CASE NO. 25-963

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

SEAN MCBRIDE, M.D. AND G SHELLYE HOROWITZ,

Plaintiffs-Appellants,

v.

KRISTINA LAWSON, IN HER OFFICIAL CAPACITY AS PRESIDENT OF THE MEDICAL BOARD OF CALIFORNIA,

Defendant-Appellee.

On Appeal from the United States District Court
for the Eastern District of California, Case No. 2:24-cv-01394-KJM-AC
(Honorable Kimberly J. Mueller)

BRIEF OF THE CATO INSTITUTE AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLANTS

Thomas Berry
Counsel of Record
Brent Skorup
Caitlyn A. Kinard
CATO INSTITUTE
1000 Mass. Ave., N.W.
Washington, DC 20001
(443) 254-6330
tberry@cato.org

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INTEREST OF *AMICUS CURIAE*[1]

The Cato Institute is a nonpartisan public policy research foundation founded in 1977 dedicated to advancing the principles of individual liberty, free markets, and limited government. Toward those ends, Cato's Robert A. Levy Center for Constitutional Studies publishes books and studies, conducts conferences, produces the annual *Cato Supreme Court Review*, and files *amicus* briefs. This case interests Cato because it implicates both the right to speak freely and the right to earn a living in one's chosen occupation free of unlawful governmental interference.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

Too often, public officials and judges characterize protected expression as illegal conduct. *See*, *e.g.*, *Hurley v. Irish-American Gay, Lesbian, and Bisexual Group of Boston*, *Inc.*, 515 U.S. 557, 581 (1995) (rejecting a lower court's characterization of parade organizing as illegal discrimination); *NAACP v. Button*, 371 U.S. 415, 437–39 (1963) (rejecting a state supreme court's characterization of the NAACP's encouragement to members of the public to bring desegregation lawsuits as illegal solicitation). The U.S. Supreme Court has repeatedly rejected licensing rules and professional codes of conduct that constrain speech because First

[1] Fed. R. App. P. 29 Statement: No counsel for either party authored this brief in whole or in part. No person or entity other than *amicus* made a monetary contribution to its preparation or submission. Pursuant to Ninth Circuit Local Rule 29-2(a), all parties have been notified and have consented to the filing of this brief.

Amendment "freedoms are delicate and vulnerable, as well as supremely precious in our society. The threat of sanctions may deter their exercise almost as potently as the actual application of sanctions." *Id*. at 433.

Still, many state licensing rules are broad. In the state of California, for instance, it is a serious crime for someone to "treat[] the sick or afflicted," or to make a diagnosis, if he does not possess a valid California medical license. *See* CAL. BUS. & PROF. CODE § 2052(a). In fact, California law penalizes even out-of-state practitioners with fines of up to $10,000 or imprisonment for discussing medical concerns with patients in California. *Id.* Further, the proliferation of high-speed internet allows Californians to benefit from "telehealth" services—the delivery of health care services and information via telecommunications—but the uncertain coverage of licensing laws means out-of-state doctors are unsure about what they can say to their California patients during telehealth appointments. *See id*. §§ 2052(a), 2290.5(a)(6). Many medical professionals self-censor rather than potentially draw the unwelcome attention of, or prosecution by, California's licensing board.

In this case, a doctor and a patient challenge California telehealth and licensing laws that chill speech that could improve the medical knowledge of chronically ill people. Sean McBride, M.D., is a board-certified physician licensed and practicing in New York. He is also "a nationally renowned radiation oncologist

specializing in genitourinary and head and neck cancers." ER-24. California residents seek out Dr. McBride's advice, but California law prohibits him from consulting virtually with prospective patients located in California. *See* CAL. BUS. & PROF. CODE §§ 2052(a), 2290.5(a)(6). It appears even discussing a patient's health and diagnosis, to determine whether they should travel to his practice in New York to obtain treatment, is criminal. *Id*. § 2052(a). Likewise, simply following up with patients post-treatment, after they return home to California, may violate California's licensing law. ER-24–25.

California's law also chills speech in ways that deprive residents of critical and personalized health information. G Shellye Horowitz was diagnosed with hemophilia A, a rare disorder for women. ER-23. Because she lives in a remote, northern California town and has a rare condition, she must drive seven hours to Portland, Oregon, to receive the medical treatment she needs. ER-6. In managing her disorder, Ms. Horowitz must regularly check in and consult with her Oregon-based doctors. ER-23. But California's law discourages Ms. Horowitz's out-of-state specialists from speaking to her via phone or video call. ER-24. As a result, Ms. Horowitz must frequently travel the 14 hours round-trip to receive medical advice that could easily be transmitted to her via a phone or video call. ER-23–24.

Dr. McBride and Ms. Horowitz brought an as-applied challenge to these California laws and sued the California Medical Board for violating their

constitutional rights, including their free speech rights. The First Amendment protects professional speech. *See Nat'l Inst. of Family & Life Advocates (NIFLA) v. Becerra*, 585 U.S. 755, 767 (2018). Yet, the court below held that California may criminalize "consult[ing] with particular patients about that patient's care." ER-14.

The district court erred in holding that the law regulates professional conduct and only incidentally regulates speech. The telehealth communications Dr. McBride and Ms. Horowitz wish to engage in are speech, not conduct. Further, California's law triggers heightened scrutiny because it is both a content-based and speaker-based restriction on speech. In assessing the government's interest in restricting patient-doctor communications, this Court should consider research indicating that telehealth improves patient health and safety outcomes. This Court should reverse the decision below and enjoin the enforcement of California's medical licensing laws that chill speech.

ARGUMENT

I. TELEHEALTH CONSULTATIONS ARE PROTECTED SPEECH UNDER THE FIRST AMENDMENT.

A. Telehealth Communications Are Typically Speech, Not Conduct.

The First Amendment, incorporated to the states through the Fourteenth Amendment, provides that "Congress shall make no law . . . abridging the freedom of speech." U.S. CONST. amend. I. Individuals do not lose their right to speak freely merely because they are professionals. *See NIFLA*, 585 U.S. at 767. "To the contrary,

professional speech may be entitled to 'the strongest protection our Constitution has to offer.'" *Conant v. Walters*, 309 F.3d 629, 637 (9th Cir. 2002) (citing *Florida Bar v. Went-For-It, Inc.*, 515 U.S. 618, 634 (1995)). First Amendment protections for professional speech are vital to "preserve an uninhibited marketplace of ideas in which truth will ultimately prevail." *Id.* at 757 (quoting *McCullen v. Coakley*, 573 U.S. 454, 476 (2014)).

In this case, California law prevents doctors who are licensed outside of the state from speaking freely to patients within the state for medical consultations and follow-ups. The Medical Board argues that doctor-patient communication about "symptoms and diagnoses, addressing recovery and patient questions, and providing information . . . is a core component of medical practice." *See* ER-18. The district court endorsed that view, *id*., and held that doctor-patient communication about diagnoses and consultations are "treatment, and not speech." ER-17. Therefore, the court ruled, California's law constitutionally regulates professional conduct and must satisfy only the deferential rational basis standard of review. ER-18.

But "[i]f speaking to clients is not speech, the world is truly upside down." *Otto v. City of Boca Raton*, 981 F.3d 854, 866 (11th Cir. 2020). While the Supreme Court has stated that "[s]tates may regulate professional *conduct*, even though that conduct incidentally involves speech," states may not use this narrow exception to diminish First Amendment protections. *NIFLA*, 585 U.S. at 768 (emphasis added).

Sister circuits are likewise alert to the constitutional harms of states regulating professional speech as conduct. As the Eleventh Circuit warned a few years ago, "labeling certain verbal or written communications 'speech' and others 'conduct' is unprincipled and susceptible to manipulation." *Wollschlaeger v. Governor*, 848 F.3d 1293, 1308 (11th Cir. 2017) (en banc) (holding that a Florida law restricting doctors from asking about firearm ownership violated the doctors' First Amendment rights). Judges must distinguish conduct and speech carefully because "characterizing speech as conduct is a dubious constitutional enterprise." *Id.* at 1309.

The Fifth Circuit correctly applied the conduct-speech distinction when a veterinarian challenged a Texas law that criminalized his communication of veterinary advice and diagnoses. *See Hines v. Pardue*, 117 F.4th 769, 771 (5th Cir. 2024). Like Dr. McBride, Dr. Hines only sought to provide consultations and medical advice to his clients online. *See id.* The Fifth Circuit held that the Texas law "directly regulat[ed] Dr. Hines's speech and that this regulation fails to survive even intermediate scrutiny." *Id.* at 771. In its analysis, the court noted that "[i]f courts were required to accept a governmental actor's speech-or-conduct designation, we would be compelled to forego our solemn duty to 'assess[] the First Amendment interest at stake and weigh[] it against the public interest allegedly served by the regulation.'" *Id.* at 777 (internal citation omitted). The court denied the state's assertion that it was regulating conduct rather than speech, because the state "only

penalized [Dr. Hines] for his *communication* with the [client] about her bird in which he gave a diagnosis and treatment plan," so "the regulation *only* kicked in when Dr. Hines began to share his opinion with his [client]." *Id.* at 778 (emphasis in original).

In contrast, the court below failed to draw the speech-conduct line correctly. This is an as-applied challenge to California's licensing and telehealth law. Dr. McBride is an oncologist; Ms. Horowitz has a severe blood disorder. Leaving aside whether some types of medical treatment can be administered virtually, the court below clearly erred in accepting the Medical Board's arguments wholesale and deeming patient-doctor consultations and communications about cancer and blood disorders "treatment" for cancer or blood disorders. *See* ER-18. Dr. McBride and Ms. Horowitz do not wish to engage in "conduct" that traditionally triggers professional conduct regulation—like surgery, prescribing medications, or medical scans. They seek only to engage in private patient-doctor communications, and a law restricting these communications must comply with the First Amendment.

Simply, "[w]hen the government restricts professionals from speaking to their clients, it's restricting speech, not conduct. And it's restricting the speech precisely . . . because of the harms that may flow from this message." Eugene Volokh, *Speech as Conduct: Generally Applicable Laws, Illegal Courses of Conduct, "Situation-Altering Utterances," and the Uncharted Zones*, 90 CORNELL L. REV. 1277, 1346 (2005). California's telehealth restriction is not a "regulation of professional practice

with only *incidental* impact on speech." *See NIFLA*, 585 U.S. at 769 (emphasis added). California's law directly regulates speech, not conduct.

B. The California Telehealth and Licensing Laws Are Speaker and Content Based.

When a law restricts speech on the basis of the speaker or the content, courts apply strict scrutiny. *See Reed v. Town of Gilbert,* 576 U.S. 155, 168–71 (2015). The Court should apply strict scrutiny here, because the regulation at issue is both speaker based and content based. At the very least, California's telehealth restrictions should be analyzed under some form of heightened scrutiny. *See Hines*, 117 F.4th at 778–79 (noting that Supreme Court jurisprudence on content-neutrality is not clear and then applying intermediate scrutiny without deciding the issue).

Because "[s]peech restrictions based on the identity of the speaker are all too often simply means to control content," the Supreme Court has "insisted that 'laws favoring some speakers over others demand strict scrutiny when the legislature's speaker preference reflects a content preference.'" *Reed*, 576 U.S. at 170 (internal citations omitted). Here, California's law is speaker based because it expressly targets a discrete group of people: "any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing" medicine. CAL. BUS. & PROF. CODE § 2052(a). This criminal law burdening patient-doctor communications thus applies only to physicians (and those posing as physicians).

In addition, California's law is content based because it criminalizes discussion of only certain topics. "Content-based laws—those that target speech based on its communicative content—are presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests." *Reed*, 576 U.S. at 163 (applying strict scrutiny). A law can be content based if it "defin[es] regulated speech by particular subject matter" or "defin[es] regulated speech by its function or purpose." *Id.*

The licensing law itself singles out patient-doctor discussion of "diagnoses." CAL. BUS. & PROF. CODE § 2052(a). And, alarmingly, the court below adopted the Medical Board's atextual and expanded definition of prohibited subjects: "discussion of symptoms and diagnoses, addressing recovery and patient questions, and providing [medical] information." ER-18 (opinion quoting medical board's legal brief). Patient-doctor communications about other subjects—the weather, last night's football game, or election results—are permitted; discussion about diagnoses and medical "information" is not. *See id*. Because California's law is content based, it should be analyzed under strict scrutiny.

The law at issue in this case is both speaker based and content based. Therefore, the district court erred when it applied deferential rational basis review. *See* ER-18.

II. THE CHILLING EFFECT ON TELEHEALTH HARMS PATIENTS IN UNDERSERVED AND RURAL COMMUNITIES MOST.

In the event this court assesses the substantial or compelling government interests in regulating physicians' speech, it should consider the public harm of overinclusive telehealth rules. *See Hines*, 117 F.4th at 780 (applying heightened scrutiny requires "consider[ing] whether the alleged harms . . . are real, and if so, whether the statute alleviates those alleged harms."). Specifically, research demonstrates that telehealth can lead to better health outcomes, especially for patients in underserved communities and for patients with rare conditions. While the state has a legitimate interest in protecting residents from unqualified physicians, criminalizing patient-doctor communications prevents residents from learning about services from licensed specialists outside of the state.

In general, patient outcomes improve when they have access to telehealth appointments. A meta-analysis of 928 studies exploring telehealth effectiveness demonstrated that "telehealth is often equally as effective, if not more, than usual care."[2] While telehealth services generally are not treatment, they improve patients'

[2] Centaine L. Snowswell et al., *The Clinical Effectiveness of Telehealth: A Systematic Review of Meta-Analyses from 2010 to 2019*, 29 J. OF TELEMEDICINE & TELECARE 669, 680 (2023). An analysis of these studies found evidence that telehealth led to "fewer major thromboembolic events in CVD, a positive change in HbA1C for patients with diabetes, no additional events in individuals post-stroke, and equally controlled blood pressure compared to patients having in-person care in nephrology . . . ." *Id.*

and doctors' knowledge and can assist in health monitoring. Researchers have found that "telemedicine has been associated with improved management of chronic conditions such as diabetes and hypertension through regular remote monitoring and virtual consultations."[3] Further, these benefits come at a decreased cost for patients. A 2018 study found that "the average in-person physician office visit costs $125 while a standard telemedicine visit costs around $45."[4] For some patients, this cost differential could be the deciding factor in whether they obtain medical care.

Predictably, patients in rural areas and patients with rare conditions suffer the most from telehealth restrictions. Not only do rural Americans have access to "fewer care locations, [but] rural [Americans] are also limited by having only 39.8 physicians per 100,000 people compared to 53.3 physicians per 100,000 people for urban patients."[5] Likewise, as Ms. Horowitz's experience shows, "[s]pecialists are disproportionately located in larger markets, as are physicians with more experience in procedures."[6] Many Americans who live in rural regions must travel to larger,

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[3] Victor C. Ezeamii et al., *Revolutionizing Healthcare: How Telemedicine Is Improving Patient Outcomes and Expanding Access to Care* 2, CUREUS (2024), https://tinyurl.com/uvtfm573.

[4] Stephanie Zawada, *Telemedicine: The Promise and the Performance*, THE HERITAGE FOUND. (Dec. 17, 2018), https://tinyurl.com/45dte5cm.

[5] *Id.*

[6] Jonathan I. Dingel et al., *Market Size and Trade in Medical Services* 34, NAT'L. BUREAU OF ECON. RSCH. (2024), https://tinyurl.com/3z8eumz8.

more populated regions to access quality healthcare.[7] Alternatively, those patients are 40 percent more likely to turn to "non-standard" specialty care than patients in larger regions, which suggests that these patients receive less quality healthcare.[8] For patients with rare conditions in these areas, their access to quality healthcare largely depends on their ability to travel outside of the region to see a specialist.[9] Telehealth services can improve rural residents' knowledge of their healthcare options, but only if licensed providers outside of the region are able to communicate with these patients.

Further, medical research requires doctors to be able to communicate freely with patients in diverse geographic areas—many prospective patients live in a different state from medical researchers. Because clinical trials typically require a large sample size and regular follow-ups, restricting telehealth communications to in-state licensed providers reduces the recruiting pool of patients available for future research.[10] Lowering the barriers to entry for participation in clinal trials also helps ensure participation of diverse populations and, thus, more accurate results.

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[7] *Id.* ("Patients travel to regions with highly-ranked hospitals, which larger markets tend to have—along with rare equipment and the ability to provide rare services.").
[8] *Id.* at 33.
[9] *Id.* at 3.
[10] *See generally* Michael Carpenter, *Telehealth Utilization in Clinical Trials: Facilitators, Barriers, and Future Directions* 9–10, MEDICAL UNIV. OF S.C. (2024). Available at https://tinyurl.com/4s5ywucm.

Finally, the Medical Board argues that Californians will receive "professionally incompetent" advice if the telehealth laws are construed liberally to accommodate free speech. *See* ER-18. That is an exaggerated concern when patients are merely speaking to doctors licensed in other states. Medical providers are already subject to professional standards of care and ethics, and they can be held accountable through malpractice laws. And waivers of telehealth restrictions during COVID-19 offered a quasi-natural experiment, showing what happens when states allow broader telehealth access.[11] One review analyzing 77 studies comparing the use of in-person care and telehealth during the COVID-19 pandemic found that "the use of telehealth during COVID-19 in many, though not all, instances is comparable to in-person care across different clinical areas and different healthcare utilization, clinical, and process outcomes."[12] During this time period, studies found that there were "significant improvements in patient satisfaction with telemedicine," and "[e]nhanced medication adherence, reduced [emergency department] visits, and strong correlations between readmission rates and medication compliance were

[11] Lisa M. Koonin et al., *Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic—United States, January–March 2020*, 69 MMWR MORBIDITY & MORTALITY WKLY. REP. 1595, 1595 (2020). During March 2020, the Center for Disease Control reported a 154 percent increase in telehealth visits compared to the same period in 2019. Available at https://tinyurl.com/3e38vccp.

[12] Elham Hatef et al., *Effectiveness of Telehealth Versus In-Person Care During the COVID-19 Pandemic: A Systematic Review* 6, NPJ DIGITAL MEDICINE (2024), https://tinyurl.com/yuvjrex4.

observed . . . ."[13] In short, increasing telehealth access seems to improve patient health outcomes.

Courts have acknowledged that "[i]n 'the fields of medicine and public health . . . information can save lives.'" *See Wollschlaeger*, 848 F.3d at 1313 (quoting *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 566 (2011)). This Court should uphold basic First Amendment protections for doctors, because frank and personalized patient-doctor communications can improve the quality of medical care and research across the United States.

CONCLUSION

For the foregoing reasons, this Court should reverse the district court's ruling and allow Dr. McBride's and Ms. Horowitz's First Amendment claims to proceed.

Respectfully submitted,

Dated: June 13, 2025

/s/ Thomas A. Berry
Thomas A. Berry
Counsel of Record
Brent Skorup
Caitlyn A. Kinard
CATO INSTITUTE
1000 Mass. Ave., N.W.
Washington, DC 20001
(443) 254-6330
tberry@cato.org

[13] Ezeamii, *supra* note 3.

CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of 9th Cir. R. 29(a)(2) because it contains 3,114 words, excluding the parts exempted by Fed. R. App. P. 32(f).
2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface in Times New Roman, 14-point font.

/s/ Thomas A. Berry

June 13, 2025

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of Court, who will enter it into the ACMS system, which will send a notification of such filing to the appropriate counsel.

/s/ Thomas A. Berry

June 13, 2025