No. 25-1240

In the Supreme Court of the United States

AZADEH KHATIBI, M.D.;
DO NO HARM, A VIRGINIA NONPROFIT CORPORATION,
LLC,

Petitioners,

v.

RANDY HAWKINS, IN HIS OFFICIAL CAPACITY AS PRESIDENT OF THE MEDICAL BOARD OF CALIFORNIA, ET AL.,

Respondents.

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

BRIEF OF THE CENTER FOR EQUAL OPPORTUNITY AND MANHATTAN INSTITUTE AS *AMICI CURIAE* SUPPORTING PETITIONERS

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June 1, 2026

QUESTION PRESENTED

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

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INTEREST OF *AMICI CURIAE*[1]

The Center for Equal Opportunity (CEO) is a nonpartisan, nonprofit research and educational organization devoted to issues of race and ethnicity. Its fundamental vision is straightforward: America has always been a multiethnic and multi-racial nation, and it is becoming even more so. This makes it imperative that our national policies do not divide our people according to skin color and national origin. CEO supports color-blind policies and seeks to block the expansion of racial preferences in all areas, including in admissions to educational institutions. CEO has participated as *amicus curiae* in numerous cases relevant to this case. *See*, *e.g.*, *Ricci v. DeStefano*, 557 U.S. 557 (2009); *Parents Involved*, 551 U.S. 701; *Grutter v. Bollinger*, 539 U.S. 306 (2003); *Fair Admissions*, 143 S. Ct. 2141 (2023); *Coalition for TJ v. Fairfax County School Board*, 601 U.S. 44 S. Ct. 1098 (2024).

The Manhattan Institute for Policy Research (MI) is a nonpartisan public policy research foundation whose mission is to develop and disseminate new ideas that foster greater economic choice and individual responsibility. To that end, MI has historically sponsored scholarship and filed *amicus* briefs supporting racial nondiscrimination.

This case interests *amici* because it involves both the appropriate application of constitutional principles central to the rule of law and racial nondiscrimination policy commitments that we share.

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

SUMMARY OF ARGUMENT

California requires its physicians to take continuing medical education (CME) courses 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." Cal. Bus. & Prof. Code § 2190; Cal. Code Regs. tit. 16, § 1336(a). In the decision below, the Ninth Circuit observed that this may be especially advisable in California due to its history of "cults and fads and a great deal of quackery." *Khatibi v. Hawkins, et al.*, 145 F.4th 1139, 1139 (9th Cir. 2025) (citing 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)).

At issue here is a form of modern quackery: implicit bias training. There is little evidence that implicit bias can be measured reliably, that it is a meaningful contributor to worse patient outcomes, or that implicit-bias training cures such patient outcomes. Nearly all implicit bias research uses a tool known as the Implicit Association Test to measure implicit bias—a test that has been rejected by researchers and courts alike. Nevertheless, California law compels *all* CME courses to include instruction on concepts of implicit bias.

In sum, California is compelling doctors to implement this modern quackery into every CME course they teach. Not only does that requirement violate the First Amendment, but it goes against the very purpose of continuing education programs in medicine: to educate physicians on treatment plans based on rigorous evidence rather than pseudoscientific theories.

ARGUMENT

I. TRAINING PHYSICIANS IN IMPLICIT BIAS LACKS EMPIRICAL SUPPORT

Implicit-bias investigations seek to ascertain whether disparities in healthcare outcomes come from the physicians themselves—namely, that implicit biases embedded in the subconsciousness of American physicians *causes* population-level disparities in healthcare outcomes. The motivation for this investigation is understandable: access to healthcare services is not uniform across racial groups in the United States, and there are many diseases and risk factors for morbidity and mortality that plague certain racial groups at comparatively higher rates. Ctrs. for Disease Control & Prevention, *CDC Health Disparities and Inequalities Report — United States, 2013*, 62 Morbidity & Mortality Wkly. Rep. (Supp. 3) (Nov. 22, 2013).

For its part, California describes its "Cultural and Linguistic Competency" CME requirements as a tool to "reduce health disparities" and "bridge the gap" caused by "endemic structural racism and biases that affect the care that an individual receives." Cultural & Linguistic Competency and Implicit Bias Standards, Cal. Med. Ass'n, https://www.cmadocs.org/cme/cme-standards (last visited May 20, 2026). Although health-outcome disparities among racial groups are real, California's solution to address it through implicit-bias training of physicians is built on a foundation of quackery. The evidence has come up short. The tools used to assess physician implicit bias lack empirical basis, as do high-quality, randomized controlled studies designed to show that physician implicit bias contributes to disparate health outcomes.

Highly cited systematic reviews and a federal agency dedicated to patient safety have recently reviewed and evaluated the quality of evidence for whether physician implicit bias results in worse patient healthcare outcomes. They found that these studies do not support the claim that adding implicit bias training to mandatory CMEs improves patient outcomes. Nevertheless, against overwhelming evidence to the contrary, California politicians believe that implicit bias training improves patient outcomes—and seeks to now reform all CME training accordingly. Cal. Bus. & Prof. Code § 2190.1(e).

Forcing concepts of implicit bias into CME programs—against the better judgment of the medical educators bringing this dispute—represents an ideological takeover of medicine that descends into quackery. This ideological imposition erodes trust in the scientific integrity of medicine by prioritizing unvalidated social interventions over proven standards of care.

A. The IAT Is an Unreliable Tool for Measuring Implicit Bias—the Existence of Which Is Disputed

Almost all studies involving healthcare provider implicit bias begin by measuring the bias of test subjects using a controversial tool known as the Implicit Association Test (IAT). The IAT attempts to "measure the strength of associations between concepts (*e.g.*, African-American, Hispanic, or Muslim persons), valuations (*e.g.*, good, bad), and stereotypes (*e.g.*, smart, dumb)" through a word association exercise to determine whether individuals possess implicit biases towards different groups. Adam Lamparello, *The Flaws of Implicit Bias and the Need for Empirical Research in Legal Scholarship and in Legal Education*, 45 J.

Legal Prof. 215, 236 (2021). Despite the wide adoption of IAT to study implicit bias, there is doubt among the developers of the IAT specifically, the field of psychology generally, and federal courts about the usefulness of the IAT in the contexts it is currently being used.

In *IAT: Fad or Fabulous?* published by the American Psychological Association, the utility of IAT was called into question, noting "[s]ome debate the test's psychometric validity and reliability. Others worry that the publicity is pushing it into the public sphere—particularly into the hands of legal scholars who argue it can be used to reshape antidiscrimination laws—before it's been properly vetted."[2] Professor Greg Mitchell warned that "The IAT is not yet ready for prime time" and while "this research is important research and the people doing it are very good scientists with noble intentions . . . noble intentions don't make good public policy." *Id.*

According to one of the psychologists who developed IAT, Dr. Brian Nosek, a test subject's IAT results are not static: "although results on the IAT are not as malleable as mood, they are "not as reliable as a personality trait." Lamparello, *supra*, at 237 (cleaned up). In other words, IAT results cannot reliably either predict implicit bias in specific scenarios, nor will it yield a consistent result in a given test subject over time.

Moreover, there is reason to believe measures of implicit bias could be entirely replaced by simply measuring explicit bias. The director of research at Project Implicit, Cavin Lai, acknowledged that the scientific community does not know whether IAT and

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[2] Beth Azar, *IAT: Fad or Fabulous?*, 39 Monitor on Psychol. 44 (2008), https://www.apa.org/monitor/2008/07-08/psychometric.

other, similar measures can predict behavior beyond that predicted by measures of explicit bias. *Id.* at 237 n.36. And in at least one study, researchers found that, after controlling for explicit bias, the IAT's significance in predicting racialized preferences for interaction among white and black counterparts was only marginally significant (below the standard applied to establish statistical significance). Gregory Mitchell & Philip E. Tetlock, *Antidiscrimination Law and the Perils of Mindreading*, 67 Ohio St. L.J. 1023, 1095 n.225 (2006).

With so much doubt about the reliability of IAT, it is no surprise that it has also been called into question by federal courts. Recently, Ninth Circuit Judge Eric Miller expressed doubts about use of IAT testing in a concurrence, noting that "even the leading advocates of implicit-association testing concede that 'attempts to diagnostically use such measures for individuals risk undesirably high rates of erroneous classifications.'" *Yu v. Idaho State Univ.*, 14 F.4th 1236, 1245 (9th Cir. 2021) (Miller, J., concurring) (quoting Anthony G. Greenwald et al., *Statistically Small Effects of the Implicit Association Test Can Have Societally Large Effects*, 108 J. Personality & Soc. Psych. 553, 557 (2015)). And the Third Circuit upheld the exclusion of expert testimony relying on IAT, holding that "population-wide statistics have only speculative application" when used to infer the rationale for decisions by specific decision-makers. *Karlo v. Pittsburgh Glass Works, LLC*, 849 F.3d 61, 84-85 (3d Cir. 2017).

Whatever utility IAT may have as a tool in empirical investigations, it is clear it is being misused in the context of trying to connect medical decision-making of physicians to their IAT scores.

B. There Is No Evidence that Implicit Bias Affects Patient Outcomes

High-quality, systematic reviews of the evidence indicates that healthcare provider implicit bias is not the cause of disparate healthcare outcomes. But, despite the lack of evidence, California politicians who insist that physicians should be trained on their implicit biases are operating under the debunked theory that implicit biases are the root of disparate outcomes. Those reviews are discussed here:

1. Hall Systematic Review

One of the most highly cited, best-quality systematic reviews of implicit bias is a 2015 paper called *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review* (hereinafter, the "Hall Systematic Review").[3] This systematic review analyzed 105 studies for either (1) the existence of bias among American healthcare providers generally, and (2) whether existence of such bias actually resulted in disparate patient outcomes. Despite reviewing all high-quality research the Hall Systematic Review could identify, the study failed to find support for the idea that physician implicit bias is causing worse treatment plans or healthcare outcomes for minority patients.

The Hall Systematic Review included six studies of the impact of healthcare providers' implicit bias on treatment decisions or healthcare outcomes. None of these showed strong evidence that implicit bias changes treatment decisions or worsens outcomes. The

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[3] William J. Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 Am. J. Pub. Health e60 (2015).

largest of these studies included "[o]ne hundred and thirty-eight primary care clinicians and 4,794 patients with hypertension."[4] In this large study, implicit bias among physicians (as measured by IAT) did not result in differences either in treatment plans or ultimate health outcomes. Researchers concluded that "implicit bias did not affect clinicians' provision of care to their minority patients, nor did it affect the patients' outcomes." *Id.* at 987. Black patients "received equivalent treatment intensification, but had lower medication adherence." *Id.* Likewise, "Latino patients received equivalent treatment intensification and had similar hypertension control, but lower medication adherence than white patients." *Id.* "Differences in treatment intensification, medication adherence and hypertension control were unrelated to clinician implicit bias for black patients." *Id.*

The Hall Systematic Review also included a pilot study of 162 spinal cord patients and their 14 doctors.[5] In this study, physician bias, as measured by IAT score, was *not* associated with any patients' physical outcomes such as reduced mobility, reduced physical independence, reduced occupational functioning, or reduced self-reported health. *Id.* at 106. Physician bias was associated only with patients' social integration, depression, and life satisfaction. *Id.*

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[4] Irene V. Blair et al., *An Investigation of Associations Between Clinicians' Ethnic or Racial Bias and Hypertension Treatment, Medication Adherence and Blood Pressure Control*, 29 J. Gen. Internal Med. 987 (2014).

[5] Leslie R.M. Hausmann et al., *Examining Implicit Bias of Physicians Who Care for Individuals with Spinal Cord Injury: A Pilot Study and Future Directions*, 38 J. Spinal Cord Med. 102 (2015).

In another small study of 95 physicians also included in the Hall Systematic Review, pediatricians were scored for implicit bias by IAT and then offered "vignettes," or hypothetical patients, and asked about their proposed treatment plans based on patient complaints.[6] There were no differences in the treatment plans for *any* of the studied conditions, which included pain control, UTI management, ADHD, and asthma.

A separate study of 86 pediatricians included in the Hall Systematic Review measured physician IAT scores and also used vignettes instead of real patients.[7] This study found no difference in treatment for UTI management, ADHD, asthma, or non-narcotic pain control, but some difference in treatment for narcotic pain control.

In a study of 202 first-year medical students included in the Hall Systematic Review, students were scored on IAT and then provided with hypothetical patient vignettes.[8] No difference was found in treatment plans for pain assessment or any of the other tested assessments.

The Hall Systematic Review found only one study with any difference in the hypothetical treatment of

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[6] Janice A. Sabin, Frederick P. Rivara & Anthony G. Greenwald, *Physician Implicit Attitudes and Stereotypes About Race and Quality of Medical Care*, 46 Med. Care 678 (2008).

[7] Janice A. Sabin & Anthony G. Greenwald, *The Influence of Implicit Bias on Treatment Recommendations for 4 Common Pediatric Conditions: Pain, Urinary Tract Infection, Attention Deficit Hyperactivity Disorder, and Asthma*, 102 Am. J. Pub. Health 988 (2012).

[8] Adil H. Haider et al., *Association of Unconscious Race and Social Class Bias with Vignette-Based Clinical Assessments by Medical Students*, 306 JAMA 942 (2011).

patients by race.[9] This study scored subjects on IAT, then offered vignettes of patients describing chest pain. It found that black patients were more likely than white patients to be regarded as suffering from coronary artery disease, but both groups were equally likely to be offered the treatment of thrombolysis.

2. FitzGerald Systematic Review

Two years after the Hall Systematic Review, a second robust review reached similar conclusions, *Implicit Bias in Healthcare Professionals: A Systematic Review* (hereinafter the "FitzGerald Systematic Review").[10] This review did not find that implicit racial bias is a systematic contributor to patient outcomes. Compiling all the high-quality research on whether physician implicit bias negatively impacts patient outcomes, the FitzGerald Systematic Review reveals that physician implicit bias does not result in disparate diagnoses, treatment plans, or medical outcomes:

- A large study of 2,872 emergency physicians found that "[t]he race/ethnicity of patients in the vignettes had no effect on physician prescription of opioids."[11]

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[9] Alexander R. Green et al., Implicit Bias among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients, 22 J. Gen. Internal Med. 1231, 1233 tbl. 1 (2007).

[10] Chloë FitzGerald & Samia Hurst, *Implicit Bias in Healthcare Professionals: A Systematic Review*, 18 BMC Med. Ethics 19 (2017), https://doi.org/10.1186/s12910-017-0179-8.

[11] *Id.* at 8 (citing Joshua H. Tamayo-Sarver et al., *The Effect of Race/Ethnicity and Desirable Social Characteristics on Physicians' Decisions to Prescribe Opioid Analgesics*, 10 Acad. Emergency Med. 1239 (2003)).

- A study of "544 family medicine physicians, internists, cardiologists, and cardiothoracic surgeons" found that a "patient's race and gender did not significantly affect the physicians' treatment preferences." [12]
- A study of 321 psychiatrists and additionally a study of 178 primary care physicians found that, in each case, "[p]atients' race and gender was not associated with significant differences in the diagnoses of major depression."[13]
- A study of 128 internists found that "[r]ace and SES of patients had no effect on provider adherence to guidelines."[14]
- A study of 33 hospital-based physicians, including emergency physicians, hospitalists, and intensivists, found that "physicians did not make different treatment decisions for black and white patients[.]"[15]

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[12] *Id.* at 6 (citing J.M. Barnhart & S. Wassertheil-Smoller, *The Effect of Race/Ethnicity, Sex, and Social Circumstances on Coronary Revascularization Preferences: A Vignette Comparison*, 14 Cardiol. Rev. 215 (2006)).

[13] *Id.* at 7 (citing Helen C. Kales et al., R*ace, Gender, and Psychiatrists' Diagnosis and Treatment of Major Depression Among Elderly Patients,* 56 Psychiatric Servs. 721 (2005)); Helen C. Kales et al., *Effect of Race and Sex on Primary Care Physicians' Diagnosis and Treatment of Late-Life Depression*, 53 J. Am. Geriatrics Soc'y 777 (2005).

[14] *Id.* at 8 (citing J.B. McKinlay et al., *Sources of Variation in Physician Adherence with Clinical Guidelines: Results from a Factorial Experiment*, 22 J. Gen. Internal Med. 289 (2007)).

[15] *Id.* (citing Amber E. Barnato et al., *A Randomized Trial of the Effect of Patient Race on Physicians' Intensive Care Unit and Life-*

- A study of 382 general internal medicine physicians concluded: "There was no significant effect of patient race alone."[16]

In only four studies was there any indication of disparate decision-making on the basis of race—and even then the evidence was underwhelming.

One study found that physicians primed with an African American man's face and asked to name diseases were more likely to name diseases stereotypically associated with black patients, including hypertension, sickle cell anemia, and HIV, and behaviors like drug use.[17] Importantly, this result was pure word association and did not result in disparate treatment plans or outcomes. Furthermore, while the study denoted when physicians identified conditions "diseases African Americans are genetically predisposed," like sickle cell anemia, it ignored diseases identified where there are in fact disparate rates of disease among racial groups, like HIV.

Another study found that physicians were less confident in diagnosing hypothetical black cardiac patients. A group of general practitioners evaluated hypothetical patient vignettes. The physicians were less confident in the accuracy of their diagnosis of coronary

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Sustaining Treatment Decisions for an Acutely Unstable Elder with End-Stage Cancer, 39 Critical Care Med. 1622 (2011)).

[16] *Id.* (citing Diana Jill Burgess et al., *Patient Race and Physicians' Decisions to Prescribe Opioids for Chronic Low Back Pain,* 67 Soc. Sci. & Med. 1852 (2008)).

[17] *Id.* at 9 (citing Gordon B. Moskowitz et al., *Implicit Stereotyping and Medical Decisions: Unconscious Stereotype Activation in Practitioners' Thoughts About African Americans*, 102 Am. J. Pub. Health 996 (2012)).

heart disease for black patients.[18] One comparative study of U.S. and U.K. physicians found black patients in the U.S. were more likely to be asked about smoking and less likely to be asked about pain or discomfort for vignettes investigating coronary heart disease relative to white patients, but more likely to ask black patients about pain and discomfort for vignettes investigating depression.[19] Finally, reviewing a study of 81 family physicians and general internists, physicians under normal time-pressure conditions presented with hypothetical patient vignettes did not have disparate diagnoses, but under higher time pressure, were more likely to reach a less serious diagnosis and less likely to refer to a specialist for black and Latino patients.[20] None of these hypothetical vignette studies showed a difference in patient health outcomes.

C. A Government Commission Found No Evidence That Implicit-Bias Training Improves Patient Outcomes

The question of whether implicit-bias training could possibly improve patient outcomes was the subject of the Department of Health and Human Service's Agency for Healthcare Research and Quality's (AHRQ) January 2024 Rapid Review. Julie Fricke et al., *Agency*

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[18] *Id.* at 8 (citing Karen E. Lutfey et al., *Is Certainty More Important than Diagnosis for Understanding Race and Gender Disparities?: An Experiment Using Coronary Heart Disease and Depression Case Vignettes*, 89 Health Pol'y 279 (2009)).

[19] *Id.* (citing John McKinlay et al., *How Do Doctors in Different Countries Manage the Same Patient? Results of a Factorial Experiment*, 41 Health Servs. Res. 2182 (2006)).

[20] *Id.* (citing Irena Stepanikova, *Racial-Ethnic Biases, Time Pressure, and Medical Decisions*, 53 J. Health & Soc. Behav. 329 (2012)).

for Healthcare Research and Quality, Healthcare Worker Implicit Bias Training and Education: Rapid Review, in Making Healthcare Safer IV: A Continuous Updating of Patient Safety Harms and Practices (2024), https://tinyurl.com/5e569h3x. The Healthcare Research and Quality Act of 1999 charged AHRQ with, among other things, "promot[ing] health care quality improvement by conducting and supporting . . . methods for measuring quality and strategies for improving quality." 42 U.S.C. § 299(b)(1)(F). Consistent with its statutory obligations, AHRQ investigated "implicit bias training and education interventions" and their impact "on patient safety, health, and healthcare outcomes." AHRQ acknowledged that this investigation was in response to "implicit bias training" being "identified as high priority for inclusion in the MHS IV reports." Fricke, *supra*, at 4.

AHRQ conducted a robust investigation of "systematic reviews, randomized controlled trials (RCTs), and observational studies with a comparison group that evaluated [healthcare provider] implicit bias training and education." *Id* at 1. In the end, AHRQ concluded that "*no conclusions could be drawn on the effectiveness of the intervention on patient outcomes*." *Id.* (emphasis added). Furthermore, AHRQ found that in its review of the "linkage between patient safety and implicit bias, evidence on causality is available but limited and frequently reported in *editorial and commentary forms*" rather than through empirical evidence. *Id.* at 28 (emphasis added). AHRQ concluded it would require "further empirical evidence . . . related to implicit bias, [healthcare provider] training, and patient safety." *Id.*

In summary, the evidence was simply too thin, and too plagued by editorialization rather than science, for the very federal agency charged with making recommendations for improving patient safety to recommend *any* implicit bias training for healthcare providers, despite pressure to do so.

II. IMPLICIT-BIAS TRAININGS DO NOT CONFORM TO CONTINUING MEDICAL EDUCATION STANDARDS

Quality of CME education is ensured through an accreditation process. The Medical Board of California automatically accepts CME credits approved by California Medical Association (CMA), the American Medical Association (AMA), and the Accreditation Council for Continuing Medical Education (ACCME), and American Academy of Family Physicians (AAFP).[21] Each of these organizations maintains rigorous standards for crediting CME coursework.

The AMA states that it expects its accredited CMEs to "[d]eliver[] unbiased educational content based on the best available evidence to our physician learners."[22] The ACCME's standards are designed to ensure CMEs are "trustworthy and are based on best practices and high-quality evidence[.]"[23] AAFP's

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[21] *Continuing Medical Education*, Med. Bd. of Cal., https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Renew/Current-Status/Continuing-Medical-Education.aspx (last visited May 20, 2026).

[22] *AMA CME*, Am. Med. Ass'n Ed Hub, https://edhub.ama-assn.org/pages/ama-cme (last visited May 24, 2026).

[23] ACCME, *ACCME Accreditation Requirements*, Accreditation Council for Continuing Medical Education, (last visited May 20, 2026).

accreditation program's mission is to "facilitate members' access to vetted, relevant and quality CME that improves the practice of family medicine, health care delivery and the health of individuals and populations."

CMEs typically embody exactly these rigorous standards, reviewing and educating physicians on cutting-edge research, new techniques, and new treatments for diseases. For example, a CME on treatment of Alzheimer's disease offered by the Journal of the American Medical Association provides a review of recent studies on the disease state, medications both in use in practice and under evaluation by the Food and Drug Administration, the current state of relevant drug trials, and warnings about side effects for existing treatments.[24]

In contrast to typical CME coursework, any training on implicit bias designed to improve patient outcomes is entirely without scientific support. Training premised on the idea that implicit bias is a cause of disparate healthcare outcomes would fail these accreditation standards if not for the mandate that physicians be trained in it. Any training that purports to connect either treatment plans or physician outcomes to the implicit bias of physicians cannot be grounded in relevant, unbiased, or high-quality evidence: to the contrary, it must either misrepresent the weight of the evidence, or fail to satisfy the mandate of the Medical Board of California.

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[24] Derek C. Angus & Gil Rabinovici, *A New Era in Dementia: Advances in Diagnostic Blood Tests, Novel Drugs, and the Power of Lifestyle Changes*, JAMA (May 20, 2026), https://edhub.ama-assn.org/jn-learning/audio-player/19064802.

III. COURTS HAVE TAKEN A DIM VIEW OF FORCING IMPLICIT-BIAS CONCEPTS INTO LEGAL PROCESSES, BECAUSE THE CONCEPTS ARE UNRELIABLE

As with the medical system, there have been attempts to introduce implicit bias training into the legal system. But courts have taken a dim view of including implicit bias in educating juries due to concerns that the use such training is unreliable, unsupported, and can even exacerbate rather than cure bias. Court have also repeatedly barred expert testimony based on the IAT standard because of its lack of reliability.

In *United States v. Mercado-Garcia*, a defendant of Mexican ancestry asked the court to display an implicit bias training video to potential jurors during voir dire to educate jurors on their own implicit bias. 989 F.3d 829, 840 (10th Cir. 2021). The video urged "jurors to be aware of their own unconscious biases" and their effect on the jury verdict. *Id.* The Tenth Circuit upheld the lower court's order declining to show the video, in part relying on a concurrence in a Supreme Court decision that raised the concern that "pointed questions" about racial bias "could well exacerbate whatever prejudice might exist without substantially aiding in exposing it." *Rosales-Lopez v. United States*, 451 U.S. 182, 195 (1981) (Rehnquist, J., concurring).

Expert testimony reliant on the IAT tool for understanding implicit bias has also been rejected. In *Jones v. Nat'l Council of Young Men's Christian Ass'ns of the U.S.A.*, the district court excluded expert witness testimony of IAT developer Dr. Anthony Greenwald. 34 F. Supp. 3d 896, 899 (N.D. Ill. 2014). Plaintiffs proffered putative expert testimony on the general principle, derived from the IAT, that "bias or stereotypes—

and particularly unconscious bias against African Americans, which is widely present in the American population—poses greater risk of manifesting itself in conjunction with subjective criteria." *Id.* Dr. Greenwald testified that "it is 'more likely than not'" that implicit discriminatory bias accounts for any disparity between the treatment of African Americans and other racial groups" and that, as a result, Dr. Greenwald believed "implicit or hidden biases . . . are now established as causes of adverse impact[.]" *Id.* at 899-900. The district court rejected these conclusions, holding that "Dr. Greenwald's opinions cross the line into the realm of causation and blur, if not erase altogether, the line between hypothetical possibility and concrete fact." *Id.* at 901. As a result, defendants' motion to strike Dr. Greenwald's testimony was granted. *Id.*

This same IAT evidence was also rejected by the Third Circuit. Here again, Dr. Greenwald's testimony was also excluded in *Karlo v. Pittsburgh Glass Works, LLC*, 849 F.3d 61 (3d Cir. 2017). Evaluating the IAT methodology, the court held that, given the nature of the evidence Dr. Greenwald's testimony would offer, and especially his reliance on "population-wide statistics" which would "have only speculative application" for specific decision-makers, the lower court's decision to exclude his testimony was upheld. *Id.* at 84-85.

Now, doctors undergoing implicit bias CMEs by California's decree are being trained on misleading theories that "blur, if not erase altogether, the line between hypothetical possibility and concrete fact." *Jones*, 34 F. Supp. 3d at 901. Our physicians, who we rely on to understand the difference between scientific fact and quackery to provide competent treatment, are

being forced to train on materials that are premised on the very IAT tool our courts have repeatedly rejected.

Furthermore, mandatory implicit bias trainings may go so far as to violate physicians' constitutional rights. The Second Circuit ruled that implicit bias trainings could support a claim for violation of § 1983 when state-mandated employment trainings discuss "'any race with a constant drumbeat of essentialist, deterministic, and negative language.'" *Chislett v. N.Y.C. Dep't of Educ.*, 157 F.4th 172, 191 (2d Cir. 2025) (quoting *De Piero v. Pa. State Univ.*, 711 F. Supp. 3d 410, 424 (E.D. Pa. 2024)).

CONCLUSION

For the reasons stated in the Petition and this amicus brief, this Court should grant the writ of certiorari. Respectfully submitted.

Respectfully submitted,

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June 1, 2026