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Case: 24-3108, 07/28/2025, DktEntry: 61.1

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

AZADEH KHATIBI, M.D., an individual; DO NO HARM, a Virginia nonprofit corporation, *Plaintiffs - Appellants*, v. RANDY HAWKINS, in his official capacity as President of the Medical Board of California; LAURIE ROSE LUBIANO, in her official capacity as Vice President of the Medical Board of California; REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California; MARINA O'CONNOR, in her official capacity as Chief of Licensing, Medical Board of California; RYAN BROOKS, in his official capacity as	No. 24-3108 D.C. No. 2:23-cv-06195-MRA-E OPINION

Secretary of the Medical Board of California, *Defendants - Appellees*.	

Appeal from the United States District Court for the Central District of California
Monica Ramirez Almadani, District Judge, Presiding

Argued and Submitted March 27, 2025
Pasadena, California

Filed July 25, 2025

Before: A. Wallace Tashima, Jacqueline H. Nguyen, and Salvador Mendoza, Jr., Circuit Judges.

Opinion by Judge Nguyen

* * * * *

OPINION

NGUYEN, Circuit Judge:

California's regulation of the medical profession dates back to the late 1800s when, following the Gold Rush, it suffered an epidemic of "cults and fads and a great deal of quackery." *See* Linda A. McCready & Billie Harris, FROM QUACKERY TO QUALITY ASSURANCE: THE FIR ST TWELVE DECADES OF THE MEDICAL BOARD OF CALIFORNIA 2-4 (MED. BD. CA. 1995). In response to this crisis, the State adopted the Medical Practice Act of 1876. *Id.* at 3. The Act created the Board of Medical Examiners, which sought to impose basic regulations on the practice of medicine. *Id.*

Today, the Medical Board of California, as the Board of Medical Examiners is now known, aims to

ensure "the continuing competence of licensed physicians and surgeons." CAL. BUS. & PROF. CODE § 2190.[1] It "adopt[s] and administer[s] standards for the continuing education of those licensees," obligating them to complete at least 50 hours of accredited continuing medical education ("CME") every two years. *Id.*; Cal. Code Regs. (CCR) tit. 16, § 1336(a). Not just any CME, however, qualifies for credit. Only classes that meet various state requirements are eligible. *See id.* at § 1337(b). For instance, CME courses must at least "increase the knowledge, skills, and professional performance that a physician and surgeon uses to provide care," address "cultural and linguistic competency in the practice of medicine," and include information about "the understanding of implicit bias." *See* §§ 2190.1(a), (b)(1), (d)(1).

This case challenges one of these CME requirements, namely section 2190.1(d)(1)'s mandate to include information about implicit bias. Plaintiffs Dr. Khatibi and Do No Harm (collectively, "Dr. Khatibi" or "Plaintiffs") claim that the implicit bias requirement violates the First Amendment.[2] The district court dismissed their suit. It held that CMEs eligible for credit constitute government speech and

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[1] All undesignated statutory references are to this code.

[2] Our opinion does not address the allegations of Dr. Marilyn Singleton, who was originally another plaintiff in this case. She passed away after the notice of appeal was filed, and we construe and grant Plaintiffs' notice as a motion to dismiss Dr. Singleton as a party in this appeal under Federal Rule Civil Procedure 25(a)(1)-(2). *See Bordallo v. Reyes*, 763 F.2d 1098, 1101 (9th Cir. 1985) (construing "whether a motion, however styled, is appropriate for the relief requested").

are therefore "'not subject to scrutiny under the Free Speech Clause.'" *See Khatibi v. Hawkins*, No. 2:23-cv-06195, 2024 U.S. Dist. LEXIS 81485, *9 (C.D. Cal. May 2, 2024) (*Khatibi II*) (quoting *Pleasant Grove City v. Summum*, 555 U.S. 460, 464 (2009); *see also Shurtleff v. City of Boston*, 596 U.S. 243, 247-48 (2022) ("[W]hen the government speaks for itself, the First Amendment does not demand airtime for all views. After all, the government must be able to promote a program . . . in order to function."). Plaintiffs appealed. We affirm.

"[W]hether the government intends to speak for itself" is determined by a "holistic inquiry" that considers "the history of the expression at issue; the public's likely perception as to who (the government or a private person) is speaking; and the extent to which the government has actively shaped or controlled the expression." *Shurtleff*, 596 U.S. at 252. On balance, these factors weigh in favor of California. We therefore hold that under the State's scheme, CMEs eligible for credit by the Medical Board of California are government speech.

Our holding is narrow. It recognizes that when California—from beginning to end—dictates, controls, and approves the provider, form, purpose, and content of CMEs, it is in fact the State that "speaks" or expresses its views. California does so consistent with its tradition, "from time immemorial," of protecting its populace from the "consequences of ignorance and incapacity" in medicine, a profession "upon which health and life depend" and requires the most careful preparation—propositions that have been "too well settled to require discussion." *See Dent v. West*

Virginia, 129 U.S. 114, 122 (1889); *Watson v. Maryland*, 218 U.S. 173, 176 (1910).

I.

California law sets forth various CME requirements "to ensure the continuing competence of licensed physicians and surgeons." § 2190. CMEs must "(1) have a scientific or clinical content with a direct bearing on the quality or cost-effective provision of patient care, community or public health, or preventive medicine, (2) concern quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine, (3) concern bioethics or professional ethics, (4) are designed to improve the physician-patient relationship and quality of physician-patient communication," or otherwise "serve to maintain, develop, or increase the knowledge, skills, and professional performance that a physician and surgeon uses to provide care, or to improve the quality of care provided to patients." *Id.* § 2190.1(a) (cleaned up).

The State charges its Medical Board to "adopt and administer standards for the continuing education of those licensees." *Id.* § 2190. The Board, in turn, requires that all licensed physicians complete at least 50 hours of approved CME every two years. CCR tit. 16, § 1336(a). Only programs the Board deems "acceptable" are approved for CME credit. *Id.* §§ 1337(b), 1300.4(e). Courses are "acceptable" if they meet the express criteria of section 2190.1 and accompanying regulations. *See id.* § 1337.5. "The content of the course or program shall be directly related to patient care, community health or public health, preventive medicine, quality assurance or

improvement, risk management, health facility standards, the legal aspects of clinical medicine, bioethics, professional ethics, or improvement of the physician-patient relationship." *Id.*§ 1337.5(a)(3); *see also id.* § 1337.5(a)(1)-(7) (imposing requirements on faculty, course rationale and content, methodology of instruction, evaluation, and attendance). Certain programs by the California Medical Association, American Medical Association, and American Academy of Family Physicians are preapproved for CME credit. *Id.* § 1337(a)-(b). The Board does "not give prior approval to individual courses or programs; however, the division will randomly audit courses or programs submitted for credit in addition to any course or program for which a complaint is received." *Id.* § 1337.5(b). In addition, no credit is awarded for "any course deemed unacceptable by the division after an audit." *Id.* § 1337.5(c).

In 2019, the Legislature enacted Assembly Bill (A.B.) 241. A.B. 241 amended section 2190.1 to require that "all continuing medical education courses . . . contain curriculum that includes the understanding of implicit bias." *See* § 2190.1(d)(1). Under A.B. 241, CMEs approved for credit must contain "(1) Examples of how implicit bias affects perceptions and treatment decisions of physicians and surgeons, leading to disparities in health outcomes" or "(2) Strategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics." *Id.* at § 2190.1(e). CMEs by out-of-state providers or "dedicated solely to

research or other issues that does not include a direct patient care component" are exempt from the requirement. *Id.* at § 2190.1(d)(2). A.B. 241 supplements section 2190.1(b)(1)'s separate cultural and linguistic competence requirement, which the Legislature enacted in 2005. *See* 2005 Cal. Stat. ch. 514 § 2; *see also* § 2190.1(c)(1)-(3) (mandating all CMEs to incorporate content such as about the use of proper names and pronouns in therapeutic relationships and application of "culturally, ethnically, and sociologically inclusive data to the process of clinical care").

The Legislature passed A.B. 241 because it had found that implicit bias, "meaning the attitudes or internalized stereotypes that affect our perceptions, actions, and decisions in an unconscious manner, exists, and often contributes to unequal treatment of people based on race, ethnicity, gender identity, sexual orientation, age, disability, and other characteristics." 2019 Cal. Stat. ch. 417 § 1(a). "Implicit bias," in the Legislature's view, "contributes to health disparities by affecting the behavior of physicians and surgeons, nurses, physician assistants, and other healing arts licensees." *Id.* § 1(b); *see also id.* § 1(c)-(e) (citing "remarkably consistent" evidence of disparities based on race, ethnicity, gender, and sexual orientation, "even after adjusting for" other factors).

Plaintiffs disagree. Dr. Khatibi is a California-licensed physician and Board-certified ophthalmologist. She is a frequent organizer and instructor of CMEs, and her past courses have been approved by state-authorized providers. Her courses have also complied with all state requirements apart

from the implicit bias one. Do No Harm is a Virginia-based nonprofit comprised of healthcare professionals and policymakers. It has at least one member who teaches CMEs in California who believes implicit bias trainings "risk infecting healthcare decisions."

Contesting the efficacy of any training on the matter[3] and alleging that the implicit bias requirement violates free speech rights, Plaintiffs sued the Medical Board of California. The district court dismissed the operative First Amended Complaint, holding that "CME courses in California constitutes government speech." *Khatibi II*, 2024 U.S. Dist. LEXIS 81485, at *23. The district court noted that Plaintiffs may "choose to no longer instruct CME courses for credit, as is their right, or err their grievances at the ballot box because 'it is the democratic electoral process that first and foremost provides a check on government speech.'" *Id*. at *25 (quoting *Walker v. Texas Div., Sons of Confederate*

[3] Plaintiffs also appear to doubt the existence of implicit bias in medicine generally; they allege that section 2190.1(d)(1) "is unlikely to address the problem of implicit bias in healthcare, *if any*." (emphasis added). Meanwhile, the Board explains that the requirement is essential to the practice of medicine, as deemed by the Legislature, and is "closely related" to that purpose. Some amici echo the Board's points, contending that "[v]irtually every major organization focused on the science of medicine has recognized the existence and impact of implicit bias in the medical sphere" and that its existence is not "subject to reasonable dispute." Still, other amici agree with Plaintiffs and find implicit bias controversial, even divisive.

Like the district court, we express no view on the issue, which is immaterial to whether CMEs are government speech. *See also Khatibi v. Hawkins*, No. 2:23-cv-06195, 2023 U.S. Dist. LEXIS 221328, at *4, n.1 (C.D. Cal. Dec. 11, 2023).

Veterans, Inc., 576 U.S. 200, 207 (2015)). Plaintiffs timely appealed.

II.

"We review de novo a district court order granting a motion to dismiss for failure to state a claim." *Olson v. California*, 104 F.4th 66, 76 (9th Cir. 2024) (en banc). "To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (cleaned up). This is "a context-specific task that requires the reviewing court to draw on its judicial experience and common sense." *Id.* at 679.

A.

"The Free Speech Clause restricts government regulation of private speech; it does not regulate government speech." *Summum*, 555 U.S. at 467-68 (collecting cases); *accord Shurtleff*, 596 U.S. at 251. "A government entity has the right to speak for itself . . . and to select the views that it wants to express." *Summum*, 555 U.S. at 467-68 (cleaned up). "Indeed, it is not easy to imagine how government could function if it lacked this freedom." *Id.* at 468. After all, "[w]hen the government . . . formulate[s] policies" or "implement[s] programs, it naturally chooses what to say and what not to say." *Shurtleff*, 596 U.S. at 251; *see also Summum*, 555 U.S. at 468 ("'It is the very business of government to favor and disfavor points of view.'" (quoting *Nat'l Endowment for Arts v. Finley*, 524 U.S. 569, 598 (1998) (Scalia, J., concurring in judgment))).

"A government entity may exercise this same freedom to express its views when it receives assistance from private sources for the purpose of

delivering a government-controlled message." *Summum*, 555 U.S. at 468. "This does not mean that there are no restraints on government speech. For example, government speech must comport with the Establishment Clause. The involvement of public officials in advocacy may be limited by law, regulation, or practice. And of course, a government entity is ultimately accountable to the electorate and the political process for its advocacy. If the citizenry objects, newly elected officials later could espouse some different or contrary position." *Id.* at 468-69 (cleaned up). Additionally, "while the government-speech doctrine is important—indeed, essential—it is a doctrine that is susceptible to dangerous misuse. If private speech could be passed off as government speech by simply affixing a government seal of approval, government could silence or muffle the expression of disfavored viewpoints. For this reason, we must exercise great caution before extending our government-speech precedents." *Matal v. Tam*, 582 U.S. 218, 235 (2017).

B.

The "boundary between government speech and private expression can blur when, as here, a government invites the people to participate in a program." *Shurtleff*, 596 U.S. at 252; *see also Summum*, 555 U.S. at 470. "In those situations, when does government-public engagement transmit the government's own message? And when does it instead create a forum for the expression of private speakers' views? In answering these questions, we conduct a holistic inquiry designed to determine whether the government intends to speak for itself or to regulate

private expression."[4] *Shurtleff*, 596 U.S. at 252. Among the factors to consider in this analysis are "the history of the expression at issue; the public's likely perception as to who (the government or a private person) is speaking; and the extent to which the government has actively shaped or controlled the expression." *Id.* (collecting cases).

Take, for example, *Johanns v. Livestock Marketing Association*, 544 U.S. 550, 560 (2005), which upheld the mandatory funding of beef commercials by private cattle merchants. The Supreme Court held that the commercials in question were government speech, not compelled private speech, because the government "effectively controlled" their message. *Id.* This was so, the Supreme Court reasoned, because "the message set out in the beef promotions is from beginning to end the message established by the Federal Government." *Id.* at 560-61. "Thus, Congress and the Secretary have set out the overarching message and some of its elements, and they have left the development of the remaining details to an entity whose members are answerable to the Secretary." *Id.* at 561.

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[4] The government speech analysis thus sometimes interfaces with the public forum doctrine. *See, e.g.*, *Shurtleff*, 596 U.S. at 248-55 (noting that City Hall was a "public forum"); *Walker*, 576 U.S. at 214 (considering how "license plates are not a traditional public forum for private speech"). *See also* Cong. Rsch. Serv., *Government Speech and Government as Speaker*, CONSTITUTION ANNOTATED. Critical to the public forum doctrine is that "[t]he government does not create a public forum by inaction or by permitting limited discourse, but only by intentionally opening a nontraditional forum for public discourse." *See Cornelius v. NAACP Legal Def. & Educ. Fund*, 473 U.S. 788, 802 (1985) (citing *Perry Educ. Ass'n v. Perry Local Educators' Ass'n*, 460 U.S. 37, 46 (1983)).

Similarly, in *Summum*, the Supreme Court held that monuments in public parks, even those financed or donated by private parties, constituted government speech because the government has always exercised control and "final approval authority" over the selection of which monuments to place in a park. 555 U.S. at 472-73. The Court emphasized how governments "have long used monuments to speak to the public," in fact "[s]ince ancient times." *Id.* at 470. And in *Walker*, the Court applied *Summum* to specialty license plates in Texas and held that they, too, were government speech. *Walker*, 576 U.S. at 209-10. According to the Court, states, including Texas, have historically used plates for messaging, the public identifies them with the state, and Texas maintains "direct control" over their content. *Id.* at 210-13. It did not matter much that "private parties take part in the design" of the specialty plates or that they convey countless messages. *See id.* at 217 ("Texas's desire to communicate numerous messages does not mean that the messages conveyed are not Texas's own."); *id.* (stressing that the "holding in *Summum* was not dependent on the precise number of monuments found within the park"); *see also id.* at 221 (Alito, J., dissenting) (noting over 350 specialty plates with distinct messages ranging from sports teams to religious organizations).

In contrast, in *Matal*, the Supreme Court held that trademarks were private and not government speech. 582 U.S. at 239. The Patent and Trademark Office ("PTO") had rejected Tam's trademark application related to his band, "THE SLANTS," which was intended to "reclaim" a "derogatory term for persons of Asian descent." *Id.* at 223, 228. The Court held that

the state's rejection constituted viewpoint discrimination, not government speech because trademarks "have not traditionally been used to convey a Government message;" the government "does not dream up," edit, or meaningfully review trademarks; and the public does not associate trademarks with the government. *Id.* at 223, 235-38. The Court also noted how the PTO "made it clear that registration does not constitute approval of a mark." *Id*. at 237. *Matal* thus distinguished trademarks from the license plates in *Walker*, stating that *Walker* "likely marks the outer bounds of the government-speech doctrine." *Matal*, 582 U.S. at 238.

The Supreme Court likewise weighed the same factors to find private speech in *Shurtleff*. Boston had allowed private groups to raise flags outside its City Hall without denial or any control of flags' contents—that is, until 2017, when it rejected a group's "Christian flag." *Shurtleff*, 596 U.S. at 248. Like the PTO's rejection of the trademark in *Matal*, Boston's rejection of the flag constituted viewpoint-based discrimination. *Id.* Acknowledging that while the history of flying flags *generally* weighed toward finding government speech, the Court found that the history of Boston's *specific* flag-flying program was ambiguous, just like the public perception of who speaks through the city's flagpole. *Id.* at 254-55. While Boston did fly its own flags outside City Hall, it had also allowed private groups to use the flagpole without reviewing or controlling those groups' flags. *Id.* The key issue was therefore government control. And because Boston never regulated any other flag's contents, the Court ruled that flag-flying outside the City Hall constituted private speech. Boston's control

over the physical premises or over flag-raisings' schedule was insufficient. *Id.* at 256. Boston "could easily have done more to make clear it wished to speak for itself by raising flags," the Court observed, and it simply did not. *Id.* at 257-58.

Accordingly, while "[t]here may be situations in which it is difficult to tell whether a government entity is speaking on its own behalf or is providing a forum for private speech," *see Summum*, 555 U.S. at 470, the Supreme Court is clear that the test to determine government speech is a "holistic" one. *Shurtleff*, 596 U.S. at 252. The "review is not mechanical; it is driven by a case's context rather than the rote application of rigid factors." *Id.* Factors that are typically considered are the history of expression at issue, the perception of who is speaking, and the extent of governmental control over the expression. *Id.* If these factors show that the government is "engaging in [its] own expressive conduct, then the Free Speech Clause has no application." *Summum*, 555 U.S. at 467-68 (collecting cases).

III.

Applying these principles with "great caution," *see Matal*, 582 U.S. at 235, we consider whether, under circumstances specific to California, CMEs eligible for Board credit constitute government speech. We hold that the *Shurtleff* factors of history, public perception, and control weigh in favor of concluding that they are.

A.

"The health professions differ from other licensed professions because they *treat* other humans, and their treatment can result in physical and psychological harm to their patients. This is why there is a historical tradition of states restricting the

medical practices health care providers can use, while not, for instance . . . preventing [lawyers] from discussing legal tax avoidance techniques." *See Tingley v. Ferguson*, 47 F.4th 1055, 1083 (9th Cir. 2022) (emphasis in original) (cleaned up). Indeed, "it has been the practice of different States, *from time immemorial*, to exact in" the medical profession "a certain degree of skill and learning upon which the community may confidently rely." *Dent*, 129 U.S. at 122 (emphasis added); *see also Hawker v. New York*, 170 U.S. 189, 192-93 (1898) (upholding this authority as a "clear . . . proper exercise" of a state's police powers). So rooted in tradition is this practice that the Supreme Court deemed it—in 1910—"too well settled to require discussion." *Watson*, 218 U.S. at 176.

California, for its part, "has long regulated the practice of medicine as an exercise of the police power." *Arnett v. Dal Cielo*, 923 P.2d 1, 2 (Cal. 1996) (recapping the history of the Board and the Medical Practice Act of 1876). California's Medical Board has generally been "charged with the duty to protect the public against incompetent, impaired, or negligent physicians" since the 1870s. *See id*; *Ex parte Gerino,* 77 P. 166, 168-69 (Cal. 1904) (upholding the Board's primordial requirements for practicing medicine). And the Board has specifically and continually "adopt[ed] and administer[ed]" CME requirements since 1980. *See, e.g.*, § 2190; 1980 Cal. Stat. ch. 1313 § 2 (ordering the Board to establish CME requirements); 2011 Cal. Stat. ch. 236 § 2 (authorizing the Board to set standards for CMEs related to chronic diseases and lifestyle behaviors); CCR tit. 16, § 1337.5 (1990) (outlining standards); *id.* (2025) (same). The Legislature, too, has conceived of its own content

requirements since 1992, requiring that all credit-eligible CMEs at least (1) focus on "scientific or clinical content" tied to patient care, cost-effectiveness, public health, or preventative medicine; (2) address quality assurance, risk management, facility standards, or legal aspects of clinical practice; (3) relate to bioethics or professional ethics; or (4) improve physician-patient relationship. *See* § 2190.1; 1992 Cal. Stat. ch. 331 § 1.

The Legislature has since continued to expand CME requirements. *Compare Walker*, 576 U.S. at 211-12 (considering Texas's authorization of various plates' messages over the past several decades). Beginning 2001, for example, the Legislature has ordered all physicians to complete CMEs in pain management and the treatment of the terminally ill, *see* §§ 2190.5-2190.6; 2001 Cal. Stat. ch. 518. It has also required all general internists and family physicians who treat a specific percentage of elderly patients to complete training in geriatric medicine around the same time. *See* § 2190.3; 2000 Cal Stat. ch. 440. All CMEs, since 2006, must also address cultural and linguistic competence to be eligible for credit. *See* § 2190.1(b)(1); 2005 Cal Stat. ch. 514.

Conversely, the Legislature has excluded certain CMEs from credit from 1992 to 2021. During that time, licensees could not earn credit for CMEs on medical office management, billing, coding, and marketing, though the Legislature now permits up to 30 percent of credit for these topics. *See* § 2190.15(i); 2021 Cal. Stat. ch. 612. Accordingly, California has not only long designated which CME courses qualify for credit, but also which courses do not.

The first factor of history therefore weighs decisively in favor of the State. There is no question that California has actively regulated the medical profession since the late nineteenth century, and the Board, in one way or another, has imposed qualifications on the practice of medicine ever since. It has also specifically adopted, updated, and enforced CME standards for almost half a century. Dr. Khatibi makes no particularized allegation to the contrary. She instead advances several arguments that either misunderstand the nature of the government speech inquiry or raise false alarms. None is availing.

Dr. Khatibi insists that CMEs have never been used to convey messages to the public. "At most," she argues, the CME scheme merely "shows that the government is communicating the importance of certain subjects to medical professionals," not the public. Dr. Khatibi also likens California with the PTO in *Matal*; both, in her view, have no history of "'dream[ing] up'" content for the speech at issue. *See* 582 U.S. at 235–39. Lastly, she says that looking to the lengthy regulatory history is "myopic" and improper because "the results would be sweeping" and susceptible to "'dangerous misuse.'" *See id.* at 235.

Dr. Khatibi's concerns are misplaced. It would be a serious affront to the Constitution if regulatory history alone were sufficient to immunize speech from First Amendment scrutiny. However, as the Supreme Court explained, history is but one factor in the context-driven, "holistic inquiry designed to determine whether the government intends to speak for itself." *See Shurtleff*, 596 U.S. at 252; *Summum*, 555 U.S. at 484 (Breyer, J., concurring) ("[T]he 'government speech' doctrine is a rule of thumb, not a

rigid category"). Indeed, it is precisely this "holistic inquiry" that serves as a bulwark against abuse. It is also why Dr. Khatibi's arguments fail. Just as we cannot equate something to monuments and conclude it is government speech, we cannot simply deem CMEs distinct from monuments and license plates, conclude they are nontraditional forms for government expression, and then terminate the inquiry. To do so would begin and end the analysis at the mere "starting point." *See Shurtleff*, 596 U.S. at 255.

It bears repeating that our analysis "is driven by a case's context rather than the rote application of rigid factors." *Id.* at 252. And the historical context of the implicit bias and other CME requirements *is* California's longstanding tradition of regulating the medical profession since the 1870s. *See, e.g.*, *Arnett*, 923 P.2d at 2-3. California created the Board to combat the problem of quack doctors in the decades following the Gold Rush. *See Gerino*, 77 P. at 167; FROM QUACKERY TO QUALITY ASSURANCE 2-4. The Board imposed basic qualifications on the practice of medicine since, and consistent with that history, eventually implemented and enforced the CME scheme in place for the past several decades. *See, e.g.*, *Gerino*, 77 P. at 167; 1980 Cal. Stat. ch. 1313 § 2. If *Shurtleff*'s historical analysis examined flags' contents, materials, symbolism, location, and how frequently they were raised (including those of *England's* Windsor Castle), *see* 596 U.S. at 254, then looking to *California's history* of regulating the medical profession is not, as Dr. Khatibi contends, "myopic." Rather, it is the crystal-clear consideration compelled by the "holistic inquiry designed to

determine whether the government intends to speak for itself." *See id*. at 252; compare Summum, 555 U.S. at 470-72 (broadly considering the histories of various public parks and monuments, including pyramids).[5]

Moreover, Dr. Khatibi's claim that the CME requirements do not express the State's views rests on a fundamental misunderstanding of how government works. "'When a government entity embarks on a course of action, it necessarily takes a particular viewpoint and rejects others.'" *See Nat'l Rifle Ass'n of Am. v. Vullo*, 602 U.S. 175, 187 (2024) (quoting *Matal*, 582 U.S. at 234); *see also Walker*, 576 U.S. at 207–08 (exemplifying how a public vaccination program necessarily promotes vaccines while discouraging opposing perspectives). This is precisely why the government speech doctrine exists. For without it, government would cease to function. *See Summum*, 555 U.S. at 468; *accord Shurtleff*, 596 U.S. at 251. *See also Walker*, 576 U.S. at 207 ("How could a city government create a successful recycling program if officials . . . had to include . . . a long plea from the local trash disposal enterprise demanding the contrary?").

In other words, California's CME requirements necessarily reflect, as Dr. Khatibi effectively concedes, "the importance of certain subjects to medical

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[5] Not all states share California's history or requirements. Colorado, for example, only began imposing CME requirements in 2024. *See* COLO. REV. STAT. § 12-240-130.5 (2024). It had expressly barred them until 2023. *See* COLO. REV. STAT. ANN. § 12-240-130(3) (2023). Montana and South Dakota, meanwhile, impose no CME requirements on physician-licensees. *See* MONT. CODE ANN. § 37-1-141 (2023); S.D. CODIFIED LAWS § 36-4-24.1 (2025).

professionals." The same holds true for California's lengthy history of regulation. That history reflects the State's evolving judgment of what subjects it has deemed essential to "ensure the continuing competence of licensed physicians and surgeons," of which implicit bias is one.[6] §§ 2190, 2190.1(d)(1).

Dr. Khatibi's assertion that there is no history of California "dreaming up" content for CMEs therefore has no footing in law or logic. As discussed, the Legislature has specified CME content requirements—i.e., what it believes are vital for the continued competence of licensees—for decades. *See, e.g.*, 1992 Cal. Stat. ch 331 § 1 (requiring, for example, that CMEs "[c]oncern bioethics"); 2005 Cal. Stat. ch. 514 § 2 (requiring all CMEs to address cultural and linguistic competence). And the Board itself has long set requirements for CME faculty qualifications, course rationale, course content, course methodology, and even what must be on evaluation forms. *See, e.g.*, CCR tit. 16, § 1337.5 (1990); *id.* (2002); *id.* (2025).

California thus sharply differs from the PTO in *Matal*. The PTO has no comparable history of telling companies like Sony to pick "'make.believe'" as its

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[6] Implicit bias certainly appears important to California beyond the CME context. *See, e.g.*, 2020 Cal. Stats. ch. 317 § 2 (criticizing "[c]urrent law, as interpreted by courts" that tolerates "negative implicit biases" in criminal proceedings and creating the Racial Justice Act); CAL. HEALTH & SAF. CODE §§ 123630.1-123630.3 (identifying implicit bias as a driver of "health disparities in communities of color" and requiring perinatal hospitals to "implement evidence-based implicit bias programs). Regardless of its merit, the implicit bias CME requirement thus aligns with California's other priorities and judgment—shaped by its electorate's "informed opinion." *See Walker*, 576 U.S. at 207.

slogan from a list of qualified slogans. *See Matal*, 582 U.S. at 235-37. Nor has it ever commanded Apple how to, or who in its team could, come up with "'Think different.'" *Id.* The PTO has also not ordered the noble patrons of Burger King to rate its motto of "'Have it your way.'" *Id.* Also, unlike the PTO, which long "made it clear that [trademark] registration does not constitute approval of a mark," *id.* at 237, the Board has never disclaimed approval of accredited CMEs. To the contrary, approved CMEs, like the grant or renewal of a medical license, has always reflected the Board's judgment of "the requisite skills and qualifications necessary to provide safe and effective services to the public"—something Dr. Khatibi does not contest.[7] *Rich Vision Ctrs. v. Bd. of Med. Exam'rs*, 192 Cal. Rptr. 455, 457 (Ct. App. 1983); *Shea v. Bd. of*

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[7] Dr. Khatibi's clarifies that her qualm with the implicit bias requirement is not "the subject matter mandated by the state in its regulatory capacity." Rather, it is that she is "being compelled to include irrelevant, controversial, and unhelpful speech" in the courses she teaches in her own "personal expressive capacity." But that puts the cart before the horse. Such reasoning short-circuits the government speech inquiry and assumes that CMEs are private speech from the get-go. Indeed, as counsel for Dr. Khatibi clarified and emphasized at oral argument, the "thorny issues" of compelled speech and viewpoint discrimination are actually "not before this court."

Setting aside that Dr. Khatibi is free to teach whatever she wishes in her own "expressive capacity," implicit bias *is* a "subject matter mandated by the state in its regulatory capacity." It is just like cultural competence or geriatric care topics the Legislature has required and content mandates with which Dr. Khatibi has admittedly complied. *See* §§ 2190.3, 2190.1(c)(1). As the Board explains, Dr. Khatibi's disagreement "with the particular subject of implicit bias does not change the nature of the expression."

Med. Exam'rs, 146 Cal. Rptr. 653, 659-60 (Ct. App. 1978). History thus squarely weighs in favor of finding government speech in this case.

B.

"Next, then, we consider whether the public would tend to view the speech at issue as the government's." *Shurtleff*, 596 U.S. at 255. Unlike history, this factor presents a much closer call. Dr. Khatibi alleges that "attendees treat her as the person responsible for the content discussed." She is the sole organizer of her CMEs. Attendees often ask her questions during and after class; they even debate with her. They evaluate her as well, giving written feedback "about the effectiveness of the course and whether the course instructor possessed any bias." Section 2190.1(e)'s requirement that instructors provide examples or strategies relating to implicit bias, as Dr. Khatibi claims, could also lead attendees to further attribute CME content to her and not the State.

On the other hand, the Board asserts that the entire CME scheme exists for licensed medical professionals, not the public. It is apparent that licensees know that their profession is heavily regulated since they must comply with myriad requirements, including various CME mandates, to maintain their licenses. Dr. Khatibi's own allegation that "'physicians are unlikely to take' CMEs if they are not eligible for credit" bolsters this conclusion. All this, in the Board's view, means that licensees perceive CMEs' content as coming from the State.

Dr. Khatibi counters that "just because individuals understand that a CME course meets state requirements" does not mean that they perceive the CME as coming from the State. To so conclude, she

cautions, risks equating accreditation or a mere "government seal of approval" with government speech, something deemed insufficient in *Matal*. Dr. Khatibi also details how CMEs can meet requirements "so long as an individual course is first approved by certain *private* organizations," and how CMEs are "largely unsupervised by the government except for the broad standards and a few mandated inclusions."

Both sides' arguments have some merit. Though some of Dr. Khatibi's allegations border on conclusory, she has plausibly alleged facts suggesting that attendees treat her as the person responsible for CME content. She is also correct that the State certainly expects, if not relies, on the participation of private parties in executing the CME scheme. *See, e.g.*, CCR tit. 16, § 1337.5(a). At the same time, however, "the fact that private parties take part in the design and propagation of a message does not extinguish the governmental nature of the message." *Walker*, 276 U.S. at 217; *see Johanns*, 544 U.S. at 562. And private parties' involvement alone, contrary to her contention, does not resolve the government speech inquiry. Otherwise, *Shurtleff*'s holistic inquiry would be a futile exercise, not a vital mode of analysis designed to clarify the very "boundary between government speech and private expression [that] can blur." 596 U.S. at 252. Moreover, "[t]hat Plaintiffs are evaluated and asked questions by course attendees—like most educators—and must come up with 'examples' and 'strategies' related to implicit bias—a pedagogical technique applicable to virtually any educational topic—does not alter the reasonable inference that CME curriculum itself, when approved for credit, is

'conveying some message on the government's behalf.'" *Khatibi II*, 2024 U.S. Dist. LEXIS 81485, at *18 (citation omitted).

It also does not seem unreasonable to infer that licensees perceive the content of accredited CMEs as coming from the State based on Dr. Khatibi's own allegations. If physicians are cognizant that their profession is heavily regulated (in light of Dr. Khatibi's recognition of the multifaceted legal and regulatory scheme in place); that they attend CMEs, primarily to secure credits to maintain their licenses (given Dr. Khatibi's allegation that licensees will not attend her courses if they do not comply with state requirements); that the Board requires licensees to take certain classes with specific content (like about implicit bias); and only compliant CMEs get credit (the very concern of Dr. Khatibi's lawsuit), then "common sense" commands that licensees could attribute approved CMEs' content to California. *See Iqbal*, 556 U.S. at 679 ("Determining whether a complaint states a plausible claim for relief . . . requires . . . judicial experience and common sense.").

The Board's argument that the entire CME scheme was created for licensees also has considerable force. As we explained in the historical analysis, California created the CME scheme "to ensure the continuing competence of licensed physicians and surgeons." § 2190. This is far from an effort to "intentionally open[] a nontraditional forum for public discourse." *Cornelius*, 473 U.S. at 802. It is also a far cry from *Shurtleff*, for example, where Boston generously offered its flagpole "to the public for events" and "accommodate[d] all applicants seeking to take

advantage." *See* 596 U.S. at 249.[8] Nor does the participation of private parties change the analysis. "[P]ermitting limited discourse," much like "inaction," is insufficient to create a public forum. *Cornelius*, 473 U.S. at 802.

Considering the above, we conclude that, on balance, this factor tilts in California's favor.[9]

C.

We next consider "the extent to which the government has actively shaped or controlled the expression," which is fundamental to the government speech inquiry. *Shurtleff*, 596 U.S. at 252. Alongside history, California's extraordinary control over accredited CMEs is the "most salient feature of this case." *Id.* at 256. Contrary to Dr. Khatibi's claims, California not only shapes the content of CMEs, but it also imposes several restrictions on their form and

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[8] That only CMEs on qualifying topics and by approved providers can receive credit is also evidence that they are not a *traditional* public forum. *See Summum*, 555 U.S. at 478 ("The forum doctrine has been applied in situations in which . . . government program was capable of accommodating a large number of public speakers without defeating the essential function of the . . . program."). "The obvious truth of the matter is that if [CMEs] were considered to be traditional public forums," then California would have to accommodate and accredit any CME taught by anyone. *Id.* at 480. This would deprive California of the ability to select which courses are necessary to ensure licensees' competence, effectively "defeating the essential function of the . . . program." *Id.* at 478.

[9] Even assuming that the public perception factor favors Dr. Khatibi, our ultimate conclusion would remain the same. Consideration of the remaining factors of history and extent of state control decisively resolves the holistic government speech inquiry in favor of California.

delivery. In short, it controls accredited CMEs "from beginning to end." *See Johanns*, 544 U.S. at 560-61.

We begin with the State's multifaceted CME statutory and regulatory scheme. *See Delano Farms Co. v. Cal. Table Grape Comm'n*, 586 F.3d 1219, 1230 (9th Cir. 2009) ("Our focus in this case . . . is the statutorily-authorized control the State has . . . and not the actual level of control evidenced in the record." (citing *Paramount Land Co. Ltd. P'ship v. Cal. Pistachio Comm'n*, 491 F.3d 1003, 1011 (9th Cir. 2007))). As discussed, section 2190 orders the Board to set and enforce CME requirements on licensees. It also authorizes the Board to "set content standards for any educational activity concerning a chronic disease that includes appropriate information on prevention of the chronic disease, and on treatment of patients with the chronic disease, by the application of changes in nutrition and lifestyle behavior." *Id.* Section 2191, meanwhile, orders the Board to consider a plethora of subjects for accredited CMEs. These include, for instance, "human sexuality, defined as the study of a human being as a sexual being and how they function with respect thereto, and nutrition to be taken by those licensees whose practices may require knowledge in those areas;" child and elder abuse; "signs exhibited by abused women" in health settings; "special care needs of drug-addicted infants;" and "psychosocial dynamics of death." *See id.* § 2191(a)-(i). Other statutory provisions order the consideration of additional topics ranging from HIV prevention, mental health and trauma in children to chronic diseases, spousal abuse, and COVID-19. *See generally id.* §§ 2191.4-2191.6.

Section 2190.1(a), meanwhile, requires that all credit-eligible CMEs must "(1) have a scientific or clinical content with a direct bearing on the quality or cost-effective provision of patient care, community or public health, or preventive medicine, (2) concern quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine, (3) concern bioethics or professional ethics, (4) are designed to improve the physician-patient relationship and quality of physician-patient communication," or otherwise "serve to maintain, develop, or increase the knowledge, skills, and professional performance that a physician and surgeon uses to provide care, or to improve the quality of care provided to patients." *See* § 2190.1(a) (cleaned up); CCR tit. 16, § 1337.5(a)(3) (imposing similar content requirements).

All accredited CMEs must also address cultural and linguistic competence. Section 2190.1(c) meticulously lists topics that CMEs "shall address at least one or a combination of:"

> (A) Applying linguistic skills to communicate effectively with the target population.
>
> (B) Utilizing cultural information to establish therapeutic relationships.
>
> (C) Eliciting and incorporating pertinent cultural data in diagnosis and treatment.
>
> (D)(i) Understanding and applying culturally, ethnically, and sociologically inclusive data to the process of clinical care, including, as appropriate, information and evidence-based cultural competency training pertinent to the treatment of, and provision of care to, individuals who identify as lesbian, gay,

bisexual, transgender, queer or questioning, asexual, intersex, or gender diverse. This includes processes specific to those seeking gender-affirming care services.

(D)(ii) An evidence-based cultural competency training implemented pursuant to clause (i) may include all of the following:

(I) Information about the effects, including, but not limited to, ongoing personal effects of historical and contemporary exclusion and oppression of transgender, gender diverse, or intersex (TGI) communities.

(II) Information about communicating more effectively across gender identities, including TGI-inclusive terminology, using people's correct names and pronouns, even when they are not reflected in records or legal documents, avoiding language, whether verbal or nonverbal, that demeans, ridicules, or condemns TGI individuals, and avoiding making assumptions about gender identity by using gender-neutral language and avoiding language that presumes all individuals are heterosexual, cisgender, or gender conforming, or nonintersex.

(III) Discussion on health inequities within the TGI community, including family and community acceptance.

(IV) Perspectives of diverse, local constituency groups and TGI-serving organizations including, but not limited to, the California Transgender Advisory Council.

(V) Recognition of the difference between personal values and professional

responsibilities with regard to serving TGI people.

(VI) Recommendations on administrative changes to make health care facilities more inclusive.

The Legislature has also designated geriatric care as a mandatory CME topic for specific licensees. § 2190.3. So, too, are CMEs for pain management, treatment of terminally ill patients, and drug dependency. *Id.* § 2190.5; *see also id.* § 2190.6 (providing alternative means of fulfilling § 2190.5's requirements). Conversely, the statutory scheme delineates which CMEs are exempt from requirements or accreditation. *See, e.g.*, *id.* § 2190.1(b)(2) (excluding CMEs "dedicated solely to research or other issues that does not include a direct patient care" and CMEs by out-of-state providers from cultural and linguistic competency requirements).

All these content-related requirements are in addition to the myriad other mandates imposed by the regulations. Section 1337.5(a)(1) of title 16 of the regulations require CME instructors to possess specific qualifications, such as "a faculty appointment . . . directly related to the practice of medicine" in an approved institution. The regulations dictate, too, that the "need for the course and how the need was determined shall be clearly stated and maintained on file;" that the content of the course address a list of specified topics; that each program "shall clearly state educational objectives that can be realistically accomplished within the framework of the course;" that the "teaching methods" be "described;" that each course shall include an evaluation; and that course

organizers "maintain a record of attendance of each participant." CCR tit. 16, § 1337.5(a)(2)-(5).

The regulations also provide that the "following programs are approved by the division for continuing education credit: (1) Programs which qualify for Category I credit from the California Medical Association or the American Medical Association; (2) Programs which qualify for prescribed credit from the American Academy of Family Physicians; (3) Programs offered by other organizations and institutions acceptable to the division." CCR tit. 16, § 1337(a). "Only those courses and other educational activities that meet the requirements of Section 2190.1 of the code which are offered by these organizations shall be acceptable for credit under this section." *Id.* § 1337(b); *id.* § 1337(c)-(f) (detailing other limitations related to CMEs provided by these private organizations).

Additionally, the Board exercises final approval authority over the entire CME scheme. The Board "shall audit during each year a random sample of physicians who have reported compliance with the continuing education requirement." CCR tit. 16, § 1338(a); *id.* § 1338(b)-(e) (detailing related auditing, recordkeeping, and disciplinary processes). "When reviewing a physician's documentation for completed continuing education," as Dr. Khatibi notes, "the Medical Board will randomly audit CME courses to determine whether the course is approved for credit." "[A]ny course deemed unacceptable by" the Board receives no credit. *Id.* § 1337.5(c). The Board "in its discretion" may also waive the CME requirements for various reasons, including undue hardship. *Id.* § 1339(a).

What we have catalogued—perhaps painstakingly—reveals that California has not only provided a "general description" of CMEs but also "detail[ed] the themes to be emphasized, the actors to be used, the demographics to be targeted, and the media to be employed." *Paramount Land*, 491 F.3d at 1011 (finding government speech). It has also provided the starting and endpoint for any CME provider. The State dictates who may teach the courses. CCR tit. 16, § 1337.5(a)(1); *id.* § 1337(a). It tells those qualified instructors to record their courses' purpose and teaching methodology as well as ensure that their courses address specific topics. *Id.* §§ 1337.5(a)(2)-(4). It also sets guidelines related to attendance and evaluation. *Id.* §§ 1337.5(a)(4)-(6). The Board may then audit, accredit, or reject the CME; it may also waive licensees' compliance obligations. *Id.* §§ 1337.5-1339. California therefore controls accredited CMEs "from beginning to end."[10] *See Johanns*, 544 U.S. at 560-61.

Dr. Khatibi resists this conclusion, but none of her arguments is persuasive. She first disputes California's control over the content of CMEs, emphasizing the role of private parties in the scheme. She also argues that unlike in *Summum*, where the

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[10] Just as not all states share California's longstanding history with CME regulation, *see supra* note 5, many also do not appear to exercise a comparable level of control over CMEs. *Compare* California's § 2190-2190.6; *id.* §§ 2191–2191.6; *id.* §§ 2196-2196.9; CCR tit. 16, §§ 1336-1339.5, *with* MD. CODE ANN., HEALTH OCC. § 15-307 (imposing no comparable specific content requirements); MD. CODE REGS. § 10.32.01.10 (2025) (same); IND. CODE ANN. § 25-22.5-3-1 (2025) (imposing no CME requirements on physician-licensees); MONT. CODE ANN. § 37-1-141 (2023) (same); S.D. CODIFIED LAWS § 36-4-24.1 (2025) (same).

city exercised "editorial control" of the monuments' messages, 555 U.S. at 472, and *Walker*, where Texas had "sole control" over license plates, 576 U.S. at 213, the Board's role of accreditation is one of "mere approval."

But as the Supreme Court explained, California's reliance on private organizations "does not extinguish the governmental nature of the message." *See Walker*, 276 U.S. at 202 (citing *Summum*, 555 U.S. at 470-471). California is free to "le[ave] the development of the remaining details to an entity . . . answerable to the" Board, which is precisely what it has done. *See Johanns*, 544 U.S at 561. The State has outlined the topics that CMEs must cover. *See, e.g.*, § 2190.1. It has set who may and how to teach them. *See, e.g.*, CCR tit. 16, § 1337.5. It has also designated specific private organizations to deliver accredited CMEs, provided that the courses meet specific criteria. *See, e.g.*, *id.* § 1337. And the Board may ultimately audit and reject any CME as unacceptable. *See id.* § 1337.5(c). As in *Johanns*, this is sufficient, "effective[] control[]." 544 U.S. at 560.

Relatedly, Dr. Khatibi's role as the "sole organizer" of a course does not mean that the State has exercised no control over content. To the contrary, Dr. Khatibi admits that her courses have complied with all CME requirements apart from the implicit bias one at issue in this case. Compliance presupposes a rule; without rules, there can be no compliance. Put another way, Dr. Khatibi has conceded that her CMEs *have* been shaped by California. They have aligned with the "overarching message" set by the State, even as California has "left the development of the remaining details" to her and other private parties. *See Johanns*,

544 U.S. at 561. Combined with the Board's auditing and ultimate approval authority, this *is* editorial control. *See id.* at 560–62.

For this reason, it is also of no moment that the Board normally accredits CMEs without an audit, *see* CCR tit. 16, § 1337.5(b), or that it has not yet chosen to audit Dr. Khatibi's courses. No one disputes that the Board may audit any course and deem it ineligible for credit. This, combined with the State's requirement that any accredited CME (which must be provided by specified, qualified providers) relate to at least a few, if broad, topics, *see, e.g.*, § 2190.1(a), means that California shapes or controls CMEs "from beginning to end." *See Johanns*, 544 U.S. at 560-61 (finding sufficient governmental control where content was "specified, *in general terms*" by Congress and where Secretary had "final approval authority" (emphasis added)).

Neither would California's "passivity" have precluded a finding of government speech here, in light of the relevant expansive history and statutory and regulatory regime. In *Paramount Land*, we applied *Johanns* and found government speech even where California "ha[d] not rejected or edited proposals, or taken a particularly active role." *See* 491 F.3d at 1011-12. What is "dispositive" is "the government's *ability* to control speech, even when it declined to do so." *See Ranchers Cattlemen Action Legal Fund United Stockgrowers of Am. v. Vilsack*, 6 F.4th 983, 990 (9th Cir. 2021) (emphasis in original) (citing *Paramount Land*, 491 F.3d at 1011-12).

Dr. Khatibi's remaining arguments fare no better. Her claim that the sheer volume of accredited CMEs dilutes California's control over them collapses under

Walker's wisdom. *Walker* made clear that the "desire to communicate numerous messages does not mean that the messages conveyed are not" the government's. 576 U.S. at 217; *see also id.* at 221-22 (Alito, J., dissenting) (noting that there are over 350 varieties of specialty plates). It is the state's right, *Walker* stressed, to convey "many more messages" if it wished. *Id.* at 217. Citing *Summum*, the Court declared that the government speech analysis was "not dependent on the precise number of" expression or messages at issue. *Id*. (citing 555 U.S. at 471-72).

Shurtleff reaffirmed this reasoning. There, the court clarified that it did "not settle [the] dispute by counting noses—or, rather, counting flags. That is so for several reasons," including the more salient importance of focusing on Boston's policies, which were unwritten, and whether Boston "wished to speak for itself by raising flags." *See* 596 U.S. at 256-57. The fact that there may be numerous accredited CMEs, therefore, "does not mean that the messages conveyed are not [the government]'s own." *Walker*, 576 U.S. at 217.

More to the point, Dr. Khatibi makes no allegation of noncompliance. She does not allege that any accredited CME has somehow deviated from the Board's "overarching message," *see Johanns*, 544 U.S. at 561, of what is necessary to "ensure the continuing competence of licensed physicians and surgeons," *see* § 2190. In fact, all the sample CMEs Dr. Khatibi references align with state-mandated topics.[11] She

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[11] *Compare* Opening Brief ("OB") 32 ("efficacy of endoscopic endonasal surgical navigation"), *with* § 2190.1(a)(2) (CMEs must "concern quality assurance or improvement . . . of clinical medicine"); OB 32 ("sexual orientation and gender identity in

accordingly fails to show that California has been "babbling prodigiously and incoherently" or "expressing contradictory views" through accredited CMEs—something that could have counseled toward finding private speech. *See Matal*, 582 U.S. at 235–36.

Second, Dr. Khatibi's comparisons of the Board to the governmental bodies in *Matal*, *Shurtleff*, *Summum*, and *Walker* are unpersuasive. The Board exercises far more control than the PTO in *Matal*. Indeed, the Board designates specific private organizations or qualified faculty to teach accredited CMEs. *See* CCR tit. 16, §§ 1337(a), 1337.5(a). These instructors' courses must at least adhere to the—in Dr. Khatibi's words—"broad parameters" set by California to be accredited. *See, e.g.*, § 2190.1. By contrast, the PTO imposes no similar requirements. Any natural or juristic person may create a mark, and they are able to do so from an entirely blank canvas. 15 U.S.C. § 1127. The PTO also "does not dream up" content standards, *Matal*, 582 U.S. at 235, whereas California has long done so, mandating that CMEs address topics like the "legal aspects of clinical medicine" and "health inequities within the TGI

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cardiovascular care"), *with* § 2191 (ordering the Board to consider "human sexuality" in licensees' practices) and § 2190.1(c) (listing cultural competency requirements touching on sexuality and gender); OB 26 (providing allegedly private speech example of CME called "Association Between the Relaxation of Public Health and Social Measures and Transmission of the SARS-CoV-2 Omicron Variant in South Korea"), *with* § 2190.1(a)(1) (CMEs must "have a scientific or clinical content with a direct bearing on the quality . . . of patient care, community or public health).

community, including family and community acceptance." *See, e.g.*, §§ 2190.1(a)(2), (c)(1)(D)(ii)(III).

The PTO normally "does not inquire whether any viewpoint conveyed by a mark is consistent with Government policy," and it lacks authority to remove the mark absent very specific and limited circumstances. *Matal*, 582 U.S. at 235. In contrast, the Board may audit and revoke the accreditation of any CME that fails to comply with its "acceptability" criteria, including content requirements. *See* § 1337.5(c). Also unlike the PTO, which "has made it clear that registration does not constitute approval of a mark," *Matal*, 582 U.S. at 237, the Board's accreditation reflects its judgment that a CME's content is essential to "ensure the continuing competence" of licensees. § 2190.

California's oversight over CMEs dwarfs the nominal supervision by the cities in *Shurtleff* and *Summum*, too. In *Shurtleff*, Boston "hadn't spent a lot of time really thinking about" the flags it permitted to fly and "had nothing—no written policies or clear internal guidance." 596 U.S. at 257 (cleaned up). Similarly, in *Summum*, Pleasant Grove lacked a written policy on monuments until a year after the plaintiffs donated the monument at issue. 555 U.S. at 465. And even then, the city's eventual policy seemed limited in nature. *Id.* (detailing the policy's focus on historical ties to the community). California's CME regime, in contrast, has long been embedded in and enforced through a complex web of statute and regulation. *See, e.g.*, § 2190.1; CCR tit. 16, § 1337.5. It is also significant that both the monument in *Summum* and the flag in *Shurtleff* were entirely privately designed, with no government input

whatsoever. The content of accredited CMEs, as we have detailed, is shaped by the State from their inception.

Walker also undercuts, rather than reinforces, Dr. Khatibi's claims. It is true that *Walker* emphasized how Texas had "sole control over the design, typeface color, and alphanumeric pattern for all license plates." 576 U.S. at 213. But the Court also highlighted that its analysis—like ours—was holistic. *See id.* at 210-13. The Board's lack of the same granular control over every element of accredited CMEs is thus inconsequential. The Board need not micromanage the drawing board or the classroom for accredited CMEs to count as government speech. Much like Texas, the Board, for decades, has "'effectively controlled,'" them "by exercising 'final approval authority,'" *id.* at 213, and by dictating content standards, pedagogical frameworks, and instructor qualifications. *See, e.g.*, § 2190.1; CCR tit. 16, § 1337.5. To otherwise hold "risks micro-managing legislative and regulatory schemes, a task federal courts are ill-equipped to undertake." *See Paramount Land*, 491 F.3d at 1012.

* * *

We hold that CMEs eligible for credit under California law constitute government speech. *See Shurtleff*, 596 U.S. at 248. And because they constitute government speech, CMEs eligible for credit are therefore immune from the strictures of the Free Speech Clause. *See Summum,* 555 U.S. at 464.[12]

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[12] Accordingly, we need not reach Plaintiffs' unconstitutional conditions claim. *See Agency for Int'l Dev. v. All. for Open Soc'y Int'l, Inc.*, 570 U.S. 205, 214 (2013) ("[T]he Government may not

"If there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox. . . ." *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943). This star yet shines. Just as California cannot compel Plaintiffs to teach subjects against their beliefs in their private capacities, Plaintiffs cannot compel California to speak against its own in its official capacity as guardian against "quacks and pretenders and from the mistakes of incapable practitioners." *Gerino*, 77 P. at 167.

AFFIRMED.

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deny a benefit to a person on a basis that infringes his constitutionally protected freedom of speech even if he has no entitlement to that benefit." (cleaned up)); *see also Matal*, 582 U.S. at 239-40 (suggesting that the doctrine only applies to "cash subsidies or their equivalent").

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

AZADEH KHATIBI, et al., Plaintiffs, v. RANDY HAWKINS, et al., Defendants.	Case No. 2:23-cv-06195-MRA-E **ORDER GRANTING DEFENDANTS' MOTION TO DISMISS FIRST AMENDED COMPLAINT WITHOUT LEAVE TO AMEND [ECF 29]**

Before the Court is Defendants' Motion to Dismiss Plaintiffs' First Amended Complaint, which challenges the constitutionality of California Business & Professions Code Section 2190.1(d)(1). ECF 29. This Court (Hon. Dale S. Fischer presiding) previously dismissed Plaintiffs' complaint with leave to amend. ECF 25. This case was reassigned to Hon. Mónica Ramírez Almadani on February 23, 2024. ECF 31. Pursuant to the Court's Reassignment Order, all pending motions were taken under submission without oral argument. ECF 33; *see also* Fed. R. Civ. P. 78; L.R. 7-15. For the reasons stated herein, the Court **GRANTS** the Motion without leave to amend.

I. FACTUAL & PROCEDURAL BACKGROUND[1]

On August 1, 2023, Plaintiffs Azadeh Khatibi, Marilyn Singleton, and Do No Harm filed this action against several officers of the Medical Board of California (the "Medical Board" or "Board") in their official capacities, alleging violations of Plaintiffs' First Amendment rights. ECF 1 (Complaint). Khatibi and Singleton are California-licensed physicians who have taught and organized continued medical education ("CME") courses for credit in California. ECF 26 (First Amended Complaint) ¶¶ 5, 6. Do No Harm is a national nonprofit corporation whose membership includes at least one individual who teaches CME courses in California. *Id.* ¶ 7.

The State of California requires licensed physicians to complete at least 50 hours of approved CME every two years. *Id.* ¶ 15; Cal. Code Regs. tit. 16 § 1336(a). The Board is responsible for "adopt[ing] and administer[ing] standards" for CME. ECF 26 ¶ 13; Cal. Bus. & Prof. Code § 2190. The Board has approved courses accredited by private associations. ECF 26 ¶ 16; Cal. Code Regs. tit. 16, § 1337(a)(1)-(2). Courses taught by "other organizations and institutions" may also qualify for CME credit provided the programming meets certain criteria set by the Board. ECF 26 ¶ 17; Cal. Code Regs. tit. 16, §§ 1337(a)(3), 1337.5. All CME courses, regardless of

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[1] When deciding a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6), the court is required to presume that all well-pleaded allegations are true, resolve all reasonable doubts and inferences in the pleader's favor, and view the pleading in the light most favorable to the non-moving party. *See Fitzgerald v. Barnstable Sch. Comm.*, 555 U.S. 246, 249 (2009); *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555 (2007).

the program or provider, must meet the requirements set forth under Cal. Bus. & Prof. Code § 2190.1. *See* Cal. Code Regs. tit. 16, § 1337(b) ("Only those courses and other educational activities that meet the requirements of Section 2190.1 of the code which are offered by these organizations shall be acceptable for credit under this section."). The Board does not pre-screen courses for regulatory compliance, but instead audits courses submitted for credit at random or when a complaint is received. ECF 26 ¶¶ 20-21; Cal. Code Regs. tit. 16, § 1337.5(b).

In 2019, the California State Legislature enacted Assembly Bill 241, codified at Cal. Bus. & Prof. Code § 2190.1(d)-(e). ECF 26 ¶ 1. Section 2190.1(d)(1) provides that, as of January 1, 2022, "all [CME] courses shall contain curriculum that includes the understanding of implicit bias."[2] Cal. Bus & Prof. Code § 2190.1(d)(1). To satisfy this requirement, CME courses must address at least one or a combination of "[e]xamples of how implicit bias affects perceptions and treatment decisions of physicians and surgeons, leading to disparities in outcomes," or "[s]trategies to address how unintended bias in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender

[2] However, CME courses "dedicated solely to research or other issues that does not include a direct patient care component or a course offered by a [CME] provider that is not located in this state is not required to contain curriculum that includes implicit bias in the practice of medicine." Cal. Bus. & Prof. Code § 2190.1(d)(2).

identity, sexual orientation, age, socioeconomic status, or other characteristics."[3] *Id.* § 2190.1(e).

Plaintiffs allege two claims in their original and amended complaints: that the State requirement that CME courses include discussion of implicit bias (1) is a content-based and viewpoint-based restriction on their freedom of speech because it compels them to accept the premise of implicit bias and its impact on healthcare disparities; and (2) serves to unconstitutionally condition the conferral of credits for their CME courses on foregoing their First Amendment right to not discuss implicit bias. ECF 26 ¶¶ 66-69, 77-83.

On December 11, 2023, the Court dismissed both claims with leave to amend. ECF 25. Pursuant to *Shurtleff v. City of Boston*, 596 U.S. 243, 252 (2022), the Court conducted a "holistic inquiry," considering several types of evidence—including the history of expression at issue, the public's likely perception as to whether the government is speaking, and the extent to which the government has actively shaped or controlled the expression—to determine whether Plaintiffs' CME courses constitute government speech or private expression. ECF 25 at 5-7. The Court found that Plaintiffs had failed to "plead [any] factual content to allow the inference that the Board does not exercise control over the content of CME courses," and

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[3] In addition, "[a]ssociations that accredit [CME] courses" were required to "develop standards before January 1, 2022, for compliance with the requirements of [§ 2190(d)(1)]" and are allowed to "update these standards, as needed, in conjunction with an advisory group established by the association that has expertise in the understanding of implicit bias." *Id.* § 2190.1(d)(3).

that "it [was] not clear whether attendees are likely to attribute the content of CME courses to the instructor or to the state (the entity that compels their attendance)." *Id.* at 6-7. When Plaintiffs choose to teach CME courses for credit, the Court held that "[they] do not speak for themselves, but for the state," and their free speech rights are therefore not implicated by Section 2190.1(d). *Id.* at 9. The Court further held that "[t]he power to give CME credits is not a pre-existing right on which compelled speech is conditioned." *Id.* at 8.

On December 22, 2023, Plaintiffs timely filed an amended complaint. ECF 26. Plaintiffs now allege that "there is no evidence" that the government has historically used CME courses to communicate with the public or medical practitioners, or that attendees attribute the content of these courses to the State or Medical Board. *Id.* ¶¶ 71-73. They also allege that each of their CME courses "was created and compiled by [them] without any supervision, approval, control, or input by any government official, including the Medical Board." *Id.* ¶¶ 35, 49. They state that their CME courses have never been audited by the Board and that attendees regularly ask questions and complete course evaluations. *Id.* ¶¶ 36-39, 50-52. Moreover, because Section 2190.1(d) requires that CME instructors provide "examples" or "strategies" regarding implicit bias, Plaintiffs now allege that course attendees are likely to attribute the content of CME courses as coming from them, not the State. *Id.* ¶¶ 44, 56.

On January 19, 2024, Defendants filed the instant Motion to Dismiss (hereinafter the "Motion"), arguing that the amended complaint "raises no materially new

factual allegations and contains the same deficiencies that previously warranted dismissal." ECF 29-1 at 6. Specifically, Defendants argue that "[Plaintiffs'] claims still rely on the incorrect premise that the speech at issue—discussion of implicit bias—constitutes private speech subject to First Amendment protection." *Id*. They insist that, "even if the speech at issue were private speech, Plaintiffs fail to state a compelled speech claim: they allege no new facts to support their conclusory claim that discussion of implicit bias in the courses they teach would be readily associated with them personally." *Id.* at 7. Furthermore, Defendants contend that Plaintiffs' conditioned speech claim fails for the same reasons the Court previously dismissed the claim: there is no requirement or right to teach CME courses for credit. *Id.*

Plaintiffs filed their Opposition to the Motion on February 20, 2024, arguing, *inter alia*, that "[p]rivate physicians speaking in their private capacity about topics on which they are experts, is not government speech." ECF 30 at 7. Defendants filed their Reply in support of the Motion on February 27, 2024, emphasizing that "State-mandated curriculum requirements for [CME] courses necessary for state licensure constitutes government speech because when physicians like Plaintiffs choose to teach [CME] courses for credit, they 'speak for the state,' as this Court has already held." ECF 32 at 5.

II. LEGAL STANDARDS

Federal Rule of Civil Procedure 12(b)(6) permits dismissal for "failure to state a claim upon which relief can be granted." Dismissal is appropriate where the

complaint lacks a cognizable legal theory or sufficient facts to support a cognizable legal theory. *See Johnson v. Riverside Healthcare Sys., LP*, 534 F.3d 1116, 1121 (9th Cir. 2008). To survive a Rule 12(b)(6) motion to dismiss, a complaint must "state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (per curiam). This is "a context-specific task that requires the reviewing court to draw on its judicial experience and common sense." *Id.* at 679. The court "must accept as true all the factual allegations contained in the complaint," but it is "not bound to accept as true a legal conclusion couched as a factual allegation." *Id.* at 678 (citing *Twombly*, 550 U.S. at 555). "Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice." *Id.*

Federal Rule of Civil Procedure 15(a) provides that after a party has amended a pleading once as a matter of course, it may amend further only after obtaining leave of the court, or by consent of the adverse party. In general, "[t]he court should freely give leave when justice so requires." Fed. R. Civ. P. 15(a)(2). "This policy is to be applied with extreme liberality." *Owens v. Kaiser Found. Health Plan, Inc.*, 244 F.3d 708, 712 (9th Cir. 2001) (quoting *Morongo Band of Mission Indians v. Rose*, 893 F.2d 1074, 1079 (9th Cir. 1990)). "If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim

on the merits." *Foman v. Davis*, 371 U.S. 178, 182 (1962). However, dismissal without leave to amend is appropriate when "it is clear that granting leave to amend would [be] futile." *Lathus v. City of Huntington Beach*, 56 F.4th 1238, 1243 (9th Cir. 2023) (internal quotations omitted).

III. DISCUSSION

A. Failure To State a Cognizable Compelled Speech Claim

The First Amendment, made applicable to the States by incorporation into the Fourteenth Amendment, provides that the government "shall make no law. . . abridging the freedom of speech." U.S. Const. amend. I; *see New York Times Co. v. Sullivan*, 376 U.S. 254, 277 (1964). But "[w]hen the government speaks, it is not barred . . . from determining the content of what it says." *Walker v. Texas Div., Sons of Confederate Veterans, Inc.*, 576 U.S. 200, 207 (2015). Government speech is thus "not subject to scrutiny under the Free Speech Clause." *Pleasant Grove City v. Summum*, 555 U.S. 460, 464 (2009).

This case is about whether teaching CME courses in California for state-issued credits constitutes government speech or private expression. The Supreme Court explained in *Shurtleff* how "[t]he boundary between government speech and private expression can blur when . . . a government invites the people to participate in a program." 596 U.S. at 252. In that context, courts must conduct a "holistic inquiry designed to determine whether the government intends to speak for itself or regulate private expression." *Id.* Courts consider "several types of evidence to guide the analysis, including: the

history of the expression at issue; the public's likely perception as to who (the government or a private person) is speaking; and the extent to which the government has actively shaped or controlled the expression." *Id.*

The Court considers each type of evidence as alleged in the amended complaint.

1. History of Expression at Issue

Defendants contend that the Legislature has a longstanding history of using CME curriculum requirements "to ensure that licensed physicians are adequately trained in subjects the State considers essential to maintaining competence in the profession." ECF 29-1 at 16. Plaintiffs do not dispute this. ECF 30 at 14. Instead, they maintain that this "uncontroversial statement" "does not show that the state has historically used CMEs to communicate a governmental message, much less communicate a message to the general public." *Id.*

Plaintiffs argue that CME courses are unlike traditional forms of government expression, which the government has historically used to speak. *Id.* at 13-14. The Court agrees, as it previously held, that "CME courses are not 'designed as a means of expression.' Governments do not have the same history of using them to communicate to the general public as monuments and flags." ECF 25 at 6 (quoting *Summum*, 555 U.S. at 470). However, Plaintiffs' insistence that the Court directly contrast the speech at issue here with public monuments (*Summum,* 555 U.S. 460), flags (*Shurtleff*, 596 U.S. 243), specialty license plates (*Walker*, 576 U.S. 200), and federal trademarks (*Matal v. Tam*, 582 U.S. 218 (2017)) is not

persuasive. *See* ECF 30 at 13-14. Comparing dissimilar forms of government expression leads to illogical results. This is why, as the Supreme Court explained in *Shurtleff*, the government-speech inquiry is "driven by a case's context rather than the rote application of rigid factors." *See* 596 U.S. at 252, 253-54 (considering the general history of flag-flying and the details of the specific flag-flying program at issue).

The proper inquiry considers the history of government supervision of licensing requirements for medical practitioners. As the Court recognized in its prior dismissal order, "[s]ince the nineteenth century, establishing the qualifications required to practice medicine within a state has been deemed a proper exercise of the legislature's police power." ECF 25 at 3 (citing *Hawker v. New York*, 170 U.S. 189, 193 (1898)); *see also* 1876 Cal. Stat., ch. 518, pp. 792-794 (indicating that California has required those practicing medicine in the state to comport with licensing and training requirements since at least 1876). In fact, "[i]t is too well settled to require discussion at this day that the police power of the states extends to the regulation of certain trades and callings, particularly those which closely concern the public health." *Watson v. Maryland*, 218 U.S. 173, 176 (1910). This power "authorizes it to prescribe all such regulations as in its judgment will secure or tend to secure [its people] against the consequences of ignorance." *Dent v. West Virginia*, 129 U.S. 114, 122 (1889). "As one means to this end it has been the practice of different states . . . to exact in many pursuits a certain degree of skill and learning upon which the community can confidently rely." *Id.* Critically, "[t]he nature and extent of the

qualifications required must depend primarily upon the judgment of the state as to their necessity." *Id.*

For decades, CME programming in California has "ensure[d] the continuing competence of licensed physicians and surgeons." Cal. Bus. & Prof. Code § 2190 (added 1980; amended 2011). Through legislation, the State has determined that physicians can satisfy the CME requirement through educational activities that meet any of the following curricular criteria:

> (1) Have a scientific or clinical content with a direct bearing on the quality or cost-effective provision of patient care, community or public health, or preventative medicine.
>
> (2) Concern quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine.
>
> (3) Concern bioethics or professional ethics.
>
> (4) Are designed to improve the physician-patient relationship and quality of physician-patient communication.

Cal. Bus. & Prof. Code § 2190.1(a).

Over time, the State has mandated additional CME requirements based on its evolving "judgment as to their necessity." *Dent*, 129 U.S. at 122. In 2006, recognizing the need "to meet the cultural and linguistic concerns of a diverse patient population," 2005 Cal. Legis. Serv. ch. 514, the Legislature mandated that all CME courses "contain curriculum that includes cultural and linguistic competency in the practice of medicine." Cal. Bus. & Prof. Code § 2190.1(b). Since 2019, licensees have been required

to complete mandatory coursework in "the subject of the risks of addiction associated with the use of Schedule II drugs." *Id.* § 2190.5(a). As an alternative to this requirement, the Legislature has authorized physicians to complete coursework in "the subject of treatment and management of opiate-dependent patients." *Id.* § 2190.6. Since 2021, licensees have been required to complete mandatory coursework in "the subjects of pain management and the treatment of terminally ill and dying patients." *Id.* § 2190.5(a)(1). Consistent with this longstanding practice, the Legislature promulgated A.B. 241 to address implicit bias, which in its judgment has "contribute[d] to health disparities by affecting the behavior of . . . licensees." 2019 Cal. Legis. Serv. ch. 417.

While Plaintiffs do not wish to teach implicit bias because they do not agree that it contributes to health disparities, they do not otherwise question the State's authority to set CME programming requirements. *See* ECF 30 at 14. In fact, as noted above, Plaintiffs concede that "history shows CME is used by the government to ensure physicians are competent to practice medicine." ECF 26 ¶ 71. Logically, the Legislature has accomplished this goal by (a) requiring physicians to complete a certain number of approved CME hours, (b) communicating through curricula requirements the subjects it views as essential for continued medical practice in the State, and (c) delegating authority to the Board to approve CME courses for credit and oversee compliance. *See generally* Cal. Code Regs. tit. 16, §§ 1336(a), 1337; Cal. Bus. & Prof. Code div. 2, ch. 5, art. 10.

Accordingly, the Court finds that the State's history of regulating medical licensure and its

longstanding practice of using continuing education requirements as part of this licensing scheme supports the finding that teaching CME courses is government speech.

2. Likely Perception as to Who Is Speaking

In determining whether the government intends to speak for itself, the Court must also consider the likely perception that the speech at issue will be attributed to the government. Plaintiffs contend that the public is not likely to recognize CME course content as government speech because courses are taught by private individuals. ECF 30 at 16. Specifically, Plaintiffs now allege that "[t]here is no evidence that the public or attendees of CME courses perceive the content of CMEs as coming from the Medical Board, or the government generally, rather than individual instructors." ECF 26 ¶ 72. Khatibi further alleges that "attendees treat her as the person responsible for the content discussed" because she is evaluated and asked questions by course attendees, *id.* ¶¶ 37-39, and she would be required to provide "examples" or "strategies" related to implicit bias, *id.* ¶ 44. Singleton makes similar allegations. *Id.* ¶¶ 51-52, 56. Moreover, Plaintiffs argue that "the public understand[s] the difference between the government requiring private organizations to develop CME courses covering certain topics to be taught by private instructors and, for example, the Medical Board itself creating and communicating information on detecting child abuse directly to every doctor and hospital in California." ECF 30 at 17.

The Court is unpersuaded by Plaintiffs' arguments. Plaintiffs voluntarily teach CME courses for credits

created and approved by the State. They are free to teach medical courses in their private capacity in California or elsewhere, but when they are communicating medical knowledge required by the Board to satisfy this State's licensing requirements, they are conveying what the California Legislature has deemed essential for the continued practice of medicine. *See* ECF 25 at 9. Because of the highly regulated nature of the medical profession, those licensed physicians taking Plaintiffs' CME courses—the audience for the challenged expression—are likely to perceive the course content as coming from the State, not private individuals. As Defendants explain, physicians "understand how their profession is regulated, that the State sets the licensing requirements, and that the State controls the content of courses they are required to take to maintain their State-issued license." ECF 29-1 at 17.

Plaintiffs' pleaded facts actually support this understanding. Plaintiffs allege that if they do not discuss implicit bias in their CME courses, and their courses are not approved for CME credit as a result, physicians are unlikely to take their courses. ECF 26 ¶¶ 45, 57. Taken to their logical conclusion, these facts lead to the inference, as the Court explained in its prior order, that physicians take Plaintiffs' CME courses because they know the content meets State requirements and comes from the State. *See* ECF 25 at 6.

The Court considers the public-school curriculum context an imperfect yet helpful analogy. In that context, the Ninth Circuit has explained that "school teachers have no First Amendment right to influence curriculum as they so choose" because such a rule

would allow the teacher "to do to the government what the government could not do to [the teacher]: compel it to embrace a viewpoint." *Downs v. Los Angeles Unified School Dist.*, 228 F.3d 1003, 1012, 1015-16 (9th Cir. 2001) (holding that a school bulletin board on which faculty and staff could post materials was "an example of the government opening up its own mouth"); *see also Nampa Classical Academy v. Goesling*, 447 Fed. App'x. 776, 778 (9th Cir. 2011) (holding that curriculum taught in a charter school is government speech because "the message is communicated by employees working at institutions that are state-funded, state-authorized, and extensively state-regulated"). Certain "activities may fairly be characterized as part of the school curriculum, whether or not they occur in a traditional classroom setting, so long as they are supervised by faculty members and designed to impart particular knowledge or skills to student participants and audiences." *Hazelwood Sch. Dist. v. Kuhlmeier*, 484 U.S. 260, 271 (1988) (holding that school newspaper was curricular).

Plaintiffs, like public school educators, are furthering state-mandated learning outcomes when they teach approved CME courses. Their courses are authorized by the State to satisfy strict requirements to practice in a State-regulated profession. *See Nampa*, 447 Fed. App'x. at 777-78 (finding that although operated by a private entity, a charter school is authorized by and extensively regulated by the State such that its curriculum is government speech). As with public-school curriculum, CME curriculum is subject to oversight and approval by government officials. *See Downs*, 228 F.3d at 1016 (identifying

oversight by school officials as evidence that the school, not private persons, are responsible for the speech at issue). That Plaintiffs are evaluated and asked questions by course attendees—like most educators—and must come up with "examples" and "strategies" related to implicit bias—a pedagogical technique applicable to virtually any educational topic—does not alter the reasonable inference that CME curriculum itself, when approved for credit, is "conveying some message on the government's behalf." *Walker*, 576 U.S. at 212 (quoting *Summum*, 555 U.S. at 471) (internal quotations omitted).

Plaintiffs argue that the school curriculum cases are inapposite because those cases involve "public entities or public officials" speaking, not private individuals voluntarily teaching continuing education courses. *See* ECF 30 at 21. That a private speaker serves as the messenger, however, "does not extinguish the governmental nature of the message." *Walker*, 576 U.S. at 217. The Supreme Court has consistently affirmed that the government can "enlist[] private entities to convey its own message." *Rosenberger v. Rector and Visitors of Univ. of Virginia*, 515 U.S. 819, 833 (1995); *see also Summum*, 555 U.S. at 468 ("A government entity may exercise [its] freedom to express its views when it receives assistance from private sources for the purpose of delivering a government-controlled message."); *Johanns v. Livestock Marketing Ass'n*, 544 U.S. 550, 562 (2005) (holding that the government "is not precluded from relying on the government-speech doctrine merely because it solicits assistance from nongovernmental sources . . ."). "[I]n that kind of situation, private persons assume a public or quasi-

public capacity." *Shurtleff*, 596 U.S. at 270 (Alito, J., concurring) (internal quotations omitted). "So long as that responsibility is voluntarily assumed, speech by a private party within the scope of his power to speak for the government constitutes government speech." *Id.*

Accordingly, the Court finds that Plaintiffs are likely to be perceived as speaking for the State, not themselves, when discussing implicit bias in for-credit CME courses.

3. Extent of Government Shaping and Control of Expression

In its prior dismissal order, the Court held that Plaintiffs pleaded "no factual content to allow the inference that the Board does not exercise control over the content of CME courses." ECF 25 at 7. Plaintiffs now allege that "[o]ther than the requirements established in section 2190.1," the content of their CME courses "was created and compiled by [them] without any supervision, approval, control, or input by any government official, including the Medical Board." ECF 26 ¶¶ 35, 39. As a result, Plaintiffs assert that "[t]here is insufficient evidence to show the Medical Board—rather than individual CME instructors and private organizations approving their courses—controls the content of CMEs." *Id.* ¶ 73.

By its plain text, the statutory language contradicts Plaintiffs' conclusory statement. Section 2190.1(d) is no aberrant exercise of state authority over CME curriculum. The Legislature has recommended courses for the Board to approve for CMEs, prescribed certain topics, and delegated authority to the Board to set additional CME

standards. *See* Cal. Bus. & Prof. Code §§ 2190, 2190.1-2190.6, 2191. The Legislature even dictates which practitioners are exempt from certain CME requirements, *see* Cal. Bus. & Prof. Code §§ 2190.1(b)(2), 2190.1(d)(2), 2190.5(b)-(c), and which courses do not qualify for CME credit. *Id.* § 2190.1(f) (determining those educational activities "directed primarily toward the business aspects of medical practice" do not meet the CME standards for physicians and surgeons). Pursuant to regulation, the Board in turn determines the programs approved for CME credit, the criteria CME courses must meet to be accepted for credit, and the process by which it will ensure CME providers' compliance with CME requirements. Cal. Code Regs. tit. 16 §§ 1337, 1337.5. Even course evaluations, which Plaintiffs newly plead in support of their position, are mandated by regulation, and thus shaped and controlled by the State. Cal. Code Regs. tit. 16, § 1337.5(a)(6) (requiring all CME courses to "include an evaluation method which documents that educational objectives have been met"). Notably, Plaintiffs do not challenge any of these other State requirements for CME courses.

Plaintiffs argue that by relying on private entities to teach and accredit CME courses, the Board has, in effect, "outsourced the implementation of standards to private organizations and instructors." ECF 30 at 17; ECF 26 ¶¶ 16, 20-21. This is not accurate. Private physicians may teach CME courses; private institutions may organize the programming; private associations may yet approve courses for their own accreditation purposes. *See* Cal. Code Regs. tit 16 § 1337(a)(1)-(2). But contrary to Plaintiffs' assertions, private entities have no say on which courses are

ultimately approved to satisfy the State's CME requirement. The Board alone has that final authority. *See generally id.* § 1337.

Although the Board does not pre-screen courses for credit, it reserves the right to "randomly audit courses or programs submitted for credit in addition to any course or program for which a complaint is received." *Id.* § 1337.5(b). When an audit is made, course organizers are required to submit documentation verifying compliance with CME criteria set by the Board. *Id.* That Khatibi's and Singleton's courses have yet to be audited, ECF 26 ¶¶ 36, 50, does not negate that their courses are subject to the State's audit in the first instance. In other words, the Board has the final say over whether their courses qualify for credit. *See Walker*, 576 U.S. at 213 (describing "final approval authority" as evidence of the government controlling the message); *Downs*, 228 F.3d at 1015-16 (finding that school bulletin boards constituted government speech because the school "had final authority over the content of the bulletin boards" even if school officials were not "spend[ing] the majority of their days roaming the school's halls strictly policing" the content). The Court concludes that the State exerts a significant degree of control over the content of CME courses.

The holistic government-speech inquiry firmly resolves in favor of finding that teaching CME courses in California constitutes government speech. Accordingly, Plaintiffs have not stated a claim that the government has compelled them to engage in protected speech subject to First Amendment scrutiny.

B. Failure To State a Cognizable Conditioned Speech Claim

Plaintiffs plead that they have "the right to teach [CME] courses for credit free from the condition" that they include discussion of implicit bias. ECF 26 ¶ 78. The Court reiterates that "[t]here is neither a requirement nor a right to teach continuing medical education courses for credit." ECF 25 at 8. That teaching approved CME courses is one means by which Plaintiffs can partially satisfy their CME hours does not alter this finding. ECF 26 ¶ 18; Cal. Code Regs. tit. 16, § 1337(c).

Plaintiffs' sole citation in support of their novel conditioned speech theory is *Perry v. Sinderman*, 408 U.S. 593, 597 (1972), in which the Supreme Court held that "even though a person has no right to a valuable government benefit . . . [the government] may not deny a benefit to a person on a basis that infringes his constitutionally protected interests—especially, his interest in freedom of speech." *Perry* concerned a public employee whose employment was not renewed allegedly in retaliation for his exercise of free speech rights.

While Plaintiffs are correct in stating that the government cannot condition a benefit on a constitutionally impermissible basis, that principle is not at issue here. *First,* as explained above, the First Amendment does not protect the speech at hand. *Second*, unlike the public employment at issue in *Perry*, CME credits are not government benefits, but rather confer a delegation of state authority. *Cf. id.* (characterizing as government benefits tax exemptions, unemployment benefits, welfare payments, and public employment). CME

programming is an essential means by which the government exercises its authority to safeguard public health. When the State approves courses taught by private instructors for credits, it is not bestowing upon the instructor any kind of benefit; it is permitting the instructor to speak for the State. *See* ECF 25 at 8.

Were any individual voluntarily teaching continuing education courses required for State professional licensing able to enjoin State-mandated curriculum they deem controversial on free speech grounds, "it is not easy to imagine how government could function." *Summum*, 555 U.S. at 467-68. If Plaintiffs disagree with the Legislature's judgment in passing A.B. 241, they can choose to no longer instruct CME courses for credit, as is their right, or err their grievances at the ballot box because "it is the democratic electoral process that first and foremost provides a check on government speech." *Walker*, 576 U.S. at 207. In the instant action, however, Plaintiffs have not presented a cognizable legal theory that would allow the Court to reasonably infer that they have been deprived of a right "secured by the Constitution and laws." 42 U.S.C. § 1983. Therefore, Plaintiffs have not met their burden of stating a claim upon which relief can be granted.

C. Dismissal Without Leave to Amend

While Federal Rule of Civil Procedure 15(a) provides that leave to amend shall be freely given, leave is "not to be granted automatically." *In re W. States Wholesale Nat. Gas Antitrust Litig.*, 715 F.3d 716, 738 (9th Cir. 2013) (quoting *Jackson v. Bank of Hawaii*, 902 F.2d 1385, 1387 (9th Cir. 1990)), *aff'd sub*

nom. Oneok, Inc. v. Learjet, Inc., 575 U.S. 373 (2015). Where "the pleading could not possibly be cured by the allegation of other facts," the district court acts within its discretion in denying leave to amend. *Lopez v. Smith*, 203 F.3d 1122, 1130 (9th Cir. 2000) (quoting *Doe v. United States*, 58 F.3d 494, 497 (9th Cir. 1995)). Defendants contend that further amendment would be futile. ECF 29-1 at 15.

In its prior dismissal order, the Court found that Plaintiffs had not pleaded sufficient facts to allow the inference that the speech at issue is constitutionally protected. ECF 25 at 6-7. In response, Plaintiffs amended their pleading to newly allege certain facts in support of their claims. *See* ECF 26 ¶¶ 35-40, 44, 49-52. Their alleged injury, claims, and theory of liability, however, remain unchanged.

The Court now finds that the underlying facts and circumstances relied upon by Plaintiffs are not "the proper subject of relief" warranting a renewed "opportunity to test [their] claims on the merits." *Foman*, 371 U.S. at 182. Plaintiffs lack a cognizable legal theory, not just facts to support a cognizable legal theory. *See Johnson*, 534 F.3d at 1121. Notwithstanding Plaintiffs' new allegations, the *Shurtleff* analysis once again permits only one reasonable inference: legally, when the government requires all CME courses include discussion of implicit bias in order to qualify towards state-mandated licensing, it is transmitting its own message, not compelling or conditioning private speech. *See Shurtleff*, 596 U.S. at 252.

Based on Plaintiffs' reliance on legal conclusions and the substantial factual similarities between the original and amended complaints, the Court

determines that Plaintiffs have no additional material facts to plead. *See Zucco Partners, LLC v. Digimarc Corp.*, 552 F.3d 981, 1007 (9th Cir. 2009). For the sake of analysis, even if Plaintiffs were to allege in an amended pleading that all the physicians they personally know would likely perceive the speech as coming from private persons, that would not prove that the speech is private speech. Indeed, given the overwhelming evidence of government shaping and control and the history of expression at issue, the holistic inquiry set forth in *Shurtleff* would still resolve in the Court finding that State-mandated discussion of implicit bias, among other CME curriculum requirements, is "meant to convey and ha[s] the effect of conveying a government message." *Walker*, 576 U.S. at 216 (quoting *Summum*, 555 U.S. at 472). The Court is not required to mechanically tally factors in conducting the government-speech analysis. *See Shurtleff*, 596 U.S. at 258. Thus, granting leave to amend would be futile. *See Lathus*, 56 F.4th at 1243.

IV. CONCLUSION

For the foregoing reasons, Defendants' Motion to Dismiss (ECF 29) is **GRANTED** without leave to amend. The Court hereby DISMISSES this action with prejudice and further ORDERS the Clerk to treat this Order as an entry of judgment. L.R. 58-6.

IT IS SO ORDERED.

Dated: May 2, 2024 s/ Mónica R. Almadani
HON. MÓNICA RAMÍREZ ALMADANI
UNITED STATES DISTRICT JUDGE

Case: 24-3108, 12/29/2025, DktEntry: 68.1

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

AZADEH KHATIBI, M.D., an individual; DO NO HARM, a Virginia nonprofit corporation, *Plaintiffs - Appellants*, v. RANDY HAWKINS, in his official capacity as President of the Medical Board of California; LAURIE ROSE LUBIANO, in her official capacity as Vice President of the Medical Board of California; REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California; MARINA O'CONNOR, in her official capacity as Chief of Licensing, Medical Board of California; RYAN BROOKS, in his official capacity as	No. 24-3108 D.C. No. 2:23-cv-06195-MRA-E Central District of California, Los Angeles ORDER

Secretary of the Medical Board of California, *Defendants - Appellees*.	

Filed December 29, 2025

Before: A. Wallace Tashima, Jacqueline H. Nguyen, and Salvador Mendoza, Jr., Circuit Judges.

Order;

Dissent by JudgeVanDyke;

Dissent by Judge Tung

* * * * *

ORDER

The panel unanimously voted to deny the petition for panel rehearing. Judges Nguyen and Mendoza voted to deny the petition for rehearing en banc and Judge Tashima so recommended. The full court was advised of the petition for rehearing en banc. A judge requested a vote on whether to rehear the matter en banc. The matter failed to receive a majority of the votes of the nonrecused active judges in favor of en banc consideration. Fed. R. App. P. 40.

The petitions for panel rehearing and rehearing en banc (Dkt. No. 64) are **DENIED**.

VANDYKE, Circuit Judge, joined by BUMATAY and TUNG, Circuit Judges, dissenting from the denial of rehearing en banc

In a published opinion, a panel of our court held that a medical course taught by a private instructor and accredited by private entities is government

speech unprotected by the First Amendment. That conclusion isn't merely incorrect—it puts our circuit out of step with Supreme Court precedent, our sister circuits' precedent, and even our own precedent. Our court's denial of rehearing en banc passes up the opportunity to rectify the panel's mistaken conclusion. I respectfully dissent from that denial.

The state of California conditions medical licenses on the completion of accredited continuing medical education ("CME") classes. Cal. Code Regs. tit. 16, § 1336(a). Plaintiff Dr. Azadeh Khatibi and at least one member of plaintiff Do No Harm, a nonprofit corporation, create content for those CME courses—content that involves speech protected by the First Amendment. But under California's relatively recent changes to its CME regulations, Plaintiffs must affirm controversial state-sanctioned political and ideological beliefs by incorporating into any CME course "curriculum that includes the understanding of implicit bias." Cal. Bus. & Prof. Code § 2190.1(d)(1). Plaintiffs challenged that requirement in federal court, arguing that CME courses are private speech and that the government cannot constitutionally compel CME instructors to adopt the state's views on divisive political subjects. The district court dismissed Plaintiffs' claims, finding that the content of CME courses—despite being crafted and taught by private parties—constitutes government speech. The panel affirmed.

The panel misread the Supreme Court's government speech precedent, deviating from the Supreme Court's instructions and creating a split with our sister circuits by focusing on the *scope* of California's regulation of CME courses rather than

examining the manner in which California's regulations shape or convey the *messages* involved in CME instruction. The result: an expansive government speech doctrine that discards the Supreme Court's cautionary instruction in *Matal v. Tam*, 582 U.S. 218, 235 (2017). A proper analysis—as prescribed by the Supreme Court, our own court's prior cases, and our sister circuits—reveals that California's prior CME regulations did not meaningfully express or shape messages through CME courses. Because California has not historically used CME courses to communicate the state's own messages, because those attending CME courses would be unlikely to perceive the instructor's message as the government's, and because the state's regulations otherwise exert very little control over CME instructors' messages, the panel erred in concluding that CME courses are government speech devoid of any First Amendment protection.

I.

Similar to continuing legal education requirements for lawyers, CME course attendance is required for California physicians and surgeons wishing to maintain their licenses. Cal. Code Regs. tit. 16, § 1336. California's express goal for having these CME regulations is to "ensure the continuing competence of licensed physicians and surgeons," and to that end the Medical Board of California is authorized to "adopt and administer standards for the continuing education of … licensees." Cal. Bus. & Prof. Code § 2190. At issue here is California's statutory requirement, added in 2019, that a CME instructor must include in his or her course "curriculum that includes the understanding of implicit bias." Cal. Bus.

& Prof. Code § 2190.1(d)(1). An instructor can satisfy that requirement by providing "[e]xamples of how implicit bias affects perceptions and treatment decisions," or by detailing "strategies to address how unintended biases in decisionmaking may contribute to health care disparities." *Id.* § 2190.1(e).

Other standards broadly dictate that the content of CME courses must—unsurprisingly—be medical in nature. Cal. Bus. & Prof. Code § 2190.1(a); Cal. Code Regs. tit. 16, § 1337.5(a)(3). CME lectures must "maintain, develop, or increase the knowledge, skills, and professional performance that a physician and surgeon uses to provide care," which may be done by educational activities that "include, but are not limited to" a broad list of options such as "scientific or clinical content with a direct bearing on the quality or cost-effective provision of patient care, community or public health, or preventive medicine." Cal. Bus. & Prof. Code § 2190.1(a). California's regulations echo these same options. Cal. Code Regs. tit. 16, § 1337.5(a)(3). More granular subject matter requirements are imposed on CME attendees: physicians with a certain percentage of elderly patients must complete CME courses in geriatric medicine, and all physicians and surgeons must complete CME courses on either pain management and the treatment of terminally ill patients or on the treatment of opiate-dependent patients. Cal. Bus. & Prof. Code §§ 2190.3, 2190.5, 2190.6. California also allows CME attendees to earn at most 30% of the required credits from CMEs on medical office management. *Id.* § 2190.15. Other standards lay out requirements for CME instructors, including that the need for the course be "maintained on file," and a

handful of other miscellaneous requirements unrelated to CME content. Cal. Code Regs. tit. 16, § 1337.5(a)(1)-(2), (4)-(7). CME courses must also "contain curriculum that includes cultural and linguistic competency in the practice of medicine." Cal. Bus. & Prof. Code § 2190.1(b). The Code directs the private associations that accredit CME courses to develop standards to assess compliance with the cultural and linguistic competency requirement and mandates that CME courses "shall address at least one or a combination of" a long list of possible ways to include such content. *Id.* §§ 2190.1(b)(3), 2190.1(c).

California does "not give prior approval to individual courses or programs." Cal. Code Regs. tit. 16, § 1337.5(b). Instead, California outsources the accreditation of CME courses to private entities. Cal. Bus. & Prof. Code § 2190.1(g); Cal. Code Regs. tit. 16, § 1337(a). The only involvement California maintains in the process is that state actors can "randomly audit courses or programs submitted for credit in addition to any course or program for which a complaint is received." Cal. Code Regs. tit. 16, § 1337.5(b). When a course is audited, "course organizers will be asked to submit" certain information, like the rationale for the course, the course content, educational objectives, attendance records, and the like. *Id.*

Dr. Khatibi and at least one member of Do No Harm have taught CME courses in California. They object to California's new implicit bias requirement, Cal. Bus. & Prof. Code § 2190.1(d), on the ground that the regulation requires them to express the state's controversial viewpoint in CME courses that they created and compiled on their own and that were approved by private CME accreditors. The district

court dismissed Plaintiffs' complaint, finding that teaching CME courses is government speech and that California was therefore free to require CME instructors to express the state's view about implicit bias. The panel affirmed.

II.

When the government speaks for itself, the First Amendment's protections for private expression are not implicated. *Pleasant Grove City v. Summum*, 555 U.S. 460, 467-68 (2009). But sometimes the line between government and private speech blurs, necessitating a more detailed analysis to assess "whether the government intends to speak for itself or to regulate private expression." *Shurtleff v. City of Boston*, 596 U.S. 243, 252 (2022). The Supreme Court has highlighted several factors of particular importance to that analysis: "the history of the expression at issue; the public's likely perception as to who (the government or a private person) is speaking; and the extent to which the government has actively shaped or controlled the expression." *Id.* Because of the risk that "government could silence or muffle the expression of disfavored viewpoints" by characterizing that expression as government speech and therefore outside the First Amendment's ambit, the Supreme Court has admonished courts to exercise "great caution" before extending the government speech doctrine. *Matal*, 582 U.S. at 235. In line with this warning, the Supreme Court has deemed that "simply affixing a government seal of approval" to private speech fails to transform private speech into government speech. *Id.*

A.

While the panel in this case paid lip service to the three-factor *Shurtleff* test, its approach boils down to a single-factor analysis: does the government "heavily" or "actively" regulate CMEs? The panel's application of the *Shurtleff* test can be aptly summarized: Does the history of the expression indicate that CME courses are government speech? Yes, because of the broad scope of the government's historical regulation of CMEs. Does the public likely perceive the government as speaking? Yes, because of the broad scope of the government's CME regulations. Does the government exercise sufficient control over the message expressed in CME courses? Yes, because of the broad scope of the government's CME regulations. This one-factor-to-rule-them-all test is not the test that prior cases have prescribed. The Supreme Court's precedent, our own prior cases, and cases from our sister circuits all indicate that the analysis is not so simple—that the mere fact of extensive regulation is far from the be-all end-all conclusion of the analysis.

Instead, prior cases establish that the analysis focuses not on the mere scope of the state's regulations, but instead on the government's particular involvement in shaping the *message* being expressed. Under *Shurtleff*, it is obvious that merely regulating private speech does not necessarily transform that speech into government speech: "we conduct a holistic inquiry designed to determine whether the government intends to speak for itself or to regulate private expression." *Shurtleff*, 596 U.S. at 252. *Shurtleff*'s subsequent description of the government speech analysis factors further clarifies

that the government's involvement in actually expressing or shaping the *message* is the touchstone of the analysis: "the history of the *expression* at issue; the public's likely perception as to who (the government or a private person) *is speaking*; and the extent to which the government has actively shaped or controlled the *expression*." *Id.* at 252 (emphases added); *see also Matal*, 582 U.S. at 238 (describing the analysis in *Walker v. Texas Div., Sons of Confederate Veterans, Inc.*, 576 U.S. 200 (2015), as partially dependent on whether the State historically used license plates "to convey state *messages*" and whether the state maintained "direct control over the *messages* conveyed" (emphases added) (quoting *Walker*, 576 U.S. at 213)).

While our own precedent on the government speech doctrine is fairly sparse, our cases that consider the doctrine display a similar emphasis on the government's involvement with the message being conveyed. For instance, we have considered whether the "*message* is 'from beginning to end' that of the State." *Delano Farms Co. v. Cal. Table Grape Comm'n*, 586 F.3d 1219, 1228 (9th Cir. 2009) (emphasis added) (quoting *Paramount Land Co. LP v. Cal. Pistachio Comm'n*, 491 F.3d 1003, 1012 (9th Cir. 2007)); *see also Ranchers Cattlemen Action Legal Fund United Stockgrowers of Am. v. Vilsack*, 6 F.4th 983, 990 (9th Cir. 2021) (same). These cases suggest that if a given regulation does not meaningfully control the message being communicated, mere regulation—even extensive regulation—carries little weight, if any, in proving that the government is actually speaking for itself.

Cases from other circuits likewise focus on whether the government is articulating its own message both overall and for each *Shurtleff* factor, rather than on the mere breadth of the government's regulations. *See Sutliffe v. Epping Sch. Dist.*, 584 F.3d 314, 331 (1st Cir. 2009) (finding government speech where a town "communicated an important message about itself"); *Women for Am. First v. Adams*, No. 21-485-cv, 2022 WL 1714896, at *4 (2d Cir. May 27, 2022) (finding that certain murals were government speech because the City propagated "its own message" through the murals); *Brown v. Yost*, 133 F.4th 725, 734 (6th Cir. 2025) (determining that summaries of proposed ballot initiatives were not government speech because they did not "historically convey[] government messages"); *Wandering Dago, Inc. v. Destito*, 879 F.3d 20, 36 (2d Cir. 2018) (finding, as part of the government speech analysis, that a private party's participation in a government program would likely not "be viewed by the public" as the government adopting the private party's speech as its own); *Little v. Llano Cnty.*, 138 F.4th 834, 860 (5th Cir. 2025) (en banc) (emphasizing that the third *Shurtleff* factor considers "the extent to which the government has actively shaped or controlled the expression" (quoting *Shurtleff*, 596 U.S. at 252)).

Because in conducting the three-factor *Shurtleff* analysis the panel here diverged from the guidance of the Supreme Court, our own precedent, and the reasoning of our sister circuits, the panel's analysis of each factor was improperly skewed by its heavy reliance on the existence of numerous regulations that have little to no connection to shaping the messages conveyed in CME courses. An analysis that properly

focuses on the formation of those messages reveals that California has historically had almost no involvement with the *content* of the speech expressed by CME instructors: not historically, nor in the eyes of the public, nor in terms of controlling CME expression.

B.

Historically, California has rarely, if ever, communicated government messages through CME courses. This is largely because most of California's CME regulations have not required that CME courses include specific content. Begin with California's "content standards" in section 2190.1(a), which suggest that qualified CMEs

> *may include, but are not limited to*, educational activities that meet any of the following criteria:
>
> (1) Have a scientific or clinical content with a direct bearing on the quality or cost-effective provision of patient care, community or public health, or preventive medicine.
>
> (2) Concern quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine.
>
> (3) Concern bioethics or professional ethics.
>
> (4) Are designed to improve the physician-patient relationship and quality of physician-patient communication.

Cal. Bus. & Prof. Code § 2190.1(a) (emphasis added). Other than unsurprisingly assuming that CME courses will be broadly related to the medical field, this incredibly expansive, nonbinding, and

nonexhaustive list imposes functionally no content restriction on CME instructors, giving them free rein to pick their topics and decide what to say about them. If someone sets out in good faith to teach a CME course, it's hard to imagine what topic would be excluded under this provision. The provision is so broad that it does not even prevent CME instructors from expressing messages that conflict with other courses, or indeed even presenting conflicting viewpoints within the same course.

The content standards in California's regulations merely parrot the language from section 2190.1(a): "The content of the course or program shall be directly related to patient care, community health or public health, preventive medicine, quality assurance or improvement, risk management, health facility standards, the legal aspects of clinical medicine, bioethics, professional ethics, or improvement of the physician-patient relationship." Cal. Code Regs. tit 16, § 1337.5(a)(3). As such, this second content standard—essentially the same as the first, but now with mandatory language—adds nothing to the analysis. Unlike the monuments that the Supreme Court deemed to be government speech in *Summum*, California's generic content standards do not aim "to convey some thought or instill some feeling." *Summum*, 555 U.S. at 470. Similarly, unlike the license plates deemed government speech in *Walker*, California's CME content standards come nowhere close to communicating messages as specific as "a graphic" or "a slogan." *Walker*, 576 U.S. at 211. Properly assessed for any historically communicated government message, California's content standards do nothing to show that the government has

historically used CME courses to communicate a government message.

California's regulations include "Criteria for Acceptability of Courses" that lay out generic quality standards for CME courses: standards for who can be certified as a CME instructor, requirements that course rationales, objectives, and teaching methods be kept on file, and the like. Cal. Code Regs. tit. 16, § 1337.5(a)(1)-(2), (4)-(7). These quality requirements evince the same absence of a historical government message as the content standards: they do not require that any specific message be conveyed during CME courses and therefore do nothing to demonstrate that the messages historically communicated through CME courses were government messages as opposed to the messages of private CME instructors.

The state's oversight role beyond its written regulations does nothing to move the needle closer to government speech. California's CME regulations allow the government to audit individual courses, which it apparently occasionally does. But because California's content and quality standards do not show that the state has historically conveyed messages through CME courses, neither does the state's ability to audit CME courses. Whether the potential for an audit means that CME courses express a government message depends entirely on what the state is auditing for: auditing for compliance with content and quality standards that don't require any particular government message means the audits cannot have required historical government messages either. And outside of sporadic audits, the state has outsourced the bulk of the approval work to private accreditors, making it even less likely that any state

message has somehow been historically communicated through CME courses. Cal. Bus. & Prof. Code § 2190.1(g); Cal. Code Regs. tit. 16, § 1337.5(b).

Finally, California's requirements that certain licensees take CME courses covering specific subject matter (like geriatric medicine) or capping how much credit can be earned from courses covering specific subject matter (like medical office management) are restrictions only on CME attendees, not on the private speakers involved in the CME process: the CME instructors. Cal. Bus. & Prof. Code §§ 2190.3, 2190.5, 2190.6, 2190.15. Nowhere does California force private parties to create CME courses on those specific topics. As such, those requirements also fail to evidence a history of California speaking through CME courses.

The panel concluded otherwise, but the closest it got to identifying any specific government message historically communicated using CME courses is California's requirement that CME instructors discuss cultural and linguistic competence. Cal. Bus. & Prof. Code § 2190.1(b)-(c). But as discussed below in applying the third *Shurtleff* factor, even the cultural and linguistic competence provisions are so broad and leave so much discretion to CME instructors that they practically exert essentially no control over the messages conveyed by CME courses, which in turn makes it impossible to point to any discrete state message communicated through CME courses as a result of these provisions.

To its credit, the panel did attempt (albeit unsuccessfully) to distill from California's historical regulations one "overarching" government message:

"what is necessary to ensure the continuing competence of licensed physicians" that "reflects the State's evolving judgment of what subjects it has deemed essential" for doctors to know. California argued in the same vein that its regulations "convey[] a message regarding what subjects the State deems important for doctors to know."

First off, this amorphous, super-generalized message is communicated, at most, only by the existence of the regulations, *not* by the content of any individual CME courses. This looks nothing like the government speech in *Summum* and *Walker*, in which the government used individual monuments to communicate discrete messages and individual license plates to communicate specific graphics, slogans, and the like. *See Summum*, 555 U.S. at 470; *Walker*, 576 U.S. at 211. The analysis in *Summum* and *Walker* suggests that *Shurtleff*'s reference to "the history of the expression at issue" looks not to whatever broad governmental priorities can be inferred from the mere fact of regulation, but to the discrete, particular messages the government has historically communicated using the regulated medium. *Shurtleff*, 596 U.S. at 252 (drawing the "history of the expression" factor from *Summum* and *Walker*). This is confirmed by *Matal*, in which the Court determined that trademarks were not government speech despite being significantly regulated. *Matal*, 582 U.S. at 239. Applying the panel's logic, the Court could have inferred from the heavy regulation of trademarks that the government was communicating its "evolving judgment" about the importance of trademark protections. But that is not how the Court approached its analysis. Instead, it

flatly stated that "[t]rademarks have not traditionally been used to convey a Government message." *Matal*, 582 U.S. at 238. Inferring a message from just the mere fact of extensive regulation and treating that nebulous message as capable of satisfying the first *Shurtleff* element would effectively erase the historical element altogether, an outcome hard to square with the Supreme Court's treatment of the historical element as a discrete and meaningful piece of the analysis.

But second, even if we ignore that the panel's reasoning clashes with Supreme Court precedent and functionally rewrites the test prescribed by *Shurtleff*, the "overarching message" here, as articulated by the panel and by California, is at such a high level and is so nonspecific that it communicates no more than "simply affixing a government seal of approval." *Matal*, 582 U.S. at 235. If all that it takes to transform private speech into government speech is the government's implied signal that it thinks some number of topics are important, or an implied "evolving judgment of what subjects it has deemed essential" for people to know, then a mere government seal of approval (which is essentially the same thing) would suffice to swallow private speech. Yet *Matal* indicates the exact opposite: that "simply affixing a government seal of approval" is categorically insufficient to transform private speech into government speech, notwithstanding the high-level messages inferable from such a seal. *Id.* The first *Shurtleff* factor therefore weighs in favor of CME messages being private speech, and the panel erred in concluding otherwise.

C.

Based purely on the fact that California "heavily" regulates CME courses, the panel concluded that "'common sense' commands that licensees could attribute approved CMEs' content to California." panel reached this conclusion despite acknowledging that Dr. Khatibi "plausibly alleged facts suggesting that [CME] attendees treat her as the person responsible for CME content."

First, this analysis runs directly counter to "accept[ing] as true all well-pleaded factual allegations, and constru[ing] all factual inferences in the light most favorable to the plaintiff," which we are required to do at the motion-to-dismiss stage. *Parents for Priv. v. Barr*, 949 F.3d 1210, 1221 (9th Cir. 2020). As the panel recognized, Dr. Khatibi clearly alleged that the attendees of her CME courses view her content as her own, not the government's. That allegation, irrespective of California's regulatory scheme, suggests that the public would likely believe that a private person is speaking through CME courses. *See Shurtleff*, 596 U.S. at 252. At the motion-to-dismiss stage, that should be the end of the analysis of *Shurtleff*'s public perception factor.

The panel, however, went on to draw inferences unfavorable to Plaintiffs based on their allegations. The basis for these unfavorable inferences, in the panel's eyes, is the Supreme Court's language from *Ashcroft v. Iqbal* that "[d]etermining whether a complaint states a plausible claim for relief . . . requires the reviewing court to draw on its judicial experience and common sense." 556 U.S. 662, 679 (2009) (citation omitted). The subsequent paragraphs in that decision, however, suggest that the point of

resorting to common sense is to weed out "legal conclusion[s]" and to ensure that a plaintiff's allegations are logically consistent, not to flatly contradict a well-pleaded allegation the court is supposed to accept as true. *Id.* at 679-80.

And even assuming it can be permissible to rely on "judicial experience and common sense" as the panel suggests, the most obvious cognate to CME from our own "judicial experience" would obviously be the comparable continuing legal education ("CLE") requirements of our profession, which like the medical profession is heavily regulated, often in very similar ways. *See, e.g.*, Cal. Bus. & Prof. Code § 6070.5 (directing the State Bar to adopt regulations requiring "that the mandatory continuing legal education . . . curriculum for all licensees . . . includes training on implicit bias and the promotion of bias-reducing strategies"). Every judge has sat through hours upon hours of CLE, and surely that experience and common sense support the eminent plausibility of Plaintiff's allegation that CLE attendees perceive CLE instructors as speaking on their own behalf, not on behalf of the government. Given the similarity between CME and CLE requirements, there is little reason to believe that CME attendees would think any differently—certainly nothing in our "judicial experience" compels a different conclusion. Just like the first factor, the second *Shurtleff* factor also supports a finding that CME courses are private speech.[1]

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[1] The panel contended that "[e]ven assuming that the public perception factor favors Dr. Khatibi, [the] ultimate conclusion would remain the same" because the "remaining factors of history and extent of state control decisively" favor California.

D.

The panel's analysis of the third Shurtleff factor involved a lengthy recitation of the laws that California has in place. As discussed above, the mere existence of a plethora of regulations is not enough to prove that the government is speaking. We must instead consider the ways in which the regulations "actively shape[] or control[] the expression" involved in the CME lectures. *Shurtleff*, 596 U.S. at 252; *cf. id.* at 256 ("[I]t is Boston's control over the flags' content and meaning that here is key; that type of control would indicate that Boston meant to convey the flags' messages."). Conducting that analysis reveals that the state in fact exercises very little control over CME expression, because every part of the regulations that have to do with the content of the CME courses is so broad as to exercise practically no control over the courses' messages.

For the same reasons that many of California's regulations do not evidence a history of the state speaking through CME courses, the same regulations impose no meaningful government control over the expression involved with CME courses. The breadth of California's content standards leaves CME instructors free to speak about whatever medical topics they choose. *See* Cal. Bus. & Prof. Code § 2190.1(a); Cal. Code Regs. tit. 16, § 1337.5(a)(3). Within the factual context of *Walker*, this would be

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But this conclusion relies on the panel's erroneous analysis of the history and extent-of-control factors. As explained, properly analyzed, neither of those factors favor the government—much less "decisively" so.

akin to the government saying, "Create whatever license plate design you want, as long as it's a license plate." Such a permissive content requirement, a far cry from Texas's granular "sole control over the design, typeface, color, and alphanumeric pattern for all license plates," would certainly not have led the Court to conclude that "Texas maintains direct control over the messages conveyed on its specialty plates." *Walker*, 576 U.S. at 213. Given that *Walker* "likely marks the outer bounds of the government-speech doctrine," *Matal*, 582 U.S. at 238, this vast disparity between Texas's control over the license plates in *Walker* and California's exercise of control over the messages conveyed in CME courses means that the third *Shurtleff* factor also favors Plaintiffs.

Since California's miscellaneous quality standards do not impact the messages conveyed in CME courses, those regulations cannot be characterized as "actively shap[ing] or controll[ing] the expression" at issue.[2] Shurtleff, 596 U.S. at 252; *see* Cal. Code Regs. tit. 16, § 1337.5(a)(1)-(2), (4)-(7). The subject matter requirements for certain licensees in California

[2] The panel makes much of the fact that "Dr. Khatibi admits that her courses have complied with all CME requirements," which the panel reads as Dr. Khatibi "conced[ing] that her CMEs *have* been shaped by California." This is another example of the panel putting dispositive weight on the mere fact of regulation, rather than properly analyzing whether those regulations shape the messages conveyed by CME instructors. *All* regulations require compliance, regardless of whether they control or shape speech. If regulatory compliance alone is sufficient to resolve the analysis of the third *Shurtleff* factor, then the distinction drawn by the Court between "the government intend[ing] to speak for itself" and the government merely "regulat[ing] private expression" would be meaningless. *Shurtleff*, 596 U.S. 243, 252 (2022).

Business and Professions Code sections 2190.3, 2190.5, 2190.6, and 2190.15 are imposed on CME attendees, not CME instructors, and therefore likewise fail to provide examples of the state asserting control over the messages CME instructors convey.

As part of its control analysis, the panel again leaned on California's cultural and linguistic competency requirements. Cal. Bus. & Prof. Code § 2190.1(c). The panel cited two pages' worth of the associated statute in an attempt to demonstrate the extent of the control California exerts over CME instructors' speech. If the cited statute listed requirements that *all* had to be met, the panel's argument might be stronger. But the statute is disjunctive: CME lectures must address "at least one or a combination of" the subsequently listed items. Cal. Bus. & Prof. Code § 2190.1(c). As a result, the length of the statute actually serves to undercut the panel's point: because CME instructors can choose among almost unlimited options to satisfy the cultural and linguistic competence requirement, section 2190.1(c) in fact exercises very little control over CME instructors' speech. This provision doesn't merely leave "the development of the remaining details" to the private speakers who create CME courses. *Johanns v. Livestock Mktg. Ass'n*, 544 U.S. 550, 561 (2005). Giving CME instructors a choice between a whole host of options for one small aspect of CME lectures and wholesale control over the rest of the message means that CME instructors are functionally building their courses from the ground up, with no meaningful state-imposed guardrails or direction. Because neither the cultural and linguistic competence provision nor the generic content

requirements significantly control or limit CME instructors' messages, the third *Shurtleff* factor too weighs against finding that the government is speaking through CME courses.

III.

In California, CME courses are created, prepared, approved, and accredited by private actors. While, as one might expect, the state extensively regulates CME courses, it has not historically used that regulation to control the courses' messages. Nor is the mere scope of California's regulatory scheme a good reason to conclude, at the motion-to-dismiss stage and in the face of Plaintiffs' well-pleaded allegations, that CME attendees perceive instructors as relaying the government's views. As a factual matter, and certainly as plausibly pled in this case, they don't. And the breadth of California's CME regulations generally belies the fact that the state actually exercises very little control over the messages expressed by CME instructors. The panel's conclusion in this case that the mere breadth of CME regulation inherently expresses a governmental message about California's priorities improperly rewrites the test prescribed by the Supreme Court in *Shurtleff*. Our court should have reheard this case en banc to correct that improperly anemic governmental speech analysis and to prevent the government from so easily coopting private speech.

TUNG, Circuit Judge, joined by BUMATAY and VANDYKE, Circuit Judges, dissenting from the denial of rehearing en banc:

This case is about whether private instructors of continuing medical education courses engage in

"government speech" when a State requires them (over their objection) to teach that "implicit bias" "lead[s] to disparities in health outcomes."

The answer is no. Such private instructors do not engage in "government speech," for the simple reason that they are not the government and they do not speak for the government. A law requiring them to convey a viewpoint they find objectionable thus restricts their private expression and is not exempt from First Amendment scrutiny. Because the panel concluded otherwise, I respectfully dissent from the denial of rehearing en banc.

* * *

The concept of "implicit bias" is controversial. Popularized in the 2000s, it espouses the view that individuals harbor unconscious biases that favor whites and males over blacks and females (or other groups) that have resulted in disparities in income, job opportunities, and most relevant here, healthcare outcomes. *See, e.g.*, Assemb. B. 241, 2019-2020 Leg., Reg. Sess. (Cal. 2019) (enacted) (codified at Cal. Bus. & Prof. Code §§ 2190.1(d)-(g), 2736.5(a)-(c), 3524.5(a)-(d)). Plaintiffs here—a female physician and a nonprofit—dispute the validity of the concept and its relevance to their curriculum. ER 36-37, 39. "Implicit bias" theory, they say, is rooted in neither evidence nor fact, disregards other potential factors that could better explain outcome disparities, and hastily (and inaccurately) identifies racism or sexism as the primary cause. *Id.* at 35-37. In Plaintiffs' view, the theory is also divisive, producing resentment by needlessly setting one racial (or other) group against another. *Id.* at 35, 39. For these reasons, Plaintiffs

object to teaching "implicit bias" in their continuing medical education courses. *Id.* at 36-39.

The State of California has taken a firm side in this debate. It has sought to disseminate the idea of "implicit bias" through various mandatory training programs. To that end, and for our purposes here, the California legislature in 2019 enacted a statute requiring that private instructors teach "implicit bias" in *all* their continuing medical education courses relating to "direct patient care." Cal. Bus. & Prof. Code § 2190.1(d). In that Act, the legislature "declares" "find[ings]" that purportedly support its mandate—though the Act itself does not cite evidence for those findings:

- Implicit bias . . . exists, and often contributes to unequal treatment of people based on race, ethnicity, gender identity, sexual orientation, age, disability, and other characteristics[.]
- Implicit bias contributes to health disparities by affecting the behavior of physicians and surgeons, nurses, physician assistants, and other healing arts licenses[.]
- African American women are three to four times more likely than white women to die from pregnancy-related causes nationwide.
- African American patients often are prescribed less pain medication than white patients who present the same complaints[.]

- African American patients with signs of heart problems are not referred for advanced cardiovascular procedures as often as white patients with the same symptoms[.]
- Implicit gender bias also impacts treatment decisions and outcomes. Women are less likely to survive a heart attack when they are treated by a male physician and surgeon.

Assemb. B. 241, 2019-2020 Leg., Reg. Sess. § 1 (Cal. 2019). In accordance with these "findings," the Act states that "all continuing medical education courses shall contain curriculum that includes the understanding of implicit bias." Cal. Bus. & Prof. Code § 2190.1(d)(1). Specifically, the Act requires private instructors to incorporate "at least one or a combination" of the following in virtually all courses:

> (1) Examples of how implicit bias affects perceptions and treatment decisions of physicians and surgeons, leading to disparities in health outcomes.
>
> (2) Strategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics.

Id. § 2190.1(e).

* * *

Let us be clear about a few points. *First*, no one disputes that Plaintiffs are a *private* instructor and a *private* entity who teach courses to physicians so that the physicians can maintain their licenses. Plaintiffs are not government employees or government agents; nor are they funded by the government. *See Khatibi v. Hawkins*, 145 F.4th 1139, 1151 (9th Cir. 2025) ("[T]he State certainly expects, if not relies[] on[,] the participation of private parties in executing the CME scheme"); Cal. Code Regs. tit. 16, §§ 1337, 1337.5 (expressly opening up continuing education courses to approved private providers). *Second*, no one contends that the government owns (by copyright or otherwise) the course materials that Plaintiffs put together. It is not disputed that the course materials (and the content contained therein) belong to Plaintiffs. *Third*, the law at issue does not purport to transform Plaintiffs into agents of the government or cloak them with the authority to speak on its behalf. Plaintiffs remain private speakers just as they were before the law was passed.

What then does the law do? Simply put, it requires Plaintiffs to convey a message that the government favors but that Plaintiffs do not. The statute mandates, in unmistakable terms, that private instructors teach (and assume) the validity of the "implicit bias" theory. That is not the *government* "speak[ing] for itself"; rather, it is the government compelling *others* to speak in a certain way. *Shurtleff v. City of Bos.*, 596 U.S. 243, 252 (2022). The State of California could have hired its own employees to spread its message of "implicit bias" and the deleterious effects of this purported phenomenon. *Matal v. Tam*, 582 U.S. 218, 234 (2017) ("The Free

Speech Clause does not require government to maintain viewpoint neutrality when its officers and employees speak."). The State could have enlisted volunteers to do the same. *See Shurtleff*, 596 U.S. at 270 (Alito, J., concurring in the judgment) ("So long as this responsibility is voluntarily assumed, speech by a private party within the scope of his power to speak for the government constitutes government speech."). The State could have even created a program in which it was involved "from beginning to end" in proposing edits or suggestions to solicited course material. *Matal*, 582 U.S. at 237 (citing *Johanns v. Livestock Mktg. Ass'n*, 544 U.S. 550, 560–61 (2005)); *see also Walker v. Texas Div., Sons of Confederate Veterans, Inc.*, 576 U.S. 200, 213 (2015) (holding that Texas specialty license plates are government speech and considering that "Texas maintains direct control over the messages conveyed on its specialty plates"). All these options might have been considered an exercise in "government speech."

But the State has done none of that. The State has chosen instead to commandeer a vast majority of course providers, who are private, to express a specific viewpoint. That may be the most efficient way for the State to proselytize its message; it may have the added benefit, too, of creating the perception of uniformity on a divisive topic, while imposing a steep social cost on those in the field who dare to dissent. In the end, the statute's aim appears to be nothing less than ideological conformity enforced through private conscription by the State.

Our First Amendment stands stubbornly athwart that approach. *See W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943) ("If there is any

fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein."). As our Supreme Court has said rather bluntly, "the government may not compel a person to speak its own preferred messages," nor "force an individual to include other ideas with his own speech that he would prefer not to include." *303 Creative LLC v. Elenis*, 600 U.S. 570, 586-87 (2023). "All that offends the First Amendment just the same." *Id.* at 587. Yet that appears to be what California is doing here—requiring physicians to treat "implicit bias" as gospel (despite their unwillingness to assent) and, worse still, to then teach it to their students in virtually every continuing education course.

Contrary to the panel's contention (and as Judge VanDyke well explains), the existence of extensive "regulation" in the "medical profession" does not justify State compulsion of a particular viewpoint. *See* Dissent at 8-11 (VanDyke, J.). If that were so, doctors could be forced to affirm viewpoints they find odious as a condition of maintaining their licenses. Lawyers could find themselves suffering the same fate, too. Both fields (and others) are highly regulated. Indeed, any professional accreditation regime, now open to and supported by a vast network of private providers expressing differing (and perhaps conflicting) viewpoints, would be in jeopardy of being converted into an engine of state-sanctioned groupthink if those providers could be compelled to announce a singular position. That maneuver is not exempt from the First Amendment's purview. But that is where the panel's

logic leads; for the panel, it is "government speech" all the way down.

Nor does private expression become "government speech" simply because that expression is made a condition of a benefit. *See, e.g.*, *Matal*, 582 U.S. at 239. Being compelled to express a particular viewpoint—on pain of losing professional accreditation—is anything but voluntarily speaking on behalf of the government. *See Shurtleff*, 596 U.S. at 271 (Alito, J., concurring in the judgment) (citing *Matal*, 582 U.S. at 234-35) ("Facilitating speech by private persons cannot constitute government speech unless the government assigns a power to speak to those persons or appropriates the products of their expressive activity to express its own message. When the government's role is limited to applying a standard of assessment to determine a speaker's eligibility for a benefit, the government is regulating private speech, and ordinary First Amendment principles apply.").

The factors announced in *Shurtleff* do not help the panel either, as Judge VanDyke correctly concludes. *See Shurtleff*, 596 U.S. at 252 ("[W]e conduct a holistic inquiry . . . look[ing] to several types of evidence to guide the analysis, including: the history of the expression at issue; the public's likely perception as to who (the government or a private person) is speaking; and the extent to which the government has actively shaped or controlled the expression."). But stepping back, the diametrically opposed outcomes that the panel and Judge VanDyke have reached in applying the *Shurtleff* "test"—and other circuits' divergence from the panel—might give us pause as to the test's workability. *Id.* at 266 (Alito, J., concurring in the judgment) ("[L]ike any factorized analysis, this

approach cannot provide a principled way of deciding cases."); *see also* Dissent at 5, 10-11 (VanDyke, J.). The panel insists that it engaged in *Shurtleff*'s "holistic inquiry" in concluding that the government speaks—indeed, it invokes the word "holistic" no fewer than nine times in its opinion. But all too often, such "holistic" multi-factor tests serve as mere cover for judges to reach their preferred result. *See Lexmark Int'l, Inc. v. Static Control Components, Inc.*, 572 U.S. 118, 136 (2014) (observing that "open-ended balancing tests[] can yield unpredictable and at times arbitrary results"). Better off, it seems, for constitutional principles to "be anchored in rules, not set adrift in some multifactored 'balancing test.'" *Granfinanciera, S.A. v. Nordberg*, 492 U.S. 33, 70 (1989) (Scalia, J., concurring in part and concurring in the judgment).

The panel here has gone adrift. If *Shurtleff* is being applied (as here) to deny First Amendment protection to undeniably private instructors, compelled by the State to teach a doctrine they disbelieve, then something has gone seriously awry and we have lost the plot. The *point* of the factors is "to determine whether the government intends to speak for itself or to regulate private expression." *Shurtleff*, 596 U.S. at 252. If they cease to serve that function reliably, then it is hard to see what function they should serve at all. Here, it is clear the State seeks to "regulate private expression." I dissent from the denial of rehearing en banc.

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

AZADEH KHATIBI, et al., Plaintiffs, v. RANDY HAWKINS, et al., Defendants.	2:23-cv-06195-DSF-E ORDER GRANTING MOTION TO DISMISS (Dkt. 16)

Defendants move to dismiss Plaintiffs' complaint. Dkt. 16 (Mot.) Plaintiffs oppose. Dkt. 18 (Opp'n). The Court deems this matter appropriate for decision without oral argument. See Fed. R. Civ. P. 78; Local Rule 7-15. For the reasons stated below, Defendants' motion is GRANTED.

I. Factual Background

California requires that all licensed physicians complete 50 hours of continuing medical education (CME) every two years. Dkt 1 (Compl.) ¶13. In 2019, the California State Legislature enacted Assembly Bill 241. Compl. ¶1. AB 241 requires that as of January 1, 2022, "all continuing medical education courses contain curriculum that includes the understanding of implicit bias." Compl. ¶19.

California law requires the Medical Board of California to enforce this mandate. Compl. ¶2.

To satisfy this requirement, courses must include "[e]xamples of how implicit bias affects perceptions and treatment decisions of physicians and surgeons, leading to disparities in health outcomes" or "[s]trategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics." Cal. Bus. & Prof. Code § 2190.1(e).

Plaintiffs are doctors and a non-profit corporation whose members include medical professionals and policy makers. Compl. ¶¶28-47. Some have taught and organized CME courses in the past. Compl. ¶¶30, 39, 45. They allege that "there is inconsistent evidence that implicit bias in healthcare is prevalent and results in disparate treatment outcomes." Compl. ¶23. And they are unpersuaded that implicit bias trainings would solve the problem, even if it does exist. Compl. ¶24. Instead, they allege that trainings can cause "counterproductive anger, frustration, and resentment among those taking the trainings." Compl. ¶25. They do not want to include AB 241's required curricula in their future courses. Compl. ¶¶33, 40, 47.

Plaintiffs allege that if they do not teach the state's mandated curriculum, their courses will not qualify for CME credit, and doctors will be unlikely to take them. Compl. ¶¶34, 42. They contend that they have therefore been compelled to include discussion of implicit bias in their courses. Compl. ¶1. They assert

this violates the First Amendment, as the government "cannot compel speakers to engage in discussions on subjects they prefer to remain silent about," and "the government cannot condition a speaker's ability to offer courses for credit on the requirement that she espouse the government's favored view on a controversial topic." Compl. ¶2.[1]

Plaintiffs sue the members of the Board in their official capacities. Compl. ¶¶8–12.

II. Legal Standard

Rule 12(b)(6) allows an attack on the pleadings for failure to state a claim on which relief can be granted. "[W]hen ruling on a defendant's motion to dismiss, a judge must accept as true all of the factual allegations contained in the complaint," Erickson v. Pardus, 551 U.S. 89, 94 (2007) (per curiam), but is "not bound to accept as true a legal conclusion couched as a factual allegation." Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009) (quoting Bell Atl. Corp. v. Twombly, 550 U.S. 544, 555 (2007)).

A complaint must "state a claim to relief that is plausible on its face." Twombly, 550 U.S. at 570. "A Rule 12(b)(6) dismissal may be based on either a lack of a cognizable legal theory or the absence of sufficient facts alleged under a cognizable legal theory." Johnson v. Riverside Healthcare Sys., LP, 534 F.3d 1116, 1121 (9th Cir. 2008). The complaint must plead "factual content that allows the court to draw the

[1] Whether implicit bias training is controversial, counterproductive, or effective, is not material to the disputed legal issues. The Court takes no position on the merits or effectiveness of implicit bias training.

reasonable inference that the defendant is liable for the misconduct alleged." Iqbal, 556 U.S. at 678.

"A district court shall grant leave to amend freely 'when justice so requires.'" Owens v. Kaiser Found. Health Plan, Inc., 244 F.3d 708, 712 (9th Cir. 2001) (quoting FRCP 15). "This policy is to be applied with extreme liberality." Id.

III. Discussion

A. Legal Background

Since the nineteenth century, establishing the qualifications required to practice medicine within a state has been deemed a proper exercise of the legislature's police power. See Hawker v. People of New York, 170 U.S. 189, 193 (1898). In Dent v. State of W.Va., 129 U.S. 114, 122 (1889), the Supreme Court upheld educational licensing requirements for medical practitioners because "[t]he power of the state to provide for the general welfare of its people authorizes it to prescribe all such regulations as in its judgment will secure or tend to secure them against the consequences of ignorance[.]"

Neither party contends that the State of California lacks the power to draft a detailed curriculum that all doctors must complete to renew their licenses. Instead, the legislature has delegated this power to the Medical Board, see Cal. Bus. & Prof. Code § 2004, tasking the Board with "[i]ssuing licenses and certificates" and "[a]dministering [a] continuing medical education program." Id. at §§(h), (i).

Although it does not draft the course curricula, the Board sets out the criteria for its continuing medical education program. This includes the exclusive content areas CME courses may address, which are

limited to: "patient care, community health or public health, preventive medicine, quality assurance or improvement, risk management, health facility standards, the legal aspects of clinical medicine, bioethics, professional ethics, or improvement of the physician-patient relationship." Cal. Code Regs. tit. 16, § 1337.5(a)(3). The Board enlists private organizations and institutions to approve for credit the CME courses offered in these content areas. Cal. Code Regs. Tit. 16, § 1337(a).

The Board does not pre-screen these courses. But, either randomly or due to complaint, the Board will audit courses and require the organizer to submit the "(1) Organizer(s) faculty curriculum vitae; (2) Rationale for course; (3) Course content; (4) Educational objectives; (5) Teaching methods; (6) Evidence of evaluation; [and] (7) Attendance records." Cal. Code Regs. tit. 16, § 1337.5(b). After an audit, if the Board determines that a course is unacceptable, credit will not be received by attending physicians. Cal. Code Regs. tit. 16, § 1337.5(c). Plaintiffs do not challenge this structure, or the CME requirement generally.

The legislature found that implicit bias, meaning "the attitudes or internalized stereotypes that affect our perception s, actions, and decisions in an unconscious manner," was contributing to health disparities across race, gender, and sexual orientation. AB 241, 2019, Cal. State Assemb. (Cal. 2019). The legislature noted, for example, that African American women were three to four times more likely than white women to die from pregnancy-related causes. Id.

To address these findings, the legislature sought to "provide specified healing arts licensees with strategies for understanding and reducing the impact of their biases in order to reduce disparate outcomes and ensure that all patients receive fair treatment and quality health care." Id.

B. Government Speech

Defendants argue that the compelled discussion of implicit bias in CME courses does not implicate Plaintiffs' free speech rights because it is government speech.

"When government speaks, it is not barred by the Free Speech Clause from determining the content of what it says." Walker v. Texas Div., Sons of Confederate Veterans, Inc., 576 U.S. 200, 207 (2015). "That freedom in part reflects the fact that it is the democratic electoral process that first and foremost provides a check on government speech." Id. But "[t]he boundary between government speech and private expression can blur when . . . a government invites the people to participate in a program." Shurtleff v. City of Boston, Massachusetts, 596 U.S. 243, 252 (2022).

To determine when the government speaks, courts must "conduct a holistic inquiry designed to determine whether the government intends to speak for itself or to regulate private expression." Id. That inquiry "is driven by a case's context rather than the rote application of rigid factors." Id. "[S]everal types of evidence . . . guide the analysis, including: the history of the expression at issue; the public's likely perception as to who (the government or a private person) is speaking; and the extent to which the government has actively shaped or controlled the

expression." Id. at 244 (citing Walker, 576 U.S. at 209-214).

Plaintiffs argue that the history of the expression weighs in their favor because "how doctors acquire knowledge the state deems essential—including who speaks to them—is left almost entirely to the doctors' discretion." Opp'n at 6. This argument duplicates Plaintiffs' later conclusion that the government exercises minimal control over the accreditation process of courses and instructors.

In any event, the proper inquiry considers the history of government supervision of licensing requirements for medical practitioners, not California's specific history. See Shurtleff, 596 U.S. at 253. CME is not "as old as human civilization[,]" id., but as noted above, governments have exercised power over educational licensing requirements since at least the nineteenth century. A review of the relevant portion of the Code reveals that the California State Legislature uses CME courses to communicate health concerns to medical practitioners. For example, the legislature requires the Board to "periodically disseminate information and educational material regarding the detection and treatment of spousal or partner abuse." Cal. Bus. & Prof. Code § 2196.5.

However, unlike the monuments in Pleasant Grove City, Utah v. Summum, CME courses are not "designed as a means of expression." 555 U.S. 460, 470 (2009). Governments do not have the same history of using them to communicate to the general public as monuments and flags. See id.; see also Shurtleff, 596 U.S. at 253. Moreover, while monuments and flags communicate to the general public (pedestrians on the

street), CME courses are directed to a limited group—medical practitioners.

Plaintiffs have alleged that but for the credits awarded, attendees would not take Plaintiffs' courses. Compl. ¶¶34, 42. Common sense therefore suggests that attendees know CME courses are approved for credits required by the Medical Board of California in order for doctors to maintain their licenses—in other words, the state. However, it is not clear whether attendees are likely to attribute the content of CME courses to the instructor or to the state (the entity that compels their attendance).

Plaintiffs contend that "California exercises almost no control over the content of CMEs." Opp'n at 8. They argue that the lack of control exercised by the legislature and Board distinguishes the CME curricula from Summum and Walker and is more closely akin to Shurtleff and Matal v. Tam, 582 U.S. 218, 237 (2017) (holding that trademarks are not government speech). However, Plaintiffs plead no factual content to allow the inference that the Board does not exercise control over the content of CME courses. See Iqbal, 556 U.S. at 678. And the Code suggests that the state exercises at least some control over the content of CMEs through audits and public-private partnerships. See Cal. Code Regs. Tit. 16, § 1337(a), 1337.5(b).

The alleged facts are mixed, and do not clearly weigh for one side. However, the Court is not required to tally factors. See Shurtleff, 596 U.S. at 258 (requiring a "holistic inquiry" and holding that flag raising was private speech although two factors weighed in support of government speech).

C. School Curricula Cases

Defendants argue that educational courses constitute government speech over which states have broad discretion. In the public school context, "the curriculum presented . . . is not the speech of teachers, parents, or students, but that of the [state] government." Nampa Classical Acad. v. Goesling, 447 F. App'x 776, 778 (9th Cir. 2011). This is "not because the school district is a crucial part of the American constitutional design with inherent rights over public school curriculum, but because states authorize the existence of school districts as political subdivisions and delegate to them the state government's authority to run state public schools." Id. at n.2.

Certain "activities may fairly be characterized as part of the school curriculum, whether or not they occur in a traditional classroom setting, so long as they are supervised by faculty members and designed to impart particular knowledge or skills to student participants and audiences." Hazelwood Sch. Dist. v. Kuhlmeier, 484 U.S. 260, 271 (1988) (holding that school newspaper was part of the curriculum); see also Downs v. Los Angeles Unified Sch. Dist., 228 F.3d 1003, 1012 (9th Cir. 2000) ("[B]ulletin boards were a manifestation of the school board's policy to promote tolerance, and because [the school] had final authority over the content of the bulletin boards, all speech that occurred on the bulletin boards was the school board's and LAUSD's speech.").

Defendants argue that "the fact that private instructors like Plaintiffs teach the continuing medical education curriculum set by the Legislature and Medical Board does not change the analysis." Mot. at 10. Plaintiffs disagree and contend that their

status as private citizens is material. They argue that the school curriculum cases are inapplicable because those cases concern "public entities or public officials" speaking, Opp'n at 11, while Plaintiffs are "private individuals [who] voluntarily teach CME courses to private licensed physicians, under the auspices of private organizations responsible for accrediting the courses, and [are] largely unsupervised by the government except for the broad standards and few mandated inclusions." Opp'n at 12. However, the Court finds the state-mandated requirements for CME courses to be more like public school curricula than monuments, license plates, trademarks, and flags.

"The government may enlist private persons to convey its governmental message, by deputizing private persons as its agents." Sangervasi v. City of San Jose, No. 22-CV-07761-VKD, 2023 WL 3604308, at *4 (N.D. Cal. May 22, 2023). CME instructors speak for the state while teaching courses because they have been delegated the power to bestow credits created and required by the state for the practice of medicine. See Nampa, 447 F. App'x at 778 n.2. There is neither a requirement nor a right to teach continuing medical education courses for credit. The power to give CME credits is not a pre-existing right on which compelled speech is conditioned. Rather, it is a power delegated and voluntarily assumed. "Simply because the government opens its mouth to speak does not give every outside individual or group a First Amendment right to play ventriloquist." Downs, 228 F.3d at 1013.

Plaintiffs are free to teach courses on any topic they choose. In their courses they may explain why they do not think "that implicit bias is the primary factor

driving disparities in healthcare[.]" See Compl. at ¶33. But if they want California to award state-created credits to participants in their courses, they must teach courses that address the content the legislature has decided is essential for medical practitioners to study. And they must communicate the information that the legislature requires medical practitioners to have. When they do so, they do not speak for themselves, but for the state.

IV. Conclusion

For the foregoing reasons, Defendants' Motion to Dismiss is GRANTED. Plaintiffs are granted leave to amend the Complaint in conformity with this Order if they can do so consistent with Rule 11 of the Federal Rules of Civil Procedure. An amended complaint must be filed and served no later than January 29, 2024. Failure to file by that date will waive the right to do so. Plaintiffs must provide a redlined version of the amended complaint to the Court's generic chambers email. The Court does not grant leave to add new defendants or new claims. Leave to add new defendants or new claims must be sought by a separate, properly noticed motion.

IT IS SO ORDERED.

Date: December 11, 2023

s/ Dale S. Fischer
Dale S. Fischer
United States
District Judge

Cal. Bus. & Prof. Code § 2190.1(d)(1)

On and after January 1, 2022, all continuing medical education courses shall contain curriculum that includes the understanding of implicit bias.

Cal. Bus. & Prof. Code § 2190.1(d)(3)

Associations that accredit continuing medical education courses shall develop standards before January 1, 2022, for compliance with the requirements of paragraph (1). The associations may update these standards, as needed, in conjunction with an advisory group established by the association that has expertise in the understanding of implicit bias.

Cal. Bus. & Prof. Code § 2190.1(e)

In order to satisfy the requirements of subdivision (d), continuing medical education courses shall address at least one or a combination of the following:

(1) Examples of how implicit bias affects perceptions and treatment decisions of physicians and surgeons, leading to disparities in health outcomes.

(2) Strategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics.

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

AZADEH KHATIBI, M.D., an individual, MARILYN M. SINGLETON, M.D., an individual, and DO NO HARM, a Virginia nonprofit corporation,

Plaintiffs,

v.

RANDY W. HAWKINS, in his official capacity as President of the Medical Board of California, LAURIE ROSE LUBIANO, in her official capacity as Vice President of the Medical Board of California, RYAN BROOKS, in his official capacity as Secretary of the Medical Board of California, REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California, and MARINA O'CONNOR, in her official capacity as Chief of Licensing, Medical Board

Case No.: 2:23-cv-06195-DSF-E

FIRST AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

of California,

Defendants.

INTRODUCTION

1. In 2019, the California Legislature enacted Assembly Bill 241. As of January 1, 2022, all continuing medical education courses in California must include discussion of "implicit bias." But the efficacy of implicit bias training in reducing disparities and negative outcomes in healthcare is controversial in the medical community and lacks evidence. Because of that controversy, because they prefer to teach different, evidence-based subjects, and because they do not want to espouse the government's view on implicit bias, Plaintiffs Azadeh Khatibi and Marilyn Singleton, as well as at least one member of Plaintiff Do No Harm, do not want to be compelled to include discussion of implicit bias in the continuing medical education courses they teach.

2. Rather than respect the freedom and judgment of continuing medical education instructors to choose which topics to teach, California law now requires the Medical Board of California to enforce the mandate that all continuing medical education courses include discussion of implicit bias. Under the First Amendment to the United States Constitution, the government cannot compel speakers to engage in discussions on subjects they prefer to remain silent about. Likewise, the government cannot condition a speaker's ability to offer courses for credit on the requirement that she espouse the government's favored view on a controversial topic. This case seeks to vindicate those important constitutional rights.

JURISDICTION AND VENUE

3. This action arises under the First and Fourteenth Amendments to the United States Constitution and 42 U.S.C. § 1983. This Court has jurisdiction over this federal claim under 28 U.S.C. §§ 1331 (federal question) and 1343(a) (redress for deprivation of civil rights). Declaratory relief is authorized by the Declaratory Judgment Act, 28 U.S.C. §§ 2201-2202.

4. Venue is proper in this Court under 28 U.S.C. § 1391(b) because a substantial part of the events giving rise to the claims occurred or will occur in this district.

PARTIES

5. Plaintiff Azadeh Khatibi, M.D., is a United States citizen and resident of Los Angeles County, California. Dr. Khatibi is a California-licensed physician and board-certified ophthalmologist who has taught and organized continuing medical education courses for credit in California.

6. Plaintiff Marilyn "Marilyne" M. Singleton, M.D., is a United States citizen and resident of Los Angeles County, California. Dr. Singleton is a California-licensed physician and board-certified anesthesiologist. Dr. Singleton teaches and organizes continuing medical education courses and has done so for many years.

7. Plaintiff Do No Harm is a national nonprofit corporation headquartered in Glen Allen, Virginia. Do No Harm's membership includes at least one individual who teaches and organizes continuing medical education courses for credit in California.

8. Defendant Randy W. Hawkins is the President of the Medical Board of California, which is responsible for regulating and licensing the practice of medicine in California, including enforcing the Medical Practice Act, Cal. Bus. & Prof. Code § 2000, *et seq*. Mr. Hawkins is sued in his official capacity.

9. Defendant Laurie Rose Lubiano is the Vice President of the Medical Board of California. Ms. Lubiano is sued in her official capacity.

10. Defendant Ryan Brooksis the Secretary of the Medical Board of California. Mr. Brooks is sued in his official capacity.

11. Defendant Reji Varghese is the Executive Director of the Medical Board of California and is sued in his official capacity.

12. Defendant Marina O'Connor is the Chief of Licensing for the Medical Board of California. As Chief of Licensing, Ms. O'Connor has principal responsibility for enforcing state requirements for continuing medical education, including Cal. Bus. & Prof. Code § 2190.1(d)(1). Ms. O'Connor is sued in her official capacity.

FACTUAL ALLEGATIONS

California's Continuing Medical Education Requirements

13. To "ensure the continuing competence of licensed physicians and surgeons," the Medical Board is responsible for "adopt[ing] and administer[ing] standards" for continuing medical education (CME). Cal. Bus. & Prof. Code § 2190.

14. Educational activities that will satisfy the Medical Board's CME standards "may include, but are

not limited to, educational activities that meet any" of four criteria: contain "scientific or clinical content" directly affecting the "quality or cost-effective provision of" healthcare; address "quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine"; address "bioethics or professional ethics"; and "improve the physician-patient relationship." Cal. Bus. & Prof. Code § 2190.1(a).

15. All California-licensed physicians are required to complete 50 hours of CME every two years. Cal. Code Regs. tit. 16, § 1336(a).

16. The Medical Board awards CME credit for all courses "which qualify for Category I credit from the California Medical Association or the American Medical Association," as well as for all courses "which qualify for prescribed credit from the American Academy of Family Physicians." Cal. Code Regs. tit. 16, § 1337(a).

17. For courses taught by "other organizations and institutions" to receive credit, Cal. Code Regs. tit. 16, § 1337(a)(3), the content "shall be directly related to patient care, community health or public health, preventive medicine, quality assurance or improvement, risk management, health facility standards, the legal aspects of clinical medicine, bioethics, professional ethics, or improvement of the physician-patient relationship." *Id.* at § 1337.5(a)(3).

18. In addition to attending CME courses, and in line with the stated purpose of ensuring the continuing competence of physicians and surgeons, Cal. Bus. & Prof. Code § 2190, doctors may satisfy some of the 50-hour CME requirement through teaching CME courses, passing a "certifying or

recertifying examination administered by a recognized specialty board," receiving the Physician's Recognition Award, and participating in an "approved postgraduate residency training program or approved clinical fellowship program." Cal. Code Regs. tit. 16, § 1337(c)-(f).

19. Physicians are required to attest that they satisfied the 50-hour CME requirement when renewing their licenses. Cal. Code Regs. tit. 16, § 1336(c).

20. Each year, the Medical Board randomly audits physicians for compliance with the CME requirement. Cal. Code Regs. tit. 16, § 1338(a). When reviewing a physician's documentation for completed continuing education, the Medical Board will randomly audit CME courses to determine whether the course is approved for credit. Cal. Code Regs. tit. 16, §§ 1337.5(b), 1338(d).

21. If a course is not audited by the Medical Board, it is awarded credit even though its content is never reviewed by the Medical Board so long as no complaint is received regarding the course. Cal. Code Regs. tit. 16, § 1337.5(b).

22. Should a course not qualify for credit after an audit, then physicians will not receive credit for that course. Cal. Code Regs. tit. 16, § 1337.5(c). And should a physician fail to satisfy the 50-hour requirement as a result, he or she will be required to cure the deficiency during the next renewal period. Cal. Code Regs. tit. 16, § 1338(b).

The Challenged Law

23. Cal. Bus. & Prof. Code § 2190.1(d)(1) declares that "[o]n and after January 1, 2022, all continuing

medical education courses shall contain curriculum that includes the understanding of implicit bias."

24. In order to satisfy the curriculum requirements of Cal. Bus. & Prof. Code § 2190.1(d)(1), continuing medical education courses must include "[e]xamples of how implicit bias affects perceptions and treatment decisions of physicians and surgeons, leading to disparities in health outcomes," or "[s]trategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics," or a combination of both. § 2190.1(e).

Implicit Bias Trainings Are Controversial

25. While there is no consensus definition, the concept of "implicit bias" refers to stereotypical or prejudicial beliefs or attitudes that an individual may unconsciously possess toward others, which can result in discriminatory actions taken by the implicitly biased individual when those beliefs or attitudes are activated.

26. In the context of healthcare, some people worry that a physician who holds implicit bias toward a patient under his or her care will render disparately worse care.

27. There is inconsistent evidence that implicit bias in healthcare is prevalent and results in disparate treatment outcomes.

28. Even assuming sufficient evidence exists that implicit bias in healthcare is prevalent and results in disparate treatment outcomes, there is no evidence-

based consensus that trainings intended to reduce implicit bias are effective.

29. Moreover, evidence shows that implicit bias trainings can cause counterproductive anger, frustration, and resentment among those taking the trainings.

30. Because neither Cal. Bus. & Prof. Code § 2190.1 nor any other California statute or regulation sets forth recognized criteria for conducting mandated implicit bias trainings, there are no measures to assure the trainings are effective.

31. By mandating all continuing medical education instructors include training on implicit bias even though evidence-based criteria ensuring the trainings are effective does not exist, section 2190.1(d) is unlikely to address the problem of implicit bias in healthcare, if any.

The Challenged Law Compels Plaintiffs' Speech

Azadeh Khatibi

32. Azadeh Khatibi was a child in Tehran during the Iranian Revolution of 1979. As a result of increasingly theocratic changes to Iranian society following the Revolution, her family joined the diaspora and uprooted to the United States, settling in Los Angeles.

33. After matriculating at UCLA, Dr. Khatibi went on to earn an M.D. from University of California, San Francisco, and master's degrees in public health and health and medical sciences from University of California, Berkeley. Now an ophthalmologist, Dr. Khatibi also teaches and organizes continuing medical education courses in California.

34. Dr. Khatibi has taught CME courses on many topics in ophthalmology, including retinal tumors, glaucoma, and other ocular diseases, as well as systemic diseases. Dr. Khatibi has also organized CME courses. All courses taught and organized by Dr. Khatibi were approved by authorized continuing medical education providers. *See* Cal. Code Regs. tit. 16, § 1337(a).

35. Other than the requirements established in section 2190.1, the content of every CME course taught by Dr. Khatibi was created and compiled by her without any supervision, approval, control, or input by any government official, including the Medical Board.

36. None of the CME courses taught by Dr. Khatibi have been audited by the Medical Board.

37. After Dr. Khatibi's courses, attendees are typically asked to fill out an evaluation. The evaluation usually includes questions asking about the effectiveness of the course and whether the course instructor possessed any bias.

38. It is not uncommon for attendees to approach Dr. Khatibi following a course taught by her to ask questions and engage in conversation about the course and material discussed.

39. CME attendees also often ask questions of Dr. Khatibi during CME courses taught by her and even debate with her.

40. Both during and after CME courses taught by Dr. Khatibi, attendees treat her as the person responsible for the content discussed.

41. In addition to the joy of sharing knowledge with others, Dr. Khatibi also benefits reputationally from teaching continuing medical education courses.

42. Dr. Khatibi wishes to continue teaching CME courses in California, but does not want to be compelled to include discussion of implicit bias in her courses when there is no relevance to her topics, or discussion of other topics is more relevant to minimize treatment outcome disparities. This is especially true given the lack of evidentiary support for implicit bias trainings and the significant time constraints usually present in delivering CME courses, which limit the amount of information capable of being discussed.

43. Further, Dr. Khatibi disagrees that implicit bias is the primary factor driving disparities in healthcare. Thus, because Dr. Khatibi's courses do not generally cover disparities in care, and because there is limited time available for instruction in a given course, section 2190.1(d)'s mandate to include discussion of implicit bias prevents her from having a more robust and appropriate discussion of the topic. Instead, she is limited to only discussing the government's preferred topic and viewpoint.

44. Even with those limitations, because section 2190.1(d) requires Dr. Khatibi to provide "examples" or "strategies" of implicit bias herself, course attendees are likely to attribute the content of CME courses taught by Dr. Khatibi as coming from her, not the Medical Board.

45. Should Dr. Khatibi teach a course without the mandated implicit bias discussion, the course would not qualify for CME credit in California. As a result, it is unlikely that physicians would elect to take such a course.

Marilyn M. Singleton

46. Dr. Singleton is a board-certified anesthesiologist and past president of the Association of American Physicians and Surgeons.

47. Dr. Singleton earned her bachelor's degree from Stanford University and her medical degree from University of California, San Francisco.

48. Dr. Singleton has taught CME courses for several years. She has also organized CME courses. All courses taught and organized by Dr. Singleton were approved by authorized continuing medical education providers. *See* Cal. Code Regs. tit. 16, § 1337(a).

49. Other than the requirements established in section 2190.1, the content of every CME course taught by Dr. Singleton was created and compiled by her without any supervision, approval, control, or input by any government official, including the Medical Board.

50. None of the CME courses taught by Dr. Singleton have been audited by the Medical Board.

51. After the courses taught by Dr. Singleton, attendees are typically asked to fill out an evaluation. The evaluation usually includes four to five questions asking about the effectiveness of the speaker and whether the speaker conveyed the stated goals of the course.

52. It is not uncommon for attendees to approach Dr. Singleton following a course taught by her to ask questions and engage in conversation about the course and material discussed.

53. Dr. Singleton is often called upon to teach CME courses and expects to be asked to do so in the future.

54. Dr. Singleton enjoys teaching CME courses and benefits financially and reputationally from doing so.

55. Should Dr. Singleton be required to include discussion of implicit bias in the courses she teaches, she would be forced to include information that is not relevant to her chosen topic. Including discussion of implicit bias in her courses would require her to change a portion of the talk to include information on implicit bias at the expense of other information she would prefer to include.

56. Further, Dr. Singleton disagrees that including discussion of implicit bias in her courses is helpful and important. To the contrary, she believes that such trainings are harmful to physicians and patients. Yet because section 2190.1(d) requires a discussion of "examples" of disparities in care resulting from implicit bias or of "strategies" to address such disparities due to implicit bias, informing an audience of her disagreement with including mandatory discussion of implicit bias would be insufficient to make clear that the government's required message is not her own. Rather, because Dr. Singleton must provide "examples" or "strategies" herself, course attendees are likely to attribute the content of CME courses taught by Dr. Singleton as coming from her, not the Medical Board.

57. If, instead, Dr. Singleton taught a course without the mandated implicit bias discussion, the course would not qualify for continuing medical education credit in California. As a result, it is unlikely that physicians would elect to take such a course.

Do No Harm

58. Do No Harm's membership is comprised of physicians, healthcare professionals, medical students, patients, and policymakers united by a mission to protect healthcare from radical, divisive, and discriminatory ideologies.

59. Do No Harm's members believe that all patients deserve access to the best possible care and that barriers to care should be broken down.

60. Do No Harm's membership includes at least one individual who teaches, has taught, and intends to teach continuing medical education courses in the future for credit in California.

61. At least one of Do No Harm's members does not want to include discussion of implicit bias in the CME courses she teaches because such trainings have not been shown to successfully reduce barriers to healthcare, and instead risk infecting healthcare decisions with divisive and discriminatory ideas.

62. If not for Cal. Bus. & Prof. Code § 2190.1(d), at least one of Do No Harm's members would not include discussion of implicit bias in the CME courses taught by her.

CAUSES OF ACTION

FIRST CLAIM FOR RELIEF

Violation of Plaintiffs' First Amendment Right to Freedom of Speech

(42 U.S.C. § 1983)

63. Plaintiffs reallege and incorporate by reference all allegations contained in the previous paragraphs.

64. An actual and substantial controversy exists between Plaintiffs, their members, and Defendants.

All Plaintiffs and their members have the right to not speak on topics they would rather remain silent about.

65. The First Amendment to the United States Constitution, as applied to the States through the Fourteenth Amendment, protects the choice of Plaintiffs and their members to not include discussions of implicit bias in the continuing medical education courses taught by them.

66. On its face and as enforced by Defendants, Cal. Bus. & Prof. Code § 2190.1(d)(1) compels Plaintiffs and their members to include discussion of implicit bias in CME courses taught by them when they would otherwise remain silent about implicit bias.

67. Compelling Plaintiffs and their members to include discussion of implicit bias in the CME courses taught by them when they would otherwise remain silent about the topic burdens their rights to free speech.

68. Section 2190.1(d)(1) is a content-based restriction on Plaintiffs' and their members' freedom of speech because it mandates the discussion of a certain topic (implicit bias) in CME courses taught by them.

69. Section 2190.1(d)(1) is also a viewpoint-based restriction on Plaintiffs' and their members' freedom of speech because it mandates speech accepting the premise of implicit bias and resulting healthcare disparities due to such bias, despite the controversial nature of both propositions.

70. Section 2190.1(d)(1) is not sufficiently tailored to serve a compelling government interest.

71. There is no evidence that CME courses have historically been used by the government to

communicate with the public or medical practitioners. Instead, history shows CME is used by the government to ensure physicians are competent to practice medicine.

72. There is no evidence that the public or attendees of CME courses perceive the content of CMEs as coming from the Medical Board, or the government generally, rather than the individual instructor.

73. There is insufficient evidence to show the Medical Board—rather than individual CME instructors and the private organizations approving their courses—controls the content of CMEs.

74. By requiring Plaintiffs and their members to include discussion of implicit bias in the CME courses they teach, Defendants maintain and actively enforce a set of laws, practices, policies, and procedures under color of state law that deprive Plaintiffs and their members of their right to free speech, in violation of the First Amendment to the United States Constitution, as applied to the States through the Fourteenth Amendment and 42 U.S.C. § 1983.

75. Plaintiffs have no adequate remedy at law to compensate for the loss of their freedom of speech and will suffer irreparable injury absent an injunction prohibiting Defendants' enforcement of the requirement in section 2190.1(d)(1) that all CME courses include a discussion of implicit bias.

76. Plaintiffs are therefore entitled to prospective declaratory and permanent injunctive relief against continued enforcement of section 2190.1(d)(1).

SECOND CLAIM FOR RELIEF
Unconstitutional Condition on Plaintiffs' First Amendment Speech Rights
(42 U.S.C. § 1983)

77. Plaintiffs reallege and incorporate by reference all allegations contained in the previous paragraphs.

78. An actual and substantial controversy exists between Plaintiffs, their members, and Defendants. All Plaintiffs and their members have the right to teach continuing medical education courses for credit free from the condition that they include the government's favored message and viewpoint in their courses.

79. On its face and as enforced by Defendants, Cal. Bus. & Prof. Code § 2190.1(d)(1), in tandem with Cal. Code Regs. tit. 16, §§ 1337.5, 1338, requires CME courses to include discussion of implicit bias in order for physician attendees to receive credit for the course.

80. Conditioning the Medical Board's conferral of continuing education credit for courses taught by Plaintiffs and their members on the requirement that Plaintiffs and their members include discussion of implicit bias violates Plaintiffs' and their members' First Amendment free speech rights.

81. By conditioning the ability of Plaintiffs and their members to teach CME courses for CME credit on the requirement that they include discussion of implicit bias in the courses they teach, Defendants maintain and actively enforce a set of laws, practices, policies, and procedures under color of state law that deprive Plaintiffs and their members of their right to free speech, in violation of the First Amendment to the United States Constitution, as applied to the States

through the Fourteenth Amendment and 42 U.S.C. § 1983.

82. Plaintiffs have no adequate remedy at law to compensate for the loss of their freedom of speech due to Defendants' condition and will suffer irreparable injury absent an injunction prohibiting Defendants' enforcement of the condition in section 2190.1(d)(1) that all CME courses include a discussion of implicit bias.

83. Plaintiffs are therefore entitled to prospective declaratory and permanent injunctive relief against continued enforcement of section 2190.1(d)(1).

REQUEST FOR RELIEF

WHEREFORE, Plaintiffs respectfully request the following relief:

A. A declaration that Cal. Bus. & Prof. Code § 2190.1(d)(1), on its face and as applied to Plaintiffs, violates the First and Fourteenth Amendments to the U.S. Constitution;

B. A permanent injunction restraining Defendants and Defendants' officers, agents, affiliates, servants, successors, employees, and all other persons in active concert or participation with Defendants from enforcing Cal. Bus. & Prof. Code § 2190.1(d)(1) against Plaintiffs and all others teaching continuing medical education courses;

C. Judgment for Plaintiffs and against Defendants for the deprivation of Plaintiffs' rights;

D. An award of attorney fees, costs, and expenses in this action pursuant to 42 U.S.C. § 1988; and

E. Any further relief as the Court may deem just, necessary, or proper.

DATED: December 22, 2023.

Respectfully submitted,

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