No. 24-932

In the Supreme Court of the United States

PIERRE KORY, *et al.*,

Petitioners,

v.

ROB BONTA, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Like every other State, California regulates the practice of medicine to protect the public. Physicians who engage in "unprofessional conduct," including by deviating from the medical standard of care, are subject to disciplinary action. Cal. Bus. & Prof. Code § 2234(c). The petitioners here allege that California's medical boards intend to carry out a "Covid misinformation censorship campaign" (Pet. 11) by enforcing Section 2234(c) against physicians who express certain views regarding COVID-19 vaccination and treatment. The court of appeals affirmed the district court's denial of a preliminary injunction. It reasoned that petitioners had disclaimed a facial challenge to Section 2234(c) and that such a challenge would fail in any event. As to petitioners' as-applied challenge, the court held that they had not demonstrated a threat of enforcement sufficient to establish standing. The question presented is:

Whether the court of appeals correctly affirmed the denial of a preliminary injunction.

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STATEMENT

1. In California, two boards are primarily responsible for licensing and training physicians: the Medical Board and the Osteopathic Medical Board (the "Boards"). The Medical Board regulates allopathic physicians (MDs) who practice traditional medicine, and the Osteopathic Medical Board regulates osteopathic physicians (DOs) who practice osteopathic medicine. *See* Cal. Bus. & Prof. Code §§ 2004, 2450. The Boards must "take action against any licensee who is charged with unprofessional conduct." *Id.* § 2234; *see also id.* §§ 3600, 3600-2. Unprofessional conduct includes "repeated negligent acts," as well as "[a]n initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care." *Id.* § 2234(c).

The "standard of care" is a "well-established legal concept" that "has governed the practice of medicine for centuries." Pet. App. 27a-28a. Like many other States, California defines the standard of care as the exercise of "the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing." *Flowers v. Torrance Mem'l Hosp. Med. Ctr.*, 8 Cal. 4th 992, 998 (1994); *see also Brown v. Colm*, 11 Cal. 3d 639, 642-643 (1974) (standard of care reflects the medical standard "prevailing in the community at the time" treatment is rendered); *see generally* Restatement (Third) of Torts: Medical Malpractice § 5 (2024). Determining the standard of care "is inherently situational" and the amount and type of care "deemed reasonable in any particular case will vary." *Flowers*, 8 Cal. 4th at 997.

When the Medical Board or Osteopathic Medical Board receives a complaint that a physician has departed from the applicable standard of care, they subject it to multiple rounds of review. The Board first assesses whether it has jurisdiction over the misconduct and, if so, whether there is sufficient evidence of a violation to open an investigation. Cal. Bus. & Prof. Code §§ 2220(a), 3600. If the Board and its panel of experts investigate and determine that a physician has violated the standard of care, the physician may dispute the charges at an administrative hearing with an opportunity for witness testimony and cross-examination. *See* Cal. Gov. Code § 11371. If the administrative law judge proposes to impose discipline, the Board must then decide whether to accept the proposed discipline or reject it and render a different decision. *See* Cal. Bus. & Prof. Code § 2013(c); Cal. Gov. Code § 11517(c). The physician may seek judicial review of the final decision in state trial court by way of administrative mandamus. *See* Cal. Bus. & Prof. Code § 2337; Cal. Code Civ. Proc. § 1094.5.

2. Petitioners are three California-licensed physicians and two nonprofit organizations that advocate for allowing physicians to provide information to their patients about topics such as "the risks and benefits of vaccines" and "booster shots and off-label drugs like Ivermectin." Pet. 9-12; *see* Pet. App. 7a. Petitioners assert that they or their members may wish to provide information to patients that is "inconsistent with the mainstream Covid narrative." Pet. 12.

In 2022, the California Legislature enacted AB 2098, specifying that "[i]t shall constitute unprofessional conduct for a physician and surgeon to disseminate misinformation . . . related to COVID-19, including false or misleading information regarding

the nature and risks of the virus, its prevention and treatment; and the development, safety, and effectiveness of COVID-19 vaccines." Cal. Bus. & Prof. Code § 2270(a) (repealed 2024). AB 2098 defined "misinformation" related to COVID-19 as "false information that is contradicted by contemporary scientific consensus contrary to the standard of care." *Id.* § 2270(b)(4).

A group of plaintiffs (some of whom are petitioners here) challenged AB 2098 on First and Fourteenth Amendment grounds. Pet. App. 7a-8a; *see Høeg v. Newsom*, No. 22-cv-1980 (E.D. Cal.); *Hoang v. Bonta*, No. 22-cv-2147 (E.D. Cal.). The district court preliminarily enjoined AB 2098 on the ground that it was unconstitutionally vague. Pet. App. 8a; *see Høeg v. Newsom*, 652 F. Supp. 3d 1172 (E.D. Cal. 2023). The California Legislature subsequently repealed AB 2098, effective January 1, 2024. Pet. App. 8a. The Boards have not sought to enforce AB 2098 since the enactment of the repeal bill. *Id.* at 26a.

3. After the repeal of AB 2098, petitioners filed a new action, "challeng[ing] the constitutionality of the Boards' powers to discipline physicians under [Section 2234(c)] for conveying COVID-19-related information to their patients." Pet. App. 7a. They alleged that the Boards had a "practice and policy of investigating and sanctioning physicians for their protected speech" through Section 2234(c), and that those enforcement activities violated the right of patient members of the nonprofits to receive information about COVID-19. D. Ct. Dkt. 1, ¶ 73.

Petitioners moved for a preliminary injunction, which the district court denied. The court determined that Section 2234(c) was a facially constitutional regulation of physician conduct, not speech, because the statute covers "unprofessional conduct" and "act[s]" or

"omission[s]" that would have "only an incidental effect on speech, if any." Pet. App. 19a. The court also concluded that petitioners did not have standing to mount an as-applied challenge to Section 2234(c), explaining that the record was "utterly devoid of any evidence that the Boards have or may use their authority under section 2234(c) to . . . discipline physicians for their protected speech" regarding COVID-19. *Id.* at 23a. Nor had petitioners produced any evidence that AB 2098 would continue to be enforced by the Boards after the Legislature repealed that statute. *Id.* at 26a.

The court of appeals affirmed. Pet. App. 2a-4a. As to petitioners' facial challenge, it held that Section 2234(c) "regulates conduct, not speech" because "[i]t provides for enforcement of the standard of care, which is the standard for physicians' treatment of patients." *Id.* at 3a. Petitioners had thus "not established any likelihood of success on a facial challenge, and in their reply brief and at oral argument, they have disclaimed pursuing one." *Id.* And petitioners lacked standing to pursue an as-applied challenge because they have not "been prosecuted under the statute, and Defendants have not threatened enforcement against them." *Id.* at 3a. Judge Callahan disagreed as to the standing holding, but concurred in the judgment because petitioners had "not established a likelihood of success on the merits at this stage of the proceedings." *Id.* at 5a.

ARGUMENT

Petitioners advance a First Amendment claim premised on the hypothetical possibility that the Boards might take enforcement action against them or other physicians for violating the general standard of care by providing patients with unspecified information regarding COVID-19. The lower courts denied

petitioners' motion for a preliminary injunction, reasoning that their as-applied claim failed for lack of standing and their facial challenge to California Business and Professions Code Section 2234(c) was both waived and meritless.

Petitioners offer no persuasive reason for further review by this Court. They cite no conflict of authority that is genuinely implicated by the decision below. As to the merits, they have disclaimed a facial challenge to Section 2234(c); their overbreadth arguments are unpersuasive; and they fail to identify any credible threat of enforcement that would confer standing for their as-applied challenge. Before this Court, petitioners argue that their claim is neither facial nor as-applied. But whatever label they prefer, petitioners seek to enjoin the Medical Boards' enforcement of the broad terms of Section 2234(c) in particular scenarios regarding COVID-19 advice and treatment. Article III prohibits them from proceeding on that claim absent a sufficiently imminent threat of enforcement, which is lacking here.

1. The court of appeals correctly affirmed the denial of a preliminary injunction based on petitioners' failure to establish a likelihood of success on the merits.

a. Here and below, petitioners have disclaimed any facial challenge to Section 2234(c), *see* Pet. 9; Pet. App. 3a, but they do contend that Section 2234(c) "is unconstitutionally overbroad," Pet. 23.

The standard for mounting a facial challenge under the First Amendment is the same as a standard for an overbreadth challenge: the plaintiff must demonstrate that "a substantial number of the law's applications are unconstitutional, judged in relation to

the statute's plainly legitimate sweep." *Moody v. NetChoice, LLC*, 603 U.S. 707, 723 (2024) (alterations omitted); *see Virginia v. Hicks*, 539 U.S. 113, 118-119 (2003). Under that "rigorous standard," a law may only be struck down if its "unconstitutional applications substantially outweigh its constitutional ones." *Moody*, 603 U.S. at 723, 724. Petitioners cannot satisfy that standard because the Board may apply Section 2234(c)'s general standard of care in countless ways that do not offend (or even implicate) the First Amendment.

Section 2234 regulates "unprofessional conduct"—not physician-patient communications. Petitioners seek to enjoin the enforcement of Section 2334(c)'s prohibition of "repeated negligent acts." But "negligent act[s] or omission[s]" that violate the standard of care often do not involve physician speech. A mistake during a medical procedure, for example, could deviate from the standard of care, but it would not affect speech. While Section 2234(c) may regulate speech in certain cases—such as a physician's recommendation as to the best course of treatment—that constitutes "professional conduct" that "incidentally involves speech." Pet. App. 10a (quoting *Nat'l Inst. of Fam. & Life Advocs. v. Becerra*, 585 U.S. 755, 768 (2019) (*NIFLA*)); *see infra* pp. 13-15.

Petitioners contend that "[t]his case involves viewpoint restrictions on speech." Pet. 18. But Section 2234(c) is viewpoint-neutral on its face and "does not purport to regulate speech unrelated to treating patients or require any particular communication" with patients. Pet. App. 3a. Indeed, petitioners identify no situations where they allege that Section 2234(c) burdens speech other than the specific context of COVID-19 treatment. Given the innumerable ways in which

the Boards may lawfully apply the general standard of care, petitioners' cursory arguments about Section 2234(c) here (Pet. 22-23) fail to satisfy the standard for First Amendment overbreadth or facial challenges.

b. As to petitioners' as-applied challenge, the court of appeals correctly held that petitioners lack standing because they cannot show a credible threat of enforcement against them. Pet. App. 3a-4a. Petitioners do not contend that any conflict of authority exists regarding the standard for establishing standing to bring a pre-enforcement challenge, *see Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 159 (2014), and the application of that standard here does not otherwise warrant this Court's review.

Article III allows pre-enforcement challenges to laws and regulations only "under circumstances that render the threatened enforcement sufficiently imminent." *Driehaus*, 573 U.S. at 159. A plaintiff must establish that he or she "inten[ds] to engage in a course of conduct arguably affected with a constitutional interest, but proscribed by a statute, and there exists a credible threat of prosecution thereunder." *Id.* Each petitioner has failed to demonstrate standing under this test.

i. The individual petitioners have not credibly alleged that the Boards have threatened to enforce Section 2234(c) against them for COVID-19 disinformation, nor even that they intend to violate the standard of care set by Section 2234(c). Petitioners generally allege that their practice involves "dealing with patients with questions about Ivermectin," communicating "the risks versus benefits for Covid vaccines and continued boostering," and discussing with patients "observations made as a result of [a] clinic's experience" treating COVID-19. Pet. 9-10. But

a general discussion with patients of the pros and cons of COVID-19 vaccines and treatments likely falls within the medically acceptable standard of care.

While petitioners declare that they intend to "advis[e] patients on treatments that diverge from mainstream medical consensus," Pet. 26, the standard of care under California law allows for reasonable disagreements among physicians. *See, e.g.*, *Siniako v. Superior Court*, 122 Cal. App. 4th 1133, 1141-1142 (2004). As the district court observed, "COVID-19 is far from the first medical topic to prompt controversy and serious disagreement among doctors and scientists." Pet. App. 33a. In the event of such disagreements, "there is not necessarily any violation of the standard of care" when a physician offers advice that might reflect a minority viewpoint within the physician community. *Id.* at 31a-32a.

Moreover, given the fact-specific nature of any inquiry into whether physician conduct violates the standard of care under Section 2234(c), it is difficult to determine whether any of the hypothetical COVID-19 treatments posited by petitioners would violate the applicable standard of care. Depending on the particular circumstances, for example, a practice of "recommending nutritional supplements and alternative therapies" (Pet. 26) may fall within the applicable standard of care for COVID-19.

The individual petitioners likewise failed to identify any "specific warning or threat to initiate proceedings against them." Pet. App. 4a (internal quotation marks omitted). They characterize the repeal of AB 2098 as a mere "tactical retreat" and assert that the Boards intend to enforce the now-repealed statute under the guise of enforcing Section 2234(c). Pet. 7. But there is no indication that the Boards are currently

threatening petitioners or other physicians with any investigations or enforcement actions related to providing information about COVID-19. While the Medical Board previously investigated petitioner Brian Tyson under AB 2098, *see* Pet. 10, that investigation concluded without any discipline. A prior investigation under a since-repealed statute provides no basis for inferring that the Board will seek to enforce Section 2234(c) against Tyson or the other petitioners.

Petitioners also quote (Pet. 7) a comment by an assemblymember who observed that after the repeal of AB 2098 "the Medical Board of California will continue to maintain the authority to hold medical licensees accountable for deviating from the standard of care and misinforming their patients about COVID-19 treatments." Of course, a comment by one state legislator does not control the enforcement authority of independently appointed Medical Boards. *See* Cal. Bus. & Prof. Code §§ 2001, 2004(a)-(d), 3600-1. And the comment does not suggest that the Boards should take any particular enforcement action. Rather, it acknowledges the Boards' continuing ability to exercise their longstanding authority to enforce the general standard of care—in the COVID-19 context as in others.

Finally, petitioners allege that the Boards have engaged in an "ongoing Covid misinformation censorship campaign." Pet. 11. But they only point to a single instance of physician discipline for allegedly providing misinformation about COVID-19, in which the physician in question "surrendered her license following the commencement of disciplinary proceedings." Pet. App. 25a. And the conduct at issue in that disciplinary proceeding—including directing patients with COVID-19

to take veterinary ivermectin, not the type of ivermectin approved for human use, *see* C.A. Dkt. 8.1 at 21—is not comparable to the advice petitioners and their members wish to give patients. A single instance of physician discipline in a factually dissimilar case does not establish any ongoing "censorship campaign."

ii. The organizational petitioners likewise failed to establish standing. They assert that "their physician members' speech is being chilled" by the prospect of enforcement under Section 2234(c). Pet. 11; *see id.* at 24-26. An argument that a plaintiff feels pressured to "self-censor" is generally insufficient to establish standing absent a credible threat of enforcement. *Murthy v. Missouri*, 603 U.S. 43, 73 (2024). Plaintiffs "'cannot manufacture standing merely by inflicting harm on themselves based on their fears of hypothetical future harm that is not certainly impending.'" *Id.* (quoting *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 416 (2013)). And just as the individual petitioners have failed to show a likelihood of enforcement against them, the organizational petitioners identify no evidence that Section 2234(c) has been (or is likely to be) enforced against their member physicians.

Petitioners also cite *Virginia Board of Pharmacy v. Virginia Citizens Consumer Council*, 425 U.S. 748 (1976), for the proposition that patients have a right to receive certain information about COVID-19. Pet. 29-30. Unlike this case, however, *Virginia Board of Pharmacy* involved a statute that directly prohibited pharmacists from communicating information about drug prices to patients. *See* 425 U.S. at 750. By contrast, Section 2234(c) is a viewpoint- and content-neutral restriction on physician conduct; it does not directly restrict the dissemination of any particular information regarding COVID-19 or any other subject.

And petitioners (again) offer no evidence supporting their theory that the Boards are likely to enforce Section 2234(c) in a manner that would deprive patients of information regarding COVID-19.

c. Petitioners now attempt to recast their First Amendment claim as "[n]either a facial [n]or [an] as-applied challenge." Pet. 26. They say their complaint instead mounts "a challenge to California's three-year (and continuing) enforcement policy and program threatening physicians' fully protected speech." *Id.* at 27. But that characterization does not undermine the lower courts' holdings or provide a basis for Article III standing.

"[T]he distinction between facial and as-applied challenges" generally turns on "the breadth of the remedy employed by the Court." *Citizens United v. Fed. Election Comm'n*, 558 U.S. 310, 331 (2010). "A facial challenge is really just a claim that the law or policy at issue is unconstitutional in all its applications." *Bucklew v. Precythe*, 587 U.S. 119, 138 (2019). An as-applied challenge contends "that a statute [is] invalid as applied to one state of facts," *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 329 (2006), and seeks a correspondingly "narrower remedy," *United States v. Nat'l Treasury Emps. Union*, 513 U.S. 454, 478 (1995). While the "line between facial and as-applied challenges can sometimes prove 'amorphous' and 'not so well defined,'" what matters is not the "label," but the nature of the claim and the relief sought. *Bucklew*, 587 U.S. at 139 (citations omitted).

Here, petitioners challenge "the current Section 2234(c) based enforcement program" with respect to physician conduct related to COVID-19. Pet. 27. They argue that policy objectives and pressure from outside

organizations will cause California's Medical Boards "to sanction physicians for information and recommendations about Covid that conflict with the mainstream Covid narrative." *Id.* at. 15. Their complaint seeks:

> a declaratory judgment that it is a First Amendment violation for the California medical boards to investigate, prosecute or sanction physicians based on information and opinions they provide to patients concerning the safety and efficacy of Covid vaccines, FDA approved drug treatments for Covid whether on or off label, or dietary supplements, or public health measures such as the benefits of masks, at least as long as there is some published scientific evidence supporting the information, opinions, recommendation, or advice.

D. Ct. Dkt. 1 at 23-24. They also "seek preliminary and permanent injunctive relief preventing the commencement of any such investigation or prosecution." *Id.* at 24.

Whatever label petitioners wish to ascribe to it, this claim challenges and seeks to enjoin the Boards' prospective application of its "statutory authority to enforce the standard of care" under Section 2234(c) to a particular set of circumstances: advice and treatment regarding COVID-19. D. Ct. Dkt. 1 at 24. This Court's precedent requires petitioners to show that a threat of enforcement in those circumstances is sufficiently imminent before that claim may proceed in an Article III court. *Supra* p. 7. They have not done so.

Petitioners' discussion (Pet. 28) of *Bantam Books, Inc. v. Sullivan*, 372 U.S. 58 (1963), and *NRA v. Vullo*, 602 U.S. 175 (2024), does not establish that they have

standing here. The plaintiffs in *Bantam Books* received dozens of "thinly veiled threats to institute criminal proceedings against them" if they did not remove certain "objectionable" titles from their shelves. 372 U.S. at 68, 70. The state defendant in *Vullo* "allegedly pressured regulated entities to help her stifle the NRA's pro-gun advocacy by threatening enforcement actions against those entities that refused to disassociate from the NRA and other gun-promotion advocacy groups." 602 U.S. at 180. Petitioners do not identify anything remotely similar in this case.[1]

2. None of the purported conflicts of authority advanced by petitioners (Pet. 17-23) provides a basis for plenary review.

a. Petitioners are mistaken in asserting (Pet. 17) that the decision below is inconsistent with the Court's decision in *NIFLA*, 585 U.S. at 755.

NIFLA clarified that the government may not "treat[] professional speech as a unique category that is exempt from ordinary First Amendment principles." 585 U.S. at 773. But "States *may* regulate professional conduct, even though that conduct incidentally involves speech." *Id.* (emphasis added). The regulation of "professional malpractice," for example, "'fall[s] within the traditional purview of state regulation of professional conduct.'" *Id.* at 769. The law at issue in *NIFLA* required that crisis pregnancy centers provide certain notices to patients. *Id.* at 770. The Court invalidated that law because it "applie[d] to all interactions between a covered facility and its clients,

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[1] *Murthy* also does not support petitioners' standing. Like petitioners here, the plaintiffs there failed to demonstrate "a likelihood of future harm" based on an alleged COVID-19 misinformation policy. *Murthy*, 603 U.S. at 70.

regardless of whether a medical procedure is ever sought, offered, or performed." *Id.* at 770. But the Court reaffirmed that States may regulate speech "as part of the practice of medicine," which is "subject to reasonable licensing and regulation by the State." *Id.* (citation omitted).

Applying *NIFLA* here, the court of appeals correctly recognized that Section 2234(c) "regulates conduct, not speech." Pet. App. 3a. It governs "act[s] or omission[s]" to ensure that medical practitioners satisfy the applicable standard of care. The legal concept of a standard of care for medical practitioners has existed for centuries, dating back to the earliest days of the common law. *See id.* at 28a.[2] It reflects "a state's legitimate concern for maintaining high standards of professional *conduct* . . . beyond initial licensing." *Barsky v. Bd. of Regents*, 347 U.S. 442, 451 (1954) (emphasis added). Petitioners cannot identify any court that has applied heightened First Amendment scrutiny to a statute or common law doctrine imposing the standard of care.

To be sure, medical treatment may sometimes involve speech. For example, a doctor may make a verbal recommendation for a COVID-19 treatment or may be required to "obtain informed consent" to perform an operation. *NIFLA*, 585 U.S. at 770. But unlike in *NIFLA*, where "the licensed notice regulate[d] speech as speech," these forms of speech would be "tied to a procedure" or treatment and would therefore constitute professional conduct. *Id.* The physician's right

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[2] Today, every State applies some version of a standard of care to regulate the conduct of the medical profession and protect the public. *See* Restatement (Third) of Torts: Medical Malpractice § 5 (2024); Vanderpool, *The Standard of Care*, 18 INNOV. CLINICAL NEUROSCI. 50, 50-51 (2021).

to speak in these instances "as part of the practice of medicine" is "subject to reasonable licensing and regulation by the State." *Id.* (citations omitted).

Nor does *NIFLA* require that petitioners' challenge be subjected to "strict scrutiny" (Pet. 18 n.2) or any other form of heightened scrutiny. Determining whether a physician violates the standard of care under Section 2234(c) will sometimes require an analysis of the content of physician communications. But this Court has "reject[ed] . . . the view that *any* examination of speech or expression inherently triggers heightened First Amendment concern." *City of Austin v. Reagan Nat'l Advert. of Austin, LLC*, 596 U.S. 61, 73 (2022). Section 2234(a) does not impose any content-, speaker-, or viewpoint-based restriction that would provide a ground for subjecting it to heightened scrutiny. And petitioners do not present any evidence that the Boards have enforced Section 2234(c) to discriminate against any particular viewpoint or message. *See supra* pp. 10-11.

b. Petitioners also identify (Pet. 21-22) a purported intra-circuit conflict between the decision below and *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002). This Court does not typically grant certiorari to resolve internal circuit conflicts, *see Wisniewski v. United States*, 353 U.S. 901, 902 (1957) (per curiam), and in any event no such conflict exists here.

Conant affirmed a preliminary injunction that prohibited the federal government from investigating physicians for violating federal law "solely on the basis of a recommendation of marijuana within a bona fide doctor-patient relationship." 309 F.3d at 636. In the court's view, that would unconstitutionally "punish physicians on the basis of the content of doctor-patient communications." *Id.* at 637. But *Conant* was not a

case about the standard of care; the federal government sought to prohibit recommendations about marijuana because use of the drug violated federal law. *Id.* at 632-633. The court was concerned that those efforts "condemn[ed] expression of a particular viewpoint, i.e., that medical marijuana would likely help a specific patient." *Id.* at 637.

Conant does not prohibit States from requiring physicians to adhere to a standard of care in treating patients with marijuana. It would not, for instance, bar a State from investigating a physician who recommended marijuana to *all* patients—even those for whom the drug was dangerous or medically unsuited. And the Ninth Circuit later clarified that States may permissibly regulate professional conduct even if that regulation also affects a physician's speech. *See Tingley v. Ferguson*, 47 F.4th 1055, 1077 (9th Cir. 2022); *Pickup v. Brown*, 740 F.3d 1208, 1230 (9th Cir. 2014). Similarly, States may require physicians to adhere to a standard of care while treating COVID-19—even if some of that treatment incidentally affects doctor-patient communications.

c. Finally, petitioners invoke an inter-circuit conflict regarding First Amendment challenges to restrictions on conversion therapy. Pet. 19-20. This Court has already granted certiorari to resolve that conflict, *see Chiles v. Salazar*, No. 24-539, and this case does not implicate the conflict.

The state law at issue in *Chiles* prohibits counselors from encouraging minors to change their "sexual orientation or gender identity." Colo. Rev. Stat. 12-245-202(3.5). Unlike Section 2234(c), it precludes doctors from recommending a specific treatment to their patients. The constitutional questions arising from

that statute are materially different from those associated with Section 2234(c)—which is a broad, viewpoint-neutral law requiring physicians to adhere to a general standard of care.

Moreover, the court of appeals in *Chiles* concluded that the petitioner had established Article III standing to assert a pre-enforcement First Amendment claim. *Chiles v. Salazar*, 116 F.4th 1178, 1194-1199 (10th Cir. 2024). Here, the decision below rests on a holding that petitioners failed to establish standing for their as-applied First Amendment challenge to Section 2234(c). Even if the petitioner in *Chiles* ultimately prevails on the merits, that outcome would not provide any basis for disturbing the judgment below in this case.

CONCLUSION

The petition for a writ of certiorari should be denied.

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