No. 21-50949

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

UNITED STATES OF AMERICA,

Plaintiff-Appellee,

v.

THE STATE OF TEXAS, ET AL.,

Defendants-Appellants.

On Appeal from the United States District Court for the Western District of Texas, Austin Division, Honorable Robert Pitman, United States District Judge
Case No. 1:21-CV-796-RP

UNOPPOSED MOTION OF TEXAS MEDICAL ASSOCIATION FOR LEAVE TO FILE AN *AMICUS CURIAE* BRIEF IN SUPPORT OF PLAINTIFF-APPELLEE AND DENIAL OF STAY

In accordance with Federal Rule of Appellate Procedure 29(a)(3) and Fifth Circuit Rule 29.1, the Texas Medical Association (TMA) requests leave to file an *amicus curiae* brief in support of Plaintiff-Appellee United States of America. The proposed brief is submitted with this motion. TMA states the following in support of its motion:

1. TMA is the nation's largest and one of the oldest state medical societies. It represents the voice of more than 55,000 physician and medical student members across the state committed to improving the health of all Texans. TMA's vision is to improve the health of all Texans, and it does so by supporting its mission—standing up for physicians by providing distinctive solutions to the challenges they encounter in the care of patients. TMA has an interest in this case because S.B. 8 substantially affects Texas physicians.

2. TMA policies, which are adopted by its House of Delegates—physicians who represent members' interests statewide—support protecting communication in the context of the physician-patient relationship from unreasonable third-party interference and oppose exposing physicians to baseless litigation. *See, e.g.*, *Policy No. 10.002 Abortion; Policy No. 170.007 Professional Liability; Policy No. 245.003 Professional Freedom Erosion;* and *Policy No. 245.020 Physicians Retaining Autonomous Clinical Decision-Making Authority*.

3. TMA seeks leave to file the attached *amicus curiae* brief in support of the United States and in opposition to Texas' emergency motion to stay in order to provide a voice for Texas' physicians consistent with TMA policies. Specifically, TMA's proposed amicus supplements the United States' arguments on two of the four motion-to-stay factors before the Court: (1) granting the motion to stay would cause irreparable harm to Texas' physicians; and (2) public interest factors support

denying the motion to stay to protect communications in the confines of the physician-patient relationship. *Thomas v. Bryant*, 919 F. 3d. 298, 303 (5th Cir. 2019) (citing the four factors). TMA's perspective on behalf of its numerous and diverse physician membership would benefit the Court, including providing the Court with real examples of how S.B. 8 interferes with providing quality medical care to Texas' patients.

4. TMA is not affiliated with the United States or the State of Texas in this matter. TMA is an active constituent of the American Medical Association, which has filed a separate *amicus curiae* in this case.

5. No party has authored the attached brief in whole or in part, nor has any party contributed money to fund the preparation and/or submission of the brief.

6. TMA conferred with the parties, and The United States, the State of Texas, and the Intervenor Defendants-Appellants consented to TMA filing a brief in this matter.

7. Therefore, TMA respectfully requests leave of the Court to file the attached brief in support of the United States.

Dated: October 13, 2021

Respectfully submitted,

/s/ Donald P. Wilcox

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CERTIFICATE OF SERVICE

I certify that on October 13, 2021 I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I further certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

/s/ *Laura J. Thetford*
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CERTIFICATE OF COMPLIANCE

I also certify on October 13, 2021 that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains approximately 461 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

This brief also complies with the typeface requirements of Fed. R. App. P. 32(a)(5)(A) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman font size 14.

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BRIEF OF TEXAS MEDICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFF-APPELLEE AND DENIAL OF STAY

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Fifth Circuit Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

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National Association of Nurse Practitioners in Women's Health
American Academy of Family Physicians

American College of Nurse-Midwives
American College of Osteopathic Obstetricians and Gynecologists
American College of Physicians
American Gynecological and Obstetrical Society
American Psychiatric Association
American Society for Reproductive Medicine
Council of University Chairs of Obstetrics and Gynecology
North American Society for Pediatrics and Adolescent Gynecology
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INTEREST OF *AMICUS CURIAE*

The Texas Medical Association (TMA) is the nation's largest and one of the oldest state medical societies. It represents the voice of more than 55,000 physician and medical student members committed to improving the health of all Texans. TMA's vision is to improve the health of all Texans, and it does so by supporting its mission—standing up for physicians by providing distinctive solutions to the challenges they encounter in the care of patients. TMA has an interest in this case because it substantially impacts Texas' physicians. In accordance with Federal Rule of Appellate Procedure 29(a)(4), TMA states that no party's counsel authored this brief, in whole or in part, and no party or party's counsel contributed money to fund the preparation or submission of this brief.

TMA's membership is divided on the issue of what the general rule of law should be with respect to the gestation period for a lawful abortion. However, TMA's members are united in their opposition against: (1) subjecting physicians to frivolous lawsuits and (2) unreasonable interference in the physician-patient relationship with respect to virtually all medical treatments, as demonstrated by TMA's policies. These policies are adopted by TMA's House of Delegates—

physicians who represent members' interests statewide. Here are a few of those policies, in relevant part, for reference[1]:

1. *Policy No. 10.002 Abortion*: TMA recognizes abortion as a legal and time-sensitive medical procedure, and the performance of abortion must be based upon early and accurate diagnosis of pregnancy; informed and nonjudgmental counseling; prompt referral to skillful and understanding personnel working in a good facility; reasonable cost; and professional follow up.

2. *Policy No. 170.007 Professional Liability: Professional Liability*: To ensure access to medical care for Texans, TMA will continue efforts to . . . reduce or limit frivolous professional liability claims...

3. *Policy No. 245.020 Physicians Retaining Autonomous Clinical Decision-Making Authority*: TMA 1) opposes policy that prohibits physicians from following best practice guidelines as developed by their various specialty societies… and 3) opposes any policy that hinders the autonomous clinical decision-making authority of a physician or prevents a physician from providing evidence-based, empathic, and comprehensive treatment options to a patient.

4. *Policy No. 245.021 Patient-Doctor Privileged Communication*: TMA (1) opposes efforts by the Texas Legislature to insert itself into the patient-physician relationship in any way that interferes with the free and full disclosure of health care information in the best interests of the patient, and (2) reaffirms its support of the free exchange of professional information in the patient-physician relationship as privileged and worthy of the highest professional protection.

TMA policies support protecting communication in the context of the physician-patient relationship from unreasonable third-party interference and oppose exposing physicians to baseless litigation. Accordingly, TMA seeks leave to

[1] *See also* TMA Policy No. 10.003 Patient Autonomy and Accuracy of Information in Informed Consent for Abortion; Policy No. 245.003 Professional Freedom Erosion; Policy No. 250.002 Ethical Practice of Medicine for Physicians Participating in the Women's Health Program; and Policy No. 250.003 Limiting Physician and Patient Conversations, available at https://www.texmed.org/Policy/Index/.

file this *amicus curiae* brief consistent with TMA policies in support of the United States' opposition to the emergency motion to stay.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

Physicians are ethically tasked with "plac[ing] patients' welfare above [their] own self-interest or obligations to others, [using] sound medical judgment on patients' behalf, and [advocating] for their patients' welfare." *See* American Medical Association (AMA) Code of Medical Ethics Policy No. 1.1.3. S.B. 8's vague language restricting certain conduct (and intent to engage in such conduct) and its oppressive enforcement measures derail this important responsibility by improperly interfering in the physician-patient relationship. TMA submits this brief to supplement the United States Response Brief on two of the four motion-to-stay factors before the Court for consideration: (1) granting the motion to stay would cause substantial, irreparable harm to Texas' physicians; and (2) public interest factors support denying the motion to stay to protect communications in the confines of the physician-patient relationship. *Thomas v. Bryant*, 919 F. 3d. 298, 303 (5th Cir. 2019) (citing the four factors). TMA asserts the following major arguments herein:

First, S.B. 8 purports to allow almost any individual or entity to file a lawsuit for an alleged violation of the law without any actualized, individual injury. Tex. Health & Safety Code § 171.208 (a). This attempts to unconstitutionally circumvent well-established standing principles required by state and federal courts. *See Susan*

B. Anthony List v. Driehaus, 573 U.S. 149, 150, 158 (2014) (discussing the injury-in-fact standard for standing); *Spokeo, Inc. v. Robins*, 578 U.S. 330, 136 S.Ct. 1540, 1548 (2016) ("For an injury to be 'particularized,' it must affect the plaintiff in a personal and individual way."); *Heckman v. Williamson County*, 369 S.W.3d 137, 155 (Tex. 2012) ("After all, our Constitution opens the courthouse doors only to those who have or are suffering an injury. As for the injury itself, it must be concrete and particularized, actual or imminent, not hypothetical.") (internal citations omitted). Further, the provision awarding a prevailing plaintiff attorneys' fees and a *minimum* of $10,000 in damages, while simultaneously ensuring a prevailing defendant cannot recover attorneys' fees, is grossly unfair and serves as a cordial invitation to open the proverbial floodgates to baseless suits. Tex. Health & Safety Code § 171.208(b) & (c).

Second, this concern about frivolous suits is amplified by the vague language in S.B. 8, which fails to clearly outline what conduct constitutes a violation of the law. *See e.g., id.* at §§ 171.208(a)(2)-(3) ("engages [or intends to engage in] conduct that aids or abets") & 171.205 ("medical emergency" exception). This due process violation interferes in the physician-patient relationship. *See Pacific Mut. Life Ins. Co. v. Haslip*, 499 U.S. 1, 44 (1991) ("Due process requires that a State provide meaningful standards to help guide the application of its laws." Otherwise "such standards are void for vagueness" and should be enjoined).

For example, the vague "conduct that aids or abets" language of S.B. 8 is deterring physician communications with pregnant patients diagnosed with certain conditions, such as cancer or Adult Congenital Heart Disease. Physicians are directed by recognized national standards to have conversations about the potential impact of the disease or the impact of a recommended treatment on the patient's pregnancy. Many times, these conversations involve the risk of a negative outcome on the patient's pregnancy. These conversations might factor into a patient's decision to pursue an abortion (thereby implicating S.B. 8). Thus, physicians are concerned these medically appropriate conversations would subject them to a lawsuit.

Similarly, it is standard practice for obstetricians to offer genetic testing and counseling for their pregnant patients. Under S.B. 8, physicians are concerned the language "conduct that aids or abets" does not provide clear guidance on whether they are restricted from providing these services if a patient ultimately pursues an abortion in violation of the law after the testing and/or counseling. In each of these examples, physicians also are concerned they will be subject to increased risk of medical liability if they do not have these conversations in accordance with their specialty guidelines.

Third, the public interest supports open, honest, and confidential physician-patient communication. State and federal law protect these communications for the

purpose of providing medical care. *See generally, e.g.*, *Nat'l Institute of Family and Life Advocates v. Becerra*, ---- U.S. ----, 138 S.Ct. 2631 (2018) (discussing free speech protections against content-based and content-neutral regulations); *see also In re Columbia Valley Reg'l Med. Ctr.*, 41 S.W.3d 797, 801 (Tex. App.—Corpus Christi 2001) ("The basis for the physician-patient and the mental health privileges, which includes…confidentiality [is] to encourage the full communication necessary for effective treatment…. The…purpose is apparent: to allow for complete communication without fear of disclosure, so that the professional can effectively render services."). And national medical ethics standards direct physicians to engage in these conversations with patients. These standards also recognize, and studies support, the positive health benefits of unrestricted, confidential dialogue between physicians and patients, including better patient health outcomes and establishing effective treatment plans. S.B. 8's interference with this public interest puts the health of Texas' patients in jeopardy.

For all of these reasons and others herein discussed, TMA urges the Court to deny the motion to stay the district court judge's order.

ARGUMENT

A motion to stay is an "extraordinary remedy" that the Court has discretion to grant or deny. *Thomas*, 919 F. 3d. at 303. The federal government established in its response that the discretionary stay factors weigh in favor of denying the motion: (1)

the State is unlikely to succeed on the merits of its case; (2) the State failed to meet its burden of showing "irreparabl[e]" harm if the stay is not granted; (3) a stay would "substantially injure" other interested parties; and (4) the "public interest" supports denying the stay. *Id.*

TMA submits this brief to supplement the federal government's arguments on the last two factors—a stay permitting enforcement of S.B. 8 would substantially injure Texas' physicians, and the public interest supports denying the stay to protect open, confidential communication within the confines of the physician-patient relationship necessary to allow physicians to provide quality care.

I. THE EMERGENCY MOTION TO STAY MUST BE DENIED TO PREVENT SUBSTANTIAL INJURY TO TEXAS' PHYSICIANS.

A. The Enforcement Structure of S.B. 8 Threatens Texas Physicians with Numerous Frivolous Lawsuits.

S.B. 8's framework threatens to continue resulting in an immeasurable number of frivolous lawsuits filed by individuals and entities with no legal standing. Under federal and state law, regardless of the venue a would-be plaintiff files suit in, it is well-settled that the exercise of judicial power is restricted to litigants who can show, *inter alia*, an injury-in-fact, one that is "concrete and particularized"—the plaintiff must have a "personal stake in the outcome of the controversy." *Driehaus*, 573 U.S. at 150, 158 (citing the injury-in-fact standard for standing); *see also Robins*, 136 S.Ct. at 1548 ("For an injury to be 'particularized,' it must affect the plaintiff in

a personal and individual way."); *Heckman*, 369 S.W.3d at 155 ("After all, our Constitution opens the courthouse doors only to those who have or are suffering an injury. As for the injury itself, it must be concrete and particularized, actual or imminent, not hypothetical.") (internal citations omitted).

Further, the statute itself does not create standing—the law is clear that jurisdiction of the courts cannot be expanded by statute. *Robins*, 136 S.Ct. at 1547-1548 ("Injury in fact is a constitutional requirement, and '[i]t is settled that Congress cannot erase Article III's standing requirements by statutorily granting the right to sue to a plaintiff who would not otherwise have standing.'"); *Nephrology Leaders and Associates v. Am. Renal Associates, LLC*, 573 S.W.3d 912, 915 (Tex. App.—Houston [1st] 2019) ("But [a statute] cannot set a lower standard than set by the general doctrine of standing because courts' constitutional jurisdiction cannot be enlarged by statute"); *see also In re Lazy W. Dist. No. 1*, 493 S.W.3d 538, 544 (Tex. 2016) ("For the Legislature to attempt to authorize a court to act without subject matter jurisdiction would violate the constitutional separation of powers.").

Yet S.B. 8 claims to allow almost *any* person *anywhere* to file a lawsuit for an alleged violation of the statute. Tex. Health & Safety Code § 171.208 (a). But in almost all cases, such a plaintiff will have not been affected in a "personal and individualized way." *Robins*, 136 S.Ct. at 1548. These plaintiffs will have had no contact or other independent connection with the physician, the pregnant patient, or

the patient's embryo at all. Thus, if S.B. 8 were stayed, it would continue to unfairly force physicians to waste money and time defending such frivolous lawsuits.

This is especially concerning when the draconian fee-shifting design that awards a prevailing plaintiff its attorneys' fees while, conversely, prohibiting courts from awarding legal fees to a prevailing defendant, encourages potential plaintiffs (without standing) to place their bets on litigation with little to lose but much to gain. Prevailing plaintiffs are further enticed by a guaranteed award of a *minimum* of $10,000 in damages. Tex. Health & Safety Code § 171.208(b) & (c). Physicians will incur significant defense costs, including costs to retain counsel to respond to a complaint, engage in discovery, and file a motion to challenge standing in an ultimately baseless lawsuit, plus incur additional fees in the event of an appeal.

B. S.B. 8's Vague Restrictions Are Substantially Harming the Physician-Patient Relationship and Increasing Liability Risk for Physicians.

TMA has received alarming reports that the vague language in S.B. 8 is (1) chilling critical healthcare communications between physicians and patients; and (2) increasing other risks of liability by causing physicians to choose between potentially violating S.B. 8 or violating nationally recognized specialty standards of medical care. These reports include concerns with the following S.B. 8 phrases: (1) "knowingly engaging in conduct that aids and abets the performance or inducement of an abortion"; (2) "intend[ing] to engage" in such conduct; and (3) a "medical

emergency." Tex. Health & Safety Code §§ 171.208(a)(2)-(3) & 171.205. Some examples of these concerns include:

1. Upon information and belief, an entire OB/GYN Department was told they could not discuss abortion with a patient in any regard after cardiac activity was detected for fear it would violate the "conduct that aids or abets" provisions of S.B. 8.

2. Physicians are concerned whether they can discuss fetal aneuploidies with pregnant patients or those planning to conceive, in a nondirective, purely informational way. Current standard of care practice is to offer pregnant patients with a prenatal screening for fetal aneuploidy, which looks for the presence of an abnormal number of specific chromosome cells. These aneuploidies are associated with fetal anomalies (including some that are life-threatening to the embryo or patient), which could factor into a pregnant patient ultimately deciding to pursue an abortion.

3. Physicians also raised concerns about whether a physician who treats cancer can discuss treatment options for a pregnant patient diagnosed with cancer at eight weeks' gestation, when some of those life-saving treatment options might cause or require terminating the pregnancy or could cause fetal anomalies.

As another example of the harm caused by these vague provisions, the defined term "medical emergency" under the law is vague in the context of a pregnant patient diagnosed with cancer:

> [A] life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.

Id. at § 171.002(3). It is unclear at what point a "serious risk of substantial impairment of a major bodily function" or "danger of death" occurs for a pregnant patient who is battling cancer, and any delay in treatment might substantially

increase a negative outcome for the health of the patient. Further, the "conduct that aids or abets" language is unclear because it does not provide adequate guidance on whether discussing medical treatments for cancer that might have the side effect of negatively impacting the patient's pregnancy would place the physician in violation of the law if the patient ultimately seeks an abortion in violation of S.B. 8.

TMA also wants to provide the Court with a practical example of how the vagueness in S.B. 8 would increase the risk of medical liability litigation for violating recognized standards of medical practice if not stayed. The American College of Cardiology released nationally recognized guidelines on treating patients with Adult Congenital Heart Disease (ACHD). These guidelines, on the next page, expressly state the option of terminating a pregnancy and obstetrical and fetal risks should be discussed for women with ACHD:

Figure

3.13. Pregnancy, Reproduction, and Sexual Health

3.13.1. Pregnancy

Recommendations for Pregnancy
Referenced studies that support recommendations are summarized in Online Data Supplement 19.

COR	LOE	RECOMMENDATIONS
I	C-LD	1. Women with CHD should receive prepregnancy counseling with input from an ACHD cardiologist to determine maternal cardiac, obstetrical and fetal risks, and potential long-term risks to the mother (S3.13.1-1–S3.13.1-4).
I	C-LD	2. An individualized plan of care that addresses expectations and contingencies should be developed for and with women with CHD who are pregnant or who may become pregnant and shared with the patient and all caregivers (S3.13.1-2, S3.13.1-3).
I	B-NR	3. Women with CHD receiving chronic anticoagulation should be counseled, ideally before conception, on the risks and benefits of specific anticoagulants during pregnancy (S3.13.1-5, S3.13.1-6).
I	B-NR	4. Women with ACHD AP classification IB-D, IIA-D, and IIIA-D* should be managed collaboratively during pregnancy by ACHD cardiologists, obstetricians, and anesthesiologists experienced in ACHD (S3.13.1-2, S3.13.1-7, S3.13.1-8).
I	C-EO	5. In collaboration with an ACHD cardiologist to ensure accurate assessment of pregnancy risk, patients at high risk of maternal morbidity or mortality, including women with pulmonary arterial hypertension (PAH), Eisenmenger syndrome, severe systemic ventricular dysfunction, severe left-sided obstructive lesions, and/or ACHD AP classification ID, IID, IIID* should be counseled against becoming pregnant or be given the option of terminating pregnancy.
I	B-NR	6. Men and women of childbearing age with CHD should be counseled on the risk of CHD recurrence in offspring (S3.13.1-9).
IIa	B-NR	7. Exercise testing can be useful for risk assessment in women with ACHD AP classification IC-D, IIA-D, and IIIA-D* who are considering pregnancy (S3.13.1-10, S3.13.1-11).
IIa	B-NR	8. When either parent has CHD, it is reasonable to perform fetal echocardiography (S3.13.1-12, S3.13.1-13).

*See Tables 3 and 4 for the ACHD AP classification system.

It is unclear if S.B. 8's vague "conduct that aids or abets" language prohibits these discussions if doing so would lead to a patient seeking and obtaining an abortion in violation of the law. Yet, a physician might be subject to a lawsuit for failing to have these types of conversations with their patients as an expected standard of care practice. This concern is not hypothetical—suits have been filed (and won) where physicians failed to follow specialty guidelines or fully discuss the risks, benefits and alternative treatments in medical care.

If not stayed, these vague restrictions will continue to deprive physicians of due process. *See Haslip*, 499 U.S. at 44 ("Due process requires that a State provide

meaningful standards to help guide the application of its laws." Otherwise "such standards are void for vagueness" and should be enjoined). The unclear law would also leave physicians at an impasse, risking civil action for a potential violation of S.B. 8's restrictive provisions or for failure to follow nationally recognized standards of medical care. There is no question on whether physicians, who are interested parties, will be substantially harmed if the Court grants the emergency motion to stay—they will be. *Thomas*, 919 F. 3d at 303.

II. Public Interest Supports Protecting Open Communication in the Confines of the Physician-Patient Relationship.

There is a strong public interest in maintaining confidential, open communication in the physician-patient relationship to encourage individuals to seek appropriate care and share relevant information for the purpose of receiving quality healthcare. Federal and state law protect open dialogue between a physician and patient for the purpose of facilitating appropriate medical care. *See generally, e.g.*, *Becerra*, 138 S.Ct. at 2631 (discussing free speech protections against content-based and content-neutral regulations); *see also In re Columbia Valley Reg'l Med. Ctr.*, 41 S.W.3d at 801 ("The basis for the physician-patient and the mental health privileges, which includes…confidentiality [is] to encourage the full communication necessary for effective treatment…. The…purpose is apparent: to allow for complete communication without fear of disclosure, so that the professional can effectively render services.") (internal quotations omitted).

Open communication in physician-patient counseling is also a pillar of providing ethical healthcare. AMA, which provides ethical guidance to the nation's physicians, has issued several applicable opinions. For example, in relevant part, AMA Code of Medical Ethics Opinion 2.1.1 states:

> Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

And Opinion 1.1.3 states in relevant part:

> To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.

Further, many studies show honest and open dialogue between a physician and the physician's patient is necessary to achieve "the best outcome and patient satisfaction," and it is "essential for the effective delivery of healthcare."[2] Good physician-patient communication can also help ensure patients share important

[2] *See e.g.*, Fong J., et al., NCBI, *Doctor-Patient Communication: A* Review (Spring 2010), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/ (discussing the importance of physician counseling on positive patient outcomes); INST. FOR HEALTHCARE COMMUNICATION, *Impact of Communication in Healthcare* (July 2011), available at https://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/ (discussing a "wealth" of studies supporting the benefit of physician-patient communication).

information necessary for an accurate diagnosis of their condition and for establishing an effective treatment plan.

If a stay were granted, S.B. 8 would continue to jeopardize the health and safety of Texas' patients by substantially interfering with communications in the physician-patient relationship. And to be clear, S.B. 8's off-hand reference to the First Amendment does not alleviate this public interest concern. *See* Tex. Health & Safety Code § 171.208(g) ("This section may not be construed to impose liability on any speech or conduct protected by the First Amendment of the United States Constitution…."). Instead, it simply pays lip service to the First Amendment's principles while at the same time effectively chilling crucial communication about patient medical care.

CONCLUSION AND PRAYER

For these reasons, the Court should deny the Motion to Stay the district court judge's order and lift the administrative stay as quickly as possible to prevent further substantial, irreparable harm to Texas' patients and physicians.

Respectfully submitted,

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/s/ *Laura J. Thetford*
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/s/ *Laura J. Thetford*
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