No. 24-3108

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

AZADEH KHATIBI, ET AL.,
Plaintiffs-Appellants,

v.

RANDY W. HAWKINS, ET AL.,
Defendants-Appellees.

On Appeal from the United States District Court
for the Central District of California
No. 2:23-cv-06195-MRA-E
The Honorable Monica Ramirez Almadani, Judge

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COURT RULES

INTRODUCTION

California has long regulated the practice of medicine to protect its residents who place their trust in medical professionals. A critical feature of that regulation is the requirement that licensed physicians complete continuing medical education ("CME") to ensure their competence in providing medical care. And as part of the CME mandate, medical professionals must take CME courses that comply with California's statutorily specified curriculum requirements, which include training on implicit bias.

Plaintiffs, who teach CME courses for credit, contend that the implicit bias requirement impermissibly compels them to speak on a topic with which they disagree and on which they would prefer to remain silent, and places unlawful conditions on their teaching. Notably, Plaintiffs do not contest the lawfulness of California's numerous other CME curricular requirements that ensure that physicians receive training on subject matters relevant to the practice of medicine, such as pain management and geriatric medicine. Indeed, Plaintiffs concede that they "are not objecting to the subject matter mandated by the state in its regulatory capacity." Opening Br. 18. But the implicit bias requirement, no less than the other statutorily mandated CME course content requirements, is government speech rather than private speech for First Amendment purposes.

CME courses are part of California's long-standing tradition of regulating the medical profession and the Legislature is communicating through statutorily specified curriculum requirements the subjects that it has determined are essential to the competent practice of medicine. As Plaintiffs point out, through CME courses, "the government is communicating the importance of certain subjects to medical professionals." Opening Br. 18. Physicians who take State-mandated CME courses to maintain their State-issued license understand how their profession is regulated, that the State sets the licensing requirements, and that the State sets the curriculum for courses they are required to take to maintain their State-issued license. And though the courses are administered by private individuals, those individuals speak for the State when teaching CME courses. California has directed the implementation of a coordinated CME program to ensure the competence of medical professionals, specified by statute what content CME programs must contain, and entrusted the Medical Board with final authority over CME courses. California controls the content of CME courses. For these reasons, CME course content, including the implicit bias requirement, is government speech.

But even if CME courses were to be considered private speech, the State's implicit bias requirement does not violate the First Amendment under the unconstitutional conditions doctrine. No one is *required* to teach CME courses, so

the government is not compelling any speech. Rather, the State seeks to ensure that individuals who choose to teach CME courses include content on implicit bias, in addition to the many other topics discussed, to achieve compliance with the State's mandate. That condition does not violate the First Amendment because it is reasonably related to the State's interest in protecting the public by ensuring the competence of its licensed medical professionals. The principle that the Legislature—not private citizens—should have the authority to require medical practitioners to receive instruction on subjects it deems important to the safe, competent, and unbiased delivery of medical care is at the core of regulating the medical profession, maintaining the quality of the profession, and protecting patients.

For these reasons the Court should reject Plaintiffs' arguments in full and affirm the judgment of the district court.

STATUTORY ADDENDUM

The relevant statutory text is included in an addendum at the end of the brief.

STATEMENT OF THE CASE

A. California's History of Regulating the Medical Profession

California has a long-standing tradition of regulating the practice of medicine to protect the public. *See Arnett v. Dal Cielo*, 14 Cal. 4th 4, 7 (1996) (citing statutes dating back to 1876 and observing that "[t]he state has long regulated the

practice of medicine as an exercise of the police power"). Since at least 1876, California has imposed licensing and training requirements on medical practitioners. *See* 1876 Cal. Stats., ch. 518, p. 792, § 1. "Since the earliest days of regulation," the State has sought to "protect the public against incompetent, impaired, or negligent physicians." *Arnett*, 14 Cal. 4th at 7.

Since the late nineteenth century, the practice of medicine in this State has been governed primarily by the Medical Board of California ("Medical Board"), which regulates physicians and surgeons by issuing or revoking licenses, imposing discipline, administering its CME program, and enforcing the statutes governing the practice of medicine. Cal. Bus. & Prof. Code § 2004.[1] In carrying out its duties, the Board's highest priority is protection of the public. § 2001.1; *see also Arnett*, 14 Cal. 4th at 9 ("[T]he purpose of the Board is to protect the health and safety of the public.").

1. The Legislature Has Enacted Specific Standards and Content Requirements for CME

California requires licensed physicians to complete 50 hours of approved CME every two years. Cal. Code Regs. tit. 16, § 1336(a). The Legislature has historically used continuing education curriculum requirements as a way to ensure that licensed physicians are adequately trained in subjects the State considers

[1] All further statutory references are to the California Business and Professions Code unless otherwise noted.

essential to maintaining competence in the profession. *See* § 2190 (continuing education standards are designed "to ensure the continuing competence of licensed physicians and surgeons").

Accordingly, the Legislature requires that CME courses meet specific content requirements to qualify for CME credit. Section 2190.1 requires that medical professionals participate in "educational activities that meet the standards of the [Medical] board and that 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." § 2190.1(a). These "may include, but are not limited to, educational activities" that:

> (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.

Id.

CME curriculum requirements include specific subjects. For example, since 2001, licensed physicians have been required to complete mandatory continuing education in the subjects of pain management and the treatment of terminally ill

and dying patients, or alternatively in the treatment and management of opiate-dependent patients. §§ 2190.5, 2190.6. "All general internists and family physicians who have a patient population of which over 25 percent are 65 years of age or older" must complete training in "geriatric medicine or the care of older patients." § 2190.3. And since 2006, all CME courses must contain curriculum on "cultural and linguistic competency in the practice of medicine." § 2190.1(b)(1). This is separate from the implicit bias requirement. *See* § 2190.1(d)(1). The Legislature also has a long history of specifying which courses do *not* qualify for CME credit. For instance, between 1992 and 2021, curriculum geared toward the business of a medical practice, such as "medical office management, billing and coding, and marketing," expressly did not qualify for licensure credit. § 2190.1(f). In 2021, the Legislature changed the law to allow up to 30 percent of the total hours required for CME to include content on practice management designed to provide better service to patients or have management content designed to support managing a healthcare facility, including, but not limited to, coding or reimbursement in a medical practice. § 2190.15.

2. The Medical Board Has Final Authority Over CME Courses

In addition to setting forth specific statutory requirements, the Legislature has delegated to the Medical Board the authority to approve courses for credit. The Board determines which courses satisfy State standards and are acceptable for

credit: "*Only those courses and other educational activities that meet the requirements of Section 2190.1* of the [Business and Professions] code which are offered by [specified] organizations shall be acceptable for credit." Cal. Code Regs. tit. 16, § 1337(b) (emphasis added). The Board must also "establish criteria that providers of continuing medical education shall follow to ensure attendance by licensees throughout the entire course." § 2190.2.

The following organizations may offer programs for CME credit: The California Medical Association, the American Medical Association, and the American Academy of Family Physicians. Cal. Code Regs tit. 16, § 1337(a). These organizations are long-standing, professional organizations accredited by the Accreditation Council for Continuing Medical Education; they are responsible for accrediting CME courses that comply with the specific curriculum requirements established by the Legislature in the code and regulations. Aside from these institutions, "organizations and institutions acceptable to the division" may also offer programs for CME credit. *Id.* These organizations must meet specific requirements set forth in the regulations "in order to be acceptable to the [Board]," including that "[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.*, § 1337.5(a).

The Medical Board has the authority to 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). As part of the audit process, course organizers must provide to the Board the instructor's curriculum vitae; rationale for the course; course content; educational objectives; teaching methods; evidence of evaluation; and attendance records. *Id.* "Credit toward the required hours of continuing education will not be received for any course deemed unacceptable by the [Board] after an audit has been made." *Id.*, § 1337.5(c). In addition to auditing CME course providers, the Board also "shall audit during each year a random sample of physicians who have reported compliance with the continuing education requirement." *Id.*, § 1338(a). It constitutes unprofessional conduct for any physician to misrepresent his or her compliance with the CME requirements. *Id.*, § 1338(c).

B. Section 2190.1's Implicit Bias Training Requirement

In 2019, the Legislature enacted AB 241 as part of its long-standing tradition of regulating the medical profession in California. AB 241 amended section 2190.1 to require that all CME courses "contain curriculum that includes specified instruction in the understanding of implicit bias." AB 241 (codified at Cal. Bus. &

Prof. Code § 2190.1). In passing AB 241, the Legislature expressly found that implicit bias "often contributes to unequal treatment of people based on race, ethnicity, gender identity, sexual orientation, age, disability, and other characteristics." AB 241, § 1(a). Specifically, the Legislature found that implicit bias "contributes to health disparities by affecting the behavior of physicians and surgeons, nurses, physician assistants, and other healing arts licensees." *Id.*, § 1(b). For example, "African American women are three to four times more likely than white women to die from pregnancy-related causes nationwide," and "African American patients with signs of heart problems are not referred for advanced cardiovascular procedures as often as white patients with the same symptoms." *Id.*, § 1(d).

As with other subjects required for CME credit, *supra* at pp. 5-6, section 2190.1 sets forth specific content requirements for implicit bias training:

> [C]ontinuing 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.

§ 2190.1(e).

PROCEDURAL HISTORY

In August 2023, Plaintiffs (physicians who teach CME courses and the Do No Harm organization) filed suit alleging that the State's requirement that for-credit CME courses include a discussion of implicit bias (1) burdens their free speech rights because it compels them to teach on a subject on which they would otherwise remain silent, and (2) improperly conditions their free speech rights, in violation of the First Amendment. SER-12, 13, 14. On December 11, 2023, the district court dismissed Plaintiffs' complaint for failure to state a claim, but granted Plaintiffs leave to amend. ER-020.

On December 22, 2023, Plaintiffs filed a First Amended Complaint raising the same claims as those in the original complaint, with some additional factual assertions. ER-029. The district court again dismissed Plaintiffs' complaint for failure to state cognizable compelled speech and unconstitutional condition claims, this time without leave to amend. ER-003. The court found that the "holistic government-speech inquiry firmly resolves in favor of finding that teaching CME courses in California constitutes government speech" and that "CME credits are not government benefits, but rather confer a delegation of state authority." ER-016, 017. The court also found that further amendment would be futile because Plaintiffs' "reliance on legal conclusions and the substantial factual similarities

between the original and amended complaint[]" indicated that Plaintiffs had "no additional material facts to plead." ER-017.

STANDARD OF REVIEW

An order granting a motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6) is reviewed de novo. *Manzarek v. St. Paul Fire & Marine Ins. Co.*, 519 F.3d 1025, 1030 (9th Cir. 2008). Review is limited to the contents of the complaint where all well-pled allegations of material fact are accepted as true. *See id.* at 1030-31. The appellate court, however, is not required to accept as true allegations that are merely conclusory, unwarranted deductions of fact, or unreasonable inferences. *See Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555 (2007); *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

In reviewing a district court's decision, the reviewing court may affirm on any ground that has support in the record, whether or not the district court's decision relied on the same grounds or reasoning. *Atel Fin'l Corp. v. Quaker Coal Co.*, 321 F.3d 924, 926 (9th Cir. 2003).

SUMMARY OF THE ARGUMENT

The district court correctly dismissed Plaintiffs' complaint because they have failed to state a First Amendment claim under either a compelled speech theory or an unconstitutional conditions theory.

The State's requirement that CME courses include discussion of implicit bias is statutorily mandated government speech under the "holistic inquiry" adopted by the Supreme Court in *Shurtleff v. City of Boston*, 596 U.S. 243, 252 (2022). *First,* California has a long-standing history of regulating the practice of medicine and establishing and supervising licensing requirements for medical practitioners. *Id.* at 252. As part of that tradition, California requires licensed physicians to take CME courses to maintain their State-issued medical licenses, and communicates through these CME courses information about medical subjects that it deems essential for the competent practice of medicine.

Second, licensed medical practitioners are likely to perceive the content of CME courses as coming from the State. *Id.* These courses are created specifically for licensed medical professionals to maintain their license—not for the public at large. As Plaintiffs concede, physicians seeking to comply with the Board's licensing requirement would not take a course if it did not fulfill the CME requirements (Opening Br. 20), and they know that the State requires courses on specific topics such as geriatric medicine and pain management (Opening Br. 22-23). There is no reason they should not also know that the State requires them to receive training on the topic of implicit bias; indeed, it is spelled out in the statute.

Third, the government speech doctrine applies because California controls, or at a minimum significantly shapes, the content of CME courses. *Shurtleff*, 596

U.S. at 252. The Legislature has set out specific content requirements for its CME curriculum, to which instructors must adhere. Plaintiffs acknowledge that the State can set such curricular requirements for CME courses apart from the implicit bias requirement (Opening Br. 22), but there is no reason to treat implicit bias differently from other CME curricular requirements. And the Medical Board need not directly develop or supervise CME course content in order for it to constitute government speech. As long as the government directs the implementation of a coordinated program to advance a particular goal, sets out the overarching message, and has final approval authority over the program, it effectively controls the content for purposes of the government speech doctrine. *Johanns v. Livestock Mktg. Ass'n*, 544 U.S. 550, 561 (2005). Here, California has directed the implementation of a coordinated CME program to ensure the competence of medical professionals and specified, by statute, what content CME programs must contain. The Medical Board has final authority over CME curriculum and may ensure compliance with CME requirements. California controls the content of CME courses.

Contrary to Plaintiffs' assertion, this conclusion does not expand the government speech doctrine "beyond reason" because all government speech is subject to the holistic inquiry mandated by *Shurtleff*. Nor does the government speech doctrine undermine the First Amendment's protections against compelled

speech, which continue to protect all private, non-governmental speech. And in any case, Plaintiffs are not compelled to do anything—they are not required to teach CME courses, and they are free to voice their opposition to the concept of implicit bias. The government-employee speech doctrine also does not apply, as Plaintiffs are not government employees but private citizens who are free to teach courses on any topic they wish and are free to include whatever content they wish; they must comply with California's specific content requirements only if they want to teach CME courses for credit so that attendees can maintain their State-issued medical license. Lastly, the outcome of this case has no bearing on the academic freedom doctrine because CME instructors are not university professors; they are "instructors" who deliver information that the State deems essential to the competent practice of medicine.

Plaintiffs' conditioned speech claim also fails because, even if the content of CME courses were private speech subject to First Amendment principles, the requirement that CME courses include discussion of implicit bias would pass constitutional muster because the condition is rationally related to the benefit of teaching CME courses for credit, which is part of a broader program that serves the State's important interest of protecting the public by ensuring the competence of its licensed medical professionals. *United States v. Geophysical Corp. of Alaska,* 732 F.2d 693, 700 (9th Cir. 1984).

For all of these reasons, the Court should affirm the district court's judgment.

ARGUMENT

I. THE DISTRICT COURT CORRECTLY REJECTED PLAINTIFFS' COMPELLED SPEECH CLAIM

Plaintiffs' principal argument is that the implicit bias requirement violates their First Amendment rights because it compels them to speak on a subject with which they disagree. Before conducting a compelled speech analysis, courts first determine whether the speech at issue is protected under the First Amendment. *Gearhart v. Thorne*, 768 F.2d 1072, 1073 (9th Cir. 1985) ("In a section 1983 action based on the first amendment, the plaintiff has the burden of alleging constitutionally protected speech.") (citing *Mount Healthy Sch. Dist. Bd. of Educ. v. Doyle*, 429 U.S. 274, 287 (1977)).[2] Here, the district court correctly determined that the implicit bias requirement does not implicate Plaintiffs' First Amendment rights because the content of CME courses is government speech.

[2] *Amicus* Young America's Foundation argues that the district court should have proceeded with a First Amendment analysis regardless of whether the speech is protected. Br. Amicus Young America's Foundation at 6 ("Thus, where compelled speech is at issue the Court does not ask whether the speech is private or not, but turns directly to the First Amendment analysis because the speech is *de facto* the individual's.") Courts have squarely rejected this proposition. *E.g., Lathus v. City of Huntington Beach*, 56 F.4th 1238, 1243 (9th Cir. 2023).

A. Government Speech Is Not Subject to First Amendment Scrutiny

The Supreme Court has made clear that "[w]hen government speaks, it is not barred by the Free Speech Clause from determining the content of what it says." *Walker v. Tex. Div., Sons of Confederate Veterans, Inc.*, 576 U.S. 200, 207 (2015) (citing *Pleasant Grove City v. Summum,* 555 U.S. 460, 467-68 (2009)). "The Free Speech Clause restricts government regulation of private speech; it does not regulate government speech." *Summum*, 555 U.S. at 467. Government speech is thus "not subject to scrutiny under the Free Speech Clause." *Id.* at 464. It "makes sense" that the government can "say what it wishes and select the views that it wants to express"; the government "could barely function otherwise." *Nat'l Rifle Ass'n of Am. v. Vullo*, 602 U.S. 175, 187 (2024) (quotations omitted); *see also Shurtleff*, 596 U.S. at 251 ("When the government wishes to state an opinion, to speak for the community, to formulate policies, or to implement programs, it naturally chooses what to say and what not to say. That must be true for government to work.") (citations omitted).

Courts consider three factors for determining whether speech constitutes government speech: (1) the history of the expression at issue; (2) the public's likely perception as to who (the government or a private person) is speaking; and (3) the extent to which the government has actively shaped or controlled the expression.

Shurtleff, 596 U.S. at 252 (citing *Walker*, 576 U.S. at 209-14).[3] This is not a set formula: courts must "conduct a holistic inquiry designed to determine whether the government intends to speak for itself" and the review should be "driven by a case's context" instead of "the rote application of rigid factors." *Shurtleff*, 596 U.S. at 252. While no one factor is dispositive, here all three factors weigh in favor of finding that the content of California's CME courses constitutes government speech.

1. California Has a Long History of Using CME Programming to Communicate Subjects It Deems Necessary for the Competent Practice of Medicine

As the district court observed, when considering "the history of the expression at issue," *Shurtleff*, 596 U.S. at 252, CME courses must be considered in the broader context of California's licensing regime of medical professionals.

As part of its longstanding history of regulating the medical profession and supervising licensing requirements for medical practitioners, California has, since the nineteenth century, required medical practitioners to comply with licensing

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[3] *Amicus* Young America's Foundation contends that the test applied in *Johanns v. Livestock Marketing Ass'n,* 544 U.S. 550 (2005) is the correct test because "the facts in *Shurtleff* (private displays on government property) are not comparable to a true compelled speech claim, especially where the speech occurs on nongovernmental property." Br. Amicus Young America's Foundation at 11. But *Johanns* was a compelled-subsidy case where beef producers challenged assessments to fund generic advertising. In contrast, Plaintiffs here are challenging speech they claim they are "compelled" to give. Moreover, Plaintiffs concede that the *Shurtleff* test applies here. Opening Br. 14.

requirements. *See* Cal. Code Regs. tit. 16, §§ 1300-1354.5. For instance, practitioners must meet certain written examination requirements for licensure. *Id.*, § 1328. Since the 1980s, California has used CME programming to ensure that licensed physicians are adequately trained in subjects the State considers essential to maintaining competence in the profession. *Supra* at pp. 4-6. The Medical Board is responsible for enforcing these requirements. *Supra* at pp. 6-8.

As part of this history, California has communicated through CME curricular requirements information that it deems important to the practice of medicine. For example, regarding pain management and the treatment of terminally ill and dying patients, the Legislature has determined that CME curriculum should include discussion of "the risks of addiction associated with the use of Schedule II drugs." § 2190.5(a)(2). The Legislature has also established specific curriculum requirements for the subject of cultural competency. § 2190.1(c)(1)(A)-(D).

As noted above, Plaintiffs do not contest the constitutionality of these other curricular requirements because they are "mandated by the state in its regulatory capacity." Opening Br. 18. But implicit bias is a subject matter "mandated by the state in its regulatory capacity," just like drug addiction and cultural competence. That Plaintiffs take issue with the particular subject of implicit bias does not change the nature of the expression. And Plaintiffs cannot draw arbitrary lines taking what they view as controversial outside the realm of government speech,

particularly where the State views the content in question—unconscious bias in the practice of medicine—to be a real threat to the treatment of patients (AB 241, § 1), and teaching implicit bias is reasonably related to the government's legitimate interest in regulating the medical profession. *Infra* at pp. 39-43.

Plaintiffs also argue that the history of the expression weighs against a finding of government speech because, unlike the monuments and license plates at issue in *Summum* and *Walker*, there is no history of California using CMEs to communicate with the public, contending that the district court acknowledged as much. Opening Br. 16. Plaintiffs are wrong. The district court only noted that "[g]overnments do not have the same history of using [CME courses] to communicate to the general public as monuments and flags."[4] ER-009. But the court recognized—consistent with the "holistic inquiry" mandated by *Shurtleff*—that the history of the expression analysis is not confined to whether California has used CMEs only to communicate to the public but must instead focus more generally on whether CMEs are part of a broader scheme to communicate with respect to its regulation of the medical field. ER-010, 011.

[4] Contrary to Plaintiffs' claim, the district court did not "fault" Plaintiffs for analogizing CME courses to monuments and license plates. Opening Br. 16. Instead, the court declined to compare these very different types of expressions because "[c]omparing dissimilar forms of government expression leads to illogical results." ER-009.

Just as the Court in *Shurtleff* did not limit its examination to Boston's flag-flying program but instead looked to the broader history of flags, their content, and their presence and position (596 U.S. at 253-54), the district court here properly considered California's "history of regulating medical licensure and its longstanding practice of using continuing education requirements as part of this licensing scheme" to determine that CME course content is government speech. ER-012. Indeed, Plaintiffs appear to agree, as they concede that through CMEs, "the government is communicating the importance of certain subjects to medical professionals." Opening Br. 18.

This does not lead, contrary to Plaintiffs' arguments, to the "sweeping results" they predict that all state-mandated course requirements, including private elementary school instruction, would constitute government speech. Opening Br. 18-19. This fundamentally misunderstands the purpose of the *Shurtleff* inquiry, which is applied on a case-by-case basis. Plaintiffs' suggestion that a lawyer publicly discussing how to draft trusts would be government speech just because she attended a CLE on the topic (Opening Br. 41) is absurd. As is the suggestion that judges teaching CLE courses "could be subject to professional discipline for speaking contrary to the government's position." *Id.* CME instructors like Dr. Khatibi would not be disciplined for speaking contrary to the State's view on implicit bias; their failure to include such discussion would simply mean that their

CME courses are not eligible for CME credit. *See infra* at pp. 39-43 (discussing Plaintiffs' unconstitutional conditions claim).

While Plaintiffs are correct that Supreme Court cases concerning monuments and trademarks "form the backbone of any legal analysis" of the government speech doctrine (Opening Br. 17), courts must adapt this backbone to the facts of any particular case as part of *Shurtleff*'s "holistic inquiry."[5] The government speech inquiry is thus "driven by a case's context rather than the rote application of rigid factors," *Shurtleff*, 596 U.S. at 252, which is what the district court properly did here.

2. Licensed Medical Professionals Are Likely to Perceive the Content of CME Courses as Coming from the State

The implicit bias requirement also meets the second *Shurtleff* factor: it is likely to be perceived as speech from the State, not private speakers. *See* 596 U.S. at 252. The State has set forth CME requirements, and CME courses are created specifically for licensed medical professionals to maintain their license—not for the public at large. Even course evaluations 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

[5] Plaintiffs' assertion that the district court failed to apply the holistic inquiry mandated by *Shurtleff* has no merit. As discussed *supra* at pp. 17, 19, the court clearly took the holistic approach in considering the *Shurtleff* factors.

that educational objectives have been met"). Because of that, as the district court observed, it is only reasonable to infer that physicians who take State-mandated CME courses to maintain their State-issued license understand how their profession is regulated, that the State sets the licensing requirements, and that the State sets the curriculum for courses they are required to take to maintain their State-issued license.

For these reasons, the district court was "unpersuaded" by Plaintiffs' contentions that course attendees would attribute CME course content to the instructors and not the State. ER-012. It was well within the court's discretion to reject Plaintiffs' conclusory allegations. *Ashcroft*, 556 U.S. at 678 ("Nor does a complaint suffice if it tenders 'naked assertion[s]' devoid of 'further factual enhancement.'") (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 557 (2007)). Courts are permitted to draw their own reasonable inferences and need not accept as true an allegation that is belied by common sense. *Nayab v. Cap. One Bank (USA), N.A.*, 942 F.3d 480, 496 (9th Cir. 2019) ("Determining whether a complaint states a plausible claim for relief will . . . be a context-specific task that requires the reviewing court to draw on its judicial experience and common sense.") (quoting *Twombly*, 550 U.S. at 679).[6]

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[6] *Amicus* Young America's Foundation contends that the district court should have credited Plaintiffs' allegations regarding likely perceptions to them (continued…)

Indeed, as the court pointed out, Plaintiffs' own pleaded facts support the inference that attendees understand the curriculum as coming from the State: Plaintiffs allege that physicians are unlikely to take Plaintiffs' courses if they do not qualify for CME credit due to non-compliance with the State's content requirements, which leads to the inference that physicians take Plaintiffs' CME courses because they know the content meets State requirements and comes from the State. ER-013 (citing ER-037, 039). Plaintiffs argue that the court's inference was unreasonable because "just because individuals understand that a CME course meets state requirements, that does not lead to the inference that it *comes from* the state." Opening Br. 21. First, as discussed, it was appropriate for the court to make its own reasonable inferences. Moreover, Plaintiffs' characterization of content meeting State requirements compared to content coming from the State is a distinction without a difference: If course attendees know that the State sets the content requirements, then that means they attribute the content to the State; it is illogical to argue otherwise.

Similarly, the district court did not "reject" Plaintiffs' allegation that attendees are likely to attribute CME course content to instructors because instructors are

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and that there was no basis for concluding that Plaintiffs are likely to be perceived as speaking for the State. Br. Amicus Young America's Foundation at 9-10. But as *amicus* recognizes, the lower court was permitted to "apply 'common sense' in reviewing the facts pleaded on a 12(b)(6) motion." *Id.* at 10 (quoting *Ashcroft,* 556 U.S. at 678).

required to provide "examples" or "strategies" in their discussion of implicit bias. Opening Br. 21. Instead, the court was unpersuaded by this unsupported conclusion, and recognized that the requirement that Plaintiffs come up with examples and strategies is "a pedagogical technique applicable to virtually any educational topic." ER-014.

Plaintiffs try to distinguish between specific topics that California requires as part of its CME curriculum—such as pain management and the treatment of terminally ill and dying patients (§ 2190.5)—and the requirement that discussion of implicit bias be included in all courses on these topics, arguing "[t]his indirect method leads physician-attendees to view the discussion on implicit bias as coming from the instructor." Opening Br. 22-23. Given that medical practitioners are aware of the State's other curriculum requirements under section 2190.1, such as geriatric medicine and pain management (Opening Br. 23), then it is only logical that they would also know that the State requires training on implicit bias and would attribute that specific subject to the State.

Plaintiffs also take the position that if "all physicians were required to simply take a course on implicit bias . . . instructors could voluntarily choose to teach courses on the topic" and "provide varying viewpoints on the issue." Opening Br. 23. But nothing prevents instructors from providing their own viewpoints on implicit bias or informing students that they do not agree with the State's

viewpoint on the topic. Plaintiffs are free to communicate to students that the content of their courses should be attributed to the State, not to the instructors. And Plaintiffs are not required to teach CME courses at all—they can choose not to teach them.

3. The State Controls the Content of CME Courses

a. The State Sets Forth Specific Requirements for CME Course Content

To exert sufficient control over speech to invoke the government speech doctrine, the government need not control every word of the speech or provide a script, but only "shape" its content. *Shurtleff*, 596 U.S. at 252.[7] Here, there is no question that the State, at a very minimum, "shapes" the content of CME courses, and in fact goes much further. "Only those courses and other educational activities that meet the requirements of Section 2190.1" and are offered by specified organizations are acceptable for credit toward licensure. Cal. Code Regs. tit. 16, § 1337(b). The State also dictates what course content does not qualify for CME

[7] *Amicus* Cato Institute contends, without any authority, that the "control" analysis under *Shurtleff* is limited to two contexts: (1) when the government adopts private speech as its own or (2) is jointly speaking with a consenting private entity, otherwise the government speech doctrine would "incentivize the government to tighten its control over private speech" to circumvent the First Amendment. Br. Amicus Cato Institute at 7-9. There is no basis in law for such a narrow application of the government speech doctrine. Courts have equally applied the government speech doctrine in cases where private individuals were delivering the speech at issue. *See, e.g., Lathus*, 56 F.4th at 1243 (government speech doctrine applied in case brought by volunteer against councilperson).

credit. *E.g.*, § 2190.1(f) (educational activities "directed primarily toward the business aspects of medical practice" do not meet the CME standards for physicians and surgeons).

The Legislature has set out specific content requirements for its CME program, to which instructors must adhere. The statute requires that course content relate to the quality or cost-effective provision of patient care, community or public health, or preventive medicine; concern quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine; concern bioethics or professional ethics; or is designed to improve the physician-patient relationship and quality of physician-patient communication. § 2190.1(a). Curriculum on cultural and linguistic competency must include specific topics of discussion and specific perspectives. § 2190.1(b)-(c); *supra* at pp. 6.

The Legislature has also set forth detailed content requirements for implicit bias: CME courses must address "[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." § 2190.1(e).

The State also exercises control over CME content through the Medical Board, which is responsible for adopting and administering standards for the continuing education of licensed physicians and surgeons, § 2190, and for determining the criteria CME courses must meet to be accepted for credit and the process by which it ensures CME providers' compliance with CME requirements. Cal. Code Regs. tit. 16 §§ 1337, 1337.5. And the Medical Board has the authority to randomly audit courses or programs submitted for CME credit to ensure compliance. Cal. Code Regs. tit. 16 § 1337.5(b).

b. As This Court Has Held, *Johanns* Does Not Require That the Government Micromanage Its Speech

These specific content requirements are not "broad parameters" within which private instructors operate, as Plaintiffs contend. Opening Br. 30. As noted above, there are specific content requirements (in addition to implicit bias) with which every course must comply: CME courses on *any topic* must relate to the quality or cost-effective provision of patient care, community or public health, or preventive medicine; concern quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine; concern bioethics or professional ethics; or must be designed to improve the physician-patient relationship and quality of physician-patient communication. § 2190.1.

But more importantly, the Supreme Court in *Johanns* made clear that the government need not micromanage the development or creation of speech for it to

be government speech. *Johanns* involved a challenge to a federal Beef Promotion and Research Act, which required beef producers and importers to pay assessments to fund a beef advertising campaign. Plaintiffs-respondents argued that the government speech doctrine did not apply because the advertising messaging was controlled by the Beef Board and Operating Committee, a nongovernmental entity. The Court rejected the argument, finding that the federal government effectively controlled the message of the promotional campaigns because Congress and the Secretary of Agriculture had set out the overarching message and some of the campaign's elements, and the Secretary had final approval authority over the promotional campaign. *Id.* at 560-61. Specifically, Congress "had directed the implementation of a coordinated program of promotion, including paid advertising, to advance the image and desirability of beef and beef products" and had "specified, in general terms, what the promotional campaigns shall contain," by requiring that campaigns "take into account different types of beef products" and not "refer to a brand or trade name of any beef product." *Id.* at 561 (citations omitted).

This Court has applied *Johanns* in cases where the government similarly did not micromanage the content at issue, but the content was still government speech. In *Ranchers Cattlemen Action Legal Fund United Stockgrowers of Am. v. Vilsack*, 6 F.4th 983, 989 (9th Cir. 2021), this Court held that mandatory assessments on

cattle sales used to fund advertisements for beef products were government speech, where the Secretary of Agriculture had final approval authority over messaging created by third parties but declined to exercise that authority, because "[t]hird-party speech not subject to pre-approval is also 'effectively controlled' by the government." Similarly, in *Delano Farms Co. v. Cal. Table Grape Com'n*, 586 F.3d 1219, 1227-30 (9th Cir. 2009), assessments on California table grape growers to fund generic advertising were government speech, where a state legislative directive defined the California Table Grape Commission's message and the State had power to appoint and remove all Commissioners, even though there was no law that required the State to review the actual messages promulgated by the Commission. And in *Paramount Land Co. LP v. Cal. Pistachio Com'n*, 491 F.3d 1003, 1010–12 (9th Cir. 2007), this Court refused to enjoin a California statute providing subsidies from assessments on pistachio sales to the California Pistachio Commission where the State had specified the overall goal of the program but had "less control" over the Commission than the Secretary of Agriculture exercised over the Beef Board in *Johanns*, noting that "[t]o draw a line between these two approaches to oversight risks micro-managing legislative and regulatory schemes, a task federal courts are ill-equipped to undertake.").

Thus, that Dr. Khatibi may create the content of her courses "without any supervision, approval, control, or input by any government official" and that her

courses may be "approved by authorized CME providers—not the government" (Opening Br. 27) does not change the fact that the Legislature has mandated the contours of the CME course content, and that CME providers are themselves authorized by the State. And while there may be 3,343 CME courses available on the American Medical Association's website (Opening Br. 26), all of these courses must comply with the content requirements mandated by the State to be eligible for CME credit. If they omit any State-mandated content, these courses would not satisfy Section 2190.1's content requirements, would not be eligible for CME credit, and the Medical Board would reject them upon an audit. As the district court recognized, just because private physicians teach CME courses and private associations accredit these courses does not mean that private institutions or individuals control their content—"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." ER-016.

c. The Board's Final Approval Authority Is Further Evidence of the State's Control Over CME Courses

That the State has final approval authority over CME courses is further evidence of its control. *See Walker*, 576 U.S. at 213 (describing "final approval authority" as evidence of the government controlling the message); *Downs v. L.A. Unified School Dist.*, 228 F.3d 1003, 1012 (9th Cir. 2000) (school bulletin boards constituted government speech because the school "had final authority over the

content of the bulletin boards"). This final approval authority is not the same as "just a government seal of approval" that the Supreme Court in *Matal v. Tam*, 582 U.S. 218 (2017) deemed insufficient to turn private speech into government speech. Opening Br. 21 (quoting *Tam*, 582 U.S. at 235); *see also* Br. of *Amicus* Young America's Foundation at 15; Br. of *Amicus* the Cato Institute at 16. In *Tam*, the Court declined to apply the government speech doctrine on the grounds that the government "does not dream up" trademarks or edit trademarks submitted for registration, examiners at the Patent and Trademark Office do not inquire whether any viewpoint conveyed by a trademark is consistent with government policy, and "if the mark meets the Lanham Act's viewpoint-neutral requirements, registration is mandatory." *Tam*, 582 U.S. at 235. In contrast here, the State has established, in Section 2190.1, detailed curriculum requirements with which every CME course must comply to be eligible for credit. The Medical Board alone has authority to determine which courses are eligible for credit, and to reject courses that are ineligible.

Plaintiffs argue that because the State has "outsourced the implementation of standards to private organizations and instructors," the government has no control over the content of CME courses. Opening Br. 26. While it is true that the Legislature has left the implementation of standards for compliance up to the three associations that may accredit CME courses in California, those standards must

nonetheless comply with the State's express content requirements. § 2190.1(d)(3). Because CME courses must ultimately be acceptable to the Medical Board for continuing education credit (§ 2190.1(a); Cal. Code Regs. tit. 16, § 1337.5(c)), these associations only approve courses that comply with Section 2190.1; approving courses that do not meet the requirements of Section 2190.1 could result in a failed audit, which would impact the license status of physicians who attend these courses and put these organizations' approval via regulation in jeopardy.

Plaintiffs emphasize that Dr. Khatibi's courses have never been audited (Opening Br. 27), but that does not negate that her courses are subject to the Medical Board's audit in the first instance. How frequently the Board audits courses is irrelevant; the Board has the power to audit courses to ensure they satisfy State standards for credit.

B. Private Individuals Can Deliver Government Speech

Nor does the involvement of private instructors lead to a presumption that attendees attribute the content of CME courses to these instructors, as Plaintiffs suggest (Opening Br. 24-25): government speech is often found even when a private person is conveying the message. *Walker*, 576 U.S. at 217 ("The fact that private parties take part in the design and propagation of a message does not extinguish the governmental nature of the message . . . ."); *see also Rosenberger v. Rector and Visitors of Univ. of Va.*, 515 U.S. 819, 833 (1995) (the government can

"enlist[] private entities to convey its own message"); *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*, 544 U.S. at 562 (holding that the government "is not precluded from relying on the government-speech doctrine merely because it solicits assistance from nongovernmental sources"); *Shurtleff*, 596 U.S. at 270 (Alito, J., concurring) ("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.").

For these reasons, Plaintiffs' contention that school curriculum cases are inapplicable because they involve public entities is wrong. Opening Br. 24. Just as high school teachers deliver State-mandated curriculum to students to meet their State-mandated requirements to earn a high school degree, instructors of CME courses teach curriculum that is authorized by the State and delivered to professionals to maintain their State-issued license to practice in a heavily State-regulated profession. *See Nampa Classical Academy v. Goesling*, 447 Fed. Appx. 776, 778 (9th Cir. 2011) (curriculum presented in charter school was not the speech of teachers, parents, or students, but that of the Idaho government); *Downs*, 228 F.3d at 1012 (bulletin board inside a school building on which faculty and staff could post materials was government speech).

C. Applying the Government Speech Doctrine to CME Courses Would Not Have the Sweeping Effects Plaintiffs and *Amici* Suggest

Plaintiffs and *amici* also argue that applying the government speech doctrine to CME courses would significantly undermine First Amendment protections by expanding the government speech "beyond reason" and "swallow" the compelled speech and government-employee speech doctrines. *E.g.,* Opening Br. 32-42. These concerns are unfounded.

1. Applying the Government Speech Here Would Not Undermine First Amendment Protections

First, Plaintiffs claim that applying the government speech doctrine to CME courses would transform "countless professional development courses," including CLE courses taught by judges and lawyers, into government speech. Opening Br. 31. But CME courses are not government speech "simply because they are mandated by the state." Opening Br. 32. Any type of speech is subject to the "holistic" analysis mandated by *Shurtleff*. It is not necessarily true that all professional development courses would meet the *Shurtleff* test in the same way that CME courses do. And even for those that do, that would simply mean that the State has exercised its longstanding authority to ensure that professionals receive the training they need to perform their jobs competently.

Nor is the State's involvement in CME courses akin to the government's involvement in approving trademarks, as Plaintiffs contend. Opening Br. 33.

Unlike the trademark approval process in *Tam*, the government's involvement here goes beyond mere regulation: The State sets specific content requirements for CME courses and retains authority to audit courses to ensure compliance with these requirements. *Cf. Tam*, 582 U.S. at 235. More than mere regulation is required for government speech. Plaintiffs' claims that applying the government speech doctrine would mean that the government could compel recitation of the Pledge of Allegiance in public elementary schools, compel parade organizers to include government messages, or require website designers to create websites contrary to their conscience, are without merit. Opening Br. 38.[8] That overlooks the significant, long-established authority of the State to regulate the practice of medicine and require physicians to receive training on certain topics; there is no comparable tradition of the State lawfully regulating the content of parades or websites, or compelling speech in public schools. And no reasonable observer would perceive the speech of parade participants to be the government's speech merely because the government issues a permit for the parade, *see Hurley*, 515 U.S. at 560-61, or perceive the content of a website to be the government's merely because the designer must abide by generally applicable business regulations, *see 303 Creative*, 600 U.S. at 579-81, or perceive the speech of students to be the

[8] Citing *Hurley v. Irish-Am. Gay, Lesbian, & Bisexual Group of Bos.*, 515 U.S. 557, 560-61 (1995); *303 Creative LLC v. Elenis*, 600 U.S. 570, 579-81 (2023); and *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 626 (1943).

government's merely because the government operates public schools, *see Barnette*, 319 U.S. at 626. Indeed, the government did not even attempt to invoke the government speech doctrine to justify its conduct in *Hurley*, *303 Creative*, or *Barnette*.

Plaintiffs assert that implicit bias is an "ideological point of view" (Opening Br. 37), but even if that is so, it is also a topic that the Legislature has determined is important to ensure that California residents of all demographic groups receive quality healthcare. This is well within the "regulatory purpose of CMEs" (Opening Br. 36) "to ensure the continuing competence of licensed physicians and surgeons." § 2190. That speech may convey an ideological point of view does not mean that it is not valid government speech; on the contrary, when the government speaks, the government may "select the views that it wants to express." *Summum*, 555 U.S. at 468 (citations omitted).

Nor are Plaintiffs required to "speak[] on behalf of the government." Opening Br. 33. Government employees acting in their official capacity speak on behalf of the government; private individuals teaching CME courses are merely delivering speech prescribed by the government. Instructors are free to express their disagreement with the government-mandated content, such as implicit bias. There is no "censorship." Opening Br. 34. Lastly, Plaintiffs contend "If it's truly the government's speech, then it can say what ought to be and what ought not be

spoken." Opening Br. 34. That is absolutely correct *in the particular context of CME instruction*, as is evidenced by the fact that the government can require CME instructors to discuss implicit bias in their courses. It is up to the Medical Board—whose highest duty is to protect the public—to determine what licensed doctors should study to maintain their State-issued medical license; this should not be left up to private individuals. Of course, CME instructors and physicians—like all other individuals—are free to speak and receive whatever messages they prefer in all other settings, where CME credit is not being provided.

Applying the government speech doctrine to CME course requirements does not "swallow" the compelled speech doctrine, as Plaintiffs contend. Opening Br. 34. The compelled speech doctrine only applies to speech that is protected by the First Amendment; government speech is not. Nor are Plaintiffs compelled to represent speech with which they disagree as their own or adopt a particular viewpoint. California's regulations do not "require[a] a doctor to represent as his own any opinion that he does not in fact hold." *Rust v. Sullivan*, 500 U.S. 173, 200 (1991) (distinguishing the government's right to insist that public funds be spent for the purposes for which they were authorized from situations where government control over the content of speech may not be justified). CME instructors are free to remind attendees that the implicit bias training is mandated by the State, and that they would not teach it if given a choice.

Finally, applying the government speech doctrine does not "swallow" the government-employee speech doctrine espoused in *Pickering v. Board of Education*, 391 U.S. 563 (1968), as Plaintiffs assert. Opening Br. 38-42. That case is inapposite. In *Pickering*, the Supreme Court considered whether a public high school teacher, who was terminated for writing a letter to a local newspaper that was critical of how the Board of Education had handled past proposals to raise revenue for schools, could bring a First Amendment claim against the Board. 391 U.S. 563 (1968). The Court held that a public school teacher may not be dismissed for exercising his right to speak on issues of public importance unless he knowingly or recklessly made false statements. *Id.* at 574. Here, Plaintiffs are not government employees speaking in their private capacity but private citizens who are free to teach courses on any topic they wish and are free to include whatever content they wish. If they teach CME courses for credit so that attendees can maintain their State-issued medical license, however, they must include discussion of implicit bias, but they need not state they agree with it.

2. The Principle of "Academic Freedom" Does Not Apply Here

Amici argue that CME instructors are like university professors and that applying the government doctrine here would infringe on instructors' "academic freedom." Br. *Amicus* AAPS at 3; Br. *Amicus* Young America's Foundation at 22-23; Br. *Amicus* Cato Institute at 20. It is true that the Supreme Court and this Court

have emphasized the importance of fostering academic freedom. However, the concept of academic freedom applies only to colleges and universities. *E.g., Johnson v. Poway Unified Sch. Dist.*, 658 F.3d 954, 966 n. 12 (9th Cir. 2011) ("*Ceballos's* academic freedom carve-out applied to teachers at public colleges and universities.") (quotations omitted). Teaching CME courses is hardly the same as teaching at a university or college. A free and interactive exchange of ideas is the bedrock of higher education, which is why the principle of academic freedom applies in that context. In contrast, CME courses are not a forum for the free exchange of information; attendees receive information that the State deems essential to the practice of medicine, as part of its regulation of the profession.

II. THE DISTRICT COURT CORRECTLY REJECTED PLAINTIFFS' UNCONSTITUTIONAL CONDITIONS THEORY

If this Court agrees that CME course instruction constitutes government speech, it need proceed no further, because government speech is "not subject to scrutiny under the Free Speech Clause." *Summum*, 555 U.S. at 464. But even if the Court concludes that CME courses are protected private speech, Plaintiffs' claim nonetheless fails because the condition is reasonably related to the conferral of CME credit, which is an intrinsic part the government's interest in protecting the public by ensuring the competence of its licensed medical professionals. This Court may affirm the judgment below on any ground supported by the record, *Atel*

Fin'l Corp., 321 F.3d at 926, and the record here makes clear that Plaintiffs' unconstitutional conditions claim has no merit.

The unconstitutional conditions doctrine is relevant here because the government is neither compelling nor restricting any speech. No one is required to teach CME courses, and Plaintiffs (along with other CME providers and physicians) are free to speak and receive whatever messages they want outside the context of CME instruction. Rather, the government is *conditioning* the receipt of a benefit—CME course credit—on the instructor's willingness to include the topics specified by the State. Because the only speech restriction at issue here comes as a condition on such a benefit, Plaintiffs' First Amendment claim can succeed, if at all, only under the unconstitutional conditions framework.

Under that framework, the government may condition the grant of a discretionary benefit on the recipient's waiver of rights "[i]f the condition is rationally related to the benefit conferred." *United States v. Geophysical Corp. of Alaska,* 732 F.2d 693, 700 (9th Cir. 1984); *see also, e.g.*, *Koontz v. St. Johns River Water Mgmt. Dist.*, 570 U.S. 595, 604-06 (2013) (unconstitutional conditions doctrine allows government to condition issuance of a building permit on an applicant's dedication of property to the government "so long as there is a 'nexus' and 'rough proportionality' between the property that the government demands and the social cost of the applicant's" proposed development). In other words, the

government may impose "a condition" on discretionary benefits, even if that condition "may affect the recipient's exercise of its First Amendment rights," when the condition is reasonably related to the policy objectives of the relevant government program. *Agency for Int'l Dev. v. Alliance for Open Soc'y Int'l*, 570 U.S. 205, 214 (2013) (*Alliance for Open Soc'y*); *see also Rust*, 500 U.S. at 196-97 (government may condition receipt of Title X public health funds on grantee's agreement not to use the funds to engage in abortion-related speech or advocacy). But the government may not "seek to leverage" discretionary benefits to "regulate speech outside the contours of the program itself." *Alliance for Open Soc'y*, 570 U.S. at 214-15.

This Court has applied those principles to uphold conditions on government benefits that require the recipient to waive certain rights where that waiver is reasonably related to the policy objectives of the government program at issue. In *Geophysical Corp. of Alaska*, for instance, this Court upheld regulations that impose conditions on permits authorizing geophysical and geological exploration of the outer continental shelf, including the release to the Secretary of the Interior of data and information gathered under the permits and the public disclosure of that data. 732 F.2d at 699-700. Rejecting the plaintiff's unconstitutional conditions claim, the Court held that the condition—release to the Secretary of geophysical data and processed information—was "[u]nquestionably" rationally related to the

benefit sought—permission to explore the outer continental shelf—which was "an intrinsic part" of the overall purpose of the Outer Continental Shelf Lands Act to allow for the orderly and productive development of energy resources. *Id.* at 700; *see also Bingham v. Holder*, 637 F.3d 1040, 1046 (9th Cir. 2011) (rejecting unconstitutional conditions claim because the condition of a noncitizen waiving their ability to contest removal is "closely related to the benefit of entering the United States" under the Visa Waiver Program).

This case plainly falls on the permissible side of the unconstitutional conditions line. Conditioning CME credit on a requirement that CME courses include the subjects that the Legislature deems essential to the practice of medicine is closely related to the benefit of teaching CME courses for credit, which is the "linchpin" of the Medical Board's CME program to ensure the competence of medical professionals. The State is not trying to "leverage" its regulatory authority over the practice of medicine, *Alliance for Open Soc'y*, 570 U.S. at 214, to achieve policy objectives unrelated to the training of doctors. Just as the unconstitutional conditions claim in *Rust* failed because the Title X grantees were free to "perform abortions, provide abortion-related services, and engage in abortion advocacy" on their own time outside the context of the federal program, 500 U.S. at 196, so too here, Plaintiffs and other CME instructors may engage in whatever speech they like outside the context of courses for State-authorized CME credit.

Here, California's CME program is intended to help the Medical Board fulfill its "traditional role" of protecting the public by ensuring the competence of those who provide medical care. The curriculum requirements for CME courses—including the implicit bias requirement—help the Board carry out this role by ensuring that licensed physicians are adequately trained in subjects the State considers essential to maintaining competence in the profession. The specific requirement that CME courses include discussion of implicit bias is undoubtedly "closely related" (*Bingham*, 637 F.3d at 1046) to the government's valid and important regulatory interest in ensuring that residents of all demographic groups receive quality healthcare. As the Legislature explicitly found, implicit bias "contributes to health disparities by affecting the behavior of physicians and surgeons, nurses, physician assistants, and other healing arts licensees." AB 241, § 1(b).

The arguments raised by Plaintiffs and their *amici* are unpersuasive. Plaintiffs assert that the concept of "implicit bias" is "highly controversial." Opening Br. 36. Even if that were true, whether a requirement is "controversial" is irrelevant to a determination of whether a condition is constitutional. The State is entitled to adopt the view that implicit bias in the healthcare system is real, and to use its longstanding regulatory authority to seek to remedy that problem—including by requiring CME courses to include material on that topic. As the

district court observed, "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.'" ER-017, 018 (quoting *Summum*, 555 U.S. at 467-68).

Amicus AAPS analogizes the requirement here that CME courses include discussion of implicit bias to be eligible for CME credit to *Alliance for Open Society*, where the Supreme Court invalidated a statutory requirement that recipient organizations of federal funding explicitly oppose prostitution and sex trafficking. Br. *Amicus* AAPS at 13-14. AAPS argues, "Where, as here, the government '[r]equirement compels as a condition of federal funding the affirmation of a belief that by its nature cannot be confined within the scope of the Government program,' then it violates the First Amendment." Br. *Amicus* AAPS at 14 (quoting *Alliance for Open Soc'y*, 570 U.S. at 221). But here, CME instructors are not required to affirm a belief in anything. Unlike in *Alliance for Open Society*, where the grantees could not plausibly "avow" an opposition to prostitution and sex trafficking but then "turn around and assert a contrary belief . . . when participating in activities on [their] own time and dime," 570 U.S. at 218, teaching a CME course that includes material on implicit bias does not prevent instructors from opposing the concept of implicit bias on their own time. If AAPS's view were

correct, it would suggest that the State could not require CME instructors to include instruction on *any* topic, from pain management to geriatric care to cultural competency. *Cf.* §§ 2190.1, 2190.3, 2190.5. That would be a far-reaching change that would significantly undermine the statutory scheme the Legislature has enacted.

The key insight here—that a condition requiring CME courses to contain certain material is permissible if it is reasonably related to the State's legitimate interest in regulating the medical profession—highlights the flaws in Plaintiffs' argument that a ruling in the State's favor here will allow it to suppress or compel speech in other contexts. It is difficult to imagine how the government could "compel [recitation] of the Pledge of Allegiance," or "compel parade organizers to include government messages," or "require website designers to create websites contrary to their conscience" (Opening Br. 38) as a valid condition on any discretionary government benefit. Nor could the State require CME courses to contain subject matter that is not reasonably related to the practice of medicine.

CONCLUSION

The judgment of the district court should be affirmed.

Dated: October 23, 2024

Respectfully submitted,

s/ Stephanie Albrecht

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No. 24-3108

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

AZADEH KHATIBI, ET AL.,
Plaintiffs-Appellants,

v.

RANDY W. HAWKINS, ET AL.,
Defendants-Appellees.

On Appeal from the United States District Court
for the Central District of California
No. 2:23-cv-06195-MRA-E
The Honorable Monica Ramirez Almadani, Judge

STATEMENT OF RELATED CASES

To the best of our knowledge, there are no related cases.

Dated: October 23, 2024

Respectfully submitted,

s/ Stephanie Albrecht

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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9th Cir. Case Number(s) 24-3108

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ADDENDUM

No. 24-3108

IN THE UNITED STATES COURT OF APPEALS
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AZADEH KHATIBI, ET AL.,
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The Honorable Monica Ramirez Almadani, Judge

STATUTORY ADDENDUM TO DEFENDANTS-APPELLEES' ANSWERING BRIEF

West's Annotated California Codes
Business and Professions Code (Refs & Annos)
Division 2. Healing Arts (Refs & Annos)
Chapter 5. Medicine (Refs & Annos)
Article 10. Continuing Medical Education (Refs & Annos)

West's Ann.Cal.Bus. & Prof.Code § 2190.1

§ 2190.1. Educational activities; cultural and linguistic competency; understanding of implicit bias

Effective: January 1, 2024
Currentness

(a) The continuing medical education standards of Section 2190 may be met by educational activities that meet the standards of the board and that 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. These 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.

(b)(1) On and after July 1, 2006, all continuing medical education courses shall contain curriculum that includes cultural and linguistic competency in the practice of medicine.

(2) Notwithstanding the provisions of paragraph (1), a continuing medical education course dedicated solely to research or other issues that does not include a direct patient care component or a course offered by a continuing medical education provider that is not located in this state is not required to contain curriculum that includes cultural and linguistic competency in the practice of medicine.

(3) Associations that accredit continuing medical education courses shall develop standards before July 1, 2006, for compliance with the requirements of paragraph (1). The associations may update these standards, as needed, in accordance with the following requirements:

(A) The standards shall be updated in conjunction with an advisory group that has expertise in cultural and linguistic competency issues and is informed of federal and state statutory threshold language requirements, with prioritization of languages in proportion to the state population's most prevalent primary languages spoken by 10 percent or more of the state population.

(B) The standards shall be updated to ensure program standards meet the needs of California's changing demographics and properly address language disparities, as they emerge.

(4) A physician and surgeon who completes a continuing education course meeting the standards developed pursuant to paragraph (3) satisfies the continuing education requirement for cultural and linguistic competency.

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

(1) Cultural competency. For the purposes of this section, “cultural competency” means a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities. At a minimum, cultural competency is recommended to include the following:

(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.

(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.

(2) Linguistic competency. For the purposes of this section, "linguistic competency" means the ability of a physician and surgeon to provide patients who do not speak English or who have limited ability to speak English, direct communication in the patient's primary language.

(3) A review and explanation of relevant federal and state laws and regulations regarding linguistic access, including, but not limited to, the federal Civil Rights Act of 1964 (42 U.S.C. Sec. 1981 et seq.), Executive Order 13166 of August 11, 2000, of the President of the United States, and the Dymally-Alatorre Bilingual Services Act (Chapter 17.5 (commencing with Section 7290) of Division 7 of Title 1 of the Government Code).

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

(2) Notwithstanding the provisions of paragraph (1), a continuing medical education course dedicated solely to research or other issues that does not include a direct patient care component or a course offered by a continuing medical education provider that is not located in this state is not required to contain curriculum that includes implicit bias in the practice of medicine.

(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.

(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.

(f) Notwithstanding subdivision (a), educational activities that are not directed toward the practice of medicine, or are directed primarily toward the business aspects of medical practice, including, but not limited to, medical office management, billing

and coding, and marketing shall not be deemed to meet the continuing medical education standards for licensed physicians and surgeons.

(g) Educational activities that meet the content standards set forth in this section and are accredited by the California Medical Association or the Accreditation Council for Continuing Medical Education may be deemed by the Division of Licensing to meet its continuing medical education standards.

(h) For the purposes of this section, the following definitions apply:

(1) "TGI" means transgender, gender diverse, or intersex.

(2) "TGI-serving organization" has the same meaning as set forth in paragraph (2) of subdivision (f) of Section 150900 of the Health and Safety Code.

Credits

(Added by Stats.1992, c. 331 (A.B.3635), § 1. Amended by Stats.2005, c. 514 (A.B.1195), § 2; Stats.2014, c. 630 (A.B.496), § 1, eff. Jan. 1, 2015; Stats.2019, c. 417 (A.B.241), § 2, eff. Jan. 1, 2020; Stats.2022, c. 822 (S.B.923), § 1, eff. Jan. 1, 2023; Stats.2023, c. 330 (A.B.470), § 1, eff. Jan. 1, 2024.)

West's Ann. Cal. Bus. & Prof. Code § 2190.1, CA BUS & PROF § 2190.1
Current with urgency legislation through Ch. 1002 of 2024 Reg.Sess. Some statute sections may be more current, see credits for details.

End of Document

2019 Cal. Legis. Serv. Ch. 417 (A.B. 241) (WEST)

CALIFORNIA 2019 LEGISLATIVE SERVICE

2019 Portion of 2019-2020 Regular Session

Additions are indicated by **Text**; deletions by
* * * .
Vetoes are indicated by ~~Text~~ ;
stricken material by ~~**Text**~~ .

CHAPTER 417

A.B. No. 241

PROFESSIONS AND OCCUPATIONS—PHYSICIANS AND SURGEONS—CONTINUING EDUCATION

AN ACT to amend Sections 2190.1 and 3524.5 of, and to add Section 2736.5 to, the Business and Professions Code, relating to healing arts.

[Filed with Secretary of State October 2, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

AB 241, Kamlager–Dove. Implicit bias: continuing education: requirements.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under the act, a physician and surgeon is required to demonstrate satisfaction of continuing education requirements, including cultural and linguistic competency in the practice of medicine, as specified.

This bill, by January 1, 2022, would require all continuing education courses for a physician and surgeon to contain curriculum that includes specified instruction in the understanding of implicit bias in medical treatment. The bill, by January 1, 2022, would require associations that accredit these continuing education courses to develop standards to comply with these provisions.

Existing law, the Nursing Practice Act, regulates the practice of nursing by the Board of Registered Nursing. The act requires persons licensed by the board to complete specified courses of instruction, including instruction regarding alcoholism and substance dependency and spousal abuse.

This bill would require the Board of Registered Nursing, by January 1, 2022, to adopt regulations requiring all continuing education courses for its licensees to contain curriculum that includes specified instruction in the understanding of implicit bias in treatment. Beginning January 1, 2023, the bill would require continuing education providers to comply with these provisions and would require the board to audit education providers for compliance with these provisions, as specified.

Existing law, the Physician Assistant Practice Act, authorizes the Physician Assistant Board to require a licensee to complete not more than 50 hours of continuing education every two years as a condition of license renewal.

This bill would require the Physician Assistant Board, by January 1, 2022, to adopt regulations requiring all continuing education courses for its licensees to contain curriculum that includes specified instruction in the understanding of implicit bias in treatment. Beginning January 1, 2023, the bill would require continuing education providers to comply with these provisions and would require the board to audit continuing education providers for compliance with these provisions.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) 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.

(b) Implicit bias contributes to health disparities by affecting the behavior of physicians and surgeons, nurses, physician assistants, and other healing arts licensees.

(c) Evidence of racial and ethnic disparities in health care is remarkably consistent across a range of illnesses and health care services. Racial and ethnic disparities remain even after adjusting for socioeconomic differences, insurance status, and other factors influencing access to health care.

(d) 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, and African American patients with signs of heart problems are not referred for advanced cardiovascular procedures as often as white patients with the same symptoms.

(e) 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. LGBTQ and gender-nonconforming patients are less likely to seek timely medical care because they experience disrespect and discrimination from health care staff, with one out of five transgender patients nationwide reporting that they were outright denied medical care due to bias.

(f) The Legislature intends 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.

SEC. 2. Section 2190.1 of the Business and Professions Code is amended to read:

<< CA BUS & PROF § 2190.1 >>

2190.1. (a) The continuing medical education standards of Section 2190 may be met by educational activities that meet the standards of the * * * **board** and that 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. These 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.

(b)(1) On and after July 1, 2006, all continuing medical education courses shall contain curriculum that includes cultural and linguistic competency in the practice of medicine.

(2) Notwithstanding the provisions of paragraph (1), a continuing medical education course dedicated solely to research or other issues that does not include a direct patient care component or a course offered by a continuing medical education provider that is not located in this state is not required to contain curriculum that includes cultural and linguistic competency in the practice of medicine.

(3) Associations that accredit continuing medical education courses shall develop standards before July 1, 2006, for compliance with the requirements of paragraph (1). The associations may update these standards, as needed, in conjunction with an advisory group that has expertise in cultural and linguistic competency issues.

(4) A physician and surgeon who completes a continuing education course meeting the standards developed pursuant to paragraph (3) satisfies the continuing education requirement for cultural and linguistic competency.

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

(1) Cultural competency. For the purposes of this section, “cultural competency” means a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities. At a minimum, cultural competency is recommended to include the following:

(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) Understanding and applying cultural and ethnic data to the process of clinical care, including, as appropriate, information pertinent to the appropriate treatment of, and provision of care to, the lesbian, gay, bisexual, transgender, and intersex communities.

(2) Linguistic competency. For the purposes of this section, “linguistic competency” means the ability of a physician and surgeon to provide patients who do not speak English or who have limited ability to speak English, direct communication in the patient's primary language.

(3) A review and explanation of relevant federal and state laws and regulations regarding linguistic access, including, but not limited to, the federal Civil Rights Act (42 U.S.C. Sec. 1981 * * * et seq.), Executive Order 13166 of August 11, 2000, of the President of the United States, and the Dymally–Alatorre Bilingual Services Act (Chapter 17.5 (commencing with Section 7290) of Division 7 of Title 1 of the Government Code).

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

(2) Notwithstanding the provisions of paragraph (1), a continuing medical education course dedicated solely to research or other issues that does not include a direct patient care component or a course offered by a continuing medical education provider that is not located in this state is not required to contain curriculum that includes implicit bias in the practice of medicine.

(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.

(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.

(f) Notwithstanding subdivision (a), educational activities that are not directed toward the practice of medicine, or are directed primarily toward the business aspects of medical practice, including, but not limited to, medical office management, billing and coding, and marketing shall not be deemed to meet the continuing medical education standards for licensed physicians and surgeons.

(g) Educational activities that meet the content standards set forth in this section and are accredited by the California Medical Association or the Accreditation Council for Continuing Medical Education may be deemed by the Division of Licensing to meet its continuing medical education standards.

SEC. 3. Section 2736.5 is added to the Business and Professions Code, to read:

<< CA BUS & PROF § 2736.5 >>

2736.5. (a)(1) The board shall adopt regulations to require that, on and after January 1, 2022, all continuing education courses for licensees under this chapter contain curriculum that includes the understanding of implicit bias.

(2) Beginning January 1, 2023, continuing education providers shall ensure compliance with paragraph (1). Beginning January 1, 2023, the board shall audit continuing education providers, pursuant to Section 2811.5.

(b) Notwithstanding the provisions of subdivision (a), a continuing education course dedicated solely to research or other issues that does not include a direct patient care component is not required to contain curriculum that includes implicit bias in the practice of nursing.

(c) In order to satisfy the requirements of subdivision (a), continuing 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 licensees, 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.

SEC. 4. Section 3524.5 of the Business and Professions Code is amended to read:

<< CA BUS & PROF § 3524.5 >>

3524.5. **(a)** The board may require a licensee to complete continuing education as a condition of license renewal under Section 3523 or 3524. The board shall not require more than 50 hours of continuing education every two years. The board shall, as it deems appropriate, accept certification by the National Commission on Certification of Physician Assistants (NCCPA), or another qualified certifying body, as determined by the board, as evidence of compliance with continuing education requirements.

(b)(1) The board shall adopt regulations to require that, on and after January 1, 2022, all continuing education courses for licensees under this chapter contain curriculum that includes the understanding of implicit bias.

(2) Beginning January 1, 2023, continuing education providers shall ensure compliance with paragraph (1).

(3) Beginning January 1, 2023, the board shall audit continuing education providers at least once every five years to ensure adherence to regulatory requirements, and shall withhold or rescind approval from any provider that is in violation of the regulatory requirements.

(c) Notwithstanding the provisions of subdivision (b), a continuing education course dedicated solely to research or other issues that does not include a direct patient care component is not required to contain curriculum that includes implicit bias in the practice of physician assistants.

(d) In order to satisfy the requirements of subdivision (a), continuing 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 physician assistants, 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.

End of Document

CHAP. DXVIII.—*An Act to regulate the practice of medicine in the State of California.*

[Approved April 3, 1876.]

The People of the State of California, represented in Senate and Assembly, do enact as follows:

Qualifications of practitioners.

SECTION 1. Every person practicing medicine in any of its departments shall possess the qualifications required by this Act. If a graduate in medicine, he shall present his diploma to the Board of Examiners, herein named, for verification as to its genuineness. If the diploma is found genuine, and if the person named therein be the person claiming and presenting the same, the Board of Examiners shall issue its certificate to that effect, signed by all of the members thereof, and such diploma and certificate shall be conclusive as to the rights of the lawful holder of the same to practice medicine in this State. If not a graduate, the person practicing medicine in this State shall present himself before said Board, and submit himself to such examinations as the said Board shall require, and if the examination shall be satisfactory to the Examiners the said Board shall issue its certificate in accordance with the facts, and the lawful holder of such certificate shall be entitled to all the rights and privileges herein mentioned.

Examiners, qualifications of.

SEC. 2. Each State Medical Society incorporated and in active existence on the tenth day of March, eighteen hundred and seventy-six, whose members are required to possess diplomas or licenses from some legally chartered medical institution in good standing, shall appoint, annually, a Board of Examiners, consisting of seven members, who shall hold their office for one year, and until their successors shall be chosen. The Examiners so appointed shall go before a County Judge and make oath that they are regular graduates and licentiates, and that they will faithfully perform the duties of their office. Vacancies occurring in a Board of Examiners shall be filled by the society appointing it, by the selection of alternates or otherwise.

Powers and duties of Examiners.

SEC. 3. The Board of Examiners shall organize within three months after the passage of this Act. They shall procure a seal, and shall receive, through their Secretary, applications for certificates and examinations. The President of each Board shall have authority to administer oaths, and the Board take testimony in all meetings relating to their duties. They shall issue certificates to all who furnish satisfactory proof of having received diplomas or licenses from legally chartered medical institutions in good standing. They shall prepare two forms of certificates, one for persons in possession of diplomas or licenses, the other for candidates examined by the Board. They shall furnish to the County Clerks of the several counties a list of all persons receiving certificates. In selecting places to hold their meetings, they shall, as far as is reasonable, accommodate applicants residing in different sections of the State, and due notice shall be

published of all their meetings. Certificates shall be signed by all the members of the Board granting them, and shall indicate the medical society to which the Examining Board is attached.

Same, fees.

SEC. 4. Said Board of Examiners shall examine diplomas as to their genuineness, and if the diploma shall be found genuine as represented, the Secretary of the Board of Examiners shall receive a fee of one dollar from each graduate or licentiate, and no further charge shall be made to the applicants; but if it be found to be fraudulent or not lawfully owned by the possessor, the Board shall be entitled to charge and collect twenty dollars of the applicant presenting such diplomas. The verification of the diplomas shall consist in the affidavit of the holder and applicant, that he is the lawful possessor of the same, and that he is the person therein named; such affidavit may be taken before any person authorized to administer oaths, and the same shall be attested under the hand and official seal of such officer, if he have a seal. Graduates may present their diplomas and affidavits, as provided in this Act, by letter or by proxy, and the Board of Examiners shall issue its certificate the same as though the owner of the diploma was present.

Examination of applicants.

SEC. 5. All examinations of persons not graduates or licentiates shall be made directly by the Board, and the certificates given by the Boards shall authorize the possessor to practice medicine and surgery in the State of California; but no examination into the qualifications of persons not holding diplomas or licenses shall be made after the thirty-first day of December, eighteen hundred and seventy-six. After that date no certificates shall be granted by them, except to persons presenting diplomas or licenses from legally chartered medical institutions in good standing.

Certificates to be recorded.

SEC. 6. Every person holding a certificate from a Board of Examiners shall have it recorded in the office of the Clerk of the county in which he resides, and the record shall be indorsed thereon. Any person removing to another county to practice shall procure an indorsement to that effect on the certificate from the County Clerk, and shall record the certificate in like manner in the county to which he removes, and the holder of the certificate shall pay to the County Clerk the usual fees for making the record.

Clerk to keep register.

SEC. 7. The County Clerk shall keep, in a book provided for the purpose, a complete list of the certificates recorded by him, with the date of issue and the name of the medical society represented by the Board of Examiners issuing them. If the certificate be based on a diploma or license he shall record the name of the medical institution conferring it, and the date when conferred. The register of the County Clerk shall be open to public inspection during business hours.

Fees for examination.

SEC. 8. Candidates for examination shall pay a fee of five dollars in advance, which shall be returned to them if a certificate be refused. The fees received by the Board shall be paid into the treasury of the medical society by which the Board shall have been appointed, and the expenses and

compensation of the Board shall be subject to arrangement with the society.

Examinations.

SEC. 9. Examinations may be in whole or in part in writing, and shall be of an elementary and practical character, but sufficiently strict to test the qualifications of the candidate as a practitioner.

Refusal and revocation of certificates.

SEC. 10. The Boards of Examiners may refuse certificates to individuals guilty of unprofessional or dishonorable conduct, and they may revoke certificates for like causes. In all cases of refusal or revocation the applicant may appeal to the body appointing the Board.

Definition of "physician."

SEC. 11. Any person shall be regarded as practicing medicine, within the meaning of this Act, who shall profess publicly to be a physician and to prescribe for the sick, or who shall append to his name the letters of "M. D." But nothing in this Act shall be construed to prohibit students from prescribing under the supervision of preceptors, or to prohibit gratuitous services in cases of emergency. And this Act shall not apply to commissioned surgeons of the United States army and navy practicing within the limits of this State.

Licenses.

SEC. 12. Any itinerant vender of any drug, nostrum, ointment, or appliance of any kind intended for the treatment of disease or injury, or who shall, by writing or printing, or any other method, publicly profess to cure or treat diseases, injury or deformity, by any drug, nostrum, manipulation, or other expedient, shall pay a license of one hundred dollars a month, to be collected in the usual way.

Penalties for violation.

SEC. 13. Any person practicing medicine or surgery in this State without complying with the provisions of this Act, shall be punished by a fine of not less than fifty dollars ($50) nor more than five hundred dollars ($500), or by imprisonment in the County Jail for a period of not less than thirty days nor more than three hundred and sixty-five days, or by both such fine and imprisonment, for each and every offense. And any person filing, or attempting to file, as his own, the diploma or certificate of another, or a forged affidavit of identification, shall be guilty of a felony, and upon conviction shall be subject to such fine and imprisonment as are made and provided by the statutes of this State for the crime of forgery.

SEC. 14. This Act shall take effect from and after its passage, but the penalties shall not be enforced till on and after the thirty-first day of December, eighteen hundred and seventy-six.

CHAP. DXIX.—*An Act for the relief of J. J. Coulin.*

[Approved April 3, 1876.]

The People of the State of California, represented in Senate and Assembly, do enact as follows:

Claims allowed.

SECTION 1. The Board of Supervisors of the City and County of San Francisco is hereby authorized to appropriate

CERTIFICATE OF SERVICE

Case Name: ***Khatibi, et al. v. Lawson, et al.***, Case No. **24-3108**

I hereby certify that on October 23, 2024, I electronically filed the following document with the Clerk of the Court by using the CM/ECF system:

ANSWERING BRIEF OF DEFENDANTS-APPELLEES

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished electronically by the CM/ECF system.

I declare under penalty of perjury under the laws of the State of California and the United States of America the foregoing is true and correct.

Executed on October 23, 2024, at Los Angeles, California.

Stephanie Albrecht	s/ Stephanie Albrecht
Declarant	Signature