No. 25-1240

In the Supreme Court of the United States

AZADEH KHATIBI, *et al.*,

Petitioners,

v.

FELIX C. YIP, PRESIDENT OF THE MEDICAL BOARD OF CALIFORNIA, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

California has long required physicians and surgeons to complete continuing medical education (CME) as a condition of state licensure, thereby ensuring that they learn what is necessary to remain competent at their jobs. Examining the history of California's CME requirements, how course attendees perceive CMEs, and the extent of the State's role in controlling and shaping CME content, the court of appeals concluded "that when California—from beginning to end—dictates, controls, and approves the provider, form, purpose, and content of CMEs," "CMEs eligible for credit by the Medical Board of California are government speech." Pet. App. 4a.

The question presented is whether the court of appeals correctly applied the context-sensitive standard established by *Shurtleff v. City of Boston*, 596 U.S. 243 (2022), and *Pleasant Grove City, Utah v. Summum*, 555 U.S. 460 (2009), among other cases, in holding that California's CME program is government speech.

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STATEMENT

1. California requires that licensed physicians and surgeons complete a minimum number of CME hours. This requirement is based on the State's commitment to "ensur[ing] the continuing competence" of those professionals. Cal. Bus. & Prof. Code § 2190. The CME curriculum thus "serve[s] to maintain, develop, [and] 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). CME courses must "[h]ave 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"; "[c]oncern quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine"; "[c]oncern bioethics or professional ethics"; or be "designed to improve the physician-patient relationship and quality of physician-patient communication." *Id.*

The California Legislature has delegated responsibility for "adopt[ing] and administer[ing] standards" for CME courses to the Medical Board. Cal. Bus. & Prof. Code § 2190. The Board, in turn, has determined that certain programs provided or accredited by third parties "are approved" for CME credit. Cal. Code Regs. tit. 16, § 1337(a). Programs accredited by the California Medical Association, the American Medical Association, and the American Academy of Family Physicians are approved for credit, as are "[p]rograms offered by other organizations and institutions acceptable" to the Board. *Id.*

The Board's regulations set out detailed criteria under which courses will be deemed "acceptable" for credit. Cal. Code Regs. tit. 16, § 1337(b). Among other

requirements, each course must meet mandatory "Course Content" criteria that reflect substantive areas of physician and surgeon competency. *Id.* § 1337.5(a)(3). Consistent with the statutory standards discussed above, *supra* p. 1, "[t]he 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.* The Board enforces these curricular standards by "randomly audit[ing] courses or programs submitted for credit in addition to any course or program for which a complaint is received." *Id.* § 1337.5(b). "[F]or any course deemed unacceptable" no CME credit will be provided. *Id.* § 1337.5(c).

Beyond delegating the responsibility of setting and enforcing content standards to the Board, the California Legislature has asserted control over the content of CME courses in other ways. In 2001, for example, it required that physicians complete CME "in the subjects of pain management and the treatment of terminally ill and dying patients," or "in the subject of treatment and management of opiate-dependent patients." Cal. Bus. & Prof. Code §§ 2190.5, 2190.6. In 2006, it enacted an additional requirement that "all continuing medical education courses shall contain curriculum that includes cultural and linguistic competency in the practice of medicine." *Id.* § 2190.1(b).

2. In 2019, the Legislature adopted the component of CME courses at issue here. The Legislature made findings that implicit bias "often contributes to unequal treatment of people" based on race, ethnicity, gender, sexual orientation, age, disability, and other

protected characteristics. 2019 Cal. Stat. ch. 417 § 1(a). It cited data showing, for example, that "African American patients are often prescribed less pain medication than white patients who present the same complaints" and "[w]omen are less likely to survive a heart attack when they are treated by a male physician and surgeon." *Id.* § 1(d), (e).

Although the Legislature concluded that it was important for CME courses to address implicit bias, it provided flexibility to CME instructors in meeting the new requirement. Beginning in 2022, CME instructors were required to address "at least one . . . of the following": (1) "[e]xamples of how implicit bias affects perceptions and treatment decisions of physicians and surgeons, leading to disparities in health outcomes," or (2) "[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, sex, and other characteristics. Cal. Bus. & Prof. Code § 2190.1(e). The second option allows CME instructors to avoid taking a position on whether implicit bias exists. Instructors can instead discuss "strategies to address" such bias, on the assumption that it "may contribute to health care disparities." *Id.*

3. a. Petitioners are a physician who teaches CME courses and an organization that counts at least one such individual as a member. Pet. App. 7a-8a. In 2023, petitioners filed suit, alleging that California's implicit-bias requirement unconstitutionally compels private speech in violation of the First Amendment. *Id.* at 117a. Petitioners challenged neither California's general requirement that licensed physicians complete a minimum number of CME hours nor any other standards governing CME content. *Id.* at 56a.

After one round of dismissal and amended pleadings, the district court dismissed petitioners' complaint. Applying *Shurtleff v. City of Boston*, 596 U.S. 243 (2022), the district court held that the "holistic government-speech inquiry firmly resolves in favor of" a finding of government speech. Pet. App. 57a. Relevant to the district court's analysis were (i) California's "longstanding practice of using continuing education requirements" as a means of "communicating . . . the subjects it views as essential for continued medical practice in the State," *id.* at 50a-51a; (ii) the likelihood that "physicians take [petitioners'] CME courses because they know the content meets State requirements and comes from the State," *id.* at 52a; and (iii) the "significant degree of control" that California exerts "over the content of CME courses," *id.* at 57a.

b. The court of appeals affirmed in a unanimous opinion. The court emphasized that this Court's recent decision in *Shurtleff* requires a "'holistic,'" context-sensitive consideration of three factors: "history, public perception, and control." Pet. App. 4a, 14a. Applying that framework, the court agreed with the district court that "California—from beginning to end—dictates, controls, and approves the provider, form, purpose, and content of CMEs." *Id.* at 4a. The court emphasized, however, that its "holding is narrow." *Id.* It is limited to California's CME program; it does not extend to other forms of professional licensing, instruction, or accreditation, or even to CME courses in other States. *See, e.g.*, *id.* at 31a n.10.

Starting with history, the court concluded that the relevant historical context "weighs decisively in favor of the State." Pet. App. 17a. Because doctors "'*treat* other humans, and their treatment can result in physical and psychological harm to their patients,'" the

degree of state regulation in the medical sphere has long been greater than in other professional contexts. *Id.* at 14a (emphasis in original). In California, the State has "actively regulated" medical professionals since the 1870s when it created the Board to "combat the problem of quack doctors in the decades following the Gold Rush." *Id.* at 17a, 18a. For many years, "the Board has specifically and continually 'adopt[ed] and administer[ed]' CME requirements," including requirements for CME courses to focus on enumerated topics. *Id.* at 15a. Over time, the State has steadily "expand[ed] [those] requirements" and "excluded certain CMEs from credit." *Id.* at 16a. As the court explained, those requirements "reflect[] the State's evolving judgment of what subjects it has deemed essential" to ensure physician competency. *Id.* at 20a.

Turning to the second factor—whether reasonable observers would likely attribute content to the government—the court emphasized that the "CME scheme exists for licensed medical professionals, not the [general] public." Pet. App. 22a. That particular audience would likely "attribute approved CMEs' content to California." *Id.* at 24a. "[T]he entire CME scheme was created" "to ensure the continuing competence of licensed physicians" under the State's standards of practice. *Id.* (internal quotation marks omitted). Physicians "attend CMEs . . . to secure credits to maintain their licenses," understanding that "the Board requires licensees to take certain classes with specific content" and "only compliant CMEs get credit." *Id.* Although the court acknowledged that California "relies . . . on the participation of private parties in executing the CME scheme," *id.* at 23a, it pointed out that there are many cases in which "'private parties take part in the design and propagation of a message'" without "'extinguish[ing] [its] governmental nature.'"

Id. (citing *Johanns v. Livestock Mktg. Ass'n*, 544 U.S. 550, 562 (2005), and *Walker v. Tex. Div., Sons of Confederate Veterans, Inc.*, 576 U.S. 200, 217 (2015)).

Finally, as to the extent of governmental control, the court concluded that California exerted "extraordinary control" over CME accreditation, including by "shap[ing] the content of CMEs" and "impos[ing] several restrictions on their form and delivery." Pet. App. 25a-26a. Examples include the Board's authority to "set content standards," *id.* at 26a (internal quotation marks omitted); the Legislature's direction to the Board to "consider a plethora of subjects for accredited CMEs," *id.*; and the "meticulous[]" statutory enumeration of topics that CME courses must cover, *id.* at 27a. The court also stressed that "the Board exercises final approval authority over the CME scheme" via its auditing authority. *Id.* at 30a; *see id.* at 31a ("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,'" and "the starting and endpoint for any CME provider.").

The court of appeals denied petitioners' request for rehearing en banc. Pet. App. 63a. Judges VanDyke and Tung dissented, joined by Judge Bumatay. *Id.* at 63a-91a. No other member of the court dissented.

ARGUMENT

Applying the context-sensitive factors that this Court identified in *Shurtleff v. City of Boston*, 596 U.S. 243 (2022), among other cases, the court of appeals held that California's continuing medical education (CME) program constitutes a form of government speech. The court's "holding is narrow": It applies

only to CME requirements, not other forms of professional licensing or accreditation. Pet. App. 4a. It is also limited to the particular features of California's CME program; it does not extend to any other State's CME regulations. *Id.* at 19a n.5, 31a n.10. And it leaves petitioners "free to teach whatever [they] wish[] in [their] own 'expressive capacity.'" *Id.* at 21a n.7. The court merely held that petitioners must abide by the State's restrictions if they wish the courses that they teach be eligible for state-approved CME credit.

Because that narrow, state-specific ruling is consistent with the precedents of this Court and other courts of appeals, certiorari should be denied. Conversely, granting review and entertaining petitioners' constitutional theory would threaten to transform regulation of the medical profession. Petitioners' theory would automatically subject all content-based restrictions of CMEs—not just in California, but everywhere—to strict scrutiny. That would imperil longstanding regulations designed to ensure the competence of doctors and protect patient health. *Cf. Free Speech Coal., Inc. v. Paxton*, 606 U.S. 461, 485 (2025) ("strict scrutiny is ill suited for such nuanced work").

1. The court of appeals' decision correctly applies this Court's precedents and does not conflict with the decisions of any other courts of appeals.

a. "[T]o determine whether the government intends to speak for itself," the Court has "conduct[ed] a holistic inquiry" that turns on several factors: "the history of the expression"; a reasonable observer's "perception as to who . . . is speaking"; and "the extent to which the government has actively shaped or controlled the expression." *Shurtleff*, 596 U.S. at 251-252; *see also, e.g.*, *Walker v. Tex. Div., Sons of Confederate Veterans, Inc.*, 576 U.S. 200, 209-210 (2015). Applying

those factors here, the court of appeals carefully examined over a century of medical regulation in California and concluded that the State's CME program qualifies as government expression. *Supra* pp. 4-6. The court emphasized that California has "actively regulated" the profession since the 1870s, Pet. App. 17a, to guard "against 'quacks and pretenders and from the mistakes of incapable practitioners,'" *id.* at 38a; *see supra* pp. 4-5. The court also explained why doctors viewing CME courses would "attribute approved CMEs' content to California." Pet. App. 24a; *see supra* pp. 5-6. And the court detailed the "meticulous[]" ways, Pet. App. 27a, in which the State has "shap[ed] the content of CMEs" to ensure physicians' competence, *id.* at 25a; *see supra* p. 6.

Petitioners nonetheless assert that the CME program is a form of "private speech" subject to regular "First Amendment scrutiny." Pet. 14, 19. If accepted, that view would have extraordinary consequences. Petitioners would subject all content or viewpoint-based restrictions on CMEs to strict scrutiny—an "unforgiving" standard that is generally "fatal in fact." *Free Speech Coal.*, 606 U.S. at 484, 485. States need flexibility to impose content-based standards in this area to ensure doctors are competent. Indeed, it is not clear how a State could feasibly manage a CME program without setting content-based standards, such as rules requiring courses to address "the subjects of pain management" and "treatment . . . of opiate-dependent patients," *e.g.*, Cal. Bus. & Prof. Code §§ 2190.5, 2190.6; "professional ethics," *e.g.*, Cal. Code Regs. tit. 16, § 1337.5(a)(3); and "preventive medicine," *e.g.*, *id.* Nor could States responsibly manage CME programs without occasionally engaging in viewpoint-based regulation—for example, by requiring that state-approved CME courses not promote unsafe

or unsupported practices that could harm patients. *Cf.* Cal. Med. Ass'n, Letter to Accredited Providers (July 24, 2023), https://tinyurl.com/3yj2d52h (warning CME providers to refrain from promoting benefits of "psychedelic and dissociative therapy," "off-label use[s] of hormones," and "fad diets").

Petitioners argue that the court of appeals relied too heavily on California's "extensive regulation" in treating CME content as government expression. Pet. 10. As the court of appeals made clear, however, "[i]t would be a serious affront to the Constitution if regulatory history alone were sufficient to immunize speech from First Amendment scrutiny." Pet. App. 17a. That is why the court identified the message that California intended to express through the CME program, *see id.* at 19a-20a, and extensively explained why the relevant audience would "attribute approved CMEs' content to California," *id.* at 24a. The court emphasized that the "CME scheme exists for licensed medical professionals, not the [general] public." *Id.* at 22a. Medical professionals have a sophisticated understanding of the ways in which the State shapes CME content to ensure it reflects the State's preferred message about competent standards of medical practice. *Id.* at 24a-25a; *see id.* at 19a-20a ("California's CME requirements necessarily reflect . . . the importance of certain subjects to medical professionals'" and "the State's evolving judgment of what subjects it has deemed essential to 'ensure the continuing competence of licensed physicians and surgeons'").

Petitioners also heavily emphasize that CME course instructors are "private speakers." *E.g.*, Pet. 12. But private-party involvement is the beginning, not the end, of the government-speech inquiry. *Supra* pp. 5-6. As the court of appeals recognized, *see*

Pet. App. 23a, "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*, 576 U.S. at 217. This Court has repeatedly recognized that expression conveyed by private parties can qualify as government speech. *See id.* (license plate designs); *Johanns v. Livestock Mktg. Ass'n*, 544 U.S. 550, 562 (2005) (beef industry marketing communications); *Pleasant Grove City v. Summum*, 555 U.S. 460, 473 (2009) (privately donated monuments); *see also Shurtleff*, 596 U.S. at 257-258 (privately submitted flags for flying on government property would likely qualify as government expression if the government exercised control over their selection).

The Court's decision in *Matal v. Tam*, 582 U.S. 218 (2017), does not support petitioners' theory. *Contra* Pet. 2, 10-12. In *Matal*, the Court refused to treat trademarks as government speech because the Patent & Trademark Office (PTO) imposed no content standards on the "vast array" of diverse marks and "made it clear that registration does not constitute [government] approval." 582 U.S. at 236-237. "Trademarks," the Court emphasized, "have not traditionally been used to convey a Government message." *Id.* at 238. In contrast, California has long controlled the list of topics available for CME credit—precisely because the objective of the CME program is to communicate what the State believes is necessary for physician competence. *See, e.g.*, Pet. App. 20a-22a; 26a-30a. And "unlike the PTO," which "'made it clear that [trademark] registration does not constitute approval of a mark,'" California "has never disclaimed approval of accredited CMEs." *Id.* at 21a.

Petitioners assert that California's CME program cannot be an exercise of government speech because

there are "thousands of privately created CME courses reflecting divergent viewpoints." Pet. 18. But the government may deliver its message through private parties without prescribing *every word* those parties say. *See Shurtleff*, 596 U.S. at 268 (Alito, J., concurring in the judgment) ("[T]he government must 'se[t] the overall message to be communicated' through official action."). As this Court has recognized, a common mode of expression is "presenting a curated compilation of [others'] speech." *Moody v. NetChoice, LLC*, 603 U.S. 707, 728 (2024). That is true when the government speaks, no less than any other type of speaker. *See, e.g.*, *Summum*, 555 U.S. at 474-477. And for the reasons detailed by the court of appeals, *see* Pet. App. 15a-16a, 19a-20a, 26a-29a, the State is certainly responsible for curating the compilation *of topics* discussed in CME courses—such as pain management, bioethics, preventive medicine, or as relevant here, implicit bias—even if it is not responsible for every word spoken by an instructor.[1]

b. Nor do petitioners identify any conflict among the courts of appeals. According to petitioners, the decision below conflicts with decisions of all other circuits because it fails to assess "whether the government has meaningfully shaped the content of the expression for the purpose of expressing its own view."

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[1] Petitioners also invoke (Pet. 10, 13) *National Institute of Family & Life Advocates v. Becerra*, 585 U.S. 755 (2018) and *Chiles v. Salazar*, 146 S. Ct. 1010 (2026). As petitioners acknowledge, however, neither case involved arguments about the scope of the government-speech doctrine and no party disputed that regulations of private speech were at issue. Decisions have little relevance to the government-speech inquiry if "the speech [at issue] was, or was presumed to be, that of an entity other than the government itself." *Johanns*, 544 U.S. at 559.

Pet. 14; *see id.* at 14-17. That is not an accurate understanding of the court of appeals' decision. *Supra* pp. 4-6, 9. The court explained at length why the State "not only shapes the content of CMEs" "'from beginning to end'" to communicate its desired message "but . . . also imposes several restrictions on [CMEs'] form and delivery." Pet. App. 25a-26a. Petitioners are wrong in suggesting that California engages only in "post hoc review" of CME content through "audits." Pet. 16. As the court of appeals explained, "the State's multifaceted CME statutory and regulatory scheme" imposes "myriad" "content-related requirements." Pet. App. 26a, 29a; *see id.* at 37a ("The content of accredited CMEs, as we have detailed, is shaped by the State from their inception.").

None of the cases invoked by petitioners involved CMEs or other analogous forms of expression. *See* Pet. 14-17. All that those cases establish is that the courts of appeals are applying the government-speech inquiry in the holistic and context-dependent manner prescribed by this Court—reaching case-specific answers based on the particular speech at issue. For example, the Sixth Circuit held that a summary of a proposed ballot measure was not government speech because the government did not prescribe the summaries' content, and any governmental review was limited to certifying the content as "fair and truthful." *Brown v. Yost*, 133 F.4th 725, 734-735 (6th Cir. 2025).[2]

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[2] *See also Cajune v. Indep. Sch. Dist. 194*, 105 F.4th 1070, 1081 (8th Cir. 2024) (posters on school walls did not qualify as government speech where, among other factors, the school district "disclaimed . . . involvement with the posters" and "did not prescribe" their content); *New Hope Family Servs., Inc. v. Poole*, 966 F.3d 145, 174 (2d Cir. 2020) (adoption agency's speech did not qualify as government expression where "nothing . . . suggests that the

(continued…)

By contrast, where the government is more involved in prescribing, selecting, or crafting the content of speech, lower courts have concluded that speech is the government's. *See, e.g.*, *Colorado v. Griswold*, 99 F.4th 1234, 1241 (10th Cir. 2024) (ballot titles are government speech because of state's longstanding control over title content); *Little v. Llano Cnty.*, 138 F.4th 834, 860-866 (5th Cir. 2025) (en banc) (state engaging in form of government speech when "curating and presenting" selection of library books); *Women for Am. First v. Adams*, 2022 WL 1714896, at *2-*3 (2d. Cir. May 27, 2022) (unpublished) (murals were government speech because of "historical communicative use" and government "control over their content").

To the extent these lower-court cases have any relevance here, they undermine petitioners' objections to the Ninth Circuit's reasoning. As discussed above, for example, petitioners assert that California's CME curriculum cannot qualify as government speech because it is presented "through thousands of privately created . . . divergent viewpoints." Pet. 18; *see supra* p. 11. But applying *Summum*, 555 U.S. at 474-477, and *Walker*, 576 U.S. at 213, lower courts have treated the government as a speaker when it curates or compiles the expression of private parties. *See, e.g.*, *Little*, 138 F.4th at 864 (treating curation of a wide "variety of books" as government speech); *Colorado*, 99 F.4th at 1241 (titles of diverse "citizen-initiated ballot measures" constitute government speech).

2. Petitioners argue that the case implicates "a question of profound and recurring national

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public understands [the agency's] expressive activities, either in generally providing adoption services or, ultimately, in recommending a child's placement, to be the State's own message").

importance: May a State compel private speakers in regulated professions to deliver the government's preferred message." Pet. 17. That is incorrect. As discussed above, *supra* pp. 4, 7-8, the court of appeals' decision is exceptionally narrow: it applies only to CME courses in California, not other States, and does not address any forms of accreditation, licensure, or instruction in other professional contexts. The decision is also relevant only insofar as instructors seek CME accreditation; it otherwise leaves them "free to teach whatever [they] wish[]." Pet. App. 21a n.7. And nothing in the court of appeals' decision dictates that every word spoken by a CME instructor must be treated as government expression. *Supra* p. 11.

In light of those limits on the court of appeals' holding, petitioners cannot show that it has "immediate and concrete" implications for "private instructional speech" in a range of other contexts. Pet. 18. Indeed, the Ninth Circuit recently refused to treat another form of instruction-related expression as government speech. *See Reges v. Cauce*, 175 F.4th 1014, 1031-1032 (9th Cir. 2026) (college course syllabus). Other courts have reached similar conclusions.[3] If any of the hypotheticals discussed by petitioners actually materialize, *see* Pet. 18-19, nothing in the Ninth Circuit's narrow opinion here will dictate the outcome of future challenges. And if the Ninth Circuit or any other court were to uphold petitioners' hypothesized laws, *see, e.g.*, *id.* at 19 (speculating about potential regulations of

[3] *See, e.g.*, *Pernell v. Fla. Bd. of Governors of State Univ.*, 181 F.4th 1135, 1154-1158 (11th Cir. 2026) (rejecting Florida's argument that "because [university] professors were hired by and . . . paid by the government, everything they say in their classrooms is really the government speaking").

continuing legal education courses), challengers would be free to seek this Court's review.

Petitioners also overstate the implications of the statutory requirements challenged in this case. According to petitioners, the relevant provision requires them "'to convey a viewpoint they find objectionable.'" Pet. 14 (quoting Pet. App. 84a (Tung, J., dissenting)). But California law does not require CME instructors to express the "contested view that unconscious biases drive disparities in [medical] outcomes." *Id.* at 1. Rather, it gives instructors flexibility in choosing what specific content about implicit bias to teach: instructions may *either* provide "[e]xamples of how implicit bias affects perceptions and treatment decisions" *or* discuss "[s]trategies to address how unintended biases in decisionmaking *may* contribute to health care disparities." Cal. Bus. & Prof. Code § 2190.1(e) (emphasis added). Under the second option, instructors who do not believe that implicit bias exists are free to say so. They may instead satisfy all applicable requirements by recommending "strategies to address" such bias on the *assumption* that it exists. *Id.* § 2190.1(e)(2). That type of recommendation is not uncommon in the medical field. Doctors frequently recommend precautions in the face of uncertain scientific evidence. *See, e.g.*, Cleveland Clinic, Caffeine & Pregnancy (Mar. 23, 2026), https://tinyurl.com/hh97rpdh (advising pregnant women to refrain from caffeine as a precaution because of possible adverse health effects).[4]

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[4] Petitioners are also free to inform CME attendees that any discussion of implicit bias is included solely to comply with state requirements. *See* Oral Arg. at 19:52-19:58, 21:04-21:15 (Mar. 27, 2025), https://tinyurl.com/4mmn574b.

While denying certiorari and leaving the court of appeal's narrow decision in place would not have the consequences alleged by petitioners, *see* Pet. 17-20, granting review and endorsing petitioners' theory would threaten to upend regulation of the medical profession. California and other States depend on content-based (and sometimes even viewpoint-based) determinations to ensure that CMEs maintain physician competency, protect patient health, and save lives. *See, e.g.*, *supra* pp. 8-9; 21 N.C. Admin. Code 32R.0101(a) (CME instruction must be consistent with "generally recognized and accepted" norms of medical science); Haw. Code R. § 16-85-32.5 (same); Fla. Admin. Code Ann. r. 64B8-13.005(1)(b) (requiring CME training on HIV/AIDS, including "universal precautions" and "treatment of patients"); Ga. Comp. R. & Regs. 360-15-0.1(5) ("professional boundaries and physician sexual misconduct"); Alaska Admin. Code tit. 12, § 40.200(a)(1)(2) (prescription standards for opioids and other controlled substances); Conn. Gen. Stat. § 20-10b(b) (same); Tenn. Comp. R. & Regs. 0880-02-.19(1)(b) (same); W. Va. Code R. § 11-1B-14.3 (same).[5] Petitioners provide no sensible reason to jeopardize the States' authority to enact such laws, "'upon which health and life depend.'" Pet. App. 4a.

[5] *See also* Ala. Admin. Code r. 540-X-14-.02(4); Ariz. Rev. Stat. Ann. § 32-1434; 17-140-11 Ark. Code R. § 1101(b)(5); Idaho Admin. Code r. 24.33.01.100(04)(a)(i); Ill. Admin. Code tit. 68, § 1285.110(c)(3); Md. Code Regs. 10.32.01.10(B); Neb. Rev. Stat. § 38-145(2); N.H. Rev. Stat. Ann. § 329:16-g; Utah Admin. Code R156-67-304(2).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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