

No. 24-3108

**UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

Azadeh Khatibi, M.D. and Do No Harm,
Plaintiffs – Appellants,

v.

Randy W. Hawkins, Laurie Rose Lubiano, Ryan Brook,
Reji Varghese, Marina O'Connor, in their official capacities as members
and officials of the Medical Board of California,
Defendants – Appellees.

On Appeal from the United States District Court
for the Central District of California
Honorable Mónica Ramírez Almadani, District Judge

**APPELLANTS' PETITION FOR PANEL
REHEARING OR REHEARING EN BANC**

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CORPORATE DISCLOSURE

Plaintiff Do No Harm Inc. is a nonprofit corporation organized under the laws of the Commonwealth of Virginia. It has no parent corporation and no publicly held corporation owns any stock in Do No Harm.

s/ *Joshua P. Thompson*
JOSHUA P. THOMPSON

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FRAP 40(b)(2) STATEMENT

Plaintiffs-Appellants Dr. Azadeh Khatibi and Do No Harm respectfully request rehearing en banc because the panel opinion conflicts with binding decisions of the United States Supreme Court, as well as other circuit courts of appeal. The issues raised in this case also involve questions of exceptional importance.

The panel held that Continuing Medical Education (CME) instruction constitutes government speech and statutory mandates for CME instruction are thus immune from First Amendment scrutiny. That holding conflicts with the Supreme Court’s decisions in *Matal v. Tam*, 582 U.S. 218 (2017), and *Shurtleff v. City of Boston*, 596 U.S. 243 (2022). It also significantly undercuts—if not completely erodes—*National Institute of Family and Life Advocates v. Becerra*, 585 U.S. 755 (2018) (“*NIFLA*”), a decision the panel never cites. The panel disregarded the limits those decisions impose on the government speech doctrine and failed to apply settled compelled speech precedent. And in so doing, it places the Ninth Circuit far outside the mainstream of appellate consensus.

Additionally, the panel’s decision presents questions of exceptional importance: whether continuing professional education courses are government speech, leaving states free to compel the private presenters to convey controversial ideological messages. If allowed to stand, the decision would give states sweeping power to impose compelled speech mandates across all licensed professions—from doctors to lawyers to veterinarians—so long as the speech is delivered in connection with a credit-bearing course to maintain licensure.

Rehearing en banc is warranted to resolve these conflicts, clarify the limits of the government speech doctrine, and reaffirm that licensed professionals do not surrender their First Amendment rights.

INTRODUCTION AND FACTUAL BACKGROUND

May the State compel private professionals to adopt a contested ideological message simply because they teach a course required for licensure? The panel here answered yes, because it held that such private instruction is government speech. This sweeping decision ignores binding precedent, erases the boundary between government and private speech, and threatens the First Amendment rights of countless professionals whose livelihoods depend on state licensure.

California mandates that every instructor of a CME course include discussion of “implicit bias,” regardless of the course’s subject matter, the instructor’s scientific judgment, or the relevance of the topic to the material being taught. *See* Cal. Bus. & Prof. Code § 2190.1(d). Specifically, every CME course must discuss either “how implicit bias affects perceptions and treatment decisions” or “strategies to address how unintended biases ... contribute to healthcare disparities.” *Id.* § 2190.1(e). The law applies across all specialties and subjects—from surgery to dermatology to medical ethics—and disqualifies any course that omits the mandatory content from counting toward biennial CME reporting requirements. If a physician refuses to include the State’s preferred message, the course is ineligible for CME credit—a professional disqualification with real consequences for reputation, access, and regulatory compliance.

Plaintiffs—Dr. Azadeh Khatibi, a board-certified ophthalmologist, and Do No Harm, a national organization of physicians and healthcare professionals—brought this First Amendment challenge to California’s implicit bias mandate. ER-031. They allege that the State is compelling them and their members to speak on a controversial topic they would not

otherwise address, in their own voices, before professional audiences who expect—and are entitled to—independent medical instruction. ER-030–031; ER-039–042.

Plaintiffs object to the mandate on scientific and professional grounds. Dr. Khatibi believes implicit bias trainings lack reliable evidentiary support for being effective, that there is insufficient data that such trainings improve clinical outcomes, and that data suggest that such trainings may backfire. ER-037. She does not believe it is appropriate to include such content in her ophthalmology courses when it is not relevant and displaces more important material, including more relevant causes of disparities in patient outcomes. ER-036–37. She does not want her speech mischaracterized as promoting a state ideology. *Id.* Nor do members of Do No Harm, who similarly object to being conscripted to advance the government’s message as a condition of teaching. ER-039.

Plaintiffs allege that they create and deliver their own CME content. ER-036, 039. The State does not draft, edit, or screen their lectures. *Id.* It does not assign topics or instructors. California delegates most enforcement to private accrediting bodies and conducts only limited,

after-the-fact audits. ER-033. In Dr. Khatibi’s case, the State has never reviewed her courses at all. ER-036.

The district court dismissed the complaint, and a panel of this Court affirmed. The panel held that CME instruction constitutes government speech and therefore any regulation thereof is categorically exempt from First Amendment scrutiny. The panel reached this holding on a motion to dismiss, without any factual development, accepting the State’s legal theory over Plaintiffs’ well-pleaded allegations. In doing so, the panel not only adopted an expansive view of government speech—it short-circuited the factual inquiry necessary to resolve whether the government is truly the speaker and whether the message is attributable to the State.

The panel’s holding—if left undisturbed—will allow governments to compel speech through licensure regimes across the professions. Lawyers, doctors, accountants, and other regulated professionals could be required to promote state viewpoints in any educational setting subject to regulation. That result conflicts with the Supreme Court’s consistent warnings that compelled speech violates the First Amendment and that the government speech doctrine must be narrowly applied. *See Tam*, 582 U.S. at 235; *NIFLA*, 585 U.S. at 766–67.

En banc review is necessary to bring this Court’s precedent into alignment with binding authority and to ensure that professionals do not lose their First Amendment rights when they teach.

REASONS FOR GRANTING THE PETITION

I. The Panel Decision Conflicts with Decisions of the United States Supreme Court

The panel’s decision—holding that private CME instruction constitutes government speech—cannot be reconciled with controlling decisions of the United States Supreme Court. In particular, it conflicts with the Court’s recent government speech cases *Tam*, *Shurtleff*, and *Walker v. Texas Div., Sons of Confederate Veterans*, 576 U.S. 200 (2015). Worse, it wholly ignores the Court’s recent compelled speech decision in *NIFLA*. Each of those cases articulates constitutional limits on the government speech doctrine and reaffirms core First Amendment protections against compelled speech—limits the panel here discarded.

Start with *Tam*, where the Court rejected the argument that trademarks registered by the government were government speech. Even though trademarks were subject to extensive regulation, reviewed by a federal agency, and catalogued in a government registry, the Court held they remained private expression. The key facts: the government did not

create the marks, did not edit or control their content, and the public did not reasonably perceive them as government-authored. *Tam*, 582 U.S. at 234–38. The Court expressly warned that the government speech doctrine must be applied with “great caution,” lest the government “silence or muffle the expression of disfavored viewpoints.” *Id.* at 235.

Here, the panel recognized that California does not create CME courses, does not edit or preapprove them, and in many cases—such as Dr. Khatibi’s—has never even seen them. Slip Op. at 18. Yet the panel still held that CMEs are government speech because California “dictates, controls, and approves the provider, form, purpose, and content” of CMEs. *Id.* at 6. That conclusion flatly contradicts *Tam*, which held that regulatory involvement and eligibility criteria are not enough to transform private expression into government speech. California’s decision to condition CME credit on the inclusion of certain content—like implicit bias instruction—is no more constitutionally significant than the PTO’s registration standards in *Tam*, which the Supreme Court found insufficient to invoke the government speech exception.

Nor does *Walker* support the panel’s result. The *Tam* Court expressly characterized *Walker* as marking the “outer bounds” of the

government speech doctrine. *Tam*, 582 U.S. at 238. In *Walker*, specialty license plates were government-issued, bore official insignia, and were historically used to convey state messages. That is a far cry from private physicians developing and delivering professional education courses to their peers. CME lectures are not government-authored, are not perceived as state publications, and—unlike license plates—do not carry the imprimatur of the State.¹ The panel’s reliance on *Walker* to sweep in thousands of privately produced CME courses obliterates the doctrinal guardrails established in *Tam*.

Shurtleff underscores the point. There, the Court rejected Boston’s claim that its flag-raising program outside City Hall was government speech because the city had not historically used the flagpole to convey messages and had allowed private groups to raise flags without review. *Shurtleff*, 596 U.S. at 254–56. So too here: CME content is created and delivered by private speakers at private locations, California does not

¹ Indeed, most CME courses contain disclaimers that the content reflects only the *author’s* viewpoints. See, e.g., Camillo Lamanna & Lauren Byrne, *Should Artificial Intelligence Augment Medical Decision Making? The Case for an Autonomy Algorithm*, AMA J. of Ethics (Sep. 1, 2018), <https://edhub.ama-assn.org/ama-journal-of-ethics/module/2710222>.

pre-screen individual lectures, relies on private accreditors, and only rarely audits courses after the fact. And when it does audit a course, the review is high-level—limited to confirming that the course has been certified or fits within approved subject matter categories. The content is not reviewed for its specific message or viewpoint. As in *Shurtleff*, there is no evidence that the state “intended to speak for itself” through CME instruction, nor does it meaningfully shape the messages being conveyed. *Id.* at 252.

The panel also conflicts with the Supreme Court’s compelled speech jurisprudence—particularly *NIFLA*. In *NIFLA*, the Court struck down a California law that required licensed medical clinics to post government-drafted notices about abortion access. The Court held that even in the context of professional licensure and regulation, the First Amendment forbids the State from conscripting private professionals to convey a government message. 585 U.S. at 766–67. The Court rejected California’s argument that professional regulation created a license to compel speech, noting that “[t]he dangers associated with content-based regulations of speech are also present in the context of professional speech.” *Id.* at 771.

Yet the panel here blessed an even broader mandate. California does not merely require clinics to post a factual notice, as in *NIFLA*—it compels instructors of every CME course, no matter the topic, to insert discussion of implicit bias, a hotly contested and ideologically loaded concept into their own lectures. The panel avoids First Amendment scrutiny entirely by characterizing the entire instructional activity as government speech, rather than asking whether this speech mandate compels private speakers to voice the State’s message. That result directly contradicts *NIFLA*, which held that government-compelled messages imposed on licensed professionals warrant strict scrutiny.

The panel’s holding obliterates that boundary. It allows the state to label any professional discourse subject to regulation as government speech and thereby insulate it from constitutional scrutiny. If permitted to stand, the panel’s reasoning would not only permit, but encourage, states to mandate controversial ideological content—under the guise of licensing standards—without ever facing First Amendment review. It would give states across the ideological spectrum free rein to mandate controversial content in professional education—whether that means requiring physicians and other licensed professionals to affirm

progressive views on race and gender or conservative positions on abortion or climate change. By shielding such mandates from First Amendment scrutiny, the decision invites government-imposed orthodoxy under the guise of licensing regulation.

II. The Panel Decision Splits with Nearly Every Other Circuit Court

Consistent with Supreme Court precedent, circuit courts consider three factors when determining whether speech is private or governmental: history, public perception, and control. In most circuits, expressiveness plays a central role at every stage. *See, e.g., Small Bus. in Transportation Coal. v. Bowser*, 610 F.Supp.3d 149, 154–55 (D.D.C. 2022) (“The thrust of the inquiry ... is whether the Government has purposefully communicated a message of its own choosing.”), *aff’d*, No. 22-7102, 2023 WL 2770986 (D.C. Cir. Apr. 4, 2023); *Fields v. Speaker of Pennsylvania House of Representatives*, 936 F.3d 142, 158 (3d Cir. 2019) (government speech “allows lawmakers to convey their own message”); *Sutcliffe v. Epping Sch. Dist.*, 584 F.3d 314, 331 (1st Cir. 2009) (government speech is when the government “communicate[s] an important message about itself”). The panel, by contrast, focused on the extent to which the government regulates the medical profession. As a

result, it applied each part of the three-part test in a way that conflicts with several circuits and invites government suppression of private speech.

A. Other circuits require a history of government expression

Take the panel’s analysis of the first prong. Whereas other circuits consider the “history of expression” associated with the government’s conduct, the panel considered the government’s history of regulation. Thus, rather than considering whether the state has traditionally used CMEs as a means of communicating a message to the public,² the panel focused on whether the state has traditionally regulated the practice of medicine, including by requiring CMEs. *See, e.g., Slip Op. at 16* (observing that “California has ... ‘long regulated the medical profession.’”). Though Khatibi argued that “CMEs have never been used to convey messages to the public,” *id.* at 18, the panel deemed this fact

² If the panel had considered the history of CME, it could not have concluded that the government has used CME to communicate to the public. *See, e.g., Clyde Partin et al., A Tale of Congress, Continuing Medical Education, and the History of Medicine, 27(2) Proceedings (Baylor Univ. Med Cent.) 156 (2014). Available at <https://pmc.ncbi.nlm.nih.gov/articles/PMC3954679/pdf/bumc0027-0156.pdf> (discussing CME as originating with individual doctors until being “embraced” by medical schools and private medical societies).*

irrelevant because, in its view, all regulation necessarily reflects certain governmental judgments and expresses those judgments to the public. *Id.* at 20–21. It therefore concluded that history weighed in favor of government speech. *Id.* at 22.

This line of reasoning not only creates a one-way ratchet in favor of government speech, it also directly conflicts with other circuits, which look not merely to whether the government regulates the content or associated profession, but to whether it uses regulation to convey a message.³ Thus, in *Women for Am. First v. Adams*, No. 21-485-cv, 2022 WL 1714896, at *2 (2d Cir. May 27, 2022), the Second Circuit deemed markings on roadways government speech not because the state had long regulated them, but because the state had historically used them to “communicate[] messages.” And in *Little v. Llano Cnty.*, 138 F.4th 834, 837–38 (5th Cir. 2025), the Fifth Circuit concluded that a public library’s choice to exclude certain books was government speech because the

³ *Small Bus. in Transportation Coal.*, 2023 WL 2770986, at *3 (considering the “history of the expression at issue”) (citation omitted); *GLBT Youth in Iowa Sch. Task Force v. Reynolds*, 114 F.4th 660, 667 (8th Cir. 2024) (same); *Mech v. Sch. Bd. of Palm Beach Cnty.*, 806 F.3d 1070, 1075–76 (11th Cir. 2015) (under the history prong, “A medium that has long communicated government messages is more likely to be government speech.”).

history revealed that “libraries curate their collections for expressive purposes.” Conversely, in *Brown v. Yost*, 133 F.4th 725, 734–35 (6th Cir. 2025), the Sixth Circuit deemed ballot summaries private speech because they had not “historically conveyed government messages.” In these circuits, the regulatory history is irrelevant unless there’s evidence that it had an expressive purpose or effect.

B. Other circuits do not use government regulation as a proxy for public perception

The panel also parted ways with other circuits when it applied the second prong: whether the public would perceive the speech as government speech. The panel acknowledged that Khatibi “plausibly alleged facts suggesting that attendees treat her as the person responsible for CME content.” Slip Op. at 24. Yet it gave dispositive weight to the fact that medicine is a regulated field, reasoning that—in light of the broader regulatory context—“it does not seem unreasonable to infer” that attendees might perceive CME content as coming from the State. *Id.*

That reasoning contradicts circuit court decisions holding that government oversight—without more—does not transform private

expression into government speech.⁴ *See, e.g., New Hope Fam. Servs., Inc. v. Poole*, 966 F.3d 145, 174 (2d Cir. 2020) (“State authorization by itself does not transform the authorized actor’s speech into government speech”); *Yost*, 133 F.4th at 735 (“Although [a government actor] has edited the summary, it is still initially and fundamentally the work of the petitioners.”); *Wandering Dago, Inc. v. Destito*, 879 F.3d 20, 36 (2d Cir. 2018) (“we find it implausible that ... permitting [the plaintiff’s] full participation in the Lunch Program” or providing “incidental assistance” to it would be “viewed by the public as having adopted WD’s speech as its own”). The correct inquiry is not whether the government has some involvement with the speech, but instead “whether [the medium] is

⁴ The panel’s use of speculation to defeat a plaintiff’s plausible allegations also inverts the federal pleading standard, which requires courts to infer all allegations in favor of the plaintiff. The Second, Sixth, and Eighth Circuits have recognized that the fact-intensive and context-specific nature of the government speech doctrine means that courts should be hesitant to dismiss plausible allegations that the speech is private. *Cajune v. Indep. Sch. Dist.* 194, 105 F.4th 1070, 1080–81 (8th Cir. 2024) (“The District would have us look solely to these indications of its approval as decisive while ignoring statements made by it that are indicative of private speech. On a motion to dismiss, we must view the facts in the light most favorable to the *plaintiffs*.”); *Cambridge Christian Sch., Inc. v. Fla. High Sch. Athletic Ass’n*, 942 F.3d 1215, 1223 (11th Cir. 2019) (district court was “too quick to dismiss” given the fact-intensive nature of the claim and in light of the fact that at least one factor was “indeterminate”).

reasonably interpreted as ‘conveying some message on the [government’s] behalf.’” *Women for Am. First*, 2022 WL 1714896, at *2. The panel thus should not have allowed the broader regulatory context to trump Khatibi’s specific allegations about how attendees view the speech at issue.

C. Other circuits consider government control “over the message”

Finally, the panel applied the third prong contrary to other circuits when it treated general regulatory authority as equivalent to editorial control over speech. Its opinion emphasized that California regulates the medical field, mandates CMEs, sets broad standards for CME courses to qualify for state credit, and may audit courses after the fact. But it failed to identify any instance in which the State controlled what Khatibi said, injected its own viewpoint, or edited her content. The panel’s analysis therefore conflicts with overwhelming consensus among the Second, Third, Fourth, Fifth, Sixth, Eighth and Eleventh Circuits, that the government must not show merely control, but control over the message. *See, e.g., Women for Am. First*, 2022 WL 1714896, at *4 (private murals were government speech where the government had “direct, editorial control over the message’s content” and final approval authority); *Fields*,

936 F.3d at 158 (third factor considers “government’s control over the message”); *Davison v. Randall*, 912 F.3d 666, 687 (4th Cir. 2019), *as amended* (Jan. 9, 2019) (third factor considers “effective[] control” over content); *Little*, 138 F.4th at 860 (third factor considers “the extent to which the government has actively shaped or controlled the expression”); *Yost*, 133 F.4th at 734–35 (same); *GLBT Youth in Iowa*, 114 F.4th at 668 (same); *Mech*, 806 F.3d at 1078 (same).

These courts emphasize that even some level of pre-approval is not sufficient to render speech governmental, let alone the kind of post hoc audits that Plaintiffs alleged were largely procedural, not editorial. *Cajune*, 105 F.4th at 1081 (“Without more, the mere existence of a review process with approval authority is insufficient by itself to transform private speech into government speech.”). Yet the panel inferred control based merely on the State’s regulation of CME providers and the requirement that content meet broad standards, like being privately certified or having to do with medical practice rather than the business aspects of medicine. This sort of high-level control, like “[an official’s] certification that [private speech] is fair and truthful,” does not suggest

that such speech “expresses [the government’s] approved message.” *Yost*, 133 F.4th at 735.

Correspondingly, the Tenth Circuit deemed ballot titles government speech only after finding that they were “fully and exclusively crafted by the government through the Secretary of State’s office.” *Colorado v. Griswold*, 99 F.4th 1234, 1241 (10th Cir. 2024). And the Eleventh Circuit found that banners placed on school property were government speech because the school controlled the design, dictated the information they could contain, regulated the size and location, required the banner to state that the school was a “Partner in Excellence,” and the principal approved every banner before it could be placed on the school fence. Without this type of active control over the content, the speech remains private.

At every step, the panel prioritized general regulatory authority over the expressiveness of the government’s action, creating a conflict with several other courts and risking allowing the government to bootstrap First Amendment scrutiny out of existence.

III. The Panel Decision Presents Questions of Exceptional Importance

Although the Supreme Court’s decision in *Walker* “mark[ed] the outer bounds of the government-speech doctrine,” *see Tam*, 582 U.S. at 238, the panel’s decision here well exceeds that case. It deems speech that was made by non-government employees, outside of government property, without any government funding, government speech. The resulting expansion of government control over private speech is exactly the “dangerous misuse” of the government speech doctrine that the Supreme Court has warned against. *See Tam*, 582 U.S. at 235.

Although the panel attempts to label its decision as “narrow,” Slip Op. at 6, the narrowest practical result is that all professional education requirements—CME and beyond—are now deemed government speech. But even if the decision is limited to CME courses—and not *every* licensed profession that requires continuing education—it would mean California is “babbling prodigiously and incoherently” over thousands of sessions. *Tam*, 582 U.S. at 236.

To start, the AMA’s hub alone offers more than 3,300 CME courses.⁵ But that is only a fraction of the courses available for credit. The California Medical Association, American Academy of Family Physicians, Accreditation Council for Continuing Medical Education, and “other organizations and institutions acceptable to” the medical board all offer additional courses. *See* Cal. Bus. & Prof. Code § 2190.1(a), (g); Cal. Code Regs. tit. 16, § 1337(a)–(b). The precise number of available courses is unknown and ever changing. Private physicians, professors, and instructors are creating new content every day (wholly unaware they are apparently speaking as the California government).

At present, those courses contain a variety of different viewpoints. One AMA-accredited course, “Child and Adolescent Gender Care Training,” supports World Professional Association for Transgender Health (WPATH) recommendations favoring gender affirmation.⁶ Another explores recent European approaches diverging from WPATH.⁷

⁵ *See* <https://edhub.ama-assn.org/by-topic>.

⁶ *Available at* <https://cme.healthpartners.com/content/child-and-adolescent-gender-care-training?>.

⁷ *Available at* <https://wsu.cloud-cme.com/course/courseoverview?P=0&EID=2516>.

A third offers a global debate on treatment models.⁸ Yet under the panel’s reasoning, *each course independently expresses California’s state-sanctioned message*. In *Tam*, the presence of contradictory views doomed the federal government’s argument that the trademark registry was government speech. 582 U.S. at 236. Not so here. The result is that these historically diverse viewpoints can now be stifled, because they are all government speech.

The same holds true for continuing *legal* education (CLE), hotly debated in the briefs, but unaddressed by the panel. *See, e.g.*, Dkt. 14.1, Open. Br. at 3–4. CME is not meaningfully different in structure—and sometimes even content—from CLE. For example, the California Medical Association offers CME courses on “The Anatomy of a Lawsuit: Understanding a California Medical Malpractice Case,”⁹ and “Documentation and Discoverability.”¹⁰ Given the fact that both occur in

⁸ *Available at* https://wsu.cloud-cme.com/course/courseoverview?EID=2517&P=0&utm_.

⁹ *Available at* https://www.cmadoes.org/store/info/productcd/CMA25_0506_TDC/t/the-anatomy-of-a-lawsuit.

¹⁰ *Available at* https://www.cmadoes.org/store/info/productcd/CMA24_1205_TDC/t/documentation-and-discoverability.

the context of professions that have long been regulated, if CME is government speech, then so too is CLE.

That result should give this Court pause. Nearly every judge on the Ninth Circuit has participated in events hosted by law schools, bar associations, the Federalist Society, or private providers like Pincus Professional Education, all of which qualify for CLE credit. Drawing on the full Court’s “judicial experience and common sense,” *Ashcroft v. Iqbal*, 556 U.S. 662, 679 (2009), should make clear that CME and CLE reflect the views of their instructors, not the government. Yet according to the panel decision, tens of thousands of CME, CLE, and other continuing education courses and their instructors are actually speaking for the government, and thus subject to state control.

In *Tam*, the Supreme Court warned that “[i]f private speech could be passed off as government speech by simply affixing a government seal of approval, government could silence or muffle the expression of disfavored viewpoints.” *Tam*, 582 U.S. at 235. It therefore advised courts to “exercise great caution” before extending its government-speech precedents. *Id.* Here, the panel deemed speech created by private individuals, without government funding, spoken on private property,

and made without government editorial control, government speech. En banc review is necessary to make sure the government speech doctrine does not swallow the First Amendment entirely.

CONCLUSION

For the foregoing reasons, the petition for rehearing en banc should be granted and the district court's decision reversed.

DATED: August 8, 2025.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on August 8, 2025, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

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

s/ Joshua P. Thompson
JOSHUA P. THOMPSON

**CERTIFICATE OF COMPLIANCE FOR PETITIONS FOR
REHEARING/RESPONSES**

Form 11

9th Cir. Case Number: 24-3108

I am the attorney or self-represented party.

I certify that pursuant to Circuit Rule 40-1, the attached petition for panel rehearing/petition for rehearing en banc/response to petition is (select only one):

☒ Prepared in a format, typeface, and type style that complies with Fed. R. App. P. 32(a)(4)–(6) and contains the following number of words: 4,194

OR

☐ In compliance with Fed. R. App. P. 32(a)(4)–(6) and does not exceed 15 pages

DATED: August 8, 2025.

s/ Joshua P. Thompson
JOSHUA P. THOMPSON
Attorney for Plaintiffs – Appellants

ADDENDUM

FOR PUBLICATION

**UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

AZADEH KHATIBI, M.D., an
individual; DO NO HARM, a
Virginia nonprofit corporation,

Plaintiffs - Appellants,

v.

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

Defendants - Appellees.

No. 24-3108

D.C. No.
2:23-cv-06195-
MRA-E

OPINION

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

Argued and Submitted March 27, 2025
Pasadena, California

Filed July 25, 2025

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

Opinion by Judge Nguyen

SUMMARY*

First Amendment/Government Speech

The panel affirmed the district court’s dismissal of an action, brought by a physician instructor of continuing medical education (CME) courses and a nonprofit comprised of healthcare professionals and policymakers, alleging that the Medical Board of California’s requirement that CME courses eligible for credit include information about implicit bias violates the Free Speech Clause of the First Amendment.

Applying the factors set forth in *Shurtleff v. City of Boston*, 596 U.S. 243 (2022), the panel held that under California’s scheme, CME courses eligible for credit by the Medical Board of California are government speech. First, California has a longstanding tradition of regulating the medical profession. Second, the public would tend to

* This summary constitutes no part of the opinion of the court. It has been prepared by court staff for the convenience of the reader.

attribute CME speech to the government rather than to CME instructors. Finally, California controls the content of CME courses and imposes several restrictions on their form and delivery.

Because CME courses eligible for credit are government speech, they are immune from the strictures of the Free Speech Clause.

COUNSEL

Joshua P. Thompson (argued) and Caleb R. Trotter, Pacific Legal Foundation, Sacramento, California; Cameron T. Norris, Consovoy McCarthy PLLC, Arlington, Virginia; for Plaintiffs-Appellants.

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OPINION

NGUYEN, Circuit Judge:

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

Today, the Medical Board of California, as the Board of Medical Examiners is now known, aims to ensure "the continuing competence of licensed physicians and surgeons." CAL. BUS. & PROF. CODE § 2190.¹ It "adopt[s]

¹ All undesignated statutory references are to this code.

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

This case challenges one of these CME requirements, namely section 2190.1(d)(1)’s mandate to include information about implicit bias. Plaintiffs Dr. Khatibi and Do No Harm (collectively, “Dr. Khatibi” or “Plaintiffs”) claim that the implicit bias requirement violates the First Amendment.² The district court dismissed their suit. It held that CMEs eligible for credit constitute government speech and are therefore “‘not subject to scrutiny under the Free Speech Clause.’” *See Khatibi v. Hawkins*, No. 2:23-cv-06195, 2024 U.S. Dist. LEXIS 81485, *9 (C.D. Cal. May 2, 2024) (*Khatibi II*) (quoting *Pleasant Grove City v. Summum*, 555 U.S. 460, 464 (2009); *see also Shurtleff v. City of Boston*, 596 U.S. 243, 247–48 (2022) (“[W]hen the

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

government speaks for itself, the First Amendment does not demand airtime for all views. After all, the government must be able to promote a program . . . in order to function.”). Plaintiffs appealed. We affirm.

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

Our holding is narrow. It recognizes that when California—from beginning to end—dictates, controls, and approves the provider, form, purpose, and content of CMEs, it is in fact the State that “speaks” or expresses its views. California does so consistent with its tradition, “from time immemorial,” of protecting its populace from the “consequences of ignorance and incapacity” in medicine, a profession “upon which health and life depend” and requires the most careful preparation—propositions that have been “too well settled to require discussion.” See *Dent v. West Virginia*, 129 U.S. 114, 122 (1889); *Watson v. Maryland*, 218 U.S. 173, 176 (1910).

I.

California law sets forth various CME requirements “to ensure the continuing competence of licensed physicians and surgeons.” § 2190. CMEs must “(1) have a scientific or clinical content with a direct bearing on the quality or cost-effective provision of patient care, community or public

health, or preventive medicine, (2) concern quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine, (3) concern bioethics or professional ethics, (4) are designed to improve the physician-patient relationship and quality of physician-patient communication,” or otherwise “serve to maintain, develop, or increase the knowledge, skills, and professional performance that a physician and surgeon uses to provide care, or to improve the quality of care provided to patients.” *Id.* § 2190.1(a) (cleaned up).

The State charges its Medical Board to “adopt and administer standards for the continuing education of those licensees.” *Id.* § 2190. The Board, in turn, requires that all licensed physicians complete at least 50 hours of approved CME every two years. CCR tit. 16, § 1336(a). Only programs the Board deems “acceptable” are approved for CME credit. *Id.* §§ 1337(b), 1300.4(e). Courses are “acceptable” if they meet the express criteria of section 2190.1 and accompanying regulations. *See id.* § 1337.5. “The content of the course or program shall be directly related to patient care, community health or public health, preventive medicine, quality assurance or improvement, risk management, health facility standards, the legal aspects of clinical medicine, bioethics, professional ethics, or improvement of the physician-patient relationship.” *Id.* § 1337.5(a)(3); *see also id.* § 1337.5(a)(1)–(7) (imposing requirements on faculty, course rationale and content, methodology of instruction, evaluation, and attendance). Certain programs by the California Medical Association, American Medical Association, and American Academy of Family Physicians are preapproved for CME credit. *Id.* § 1337(a)–(b). The Board does “not give prior approval to individual courses or programs; however, the division will

randomly audit courses or programs submitted for credit in addition to any course or program for which a complaint is received.” *Id.* § 1337.5(b). In addition, no credit is awarded for “any course deemed unacceptable by the division after an audit.” *Id.* § 1337.5(c).

In 2019, the Legislature enacted Assembly Bill (A.B.) 241. A.B. 241 amended section 2190.1 to require that “all continuing medical education courses ... contain curriculum that includes the understanding of implicit bias.” *See* § 2190.1(d)(1). Under A.B. 241, CMEs approved for credit must contain “(1) Examples of how implicit bias affects perceptions and treatment decisions of physicians and surgeons, leading to disparities in health outcomes” or “(2) Strategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics.” *Id.* at § 2190.1(e). CMEs by out-of-state providers or “dedicated solely to research or other issues that does not include a direct patient care component” are exempt from the requirement. *Id.* at § 2190.1(d)(2). A.B. 241 supplements section 2190.1(b)(1)’s separate cultural and linguistic competence requirement, which the Legislature enacted in 2005. *See* 2005 Cal. Stat. ch. 514 § 2; *see also* § 2190.1(c)(1)–(3) (mandating all CMEs to incorporate content such as about the use of proper names and pronouns in therapeutic relationships and application of “culturally, ethnically, and sociologically inclusive data to the process of clinical care”).

The Legislature passed A.B. 241 because it had found that implicit bias, “meaning the attitudes or internalized stereotypes that affect our perceptions, actions, and

decisions in an unconscious manner, exists, and often contributes to unequal treatment of people based on race, ethnicity, gender identity, sexual orientation, age, disability, and other characteristics.” 2019 Cal. Stat. ch. 417 § 1(a). “Implicit bias,” in the Legislature’s view, “contributes to health disparities by affecting the behavior of physicians and surgeons, nurses, physician assistants, and other healing arts licensees.” *Id.* § 1(b); *see also id.* § 1(c)–(e) (citing “remarkably consistent” evidence of disparities based on race, ethnicity, gender, and sexual orientation, “even after adjusting for” other factors).

Plaintiffs disagree. Dr. Khatibi is a California-licensed physician and Board-certified ophthalmologist. She is a frequent organizer and instructor of CMEs, and her past courses have been approved by state-authorized providers. Her courses have also complied with all state requirements apart from the implicit bias one. Do No Harm is a Virginia-based nonprofit comprised of healthcare professionals and policymakers. It has at least one member who teaches CMEs in California who believes implicit bias trainings “risk infecting healthcare decisions.”

Contesting the efficacy of any training on the matter³ and alleging that the implicit bias requirement violates free

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

speech rights, Plaintiffs sued the Medical Board of California. The district court dismissed the operative First Amended Complaint, holding that “CME courses in California constitutes government speech.” *Khatibi II*, 2024 U.S. Dist. LEXIS 81485, at *23. The district court noted that Plaintiffs may “choose to no longer instruct CME courses for credit, as is their right, or err their grievances at the ballot box because ‘it is the democratic electoral process that first and foremost provides a check on government speech.’” *Id.* at *25 (quoting *Walker v. Texas Div., Sons of Confederate Veterans, Inc.*, 576 U.S. 200, 207 (2015)). Plaintiffs timely appealed.

II.

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

A.

“The Free Speech Clause restricts government regulation of private speech; it does not regulate government

reasonable dispute.” Still, other amici agree with Plaintiffs and find implicit bias controversial, even divisive.

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

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

“A government entity may exercise this same freedom to express its views when it receives assistance from private sources for the purpose of delivering a government-controlled message.” *Summum*, 555 U.S. at 468. “This does not mean that there are no restraints on government speech. For example, government speech must comport with the Establishment Clause. The involvement of public officials in advocacy may be limited by law, regulation, or practice. And of course, a government entity is ultimately accountable to the electorate and the political process for its advocacy. If the citizenry objects, newly elected officials later could espouse some different or contrary position.” *Id.* at 468–69 (cleaned up). Additionally, “while the government-speech doctrine is important—indeed, essential—it is a doctrine that is susceptible to dangerous misuse. If private speech could be passed off as government speech by simply affixing a government seal of approval, government could silence or muffle the expression of disfavored viewpoints. For this reason, we must exercise

great caution before extending our government-speech precedents.” *Matal v. Tam*, 582 U.S. 218, 235 (2017).

B.

The “boundary between government speech and private expression can blur when, as here, a government invites the people to participate in a program.” *Shurtleff*, 596 U.S. at 252; *see also Summum*, 555 U.S. at 470. “In those situations, when does government-public engagement transmit the government’s own message? And when does it instead create a forum for the expression of private speakers’ views? In answering these questions, we conduct a holistic inquiry designed to determine whether the government intends to speak for itself or to regulate private expression.”⁴ *Shurtleff*, 596 U.S. at 252. Among the factors to consider in this analysis are “the history of the expression at issue; the public’s likely perception as to who (the government or a private person) is speaking; and the extent to which the government has actively shaped or controlled the expression.” *Id.* (collecting cases).

Take, for example, *Johanns v. Livestock Marketing Association*, 544 U.S. 550, 560 (2005), which upheld the

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

mandatory funding of beef commercials by private cattle merchants. The Supreme Court held that the commercials in question were government speech, not compelled private speech, because the government “effectively controlled” their message. *Id.* This was so, the Supreme Court reasoned, because “the message set out in the beef promotions is from beginning to end the message established by the Federal Government.” *Id.* at 560–61. “Thus, Congress and the Secretary have set out the overarching message and some of its elements, and they have left the development of the remaining details to an entity whose members are answerable to the Secretary.” *Id.* at 561.

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

within the park”); *see also id.* at 221 (Alito, J., dissenting) (noting over 350 specialty plates with distinct messages ranging from sports teams to religious organizations).

In contrast, in *Matal*, the Supreme Court held that trademarks were private and not government speech. 582 U.S. at 239. The Patent and Trademark Office (“PTO”) had rejected Tam’s trademark application related to his band, “THE SLANTS,” which was intended to “reclaim” a “derogatory term for persons of Asian descent.” *Id.* at 223, 228. The Court held that the state’s rejection constituted viewpoint discrimination, not government speech because trademarks “have not traditionally been used to convey a Government message;” the government “does not dream up,” edit, or meaningfully review trademarks; and the public does not associate trademarks with the government. *Id.* at 223, 235–38. The Court also noted how the PTO “made it clear that registration does not constitute approval of a mark.” *Id.* at 237. *Matal* thus distinguished trademarks from the license plates in *Walker*, stating that *Walker* “likely marks the outer bounds of the government-speech doctrine.” *Matal*, 582 U.S. at 238.

The Supreme Court likewise weighed the same factors to find private speech in *Shurtleff*. Boston had allowed private groups to raise flags outside its City Hall without denial or any control of flags’ contents—that is, until 2017, when it rejected a group’s “Christian flag.” *Shurtleff*, 596 U.S. at 248. Like the PTO’s rejection of the trademark in *Matal*, Boston’s rejection of the flag constituted viewpoint-based discrimination. *Id.* Acknowledging that while the history of flying flags *generally* weighed toward finding government speech, the Court found that the history of Boston’s *specific* flag-flying program was ambiguous, just like the public perception of who speaks through the city’s

flagpole. *Id.* at 254–55. While Boston did fly its own flags outside City Hall, it had also allowed private groups to use the flagpole without reviewing or controlling those groups’ flags. *Id.* The key issue was therefore government control. And because Boston never regulated any other flag’s contents, the Court ruled that flag-flying outside the City Hall constituted private speech. Boston’s control over the physical premises or over flag-raising’s schedule was insufficient. *Id.* at 256. Boston “could easily have done more to make clear it wished to speak for itself by raising flags,” the Court observed, and it simply did not. *Id.* at 257–58.

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

III.

Applying these principles with “great caution,” *see Matal*, 582 U.S. at 235, we consider whether, under circumstances specific to California, CMEs eligible for Board credit constitute government speech. We hold that the

Shurtleff factors of history, public perception, and control weigh in favor of concluding that they are.

A.

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

California, for its part, “has long regulated the practice of medicine as an exercise of the police power.” *Arnett v. Dal Cielo*, 923 P.2d 1, 2 (Cal. 1996) (recapping the history of the Board and the Medical Practice Act of 1876). California’s Medical Board has generally been “charged with the duty to protect the public against incompetent, impaired, or negligent physicians” since the 1870s. *See id.*; *Ex parte Gerino*, 77 P. 166, 168–69 (Cal. 1904) (upholding the Board’s primordial requirements for practicing medicine). And the Board has specifically and continually “adopt[ed] and administer[ed]” CME requirements since

1980. *See, e.g.*, § 2190; 1980 Cal. Stat. ch. 1313 § 2 (ordering the Board to establish CME requirements); 2011 Cal. Stat. ch. 236 § 2 (authorizing the Board to set standards for CMEs related to chronic diseases and lifestyle behaviors); CCR tit. 16, § 1337.5 (1990) (outlining standards); *id.* (2025) (same). The Legislature, too, has conceived of its own content requirements since 1992, requiring that all credit-eligible CMEs at least (1) focus on “scientific or clinical content” tied to patient care, cost-effectiveness, public health, or preventative medicine; (2) address quality assurance, risk management, facility standards, or legal aspects of clinical practice; (3) relate to bioethics or professional ethics; or (4) improve physician-patient relationship. *See* § 2190.1; 1992 Cal. Stat. ch. 331 § 1.

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

Conversely, the Legislature has excluded certain CMEs from credit from 1992 to 2021. During that time, licensees could not earn credit for CMEs on medical office management, billing, coding, and marketing, though the

Legislature now permits up to 30 percent of credit for these topics. *See* § 2190.15(i); 2021 Cal. Stat. ch. 612. Accordingly, California has not only long designated which CME courses qualify for credit, but also which courses do not.

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

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

Dr. Khatibi’s concerns are misplaced. It would be a serious affront to the Constitution if regulatory history alone were sufficient to immunize speech from First Amendment scrutiny. However, as the Supreme Court explained, history is but one factor in the context-driven, “holistic inquiry

designed to determine whether the government intends to speak for itself.” See *Shurtleff*, 596 U.S. at 252; *Summum*, 555 U.S. at 484 (Breyer, J., concurring) (“[T]he ‘government speech’ doctrine is a rule of thumb, not a rigid category”). Indeed, it is precisely this “holistic inquiry” that serves as a bulwark against abuse. It is also why Dr. Khatibi’s arguments fail. Just as we cannot equate something to monuments and conclude it is government speech, we cannot simply deem CMEs distinct from monuments and license plates, conclude they are nontraditional forms for government expression, and then terminate the inquiry. To do so would begin and end the analysis at the mere “starting point.” See *Shurtleff*, 596 U.S. at 255.

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

“holistic inquiry designed to determine whether the government intends to speak for itself.” *See id.* at 252; *compare Summum*, 555 U.S. at 470–72 (broadly considering the histories of various public parks and monuments, including pyramids).⁵

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

In other words, California’s CME requirements necessarily reflect, as Dr. Khatibi effectively concedes, “the importance of certain subjects to medical professionals.” The same holds true for California’s lengthy history of

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

regulation. That history reflects the State’s evolving judgment of what subjects it has deemed essential to “ensure the continuing competence of licensed physicians and surgeons,” of which implicit bias is one.⁶ §§ 2190, 2190.1(d)(1).

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

California thus sharply differs from the PTO in *Matal*. The PTO has no comparable history of telling companies like Sony to pick ““make.believe”” as its slogan from a list of qualified slogans. *See Matal*, 582 U.S. at 235–37. Nor has it ever commanded Apple how to, or who in its team

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

could, come up with ““Think different.”” *Id.* The PTO has also not ordered the noble patrons of Burger King to rate its motto of ““Have it your way.”” *Id.* Also, unlike the PTO, which long “made it clear that [trademark] registration does not constitute approval of a mark,” *id.* at 237, the Board has never disclaimed approval of accredited CMEs. To the contrary, approved CMEs, like the grant or renewal of a medical license, has always reflected the Board’s judgment of “the requisite skills and qualifications necessary to provide safe and effective services to the public”—something Dr. Khatibi does not contest.⁷ *Rich Vision Ctrs. v. Bd. of Med. Exam’rs*, 192 Cal. Rptr. 455, 457 (Ct. App. 1983); *Shea v. Bd. of Med. Exam’rs*, 146 Cal. Rptr. 653, 659–60 (Ct. App. 1978). History thus squarely weighs in favor of finding government speech in this case.

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

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

B.

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

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

Dr. Khatibi counters that “just because individuals understand that a CME course meets state requirements” does not mean that they perceive the CME as coming from the State. To so conclude, she cautions, risks equating accreditation or a mere “government seal of approval” with government speech, something deemed insufficient in *Matal*. Dr. Khatibi also details how CMEs can meet

requirements “so long as an individual course is first approved by certain *private* organizations,” and how CMEs are “largely unsupervised by the government except for the broad standards and a few mandated inclusions.”

Both sides’ arguments have some merit. Though some of Dr. Khatibi’s allegations border on conclusory, she has plausibly alleged facts suggesting that attendees treat her as the person responsible for CME content. She is also correct that the State certainly expects, if not relies, on the participation of private parties in executing the CME scheme. *See, e.g.*, CCR tit. 16, § 1337.5(a). At the same time, however, “the fact that private parties take part in the design and propagation of a message does not extinguish the governmental nature of the message.” *Walker*, 276 U.S. at 217; *see Johanns*, 544 U.S. at 562. And private parties’ involvement alone, contrary to her contention, does not resolve the government speech inquiry. Otherwise, *Shurtleff*’s holistic inquiry would be a futile exercise, not a vital mode of analysis designed to clarify the very “boundary between government speech and private expression [that] can blur.” 596 U.S. at 252. Moreover, “[t]hat Plaintiffs are evaluated and asked questions by course attendees—like most educators—and must come up with ‘examples’ and ‘strategies’ related to implicit bias—a pedagogical technique applicable to virtually any educational topic—does not alter the reasonable inference that CME curriculum itself, when approved for credit, is ‘conveying some message on the government’s behalf.’” *Khatibi II*, 2024 U.S. Dist. LEXIS 81485, at *18 (citation omitted).

It also does not seem unreasonable to infer that licensees perceive the content of accredited CMEs as coming from the State based on Dr. Khatibi’s own allegations. If physicians are cognizant that their profession is heavily regulated (in

light of Dr. Khatibi's recognition of the multifaceted legal and regulatory scheme in place); that they attend CMEs, primarily to secure credits to maintain their licenses (given Dr. Khatibi's allegation that licensees will not attend her courses if they do not comply with state requirements); that the Board requires licensees to take certain classes with specific content (like about implicit bias); and only compliant CMEs get credit (the very concern of Dr. Khatibi's lawsuit), then "common sense" commands that licensees could attribute approved CMEs' content to California. *See Iqbal*, 556 U.S. at 679 ("Determining whether a complaint states a plausible claim for relief . . . requires . . . judicial experience and common sense.").

The Board's argument that the entire CME scheme was created for licensees also has considerable force. As we explained in the historical analysis, California created the CME scheme "to ensure the continuing competence of licensed physicians and surgeons." § 2190. This is far from an effort to "intentionally open[] a nontraditional forum for public discourse." *Cornelius*, 473 U.S. at 802. It is also a far cry from *Shurtleff*, for example, where Boston generously offered its flagpole "to the public for events" and "accommodate[d] all applicants seeking to take advantage." *See* 596 U.S. at 249.⁸ Nor does the participation of private

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

parties change the analysis. “[P]ermitting limited discourse,” much like “inaction,” is insufficient to create a public forum. *Cornelius*, 473 U.S. at 802.

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

C.

We next consider “the extent to which the government has actively shaped or controlled the expression,” which is fundamental to the government speech inquiry. *Shurtleff*, 596 U.S. at 252. Alongside history, California’s extraordinary control over accredited CMEs is the “most salient feature of this case.” *Id.* at 256. Contrary to Dr. Khatibi’s claims, California not only shapes the content of CMEs, but it also imposes several restrictions on their form and delivery. In short, it controls accredited CMEs “from beginning to end.” *See Johanns*, 544 U.S. at 560–61.

We begin with the State’s multifaceted CME statutory and regulatory scheme. *See Delano Farms Co. v. Cal. Table Grape Comm’n*, 586 F.3d 1219, 1230 (9th Cir. 2009) (“Our focus in this case . . . is the statutorily-authorized control the State has . . . and not the actual level of control evidenced in the record.” (citing *Paramount Land Co. Ltd. P’ship v. Cal. Pistachio Comm’n*, 491 F.3d 1003, 1011 (9th Cir. 2007))). As discussed, section 2190 orders the Board to set and

anyone. *Id.* at 480. This would deprive California of the ability to select which courses are necessary to ensure licensees’ competence, effectively “defeating the essential function of the . . . program.” *Id.* at 478.

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

enforce CME requirements on licensees. It also authorizes the Board to “set content standards for any educational activity concerning a chronic disease that includes appropriate information on prevention of the chronic disease, and on treatment of patients with the chronic disease, by the application of changes in nutrition and lifestyle behavior.” *Id.* Section 2191, meanwhile, orders the Board to consider a plethora of subjects for accredited CMEs. These include, for instance, “human sexuality, defined as the study of a human being as a sexual being and how they function with respect thereto, and nutrition to be taken by those licensees whose practices may require knowledge in those areas;” child and elder abuse; “signs exhibited by abused women” in health settings; “special care needs of drug-addicted infants;” and “psychosocial dynamics of death.” *See id.* § 2191(a)–(i). Other statutory provisions order the consideration of additional topics ranging from HIV prevention, mental health and trauma in children to chronic diseases, spousal abuse, and COVID-19. *See generally id.* §§ 2191.4–2191.6.

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

See § 2190.1(a) (cleaned up); CCR tit. 16, § 1337.5(a)(3) (imposing similar content requirements).

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

(A) Applying linguistic skills to communicate effectively with the target population.

(B) Utilizing cultural information to establish therapeutic relationships.

(C) Eliciting and incorporating pertinent cultural data in diagnosis and treatment.

(D)(i) Understanding and applying culturally, ethnically, and sociologically inclusive data to the process of clinical care, including, as appropriate, information and evidence-based cultural competency training pertinent to the treatment of, and provision of care to, individuals who identify as lesbian, gay, bisexual, transgender, queer or questioning, asexual, intersex, or gender diverse. This includes processes specific to those seeking gender-affirming care services.

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

(I) Information about the effects, including, but not limited to, ongoing personal effects of historical and

contemporary exclusion and oppression of transgender, gender diverse, or intersex (TGI) communities.

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

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

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

(V) Recognition of the difference between personal values and professional responsibilities with regard to serving TGI people.

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

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

All these content-related requirements are in addition to the myriad other mandates imposed by the regulations. Section 1337.5(a)(1) of title 16 of the regulations require CME instructors to possess specific qualifications, such as "a faculty appointment . . . directly related to the practice of medicine" in an approved institution. The regulations dictate, too, that the "need for the course and how the need was determined shall be clearly stated and maintained on file;" that the content of the course address a list of specified topics; that each program "shall clearly state educational objectives that can be realistically accomplished within the framework of the course;" that the "teaching methods" be "described;" that each course shall include an evaluation; and that course organizers "maintain a record of attendance of each participant." CCR tit. 16, § 1337.5(a)(2)–(5).

The regulations also provide that the "following programs are approved by the division for continuing

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

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

What we have catalogued—perhaps painstakingly—reveals that California has not only provided a “general description” of CMEs but also “detail[ed] the themes to be emphasized, the actors to be used, the demographics to be targeted, and the media to be employed.” *Paramount Land*, 491 F.3d at 1011 (finding government speech). It has also provided the starting and endpoint for any CME provider.

The State dictates who may teach the courses. CCR tit. 16, § 1337.5(a)(1); *id.* § 1337(a). It tells those qualified instructors to record their courses’ purpose and teaching methodology as well as ensure that their courses address specific topics. *Id.* §§ 1337.5(a)(2)–(4). It also sets guidelines related to attendance and evaluation. *Id.* §§ 1337.5(a)(4)–(6). The Board may then audit, accredit, or reject the CME; it may also waive licensees’ compliance obligations. *Id.* §§ 1337.5–1339. California therefore controls accredited CMEs “from beginning to end.”¹⁰ See *Johanns*, 544 U.S. at 560–61.

Dr. Khatibi resists this conclusion, but none of her arguments is persuasive. She first disputes California’s control over the content of CMEs, emphasizing the role of private parties in the scheme. She also argues that unlike in *Summum*, where the city exercised “editorial control” of the monuments’ messages, 555 U.S. at 472, and *Walker*, where Texas had “sole control” over license plates, 576 U.S. at 213, the Board’s role of accreditation is one of “mere approval.”

But as the Supreme Court explained, California’s reliance on private organizations “does not extinguish the governmental nature of the message.” See *Walker*, 276 U.S. at 202 (citing *Summum*, 555 U.S. at 470–471). California is

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

free to “le[ave] the development of the remaining details to an entity . . . answerable to the” Board, which is precisely what it has done. *See Johanns*, 544 U.S. at 561. The State has outlined the topics that CMEs must cover. *See, e.g.*, § 2190.1. It has set who may and how to teach them. *See, e.g.*, CCR tit. 16, § 1337.5. It has also designated specific private organizations to deliver accredited CMEs, provided that the courses meet specific criteria. *See, e.g., id.* § 1337. And the Board may ultimately audit and reject any CME as unacceptable. *See id.* § 1337.5(c). As in *Johanns*, this is sufficient, “effective[] control[].” 544 U.S. at 560.

Relatedly, Dr. Khatibi’s role as the “sole organizer” of a course does not mean that the State has exercised no control over content. To the contrary, Dr. Khatibi admits that her courses have complied with all CME requirements apart from the implicit bias one at issue in this case. Compliance presupposes a rule; without rules, there can be no compliance. Put another way, Dr. Khatibi has conceded that her CMEs *have* been shaped by California. They have aligned with the “overarching message” set by the State, even as California has “left the development of the remaining details” to her and other private parties. *See Johanns*, 544 U.S. at 561. Combined with the Board’s auditing and ultimate approval authority, this *is* editorial control. *See id.* at 560–62.

For this reason, it is also of no moment that the Board normally accredits CMEs without an audit, *see* CCR tit. 16, § 1337.5(b), or that it has not yet chosen to audit Dr. Khatibi’s courses. No one disputes that the Board may audit any course and deem it ineligible for credit. This, combined with the State’s requirement that any accredited CME (which must be provided by specified, qualified providers) relate to at least a few, if broad, topics, *see, e.g.*, § 2190.1(a),

means that California shapes or controls CMEs “from beginning to end.” See *Johanns*, 544 U.S. at 560–61 (finding sufficient governmental control where content was “specified, *in general terms*” by Congress and where Secretary had “final approval authority” (emphasis added)).

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

Dr. Khatibi’s remaining arguments fare no better. Her claim that the sheer volume of accredited CMEs dilutes California’s control over them collapses under *Walker*’s wisdom. *Walker* made clear that the “desire to communicate numerous messages does not mean that the messages conveyed are not” the government’s. 576 U.S. at 217; see also *id.* at 221–22 (Alito, J., dissenting) (noting that there are over 350 varieties of specialty plates). It is the state’s right, *Walker* stressed, to convey “many more messages” if it wished. *Id.* at 217. Citing *Summum*, the Court declared that the government speech analysis was “not dependent on the precise number of” expression or messages at issue. *Id.* (citing 555 U.S. at 471–72).

Shurtleff reaffirmed this reasoning. There, the court clarified that it did “not settle [the] dispute by counting

noses—or, rather, counting flags. That is so for several reasons,” including the more salient importance of focusing on Boston’s policies, which were unwritten, and whether Boston “wished to speak for itself by raising flags.” *See* 596 U.S. at 256–57. The fact that there may be numerous accredited CMEs, therefore, “does not mean that the messages conveyed are not [the government]’s own.” *Walker*, 576 U.S. at 217.

More to the point, Dr. Khatibi makes no allegation of noncompliance. She does not allege that any accredited CME has somehow deviated from the Board’s “overarching message,” *see Johanns*, 544 U.S. at 561, of what is necessary to “ensure the continuing competence of licensed physicians and surgeons,” *see* § 2190. In fact, all the sample CMEs Dr. Khatibi references align with state-mandated topics.¹¹ She accordingly fails to show that California has been “babbling prodigiously and incoherently” or “expressing contradictory views” through accredited CMEs—something that could have counseled toward finding private speech. *See Matal*, 582 U.S. at 235–36.

¹¹ *Compare* Opening Brief (“OB”) 32 (“efficacy of endoscopic endonasal surgical navigation”), *with* § 2190.1(a)(2) (CMEs must “concern quality assurance or improvement ... of clinical medicine”); OB 32 (“sexual orientation and gender identity in cardiovascular care”), *with* § 2191 (ordering the Board to consider “human sexuality” in licensees’ practices) and § 2190.1(c) (listing cultural competency requirements touching on sexuality and gender); OB 26 (providing allegedly private speech example of CME called “Association Between the Relaxation of Public Health and Social Measures and Transmission of the SARS-CoV-2 Omicron Variant in South Korea”), *with* § 2190.1(a)(1) (CMEs must “have a scientific or clinical content with a direct bearing on the quality ... of patient care, community or public health).

Second, Dr. Khatibi's comparisons of the Board to the governmental bodies in *Matal*, *Shurtleff*, *Summum*, and *Walker* are unpersuasive. The Board exercises far more control than the PTO in *Matal*. Indeed, the Board designates specific private organizations or qualified faculty to teach accredited CMEs. *See* CCR tit. 16, §§ 1337(a), 1337.5(a). These instructors' courses must at least adhere to the—in Dr. Khatibi's words—"broad parameters" set by California to be accredited. *See, e.g.*, § 2190.1. By contrast, the PTO imposes no similar requirements. Any natural or juristic person may create a mark, and they are able to do so from an entirely blank canvas. 15 U.S.C. § 1127. The PTO also "does not dream up" content standards, *Matal*, 582 U.S. at 235, whereas California has long done so, mandating that CMEs address topics like the "legal aspects of clinical medicine" and "health inequities within the TGI community, including family and community acceptance." *See, e.g.*, §§ 2190.1(a)(2), (c)(1)(D)(ii)(III).

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

California's oversight over CMEs dwarfs the nominal supervision by the cities in *Shurtleff* and *Summum*, too. In *Shurtleff*, Boston "hadn't spent a lot of time really thinking

about” the flags it permitted to fly and “had nothing—no written policies or clear internal guidance.” 596 U.S. at 257 (cleaned up). Similarly, in *Summum*, Pleasant Grove lacked a written policy on monuments until a year after the plaintiffs donated the monument at issue. 555 U.S. at 465. And even then, the city’s eventual policy seemed limited in nature. *Id.* (detailing the policy’s focus on historical ties to the community). California’s CME regime, in contrast, has long been embedded in and enforced through a complex web of statute and regulation. *See, e.g.*, § 2190.1; CCR tit. 16, § 1337.5. It is also significant that both the monument in *Summum* and the flag in *Shurtleff* were entirely privately designed, with no government input whatsoever. The content of accredited CMEs, as we have detailed, is shaped by the State from their inception.

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

* * *

We hold that CMEs eligible for credit under California law constitute government speech. *See Shurtleff*, 596 U.S. at 248. And because they constitute government speech, CMEs eligible for credit are therefore immune from the strictures of the Free Speech Clause. *See Summum*, 555 U.S. at 464.¹²

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

AFFIRMED.

¹² Accordingly, we need not reach Plaintiffs’ unconstitutional conditions claim. *See Agency for Int’l Dev. v. All. for Open Soc’y Int’l, Inc.*, 570 U.S. 205, 214 (2013) (“[T]he Government may not deny a benefit to a person on a basis that infringes his constitutionally protected freedom of speech even if he has no entitlement to that benefit.” (cleaned up)); *see also Matal*, 582 U.S. at 239–40 (suggesting that the doctrine only applies to “cash subsidies or their equivalent”).