Docket Nos. 22-56220 (L), 23-55069

In the

United States Court of Appeals

For the

Ninth Circuit

MARK MCDONALD, et al.

Plaintiffs-Appellants,

v.

KRISTINA D. LAWSON, , in her official capacity as President of the Medical Board of California, et al.,

Defendants-Appellees.

Appeal from a Decision of the United States District Court for the Central District of California, No. 8:22-cv-01805-FWS-ADS · Honorable Fred W. Slaughter

BRIEF OF *AMICUS CURIAE* COMPASSION & CHOICES IN SUPPORT OF NEITHER PARTY

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, amicus curiae Compassion & Choices is a non-profit organization with no parent corporation and does not issue stocks.

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

TABLE OF AUTHORITIES
(continued)

TABLE OF AUTHORITIES
(continued)

Page(s)

STATEMENT OF INTEREST[1]

Amicus curiae is Compassion & Choices, a non-profit organization whose mission is to improve end-of-life care, expand options, and empower everyone to chart their own end-of-life journey. For over thirty years, Compassion & Choices has envisioned a society where people receive state-of-the-art healthcare and a full range of choices for dying in comfort and control. Compassion & Choices aims to ensure that individuals understand the benefits and burdens of all feasible treatment options, that treatment decisions are fully respected, and that healthcare reflects a person's values and priorities for life's final chapter. Its services include improving end-of-life medical care through advocacy, expanding end-of-life options and medical practices that prioritize patients, educating the public about the importance of end-of-life planning and about the range of end-of-life services available, and opposing efforts to restrict access to end-of-life options.

Compassion & Choices advocates for a medical model that places patients in control of the medical care they receive, a concept known as patient-directed care.[2]

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[1] No counsel for a party wrote this brief in whole or in part, and no one other than amici or their counsel contributed money to fund the preparation or submission of this brief. Additionally, this brief is filed with the consent of all parties as permitted by Rule 29(a)(2) of the Federal Rules of Appellate Procedure.

[2] Raman Kumar & Vijay Kumar Chattu, *What is in the name? Understanding terminologies of patient-centered, person-centered, and patient-directed care!*, 7 J. Fam. Med. Prim. Care 487, 487 (2018), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6069658/pdf/JFMPC-7-487.pdf.

While the traditional medical model is focused on treating a patient's illness through a physician-directed approach, Compassion & Choices believes the patient-physician relationship should be one that supplies patients with all necessary information about their medical options and empowers patients to make treatment decisions in line with their medical needs *and* individual priorities.

Compassion & Choices offers free consultation, planning resources, referrals, assistance with advance directives, and support throughout the country through its End of Life Consultation Program. Advocating at the state and federal levels, Compassion & Choices pursues policies that empower individuals in relation to their healthcare decisions and, if necessary, litigates or participates as amicus to achieve better medical care and access to a full range of end-of-life options.

Compassion & Choices has an interest in this appeal because it believes that the First Amendment does not prohibit the states from enacting reasonable laws that require providers of healthcare-related services, including physicians, long-term care facilities and hospices, to disclose neutral and truthful information to individuals regarding lawful healthcare alternatives. Compassion & Choices is concerned that this Court's and the district courts' analyses of the constitutionality of Assembly Bill ("AB") 2098 could threaten the enforceability of end-of-life disclosure rules, including those under California's End of Life Options Act

("EOLOA"), which was amended by SB 380, and substantially impair patient decision-making. The EOLOA authorizes participating doctors to evaluate and then write a prescription to terminally ill patients who request and qualify for this treatment to avoid unbearable suffering at the end of life. Compassion & Choices also has an interest in safeguarding informed consent and the standard of care in all end-of-life care, which could be impacted by the Court's analysis. In evaluating the appropriateness of a preliminary injunction of AB 2098, the Court should recognize that the First Amendment does not forbid reasonable regulations requiring healthcare providers to disclose—orally and in a patient's medical record—neutral, truthful information regarding lawful treatment options. Requirements to disclose treatment options may be needed to obtain informed consent and to ensure treatment consistent with the standard of care, even if the provider does not offer, or even morally opposes, a particular treatment option.

In filing this amicus brief, Compassion & Choices does not support any party to the subject litigations. Instead, Compassion & Choices seeks a ruling that allows states to enact reasonable laws that require healthcare providers to disclose—consistent with the medical standard of care—neutral, truthful information to individuals regarding lawful healthcare alternatives to further the compelling interests of informed consent.[3]

INTRODUCTION

Historically, healthcare providers were required to disclose only that information necessary to persuade patients to do what they believed was best, or to offer hope and comfort. Sonia M. Suter, *The Politics of Information: Informed Consent in Abortion and End-of-Life Decision Making*, 39 Am. J.L. & Med. 7, 12 (2013). Over time, the focus shifted to patient consent, which required providers to disclose enough information for the patient's treatment decision to be a "true exercise of self-determination." *Id.* Today, the doctrine of informed consent "has become firmly entrenched in American tort law." *Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 269 (1990). Despite this doctrine, providers with religious or moral objections to certain lawful medical treatments—including end-of-life-options—do not always believe they have an obligation to give patients information regarding such treatments. *See* Nadia N. Sawicki, *Mandating Disclosure of Conscience-Based Limitations on Medical Practice*, 42 Am. J.L. & Med. 85, 88 (2016). This is especially problematic when patients request information about specific treatment options, but providers refuse to discuss it, or

[3] As this brief explains, laws designed to prevent providers from misleading their patients about the availability of lawful treatment options by requiring disclosure of truthful, factual information are permissible because they further a patient's ability to make an informed decision in line with their values.

they otherwise obfuscate.[4] As a result, many individuals are left unaware of certain end-of-life options.[5]

The medical standard of care is a separate, but related concept that arises in physician-patient interactions. A healthcare provider who breaches the standard of care in their practice can be liable if it causes injury to a patient. Sawicki, *supra*, at 90. Courts have formulated this differently, but generally, "[t]he standard by which the physician should be judged is the degree of knowledge and concomitant medical or surgical skill that a physician under the same or similar circumstances should 'reasonably' possess." Steven E. Pegalis, AM. LAW MED. MALPRACTICE § 3:3 (3d ed. 2015). Although refusing to inform a patient about lawful treatment options on moral or religious grounds is arguably a breach of the standard of care,[6] some providers are nonetheless unwilling to inform patients of their non-

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[4] *See* Yan Ming Jane Zhou & Wayne Shelton, *Physicians' End of Life Discussions with Patients: Is There an Ethical Obligation to Discuss Aid in Dying?*, 32 HEC Forum 227, 230 (2020) ("Even if the physician exercises his or her legitimate right to not participate in [Aid in Dying], refusing to discuss it as an option with a patient, who may otherwise fit the criteria and has expressed goals of care that can be addressed by [Aid in Dying], is not defensible.").

[5] As the Michigan legislature found, "patients with reduced life expectancy due to advanced illnesses are often unaware of their legal rights, particularly with regard to controlling end-of-life decisions." Mich. Comp. Laws § 333.5652(1)(c) (2018).

[6] *See*, *e.g.*, Thomas May and Mark P. Aulisio, *Personal Morality and Professional Obligations: Rights of Conscience and Informed Consent*, 52 PERSP. IN BIOLOGY & MED. 30, 32 (2009) (arguing for limits to "conscience-based refusal to provide information" because "allowing refusal could deprive patients of even knowing what options exist.").

participation in certain treatments. Sawicki, *supra*, at 100.

To ensure that patients are fully informed of their end-of-life options, some states have, consistent with the standard of care, enacted supplemental laws that require healthcare providers to disclose truthful information regarding lawful end-of-life options. California's End of Life Option Act (the "EOLOA") provides an example of required disclosures. The EOLOA allows terminally ill Californians who satisfy a number of criteria to obtain aid-in-dying medication. *See* Cal. Health & Safety Code §§ 443-443.2. Provider participation in the EOLOA has always been entirely voluntary. Before a patient can qualify for a prescription, the EOLOA requires the participating physician to fully inform a patient of their medical diagnosis and prognosis, of potential risks associated with the aid-in-dying prescription, of the probable result of taking the prescription, that they may obtain the prescription and fill it but decline to take the prescription after obtaining it, and of feasible treatment alternatives, including "comfort care, hospice care, palliative care, and pain control." *Id.* §§ 443.1(j), 443.5(a)(2). In October 2021, the California Legislature enacted Senate Bill ("SB") 380, which amended the EOLOA to specify:

> A health care provider who objects for reasons of conscience, morality, or ethics to participate under this part shall not be required to participate . . . [but] the provider shall, at a minimum, inform the individual that they do not participate in the End of Life Option Act, document the individual's date of request and provider's notice to the individual of their objection in the medical record, and transfer the

individual's relevant medical record upon request.

Id. § 443.14(e)(2).

Therefore, if a patient requests aid-in-dying medication, SB 380 requires providers to disclose that they do not prescribe such medication and document both their objection and the patient's request in the patient's medical record. While the regulations at issue in this case prohibit dissemination of "misinformation or disinformation related to COVID-19," AB 2098, 2021-2022 Reg. Sess. (Cal. 2022) § 2(a), this Court's analysis of those laws' constitutionality has potential implications for the enforceability of other medical disclosure requirements, including those found in the EOLOA.[7]

SUMMARY OF ARGUMENT

Historical "informed consent" practices have left many patients ill-informed about their end-of-life healthcare choices. Therefore, states have enacted supplemental regulations requiring disclosures regarding end-of-life treatment options. The California Legislature, for example, amended the EOLOA to require providers to disclose their non-participation and record a patient's request for aid-

[7] In *Christian Med. and Dental Ass'n, et al. v. Bonta, et al.*, No. 5:22-cv-00335-FLA (GJSx), the Central District of California partially enjoined the provisions of SB 380 that require non-participating providers to "document the individual's date of request and provider's notice to the individual of their objection in the medical record" (*i.e.*, clause in Cal. Health & Safety Code § 443.14(e)(2)). *See* Order, ECF No. 108 (Sept. 2, 2022). Compassion & Choices Action Network's motion to intervene in that action has been pending since May 18, 2022. *Id.*, ECF No. 64.

in-dying medication in the patient's medical record.

Because laws requiring truthful, uncontroversial disclosures to patients regulate conduct, not speech, EOLOA's disclosure requirements are subject to rational basis review. These disclosure requirements do not advocate for a particular viewpoint, nor do they limit a provider's ability to communicate any particular message to their patients. In fact, a provider is free to disclose that they will not participate under the EOLOA because they believe doing so is immoral and contrary to their beliefs. Additionally, the EOLOA's disclosure requirements fall squarely within the authority of states to enact regulations consistent with the medical standard of care. Without these regulations, providers would be allowed to withhold their non-participation and potentially mislead vulnerable patients into believing they and their physician are aligned on a proposed course of treatment, including the possibility that the physician is willing to evaluate the patient's eligibility and ultimately write a prescription pursuant to medical aid in dying in their final days and weeks. The EOLOA is thus rationally related to the state's interest in ensuring that patients are, consistent with the standard of care, able to make informed decision regarding their end-of-life treatment.

In evaluating the appropriateness of a preliminary injunction of AB 2098, the Court's ruling should safeguard a state's ability to enact reasonable regulations requiring healthcare providers to disclose neutral, truthful information to patients or prospective patients regarding their lawful treatment options.

ARGUMENT

I. Laws That Require Truthful Disclosures To Ensure A Patient's Ability To Make Fully Informed Decisions Regarding Their Own End-of-Life Health Care Do Not Violate The First Amendment.

A. Laws requiring truthful disclosures to patients are permissible regulations of professional conduct.

The First Amendment does not prohibit reasonable laws that require healthcare providers to disclose truthful information regarding lawful healthcare options that ensure patient-directed treatment consistent with the standard of care—such as the disclosure requirements of the EOLOA—even if the healthcare provider does not offer, or even morally opposes, a particular treatment option that is subject to disclosure.

States may regulate professional conduct even when that conduct incidentally involves speech. *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2372 (2018) ("*NIFLA*").[8] Although professional speech is protected speech, *id.* at 2371-72, the Supreme Court has upheld requirements to disclose "'purely factual and uncontroversial information about the terms under

[8] Contrary to what the *McDonald* Appellants appear to suggest, AOB, p. 15, the "dissemination of information by doctors" is not always protected speech. Moreover, just because "AB 2098 covers speech," *id.* p. 11, the law does not "necessarily" violate the First Amendment. Those statements go too far. As discussed below, the First Amendment allows the government to regulate medical conduct by requiring disclosure of factual information, even if it has an incidental effect on speech. *See infra* at pp. 10-13.

which . . . services will be available'" so long as the requirements are not "'unjustified or unduly burdensome,'" *id.* at 2372 (quoting *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626, 651 (1985)), and has upheld "regulations of professional conduct that incidentally burden speech." *Id.* at 2373.

This Court applies a continuum approach to determine whether a law interferes with healthcare providers' speech or is merely regulating their professional conduct. *Tingley v. Ferguson*, 47 F.4th 1055, 1072 (9th Cir. 2022). Drawing the line between speech and conduct is an exercise "long familiar to the bar." *NIFLA*, 138 S. Ct. at 2373 (internal quotation marks omitted). If the law interferes with speech, strict scrutiny applies. *See Tingley*, 47 F.4th at 1072-73. And if the law interferes with conduct, the regulation must only satisfy rational basis review, under which states carry a "light burden." *See id.* at 1077-78 (quoting *Erotic Serv. Provider Legal Educ. & Rsch. Project v. Gascon*, 880 F.3d 450, 457 (9th Cir. 2018), *amended*, 881 F.3d 792 (9th Cir. 2018)); *see Nat'l Conf. of Pers. Managers, Inc. v. Brown*, 690 F. App'x 461, 464 (9th Cir. 2017) (affirming dismissal of First Amendment claim with prejudice because the law at issue "regulate[d] non-expressive conduct, not speech" and survived rational basis review); *Retail Digital Network, LLC v. Prieto*, 861 F.3d 839, 847 (9th Cir. 2017) (noting that courts apply rational basis review to "non-speech regulations of commerce and non-expressive conduct").

On the one end of the continuum is "public dialogue" by a professional, which receives the greatest First Amendment protection. *Tingley*, 47 F.4th at 1072-73. Conduct is at the other end of the spectrum, where "the state's power to regulate is great even though this type of regulation may have an incidental effect on speech." *Id.* For example, state regulation of conduct may include requirements for certain truthful disclosures, regulation of malpractice, and regulation of medical treatments. *Id.* at 1072-73, 1074 (quoting *Pickup v. Brown*, 740 F.3d 1208, 1229 (9th Cir. 2014)) (quotations omitted). "Most medical treatments require speech . . . but a state may still ban a particular treatment it finds harmful; otherwise, any prohibition of a medical treatment would implicate the First Amendment and unduly limit the states' power to regulate licensed professions." *Id.* at 1072-73.

For example, in *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002), the Ninth Circuit invalidated a federal policy that allowed physicians' licenses to be revoked if they recommended medical marijuana to a patient. There, this Court distinguished between prohibiting doctors from treating patients with marijuana (which the government could do) and prohibiting doctors from simply recommending marijuana, since the latter is based on the content and viewpoint of speech, while the former is based on conduct.

Laws that require healthcare providers to disclose their non-participation in a particular end-of-life treatment option, document those patient interactions, and transfer patient records are content-neutral regulations governing conduct, not speech. There is no expressive conduct involved in the act of transferring a patient's medical records. Similarly, there is nothing expressive in a healthcare provider merely informing a patient that they do not offer a treatment option (*e.g.*, they do not participate in medical aid in dying) or in accurately recording in the patient's medical records that the patient requested a certain treatment. In contrast to the policy at issue in *Conant*, 309 F.3d at 629, none of these requirements limits a physician's ability to communicate with their patients.

A requirement to provide neutral, truthful information on treatment options does not amount to advocating for a "viewpoint" favoring that option. *Cf. Hill v. Colorado*, 530 U.S. 703, 724-25 (2000) (statute regulating speech-related conduct near healthcare facilities without reference to content of speech is not "viewpoint based"); *Employment Div., Dep't of Human Resources of Oregon v. Smith*, 494 U.S. 872, 878-79 (1990) (if a "valid and neutral law of general applicability" has the "incidental effect" of burdening the free exercise of religion or freedom of the press, "the First Amendment has not been offended.") (citation omitted).

At best, the EOLOA's requirements that doctors inform patients of their non-participation in medical aid in dying, document patient requests for medical aid in dying, and transfer medical records are merely incidental infringements that need only have "a rational relationship to a legitimate state interest." *Pickup*, 740 F.3d at 1231. As discussed in more detail below, *see infra* at pp. 15-18, these laws further the government's interest in ensuring that the standard of care is met and in enabling terminally ill patients to make informed decisions about their end-of-life care.

II. End-of-Life Disclosure Requirements Are Designed To Provide Patients With Neutral And Truthful Information Concerning Lawful End-of-Life Treatment Options To Ensure Treatment Consistent With The Standard Of Care.

A. States have authority to enact disclosure and recordkeeping requirements consistent with the medical standard of care.

The medical standard of care is an objective standard informed by generally accepted practices, and it is breached when those practices fall below the degree of care and skill that other like providers would ordinarily exercise under the same or similar circumstances. *See Mendoza-Gauna v. Corrections Corp. of America*, 308 F. App'x 229, 230 (9th Cir. 2009); Sawicki, *supra* at 90. Because "medicine is an inexact science," however, even where a treatment is controversial and opposed by most, it may still fall within the standard of care if supported by a "respectable minority." Sawicki, *supra*, at 90-91.

The government has authority to enact legislation governing professional conduct that ensures treatment consistent with the standard of care. *See NIFLA*, 138 S. Ct. at 2373 ("Longstanding torts for professional malpractice. . .'fall within the traditional purview of state regulation of professional conduct.'") (internal citation omitted). Indeed, it is long-established that this authority extends beyond governing medical treatments and covers, among other things, requirements for disclosure of health information, *see generally* Pub. L. 104-191, 110 Stat. 1936 (*i.e.*, the Health Insurance Portability and Accountability Act of 1996),[9] and keeping complete and accurate records for patients. *E.g.*, Cal. Bus. & Prof. Code § 2266 ("The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct"); *see also Sears v. Rekuc*, 468 N.Y.S.2d 995, 996 (N.Y. Sup. Ct. 1983) (involving state law requiring physicians to maintain accurate records).

B. Because the California End Of Life Option Act requires disclosure of purely factual and uncontroversial information, it is rationally related to meet the statutory end.

Laws that require disclosure of neutral, truthful information regarding a provider's non-participation in a treatment option and the documentation of those patient interactions are consistent with the medical standard of care and do not offend the First Amendment's guarantee of free speech. As discussed above, the

[9] *See also* 42 C.F.R. § 483.10(c) (requiring disclosure of patient's rights in long-term care facilities); Cal. Health & Safety Code § 1599.1 (requiring disclosure of patients' rights in skilled nursing and intermediate care facilities); 22 C.C.R. § 72527 (same); W.A.C. 246-320-141 (requiring disclosure of patients' rights in hospital settings).

First Amendment differentiates between laws restricting speech and properly tailored laws mandating disclosure of neutral, factual information concerning statutory rights and services. *See supra* at pp. 9-13. To ensure that people make decisions based on accurate information, courts have long upheld states' authority to impose factual disclosure requirements on service providers in a number of contexts. *E.g.*, *CTIA – The Wireless Assoc. v. City of Berkeley, Cal.*, 928 F.3d 832, 848 (9th Cir. 2019) (upholding city ordinance's disclosure requirements for cellphone retailers); *American Meat Inst. v. U.S. Dep't of Agric.*, 968 F. Supp. 2d 38, 52 (D.C. Cir. 2013) (rejecting First Amendment challenge to government's country-of-origin disclosure requirements for certain commodities). Without the Act's disclosure requirements, patients run the risk of not knowing whether their provider would even evaluate them for the purpose of qualifying for aid-in-dying medication, despite the fact that this treatment is available in California under the EOLOA.[10] After all, "[a] patient who does not know that her provider is not offering her the full scope of medical options lacks the information necessary to make an informed decision about her own care." Sawicki, *supra*, at 100.

Although laws compelling or restricting speech are generally subject to strict scrutiny, *Turner Broad. Sys., Inc. v. FCC*, 512 U.S. 622, 642 (1994), certain types

[10] *See* Cal. Health & Safety Code § 443.1(j)(5) (requiring disclosure of alternatives to aid-in-dying medication, such as hospice and palliative care, before a patient can make an "informed decision").

of compelled disclosures are not. Laws requiring disclosure of "purely factual and uncontroversial information about the terms under which [] services will be available" are generally upheld where they are "reasonably related to the State's interest." *Zauderer*, 471 U.S. at 651 (upholding advertising disclosure requirements because they were "reasonably related to the State's interest in preventing deception of consumers").

The EOLOA's disclosure and recordkeeping requirements are therefore subject to rational basis review. Although some may believe the objective of the EOLOA is controversial, the actual disclosures required under the EOLOA, *i.e.*, that the patient requested medication and the provider does not evaluate patients for and ultimately prescribe that medication, are not. Disclosure requirements like these enhance the constitutional protections afforded by the First Amendment because they ensure the "robust and free flow of accurate information." *Nat'l Elec. Mfrs. Ass'n v. Sorrell*, 272 F.3d 104, 114 (2d Cir. 2001). Particularly when the disclosures advance an objective to allow terminally ill-patients to make informed decisions about their end-of-life care in a timely manner, any interest in refusing to provide factual information "is minimal." *Zauderer*, 471 U.S. at 651. Moreover, the Act does not prohibit any particular communications, but merely requires factual information to be disclosed to patients and documented in their medical record. *See Milavetz, Gallop & Milavetz P.A. v. United States*, 559 U.S. 229, 250

(2010) (explaining that the challenged disclosure obligations "do not prevent debt relief agencies . . . from conveying any additional information"). Therefore, because the EOLOA does not "entirely foreclose any means of communication," it satisfies constitutional scrutiny even if other less restrictive means are available. *See Hill*, 530 U.S. at 726 .

Healthcare choices are among the most consequential, emotional decisions that a person makes in their life. This could not be more true at the end of life. As reflected in committee hearings for SB 380, the EOLOA's amended disclosure requirements provide "greater transparency . . . so that patients know whether or not providers and health systems are willing to support them in accessing the law."[11] At those vulnerable junctures when healthcare choices must be made, patients rely on their providers to provide them with complete, truthful information regarding their options. Allowing providers to violate that trust on the sole basis of their personal aversion to a particular treatment option leaves those patients ill-served and erodes the basis of the special relationship between providers and their patients. The First Amendment is not offended by requiring neutral, truthful disclosures in the context of that relationship.

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[11] Senate Committee on Health, Senate Bill No. 380, version Feb. 10, 2021 (March 24, 2021). The Court may take judicial notice of matters of public record. *See* Fed. R. Evid. 201; *Harris v. Cnty. of Orange*, 682 F.3d 1126, 1132 (9th Cir. 2012).

CONCLUSION

In evaluating the appropriateness of a preliminary injunction of AB 2098, the Court should recognize that the First Amendment does not forbid reasonable regulations requiring healthcare providers to disclose—orally and in a patient's medical record—neutral, truthful information regarding lawful treatment options, even if the provider does not offer or even morally opposes a particular treatment option.

Dated: February 9, 2023

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CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

9th Cir. Case Number(s) 22-56220 (L), 23-55069

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I hereby certify that on February 9, 2023, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

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