No. 25-61

IN THE

Supreme Court of the United States

MARK MURPHY AND JENNIFER MURPHY,

Petitioners,

v.

UNITED STATES,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF OF UNIVERSITY OF MICHIGAN FEDERAL APPELLATE LITIGATION CLINIC AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

MELISSA M. SALINAS
UNIVERSITY OF MICHIGAN
LAW SCHOOL
FEDERAL APPELLATE
LITIGATION CLINIC
2058 Jeffries Hall,
Room 2058
701 South State Street
Ann Arbor, MI 48104

RONALD W. CHAPMAN II
Counsel of Record
1441 West Long Lake Road,
Suite 310
Troy, MI 48098
(248) 644-6326
rwchapman@
chapmanlawgroup.com

Counsel for Amicus Curiae

131446

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

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INTEREST OF AMICUS CURIAE[1]

The University of Michigan Federal Appellate Litigation Clinic is a non-profit law-school clinic devoted to representing indigent federal defendants-appellants and other public-interest litigants. The Clinic's mission is simple: deliver the level of appellate advocacy that only well-resourced clients typically receive. Under the direction of Professor Melisa Salinas, third-year law students—trained in federal criminal law, brief-writing, and advocacy—work as part of counsel's team to research, draft, and argue appeals for clients who could not otherwise obtain this caliber of representation.

That model matters here. The Clinic has a front-row seat to how post-*Ruan* instructions are actually being given in physician prosecutions, and it brings to this Court the informed perspective of counsel who live with those charges in trial records and transcripts, not just in treatises. See *Ruan v. United States*, 597 U.S. 450, 142 S. Ct. 2370 (2022).

The Clinic currently serves as counsel for Mark Dyer, a co-defendant in *United States v. Campbell*, 135 F.4th 376 (6th Cir. 2025) (addressing related claims in *United States v. Dyer*, No. 23-5311, 2025 U.S. App. LEXIS 19396 (6th Cir. July 31, 2025)), petition for certiorari forthcoming. In *Campbell*, the panel affirmed while acknowledging that the case presented a "strong argument that the jury

1. Under Rule 37.2, *amici* provided notice of their intention to file this brief. Under Rule 37.6, no counsel for a party authored this brief in whole or part, and no person other than *amici curiae* or their counsel made a monetary contribution to its preparation or submission.

instructions did not comply with *Ruan*" (135 F.4th at 387) under *Ruan*, but explained that recent circuit precedent compelled the result—precisely the dynamic the petition in this case identifies. See Appellant's Pet. for Panel Reh'g & Reh'g En Banc at 1-3, *Campbell*, 135 F.4th 376 (No. 23-5298) (describing the panel's recognition of the instructional defect and its reliance on *United States v. Anderson*, 67 F.4th 755 (6th Cir. 2023), *United States v. Bauer,* 132 F.3d 504 (9th Cir. 1997), and *United States v. Stanton,* 103 F.4th 1204 (6th Cir. 2024), to affirm).

The Clinic's briefing and *en banc* petition in *Campbell* trace how Sixth Circuit panels have allowed a generic deliberate-ignorance instructions to muddy the waters, thereby allowing conviction without a finding that the defendant knew he was acting or intended to act, "in an unauthorized manner." See id. (collecting *Anderson*, *Bauer*, and *Stanton* and explaining why those decisions "bypass" *Ruan*'s *mens rea*); see also Appellant's Br. at 20-33, *Campbell*, 135 F.4th 376 (No. 23-5298) (arguing that the willful blindness charge cannot cure the omission of *Ruan*'s knowledge-of-authorization requirement).

From that day-to-day work flows a broader concern the Court should hear now. The Clinic's docket—including its representation in *Campbell*—has brought into sharp focus a live circuit conflict over whether § 846 conspiracies premised on § 841 require correct § 841 instructions after *Ruan*, and an intra-circuit pattern of decisions that dilute *Ruan* by "stacking" deliberate-ignorance over objective, malpractice-style criteria. Those rulings do not just misstate the law and result in wrongful convictions; they chill legitimate medical practice by making felony liability turn on moving targets rather than on the defendant's

actual knowledge. Other writings in this circuit, too, have opined that jury instructions violate *Ruan* when they do not clearly require a *mens rea* of knowledge or intent in the authorization element. *See, e.g.,* Appellant's Pet. for Panel Reh'g & Reh'g En Banc at 1-3, *Campbell*, 135 F.4th 376 (No. 23-5298) (detailing the panel's acknowledgement that the instructions "do not fully comport with Ruan" and its view that precedent nonetheless required affirmance). See also *United States v. Bauer*, 82 F.4th 522, 533 (6th Cir. 2023) ("In our view, the instructions in Anderson—and thus [in Bauer] as well—do not fully comport with Ruan."); *United States v. Anderson*, 67 F.4th 755, 771-73 (6th Cir. 2023) (White, J., concurring in part and dissenting in part); *United States v. Hofstetter*, 80 F.4th 725, 732-34 (6th Cir. 2023) (Cole, J., Case: 23-5311 Document: 82 Filed: 05/19/2025 Page: 53 concurring).

Because the Clinic's work places it at the center of these recurring questions—and because its students and faculty have already briefed and preserved the precise instructional issues now before the Court—amicus can assist the Court in evaluating both the doctrinal stakes and the practical consequences for indigent defendants and the medical community. The Clinic respectfully submits this perspective to help the Court restore the uniform, defendant-focused *mens rea* that *Ruan* requires and that indigent clients, no less than the well-resourced, are entitled to have accurately charged and faithfully applied jury instructions. See Murphy Pet. at ii-iii (framing the split and its practical importance).

Counsel of record, Ronald Chapman II, has over a decade of experience representing physicians in Controlled Substances Act prosecutions and advocating

for a *mens rea* standard based on physicians' subjective understanding of medical practice. He has written two NACDL articles, spoken at Cato Institute conferences, and litigated key cases including *Naum v. United States*, 142 S. Ct. 2893 (2022); *Campbell*, 135 F.4th 376; *Anderson*, 67 F.4th 755; and *United States v. Parker*, No. 24-2813 (8th Cir. 2025).

SUMMARY OF ARGUMENT

Ruan held that § 841's "knowingly or intentionally" *mens rea* "applies to the 'except as authorized' clause," so that, once a physician produces evidence of authorization, "the Government must prove beyond a reasonable doubt that the defendant knowingly or intentionally acted in an unauthorized manner." 597 U.S. at 459-60.

In the Sixth Circuit, however, a sequence of decisions has allowed juries to infer "knowledge" through deliberate ignorance charges that pivot the focus back to objective malpractice-style criteria and away from the physician's subjective awareness that he was acting "in an unauthorized manner." See *Anderson*, 67 F.4th at 764-66; *Bauer*, 82 F.4th at 532-33; *Stanton*, 103 F.4th at 1212-13. The cumulative effect is precisely what *Ruan* warned against: criminalizing clinical judgment by proxy, eroding the scienter requirement through instructions that invite conviction for "closing [one's] eyes to the obvious" rather than for knowing or intending to prescribe without authorization. *Anderson*, 67 F.4th at 766 (quoting the jury charge).

The error deepens in conspiracy prosecutions under § 846. *Stanton* sustained a drug-conspiracy conviction

because while proof of unauthorized prescriptions "matter[ed] only if the government had charged [under § 841(a)]," which it did not. 103 F.4th at 1210-11. Stacking a willful blindness instruction atop a conspiracy theory permits punishment for medical prescribing absent the *Ruan mens rea*.

This Court's intervention is urgently needed.

ARGUMENT

I. *Ruan* Requires the Government to Prove a Physician "Knew or Intended" He Was Acting Without Authorization; the Sixth Circuit's Pattern of Deliberate Ignorance Instructions Undercuts That Requirement.

Ruan's holding is straightforward: § 841's scienter—"knowingly or intentionally"—attaches to authorization. After a defendant produces evidence of authorization, "the Government must prove beyond a reasonable doubt that the defendant knew that he or she was acting in an unauthorized manner, or intended to do so." 597 U.S. at 454-55. The Court emphasized that conviction cannot rest on an objective departure from "legitimate medical purpose" or the "usual course of professional practice" standing alone; those "objective criteria" are circumstantial evidence but not the legal standard. Id. at 466-67, 472-73 (explaining how juries may consider objective markers while focusing on subjective culpability).

The Sixth Circuit's post-*Ruan* cases accept *Ruan*'s words but dilute its substance through the vehicle of deliberate ignorance instructions. Those instructions

invite jurors to collapse subjective knowledge into objective red flags, permitting conviction if a physician "deliberately ignored a high probability" that his prescribing lacked a legitimate purpose or usual course—even where the charge omits the crucial requirement that he knew or intended his conduct to be unauthorized. See *Anderson*, 67 F.4th at 766 (approving instruction that "knowledge may be inferred if the defendant deliberately blinded himself to the existence of a fact," that "no one can avoid responsibility for a crime by deliberately ignoring the obvious," and that the jury may find knowledge if he "deliberately ignored a high probability" the prescriptions were illegitimate), with internal record cites to the charge conference

II. The Sixth Circuit's First Attempt at Eroding *Ruan* and a "Substantially Covered" *Mens Rea*

Dr. Roger Anderson, an infectious-diseases physician in Marietta, Ohio, was investigated after concerns were raised by pharmacists and the state board. A confidential informant visited eight times; Anderson sometimes wrote or left signed prescriptions without an exam for existing patients who were stable on their medication. The government called multiple patients, pharmacists, and a pain-medicine expert (Dr. King) who opined that Anderson failed to meet documentation and monitoring norms. *Anderson*, 67 F.4th at 761-63.

The district court declined to give a requested "good faith" instruction, but it charged the jury that "knowledge may be inferred if the defendant deliberately blinded himself to the existence of a fact" and that, if the jury was "convinced that the defendant deliberately ignored a high

probability that the controlled substance was distributed or dispensed without a legitimate medical purpose in the usual course of professional practice, then [it] may find that the defendant knew this was the case." It added that "[c]arelessness, or negligence, or foolishness … are not the same as knowledge." *Anderson*, 67 F.4th at 775-76. The panel held these instructions "appear[ed] to comport with Ruan," finding they "substantially cover[ed] the concept of knowledge." Id. at 765-66; (approving deliberate ignorance juxtaposed with negligence).

Ruan requires proof that the doctor "knew … [he] was acting in an unauthorized manner." 597 U.S. at 466-67. The *Anderson* instruction never told the jury that "lack of authorization" was an element it must find beyond a reasonable doubt; instead, it permitted an inference of knowledge from a high probability that prescriptions were outside the "usual course" or lacked "legitimate medical purpose"—objective criteria *Ruan* relegated to circumstantial evidence. See 67 F.4th at 766; *Anderson*, 67 F.4th at 766.

Short snippets of the charge—"deliberately ignoring the obvious," "high probability"—do not cure the missing element. They risk returning to the very objective proxy *Ruan* rejected.

III. The Sixth Circuit's Second Attempt at Eroding *Ruan* and its Shift from "Substantially Covered" to "Do Not Fully Comport"

Emboldened by the *Anderson* decision, the Government successfully criminalized the potential for criminal conduct where a physician "ignores" "red flags".

Dr. William Bauer, a neurologist with extensive tenure, faced prosecution for prescribing medications to fourteen patients. The government's expert emphasized shortcomings such as the failure to order confirmatory tests, the omission of conservative therapies, the neglect to identify "red flags," and the lack of caution regarding high-risk polypharmacy. Additionally, some prescriptions were refused by local pharmacies. One patient subsequently overdosed. Refer to *Bauer*, 82 F.4th at 525-31 (excerpt from jury instructions).

Bauer's conduct was problematic, to the prosecution, in that he failed to appreciate the risk of diversion, not that actual diversion occurred.

The court gave a deliberate ignorance instruction functionally identical to Anderson's and two "good-faith" definitions—one objective, one nominally subjective but still referencing what the doctor "reasonably believed." Id. at 532-33. The panel forthrightly conceded these are not the instructions that should be used in unauthorized distribution cases going forward and that the instructions "do not fully comport with Ruan." Id. at 532-33 ("Anderson controls and requires that we find the jury instructions adequate")

When a circuit acknowledges that its pattern instructions "do not fully comport" with this Court's decision yet affirms on the strength of its own prior precedent, the conflict with *Ruan* is squarely presented. Id. at 533. The deliberate ignorance language and poor precedent again allowed the jury to equate "ignoring red flags" and exceeding advisory dosage thresholds with "knowing" lack of authorization, even though *Ruan*

teaches that objective deviations are only circumstantial evidence toward (not a substitute for) the doctor's subjective state of mind. See 597 U.S. at 466-67.

IV. The Problem Deepens in § 846 Conspiracy Cases—Deliberate Ignorance Stacked on Conspiracy Sidesteps *Ruan* and Criminalizes an Agreement to Ignore "Red Flags"

Dr. Stanton served as medical director at a Tennessee clinic (Gateway). The government portrayed Gateway as a "pill mill": long hours, out-of-state clientele, high-dose templates, and continued prescriptions despite failed drug screens. Stanton saw patients briefly and signed pre-printed prescriptions; his assistant said the doctors did not use the Electronic Medical Record (EMR); a pharmacy expert said the scripts lacked individualized dosing. 103 F.4th at 1209-11 (summarizing testimony).

Reviewing sufficiency and instructions, the panel stated flatly: proof that Stanton himself wrote "unauthorized" prescriptions "would have mattered only if the government had charged [him] with distributing controlled substances under 21 U.S.C. § 841(a). It did not. It instead charged him with conspiring to distribute drugs, § 846." 103 F.4th at 1210-11. Addressing the deliberate ignorance instruction, the court reiterated that such a charge "satisfies *Ruan* when, as here, it reminds the jury that this standard sits well above carelessness, negligence, and mistake," citing *Anderson*. Id. at 1213 (cleaned up).

A § 846 conspiracy to violate § 841 inherits § 841's elements—including *Ruan*'s *mens rea*—because the object of the agreement is the same unlawful distribution

"except as authorized." See 21 U.S.C. §§ 841(a)(1), 846; *Ruan*, 597 U.S. at 459-60. Treating proof of unauthorized prescriptions as irrelevant (because the charge is conspiracy) and then using deliberate ignorance to infer knowledge from systemic "red flags" creates an end run around *Ruan*: it criminalizes participation in a medical practice based on objective irregularities without proving that the doctor agreed to commit acts he knew were unauthorized.

Stanton thus "stacks" willful blindness atop conspiracy to completely erase the knowledge element and hinge criminal liability on a retrospective analysis of a Government expert and subjective standards of practice.

V. In Campbell, the Sixth Circuit Refused to Reverse Instructions that do not Comport this Court's Mandate in *Ruan*

The Sixth Circuit's published opinion in *Campbell* crystallizes how courts can acknowledge *Ruan*'s *mens rea* rule and yet preserve convictions through a willful blindness work-around—particularly in § 846 conspiracy prosecutions premised on § 841. Dr. Jeffrey Campbell, a physician, owned a primary-care clinic (Physicians Primary Care, "PPC") in Louisville; Mark Dyer, a nurse practitioner, also practiced there. 135 F.4th at 385-86.

A 2020 indictment charged multiple § 841 distribution counts (including a "death results" enhancement), a § 846 drug conspiracy, healthcare fraud counts and conspiracy, and money laundering. After trial, the jury acquitted both defendants on all substantive § 841 distribution counts

and on the "death results" theories, but convicted each on § 846 drug conspiracy; the jury also convicted Campbell and Dyer on healthcare fraud conspiracy and money laundering, with additional healthcare fraud counts as to Campbell. Sentences were 105 months (Campbell) and 60 months (Dyer), with restitution ordered post-judgment. Id. at 385-86.

The panel began by accurately stating *Ruan*: § 841's "knowingly or intentionally" applies to the "except as authorized" clause; thus, after a defendant produces evidence of authorization, the government must prove the defendant "knew that he was acting in an unauthorized manner, or intended to do so," and liability may not turn on the mental state of a "reasonable doctor" rather than "the defendant himself." Id. at 386-87 (citing *Ruan v. United States*, 597 U.S. 450, 454-67 (2022)). The court also recognized the straightforward corollary for § 846: because a conspiracy to violate § 841 requires knowingly joining an agreement to commit the object offense, "after *Ruan*, a person cannot 'knowingly' agree to violate § 841 unless he agrees to commit acts he knows are unauthorized." Id. at 386.

Measured against that standard, the panel candidly found the jury charge wanting. The elements instructions "nowhere" stated that the government had to prove defendants "knew" they were acting without authorization; instead, the court told jurors a § 841 violation occurs when a defendant "knowingly, intentionally, and unlawfully distributes or dispenses controlled substances and he knows the substances are controlled substances." Id. at 387.

The closest the charge came was a willful blindness paragraph permitting jurors to infer "knowledge" if defendants "deliberately ignored a high probability" that drugs were "being dispensed or distributed outside the course of professional practice and not for a legitimate medical purpose," or that "patients were diverting" controlled substances—while cautioning that "carelessness or negligence or foolishness" is insufficient. Id.

The panel's bottom line, "Simply put, the district court never instructed the jury that it could convict Defendants only if it found that they 'knew or intended that [their] … conduct was unauthorized.' So it is doubtful that these instructions conveyed the *mens rea Ruan* requires for distribution." Id. (quoting *Ruan*, 597 U.S. at 467).

Having said all that, the court affirmed because it regarded itself as bound by its own post-*Ruan* trilogy—*United States v. Anderson*, 67 F.4th 755 (6th Cir. 2023), *United States v. Bauer*, 82 F.4th 522 (6th Cir. 2023), and *United States v. Stanton*, 103 F.4th 1204 (6th Cir. 2024)—which treats a generic willful blindness instruction as "substantially" covering *Ruan*. *Campbell*, 135 F.4th at 388-89.

The panel then rejected several distinctions the defendants pressed. First, defendants argued the "good-faith" instruction compounded the error by defining good faith in objective terms ("acted in accordance with what he reasonably believed to be proper medical practice"), which *Ruan* rejected. The court acknowledged *Bauer* had called similar language "muddying," but held *Bauer* still binds and does not compel reversal. *Campbell*, 135 F.4th

at 389 (discussing *Bauer*, 82 F.4th at 532-33). Second, Campbell argued that the willful blindness paragraph's reference to patient "diversion" improperly equated diversion with lack of authorization; the panel disagreed, reasoning the paragraph permitted only an inference of knowledge, not a substitution of elements, and otherwise mirrored *Anderson*'s approved formulation. Id. at 388-89. Finally, the court declined to entertain a categorical bar on willful blindness instructions in CSA cases, citing its own precedents to the contrary. Id. at 389.

Although the § 841 counts yielded acquittals, the panel sustained the § 846 conspiracy based on clinic operations evidence: PPC's high volume flow; Dyer's seeing up to fifty patients every morning and prescribing opioids to "more than 90%"; pre-signed scripts; prescriptions despite failed drug screens; short visits; cross-border signing; and out-of-state travelers—"similar evidence" the Sixth Circuit has previously found sufficient. Id. at 389-90 (citing *Stanton*, 103 F.4th at 1210-11; *United States v. Elliott*, 876 F.3d 855, 863-64 (6th Cir. 2017)).

For present purposes, *Campbell* is instructive in two ways. Doctrinally, it confirms the precise dilemma prompting review: a circuit can fully recite *Ruan*'s rule, diagnose that the jury was never told to find knowledge of lack of authorization, and yet affirm because earlier circuit cases say a willful blindness paragraph "substantially covers" the missing element—even in § 846 conspiracies. *Campbell*, 135 F.4th at 387-89. Practically, it shows how the combination of (i) an elements paragraph drained of *Ruan*'s subjective-authorization requirement, (ii) a willful blindness paragraph keyed to objective "usual course/ legitimate purpose" language and patient diversion, and

(iii) a generic conspiracy framework can produce drug trafficking that results in convictions in a medical setting that turn on negligence-like proxies rather than the defendant's actual knowledge. The panel itself reiterates that these "are not the instructions that should be used in unauthorized distribution cases going forward," quoting *Bauer*—but affirms anyway because "those holdings bind us." Id. at 388 (quoting *Bauer*, 82 F.4th at 533).

In short, *Campbell* lays bare the post-*Ruan* landscape in the Sixth Circuit: even where courts acknowledge that juries were not told to find knowledge of unauthorization, convictions stand under *Anderson/Bauer/Stanton*. That approach entrenches a negligence-adjacent standard in § 841 and § 846 prosecutions and squarely presents the need for this Court to say, unequivocally, that the *Ruan* element must appear in the elements paragraph and cannot be supplied by willful blindness inferences or conspiracy boilerplate.

Only this Court can act.

VI. The Eighth Circuit Injects a "National" Prescribing Standard, Where None Exists

The Eighth Circuit's recent decision in *Parker* provides a revealing snapshot of how some courts have grappled with—and, in practice, pared back—this Court's holding in *Ruan*. Dr. Lonnie Joseph Parker, a licensed Arkansas physician, was convicted by a jury of four § 841 counts for prescribing oxycodone and promethazine with codeine "in a manner unauthorized by the [CSA]" and sentenced to 87 months; the jury acquitted him of a fifth § 841 count

and of the § 841(b)(1)(C) "death results" enhancement. Slip Opinion at 1-4, *United States v. Parker*, No. 24-2813, (8th Cir. Aug. 1, 2025).

The facts the panel recites are familiar from post-*Ruan* prosecutions. After a motorist (identified as N.C.) was arrested in Texas and later died, DEA agents suspected Parker's Texarkana clinic of operating as a "pill mill," executed a search warrant, and retained a pain-management expert (Dr. Mark Rubenstein) to review a subset of charts. At trial, the government's expert opined that Parker failed to conduct necessary examinations, prescribed "excessive" quantities or inappropriate drugs, and kept deficient records; the government highlighted "red flags" and Arkansas regulatory criteria. Id. at 2-3. On that record, the panel held the evidence sufficient because the jury could accept the expert's view that the prescriptions were not "appropriate for the claimed ailment" or were "excessive," treating those conclusions as proof of prescribing without a "legitimate medical purpose." Id. at 5 (citing 21 C.F.R. § 1306.04(a) and relying on *United States v. Heaton*, 59 F.4th 1226, 1246 (11th Cir. 2023)).

Two jury instructions framed the legal issues. First, Instruction No. 6 defined "legitimate medical purpose" and "usual course of professional practice" as "acting in accordance with appropriate criteria for prescribing controlled substances in the State of Arkansas." Slip Opinion at 3, 6, *Parker*, No. 24-2813, (8th Cir. Aug. 1, 2025). Second, Instruction No. 14 delivered a willful blindness charge keyed to patient addiction or diversion: the jury could find Parker "acted knowingly" if he believed there was a "high probability" that named patients "were

addicted to oxycodone" or "were diverting promethazine with codeine cough syrup," and he "took deliberate actions to avoid learning of that fact." Id. at 3, 6-7. Although the court also instructed on "good faith" (Instruction No. 13), the fulcrum of the government's case—as the panel's sufficiency analysis confirms—was objective nonconformity with Arkansas prescribing criteria coupled to an addiction/diversion focused willful blindness path to "knowledge." Id. at 3-7.

On appeal, Parker argued—in essence—that *Ruan* requires the government to prove he *knew* his prescribing was *unauthorized*, not merely that an expert could later label it excessive or inconsistent with Arkansas guidance; he further challenged the state-law definition of authorization and the willful blindness charge.

Applying plain-error review (because the objections were not preserved), the Eighth Circuit rejected each challenge. On Instruction No. 6, the panel concluded nothing in § 841 "suggests that a physician's conduct must be compared to a national standard," and it read *Ruan* as addressing only the *mens rea*, not the source of objective criteria. Slip Opinion at 6, *Parker*, No. 24-2813, (8th Cir. Aug. 1, 2025) On Instruction No. 14, the panel accepted that "treating addicted patients is not in and of itself criminal," but, citing *Boyde*, refused to "judge [a] single instruction in artificial isolation," emphasizing that the overall charge included "legitimate medical purpose/usual course" and "good faith" language and that the willful blindness paragraph described "a willfully blind defendant" as one who "can almost be said to have actually known the critical facts." Id. at 7 (cleaned up). Finally, it rejected the claim that *Global-Tech* requires the court to

specify the "critical fact" in the charge, reading *Global-Tech* to require only belief in a high probability plus deliberate avoidance. Id. at 8 (citing 563 U.S. 754, 769 (2011)).

Parker thus illustrates three ways in which lower courts can, post-*Ruan*, ratchet the government's burden downward and a physician's burden upward while plausibly reciting *Ruan*'s words. First, by defining "legitimate medical purpose/usual course" in purely state-law terms—"appropriate criteria … in the State of Arkansas"—the instruction invites conviction for deviations from state guidance without ever requiring the jury to find that this physician "knew or intended" his prescribing was unauthorized under the CSA. Slip Opinion at 6, *Parker*, No. 24-2813, (8th Cir. Aug. 1, 2025) That approach risks a 50-state patchwork of criminal exposure and blurs the difference between civil/regulatory noncompliance and federal felonies—a distinction *Ruan* underscored when it tied *mens rea* to the "except as authorized" clause and cautioned that liability cannot "turn on the mental state of a hypothetical reasonable doctor." See *Ruan*, 142 S. Ct. at 2378-79; cf. Slip Opinion at 5-6, *Parker*, No. 24-2813, (8th Cir. Aug. 1, 2025) (resting sufficiency on "excessive" or "inappropriate" prescriptions under Arkansas criteria).

Second, by reorienting willful blindness away from "authorization" and toward patient behavior—addiction and diversion—Instruction No. 14 permits a jury to find "knowledge" if a doctor suspected addiction/diversion and avoided confirming it, even if jurors were never directed to decide whether he knew his *own conduct* was unauthorized. That is the very "stacking" problem surfacing elsewhere: willful blindness becomes a back-

door substitute for an omitted element. The panel's reliance on viewing the charge "as a whole" does not cure a misdirected mens rea; it simply makes the path to conviction smoother by pairing state-law yardsticks with an addiction-centric knowledge inference. Slip Opinion at 6-7, *Parker*, No. 24-2813, (8th Cir. Aug. 1, 2025)

Third, plain-error review allowed the court to sidestep whether these formulations are wrong as a matter of law after *Ruan*. The panel emphasized forfeiture and faulted Parker for not identifying a concrete divergence between Centers for Disease Control (CDC) guidance and Arkansas criteria. Id. at 6. But the *Ruan* problem is not CDC-versus-Arkansas; it is element-versus-proxy. When "authorization" is effectively equated to compliance with state "appropriate criteria," and "knowledge" is proved by suspicion of patient addiction or diversion, juries are never squarely asked to decide the *Ruan* element: whether the physician knew or intended to prescribe without authorization under the CSA. Id. at 5-7.

In short, *Parker* shows a post-*Ruan* template that elevates the conduct a physician must undertake to "escape prosecution" (compliance with state-specific criteria, exhaustive examinations, exhaustive records) while lowering what the government must prove about the physician's state of mind (substituting addiction/diversion-based willful blindness for actual knowledge of unauthorized prescribing). It is a faithful recitation of *Ruan*'s language paired with an operational regression to pre-*Ruan* objectivity.

That is precisely the fall that this Court should arrest by clarifying that knowledge of unauthorization is an

element that must be placed in the *elements* paragraph—equally in § 841 and § 846—and may not be supplied by state-law proxies or addiction-focused willful blindness glosses. *See generally* Slip Opinion at 1-9, *Parker*, No. 24-2813, (8th Cir. Aug. 1, 2025)

VII. The Sixth Circuit's Approach Illustrates How Willful Blindness Instructions, Untethered to *Ruan*'s Elemental Requirement, Gut the "Knowing" Standard.

The deliberate ignorance charge has a legitimate but narrow role: it permits juries to treat purposeful avoidance as knowledge where the defendant believes a fact is highly probable and deliberately avoids confirming it. See, e.g., *Global-Tech Appliances*, *Inc. v. SEB S.A.*, 563 U.S. 754, 769 (2011). In physician-prosecution cases, the Sixth Circuit has transformed that narrow doctrine into a primary vehicle for conviction—permitting juries to find "knowledge" if the defendant "deliberately ignored a high probability" that prescriptions lacked a "legitimate medical purpose" or were outside the "usual course," while never requiring a finding that he knew his conduct was "unauthorized." *Anderson*, 67 F.4th at 766, 772 ("No one can avoid responsibility … by deliberately ignoring the obvious." "If you are convinced that the defendant deliberately ignored a high probability … then you may find that the defendant knew this was the case.").

Bauer candidly recognized the problem, noting that *Anderson*-style charges "do not fully comport with Ruan," yet deeming them sufficient because Anderson "controls." 82 F.4th at 533. *Stanton* then extends the same logic to conspiracies, insulating convictions from

Ruan's element by declaring proof of unauthorized prescriptions beside the point in § 846 cases. 103 F.4th at 1210-13. That is precisely the dynamic *Ruan* sought to prevent. The government may rely on "objective criteria" as circumstantial evidence, but it must still prove that the physician knew or intended his conduct was unauthorized. 597 U.S. at 466-67.

VIII. The Court Should Grant Certiorari to Restore *Ruan*'s *Mens Rea* and Resolve the Entrenched Conflict.

The Sixth Circuit has now issued a trilogy that, taken together, invites juries to convict physicians (and to uphold conspiracy convictions) based on aggregated "red flags," administrative noncompliance, and advisory threshold exceedances—while substituting willful blindness for the element *Ruan* requires. *Anderson* says the defect is close enough because willful blindness "substantially covered" knowledge, 67 F.4th at 766; *Bauer* admits the pattern "do[es] not fully comport with Ruan" but affirms anyway, 82 F.4th at 533; *Stanton* says the underlying § 841 authorization element "would have mattered only" if the charge were § 841, 103 F.4th at 1210-11. That approach is incompatible with *Ruan*'s holding and with basic conspiracy doctrine.

This case is an ideal vehicle to clarify that: (1) juries must be instructed that the government must prove the physician *knew or intended* that his prescribing was *unauthorized*; (2) objective evidence is circumstantial only, and cannot substitute for the element; (3) deliberate ignorance instructions must not be used to evade *Ruan*; and (4) § 846 prosecutions require the same *Ruan mens*

rea as § 841 because the object of the agreement is unauthorized distribution.

IX. The Uncertainty and Doctrinal Drift Under § 841 and 846 Hurts Patients and Chills Care

The stakes of this case are not theoretical, and they deeply impact 50 million Americans.[2]

When criminal standards blur, medicine bends toward fear, not care. The Centers for Disease Control and Prevention expressly cautions that its opioid guideline "should not be applied as inflexible standards of care," nor as "absolute limits," and that it is not intended to "lead to the rapid tapering or abrupt discontinuation of opioids." CDC, Clinical Practice Guideline for Prescribing Opioids for Pain—United States, 2022, 71 MMWR Recomm. Rep. 1 (No. RR-3) (Nov. 4, 2022) (internal section headings omitted). Those cautions exist because rigid rules about dose or duration predictably harm patients with severe pain. See U.S. Dep't of Health & Hum. Servs., *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics 1-2* (2019) ("Opioids should not be tapered rapidly or discontinued suddenly … [abrupt tapering] include[s] … serious psychological distress, and thoughts of suicide.").

The nation's largest physicians' organization has warned for years that the misapplication of public-health guidance—especially hard thresholds—has fueled undertreatment of pain and penalized individualized care.

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2. S. Michaela Rikard, PhD[1]; Andrea E. Strahan, PhD[1]; Kristine M. Schmit, MD[1]; Gery P. Guy Jr., PhD[1]

In urging revision of the 2016 guideline, the American Medical Association (AMA) explained that "arbitrary thresholds" had been turned into "hard law and inflexible policy," leaving "patients with pain [to] suffer from the undertreatment of pain and the stigma of having pain." Am. Med. Ass'n, *AMA Backs Update to CDC Opioid Prescribing Guidelines* (July 22, 2021). The CDC's own authors made the same point in the New England Journal of Medicine: post-2016 misapplications "include inflexible application of recommended dosage and duration thresholds and policies that encourage hard limits and abrupt tapering." Deborah Dowell, Tamara Haegerich & Roger Chou, *No Shortcuts to Safer Opioid Prescribing*, 380 N. Engl. J. Med. 2285, 2286-87 (2019).

Federal clinical guidance now uniformly directs collaborative, patient-centered care rather than fear-driven practice. The 2022 United States Department of Veterans Affairs and United States Department of Defense (VA/DoD) Chronic Pain Guideline warns that forced tapering—especially forced rapid tapering—"can destabilize patients," precipitating withdrawal, "worsening pain," and "increased suicidal ideations and attempts." U.S. Dep't of Veterans Affs. & U.S. Dep't of Def., *Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain 53* (May 2022). That is the front-line view of clinicians who actually treat pain, not an abstract policy concern.

These medical cautions align with a broader historical lesson: deputizing law enforcement to referee medical judgment reliably produces collateral damage. See Jeffrey A. Singer & Trevor Burrus,*Cops Practicing Medicine: The Parallel Histories of Drug War I and Drug War*

II 1-8 (Cato Inst. 2022) (tracing how prosecutions under the Harrison Narcotics Act and, later, the Controlled Substances Act intruded into clinical decision-making and chilled care. The same pattern is visible today. The Center for U.S. Policy has documented how "law enforcement and regulatory agencies (state and federal) misinterpreted the CDC Guidelines and used them to pursue 'opioid overprescribing' investigations," despite "longstanding warnings" that general guidelines "are not a substitute for prescriber judgment or patient consent." Ctr. for U.S. Policy, *Response to CDC's November 2024 Opioid Guideline Update 1-2* (Jan. 18, 2025).

The patient-level consequences are severe. Empirical work shows that tapering "too quickly or without appropriate support may harm patients," including deterioration in mental health and suicidality. See B.J.H. Yarborough et al., *Patient Perspectives on Mental Health and Pain During Opioid Tapering*, J. Pain (2024) (early online) (summarizing harms from unsupported tapering). The federal government's own clinician guide is equally blunt: unless there is an imminent, life-threatening risk, "HHS does not recommend abrupt opioid dose reduction or discontinuation," and clinicians "should never abandon patients." HHS Guide, *supra* p. 21, at 1-2.

When prosecutions press physicians to guess which evolving, nonbinding clinical criteria a jury may later treat as the yardstick for "usual course" or "legitimate medical purpose," rational doctors retreat. They discharge complex pain patients, decline referrals, and practice defensive medicine. See *Cops Practicing Medicine*, supra p. 22, at 4-8 (describing the rise of "pain refugees"—patients cut off from care—as enforcement intensifies). The human

toll is widely reported. See, e.g., Kate M. Nicholson, *The clampdown on opioid prescriptions is hurting pain patients, L.A. Times*, Jan. 18, 2019 (first-person account of undertreatment and stigma in care).

None of this is to deny the tragedy of overdose. It is to insist on the right target. As the AMA emphasized, the modern overdose crisis "is now mostly fueled by illicitly manufactured fentanyl," not prescriptions to stabilized patients; yet rigid thresholds continue to be "used against patients with pain to deny care."AMA Guidelines, *supra* p. 22. Public-health authorities themselves ask policymakers to avoid turning flexible guidance into criminal rules. See CDC 2022 Guideline, *supra* p. 21 (stressing individualized decisions and warning against inflexible applications).

This Court should therefore grant review to prevent prosecutorial and instructional practices that effectively convert clinical guidelines into *per se* criminal standards. *Ruan* holds that § 841's "knowingly or intentionally" *mens rea* applies to the "except as authorized" clause; liability thus turns on the physician's subjective knowledge or intent that her prescriptions were unauthorized—not on whether a juror later deems them inconsistent with an administrative guideline. See *Ruan v. United States*, 142 S. Ct. 2370 (2022). Allowing deliberate ignorance instructions to stand in for actual knowledge based on nothing more than nonconformity with evolving guidance reintroduces strict-liability risks through the back door and invites the very chill *Ruan* rejected. A uniform, text-true standard is not a gift to scofflaws; it is the only way to ensure that criminal law does not punish good-faith medical judgment or force physicians to choose between liberty and their patients.

Finally, consistency matters. Variations among circuits about what conduct suffices to "knowingly" prescribe "outside the usual course" leave physicians guessing and patients suffering. HHS, the VA/DoD, and the CDC have all emphasized individualized, patient-centered care and warned against hard caps and abrupt discontinuation. HHS Guide, *supra* p. 21, at 1-3; VA/DoD Guidline, *supra* p. 22, at 51-53; CDC 2022 Guideline, *supra* p. 22. Those same institutions have acknowledged that misapplication of the 2016 guideline caused harm; the 2022 update course corrected. The criminal law should not lag behind. By clarifying that § 841 and § 846 require proof beyond a reasonable doubt of a physician's actual knowledge or intent that her prescribing was unauthorized—and by warning against "stacking" deliberate ignorance on top of thin evidence tethered only to guideline nonconformity—the Court would align doctrine with medicine and reduce the mounting, unnecessary suffering of patients with severe pain.

CONCLUSION

The Court should grant the petition and make clear that *Ruan* means what it says: the "knowingly or intentionally" *mens rea* attaches to the "except as authorized" clause, in § 841 and in conspiracies to violate it, and it cannot be displaced by deliberate ignorance instructions that invite conviction without proof of the indispensable element.

Respectfully Submitted,

Melissa M. Salinas
University of Michigan
Law School
Federal Appellate
Litigation Clinic
2058 Jeffries Hall,
Room 2058
701 South State Street
Ann Arbor, MI 48104

Ronald W. Chapman II
Counsel of Record
1441 West Long Lake Road,
Suite 310
Troy, MI 48098
(248) 644-6326
rwchapman@
chapmanlawgroup.com

Counsel for Amicus Curiae