No. _____

IN THE SUPREME COURT OF THE UNITED STATES

RANDY LAMARTINIERE,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

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

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PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Did Congress delegate authority to the Attorney General to define what constitutes an "effective prescription" or an "authorized" distribution of narcotics under 21 U.S.C. § 841 of the Controlled Substances Act ("CSA")?
2. May a court uncritically defer to administrative regulations when defining authorization for purposes of 21 U.S.C. § 841(a)'s criminal prohibitions, or must courts conduct an independent interpretation of the statute to ascertain its meaning?
3. Does stepping outside of "generally accepted standards of practice" render a prescription unauthorized under the CSA, even where it is issued for a medical purpose?
4. Does 21 U.S.C. § 841(a)'s *mens rea* attach to the statutory requirement of authorization, such that the government bears the burden of proving that a defendant knew a given prescription was legally unauthorized, or does the statute's *mens rea* attach to regulatory interpretations of 21 U.S.C. § 829's prescription requirement?

LIST OF PARTIES TO THE PROCEEDINGS

Petitioner, defendant-appellant below, is Randy J. Lamartiniere.

Respondent is the United States of America, appellee below.

RELATED PROCEEDINGS

Fifth Circuit Court of Appeals:

United States v. Randy J. Lamartiniere , No. 23-30191, United States Court of Appeals for the Fifth Circuit. Judgment entered May 06, 2024. *United States v. Lamartiniere*, 100 F.4th 625, 638 (5th Cir. 2024).

United States District Court for the Middle District of Louisiana:

United States v. Lamartiniere, No. 3:18-cr-00087. Judgement entered April 03, 2023.

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JURISDICTION

The Court of Appeals judgment was entered on May 06, 2024. The petition for rehearing *en banc* was denied on June 17, 2024. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

CONSITUTIONAL AND STATUTORY PROVISIONS INVOLVED

21 U.S.C.A § 841 (a)(1) states:

> "Except as authorized by this subchapter, it shall be unlawful for any person knowingly or intentionally -to manufacture, distribute, or

dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance."

21 U.S.C. §871 states:

> "The Attorney General may promulgate and enforce any rules, regulations, and procedures which he may deem necessary and appropriate for the efficient execution of his functions under this subchapter."

21 U.S.C. § 821 states:

> "The Attorney General is authorized to promulgate rules and regulations and to charge reasonable fees relating to the registration and control of the manufacture, distribution, and dispensing of controlled substances and to listed chemicals."

21 U.S.C. §802 states:

> "The term 'control' means to add a drug or other substance, or immediate precursor, to a schedule under part B of this subchapter, whether by transfer from another schedule or otherwise."

21 U.S.C. §829(a) states:

> **"**Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance in schedule II, which is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act, may be dispensed without the written prescription of a practitioner, except that in emergency situations, as prescribed by the Secretary by regulation after consultation with the Attorney General, such drug may be dispensed upon oral prescription in accordance with section 503(b) of that Act. Prescriptions shall be retained in conformity with the requirements of section 827 of this title. No prescription for a controlled substance in schedule II may be refilled."

21 C.F.R § 1306.04(a) purports to define what constitutes an effective prescription:

> "A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription

> within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances."

21 C.F.R. § 1306.03 purports to define the scope of an authorized prescription:

> (a) A prescription for a controlled substance may be issued only by an individual practitioner who is:
>
> (1) Authorized to prescribe controlled substances by the jurisdiction in which he is licensed to practice his profession and
>
> (2) Either registered or exempted from registration pursuant to §§ 1301.22(c) and 1301.23 of this chapter.
>
> (b) A prescription issued by an individual practitioner may be communicated to a pharmacist by an employee or agent of the individual practitioner.

STATEMENT

A doctor can sincerely believe that he is acting in his patient's interest in issuing a prescription but fall short of generally accepted medical practices. Such a doctor may not be a *good* doctor. But one can be a bad doctor without so far transcending the bounds of medicine as to become a drug pusher who is criminally liable under the Controlled Substances Act's drug trafficking prohibitions.

This case involves the prosecution of a medical practitioner registered with the DEA to dispense controlled substances. The questions presented by petitioner ask this Court to determine whether a doctor's liability under 21 U.S.C. § 841 turns upon the circuit court's interpretation of the language of an administrative regulation (21 C.F.R § 1306.04) or whether it turns upon the meaning of the language of the Controlled Substances Act ("CSA") itself. Section 841 states:

> "Except as authorized by this subchapter, it shall be unlawful for any person knowingly or intentionally – to manufacture, distribute, or

> dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance".

21 USC § 841(a). It does not say: "except in conformity with regulations promulgated by the attorney general." Congress has repeatedly proven that it knows how to write statutes that define criminal liability on yet to be enacted regulations. *See, e.g.*, *Liparota v. United States*, 471 U.S. 419, 430 (1985). Section 841 is not such a statute.

Neither the Fifth Circuit below, nor any other Circuit, has identified any language in the CSA delegating to the Attorney General or any other executive agency the authority to issue a regulation defining what constitutes an "effective prescription" or the "authorized" practice of medicine. The text of the CSA explicitly withheld from the federal executive the authority to regulate "the practice of medicine or the manner in which medical services are provided." 21 U.S.C. § 823(g)(2)(H)(i).

This Court has described CFR §1306.04(a) as a "parroting regulation." *Gonzales v. Oregon*, 546 U.S. 243, 257 (2006). That is true only if the regulation is interpreted as prohibiting nothing more than the statute itself.

The only description of what constitutes an "authorized" prescription in the CSA comes from §§822(b) and 823 of the CSA. As this Court has recognized, these sections provide a "circular" definition of "authorization" that does not explicitly impose any limitation beyond the requirement that the defendant obtain a DEA registration. *United States v. Moore*, 423 U.S. 122, 124 (1975). *Moore* held that Congress could not have intended a DEA registration to serve as a cover for

intentional drug dealing. *Id.* at 138-40. As such, the Court reasoned that Congress must have intended to authorize only those prescriptions that meet the standard articulated in the Harrison Act of 1914 and the attendant cases. *Id.* at 140; *Ruan v. United States*, 597 U.S. 450, 478 (2022) (Alito, J., concurring) ("The notion of action taken 'in the course of professional practice' is not defined in the CSA, but our precedents hold that when Congress employs a term of art 'obviously transplanted from another legal source,' it 'brings the old soil with it.'" (quoting *George v. McDonough*, 119 S. Ct. 1953 (2022)). Under the "old soil" of the Harrison Act cases, medical professionals were only prohibited from issuing prescriptions for non-medical purposes, such as promoting redistribution on the street or catering to the cravings of a drug addict. *See Boyd v. United States*, 271 U.S. 104, 105 (1926); *Linder v. United States*, 268 U.S. 5, 22 (1925).

In this case, the Fifth Circuit relied upon its pre-*Ruan* interpretation of CFR §1306.04 to hold that a doctor registered and authorized to distribute controlled substances under the CSA can be convicted as a drug dealer under §841 even if he truly (and in most cases correctly) believed that the charged prescriptions were serving a medical purpose. *United States v. Lamartiniere*, 100 F.4th 625, 638 (5th Cir. 2024) ("As to the third element, we acknowledged that it was 'not expressly required by the text of § 841, but relevant regulations [21 C.F.R. § 1306.04(a)] provide'…"). The government did not prove, and the Fifth Circuit did not find, that any of petitioner's patients were either abusing or diverting their medications. The Fifth Circuit's decision was based exclusively on its pre-*Ruan* interpretation of CFR

§ 1306.04. Under the Fifth Circuit's interpretation of that regulation, a prescription is unauthorized if the doctor knows he is, in any way, falling short of "generally accepted standards of practice." *Lamartiniere*, 100 F.4th at 638. In reaching this conclusion, the Fifth Circuit did not reference the language or legislative history of the CSA itself.

The Seventh, Eleventh, and Sixth Circuits have joined the Fifth Circuit in holding that *Ruan* does not disturb their case law defining the elements of § 841 as applied to medical practitioners. *Lamartiniere*, 100 F.4th at 641; *United States v. Hofschulz*, 105 F.4th 923, 929 (7th Cir. 2024); *United States v. Heaton*, 59 F.4th 1226, 1240 (11th Cir. 2023); *United States v. Anderson*, 67 F.4th 755, 764 (6th Cir. 2023). In those circuits, the government is not required to prove "that a defendant knew or intended that his or her conduct was unauthorized." *See Ruan*, 597 U.S. at 467 (2022).

The Tenth Circuit interprets *Ruan* very differently. The Tenth Circuit interpreted *Ruan* as imposing something close to specific intent. In the Tenth Circuit, it is not sufficient for a defendant to knowingly act either outside the usual course of professional practice or without a legitimate medical purpose. *United States v. Kahn* ("*Kahn II*"), 58 F.4th 1308, 1316 (10th Cir. 2023) ("Both approaches run counter to *Ruan*."). Instead, the government must prove "that petitioner knew that his conduct was unauthorized or illegal." *Kahn II*, 58 F.4th at 1315 (quoting *Liparota*, 471 U.S. at 434); *Id.* 1317 (jury instructions did not require the government to prove that "[the defendant] intended to act without authorization").

In the Tenth Circuit the "usual course of professional practice" and "medical purposes" language of CFR §1306.04 do not serve "as distinct bases to support a conviction, but as 'reference to objective criteria' that may serve as circumstantial evidence of a defendant's subjective intent to act in an unauthorized manner." *Kahn II*, 58 F.4th at 1316 (quoting *Ruan*, 142 S. Ct. at 2377).

This is not merely an academic question. The jury instructions upheld by the Fifth Circuit in the case below are materially indistinguishable from those rejected by the Tenth Circuit in *Kahn II*.

This circuit split cannot be resolved short of review from this Court. In *Ruan* this Court stated: "We assume, as did the courts below and the parties here, that a prescription is 'authorized' and therefore lawful if it satisfies this standard." *Ruan*, 597 U.S. at 455. This Court, however, made that assumption in the face of the solicitor general's concession, that (1) the words "usual course of professional practice" and "legitimate medical purpose" should be read as a single unified phrase and (2) that the meaning of 21 C.F.R. § 1306.04(a) cannot say more than the statute itself. Transcript of Oral Arg., *Ruan v. United States*, Nos. 20-1410 and 21-5261, at 67-86. Nevertheless, the Fifth, Eleventh, and Seventh Circuits rely on this language in support of defining the elements of §841 based on their pre-*Ruan* interpretation of CFR § 1306.04—interpretations that are inconsistent with the position taken by the government in *Ruan. See, e.g.*, *Lamartiniere*, 100 F.4th at 641; *Hofschulz*, 105 F.4th at 929; *Heaton*, 59 F.4th at 1240.

FACTUAL BACKGROUND

This case involves the prosecution of a registered medical practitioner for allegedly issuing unauthorized prescriptions in violation of 21 U.S.C. §841. At all times relevant to this prosecution, petitioner held a valid registration under the Controlled Substances Act to distribute controlled substances. ROA.1886.

The charges in this case can be broken down into two groups. Counts 8-9 and 12-30 involved prescriptions issued prior to January 4, 2016. The prescriptions were issued to four patients and two undercover officers posing as patients. ROA.378. The government argued that pursuant to 21 C.F.R. §1306.04(a) and Fifth Circuit law interpreting that regulation, those prescriptions were not issued in compliance with "generally accepted medical practice" and therefore were outside the "usual course of professional practice".

Counts 1-7 involve prescriptions issued by petitioner on January 5, 2016. ROA.377. The day prior, the defendant received notice that his Louisiana state medical license to issue controlled substance prescriptions had been suspended. ROA.2410. The government argued that once a doctor's state license to issue prescriptions has been removed, the effect of 21 C.F.R. §1306.03 is to automatically revoke petitioner's federal registration to distribute controlled substances under the CSA.

A. Facts At Trial

This case is somewhat unique in that the government did not present any evidence the patients at issue were diverting prescriptions issued by petitioner onto the street, or that petitioner issued any of the charged prescriptions for the purpose

of catering to the needs of a drug addict. The government's medical expert did not testify that the prescriptions issued by petitioner were *a priori* too high or that the patients did not have *bone fide* medical conditions or that the charged prescriptions were not an appropriate treatment for those conditions. ROA.2627.

The government's case was entirely dependent upon the argument that the petitioner's medical records did not comply with the standards of professional practice. Petitioner's medical records did not document with sufficient detail the basis of the decisions he made, the examinations he performed, or the medical records he collected from patients. The government's expert acknowledged that, had petitioner's medical records included the information reported by the testifying patients and the interactions contained in the undercover recordings that dd not appear in the records, he very well might have changed his view on the legitimacy of those prescriptions. ROA.2627.

Petitioner's medical practice is a far cry from that of the defendant in *Moore*. *See Moore*, 423 U.S. at 135. Petitioner did not charge for individual prescriptions or even individual office visits. Patients paid $300 for a three-month subscription to his medical practice. ROA.2016. Patients could receive twenty-four-hour care for any medical problems that might arise. ROA.2241 ("A. Yeah, from cough syrup – if you needed cough syrup or something, you could contact him. If you had the flu and you know you needed help, you can contact him. Q. So … you weren't buying prescriptions. That's not what you were doing, was it? A. No. No."); ROA.2263; ROA.2016.

Petitioner did not prescribe patients with whatever medicine they requested. He "spent several hours" with patients, performing physical examinations and discussing his pain and treatment options. ROA.2235-36; ROA.2210; ROA.2281; ROA.3368; ROA.2563; ROA.2624. He obtained medical records, conducted urinalysis, and adjusted medication depending upon a patient's complaints and circumstances. ROA.2209-10; ROA.2211 ROA.2273-74; ROA.2613-14; ROA.3368; ROA.2563; ROA.3368; ROA.2563.

With the exception of the undercover officers, every single one of the patients at issue had a bone fide medical condition that caused pain, which the charged prescriptions were working to alleviate. ROA.2233; ROA.2277; ROA.2624. The government presented no evidence that the prescriptions were being diverted onto the street or that petitioner intentionally issued the prescriptions for the purpose of catering to the appetites of a drug addict.

Two undercover officers posed as patients. Both undercover officers testified repeatedly that they crafted their answers to petitioner's medical questions for the purpose of convincing him that they suffered from legitimate pain and that lesser medications had been unsuccessful in the past. ROA.2136-40 ("listing too many details could cause the doctor to get suspicious. Too many details would lead him to believe that I'm, you know, making false statements."); ROA.2099; ROA.2002 ("You made states to Dr. Lamartiniere to lead him to believe that you were in pain. That is true, Isn't it?. A. Yes, sir."); ROA.2025.

Dr. Lamartiniere did not prescribe them the dosage of medication they requested. ROA.2078. ROA.2070. ROA.2107; ROA.2170. The transcript of the recordings between petitioner and the undercover officers are lengthy and include involved conversations as to the type of medications available and their likely side effects. When Lamartiniere suggests a non-narcotic medication, both officers pushed back with explanations that the medication was either too expensive or that they had tried it in the past. ROA.2167-68; ROA.2677-78.

When petitioner checked the Louisiana Prescription Monitoring Data Bank and did not find records of the prescriptions being filled in Louisiana, the undercover patients explained that they had filled the prescriptions at an out-of-state pharmacy. ROA.2045-46; ROA.2115. Dr. Lamartiniere did not simply accept the explanations; he threatened to discharge them if they were "not going to follow these rules." ROA.2063; ROA.2116-17; ROA.2173.

The two patient witnesses who testified stated that petitioner appeared to be well intentioned and conservative in the dosages he issued as compared to other doctors they had seen in the past. ROA.2238 (Petitioner "was always trying to find the right dosage that would help [him] and be the lowest possible."). ROA.2287 (agreeing that during his "two years with [petitioner], it was always clear to [the witness] that [petitioner] cared about [him] as a patient and was trying to help [him] with [his] pain."); ROA.2235 (describing petitioner as "one of the most hardest [of previous pain doctors he had seen] to get drugs from."). Even one of the

undercover "patients" testified that it always seemed as though Dr. Lamartiniere was trying to help. ROA.2194.

Each of Counts 1-7 involved prescriptions issued by Lamartiniere on the day after he received notice that his state license to prescribe controlled substances had been suspended (January 5, 2016). None of these patients testified, and the underlying medical records were not admitted into evidence. The government's expert testified that, under state and federal regulations, issuing a prescription on a suspended license was definitionally outside the usual course of professional practice regardless of whether the prescriptions were otherwise medically appropriate. ROA.2478.

Dr. Lamartiniere was convicted on each of Counts 1-7 and fourteen of the remaining twenty pre-suspension counts. ROA.1013-16. Petitioner was sentenced to 180 months. ROA.1206.

B. Decision of the Court of Appeals and Jury Instructions at Issue.

The controversy in this case primarily revolves around two jury instructions. First, the district court defined "authorization" as dependent upon compliance with C.F.R. § 1306.04(a).

> "A prescription is 'authorized' if it is issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. Both prongs are necessary for a prescription to be authorized; one is not sufficient. That is, the prescription must be issued for a legitimate medical purpose and within the usual course of a practitioner's professional practice.
>
> By contrast, a prescription is unauthorized if the prescription either lacks a legitimate medical purpose or is outside the usual course of professional practice. In other words, knowingly issuing a prescription

> outside the course of professional practice is a sufficient condition to convict a medical practitioner of unlawful dispensation of a controlled substance. Likewise, knowingly issuing a prescription without a legitimate medical purpose is a sufficient condition to convict a medical practitioner of unlawful dispensation of a controlled substance.
>
> The term 'legitimate medical purpose in the usual course of his professional practice' is defined by reference to the standard of medical practice generally recognized and accepted by the medical profession in the United States.

ROA.3115-19. The instruction states that both the "usual course of professional practice" and "legitimate medical purpose" prongs are defined by the defendant's "good faith" efforts to "prescribe for a patient's condition in accordance with the standards of medical practice generally recognized or accepted in the United States." ROA.3115-19.

> "A controlled substance is prescribed by a physician for a legitimate medical purpose in the usual course of professional practice, and therefore, "authorized", if the controlled substance is prescribed by him in good faith. Good faith in this context means an honest effort to prescribe for a patient's condition in accordance with the standards of medical practice generally recognized or accepted in the United States.

ROA.3115-19. Dr. Lamartiniere proposed, and the district court rejected, an instruction which would have defined authorization exclusively based of whether the prescription was serving a legitimate medical purpose.

> "As to the third element, A defendant acts in an unauthorized manner when he distributes a controlled substance other than for a legitimate medical purpose. … the question in this case is not whether the doctor acted prudently or whether a reasonable physician would have issued the same prescriptions. … gross negligence or even intentional malpractice is not sufficient to establish the defendant's guilt."

ROA.875. The district court also rejected a jury instruction that would have required the government to prove that petitioner knew that the charged prescription was unauthorized.

> "As to the Fourth element, the government must prove that the defendant acted voluntarily and purposely, with the specific intent to do something the law forbids; that is to say, with bad purpose either to disobey or disregard the law. The defendant cannot be found guilty in this case unless the government proves beyond a reasonable doubt that at the time of the charged offense the defendant knew the charged distributions were unauthorized because they were issued without a legitimate medical purpose."

ROA.877. Petitioner argued that the CSA does not grant to the attorney general the authority to define what constitutes an "effective prescription" under the CSA and that the CSA does not condition authorization on compliance with the "the standards of medical practice generally recognized or accepted in the United States". Therefore, defining the elements of the offense based on the language of CFR § 1306.04 violated the Separation of Powers and this Court's Major Questions Doctrine.

The Fifth Circuit rejected those arguments. In doing so the Fifth Circuit relied exclusively, and expressly, on its pre-*Ruan* case law interpreting the meaning of 21 C.F.R. § 1306.04(a). *Lamartiniere*, 100 F.4th at 638 ("As to the third element, we acknowledged that it was 'not expressly required by the text of § 841, but relevant regulations [21 C.F.R. § 1306.04(a)] provide'"…); *Id.* ("Consistent with the relevant regulation, the district court here instructed the jury that…); *id.* 639 (5th Cir. 2024) ("a logical reading of 21 C.F.R. § 1306.04" shows that "[b]oth prongs are necessary for a prescription to be legitimate;" and the "logical converse is that a

practitioner is unauthorized to dispense a controlled substance if the prescription either lacks a legitimate medical purpose or is outside the usual course of professional practice."). In doing so the Court was clear that the "usual course of professional practice" involved whether the method or manner in which the prescriptions were issued was in compliance with generally accepted standards, not the whether the prescriptions were serving a medical purpose or conformed to the "standard of care". *United States v. Lamartiniere*, 100 F.4th 625, 634 (5th Cir. 2024).

The Fifth Circuit did not discuss or address the language of the CSA, nor did it address petitioner's arguments regarding separation of powers, non-delegation, or the major question doctrine. Instead, the Fifth Circuit, noted that it was bound by its pre-*Ruan* caselaw and that neither *Cargill* nor *Ruan* directly addressed the propriety of defining authorization based on compliance with CFR §1306.04. *Lamartiniere*, 100 F.4th at 642.

The Fifth Circuit recognized a circuit split with the Tenth Circuit in *Kahn II*. *Lamartiniere*, 100 F.4th at 646–47 ("But as Lamartiniere acknowledges, we are not bound by *Kahn II*, and both the Eleventh and Sixth Circuits have affirmed—consistent with the instructions given in this case—that a defendant knowingly acts in an unauthorized manner when he or she prescribes controlled substances knowing they are without a legitimate medical purpose *or* knowing they are outside the usual course of professional practice.") (emphasis added).

The Fifth Circuit noted that "To the extent *Ruan* mentioned the definition of an authorized prescription, it did so with reference to the regulatory definition Lamartiniere challenges here." *Lamartiniere*, 100 F.4th at 641.

Dr. Lamartiniere's argument as to Counts One-Seven was similarly based on a non-delegation argument. The CSA lays out an explicit and specific procedure that the DEA must follow when deciding whether to revoke an individual medical practitioner's DEA registration. 21 U.S.C. §824(c). It outlines five factors that must be considered. 21 U.S.C. §§823-24. One of the relevant factors that should be considered is whether the defendant's state license has been revoked. 21 U.S.C. §824. That factor is not dispositive. Petitioner argued that, at least under the instructions issued by the district court, C.F.R. § 1306.03 essentially allowed the attorney general to forgo the process outlined in 21 U.S.C. §§ 823 and 824.

The Fifth Circuit held that the instruction did not state that a prescription was unauthorized if it was not issued in compliance with C.F.R. § 1306.03, but rather that a violation of C.F.R. § 1306.03 could be used as evidence that a defendant is acting outside the usual course of professional practice.

> "Instead, the instructions permitted jurors to consider the fact that Lamartiniere issued prescriptions with a suspended state license in violation of § 1306.03(a) as evidence that those prescriptions were not issued for a legitimate medical purpose or in the usual course of professional practice."

Lamartiniere, 100 F.4th at 643.

Petitioner argued that the evidence was insufficient to establish that any of the prescriptions charged in Counts One through Seven were being diverted onto

the streets, were issued for the purpose of catering to the needs of a drug addict, or for any illegitimate medical purpose. The Fifth Circuit did not appear to disagree with that argument. *Lamartiniere*, 100 F.4th at 653 ("In other words, Lamartiniere's argument that there was insufficient evidence that the prescriptions lacked a legitimate medical purpose ignores the fact that the Government can also establish a prescription is unauthorized if it is issued outside the usual course of professional practice"). Instead, the Fifth Circuit pointed to the government expert's testimony that issuing a prescription after one's state license to issue such a prescription had been revoked is acting outside the usual course of professional practice. *Id*. at 653. Because acting outside the "usual course of professional practice" is a sufficient condition for conviction by itself, petitioners reason for issuing the prescription, the fact that he continued to hold a federal license to distribute controlled substances at the time of writing the prescription, and the fact that the medication may well have been effective in serving the medical purpose for which it was authored are irrelevant. *Id*.

REASONS FOR GRANTING REVIEW

I. REVIEW FROM THIS COURT IS NECESSARY TO REMEDY A CIRCUIT SPLIT REGARDING THE BASIC *MENS REA* AND *ACTUS REUS* ELEMENTS THE GOVERNMENT MUST PROVE TO ESTABLISH THAT A DEFENDANT HAS ISSUED AN UNAUTHORIZED PRESCRIPTION IN VIOLATION OF §841.

21 CFR §1306.04 states in order for "A prescription for a controlled substance to be effective [it] must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." Prior to *Ruan*, the Circuits held that any prescription that is not "effective" as defined by CFR §

1306.04 is not "authorized" under § 841. The elements were, therefore, dependent upon the circuit's interpretation of the meaning of the language of the CFR. Every circuit, save the Ninth, interpreted the CFR as articulating two different theories of guilt which could be proven in the disjunctive. The government must prove either: (1) that the prescription was not written for a legitimate medical purpose; or (2) that the prescription was issued outside the usual course of professional practice. *United States v. McIver*, 470 F.3d 550, 559 (4th Cir. 2006); *United States v. Armstrong*, 550 F.3d 382 at 395-401 (5th Cir. 2008); *United States v. Bek*, 493 F.3d 790, 798 (7th Cir. 2007); *United States v. Nelson*, 383 F.3d 1227, 1231–32 (10th Cir. 2004); *United States v. Joseph*, 709 F.3d at 1082, 1094 (11th Cir. 2013).

As interpreted by the circuits, "medical purpose" and "usual course of professional practice" mean different things. "Medical purpose" is a subjective question regarding whether the doctor intended the prescription to alleviate what he believed to be a bone fide medical condition. By contrast "usual course of professional practice" requires that a doctor issue the prescription in accordance with a standard of medical practice "generally recognized throughout the United States." *United States v. Nelson*, 383 F.3d 1227, 1233 (10th Cir. 2004); *See also*, *United States v. Merrill*, 513 F.3d 1293, 1306 (11th Cir. 2008); see also *United States v. Feingold*, 454 F.3d 1101, 1011 n.3 (9th Cir. 2006); *United States v. Norris*, 780 F.2d 1206, at 1209 (5th Cir. 1986); *United States v. Hurwitz*, 459 F.3d 463, 480 (4th Cir. 2006); *United States v. Vamos*, 797 F.2d 1146, 1153 (2d Cir. 1986); *United*

States v. Smith, 573 F.3d 639, 647-48 (8th Cir. 2009). This interpretation is based exclusively on the language of the CFR, not the language of the CSA itself. *Id.*

A circuit split has developed as to how, and to what extent, *Ruan* changes that analysis. The Fifth Circuit below, as well as the Eleventh, Seventh, and Sixth circuits hold that CFR §1306.04 continues to define the elements of the offense, and that *Ruan* did not alter its interpretation of that regulation. *United States v. Hofschulz,* 105 F.4th 923, 929 (7th Cir. 2024) ("We therefore assume, as *Ruan* did, 'that a prescription is 'authorized' and therefore lawful if it satisfies [the § 1306.04(a)] standard.'") (*quoting Ruan*, 597 U.S. at 455); *United States v. Heaton*, 59 F.4th 1226, 1240 (11th Cir. 2023) ("As the government points out, the plain language of 21 C.F.R. § 1306.04(a) demonstrates that the jury instruction here correctly used "or" in defining the elements of a § 841(a) offense." … Thus, both requirements must be satisfied to make a prescription authorized."); *United States v. Lubetsky*, No. 23-10142, 2024 WL 577543, at 1 (11th Cir. Feb. 13, 2024) ("Because the government didn't prove a lack of legitimate medical purpose, the argument goes, the government did not prove the prescriptions were unauthorized. …[defendants] first argument is squarely foreclosed by circuit precedent."); *See also*, *United States v. Cristobal*, No. 23-6107, 2024 WL 1506750, at 4 (2d Cir. Apr. 8, 2024) (upholding jury instructions that rest on the language of CFR 1304.06 requiring that the defendant "acting in accordance with a standard of medical practice generally recognized and accepted in the State of New York."); *United States v. Titus*, 78 F.4th 595, 598–99 (3d Cir. 2023) ("Here, the instructions required

the jury to find that Titus had knowingly or intentionally distributed controlled substances outside "the usual course of professional practice and not for a legitimate medical purpose."). Those circuits find that CFR §1306.04 (and by reference, § 841) criminalizes any prescription that a defendant knows to be outside of the "standard of medical practice generally recognized and accepted by the medical profession in the United States." *Lamartiniere*, 100 F.4th at 637.

These circuits interpret *Ruan* as leaving the above analysis essentially intact. The only effect of *Ruan* in these circuits is to require the government to prove that a defendant *knew* that the manner in which a prescription was issued is outside of generally accepted standards of medical practice. None require the government to prove that a defendant issued the prescription knowing that it would be diverted onto the street or that the prescription was not serving the purpose of treating a bone fide pain condition. None require the government to prove that the defendant "knew or intended that his or her conduct was unauthorized." *Ruan*, 142 S.Ct. at 2382.

The Tenth Circuit's interpretation of the scope and breadth of *Ruan* is vastly different. The Tenth Circuit interpreted *Ruan* as imposing something close to specific intent. In the Tenth Circuit, the government is required to prove that "that petitioner knew that his conduct was unauthorized or illegal." *Kahn II*, 58 F.4th at 1315 (*quoting*, *Liparota*, 471 U.S. at 434); *Id.* 1317 (jury instructions did not require the government to prove that "[the defendant] intended to act without authorization").

The Tenth Circuit rejected jury instructions that were materially identical to the "generally accepted standard of practice" language approved of by the Fifth Circuit in the instant case. In the Tenth Circuit, "[it] is not enough that the jury found that [a defendant] failed to attempt or make some honest effort to apply the appropriate standard of care,". *Id.* 1320 ("While proof that [the defendant] failed to try to conform his prescribing practices to the standards of his profession may 'go far to show, circumstantially at least, that [the defendant] actually knew he was acting outside the standards of his profession,' … that evidence does not fully satisfy the requirement that the government prove that [the defendant] "knowingly or intentionally acted in an unauthorized manner.") (quoting, *Ruan*, 142 S. Ct. at 2376). In fact, in the Tenth Circuit "it [is not] enough that the jury accepted that [the defendant] subjectively knew a prescription was issued not for a legitimate medical purpose, and/or issued a prescription that was objectively not in the usual course of professional practice.". *Id.* 1320.

There is a great moral difference between a doctor who issues a prescription for the purpose of exploiting the addiction of his patients or redistribution on the streets, and one who is honestly trying to help, but is lazy or behind the times in his medical record keeping. The instructions rejected by the Tenth Circuit in *Kahn II* were materially similar to those upheld by the Fifth Circuit below.

For example, in this case the Fifth Circuit upheld as consistent with Ruan a jury instruction which stated:

> A controlled substance is prescribed by a physician for a legitimate medical purpose in the usual course of professional practice, and therefore,

> "authorized", if the controlled substance is prescribed by him in good faith. Good faith in this context means an honest effort to prescribe for a patient's condition in accordance with the standards of medical practice generally recognized or accepted in the United States.

ROA.3115-19. That definition of authorization does not require the government to prove that the defendant either knew or intended that any of the prescriptions were being diverted onto the streets, catering ot the needs of a drug addict, were not serving a legitimate medical purpose, or that he knew them to be outside of the scope of his authorization under the CSA.

On remand from this Court, the Tenth Circuit rejected a materially similar "good faith" instruction that stated: "The good faith defense requires the jury to determine whether Defendant Shakeel Kahn acted in an honest effort to prescribe for patients' medical conditions in accordance with generally recognized and accepted standards of practice." *Kahn II*, 58 F.4th at 1317.

In Petitioner's case, the government did not present any evidence that any prescriptions were being diverted onto the street or that they were being used for any purpose other than treating a bone fide condition.

This circuit split cannot be resolved organically. In upholding their pre-*Ruan* case la, the Fifth, Seventh and Eleventh circuits each cite this Court's language: "We assume, as did the courts below and the parties here, that a prescription is 'authorized' and therefore lawful if it satisfies this standard.". *Ruan*, 597 U.S. at 455; *Hofschulz*, 105 F.4th at 929 (7th Cir. 2024); *Lamartiniere*, 100 F.4th at 638 (5th Cir. 2024); *Heaton*, 59 F.4th at 1240.

The irony is that the court made this assumption based on the solicitor general's concession at oral argument and in briefing that the "usual course of professional practice" and "usual course of medical purpose" language from 21 C.F.R. § 1306.04(a) articulate a single unified standard that cannot be interpreted to impose any limitation on medical practitioners beyond those included in the CSA itself. Transcript of Oral Arg, *Ruan v. United States* at 67-86. That concession is plainly inconsistent with how the circuit courts interpreted and applied CFR § 1306.04.

Nevertheless, based on language in *Ruan*, circuits continue to hold that "usual course of professional practice" and "legitimate medical purpose" language from CFR § 1306.04 impose two different standards with different meanings. Courts continue to interpret "usual course of professional practice" as requiring that a medical practitioner act in accordance with "the standard of medical practice generally recognized and accepted by the medical profession in the United States." *Lamartiniere*, 100 F.4th at 637. And these Courts continue to permit conviction of doctors who intend to treat their patients' medical conditions but choose to act outside of practices that are deemed "generally accepted."

II. FURTHER GUIDANCE FROM THIS COURT IS NECESSARY TO RESOLVE CONFUSION AS TO WHAT IT IS THAT RENDERS A PRESCRIPTION AUTHORIZED UNDER § 841 AND RECTIFY A SIGNIFICANT SEPARATION OF POWERS ERROR THAT HAS WORKED ITS WAY INTO THE CASE LAW SINCE *MOORE*.

In *Moore*, this Court considered the question of whether a registered medical practitioner was "exempted from prosecution under § 841 by virtue of his status as a registrant" under the CSA. *Moore,* 423 U.S. at 124. The Court recognized that a

doctor's scope of authority as defined in the CSA, is somewhat circular. *Id.* ("Section 822(b) defines the scope of authorization under the Act in circular terms. 'Persons registered . . . under this subchapter . . . are authorized (to dispense controlled substances) . . . to the extent authorized by their registration and in conformity with the other provisions of this subchapter."). The CSA includes a number of penalty provisions that are specifically targeted at registrants. For example, 21 U.S.C. §843(a)(2) states:

> "It shall be unlawful for any person *knowingly or intentionally*— … to use in the course of the … dispensing of a controlled substance … a registration number which is fictitious, *revoked, suspended*, expired… [A]ny person who violates this section shall be sentenced to a term of imprisonment of not more than 4 years, a fine under title 18, or both."

21 U.S.C. §843(a)(2). This offense was included in the list of "minor or technical" violations that fall short of constituting a violation of §841. *Moore*, 423 U.S. at 135.

Moore held that, were the CSA construed to authorize all prescriptions a registrant was licensed to issue, it would "constitute a sharp departure from other laws." *Id*. 132-33 ("It is unlikely that Congress would seek, in this oblique way, to carve out a major new exemption, not found in the Harrison Act…").

Prior to the enactment of the CSA, the distribution of narcotics was governed by the Harrison Act, 38 Stat. 785. Under the Harrison Act, distribution of controlled substances by registered medical professionals was permitted "in the course of his professional practice only." *Linder v. United States*, 268 U.S. 5, 13 (1925). In *Linder*, the Court reversed because the indictment failed to articulate facts that the defendant doctor had any "conscious design to violate the law." 268 U.S at 17. In

Boyd the "disputed question was whether the defendant issued the prescriptions in good faith." *Boyd v. United States*, 271 U.S. 104, 105 (1926). The instruction in *Boyd* read in part: "whether or not the defendant in prescribing morphine to his patients was honestly seeking to cure them of the morphine habit, while applying his curative remedies, it is not necessary for the jury to believe that defendant's treatment would cure the morphine habit, but it is sufficient if defendant honestly believed his remedy was a cure for this disease." *Id*. 107–08. Nothing in these cases discusses a defendant's conformity with the standard of care, or generally recognized standard of care medical practice.

Initially, in early CSA cases, the Circuits interpreted the phrases "usual course" and "medical purpose" as meaning approximately the same thing. A registered practitioner was authorized to issue a prescription so long as his registration allowed it and he believed the medication was working to alleviate a bone fide medical problem. *United States v. Rosenberg*, 515 F.2d 190, 197 (9th Cir. 1975) ("The language clearly means that a doctor is not exempt from the statute when he takes actions that he does not in good faith believe are for legitimate medical purposes.") (cited with approval in *United States v. Plesons*, 560 F.2d 890, 896-97 (8th Cir. 1977)); *United States v. Jackson*, 576 F.2d 46, 48 (5th Cir. 1978) ("Although the indictment does not state that Dr. Jackson acted outside the scope of professional practice, it does allege a more specific activity, i.e., that he dispensed drugs unlawfully 'under the guise and artifice of operating' his clinic. Even a casual reading of the indictment makes clear that Dr. Jackson was alleged to have utilized

his clinic as a "front" for dealing drugs, and the language obviously embraces an activity lacking legitimate medical purpose."); *United States v. Kirk*, 584 F.2d 773, 784 (6th Cir. 1978) ("[T]here is no difference in the meanings of the statutory phrase, 'In the usual course of professional practice' and the regulations' phrase, 'legitimate medical purpose.'").

Over time, the circuits began to rely more and more on the CFR rather than the language of the statute. Today, in at least the Fifth, Sixth, Seventh and Eleventh circuits, the language of the CFR, rather than the language of the statute, defines the scope of a physician's "authorization" under 18 USC § 841. *Lamartiniere*, 100 F.4th at 641; *Hofschulz,* 105 F.4th at 929; *Heaton*, 59 F.4th at 1240; *Anderson*, 67 F.4th at 764. Since *Moore*, the interpretation of what that CFR means has evolved from one that requires only that a doctor issue a prescription that he believes will alleviate a bone fide medical problem, into one that requires each prescription be issued in strict accordance with "generally accepted standard of practice". This evolution is based explicitly upon the circuit courts treating CFR § 1306.04 as a binding regulation defining the scope of a doctor's prescription writing authority.

The CSA did not grant the Attorney General the authority to regulate the manner of medical practice or determine what constitutes an effective prescription (as §1306.04 purports to), let alone bypass the detailed procedures for revoking an individual registrant's CSA authorization by issuing conditions for automatic revocation (as §1306.03 purports to).

The CSA includes only two potentially relevant grants of authority to the Attorney general. 21 U.S.C. §871 states:

> "The Attorney General may promulgate and enforce any rules, regulations, and procedures which he may deem necessary and appropriate for the efficient execution of his functions under this subchapter."

Under the CSA, the Attorney General, in coordination with the Secretary of Health and Human services is charged with two basic functions. First, the Attorney General is given the authority to review new medications and place them on a temporary and permanent basis on one of the five schedules. 21 U.S.C. §811. Second, the Attorney General is charged with registering medical practitioners to issue controlled substances. 21 U.S.C. §823. The Attorney General also has the authority to revoke a medical practitioner's CSA registration pursuant to procedures specifically outlined in the statute. 21 U.S.C. §824. Defining what constitutes authorization under §841 simply does not fall within the ambit of either function. Importantly, in these two areas, the CSA provides explicit and detailed procedures and criteria that the Attorney General should use in exercising its rule making authority.

Section 821 states:

> "The Attorney General is authorized to promulgate rules and regulations and to charge reasonable fees relating to the registration and control of the manufacture, distribution, and dispensing of controlled substances and to listed chemicals."

The word "control" is explicitly defined by the CSA. It does not include the power to generally regulate the practice of medicine or to further define what constitutes an

authorized prescription. 21 U.S.C. §802 ("The term 'control' means to add a drug or other substance, or immediate precursor, to a schedule under part B of this subchapter, whether by transfer from another schedule or otherwise."). The CSA does not include any explicit grant of authority allowing the attorney general to define what constitutes an "effective" prescription under §841 or to articulate the criteria against which "authorization" should be measured. *Gonzales*, 546 U.S. at 269–70; *see also id.* at 262 ("The problem with the design of the Interpretive Rule is that it cannot, and does not, explain why the Attorney General has the authority to decide what constitutes an underlying violation of the CSA in the first place.").

Any ambiguity in §§821 and 871 is affirmatively obviated by the legislative history and Major Questions Doctrine. Under the Major Questions Doctrine, courts must presume that "Congress intends to make major policy decisions itself, not leave those decisions to agencies." *W. Virginia v. Env't Prot. Agency*, 142 S. Ct. 2587, 2609 (2022). "Where the statute at issue is one that confers authority upon an administrative agency, that inquiry must be 'shaped, at least in some measure, by the nature of the question presented'—whether Congress in fact meant to confer the power the agency has asserted." *Id.* at 2607–08. The regulation of medical practice is an area of traditional state concern that Congress has been (perhaps uncharacteristically) inclined to protect. *Hawker v. New York*, 170 U.S. 189 (1898) (detailing how the medical practice had been policed by the states); *Bond v. United States*, 134 S. Ct. 2077, 2088 (2014) (rejecting presumption "that Congress had meant to effect a significant change in the sensitive relation between federal and

state criminal jurisdiction"); 21 U.S.C. §823(g)(2)(H)(i) ("Nothing in this subchapter shall be construed as to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided."); H.R. Rept. 91-1444 at 14.

The manner in which circuit court law has evolved seems to be directly contrary to the intent of Congress. The House report states that Congress did not believe it appropriate for "federal officials to determine the appropriate method of the practice of medicine." H.R. Rept . 91-144 at 14. The House Report goes on to note that "it is necessary to acknowledge that this is precisely what has happened through the criminal prosecution of physicians whose methods of prescribing narcotic drugs have not conformed to the opinions of federal prosecutor of what constitutes appropriate methods of professional practice". *Id*. at 15 (emphasis added).

Nothing in the text of the CSA suggests that Congress intended to allow physicians to be prosecuted for stepping outside of the generally accepted standards of medical practice. The effect of the circuit court's interpretation of CFR § 1304.06 has been to allow prosecutors to do exactly what the drafter's of the CSA sought to prevent.

The CSA's structure and specific language "confirms that the authority" to define legitimate prescribing and medical practice is "both beyond [the Attorney General's] expertise and inconsistent with the statutory purposes and design." *Id*. at 267.

Courts must "be certain of Congress's intent" before "legislating in areas traditionally regulated by the States." *Gregory v. Ashcroft*, 501 U.S. 452, 459-60 (1991). Here, Congress's intent is clear. Congress clearly did not intend to grant the attorney general authority to issue regulations delineating the scope of a registrant's prescription writing authority or to police the manner of medical practice.

Even were a contrary construction possible, §§821 and 871 fall far short of providing an "intelligible principle" guiding the delegation of that power. *United States v. Touby*, 500 U.S. 160, 166 (1991). Separation of Powers requires that where Congress delegates rulemaking authority to the executive branch, it must "clearly delineate[] the general policy, the public agency which is to apply it, and the boundaries of this delegated authority." *Mistretta v. United States*, 488 U.S. 361, 372–73 (1989) (emphasis added); *United States v. Robel*, 389 U.S. 258, 275 (1967) (Brennan, J., concurring) (explaining that "the area of permissible indefiniteness narrows … when the regulation invokes criminal sanctions").

The CSA identifies very specific factors that the Attorney General must consider in determining whether a medical practitioner's DEA registration can be revoked on an emergency or temporary basis. The CSA identifies the factors which the Attorney General should use in determining whether a substance should be scheduled on an emergency basis. *Touby*, 500 U.S. at 166. Sections 821 and 871 include no similar "intelligible principle" outlining factors for the Attorney General

to consider in determining the scope of authorization or what constitutes an "effective prescription."

In our system of government, Congress writes the laws, the judiciary interprets them, and the executive enforces them. "If the separation of powers means anything, it must mean that the prosecutor isn't allowed to define the crimes he gets to enforce." *United States v. Nichols*, 784 F.3d 666, 668 (10th Cir. 2015) (J. Gorsuch, dissenting from the denial of rehearing *en banc*). "After all, crimes are supposed to be defined by the legislature, not by clever prosecutors riffing on equivocal language." *Dubin v. United States*, 599 U.S. 110, 129–30 (2023) (quotation marks and brackets omitted).

Preventing federal prosecutors from defining the practice of medicine through regulations and targeted prosecutions was the explicit purpose of the framers of the CSA. The legislative history of the CSA suggests that Congress did not believe it appropriate for "federal officials to determine the appropriate *method* of the practice of medicine." H.R. Rept. 91-1444 at 14. The congressional record concluded that many of the previously enacted regulations deviated from binding Supreme Court precedent. *Id.* at 14 ("The regulations of the Bureau of Narcotics, however, do not seem to me in accord with [prior Supreme Court case law]").

Ruan addressed a circuit split regarding the *mens rea* necessary to convict a registered physician under § 841. Since *Ruan*, a circuit split as developed regarding what it is, as a matter of *actus reus*, that renders a prescription authorized. Is the act defined by the statute or the regulation? As the Circuit courts interpret the

regulation, it renders far more conduct "unauthorized" than what could possibly be intended by the drafters of the CSA. The drafters of the CSA manifestly intended reserve to the states the regulation of the manner of medical practice.

The decision below is not only inconsistent with the text, structure, and legislative history of the CSA, but it extends the scope of the regulation beyond what is indicated by the regulatory text. This Court has recognized that Section "829 by its terms does not limit the authority of a practitioner." *Moore*, 423 U.S. at 138. And the regulation at issue in this case purports to implement §829 of the statute. 21 C.F.R. § 1306.01; § 1306.04(a) ("An order purporting to be a prescription issued not in the usual course of professional treatment . . . is not a prescription *within the meaning and intent of section 309 of the Act (21 U.S.C. 829)* . . . ." (emphasis added)). Congress specifically provided consequences for violations of § 829 in § 842(a)(1). Assuming, *arguendo*, that a violation of the regulation was criminally sanctionable, the proper provision for the government to proceed under is § 842, not § 841. Indeed, the only context in which *Moore* discussed the regulation was in reference to the lower Court's discussion regarding whether the defendant in that case "could be prosecuted under [§] 842 (a)(1) for having violated the provisions of [§] 829 with respect to the issuing of prescriptions." *Moore*, 423 U.S. at 135–36, n.12, n.13.

While a DEA registration does not exempt doctors who "us[e] their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood" from prosecution under § 841, *Gonzales*,

546 U.S. at 270, Congress did not intend to subject well-intentioned doctors who fail to adhere to generally accepted medical practices to "prosecution under [§] 841 for the significantly greater offense of acting as a drug 'pusher.'" *See Moore*, 423 U.S. at 138. As Justice Alito correctly explained in his concurring opinion in *Ruan*, "acting 'as a physician' does not invariably mean acting as a *good* physician, as an objective understanding of the 'in the course of professional practice' standard would suggest." *Ruan*, 597 U.S. at 479 (Alito, J., concurring). "A doctor who makes negligent or even reckless mistakes in prescribing drugs is still 'acting as a doctor'—he or she is simply acting as a *bad doctor*." *Id.*

Nothing in the text, structure, or history of the Controlled Substances Act suggests that Congress equated being a bad doctor with being a drug trafficker. But the decision below allows for no distinction between the two and holds a bad doctor equally culpable as an intentional drug pusher. And it does so without even attempting to undertake an independent analysis of the statute. Instead, it defers uncritically to the Attorney General's regulation implementing a different section of the statute, which does not even limit a registrant's authority. As this Court has recently reiterated, "[j]udges have always been expected to apply their 'judgment' *independent* of the political branches when interpreting the laws those branches enact." *Loper Bright Enterprises v. Raimondo*, 144 S. Ct. 2244, 2273 (2024) (citing The Federalist No. 78, at 523 (J. Cooke ed. 1961) (A. Hamilton)); *see also Whitman v. United States*, 574 U.S. 1003 (2014) (statement of Scalia, J., respecting the denial of certiorari) ("Deferring to the prosecuting branch's expansive views of these

statutes would turn their normal construction upside-down, replacing the doctrine of lenity with a doctrine of severity." (quotation marks, brackets, and ellipsis omitted)). That expectation was not met in this case.

This error cannot be resolved short of review by this Court. Petitioner's case provides a clear opportunity for that review. The Fifth Circuit was explicit in holding that it was the language of the CFR that defined authorization. The Fifth Circuit was explicit in finding that an intentional deviation from the standard of care is enough to render a physician culpable as a drug dealer even if the prescriptions were issued for what the physician believed to be a legitimate medical purpose, and even if the prescriptions were serving that legitimate medical purpose. The purpose of the CSA is to prevent the diversion of narcotics from legitimate to illegitimate distribution channels. *Moore*, 423 U.S. at 135. If each and every one of a doctor's patients have a bone fide pain condition, and if none are diverting their drugs onto the street, the question becomes: what is the act that that renders the prescription unauthorized?

CONCLUSION

For the foregoing reasons, Petitioner respectfully prays that this Honorable Court will grant his Petition for Certiorari.

Respectfully Submitted,

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By: /s/ Beau B Brindley

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