. *Comite de Jornaleros de Rondondo Beach v. City of Redondo Beach*, 657 F.3d 936, 951 n.10 (9th Cir. 2011); *see also United States v. City of Arcata*, 629 F.3d 986, 992 (9th Cir. 2010) (declining to consider "non-jurisdictional arguments," including severability, that were forfeited). Although this Court has the discretion to excuse forfeiture for purely legal issues, severance is a thorny issue because it risks the Judiciary "assum[ing] a legislative function" by imposing "its own new statutory regime." *NFIB v. Sebelius*, 567 U.S. 519, 692 (2012) (joint dissent); *see generally* William Baude, *Severability First Principles*, 109 Va. L. Rev. __ (forthcoming 2023). AB 2098's severability clause only contemplates whole "provisions" or "applications" being held invalid, it does not anticipate a court redlining a *portion* of one statutory definition to rewrite the statute. Even if it did, courts may not rewrite statutory definitions. *Gutierrez v. Comm'r of Soc. Sec.*, 740 F.3d 519, 527 (9th Cir. 2014) (citing *Sorenson v. Weinberger*, 514 F.2d 1112, 1118-19 (9th Cir. 1975)). Not even "to conform it to constitutional requirements" for redrafting the law is "quintessentially legislative work." *Iancu v. Brunetti*, 139 S. Ct. 2294, 2301 (2019) (internal quotation omitted); *Ayotte v. Planned Parenthood*, 546 U.S. 320, 329 (2006).

At any rate, severance of "scientific consensus" cannot cure the First Amendment violation here. Defendants attempt to do that by distinguishing verboten "advice given to a patient as part of medical care" from permitted "advice disconnected from care." DB28. If accepted, this proposal introduces unconstitutional vagueness into the definition of "dissemination." Dissemination would "depend[] largely on the meaning the patient attributes to the doctor's words." *Conant*, 309 F.3d at 639.

Severance will only abet the legislature's improper motivation when it drafted AB 2098. It still leaves us with a statute that, by design, chills dissenting views.

Conclusion

This Court should reverse and remand with instructions to grant the preliminary injunction.

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Respectfully submitted,

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Executed on March 23, 2023.

/s/Theodore H. Frank
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I hereby certify that on March 23, 2023, I electronically filed the foregoing with the Clerk of the United States Court of Appeals for the Ninth Circuit using the CM/ECF system, which will provide notification of such filing to all who are ECF-registered filers.

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