No. 08-17649

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

PHILIP MORRIS USA INC.,
Plaintiff-Appellant,
v.
CITY AND COUNTY OF SAN FRANCISCO;
BOARD OF SUPERVISORS OF THE CITY AND COUNTY OF SAN FRANCISCO;
and GAVIN NEWSOM, in his official capacity as
MAYOR OF THE CITY AND COUNTY OF SAN FRANCISCO,
Defendants-Appellees.

On Appeal from the United States District Court for the Northern District of California, Case No. C-08-4482-CW The Honorable Claudia Wilken, United States District Judge

BRIEF OF *AMICI CURIAE* TOBACCO CONTROL LEGAL CONSORTIUM, PUBLIC HEALTH INSTITUTE, *ET AL.*, IN SUPPORT OF APPELLEES

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INTEREST OF THE AMICI CURIAE

Amici curiae Tobacco Control Legal Consortium, Public Health Institute, American Legacy Foundation, American Medical Association, Americans for Nonsmokers' Rights, Boston Public Health Commission, California Center for Public Health Advocacy, California Medical Association, California Public Health Association-North, Massachusetts Association of Health Boards, Massachusetts Public Health Association, National Association of County and City Health Officials, National Association of Local Boards of Health, Pharmacists Planning Service, Inc., San Francisco Medical Society, Southern California Public Health Association, Dean and Professor Mary Anne Koda-Kimble, Professor Lisa Bero, Professor Robin Corelli, and Professor Lisa Kroon, are non-profit organizations, public health and medical professional associations, governmental entities, associations of governmental entities, and individuals involved in different aspects of public health. They are unified by their commitment to the public health goals of disease prevention and health promotion through policies that limit and prevent tobacco use and addiction. *Amici* have a strong interest in the present appeal because it involves a local ordinance that promotes *amici*'s public health goals. The interest of each of the *amici curiae* is set forth in the accompanying motion for

leave to file a brief *amici curiae.*

INTRODUCTION

Cigarettes are the only legal product that, when used as intended, will contribute to the death of at least one half of all users.[1] For this reason, public health organizations have sought for decades to reduce and ultimately eliminate cigarette consumption. San Francisco's ordinance banning the sale of tobacco products in pharmacies is a modest, yet pioneering, measure that responds to the longstanding calls by the public health community for a ban of tobacco products sales in stores ostensibly committed to the health and well-being of their customers.

We submit this brief *amici curiae* to show the evidence-based public health reasons for a ban of tobacco product sales in pharmacies. Extensive research demonstrates that social perception and the ubiquity of tobacco products exert a strong influence on whether non-smokers will experiment with and become addicted to cigarettes. As a result, public health advocates have long sought to change social and cultural attitudes toward tobacco and to restrict its availability.

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[1] *See, e.g.*, Doll R., et al., *Mortality in relation to smoking: 50 years' observations on male British doctors*, 328 British Med. J. 1519 (2004).

San Francisco's ordinance is an entirely reasonable governmental effort to do just that. The sale of tobacco products in stores that hold themselves out as health-oriented counterproductively contributes to the perception that cigarettes are compatible with a healthy lifestyle. Pharmacist associations have therefore opposed the sale of tobacco products in pharmacies and view such sales as conflicting with the Code of Ethics for Pharmacists, who make a professional pledge to act in their best interest of their patients. Although the ordinance will not of its own force bring about the ultimate goal of eliminating tobacco use, it is a critical step in the right direction. *See Williamson v. Lee Optical of Oklahoma*, 348 U.S. 483, 489 (1955) (government may address problems "one step at a time").

Appellant Philip Morris USA's contention that the ordinance reflects San Francisco's hostility to tobacco industry advertising is factually incorrect and legally wide of the mark. The record amply demonstrates that the Board of Supervisors enacted the ordinance based on the public health desire to contribute to the long-term goal of reducing and ultimately eliminating tobacco use and addiction. References in the record to the importance of "sending a message" about tobacco reflect San Francisco's embrace of the public health research – which emphasizes the important influence of social perception on tobacco experimentation and addiction. San Francisco's effort to shape social perception

about tobacco underscores, rather than undercuts, the ordinance's public health basis.

Equally to the point, the ordinance prohibits tobacco sales, not tobacco advertising, in pharmacies. Nothing in the Constitution prohibits San Francisco from being hostile to tobacco use. Indeed, San Francisco's ordinance reflects respect for the Supreme Court's commercial speech jurisprudence. Where the government seeks to regulate conduct by restricting advertising about that conduct, its actions are subject to intermediate scrutiny. *See, e.g., Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525 (2001); *44 Liquormart, Inc. v. Rhode Island*, 517 U.S. 484 (1996); *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748 (1976). But where, as here, the government has not sought to restrict advertising at all, and instead has regulated the underlying conduct directly, the First Amendment is simply not implicated.

BACKGROUND

The prevailing consensus in the public health community is that tobacco products should not be sold in pharmacies. Empirical research establishes the need for a comprehensive, multi-prong approach to tobacco control, including measures that change social and cultural norms about tobacco use, limit tobacco

accessibility, and restrict smoking. Governments at all levels have responded with measures, some incremental, some more sweeping, in each of these areas. San Francisco's ban on tobacco sales in pharmacies is simply the latest governmental tobacco control measure aimed at promoting public health.

1. Empirical research has repeatedly confirmed the common sense view that negative social perceptions, as well as reduced access to and visibility of smoking and cigarettes may lower the rate at which current non-smokers experiment with and ultimately become addicted to smoking.

Social norms about smoking influence smoking rates, particularly among those not yet addicted. *See, e.g.*, Christakis, Nicholas and Fowler, James, *The collective dynamics of smoking in a large social network*, 358 New Engl. J. Med. 2249 (2008); Katz, Mitchell, *Banning Tobacco Sales in Pharmacies: The Right Prescription*, 300 J. Am. Med. Assn. 1451 (2008); Alesci, Nina, *et al*., *Smoking visibility, perceived acceptability, and frequency in various locations among youth and adults*, 36 Prev. Med. 272 (2003). "Social unacceptability has been repeatedly shown to be an important influence on both initiation and quitting." Alamar, Benjamin and Glantz, Stanton, *Effect of Increased Social Unacceptability of Cigarette Smoking on Reduction in Cigarette Consumption*, 96 Health Policy &

Ethics 8, 8 (2006) (citing *Preventing Tobacco Use Among Young People: A Report of the Surgeon General*, U.S. Dept. of Health & Hum. Servs. (1994) & *Reducing Tobacco Use: A Report of the Surgeon General*, U.S. Dept. of Health & Hum. Servs. (2000)).

Studies have found that strong governmental regulation of smoking corresponds and may contribute to anti-smoking community norms. *See* Hamilton, W., *et al.*, *Do local tobacco regulations influence perceived smoking norms? Evidence from adult and youth surveys in Massachusetts*, 23 Health Educ. Res. 709 (2008); Macy, Jonathan T., *et al.*, *Smoke-free Air Laws and Perceived Norms About Smoking in Four Texas Cities*, Poster Presented at 136th American Public Health Association Annual Meeting and Exposition (Oct. 27, 2008); Albers, A.B., *et al.*, *Relation between restaurant smoking regulations and attitudes towards the prevalence and social acceptability of smoking*, 13 Tobacco Control 347 (2004).

Furthermore, empirical research connects lower densities of retail outlets with lower consumption, particularly among youth. *See, e.g.*, Pearce, J., *et al.*, *The neighbourhood effects of geographical access to tobacco retailers on individual smoking behaviour*, 63 J. Epidemiol. Cmty. Health 69 (2009) (individuals living in neighborhoods with best access to supermarkets and convenience stores where

tobacco sold had higher odds of smoking); Leatherdale, S.T. and Strath, J.M., *Tobacco retailer density surrounding schools and cigarette access behaviors among underage smoking students*, 33 Ann. Behav. Med. 105 (2007) (tobacco retailer density surrounding schools is related to student cigarette access behaviors); Novak, Scott, *et al.*, *Retail Tobacco Outlet Density and Youth Cigarette Smoking: A Propensity-Modeling Approach*, 96 Am. J. Pub. Health 670 (2006) (reductions in retail tobacco outlet density may reduce rates of youth smoking).

Finally, studies conclude that reduced visibility of smoking and cigarettes "may significantly lower youth smoking initiation by impeding the progression from cigarette experimentation to established smoking." Siegel, Michael, *et al.*, *Local Restaurant Smoking Regulations and the Adolescent Smoking Initiation Process*, 162 Arch. Pediatr. Adolesc. Med. 477, 477 (2008); *see also* Alamar & Glantz, 96 Health Policy & Ethics at 8 ("Social circumstances, such as policies establishing smoke-free workplaces and restaurants . . . also affect cigarette consumption.").

2. This empirical research establishes the need for a comprehensive, multi-prong approach to tobacco control. Critical elements of any tobacco control

strategy include measures that "chang[e] the social and cultural attitudes surrounding tobacco use" and "restrict tobacco accessibility." Tobacco Education and Research Oversight Committee for California, *Toward A Tobacco-Free California 2006-2008* at 3 (March 2006).[2] Restrictions on smoking (and not just tobacco sales) are also central because they serve the twin purposes of decreasing harmful exposure to secondhand smoke, *see id.* at 4, and potentially reducing future addiction rates of current non-smokers. *See* Siegel, 162 Arch. Pediatr. Adolesc. Med. at 477; Alamar & Glantz, 96 Health Policy & Ethics at 8.

Government at all levels, especially the State of California, has been extremely responsive to these public health recommendations and has implemented significant measures in each of these three areas.

For example, the campaign by the State of California to shape social and cultural attitudes about tobacco is well known (and the subject of unsuccessful legal challenges by the tobacco industry). California uses cigarette tax revenue to fund a media "campaign to 'denormalize' smoking, by creating a climate in which

[2]The California State Legislature created the Tobacco Education and Research Oversight Committee as an advisory committee to provide the state Departments of Health Services and Education with recommendations regarding tobacco control, tobacco use prevention education, and tobacco-related disease research. *See* Cal. Health & Safety Code §104365-70.

smoking would seem less desirable and less socially acceptable." *R.J. Reynolds Tobacco Co. v. Shewry*, 423 F.3d 906, 912 (9th Cir. 2005). In one television advertisement,

> entitled "Rain," children in a schoolyard are shown looking up while cigarettes rain down on them from the sky. A voice-over states "We have to sell cigarettes to your kids. We need half a million new smokers a year just to stay in business. So we advertise near schools, at candy counters. We lower our prices. We have to. It's nothing personal. You understand." At the conclusion, the narrator says, "The tobacco industry: how low will they go to make a profit?"

Id. (quoting *R.J. Reynolds v. Bonta*, 272 F.Supp.2d 1085, 1089 (E.D. Cal. 2003)). "'[T]here is substantial evidence, including published medical studies indicating that the [state's Tobacco Control] programs, and the media campaign in particular, have been successful in achieving their goals'" of "preventing tobacco use by children and young adults." *Id.* at 913 (quoting *Bonta*, 272 F.Supp.2d at 1088 n.5).

In addition, restrictions on the sale of tobacco are widespread. The sale of tobacco products to minors is prohibited throughout the state of California. *See* Cal. Penal Code §308; Cal. Bus. & Prof. Code §22952. Over twenty campuses of the University of California, California State University, and California Community College system have prohibited the sale of tobacco products.[3]

[3]*See* http://www.cyanonline.org/College/CollegePolicies/CaliforniaPolicies/ (continued)

Finally, modest and limited restrictions enacted over thirty years ago eventually culminated in what is now a virtual ban by the State of California on indoor smoking in public places and even some outdoor locations. The history of these restrictions demonstrates that incremental measures have been necessary precursors to more extensive prohibitions. For example:

- In 1976, California enacted the Indoor Clean Air Act, which requires that publicly owned buildings, health facilities, and retail food establishments dedicate significant portions of indoor spaces open to the general public as non-smoking areas. *See* Cal. Health & Safety Code §§118885-915.
- Throughout the 1980s and early 1990s, hundreds of California municipalities adopted ordinances limiting smoking in government buildings, public places, restaurants, and private workplaces. *See, e.g.*, Rigotti, N. and Pashos, C., *No-smoking laws in the United States. An analysis of state and city actions to limit smoking in public places and workplaces*, 266 J. Am. Med. Assn. 3162 (1991); California Department of Health Services, Tobacco Control Section, *A Model for Change: The California Experience in Tobacco Control*, at 7 (Oct. 1998).

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UniversityofCalifornia/tabid/586/Default.aspx (visited March 14, 2009) (sale of tobacco products prohibited at Berkeley, Davis, Irvine, Los Angeles, and Santa Cruz campuses); http://www.cyanonline.org/College/CollegePolicies/CaliforniaPolicies/CaliforniaStateUniveristy/tabid/587/Default.aspx (visited March 14, 2009) (sale of tobacco products prohibited at Channel Islands, Fresno, Humboldt, Cal Poly Pomona, Sacramento, San Francisco, San Jose, Sonoma, and Stanislaus campuses); http://www.cyanonline.org/College/CollegePolicies/CaliforniaPolicies/CommunityColleges/tabid/588/Default.aspx (visited March 14, 2009) (sale of tobacco products prohibited at Cabrillo College, Gavilan College, Los Angeles Harbor College, Mendocino College, City College of San Francisco, Santa Barbara City College, Shasta College, College of the Siskiyous, Taft College).

- In 1987, California prohibited smoking on all forms of transit in the state, including airplanes, trains, and buses. *See* Cal. Health & Safety Code §§118925-45 (originally codified at Cal. Health & Safety Code §§25948-25949.8).
- In 1989, the federal government enacted legislation banning smoking on all domestic airline flights of six hours or less. *See* Pub. L. 101-164, §335, 103 Stat. 1098, 1099 (1989).
- In 1993, California prohibited smoking in licensed day care centers and, during hours of operation, in private residences licensed as family day care homes in areas where children are present. *See* Cal. Health & Safety Code §1596.795.
- In 1995, California's comprehensive smokefree workplace law took effect, prohibiting smoking in virtually all enclosed workplaces, including offices, restaurants, and shops. *See* Cal. Labor Code §6404.5.
- In 1998, bars in California became smokefree. *See* Cal. Labor Code §6404.5.
- In 2000, the federal government banned smoking on all domestic flights, as well as flights to and from the country. *See* Pub. L. 106-181, Title VII, §708(a), 114 Stat. 159 (2000), *codified at* 49 U.S.C. §41706.
- In 2001, California prohibited smoking on playgrounds or tot lot sandbox areas. *See* Cal. Health & Safety Code §104495.
- In 2003, California prohibited smoking within 20 feet of a main entrance, exit, or operable window of a public building owned or leased by the state, a county, a city, a city and county, or a California Community College district. *See* Cal. Gov. Code §§7596-98.
- In 2004, California prohibited tobacco possession or use by inmates under the jurisdiction of the Department of Corrections and the Department of the Youth Authority. *See* Cal. Penal Code §5030.1 & Cal. Welf. & Inst. Code §1712.5.
- In 2007, California prohibited smoking in vehicles with children. *See* Cal. Health & Safety Code §118948.

3. The public health research also establishes the need for a ban on tobacco products sales in pharmacies in particular. Such a ban serves as an important means of shaping social norms and reducing the ubiquity of smoking and cigarettes, toward the ultimate goal of eliminating tobacco use. *See, e.g.*, Tobacco Education and Research Oversight Committee for California, *Toward A Tobacco-Free California 2009-2011* at 3 (Jan. 2009) ("TEROC objects to the continued sale of tobacco products in pharmacies and drug stores"); Tobacco Education and Research Oversight Committee for California, *Toward A Tobacco-Free California 2006-2008* at 17 (recommending "[s]upport [for] initiatives to prohibit the sale of tobacco products by pharmacies and drug stores").

First, "[s]elling tobacco products sends misleading messages that conflict with a pharmacy's purpose of promoting health." Tobacco Education and Research Oversight Committee for California, *Toward A Tobacco-Free California 2009-2011* at 21. Because research has demonstrated the centrality of social norms in tobacco use prevention, public health advocates have understandably been vigilant in their efforts to combat factors that contribute to positive perceptions about smoking. Pharmacies affirmatively hold themselves out as stores where customers can receive trustworthy healthcare advice. *See, e.g.*, ER 292 (Walgreens refers to itself as the "Pharmacy America Trusts"). Indeed, the public perceives

community pharmacists as among the most trusted health care professionals. *See* National Association of Chain Drug Stores, Chain Pharmacy Industry Profile at 61 (2008-09).[4] The sale of tobacco products in pharmacies contributes to the intolerable danger that non-smokers, particularly impressionable youth, will perceive smoking to be somehow compatible with a healthy lifestyle.

Second, tobacco control groups have long advocated for increased restrictions on the accessibility of tobacco products. *See* Tobacco Education and Research Oversight Committee for California, *Toward A Tobacco-Free California 2006-2008* at 3. Empirical research connects lower densities of retail outlets with lower consumption, particularly among youth. *See* Pearce, 63 J. Epidemiol. Cmty. Health at 69; Leatherdale, 33 Ann. Behav. Med. at 105; Novak, 96 Am. J. Pub. Health at 670. Eliminating tobacco products from pharmacies is squarely in line with other restrictions on tobacco products sales, such as the ban on sales to minors, and the ban on public college campuses throughout California. *See supra* at 9.

Third, pharmacy customers – who may be patronizing the store for the express purpose of seeking healthcare advice or purchasing healthcare products to

[4]Available at http://www.nacds.org/wmspage.cfm?parm1=605 (visited

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aid in their efforts to quit – are especially vulnerable. A survey of San Francisco pharmacies in 2003 revealed that 55.2% of the pharmacies that sold both tobacco cessation products and tobacco products, sold the items "immediately adjacent" to each other. Eule, B., *et al*., *Merchandising of cigarettes in San Francisco pharmacies*, 13 Tobacco Control 429, 430 (2004) (hereinafter "Eule"). The sale of tobacco products in pharmacies undermines the efforts of those seeking to quit.

Fourth, and related to all of the above reasons, tobacco products sales in pharmacies directly contradicts the Code of Ethics for Pharmacists. The Code considers "the patient-pharmacist relationship as a covenant," pursuant to which the "pharmacist has moral obligations in response to the gift of trust received from society. In return for this gift, a pharmacist promises to help individuals achieve optimum benefit from their medications, to be committed to their welfare, and to maintain their trust." Code of Ethics for Pharmacists, §I. Further, the Code requires pharmacists to avoid "behavior or work conditions that impair professional judgment, and actions that compromise dedication to the best interests of patients." *Id.* at §IV. The sale of a product that will contribute to the death of at least half of its users simply does not contribute to patient welfare. And the profit

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off of the sale of such products creates an inherent and unacceptable financial conflict of interest for pharmacists.

4. It is thus far from surprising that pharmacists have long been opposed to the sale of tobacco products in pharmacies.

In 1970, the American Pharmaceutical Association ("APhA") stated, "Mass display of cigarettes is in direct contradiction to the role of the pharmacy as a public health facility." *See* Hudmon, Karen S., *et al.*, *Pharmacy Students' Perceptions of Tobacco Sales in Pharmacies and Suggested Strategies for Promoting Tobacco-Free Experiential Sites*, 70 Am. J. Pharm. Educ. 75 (2006). The next year, the APhA House of Delegates recommended that tobacco products not be sold in pharmacies. *See id.* In 1973 and 1977, the California Pharmacists Association recommended that pharmacists discourage the sale of tobacco products in the pharmacies in which they practice "in the interest of raising the standards for public health and social welfare in the community." *Id.* A study published in 2006 found that 81.7% of licensed pharmacists are opposed to the sale of tobacco products in pharmacies and only 1.6% of licensed pharmacists favored such sales. *See* Hudmon, Karen S., *Tobacco sales in pharmacies: time to quit*, 15 Tobacco Control 35 (2006).

5. Pharmacists themselves, however, often do not control decisions over products sales, especially when the pharmacy is part of a larger chain. Notwithstanding the public health consensus, most pharmacies, especially chain pharmacies, continue to sell tobacco products. *See* Eule, B., 13 Tobacco Control at 429. Longstanding efforts of public health groups to convince these companies voluntarily to discontinue tobacco sales San Francisco were largely unsuccessful.

San Francisco thus responded to the recommendations of its public health director, "[a]ll of the professional pharmac[ist] associations, both the national and . . . the California Medical Association, the San Francisco Medical [Society]," and numerous other public health advocates when it adopted this ordinance.[5]

San Francisco is not, however, the first or only governmental entity to do so. In 1994, the province of Ontario in Canada passed the landmark Ontario Tobacco Control Act, S.O. 1994, c. 10. Ontario now prohibits the sale of tobacco products in a wide array of healthcare institutions, including pharmacies, but also in public and private hospitals, psychiatric facilities, and nursing homes. Since then, six jurisdictions in Canada have followed suit, with New Brunswick, Quebec, Nova Scotia, Nunavut, Newfoundland and Labrador, and Price Edward Island also

[5]The American Medical Association, California Medical Association, and (continued)

banning tobacco sales in pharmacies. *See* Physicians for a Smoke-Free Canada, *Tobacco Free Pharmacies* at 3 (January 2006).

In December 2008, *amicus curiae* Boston Public Health Commission's Board of Health unanimously approved a regulation prohibiting tobacco sales at healthcare and educational institutions – including pharmacies – in the city.[6]

San Francisco's pharmacy ban is also similar to the common prohibitions against tobacco products sales in healthcare facilities such as hospitals. *See, e.g.*, Associated Press, *Veterans' Hospital to Stop Tobacco Sales*, NY Times, Aug. 7, 1991, at A8 (Department of Veterans Administration ordered all VA hospitals to stop sale of tobacco products as of October 1, 1991).

ARGUMENT

San Francisco's ban on tobacco sales in pharmacies is a classic exercise of the government's traditional "police power" "to protect public health and safety." *See City of Erie v. Pap's A.M.*, 529 U.S. 277, 296 (2000) (plurality). Philip Morris' effort to ascribe an "anti-speech" motive to San Francisco is factually

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San Francisco Medical Society are among the *amici curiae* submitting this brief.

[6]A copy of the regulation is available at http://www.bphc.org/board/pdfs/regs_TobaccoRestrictionRegulation_12-11-08.pdf.

inaccurate and legally irrelevant. San Francisco's ordinance rests on the government's strong public health interest in preventing tobacco use and addiction. Moreover, San Francisco may constitutionally exhibit hostility to tobacco use and addiction, and the ordinance is not subject to First Amendment review because its chosen means for accomplishing its public health goal was to regulate conduct and not speech.

I. San Francisco's Ordinance Is An Entirely Constitutional Exercise Of The Government's Established Authority To Take Incremental Steps Toward The Public Health Goal Of Preventing Tobacco Use and Addiction

The government's traditional "police power" unquestionably vests San Francisco with the authority "to protect public health and safety." *See City of Erie*, 529 U.S. at 296 (plurality); *Barnes v. Glen Theatre, Inc.*, 501 U.S. 560, 560-561 (1991) ("The States' traditional police power is defined as the authority to provide for the public health, safety, and morals, and such a basis for legislation has been upheld.").

As discussed above, there are sound evidence-based public health reasons to prohibit tobacco sales in pharmacies. Social perceptions regarding smoking exert an enormous influence on whether non-smokers, especially youth, will become addicted. Lower densities of retail outlets selling tobacco correspond to lower

consumption rates. Strong anti-smoking governmental enactments correlate with more negative perceptions of smoking, and legislation reducing the prevalence of smoking reduces use and addiction rates among youth. *See supra* at 5-7.

San Francisco's ban on the sale of tobacco products in pharmacies heeds the lessons of this empirical research. It engages in the larger tobacco control war on the all-important battle front of social perception. The ordinance helps smokers and non-smokers alike avoid the dangerous social perception that smoking is compatible with a healthy lifestyle and reduces the ubiquity of tobacco. Pharmacists are healthcare providers who hold an ethical duty to act in the welfare of their patients. Eliminating tobacco sales allows pharmacists to help support their patients who are attempting to quit smoking and to avoid the inherent conflict of interest created when pharmacists profit from the sale of a product which, when used as intended, will contribute to the death of at least half its users. *See supra* at 12-15.

The record in this case amply demonstrates that San Francisco enacted the ordinance for these very public health reasons and belies the claim that the ordinance was surreptitiously enacted to suppress tobacco *advertising*. *See, e.g.*, Excerpts of Record ("ER") 290 ("It's the health focus of pharmacies, it's the

vulnerability of the people who are going to pharmacies, and it's the inherent conflict of interest on making money from selling cigarettes, and then making money from selling prescription medication and over-the-counter medications to treat the effect of tobacco"); ER 293 ("a chance for this board to make a positive statement that pharmacies, health-promoting behaviors and tobacco don't mix"); *id.* (The data shows "bans matter. . . . [B]ans do affect social perceptions").

It is, of course, irrelevant that the ordinance may not immediately or completely eliminate all harm caused by tobacco. *Cf.* Appellant's Opening Brief at 11. Philip Morris emphasizes that the ordinance was not anticipated to reduce overall tobacco sales from *current* levels. Research, however, indicates that lower densities of retail outlets selling tobacco do correlate to lower consumption rates. Pearce, 63 J. Epidemiol. Cmty. Health at 69; Leatherdale, 33 Ann. Behav. Med. at 105; Novak, 96 Am. J. Pub. Health at 670. In any event, any predictions about current sales levels do not negate the public health basis for the ordinance, which public health research also indicates will contribute to a reduction in *future* use and addiction. *See supra* at 13-14.

Just as the government has permissibly prohibited indoor smoking in public places through incremental enactments, *see supra* at 10-11, so too was San

Francisco entitled to "address[] itself to the [overall] problem" of tobacco consumption "one step at a time." *Williamson v. Lee Optical of Oklahoma*, 348 U.S. 483, 489 (1955).

II. San Francisco's Approach To Tobacco Regulation Does Not Implicate the First Amendment Because The Ordinance Regulates Conduct And Not Speech

Philip Morris contends that San Francisco enacted the ordinance based on a hostility to the tobacco industry's commercial speech. The record demonstrates that San Francisco adopted the ordinance based on public health concerns and not out of any surreptitious censorial motive. Equally to the point, San Francisco's approach to the regulation of tobacco products reflects respect for First Amendment values because it regulates conduct.

As a threshold matter, it bears emphasis that Philip Morris' "illicit motive" argument rests on a strained construction of references in the record to "messages" about tobacco use. *See, e.g.*, Appellant's Opening Brief at 43. These references plainly refer to San Francisco's embrace of the public health research about the influence of social perception and social norms on tobacco experimentation, use, and eventual addiction and the consequent importance of combating "messages" that contribute to the perception of tobacco products as healthful, cool, sophisticated, or otherwise positive. San Francisco's effort to shape social

perception underscores, rather than undercuts, the public health basis for this ordinance. And San Francisco, like the State of California through its media campaign about the tobacco industry, *see Shewry*, 423 F.3d at 914 (rejecting First Amendment challenge to "government-sponsored advertising campaign" against tobacco industry), is entitled to enact legislation that "sends a message" that smoking is bad.

Philip Morris cannot avoid the fact that the ordinance prohibits tobacco sales and leaves tobacco advertising completed unregulated.[7] Of course, had San Francisco chosen to restrict tobacco advertising, it would have been constitutionally permitted to do so, provided any such restrictions satisfied intermediate scrutiny. *See generally Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525 (2001). But where, as here, San Francisco chose to send its message about tobacco by regulating conduct – and not speech – the First Amendment is not implicated at all.

[7]Because the ordinance regulates conduct and not speech, and for the reasons set forth in San Francisco's brief, which *Amici* will not repeat here, the ordinance is not subject to First Amendment scrutiny at all. *See, e.g., Rumsfeld v. Forum for Academic and Inst. Rights, Inc.*, 547 U.S. 47, 66 (2006) ("First Amendment protection [extended] only to conduct that is inherently expressive").

The Supreme Court first definitively extended constitutional protection to commercial speech in a case involving advertising by pharmacies. *See Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748 (1976).[8] In that case, the Court struck down a prohibition against prescription drug price advertising by licensed pharmacists. The state contended that the advertising ban was necessary to maintain professionalism – absent the ban, "aggressive price competition [would] result from unlimited advertising," forcing pharmacists to sacrifice quality of care. *Id.* at 767-68. The Court struck down the advertising ban because the State sought to accomplish its goals – maintaining professionalism among pharmacists – by suppressing "the free flow of prescription drug price information." *Id.* at 770 ("Virginia is free to require whatever professional standards it wishes of its pharmacists; it may subsidize them or protect them from competition in other ways. But it may not do so by keeping the public in ignorance of the entirely lawful terms that competing pharmacists are offering.") (citation omitted).

Similarly, in *44 Liquormart, Inc. v. Rhode Island*, 517 U.S. 484 (1996), the Supreme Court applied intermediate scrutiny and held invalid Rhode Island's

[8]The Supreme Court first indicated that commercial speech might be entitled to constitutional protection in *Bigelow v. Virginia*, 421 U.S. 809, 825-26 (1976).

statutory ban on price advertising for alcoholic beverages. The state's asserted goal was to promote temperance. *Id.* at 492. No justice questioned the state's substantial interest in reducing alcohol consumption, but eight of nine justices agreed that the statute raised constitutional questions because of the speech-suppressive means it chose to accomplish that end. *See id.* at 512 ("[T]he First Amendment directs that government may not suppress speech as easily as it may suppress conduct, and that speech restrictions cannot be treated as simply another means that the government may use to achieve its ends.") (Stevens, J., joined by Kennedy, Thomas, Ginsburg, JJ.); *id.* at 526 ("I would adhere to the doctrine adopted in *Virginia Bd. of Pharmacy* . . . that all attempts to dissuade legal choices by citizens by keeping them ignorant are impermissible") (Thomas, J., concurring); *id.* at 530 ("If the target is simply higher prices generally to discourage consumption, the regulation imposes too great, and unnecessary, a prohibition on speech in order to achieve it. The State has other methods at its disposal – methods that would more directly accomplish this stated goal without intruding on sellers' ability to provide truthful, nonmisleading information to customers.") (O'Connor, J., joined by Rehnquist, C.J., Souter and Breyer, JJ., concurring).

The core teaching of these cases is that the First Amendment requires review of governmental efforts to regulate conduct through restrictions on speech. But

rather than suppressing speech about conduct, San Francisco has regulated the underlying conduct directly. Nothing in the First Amendment prohibits it from doing so.

CONCLUSION

For the foregoing reasons, Philip Morris' challenge to San Francisco's ordinance is unlikely to succeed on the merits and the decision below denying a preliminary injunction should be affirmed.

DATED: March 24, 2009

Respectfully submitted,

LINDA LYE, Esq.
Altshuler Berzon LLP

By: */s/ Linda Lye*
Linda Lye

Attorneys for Amici Curiae

CERTIFICATE OF COMPLIANCE PURSUANT TO FEDERAL RULE OF APPELLATE PROCEDURE 32(a)(7)(c) AND NINTH CIRCUIT RULE 32-1

I certify that:

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(c) and Ninth Circuit Rule 32-1, the attached opening brief is proportionately spaced, has a typeface of 14 points or more, and contains 5,080 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

DATED: March 24, 2009

LINDA LYE, Esq.
Altshuler Berzon LLP

By: */s/ Linda Lye*
Linda Lye

Attorneys for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that on March 24, 2009, 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.

Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system. All participants in the case are registered CM/ECF users.

/s/Jean Perley
Jean Perley