

No. 25-1240

In the Supreme Court of the United States

—————
AZADEH KHATIBI, ET AL.,

Petitioners,

v.

KRISTINA D. LAWSON, PRESIDENT OF THE MEDICAL
BOARD OF CALIFORNIA, ET AL.,

Respondents.

—————
*On Petition for a Writ of Certiorari to the
United States Court of Appeals for the Ninth Circuit*

—————
**BRIEF OF THE CATO INSTITUTE AS *AMICUS*
CURIAE IN SUPPORT OF PETITIONERS**

—————
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QUESTION PRESENTED

Whether private instruction in courses required for state licensure constitutes government speech.

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INTEREST OF *AMICUS CURIAE*¹

The Cato Institute is a nonpartisan public policy research foundation founded in 1977 and dedicated to advancing the principles of individual liberty, free markets, and limited government. Toward that end, Cato's Robert A. Levy Center for Constitutional Studies publishes books and studies about legal issues, conducts conferences, produces the annual *Cato Supreme Court Review*, and files *amicus* briefs in constitutional law cases. This case interests Cato because it concerns the government's infringement on the First Amendment. The decision below invites states to use their licensing powers to mandate speech from private professionals.

¹ Rule 37 statement: No part of this brief was authored by any party's counsel, and no person or entity other than *amicus* funded its preparation or submission. All parties were timely notified of the filing of this brief.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

A few years ago, California legislators conscripted private medical educators to deliver the State's preferred message about implicit bias. The State did so by mandating that they deliver this message in continuing-medical-education ("CME") courses for licensed physicians. When Petitioners—medical educators subject to the speech mandates—challenged that statute under the First Amendment, California recast the compelled private speech as government speech. The courts below accepted that maneuver, transforming a narrow doctrine that protects the government's own expression into a roadmap for evading constitutional limits on compelled speech. They erred in expanding government-speech doctrine to allow States to dictate private professionals' speech and then call it their own.

Physicians in California are required to obtain CME credits to maintain their medical licenses. *See* CAL. BUS. & PROF. CODE § 2190; CAL. CODE REGS. tit. 16, § 1336(a). This suit commenced after lawmakers imposed new CME content requirements in 2019: almost all state-accredited courses or lectures must include a discussion about the impact of unconscious or "implicit bias." CAL. BUS. & PROF. CODE § 2190.1(d)(1). Private lecturers now must discuss implicit bias consistent with the State's favored

viewpoint. A course omitting the State's required message will not qualify for CME credit.

Petitioners—Dr. Azadeh Khatibi and an organization representing medical professionals—sued the Medical Board of California over this requirement. Pet. Br. 5–6, 8. Dr. Khatibi is a California ophthalmologist who organizes and teaches CME courses on medicine and ophthalmology. *Id.* at 5. Dr. Khatibi objects to the requirement because it consumes valuable lecture time in her courses and displaces her own speech. Further, she regards implicit bias theory as often irrelevant in her courses. And she views the underlying assumption of the theory—that implicit bias is a major factor driving disparities in healthcare—as thinly supported and socially divisive. *Id.*

She and Do No Harm initiated their lawsuit in August 2023 and argued that the 2019 implicit bias mandate violates their First Amendment rights against compelled speech. *See* Pet. Br. 8. But the State argued that Petitioners' lectures constituted government speech and thus were not protected by the First Amendment. App. 3a–4a. The district court agreed and dismissed the complaint, and the U.S. Court of Appeals for the Ninth Circuit affirmed. *See* Pet. Br. 8. In the panel's view, California's longstanding regulation of the medical profession, the public's likely perception, and the State's asserted control over accredited CME transformed Dr. Khatibi's instruction into the government's own expression.

App. 1a–38a. The Petitioners now seek this Court’s review of the decision below.

We write separately to make three points. First, Petitioners’ speech here is not government speech—they create and compile their own courses without any meaningful government supervision, approval, control, or input. This Court’s government-speech doctrine narrowly protects the government’s ability to speak for itself. It does not empower the government to force private parties to repeat the government’s viewpoint and then claim ownership of that speech to avoid free speech problems.

Second, the Ninth Circuit’s expansion of government-speech doctrine would profoundly stifle debate in licensed professions nationwide. If California may convert private CME instruction into government speech merely by attaching credit to state-mandated courses, then the free speech effects would extend far beyond medicine. States could use occupational licensing to censor and shape continuing legal education, accounting seminars, engineering instruction, counseling programs, and other forms of private professional speech.

Third, we highlight that California has conscripted private physicians to teach a theory that is, at best, contested and, at worst, counterproductive. The scientific literature supporting implicit bias training is thin, and mandatory training may even *increase* some forms of bias. Indeed, some proponents of the implicit bias theory, including one of its cofounders, oppose

mandatory training. The decision below invites states to adopt and mandate the teaching of controversial theories, which would likely degrade public trust in regulators and licensed professionals.

For these reasons, this Court should grant the Petition and reaffirm that the government-speech doctrine does not permit states to compel private professional speech and call it their own.

ARGUMENT

I. THE GOVERNMENT SPEECH DOCTRINE DOES NOT EMPOWER THE GOVERNMENT TO COMPEL PRIVATE SPEECH.

“The First Amendment, applicable to the States through the Fourteenth Amendment, prohibits the enactment of laws ‘abridging the freedom of speech.’” *Reed v. Town of Gilbert*, 576 U.S. 155, 163 (2015) (quoting U.S. CONST. amend. I). This Court has ruled that “[c]ontent-based laws—those that target speech based on its communicative content—are presumptively unconstitutional,” *id.*, and that compelling individuals to speak a particular message is a regulation of speech subject to strict scrutiny. *Nat’l Inst. of Family & Life Advocates v. Becerra*, 585 U.S. 755, 766 (2018) (“*NIFLA*”). This Court affirmed this very Term that states may not force private speakers to affirm any orthodoxy.²

² *Chiles v. Salazar*, 146 S. Ct. 1010, 1029 (2026) (“[T]he First Amendment stands as a shield against any effort to enforce orthodoxy in thought or speech in this country.”). *See also NIFLA*,

The statutes challenged here require endorsement of an orthodoxy. California requires physicians to complete 50 hours of CME every two years. CAL. CODE REGS. tit. 16, § 1336(a). Private instructors have wide discretion on what to cover in their courses. *See* CAL. BUS. & PROF. CODE § 2190.1(a); CAL. CODE REGS. tit. 16, § 1337(a). However, in 2019, California lawmakers required that “all [CME] courses . . . contain curriculum that includes the understanding of implicit bias.” CAL. BUS. & PROF. CODE § 2190.1(d)(1). To satisfy this requirement, all CME course instructors must develop, as a part of their lesson, (1) “[e]xamples of how implicit bias affects perceptions and treatment decisions of physicians and surgeons, leading to disparities in health outcomes,” or (2) “[s]trategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics.” *Id.* § 2190.1(e).

Clearly, these are not mere disclosure rules. To comply with the law, CME instructors must draw on their professional expertise to develop arguments and explanations of how implicit bias contributes to healthcare disparities in their field. Even if instructors believe that implicit bias does not affect healthcare

585 U.S. at 774–79; *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943); *303 Creative LLC v. Elenis*, 600 U.S. 570 (2023).

outcomes in their field, they are still required to teach that it does.

The statute here compels the expression of a specific viewpoint—that unconscious bias creates disparate health outcomes along race and class lines. So, to avoid strict scrutiny—which is typically fatal for a statute—the State defends the CME mandate as government speech. The government-speech doctrine exists to preserve a zone in which the government may communicate its own positions without triggering the First Amendment’s neutrality requirements. *See Pleasant Grove City v. Summum*, 555 U.S. 460, 467–68 (2009); *Shurtleff v. City of Boston*, 596 U.S. 243, 251–52 (2022). It simply recognizes that the government itself is free to express its own viewpoints. *See Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 541–42 (2001). But the doctrine is also “susceptible to dangerous misuse,” and this Court has instructed lower courts to “exercise great caution before extending” it. *Matal v. Tam*, 582 U.S. 218, 235 (2017).

The Ninth Circuit did not heed that warning. Its decision treated extensive regulation as sufficient to convert privately created professional instruction into state speech. That extension of the government-speech doctrine is an error that threatens the First Amendment rights of licensed professionals.

This Court makes “a holistic inquiry” to determine whether expression is government or private speech. *Shurtleff*, 596 U.S. at 252. In this non-mechanical inquiry, the Court has highlighted three factors to

consider: (1) “the history of the expression at issue,” (2) “the public’s likely perception as to who (the government or a private person) is speaking,” and (3) “the extent to which the government has actively shaped or controlled the expression.” *Id.*

The speech mandate here fails each prong of the *Shurtleff* test. *See id.* at 252. First, while California has a long tradition of regulating the medical field, there is no tradition for compelling speech on the “expression at issue”—endorsement of implicit bias training. *See id.* Thus, California’s tradition argument “proceeds at far too high a level of generality.” *Chiles*, 146 S. Ct. at 1027. Second, attendees are unlikely to view CME courses as government speech. CME instructors are typically physicians in private practice—like Dr. Khatibi—speaking at self- or privately-organized events. Third, the State doesn’t exert any meaningful control over the development of these lessons.

This Court’s precedents illustrate the narrow circumstances where expression qualifies as government speech. In *Johanns v. Livestock Marketing Ass’n*, the Court upheld a compelled subsidy for beef advertisements because “[t]he message set out in the beef promotions [was] from beginning to end the message established by the Federal Government.” 544 U.S. 550, 560 (2005). The government was intimately involved at every step of content development. Federal officials participated in development meetings, edited content, and

maintained “authority over every word used in every” message. *Id.* at 561–62.

In *Summum*, this Court recognized monuments as government speech because the government accepted and took ownership of monuments for permanent display on government property, thereby adopting them as part of its own expressive presentation. 555 U.S. at 472–74. And in *Walker v. Texas Division, Sons of Confederate Veterans, Inc.*, Texas maintained direct control over the content of specialty license plates, which the public closely associates with the State itself. 576 U.S. 200, 210–14 (2015).

Walker deserves attention here because it has been understood to mark “the outer bounds of the government-speech doctrine.” *Matal*, 582 U.S. at 238. There, the license plates were state-issued government property, were forms of government ID, and prominently bore the State’s name, which is why the public associated their content with Texas itself. *Walker*, 576 U.S. at 212. Moreover, Texas’s board exercised “sole control over the design, typeface, color, and alphanumeric pattern” of every plate and gave affirmative, case-by-case approval to every specialty design before any plate could issue. *Id.* at 213 (internal quotation marks omitted). The State had complete discretion over what it approved, *id.*, and ultimately owned the designs it approved. *Id.* at 212. Even there, the government-speech designation was a close call, and this Court’s ruling drew four dissenting votes.

The lesson from these cases is that expression is the government's when the message is (a) authored or directly developed by the government, or (b) *voluntarily* conveyed from a private party and officially adopted by the government.

The CME courses fall outside these categories. California does not meaningfully develop or author CME curricula. It does not draft lesson plans, compile reading lists, or craft lecture notes. Unlike in *Sumnum* and *Walker*, California owns no part of the expressive materials. In contrast to *Johanns*, involving beef promotional materials, the State here does not review the content before it is presented. California does not assign an official to supervise the instructors' classrooms and does not exercise anything resembling the design-level control Texas exercised over plates. Texas's total control over every specialty plate marked the outer boundary of the doctrine, and California's topic-level content prescription for privately authored, privately delivered, privately branded professional instruction falls far outside that boundary.

For those reasons, no reasonable member of the public believes that a physician teaching a continuing medical education course in her own name, at a privately organized venue, is speaking for the State of California. No one would consider continuing legal education programs—which often present contentious legal concepts and debates—to be government speech, and CMEs are no different. In reality, California labels

these lessons as government speech solely for litigation purposes.

That the State occasionally audits CME courses to ensure compliance does not change the result. *See* CAL. CODE REGS. tit. 16, § 1337.5(b). When auditing a course, the government is not taking ownership over its content. The government uses audits only to enforce its speech requirement. And lesson plans are presumed compliant unless audited. *See id.*; CAL. CODE REGS. tit. 16, § 1337.5(b), (c). The State does not use audits to shape the remainder of the CME programming, and auditors do not participate in shaping the private lesson plans they review; those plans are wholly the product of private speakers.

The State’s auditing scheme resembles the trademark approval scheme at issue in *Matal*. 582 U.S. at 225–26. There, once found compliant, trademarks were automatically registered; the government did not choose speech to adopt. *Id.* at 235. Accordingly, this Court ruled that federal trademark registration did not transform privately created marks into government speech, as registration amounted at most to a mechanism for conferring legal consequences on private expression. *Id.* at 235–39. That principle is critical here. “[S]imply affixing a government seal of approval” cannot convert private speech into government speech. *Id.* at 235.

In the end, “[t]he ultimate question is whether the government is actually expressing its own views or . . . the government is surreptitiously engaged in the

‘regulation of private speech.’” *Shurtleff*, 596 U.S. at 263 (Alito, J., concurring in the judgment). Here, it is the latter. The government is using its power of licensure to mandate a contested viewpoint that private instructors must teach.

II. THE DECISION BELOW INVITES STATES TO USE THEIR LICENSING POWERS TO MANDATE SPEECH FROM PRIVATE PROFESSIONALS.

The rationale in the decision below has implications far beyond California’s implicit-bias mandate. The Ninth Circuit adopted a broad definition of government speech because, it said, California has “a longstanding tradition of regulating the medical profession,” App. 18a, “the public would tend to” perceive the State as standing behind accredited CME,³ App. 22a, and the Medical Board exercises regulatory and auditing authority over course content, *see* App. 27a–34a. Under that standard, most states can regulate the speech within many regulated professions, including law, veterinary medicine, dentistry, and education.

That cannot be right. If regulation alone can do that work, then the government-speech doctrine becomes a ready-made loophole around the compelled-speech doctrine. Any state could compel ideological or

³ If the CMEs here are perceived to have the government’s backing, then the same is true of all such credited courses across all licensed professions.

controversial viewpoints in privately organized professional education, then defend the mandate by saying that the regulated speech was governmental all along.

The effects could be profound. Occupational licensing has exploded in the United States and now covers some twenty⁴ or thirty⁵ percent of the workforce. By 2003, in at least one state, it was estimated that approximately 1,100 occupations required a license, certification, or registration.⁶

Each of the following hypotheticals is permissible under the panel's reasoning:

- *Continuing legal and judicial education:* A state could require that every accredited CLE and CJE course on constitutional law include instruction endorsing originalism as the only legitimate method of constitutional interpretation. A different state could require that every accredited course include instruction rejecting originalism as discredited. A state could require that every accredited judicial-

⁴ See Chris Edwards, *Occupational Licensing*, in EMPOWERING THE NEW AMERICAN WORKER: MARKET-BASED SOLUTIONS FOR TODAY'S WORKFORCE 59 (Scott Lincicome ed., 2022), <https://tinyurl.com/mtpfuus8>

⁵ See Morris M. Kleiner, *Reforming Occupational Licensing Policies*, THE HAMILTON PROJECT 14 (Mar. 2015), <https://tinyurl.com/2yrha6c2>.

⁶ *Id.* at 8.

education program include instruction that endorses or rejects particular sentencing philosophies.

- *Continuing medical education:* A state whose legislature is hostile to gender-affirming care could require that every CME course touching on adolescent medicine include warnings against social and medical interventions. A state whose legislature is supportive of such care could require endorsement. Either mandate would override the conscience and medical judgment of physician-instructors on a politically contested question of medicine and ethics. The same is true of CME requirements directed at the appropriate counseling of patients seeking abortion.
- *Continuing education for mental-health professionals:* A state could require that every continuing-education course for licensed psychologists, marriage and family therapists, or social workers include instruction endorsing a particular framework for understanding gender identity, same-sex attraction, or the causes of addiction.

With an expanded government-speech doctrine, states could suffocate debate in any licensed field. Continuing-education courses are one of the means by

which expert knowledge is transmitted, contested, and refined within the professions that shape American life: medicine, law, engineering, education, finance, mental-health care, and many others.

In *Matal*, this Court stressed that the government-speech doctrine is “susceptible to dangerous misuse” because, if private speech could be recast as government speech merely through governmental involvement or approval, “government could silence or muffle the expression of disfavored viewpoints.” 582 U.S. at 235. The decision below presents that danger.

III. CALIFORNIA HAS CONSCRIPTED PRIVATE PHYSICIANS TO TEACH A CONTESTED THEORY.

California has not enacted a law requiring disclosure of mere “factual, noncontroversial information.” *See Chiles*, 146 S. Ct. at 1022. It has taken a side in a politically charged controversy and forced private physicians to endorse the State’s position as established truth. The premise of the CME requirement is that implicit bias is a real, measurable, and remediable cause of disparities in patient care, and that mandatory continuing education on the subject will reduce those disparities. *See* App. 6a–7a; 2019 CAL. STAT. ch. 417 § 1(a)–(e).

These premises are dubious. The state-mandated theory is contested, and the research behind the implicit bias theory “fails to satisfy key scientific tests of validity.” Gregory Mitchell & Philip E. Tetlock, *Antidiscrimination Law and the Perils of*

Mindreading, 67 OHIO ST. L.J. 1023, 1023, 1030–34 (2006). Indeed, there is little evidence that people possess *unconscious* racist attitudes to begin with. Hart Blanton & James Jaccard, *Unconscious Racism: A Concept in Pursuit of a Measure*, 34 ANN. REV. SOCIO. 277, 277–93 (2008). The theory’s key measure has been widely panned, and the scientific literature demonstrates that interventions have little to no positive effect.

A. The Flagship Instrument of Implicit Bias Science—The Implicit Association Test—is a Poor Predictor of Real-World Behavior.

The Implicit Association Test (“IAT”) is the measurement tool on which most implicit bias science and training rest.⁷ However, its predictive validity has been the subject of sustained, rigorous criticism.⁸ “The

⁷ See Kate A. Ratliff & Colin Tucker Smith, *The Implicit Association Test*, 153 DÆDALUS 51, 51 (2024), <https://tinyurl.com/bddhz7m4>; Jared M. Bartels & Patricia Schoenrade, *The Implicit Association Test in Introductory Psychology Textbooks: Blind Spot for Controversy*, 21 PSYCHOL. LEARNING & TEACHING 113, 113–14 (2022).

⁸ See, e.g., Jesse Singal, *Psychology’s Favorite Tool for Measuring Racism Isn’t Up to the Job*, THE CUT (Jan. 11, 2017), <https://tinyurl.com/awjz357r>; Lee Jussim, *12 Reasons to Be Skeptical of Common Claims About Implicit Bias*, PSYCHOL. TODAY (Mar. 28, 2022), <https://tinyurl.com/unyarhhj>. Moreover, peer-reviewed work has shown that what has been defined as the core feature of implicit bias—that it operates outside the test-taker’s conscious awareness—is not supported by the evidence. People can, in fact, accurately predict their own IAT scores. Adam

IAT has serious psychometric flaws and an alarmingly high false alarm rate.” Mitchell & Tetlock, *supra*, at 1033 (emphasis deleted). Authors of a meta-analysis of IAT criterion studies concluded that “IATs were poor predictors of every criterion category other than brain activity.” Frederick L. Oswald et al., *Predicting Ethnic and Racial Discrimination: A Meta-Analysis of IAT Criterion Studies*, 105 J. PERSONALITY & SOC. PSYCHOL. 171, 171, 188 (2013). Other researchers find that IAT scores are “not good predictors of ethnic or racial discrimination.” Frederick L. Oswald et al., *Using the IAT to Predict Ethnic and Racial Discrimination: Small Effect Sizes of Unknown Societal Significance*, Va. Pub. L. & Legal Theory Research Paper No. 11, at 2 (Feb. 2015).⁹ They add that claims based on IAT scores “depend crucially on untested and arguably untenable assumptions.” *Id.*

Hahn et al., *Awareness of Implicit Attitudes*, 143 J. EXPERIMENTAL PSYCHOL. 1369 (2014).

⁹ Available at <https://ssrn.com/abstract=2564290>. See also Hart Blanton et al., *Strong Claims and Weak Evidence: Reassessing the Predictive Validity of the IAT*, 94 J. OF APPLIED PSYCHOL. 567 (2009); Rickard Carlsson & Jens Agerström, *A Closer Look at the Discrimination Outcomes in the IAT Literature*, 57 SCANDINAVIAN J. PSYCHOL. 278 (2016) (finding little evidence that the IAT can predict discrimination and strongly cautioning against practical applications).

B. Implicit Bias Interventions Often Fail, and Mandatory Ones Can Affirmatively Backfire.

Setting aside disputes about measurement, California’s mandate depends on a dubious presumption: that training physicians about implicit bias will reduce biased clinical decisions.

The most comprehensive meta-analysis of implicit bias interventions, synthesizing nearly 500 studies with over 80,000 participants, found that interventions produced only “trivial changes in behavior.” Patrick S. Forscher et al., *A Meta-Analysis of Procedures to Change Implicit Measures*, 117 J. PERSONALITY & SOC. PSYCHOL. 522 (2019).¹⁰ A separate 2021 *Annual Review of Psychology* article reviewing hundreds of experiments identified “troubling indications of publication bias that may exaggerate effects” and noted that “landmark studies often find limited effects.” Elizabeth Levy Paluck et al., *Prejudice Reduction: Progress and Challenges*, 72 ANN. REV. PSYCHOL. 533, 533 (2021). Another recent review of implicit bias training in healthcare—reviewing seventy-seven studies published over two decades—concluded that “there is little scientific evidence to support that implicit bias training improves the quality of patient care.” Nao Hagiwara et al., *The Nature and Validity of Implicit Bias Training for*

¹⁰ Available at <https://tinyurl.com/3958ffyu>.

Health Care Providers and Trainees: A Systematic Review, 10 SCI. ADVANCES, at 1, 6, 9 (2024).¹¹

Compounding all of the foregoing, a separate body of peer-reviewed research suggests that *mandatory* implicit bias training—like California’s—may increase some forms of bias. Lisa Legault and colleagues found that participants who received “controlling” anti-prejudice messages (i.e., messages framed as externally imposed obligations) exhibited *more* prejudice afterward than participants who received no intervention at all.¹²

The Ninth Circuit’s decision requires educators like Dr. Khatibi to devote precious medical education time to a contested psychological theory. Its reasoning, if allowed to stand, will likely damage public trust in the medical field. The First Amendment does not permit

¹¹ Available at <https://tinyurl.com/4t4t23zw>. The researchers found that 99.9% of the studies lacked internal validity, 93.5% lacked face validity, and 100% lacked external validity. Hagiwara et al. at 9.

¹² Lisa Legault et al., *Ironic Effects of Antiprejudice Messages: How Motivational Interventions Can Reduce (but Also Increase) Prejudice*, 22 PSYCHOL. SCI. 1472, 1472–77 (2011). This aligns with broader research on diversity training. Frank Dobbin and Alexandra Kalev’s three-decade study of more than 800 firms found that mandatory diversity training actually *decreased* the share of women and minorities in management positions. Frank Dobbin & Alexandra Kalev, *Why Diversity Programs Fail*, HARV. BUS. REV. (July–Aug. 2016), <https://tinyurl.com/3muwa9eh>.

the State to settle professional disagreements by compelling licensed speakers to teach the State's preferred answer—much less to avoid scrutiny by declaring the compelled answer “government speech.”

The First Amendment protects licensed professionals' right to express good-faith disagreements, even when those disagreements contradict prevailing medical consensus, as enforced conformity stifles free speech. *Chiles*, 146 S. Ct. at 1029. As this Court said recently, “[f]ar from a test of professional consensus, the First Amendment rests instead on a simple truth: ‘[T]he people lose’ whenever the government transforms prevailing opinion into enforced conformity.” *Id.* (quoting *NIFLA*, 585 U.S. at 772).

CONCLUSION

For the foregoing reasons, this Court should grant the Petition and reaffirm that the government-speech doctrine is not a tool to compel private speech.

Respectfully submitted,

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