No. 25-963

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Sean McBride, M.D., and G Shellye Horowitz,

Plaintiffs – Appellants,

v.

Kristina D. 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
Honorable Kimberly J. Mueller, District Judge

APPELLANTS' REPLY BRIEF

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authority

INTRODUCTION

The First Amendment does not shrink when the government calls speech "professional." Yet California has done exactly that. By forbidding physicians not licensed in California from speaking with Californians through telehealth—no matter how limited, advisory, or life-saving the conversation—the State has turned the exchange of medical knowledge into a regulated privilege.

Without the ability to use modern telehealth technology to speak to out-of-state medical specialists, California patients with rare diseases and cancers suffer. They must travel—often at great cost and over great distances—or forego the expert advice that could save their lives or make them bearable. Defendant-Appellee Kristina Lawson ("Medical Board") calls this an unavoidable byproduct of California's licensure regime. But the Constitution calls it censorship: a prohibition on conversations based solely on a doctor's state of licensure.

For Plaintiff-Appellant Shellye Horowitz, that censorship is personal. She suffers from a rare bleeding disorder and relies on out-of-state specialists for care. Under California's rule, those physicians must remain silent the moment she crosses the state line home. The Medical

Board insists that her doctors' words are illegal, not because of their content, but because of their location. The result is predictable and cruel: patients like Ms. Horowitz are denied information, guidance, and hope—not by medical judgment, but by government decree.

What Plaintiff-Appellant Dr. McBride seeks to do is speak—to answer questions, to share expertise, to give counsel that only his training allows. What California forbids is that very speech, not a scalpel cut or a prescription pad. Its law draws a red line across state borders and declares that a physician's words lose constitutional protection the moment they reach a patient in California. That is not regulation of conduct; it is suppression of speech.

The First Amendment's core promise is that government may not silence speakers because of who they are or to whom they speak. Yet California's rule does both. It silences physicians because they are not licensed by the state and forbids patients from hearing them unless the government first grants permission. A state may regulate medicine, but it may not license ideas. When California bars doctors from speaking freely with potential patients, it does more than burden telehealth—it

undermines the very principle that knowledge and advice belong to the public, not to the government.

The same constitutional flaws appear in California's treatment of interstate commerce and individual liberty. By walling off its residents from out-of-state medical expertise, California has erected a protectionist barrier that isolates its market for medical advice and shields its own licensees from competition—precisely the kind of state parochialism the Commerce Clause forbids. And by forcing out-of-state doctors to obtain a duplicative California license before helping a patient there, the State violates the Privileges and Immunities Clause's guarantee that citizens of every state may pursue their calling on equal terms.

This case is not about erasing professional standards or deregulating medicine. It is about reaffirming a constitutional boundary older than any licensing board: that the exchange of ideas, advice, and information across state lines is protected speech and protected commerce. When government silences that exchange, it harms both speaker and listener alike.

This case asks a simple but consequential question: when the government demands silence from those most qualified to speak, and

walls off patients from hearing them, does the Constitution stand aside? The answer, consistent with precedent and principle, is no.

ARGUMENT

I. PLAINTIFFS' COMPLAINT STATES A FIRST AMENDMENT CLAIM

A. The Telehealth Licensure Rule Restricts Speech[1]

This case does not call into question California's general authority to license physicians. It challenges something narrower—and far more constitutionally fraught: California's decision to criminalize words spoken by a doctor to a patient when those words cross a state line. The Medical Board insists that Cal. Bus. & Prof. Code § 2052(a) ("telehealth licensure rule") regulates conduct, not speech, but that framing collapses under scrutiny. If this case was a facial challenge to Section 2052(a), perhaps the Medical Board could invoke its traditional power over

[1] As noted in Dr. McBride's and Ms. Horowitz's Opening Brief, *see* AOB at 21 n.5, the Supreme Court recently granted cert in *Chiles v. Salazar*, 116 F.4th 1178 (10th Cir. 2024), *cert. granted*, 145 S. Ct. 1328 (2025), argued October 7, 2025. If the form of in-person *therapeutic conversation* in that case is protected speech—and it must be—then this case follows *a fortiori*: telehealth consultations and follow-up conversations that consist solely of the exchange of medical information, without physical treatment of any kind, are quintessential speech. Indeed, if "talk therapy" is speech, then this case—where nothing occurs but talking—is speech even more plainly.

medical practice. *See* Resp. Br. at 14. But this case is not a facial challenge. The rule, as applied here, forbids one thing only—conversation. When Dr. McBride or a specialist like him uses telehealth to advise a California patient, nothing happens but speech. The State's law regulates that speech directly, not incidentally.[2]

The Medical Board relies on *Nat'l Ass'n for the Advance. of Psych. (NAAP) v. Cal. Bd. of Psych.*, 228 F.3d 1043 (9th Cir. 2000), to claim that the rule regulates conduct with only incidental restrictions on speech. Resp. Br. at 14–15. But *NAAP* held that "psychoanalysis is the *treatment* of emotional suffering and depression, *not* speech." 228 F.3d at 1054 (first emphasis added). The same was true in *Tingley v. Ferguson*, 47 F.4th 1055, 1080–81 (9th Cir. 2022), where the State prohibited counseling as "treatment." But *Conant v. Walters*, 309 F.3d 629, 634–37 (9th Cir. 2002), drew the critical line: when a doctor speaks to recommend, inform, or advise, that is speech protected by the First Amendment. Dr. McBride does exactly that—and nothing more. He does not "treat" by telehealth;

[2] Like the district court below, the Medical Board does not respond to Ms. Horowitz's argument that her speech as a patient is restricted distinctly from Dr. McBride's. *See* AOB at 22–24.

he speaks. ER-31 (Dr. McBride "does not use telehealth to directly treat patients."). *See also* AOB at 15–22.

The Medical Board next claims that the telehealth licensure rule cannot restrict speech by gesturing to First Amendment violations that arguably went further than here. *See* Resp. Br. at 16. That argument misunderstands the First Amendment. The question is not *how much* speech is restricted, but whether speech is restricted at all. *See United States v. Playboy Ent. Group, Inc.*, 529 U.S. 803, 812 (2000) ("Government's content-based burdens must satisfy the same rigorous scrutiny as its content-based bans."). *See also Reed v. Town of Gilbert*, 576 U.S. 155, 163–64 (2015).

As a practical matter, the telehealth licensure rule "bans a category of speech." *See contra* Resp. Br. at 16. It forbids any physician not licensed in California from using telehealth to consult or follow up with patients located in California. Full stop. *See* ER-26–28, 40–46. That prohibition is undisputed. That the rule does not merely single out a "specific diagnosis or consultative message" for restriction, Resp. Br. at 16, is irrelevant; a speech ban is a speech ban. The Supreme Court has long rejected such formalism. In *Reed*, 576 U.S. at 163–64, the Court

clarified that both "facial distinctions based on a message" (a ban on a specific message), *id.* at 163, and "more subtle" restrictions "that cannot be 'justified without reference to the content of the regulated speech'" (a ban on medical consultations and follow-ups), *id.* at 163–64 (quoting *Ward v. Rock Against Racism*, 491 U.S. 781, 791 (1989)), are content-based speech restrictions. California's law does exactly that: it bans medical conversations because they are medical conversations. That is textbook content discrimination.

The Medical Board's reliance on *NAAP* misstates the case's holding. *See* Resp. Br. at 16. The portions it cites dealt with whether the law challenged in that case was content- or viewpoint-based, not whether it was speech at all. *See NAAP*, 228 F.3d at 1055–56. This Court already assumed the law restricted speech. And in any event, *NAAP* predated *Reed*, which swept away the old motive-based test. *Compare id.* at 1056 ("The licensing scheme … was not adopted because of any disagreement with psychoanalytical theories."); *with Reed*, 576 U.S. at 164 (disagreement with a message only a subset of content-based restrictions).

When the question is *whether* speech is restricted—not how much—the answer here is obvious. This case fits comfortably within the line of decisions recognizing First Amendment protection for professional advice. In *Conant*, the Court struck down a federal attempt to punish doctors for merely recommending marijuana. The Eleventh Circuit in *Wollschlaeger v. Gov., Fla.*, 848 F.3d 1293 (11th Cir. 2017) (en banc) did the same for physicians discussing firearm safety. More recently the Fifth and Third Circuits in *Hines v. Pardue*, 117 F.4th 769 (5th Cir. 2024), and *Veterans Guardian VA Claim Consulting LLC v. Platkin*, 133 F.4th 213 (3d Cir. 2015), reaffirmed that professional speech does not lose its constitutional protection. California's law violates those same principles: it punishes pure speech between doctors and patients. *See* AOB at 16–19.

Most strikingly, the Medical Board claims that "California may regulate all aspects of medical practice" as conduct. Resp. Br. at 19. That sweeping assertion is flatly false. The Supreme Court in *Nat'l Inst. of Family & Life Advocates (NIFLA) v. Becerra*, 585 U.S. 755, 773 (2018), rejected the notion that states can "reduce a group's First Amendment rights by simply imposing a licensing requirement." This Court said the same in *Conant*. *See* 309 F.3d at 637 ("Being a member of a regulated

profession does not, as the government suggests, result in a surrender of First Amendment rights."). The question here is no different—does California's rule "regulate[] [physician] speech as speech," *NIFLA*, 585 U.S. at 770, or only incidental to conduct? Like *Conant,* this law targets nothing but speech itself: a doctor's communication with another person. That is the heart of the First Amendment, not the periphery.

Far from being "irrelevant," Resp. Br. at 19, the distinction between *treatment* and *advice* is critical. In *Tingley*, this Court upheld restrictions on controversial counseling methods precisely because the speech was part of the treatment itself. 47 F.4th at 1072, 1082. Likewise, in *Pickup v. Brown*, this Court emphasized that "the government has more leeway to regulate the conduct necessary to administering treatment itself," but that "doctor-patient communications *about* medical treatment receive substantial First Amendment protection." 740 F.3d 1208, 1227 (9th Cir. 2014). *Conant* applied that principle directly, holding that physicians recommending marijuana were engaged in protected speech.[3] 309 F.3d at 634–37.

[3] Multiple Supreme Court Justices found the distinction between treatment and medical speech relevant in the recent *Chiles v. Salazar*

This case falls entirely on the *Conant* side of the line. Dr. McBride does not treat anyone through telehealth; he speaks. The rule he challenges bars nothing but conversation—advice, consultation, and follow-up discussions—conducted over a screen or phone. That is pure expression, not medical procedure. *See*, *e.g.*, ER-24–26, 29–31, 38.

The Medical Board's appeal to informed consent laws only underscores its error. Resp. Br. at 19.[4] Those laws regulate disclosures tethered to a specific procedure. In *NIFLA*, the Supreme Court rejected that informed consent laws were sufficiently analogous to bless California's attempt to require licensed pregnancy centers to provide patients with a notice about abortions. 585 U.S. at 770. According to the Court,

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oral argument. *See*, *e.g.*, Tr. at 12:3–8 (Roberts, C.J.) ("if, in addition to the counseling, there is more what I'll call medical treatment, whether it's medications, shots, whatever?"); 13:4–9 (Kagan, J.) ("if the speech is the speech that your client engages in and, in addition, she engages in something that's non-speech"). The Court thus appears poised to reaffirm what Appellants argue here: that when the government punishes a conversation simply because it concerns medicine, it regulates speech.

[4] Contrary to the Medical Board, informed consent laws are not mere "advice," but a requirement that physicians must comply with prior to treating a patient and are "firmly entrenched in American tort law." *NIFLA*, 585 U.S. at 770 (quoting *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 269 (1990)).

> The notice does not facilitate informed consent to a medical procedure. In fact, it is not tied to a procedure at all. It applies to all interactions between a covered facility and its clients, regardless of whether a medical procedure is ever sought, offered, or performed.

Id. The same is true here. California's rule "applies to all interactions" between Dr. McBride and California patients "regardless of whether a medical procedure is ever sought, offered, or performed." *See id.* It thus "regulates speech as speech"—the precise danger the Supreme Court condemned in *NIFLA*. *Id.*

B. There Is No Medical-Speech Exception to the First Amendment

The Medical Board seeks to avoid the First Amendment by claiming free rein over all physician speech. *See* Resp. Br. at 22. But "regulation of the medical profession is not a First-Amendment-free zone." *Tingley v. Ferguson*, 57 F.4th 1072, 1074 (9th Cir. 2023) (O'Scannlain, J., respecting the denial of rehearing en banc). In *NIFLA*, the Court refused to recognize a lower tier of protection for so-called "professional speech," warning of the "danger of content-based regulations 'in the fields of medicine and public health, where information can save lives.'" 585 U.S. at 771 (quoting *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 566 (2011)). The

Court reaffirmed that states cannot reduce a "group's First Amendment rights by simply imposing a licensing requirement." *See id.* at 768, 773.

If a tradition of licensing healthcare practitioners was sufficient to avoid heightened scrutiny, then the Court in *NIFLA* would have said so. Nor can the Board conjure a new category of unprotected expression. The Supreme Court has been "reluctant to mark off new categories of speech for diminished constitutional protection." *Id.* at 767 (quoting *Denver Area Educ. Telecomms. Consortium, Inc. v. FCC*, 518 U.S. 727, 804 (1996) (Kennedy, J., concurring in part, concurring in judgment in part, and dissenting in part)). Instead, it requires "persuasive evidence ... of a long (if heretofore unrecognized) tradition" of content-based restrictions on a category of speech before doing so. *Id.* (quoting *Brown v. Ent. Merchants Ass'n*, 564 U.S. 786, 792 (2011)). There is no such tradition here—certainly not for conversations that are purely informational and untethered to any medical procedure. California's rule thus demands exactly what *NIFLA* forbids: that courts treat speech differently merely because the speaker is a doctor. The Constitution draws no such line.

While the practice of medicine has a long tradition of regulation, *see Tingley*, 47 F.4th at 1080, there is no tradition of regulating physician

speech.[5] The Medical Board identifies none—let alone for the kind of non-treatment conversations at issue here. *Tingley* noted that some forms of therapy involve speech intertwined with treatment, *id.* at 1081 (discussing history of regulating speech "where speech is part of the treatment"), but that history does not extend to purely informational consultations or follow-up discussions. Those forms of communication are new only in technology, not in kind: they are conversations, not medical procedures. *See* ER-27, 34, 42–43 (telehealth for such purposes is relatively new, particularly since the onset of the COVID-19 pandemic).

Even if the Board had made a showing of regulation of physician speech generally—or if it could point to isolated examples of regulated speech specifically—that would still fall short of the "long (if heretofore unrecognized) tradition" the Supreme Court demands before carving out a new category of unprotected speech. *NIFLA*, 585 U.S. at 767. *See also Tingley*, 57 F.4th at 1079 (category must be "as narrow as the existing exceptions, whose narrowness the Supreme Court has repeatedly emphasized") (collecting cases).

[5] The burden to make that showing is substantial and cannot be overcome at the motion-to-dismiss stage. *See Tingley*, 57 F.4th at 1079 ("[A] new tradition requires extensive historical evidence.").

Nor does *Tingley* support the Board's claim to regulate all physician speech. If a tradition of licensing is sufficient to justify suppressing professional communication, then *Conant* would come out the other way. There, this Court held that a content- and viewpoint-based restriction on physicians recommending marijuana violated the First Amendment. 309 F.3d at 634–37. *Tingley* did not disturb *Conant*; it reaffirmed it, distinguishing between speech that *is* treatment and speech *about* treatment. 47 F.4th at 1079. The Medical Board's rule targets the latter—it prohibits mere communication—and thus cannot be shielded by appeals to "licensing tradition." The Board's contrary reading would license censorship on a breathtaking scale, allowing the state to control every professional conversation so long as the speaker holds a credential. That is precisely the danger *NIFLA* warned against; this Court should not reopen the door.

As a practical matter—and contrary to the Medical Board—the telehealth licensure rule does not just "control content" of medical conversations, Resp. Br. at 23, it eliminates them entirely. That is true even when the physician is not providing treatment with his speech and is merely consulting or following up with a patient. That is not viewpoint

neutrality; it is a total gag order. The rule silences every conversation between a doctor and a willing listener based solely on who speaks and what they speak about.

As a result, the Medical Board asks this Court to bless a sweeping attempt to control all speech uttered by physicians in their professional capacity without heightened judicial scrutiny. The Supreme Court has repeatedly warned against this kind of categorical control over professional communication. *See NIFLA*, 585 U.S. at 771–73. By claiming authority to license speech itself, California asserts a power the Constitution has never recognized—the power to decide which professionals may speak and which citizens may listen.

The Medical Board concedes the point that ends the debate: the telehealth licensure rule is content-based because it restricts speech "based on 'subject matter.'"[6] Resp. Br. at 24. Under *Reed*, that admission is dispositive. 576 U.S. at 163 (no state "power to restrict expression

[6] The Board's insistence that the rule "criminalizes *all* unlicensed medical practice" is a red herring. *See* Resp. Br. at 23. Dr. McBride and Ms. Horowitz only challenge the statute as applied to telehealth consultations and follow-ups, so it is true in this case that the rule "only applies when a physician speaks on the 'particular subject matter' of healthcare." *See* AOB at 24.

because of its message, its ideas, *its subject matter*, or its content") (quoting *Police Dep't of Chicago v. Mosley*, 408 U.S. 92, 95 (1972)) (emphasis added). When a law singles out expression for regulation because of what it is about, strict scrutiny applies—no matter how benign the State's motives.

But rather than accept the constitutional consequence of its concession, the Board urges this Court to dilute the First Amendment by applying intermediate scrutiny. *See* Resp. Br. at 24–25. Content-based restrictions on speech by licensed professionals are no less dangerous than content-based restrictions on anyone else's speech—and the Supreme Court has never said otherwise. The Board cannot rewrite the First Amendment simply because the speaker holds a medical degree.

The Supreme Court's recent decision in *Free Speech Coalition, Inc. v. Paxton*, 606 U.S. 461 (2025), offers no refuge for the Board. There, the Court considered a Texas law that required age verification prior to accessing material considered obscene to minors. *Id.* at 466. The Court held that the law was not content-based because "it ha[d] 'only an incidental effect on protected speech,'" and applied intermediate scrutiny. *Id.* at 478 (quoting *Boy Scouts of Am. v. Dale*, 530 U.S. 640, 659 (2000)).

The law there merely regulated access to speech; it did not forbid speech itself. *Id.* at 483.

The telehealth licensure rule is the opposite. It does not incidentally burden communication—it criminalizes it. The Medical Board admits the law is content-based because it singles out one subject matter, medical advice, for prohibition. Resp. Br. at 24. That restriction silences both the speaker and the listener and therefore triggers the most exacting form of scrutiny. Unlike *Paxton*, this case involves a direct ban on expression about lawful subject matter—a core First Amendment violation.

In pointing out that the practice of medicine is traditionally regulated, Resp. Br. at 25, the Board again misses the point. The issue is not whether California may license the practice of medicine—it may—but whether it may license *speech about medicine*. Those are not the same thing. And this Court has already drawn that line in cases like *Conant* and *Tingley*. Limiting this case to telehealth consultations and follow-ups therefore poses no unique challenges; it simply applies settled law to modern technology. Because the rule is defined by subject matter and suppresses communication as such, it is content-based. Nothing less than strict scrutiny applies.

Regardless, the Medical Board claims that the telehealth licensure rule "easily clears" intermediate scrutiny.[7] Resp. Br. at 26. It does not. Intermediate scrutiny is a high burden that the Board cannot "easily" satisfy, especially at the motion-to-dismiss stage. A content-neutral speech restriction satisfies intermediate scrutiny when it "advances important governmental interests unrelated to the suppression of free speech and does not burden substantially more speech than necessary to further those interests." *Turner*, 520 U.S. at 189. The Board proves neither.

Its asserted interest in "regulating the medical profession" is inseparable from "the suppression of speech"—that is the very mechanism of the licensure rule, as applied to consultations and follow-up conversations. The rule's only operative feature is to silence out-of-state doctors when they speak to Californians. Nor is the rule tailored to

[7] In addition to the reasons discussed above that intermediate scrutiny is not the proper standard, intermediate scrutiny is only properly applied to content-neutral restrictions, *Turner Broadcasting Sys., Inc. v. F.C.C.*, 520 U.S. 180, 189 (1997), or commercial speech, *see Central Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of N.Y.*, 447 U.S. 557, 561–64 (1980). As the Medical Board makes no argument that the telehealth licensure rule regulates commercial speech—nor could it—there is no basis to apply intermediate scrutiny here.

the Board's claimed interest. It is the most speech-restrictive means imaginable, barring all communication rather than targeting any actual misconduct. Under *Paxton*, 606 U.S. at 496, such a blunt instrument cannot satisfy even intermediate scrutiny, much less strict scrutiny. And it is plain that, at this stage of the proceedings, the Medical Board has failed to make either showing.

First, the Board insists—without evidence—that it "cannot guarantee the qualifications and competence of physicians" unless they hold a California license. Resp. Br. at 26. But that argument misses the point. This case is about speech, not practice. The Board has no legitimate interest in licensing who may *speak*. Once a law targets words rather than medical acts, the usual justifications for professional regulation disappear. *See NIFLA*, 585 U.S. at 773.

Even if qualifications mattered, the Complaint alleges—and must be taken as true—that Dr. McBride is board-certified and meets the same standards as California physicians. *See* ER-26, ER-42; *see also* AOB at 42–43 & n.7. The Board's claim that it lacks "enforcement power" is equally hollow as state law already punishes anyone who commits medical misconduct within its borders. *See* Cal. Bus. & Prof. Code § 2314

("any person, *whether licensed under this chapter or not*, who violates any provision of this article is guilty of a misdemeanor [and] is punishable pursuant to" § 2315(b)) (emphasis added). What the Board truly lacks is constitutional authority to silence lawful speech. By forbidding cross-border conversations between physicians and willing listeners, California does not protect patients—it isolates them. *See* ER-24–25, 29–39.

Second, even if the Medical Board's interests were legitimate, it makes no attempt to show that the telehealth licensure rule does "not burden substantially more speech than is necessary to further" them. *Paxton*, 606 U.S. at 496 (citation omitted). Nor could it. The rule is not a narrow measure designed to prevent malpractice; it is a blanket ban on communication. That's especially true here where Dr. McBride and Ms. Horowitz offer several non-exhaustive alternatives. *See* ER-42–43.

When the government suppresses speech, the question is not whether the speaker is licensed—it is whether the restriction is necessary to achieve a compelling interest. *See NIFLA*, 585 U.S. at 773–75. The Board's rule fails that test on its face. It silences every out-of-state physician regardless of their qualifications, the content of their advice, or the listener's consent. The Board could easily protect

consumers through less restrictive means: disclaimers, discipline, or fraud laws. Instead, it chose censorship. That choice burdens substantially more speech than the Constitution allows, under any level of scrutiny.

Strict scrutiny is the only proper standard for a law that bans speech based on its subject matter. The Medical Board does not seriously attempt to meet it—nor could it at this stage. *See Paxton*, 606 U.S. at 484 ("In the First Amendment context, we have held only once that a law triggered but satisfied strict scrutiny[.]").

Even if intermediate scrutiny applied, the rule would fail. The Board's justifications are speculative, its tailoring nonexistent, and its effect unmistakable: it silences lawful speech between qualified professionals and willing listeners. The First Amendment does not permit the government to criminalize a conversation because it concerns medicine. This Court must thus reverse the district court's dismissal of Dr. McBride's and Ms. Horowitz's First Amendment claim.

II. PLAINTIFFS ALLEGE FACTS TO STATE A COMMERCE CLAUSE CLAIM

A. The Telehealth Licensure Rule Discriminates Against Interstate Commerce

Dr. McBride and Ms. Horowitz do not claim that the telehealth licensure rule is facially discriminatory. Rather, it is the practical effects of the rule applied to interstate telehealth conversations that result in discrimination because those effects "cause local goods to constitute a larger share, and goods with an out-of-state source to constitute a smaller share, of the total sales in the market." *West Lynn Creamery, Inc. v. Healy*, 512 U.S. 186, 196 (1994) (quoting *Exxon Corp. v. Gov. of Maryland*, 437 U.S. 117, 126 n.16 (1978)).

The Medical Board distinguishes *Hunt v. Wash. State Apple Advert. Comm'n*, 432 U.S. 333 (1977), on the grounds that the law there was "directly responsible" for causing discriminatory effects against Washington growers. Resp. Br. at 34. According to the Board, the law in *Hunt* was discriminatory only because it was newly enacted and changed "comparative economic positions." *Id.* at 34–35 (citing *Hunt*, 432 U.S. at 351–52).

But the situation faced by the Washington apple growers in *Hunt* is similar to that faced by Dr. McBride. While California has licensed physicians for many years, applying licensure requirements to certain uses of telehealth after the COVID-19 pandemic presents new circumstances—chiefly, greater acceptance of telehealth and expectation of its use. *See* ER-27, 32–33. These changed circumstances, combined with California's insistence on enforcing its licensure requirements without recognition of the post-pandemic sea change, has the "consequence of raising the costs of doing business in the [California] market for [out-of-state physicians], while leaving those of their [California] counterparts unaffected." *Hunt*, 432 U.S. at 351. The discriminatory effects of the telehealth licensure rule are further evidenced by the fact that once telehealth became a regular aspect of medical practice during and following the pandemic, California physicians, "unlike their [out-of-state] competitors, were not forced to [obtain a duplicative license] in order to comply with the statute." *Id.* And like in *Hunt*, the telehealth licensure rule's increased costs "shield" California physicians from competing with out-of-state physicians who do not have California licenses. *Id.*

The Medical Board discounts any discrimination as "a function of the doctor's decision to practice in multiple states." Resp. Br. at 35. But if a state's discrimination could be excused as simply the result of an out-of-state challenger's decision to operate in the state, then no law would ever been found discriminatory. Every Dormant Commerce Clause claim arises because an out-of-state business (or physician) seeks to do business in a new state.

The Medical Board also argues that physicians like Dr. McBride are "not similarly situated to California physicians because only the former have availed themselves to practice in *multiple states*." Resp. Br. at 36. First, there is nothing in the record to substantiate the Board's assertion, and it is likely not true. Second, a California physician need only a California license to physically treat and use telehealth to consult with California patients. Conversely, an out-of-state doctor needs a license from the state where he treats patients *and* a license from California to speak with patients in California via telehealth. Third, the Medical Board admits that all physicians need the same California medical license regardless of the scope of their practice. *See* Resp. Br. at 17–18 (2052(a) "bars all unlicensed medical practice, from surgeries and

prescriptions to communication of diagnoses and consultation."). There is simply no "difference in products" such that physicians would not be similarly situated merely by how many states they seek to practice in. *See Gen. Motors Corp. v. Tracy*, 519 U.S. 278, 299 (1997).

B. The Licensure Rule's Interstate Burdens Far Exceed Any Local Benefits

Responding to the burdens caused by the telehealth licensure rule, AOB at 34–38, the Medical Board can only shrug—claiming they are insignificant and do not burden interstate commerce. Resp. Br. at 38–40.

To show that a law substantially burdens interstate commerce, there must be "evidence that the [law] will affect the interstate flow of goods." *Pharm. Rsch. & Mfrs. of America v. Cnty. of Alameda*, 768 F.3d 1037, 1045 (9th Cir. 2014). *See also Nat'l Ass'n of Optometrists & Opticians v. Harris*, 682 F.3d 1144, 1153 (9th Cir. 2012) (citing *Exxon*, 437 U.S. at 126–29). Whether from the perspective of physicians like Dr. McBride or patients like Ms. Horowitz, that is precisely what is alleged here.

As a result of the telehealth licensure rule, Ms. Horowitz's Oregon specialists no longer provide the advice she needs via telehealth to her in California. ER-24, 29, 34, 37–38, 44–45. Dr. McBride is prevented from

giving advice via telehealth to California patients from his office in New York. ER-35–37, 39–41, 44–45. The "flow of goods" across state lines is thus prevented. *See Pharm. Rsch.*, 768 F.3d at 1045. The rule's damming of interstate medical advice distinguishes this case from those where only "increase[d] compliance costs, without more," were insufficient to burden interstate commerce. *See*, *e.g.*, *Nat'l Pork Producers Council v. Ross*, 6 F.4th 1021, 1032 (9th Cir. 2021). And it is that dam that separates this case from those where only some out-of-state participants exit a market. *See id.* at 1033. It is not just Dr. McBride and Ms. Horowitz's specialists who have stopped providing telehealth advice to Californians due to the telehealth licensure rule, but all out-of-state specialists with only an occasional need to consult with Californians. *See* ER-35–36.

Because the telehealth licensure rule substantially burdens the flow of medical advice via telehealth across state lines, the resulting burdens heavily outweigh the Medical Board's interest in regulating medical practice. The result of stopping the flow of specialized medical advice is that patients in California are harmed. For example, without specialized advice, Ms. Horowitz has had severe health complications, ER-31–32, and still other patients are unable to participate in life-saving

clinical trials, ER-37. Far from "minimal," *see* Resp. Br. at 40, these burdens are consequential.

Again, nothing about this case challenges the Medical Board's general ability to regulate medicine in California. It is only when that regulation impedes the interstate flow of specialized advice that the Board's general interest must be balanced against the harms caused. And while the Board may prefer its most-restrictive approach, the Board does not adequately explain why alternatives "with a lesser impact on interstate activities" cannot sufficiently address the Board's regulatory interest. *See Pike v. Bruce Church, Inc.*, 397 U.S. 137, 142 (1970); AOB at 38; Resp. Br. at 42–43. Further, in arguing that California need not "trust that a physician licensed according to the standards of another state" will comport with "California standards for medical care," Resp. Br. at 43, the Medical Board ignores the allegations that licensing standards are uniform from state to state, ER-42. It also overstates things, as California still retains the ability to regulate what medical advice or treatments are provided to Californians within its borders even if it cannot require a duplicative license.

III. DR. MCBRIDE SUFFICIENTLY ALLEGES A PRIVILEGES AND IMMUNITIES CLAIM

A law implicates the Privileges and Immunities Clause when it: (1) discriminates against out-of-state actors who (2) wish to exercise a fundamental right protected by the Constitution. *Marilley v. Bonham*, 844 F.3d 841, 846 (9th Cir. 2016) (en banc).

First, the Medical Board asserts that "it is not clear that [Section 2052(a)] impinges on a fundamental right" because the telehealth licensure rule "does not bar anyone from practicing medicine in California." Resp. Br. at 44–45. But even the Board acknowledges that unless a physician is licensed by the Board to practice medicine in California, he cannot practice in California. *See* Resp. Br. at 5 (citing Section 2052(a)). Indeed, that is precisely why Dr. McBride brought this lawsuit. And even though the bar on practicing in California can be overcome by obtaining a California medical license, that fact does not render the Privileges and Immunities Clause unavailable to Dr. McBride.

The Supreme Court confirmed that laws *burdening* the ability of out-of-staters to practice their profession implicate the Privileges and Immunities Clause. For example, in *Toomer v. Witsell*, 334 U.S. 385, 389–91 (1948), South Carolina did not prohibit commercial shrimping by

out-of-staters, but singled them out for hefty financial, record-keeping, and operational burdens. After recognizing that "it was long ago decided that one of the privileges which the clause guarantees to citizens of State A is that of doing business in State B on terms of substantial equality with the citizens of that State," the Court held that "commercial shrimping … like other common callings, is within the purview of the privileges and immunities clause," and declared that South Carolina violated it. *Id.* at 396, 403. *See also Mullaney v. Anderson*, 342 U.S. 415, 416–19 (1952) ($50 state license fee for nonresident commercial fishermen unconstitutional where the fee was $5 for residents); *Sup. Ct. of Virginia v. Friedman*, 487 U.S. 59, 66 (1988) ("Nothing in our precedents … supports the contention that the Privileges and Immunities Clause does not reach a State's discrimination against nonresidents when such discrimination does not result in their total exclusion from the State."). Just as burdens on commercial fishermen operating across state lines implicate the Privileges and Immunities Clause, so too do the burdens that the telehealth licensure rule imposes on out-of-state physicians.

Second, Dr. McBride plausibly alleged that the rule discriminates against out-of-state physicians. ER-34–37, 41–42. The Board counters that every physician, whether a California resident or not, must obtain a California medical license to practice within the state. Resp. Br. at 45. But a lack of facial discrimination against nonresidents does not automatically exempt a law from scrutiny under the Privileges and Immunities Clause. In fact, in *Hillside Dairy Inc. v. Lyons*, 539 U.S. 59, 67 (2003), the Court expressly rejected the contention that a law must facially target nonresidents before the Clause is triggered. *Id.* ("[T]he absence of an express statement in the California laws and regulations identifying out-of-state citizenship as a basis for disparate treatment is not a sufficient basis for rejecting" Privileges and Immunities claims.). *See also Chalker v. Birmingham & Nw. Ry. Co.*, 249 U.S. 522, 527 (1919). Thus, where the "practical effect of the provision [is] discriminatory," a Privileges and Immunities claim lies. *See Hillside Dairy*, 539 U.S. at 67.

This Court's decision in *Nat'l Ass'n for the Adv. of Multijurisdiction Prac. (NAAMP) v. Berch*, 773 F.3d 1037 (9th Cir. 2014),[8] does not compel

[8] It is unclear what provided the basis for the Privileges and Immunities claim in *NAAMP*. Of the three plaintiffs, only Anderson could have had

dismissal of Dr. McBride's claim. While this Court did hold that the rule in *NAAMP* was "neutral" because "Arizona imposes the same bar admission requirements on its own citizens as it does on citizens of other states," *id.* at 1046, it did not consider whether the "practical effect of the [rule] was discriminatory," *see Hillside Dairy*, 539 U.S. at 67. *NAAMP* is thus distinct from Dr. McBride's claim.

In addition to running counter to *Hillside Dairy* and *Chalker*, should this Court agree with the Medical Board that the Privileges and Immunities Clause is not implicated when all physicians practicing medicine in California must have a California medical license regardless of their licensure status out of state and the practical burdens imposed by the California license requirement, then California could impose all manner of facially neutral requirements that have the practical effect of preventing out-of-staters from pursing their profession in California.

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standing, but this Court did not analyze Anderson's standing except in the context of a First Amendment claim. *See NAAMP*, 773 F.3d at 1042–45. Plaintiff NAAMP could not have had standing itself to bring the claim, *see Paul v. Virgina*, 75 U.S. (8 Wall.) 168, 177 (1868) ("The term citizens as [] used [in the Privileges and Immunities Clause] applies only to natural persons[.]"), and as Plaintiff Girvin was a resident of Arizona challenging an Arizona rule, *NAAMP*, 773 F.3d at 1043, there was no discrimination applicable to her, *see United Bldg. Council of Camden Cnty. v. City of Camden*, 465 U.S. 208, 217 (1984).

Worse still, California would be free to require any motorist driving through California to obtain a California driver's license. Just like "the pursuit of a common calling is one of the most fundamental of those privileges protected by the Clause," *United Bldg.*, 465 U.S. at 219, so too is the right to travel across state lines, *Saenz v. Roe*, 526 U.S. 489, 501–02 (1999). And just like the burdens of duplicative licensure imposed on out-of-state physician-specialists are discriminatory, ER-34–37, 41–42, so too would be a requirement that any motorist obtain a California driver's license regardless of the motorist's state of residence, duration of stay in California, or intent to remain in California. That such an outcome may seem unlikely does not change that it is possible unless this Court accepts Dr. McBride's allegations that the telehealth licensure rule's burdens are discriminatory in effect.

In reversing the dismissal of Dr. McBride's claim, this Court need not decide the claim's merits. Indeed, the district court did not consider the claim's merits, ER-16, and it is ultimately the Medical Board's burden to show that the rule withstands scrutiny under the Privileges and Immunities Clause, *Marilley*, 844 F.3d at 846. That burden cannot be satisfied at this motion-to-dismiss stage of the proceedings. *See Ashcroft*

v. Iqbal, 556 U.S. 662, 678 (2009); *Epstein v. Washington Energy Co.*, 83 F.3d 1136, 1140 (9th Cir. 1996). Were this Court to consider whether the Medical Board has satisfied its burden at this stage, then reversal is still required.

To prevail on the merits, the Board must "show that the [telehealth licensure rule] is 'closely related to the advancement of a substantial state interest.'" *Marilley*, 844 F.3d at 846 (quoting *Friedman*, 487 U.S. at 65). Even assuming the Board can establish a substantial state interest in requiring duplicative medical licenses for out-of-state physicians using telehealth to merely consult and follow up with patients in California, because there are "less restrictive means" available to achieve that interest, *see* ER-42–43; AOB at 42–43, the Board cannot meet its burden to justify the rule. *See Sup. Ct. of New Hampshire v. Piper*, 470 U.S. 274, 284 (1985) ("In deciding whether the discrimination bears a close or substantial relationship to the State's objective, the Court has considered the availability of less restrictive means."). Indeed, aside from prohibiting out-of-state physicians from communicating with California patients via telehealth—a prohibition which would violate the Constitution *per se*—the telehealth licensure rule is the most restrictive

means available to California to address any substantial state interest in regulating the practice of medicine.

The Medical Board's remaining justifications likewise fail to satisfy the Board's burden. First, while the Board is concerned about the extent of the relief requested in Dr. McBride's Complaint, *see* Resp. Br. at 47 n.9, whether, and to what extent, any relief is granted against the Board's enforcement of the telehealth licensure rule is ultimately at the discretion of the district court. *See Melendres v. Arpaio*, 784 F.3d 1254, 1265 (9th Cir. 2015).

Second, because Dr. McBride alleges that the requirements for a medical license in California "mirror, in all material respects," those in New York, ER-42, the Medical Board's claim that it must be free to "make individual determinations about appropriate standards for practice," and "need not rely on the licensing standards … of other states," Resp. Br. at 47–48, is misplaced.

Third, despite the Board's assertion, Dr. McBride makes no allegation or argument that he "must be allowed to practice in California with no oversight or supervision by California." *See* Resp. Br. at 48. Indeed, should Dr. McBride fail to comply with any constitutional

regulation of the practice of medicine within California, even when done via telehealth, he could be subject to criminal proceedings in California, *see*, *e.g.*, *Texas v. Carpenter*, No. 471-08943-2024 (Collin Cnty., Tex. Dist. Ct. Dec. 12, 2024),[9] or have a complaint filed against him in New York. Thus, any claim by the Board that without being licensed in California the Board is helpless to address any hypothetical harm that Dr. McBride could cause by merely consulting and following up with patients that he lawfully treats in New York lacks merit.

CONCLUSION

For the reasons discussed above and in the Opening Brief, the district court's order and judgment dismissing the Complaint should be reversed.

DATE: October 27, 2025.

Respectfully submitted,

Pacific Legal Foundation

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[9] Available at https://www.texasattorneygeneral.gov/sites/default/files/images/press/Dr%20Carpenter%20Filed%20Petition.pdf.

CERTIFICATE OF COMPLIANCE FOR BRIEFS

9th Cir. Case Number: 25-963

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