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Gonzales v. Oregon: Physician-Assisted Suicide and the Controlled Substances Act

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Gonzales v. Oregon: Physician-Assisted Suicide and the Controlled Substances Act

Summary

The State of Oregon's Death with Dignity Act (DWDA) is the first and only state law in the nation that legalizes physician-assisted suicide. The DWDA permits Oregon physicians to prescribe a lethal dose of medication to mentally competent, terminally ill patients, who then may voluntarily elect to hasten their death.

Under the Controlled Substances Act (CSA), a federal law that regulates the legal and illicit manufacture, distribution, and possession of drugs, a physician may prescribe controlled substances to patients only for a "legitimate medical purpose." In 2001, then-U.S. Attorney General John Ashcroft issued a memorandum in which he declared that physician-assisted suicide is not a "legitimate medical purpose" for prescribing federally controlled substances. The "Ashcroft Directive" means that any Oregon doctor who prescribes drugs pursuant to the DWDA would be in violation of the federal CSA, and risks losing his or her privilege to prescribe drugs and possibly face criminal prosecution.

On November 7, 2001, the State of Oregon, an Oregon physician and pharmacist, and several terminally ill patients filed a lawsuit to prevent the enforcement of the Ashcroft Directive. A federal district court and the U.S. Court of Appeals for the Ninth Circuit held the Directive invalid and unenforceable because Congress did not authorize the Attorney General to determine that physician-assisted suicide is not a legitimate medical purpose under the CSA. These courts determined that Congress did not intend for the CSA to override a state's traditional power to regulate the practice of medicine.

Attorney General Ashcroft appealed the Ninth Circuit's decision to the U.S. Supreme Court. Alberto Gonzales had replaced John Ashcroft as Attorney General by the time the Court agreed to review the case. On October 5, 2005, the Supreme Court heard the parties' oral argument. The Court in *Gonzales v. Oregon* is to decide whether the CSA authorizes the Attorney General to prohibit the distribution of federally controlled substances for purposes of facilitating an individual's suicide, regardless of Oregon's law authorizing such distribution.

This report will be updated after the Supreme Court issues its decision.

Contents

| | |
|---|----|
| Introduction | 1 |
| Background | 1 |
| The Controlled Substances Act | 1 |
| Oregon's Death with Dignity Act | 2 |
| The Ashcroft Directive | 3 |
| Prior Case History | 4 |
| U.S. District Court's Decision | 4 |
| The Ninth Circuit's Decision | 5 |
| Discussion | 7 |
| Federalism and State Sovereignty | 7 |
| Statutory Interpretation of the CSA | 10 |
| Standard of Judicial Review | 11 |
| Concluding Observations | 14 |

Gonzales v. Oregon: Physician-Assisted Suicide and the Controlled Substances Act

Introduction

Gonzales v. Oregon,¹ argued before the United States Supreme Court during its October 2005 term, generated considerable publicity and public interest in physician-assisted suicide and end-of-life decision-making. Yet the legal dispute in *Oregon* does not require the Court to resolve authoritatively the moral, political, ethical, medical, and emotional debate over physician-assisted suicide. Rather, the Court is to rule on a technical legal question: Whether the U.S. Attorney General has permissibly construed the Controlled Substances Act (CSA) and its implementing regulations to prohibit distribution of federally controlled substances for purpose of facilitating an individual's suicide, regardless of the State of Oregon's law that authorizes such distribution.

Given this narrowly drawn issue, the Court need not express an opinion on the merits of physician-assisted suicide. Instead, the outcome of the case will likely turn on statutory interpretation of the CSA and the degree of judicial deference accorded to the decisions of administrative agency officials. This report explains the background of this case and analyzes the arguments offered by the parties to the Supreme Court. The report is intended to provide an overview of only the specific legal issues involved in the *Oregon* case,² and it will not offer predictions as to the ultimate decision of the Court.

Background

The Controlled Substances Act. Congress enacted the CSA as Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970.³ The purpose of the CSA is to regulate the use of controlled substances for legitimate medical purposes and to prevent these substances from being diverted for illegal manufacture, distribution, and use. Controlled substances are categorized into five schedules, ranging from Schedule I substances that have no currently accepted medical use in treatment and can only be used in very limited circumstances, to substances in

¹ *Oregon v. Ashcroft*, 368 F.3d 1118 (9th Cir. 2004), *cert. granted*, *Gonzales v. Oregon*, 125 S. Ct. 1299 (2005).

² For a detailed discussion concerning the "right to die" and assisted suicide, *see* CRS Report 97-244A, *The "Right to Die": Constitutional and Statutory Analysis*, by Kenneth R. Thomas.

³ P. L. 91-513, 84 Stat. 1236 (1970) (codified at 21 U.S.C. §§ 801-904).

Schedules II, III, IV, and V that have recognized medical uses and may be manufactured, distributed, and used in accordance with the CSA.⁴

It is unlawful for a physician to prescribe or dispense controlled substances without first registering with the U.S. Attorney General and obtaining a Drug Enforcement Administration (DEA) certificate.⁵ A prescription for a controlled substance may be issued only for a “legitimate medical purpose” by a physician “acting in the usual course of his professional practice.”⁶ The CSA authorizes the Attorney General to suspend or revoke a physician’s prescription privileges upon a finding that the physician has “committed such acts as would render his registration ... inconsistent with the public interest.”⁷ In determining the public interest, the Attorney General is required to consider the following factors:⁸

- The recommendation of the appropriate State licensing board or professional disciplinary authority.
- The applicant’s experience in dispensing, or conducting research with respect to controlled substances.
- The applicant’s conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.
- Compliance with applicable State, Federal, or local laws relating to controlled substances.
- Such other conduct which may threaten the public health and safety.

Oregon’s Death with Dignity Act. Oregon’s Death with Dignity Act (DWDA) is the first and only state law in the nation that legalizes physician-assisted suicide.⁹ The DWDA specifies detailed requirements and procedures by which a mentally competent, terminally ill adult resident of Oregon may voluntarily make a “written request for medication for the purpose of ending his or her life in a humane and dignified manner.”¹⁰ The patient must be suffering from “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”¹¹ The patient’s written request

⁴ See 21 U.S.C. § 812.

⁵ 21 U.S.C. §§ 822, 841(a)(1).

⁶ 21 C.F.R. § 1306.04(a).

⁷ 21 U.S.C. § 824(a)(4).

⁸ 21 U.S.C. § 823(f).

⁹ OR. REV. STAT. §§ 127.800-897. This act was enacted through a voter initiative process in November 1994. After surviving legal challenges and a ballot measure that would have repealed it, the DWDA went into effect in November 1997.

¹⁰ OR. REV. STAT. § 127.805(1).

¹¹ OR. REV. STAT. § 127.800(12).

must be signed and dated in the presence of at least two witnesses who attest that the patient is competent and acting voluntarily.¹²

Under the DWDA, an Oregon physician may prescribe, but not administer, lethal doses of medication to enable the patient to end his or her life.¹³ The most effective and reliable means for painlessly ending a terminally ill person's life is by ingesting certain controlled substances listed under Schedule II of the CSA.¹⁴ Between 1998 and 2004, 208 persons in Oregon chose to take their lives pursuant to the DWDA.¹⁵ The most frequently given reasons for terminally ill patients making prescription requests under the DWDA are: a decreasing ability to participate in activities that made life enjoyable, loss of autonomy, and a loss of dignity.¹⁶

The Ashcroft Directive. In 1997, in reaction to a congressional inquiry, the DEA Administrator issued an opinion letter which stated that assisting suicide is not a "legitimate medical purpose" under the CSA, and therefore Oregon physicians and pharmacists would be violating the CSA if they acted under the DWDA to prescribe or dispense controlled substances.¹⁷ However, on June 5, 1998, after conducting "a thorough and careful review of the issue," then-Attorney General Janet Reno overruled the DEA Administrator's determination, explaining that the CSA was not "intended to displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice."¹⁸ She concluded that "the CSA does not authorize the DEA to prosecute, or to revoke DEA registration of, a physician who has assisted in a suicide in compliance with Oregon law."¹⁹

In response, some Members of Congress introduced bills in 1998 and 1999 to amend the CSA to "provide explicit clarification that the dispensing or distribution of controlled substances to assist with a suicide ... is not a legitimate medical purpose."²⁰ The Lethal Drug Abuse and Prevention Act of 1998²¹ would have required the Attorney General to determine that a physician's DEA registration is

¹² OR. REV. STAT. § 127.810(1).

¹³ See Brief for Respondent State of Oregon, at 2 n.2, *Gonzales v. Oregon*, No. 04-623 (July 18, 2005) ("[N]either the physicians who prescribe nor the pharmacists who dispense drugs under the DWDA may provide physical assistance to the patient.").

¹⁴ *Oregon v. Ashcroft*, 368 F.3d 1118, 1123 n.5 (2004); *Oregon v. Ashcroft*, 192 F.Supp. 2d 1077, 1082 (2002).

¹⁵ Oregon Department of Human Services, *Seventh Annual Report on Oregon's Death with Dignity Act*, 5 (2005), available at [<http://egov.oregon.gov/DHS/ph/pas/docs/year7.pdf>].

¹⁶ *Id.* at 15.

¹⁷ *Oregon*, 368 F.3d at 1132 (Wallace, J., dissenting).

¹⁸ Statement of Attorney General Reno on Oregon's Death with Dignity Act (June 5, 1998), available at [<http://www.usdoj.gov/opa/pr/1998/June/259ag.htm.html>].

¹⁹ *Id.*

²⁰ S. REP. NO. 105-372, at 4, 105th Cong., 2nd Sess. (1998).

²¹ H.R. 4006, 105th Cong., 2nd Sess. (1998).

inconsistent with the public interest (and thus subject to suspension or revocation), upon a finding that the registrant has intentionally dispensed or distributed a controlled substance with the purpose of causing, or assisting in causing, the suicide or euthanasia of an individual.²² The Pain Relief Promotion Act of 1999²³ would have prohibited the Attorney General, in evaluating whether a DEA registration is consistent with the public interest, from giving any force and effect to state laws authorizing assisted suicide or euthanasia. However, neither of these bills passed the Senate.²⁴

After John Ashcroft became the new Attorney General, the Department of Justice's interpretation of the CSA changed. On November 6, 2001, Attorney General Ashcroft issued a memorandum to the DEA Administrator which reversed the legal analysis of his predecessor. This interpretive rule, known as the "Ashcroft Directive," states that the Attorney General has determined:

"[A]ssisting suicide is not a 'legitimate medical purpose' within the meaning of 21 C.F.R. § 1306.04 (2001), and that prescribing, dispensing, or administering federally controlled substances to assist suicide violates the CSA. Such conduct by a physician registered to dispense controlled substances may 'render his registration ... inconsistent with the public interest' and therefore subject to possible suspension or revocation under 21 U.S.C. § 824(a)(4). This conclusion applies regardless of whether state law authorizes or permits such conduct by practitioners or others and regardless of the condition of the person whose suicide is assisted."²⁵

On November 7, 2001, the State of Oregon, joined by an Oregon physician and pharmacist and several terminally ill patients, filed a lawsuit for declaratory and injunctive relief together with a motion for a temporary restraining order to enjoin the enforcement of the Ashcroft Directive.

Prior Case History

U.S. District Court's Decision. On November 8, 2001, a U.S. district judge granted Oregon's motion for a temporary restraining order.²⁶ After a full hearing on the merits in March 2002, the district judge entered a permanent injunction which effectively invalidated the Ashcroft Directive. Relying on statutory interpretation and the legislative history of the CSA, the district judge concluded that the Ashcroft

²² The bill provided exceptions for palliative care and for carrying out a death sentence under federal or state law.

²³ H.R. 2260, 106th Cong., 1st Sess. (1999).

²⁴ *Oregon*, 192 F.Supp. 2d at 1083 n.6 ("The Lethal Drug Abuse and Prevention Act of 1998 ... failed to reach the floor of either the House or the Senate. The Pain Relief Promotion Act of 1999 passed the House in 1999, but failed to reach the Senate floor for a vote."). See also CRS Report RS20677, *Assisted Suicide and the Controlled Substances Act: Legal Issues Associated with the Proposed Pain Relief Promotion Act*, by Kenneth R. Thomas.

²⁵ 66 Fed. Reg. 56,608.

²⁶ *Oregon*, 192 F.Supp. 2d at 1084.

Directive exceeded the authority delegated to the Attorney General under the CSA.²⁷ In dicta, he observed: “To allow an attorney general — an appointed executive whose tenure depends entirely on whatever administration occupies the White House — to determine the legitimacy of a particular medical practice without a specific congressional grant of such authority would be unprecedented and extraordinary.”²⁸ Attorney General Ashcroft then appealed the court’s decision to the U.S. Court of Appeals for the Ninth Circuit.

The Ninth Circuit’s Decision. On May 24, 2004, a divided panel of the court of appeals adopted many of the district judge’s conclusions²⁹ and held that the Ashcroft Directive is “unlawful and unenforceable.”³⁰ In support of its determination, the majority opinion cited federalism concerns, statutory interpretation, and the legislative history of the CSA.

The appellate court first noted that in our system of federalism, “state lawmakers, not the federal government, are ‘the primary regulators of professional [medical] conduct.’”³¹ The Ashcroft Directive “interferes with Oregon’s authority to regulate medical care within its borders” by criminalizing medical practices specifically authorized under Oregon law.³² The court explained that Congress has not provided an “unmistakably clear” indication that it intended to authorize the Attorney General to regulate the practice of physician-assisted suicide.³³ Without a “clear statement” manifesting such congressional purpose, the court asserted, federal authority may not be exercised over an area of law traditionally reserved for the states, such as the regulation of medical care.³⁴

As a second basis for invalidating the Directive, the panel majority argued that the Directive is contrary to the plain language of the CSA, in three respects:³⁵

- The scope of federal authority under the CSA is expressly limited to the “field of drug abuse.” Congress did not intent physician-assisted suicide to be considered a form of drug “abuse.”

²⁷ *Id.* at 1085.

²⁸ *Id.* at 1091.

²⁹ The Ninth Circuit panel first concluded that the district court lacked jurisdiction over final determinations of the Attorney General made under the CSA. Pursuant to the CSA’s judicial review provision, 21 U.S.C. § 877, the court of appeals asserted original jurisdiction to review the case. *Oregon*, 368 F.3d at 1120 n.1.

³⁰ *Id.* at 1120.

³¹ *Id.* at 1124 (citation omitted).

³² *Id.*

³³ *Id.* at 1125.

³⁴ *Id.* (citing *Solid Waste Agency of N. Cook County v. U.S. Army Corps of Eng’rs*, 531 U.S. 159, 172-73 (2001)).

³⁵ *Oregon*, 368 F.3d at 1125.

- The Attorney General made a unilateral medical determination in violation of the CSA’s statutory requirement that the Secretary of Health and Human Services make such determinations.
- While the CSA authorizes the Attorney General to revoke prescription privileges for physician conduct that is inconsistent with the public interest, the Attorney General had failed to consider all five factors in evaluating the public interest. Since the text of the Directive states that it will apply “regardless of whether state law authorizes or permits” assisted suicide, the Attorney General ignored the first factor that the CSA required him to consider: “the recommendation of the appropriate State licensing board or professional discipline authority.”

Finally, the majority opinion examined the CSA’s legislative history and found no support for the Attorney General’s proclamation that physician-assisted suicide violates the CSA. The CSA was enacted to combat the problem of drug abuse and addiction and to prevent the diversion of drugs out of legitimate channels of distribution into the illegal market.³⁶ The DWDA does not contribute to these problems.

Since the Ashcroft Directive exceeds the scope of the CSA for the reasons mentioned above, the appellate court reasoned that the Attorney General’s interpretation is not entitled to judicial deference under principles of administrative law.³⁷

The Dissent. The Ninth Circuit panel’s dissenting judge emphasized that the sole legal issue in this case is whether the Ashcroft Directive is entitled to judicial deference. In his opinion, “customary canons of deference to agency action” requires the court to uphold the Attorney General’s interpretive rule as valid and controlling.³⁸ In reaching this conclusion, the dissenting judge largely rejected the majority’s analysis of the CSA.

First, he disputed the majority opinion’s claim that the CSA is expressly limited to the field of drug abuse; instead, he could find nothing in the CSA’s text which would preclude its application to physician-assisted suicide.³⁹ In addition, the dissent cited a portion of the CSA’s legislative record that quoted some Members of Congress as identifying “suicides and attempted suicides” as a “misuse of a drug.”⁴⁰

³⁶ *Id.* at 1128.

³⁷ *Id.* at 1129 (“Agency determinations that squarely conflict with governing statutes are not entitled to deference.” *Chevron U.S.A., Inc. v. Natural Res. Def. Council*, 467 U.S. 837, 842-43 (1984).)

³⁸ *Oregon*, 368 F.3d at 1131, 1133 (Wallace, J., dissenting).

³⁹ *Id.* at 1135-36.

⁴⁰ *Id.* at 1136 (citing H.Rept. 91-1444 (1970), reprinted in 1970 U.S.C.C.A.N. 4566, 4572).

He also argued that the “clear statement rule” does not apply to the CSA since the Ashcroft Directive did not raise “grave and doubtful” concerns about the constitutionality of the CSA.⁴¹ Congress acts well within its Commerce Clause power when it regulates interstate economic activity related to the prescribing and dispensing of controlled substances. By prohibiting the dispensing of controlled substances for physician-assisted suicide, the Ashcroft Directive does not “invoke[] the outer limits of Congress’ power” by encroaching on state authority to regulate medical practices.⁴²

Since the dissent determined that the Attorney General acted “well within the scope of his statutory authority,”⁴³ and that the Directive is an interpretation of an agency regulation rather than a statutory interpretation of the CSA itself, a “highly deferential standard of review” is mandated by “firmly established principles of administrative law.”⁴⁴ Finally, the dissenting judge opined:

The Ashcroft Directive does not spell the end of the public’s “earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide,” nor does it halt states’ “extensive and serious evaluation of physician-assisted suicide and other related issues.” ... [It] is not even an immutable expression of *federal* policy. A change in presidential administrations or a shift in the current President or Attorney General’s perspective might precipitate the Ashcroft Directive’s rescission. Certainly, Congress is free to enact legislation limiting or counteracting the Ashcroft Directive’s effects.⁴⁵

Discussion

As the Ninth Circuit’s majority and dissenting opinions demonstrate, the legal issues raised in *Oregon* are subject to plausible, supportable differences in opinion. The U.S. Supreme Court will likely consider these differing views and balance federalism concerns, statutory interpretation, and administrative law principles, in order to decide whether the CSA authorizes the Attorney General to prohibit the distribution of controlled substances for physician-assisted suicide purposes.

Federalism and State Sovereignty. Both the U.S. district court and the court of appeals in *Oregon* cited *Washington v. Glucksberg*⁴⁶ as judicial precedent for upholding the DWDA.⁴⁷ This decision was the last time prior to *Oregon* that the Supreme Court considered the issue of physician-assisted suicide. In *Glucksberg*, the

⁴¹ *Id.* at 1142 (citation omitted).

⁴² *Id.* at 1143 (citation omitted).

⁴³ *Id.* at 1140.

⁴⁴ *Id.* at 1145, 1149.

⁴⁵ *Id.* at 1148 (quoting *Washington v. Glucksberg*, 521 U.S. 702, 735-37 (1997)) (emphasis in original).

⁴⁶ 521 U.S. 702 (1997).

⁴⁷ *Oregon*, 368 F.3d at 1123-24; *Oregon*, 192 F. Supp. 2d at 1078.

Court decided that the State of Washington’s prohibition against “causing” or “aiding” a suicide did not offend the Fourteenth Amendment to the United States Constitution.⁴⁸ Since the Due Process Clause does not protect or provide a fundamental liberty interest in obtaining assistance with suicide, the Washington law banning such practice survives constitutional attack.

However, at the close of the *Glucksberg* opinion, the Court stated: “Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.”⁴⁹ In elaboration of this point, Justice Sandra Day O’Connor offered a concurrence in which she stated:

There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State’s interests in protecting those who might seek to end life mistakenly or under pressure. ... States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. ... In such circumstances, “the ... challenging task of crafting appropriate procedures for safeguarding ... liberty interests is entrusted to the ‘laboratory’ of the States ... in the first instance.”⁵⁰

The State of Oregon relies on this dicta in *Glucksberg* as supporting its argument that the physician-assisted suicide issue should be entrusted to state lawmakers under their traditional police powers to provide for the general welfare of their citizens.⁵¹ States have historically enjoyed independent, sovereign power to regulate the practice of medicine. Oregon thus appeals to the Court to invalidate the Ashcroft Directive on federalism grounds.⁵²

The U.S. Attorney General’s brief before the Supreme Court in *Oregon* dismisses Oregon’s reliance on *Glucksberg*. On the contrary, the Attorney General cites *Glucksberg* as judicial precedent for the proposition that physician-assisted suicide is not a legitimate medical treatment, since the Court in that case also had observed, “In almost every State — indeed, in almost every western democracy — it is a crime to assist a suicide. The States’ assisted-suicide bans are not innovations. Rather, they are longstanding expressions of the States’ commitment to the protection and preservation of all human life.”⁵³

⁴⁸ *Glucksberg*, 521 U.S. at 705-06.

⁴⁹ *Id.* at 735.

⁵⁰ *Id.* at 737 (O’Connor, J., concurring) (citations omitted).

⁵¹ Brief for Respondent State of Oregon, at 9, 40, *Gonzales v. Oregon*, No. 04-623 (July 18, 2005).

⁵² *Id.* at 29-30.

⁵³ Brief for the Petitioners, at 21-22, *Gonzales v. Oregon*, No. 04-623 (May 2005) (citing *Glucksberg*, 521 U.S. at 710-719).

It may be significant to note that *Glucksberg* only answered the question of state authority to prohibit physician-assisted suicide in the *absence* of federal regulation.⁵⁴ *Glucksberg* did not address whether the Attorney General could prevent the dispensing of controlled substances for physician-assisted suicide in an attempt to override a state’s law that validates such medical practice. However, the Attorney General notes that the Directive does not prohibit physician-assisted suicide outright: “[T]o the extent doctors in Oregon dispense substances other than those regulated under the CSA to hasten their patients’ deaths, the Attorney General’s interpretive ruling has no relevance to their conduct.”⁵⁵ In response to this claim, however, Oregon points out that since controlled substances are the best and most reliable means for ending a terminally ill patient’s life, “preventing Oregon physicians from using [these means] would make the law largely ineffective by making the ability to provide a quick, sure, and painless death speculative at best.”⁵⁶ Also, the Attorney General may suspend or revoke a physician’s prescription privilege for actions deemed inconsistent with the public interest; such conduct need not necessarily involve controlled substances.⁵⁷

The Attorney General raises concerns that the DWDA would prevent uniform federal enforcement of the CSA. He argues that there needs to be a “national definition” for what constitutes a “legitimate medical purpose” under the CSA and its implementing regulations.⁵⁸ The DWDA is a state law that frustrates the CSA’s objective in creating a “comprehensive federal scheme” for regulating controlled substances.⁵⁹

Supporting his claim that the CSA is binding federal law even when it invalidates medical practices authorized by state law, the Attorney General cites *United States v. Oakland Cannabis Buyers’ Cooperative*.⁶⁰ At issue in *Oakland Cannabis* was a California law that had created a medical necessity exception to its marijuana prohibitions. The Supreme Court held that a medical necessity defense for the cultivation and distribution of marijuana is “at odds with” the CSA, since marijuana is a Schedule I controlled substance that has been congressionally determined to have no accepted medical use in the United States.⁶¹ In June 2005, the Supreme Court ruled in *Gonzales v. Raich* that Congress has the power under the Commerce Clause to prohibit the cultivation or possession of marijuana for medical

⁵⁴ *Oregon*, 368 F.3d at 1137 (Wallace, J., dissenting).

⁵⁵ Brief for the Petitioners, at 44.

⁵⁶ Brief for Respondent State of Oregon, at 19.

⁵⁷ *Oregon*, 368 F.3d at 1123 n.5.

⁵⁸ Brief for the Petitioners, at 25.

⁵⁹ *Id.* at 26.

⁶⁰ Brief for the Petitioners, at 12, citing 532 U.S. 483 (2001).

⁶¹ *Oakland Cannabis*, 532 U.S. at 491. For more information concerning this decision, see CRS Report RL31100, *Marijuana for Medical Purposes: The Supreme Court’s Decision in United States v. Oakland Cannabis Buyers’ Cooperative and Related Legal Issues*, by Charles Doyle.

purposes, despite a California law that permitted it.⁶² Thus, federal authorities could prosecute medical marijuana users as violating the CSA.

Oregon distinguishes *Oakland Cannabis* and *Raich* by explaining that Congress has expressed an unambiguous intention to displace the states' determination of legitimate medical purpose for marijuana by categorizing it as a Schedule I controlled substance.⁶³ However, physicians acting pursuant to the DWDA prescribe Schedule II controlled substances, which have accepted medical uses. Congress has not clearly expressed an intent to permit the Attorney General "to ban any particular use of any scheduled drug ... and ... to identify any disfavored medical practice and declare that no scheduled drug could be used for that purpose."⁶⁴

Statutory Interpretation of the CSA. Neither the CSA nor its implementing regulations provide a definition for "legitimate medical purpose." Thus, for guidance on this potentially determinative matter, courts rely on the context and structure of the statutory text as well as the legislative history of the CSA.

According to the Attorney General's brief, the Supreme Court has previously noted that the federal government, not the states, normally defines the terms in federal laws in order to provide such laws with a single, nationwide definition.⁶⁵ The Attorney General reasons that the CSA requires a uniform federal meaning for "legitimate medical purpose" since that term provides an important limitation throughout the act. The Ashcroft Directive's opinion that assisted suicide is *not* a legitimate medical purpose is reasonable, the Attorney General asserts, since the same conclusion has been made by 49 states, other laws and policies of the federal government,⁶⁶ and leading associations of the medical profession.⁶⁷

Oregon emphasizes that there is no explicit language in the CSA authorizing the Attorney General to prohibit particular medical practices involving drugs that have accepted medical uses.⁶⁸ Furthermore, the CSA's legislative history reveals that Congress intended to limit the CSA to problems associated with drug abuse and addiction.⁶⁹ In enacting the CSA, Congress was particularly concerned about the

⁶² ___ U.S. ___, 125 S. Ct. 2195 (2005). For more information concerning this decision, see CRS Report RS22167, *Gonzales v. Raich: Congress' Power Under the Commerce Clause to Regulate Medical Marijuana*, by Todd B. Tatelman.

⁶³ Brief for Respondent State of Oregon, at 41.

⁶⁴ *Id.*

⁶⁵ Brief for the Petitioners, at 11 (citing *Mississippi Band of Choctaw Indians v. Holyfield*, 490 U.S. 30 (1989)).

⁶⁶ See, e.g., Assisted Suicide Funding Restriction Act of 1997, P.L. 105-12 (1997) (codified at 42 U.S.C. § 14402) (prohibiting the use of federal funds to pay for assisted suicide).

⁶⁷ Brief for the Petitioners, at 12.

⁶⁸ Brief for Respondent State of Oregon, at 11.

⁶⁹ The preamble to the CSA states its purpose: "to provide increased research into, and prevention of, drug abuse and drug dependence; to provide for treatment and rehabilitation (continued...)"

diversion of drugs from legitimate to illicit channels.⁷⁰ Oregon argues that the drugs prescribed under the DWDA are not being diverted into illicit markets, nor are such drugs being “abused”⁷¹ since they are not being used to feed addictions but rather to provide terminally ill patients with the “right to avoid the intractable pain or the loss of control and dignity that accompany some forms of fatal disease.”⁷² The Attorney General insists that the intentional taking of drugs to commit suicide is a form of drug “abuse” since the CSA permits the use of controlled substances only for “medical” purposes — “a word that connotes cure, amelioration, treatment, or prevention of disease.”⁷³

Standard of Judicial Review. How the Supreme Court analyzes the federalism and statutory interpretation issues discussed above may depend significantly upon the degree of judicial deference it accords the Attorney General’s interpretation of the CSA and its implementing regulations. There are three levels of judicial review that the Court may apply to the Ashcroft Directive: no deference (strict scrutiny of agency interpretation), intermediate deference (moderate scrutiny), and substantial deference (highly deferential to agency interpretation unless “plainly erroneous”).

No Deference. Oregon prevailed in the Ninth Circuit with its argument that the Ashcroft Directive should be given no judicial deference since the Attorney General exceeded his authority under the CSA to issue the interpretive rule. This argument is based on the “clear statement rule” as articulated in the Supreme Court case *Solid Waste Agency of Northern Cook County v. U.S. Army Corps of Engineers*:

Where an administrative interpretation of a statute invokes the outer limits of Congress’ power, we expect a clear indication that Congress intended that result. This requirement stems from our prudential desire not to needlessly reach constitutional issues and our assumption that Congress does not casually authorize administrative agencies to interpret a statute to push the limit of congressional authority. This concern is heightened where the administrative interpretation alters the federal-state framework by permitting federal encroachment upon a traditional state power.⁷⁴

⁶⁹ (...continued)

of drug abusers and drug dependent persons; and to strengthen existing law enforcement authority in the field of drug abuse.” Comprehensive Drug Abuse Prevention and Control Act of 1970, P.L. 91-513, 84 Stat. 1236 (1970) (preamble).

⁷⁰ *Raich*, 125 S. Ct. at 2203 (citations omitted).

⁷¹ The Ninth Circuit’s decision in *Oregon* also refused to characterize physician-assisted suicide as a form of drug “abuse,” instead calling it “a general medical practice regulated by the states.” *Oregon*, 368 F.3d at 1125-26.

⁷² Brief for Respondent State of Oregon, at 14-15, 18.

⁷³ Brief for the Petitioners, at 45.

⁷⁴ 531 U.S. 159, 172-73 (2001) (citations omitted).

Oregon claims, and the Ninth Circuit agreed, that Congress has not provided a “clear indication” that it intended to empower the Attorney General to regulate physician-assisted suicide. Without such clear congressional authorization, the Ashcroft Directive violates the clear statement rule since it “invokes the outer limits of Congress’ power” by encroaching on traditional state authority to regulate the practice of medicine.⁷⁵ The Ashcroft Directive’s definition of “legitimate medical purpose” is thus entitled to no judicial deference and is invalid.⁷⁶

However, as the Ninth Circuit dissenting judge in *Oregon* objected, “Not every colorable constitutional question triggers *Solid Waste*’s clear statement rule.”⁷⁷ The clear statement rule applies only when a condition precedent has been satisfied: the agency interpretation must invoke “the outer limits” of Congress’s power. Since Congress has extensive power under the Commerce Clause to regulate the channels of interstate commerce, the instrumentalities of interstate commerce, and activities that substantially affect interstate commerce,⁷⁸ the Ashcroft Directive appears to fall well within this federal authority. The recent Supreme Court case *Gonzales v. Raich* may add further support for this assessment, since that case had upheld Congress’ power to prohibit intrastate, noncommercial cultivation, possession, and use of marijuana for personal medical purposes.⁷⁹ Here, the Ashcroft Directive regulates physicians prescribing controlled substances for a fee, an economic transaction usually involving interstate commerce.⁸⁰ Thus, if the Court believes that the Ashcroft Directive does not “invoke[] the outer limits” of congressional authority, the clear statement rule would not apply.

Intermediate Deference. If the clear statement rule is deemed inapplicable, the Supreme Court would then need to clarify whether the Attorney General’s Directive concerning “legitimate medical purpose” represents a statutory interpretation of the CSA itself,⁸¹ or an agency interpretation of the CSA’s implementing regulations.⁸² In *United States v. Moore*,⁸³ the Supreme Court observed that various provisions of the CSA *imply* that a controlled substance may

⁷⁵ *Oregon*, 368 F.3d at 1125.

⁷⁶ As an alternative basis for according no deference to the Attorney General’s interpretation, the Ninth Circuit noted that the Ashcroft Directive conflicts with the plain language of the CSA and its legislative record. *Id.* at 1130 (“Agency determinations that squarely conflict with governing statutes are not entitled to deference.” *Chevron U.S.A., Inc., v. Natural Res. Def. Council*, 467 U.S. 837, 842-43 (1984)).

⁷⁷ *Oregon*, 368 F.3d at 1141 (Wallace, J., dissenting).

⁷⁸ *United States v. Lopez*, 514 U.S. 549, 558 (1995) (citations omitted).

⁷⁹ *U.S. ___*, 125 S. Ct. 2195 (2005).

⁸⁰ *Oregon*, 368 F.3d at 1142 (Wallace, J., dissenting).

⁸¹ The “findings and declarations” section of the CSA states, “Many of the drugs included within this title have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people.” 21 U.S.C. §§ 801(1).

⁸² 21 C.F.R. § 1306.04 states, “A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner.”

⁸³ 423 U.S. 122 (1975).

only be prescribed for a legitimate medical purpose, but such a requirement was made explicit in the implementing regulation.⁸⁴

This distinction is important because it will dictate whether the Court applies intermediate deference or substantial deference to the Directive. Under *Skidmore v. Swift & Co.*,⁸⁵ an administrative agency's interpretative rule that construes a statute is entitled to an intermediate standard of review. The intermediate deference standard is explained as follows: "the weight of [an agency interpretation] will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control."⁸⁶

Applying *Skidmore*, the Court would likely consider the fact that the Ashcroft Directive reverses the Justice Department's earlier pronouncement by Attorney General Reno. However, the Court has previously suggested that an agency interpretation that conflicts with past agency practices is not a sufficient reason, by itself, for a federal court to reject the agency's construction of a statute.⁸⁷ Another factor the Court could examine is the validity of the Attorney General's reasoning, since 49 states, other federal laws, and professional medical associations all have determined physician-assisted suicide as not being a "legitimate medical purpose."

Substantial Deference. If the Court regards the Ashcroft Directive as an interpretation of an agency regulation, rather than the CSA itself, it would accord it "substantial deference." This highly deferential review means that an agency's interpretation of its own regulation is given "controlling weight unless it is plainly erroneous or inconsistent with the regulation."⁸⁸

According to an agency regulation promulgated to implement the CSA, "A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner."⁸⁹ The Ashcroft Directive states that "assisting suicide is not a 'legitimate medical purpose' within the meaning of 21

⁸⁴ *Moore*, 423 U.S. at 138 n.13 ("On its face [21 U.S.C.] § 829 addresses only the form that a prescription must take. A written prescription is required for Schedule II substances. § 829(a). Either a written or an oral prescription is adequate for drugs in Schedules III and IV. § 829(b). The only limitation on the distribution or dispensing of Schedule V drugs is that it be 'for a medical purpose.' § 829(c). The medical purpose requirement explicit in subsection (c) could be implicit in subsections (a) and (b). Regulation [21 C.F.R.] § 306.04 makes it explicit. But § 829 by its terms does not limit the authority of a practitioner.")

⁸⁵ 323 U.S. 134 (1944)

⁸⁶ *Id.* at 140.

⁸⁷ *See Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 417 (1993) ("The [agency] is not estopped from changing a view [it] believes to have been grounded upon a mistaken legal interpretation."); *see also Nat'l Cable & Telecomms. Ass'n v. Brand X Internet Servs.*, ___ U.S. ___, 125 S. Ct. 2688 (2005) ("[I]f the agency adequately explains the reasons for a reversal of policy, 'change is not invalidating'...").

⁸⁸ *Seminole Rock v. Bowles*, 325 U.S. 410, 414 (1945).

⁸⁹ 21 C.F.R. § 1306.04.

C.F.R. § 1306.04 (2001).”⁹⁰ Applying substantial deference, the Court would be required to uphold the Ashcroft Directive unless it deems the agency interpretation “plainly erroneous or inconsistent with the regulation.” As noted previously, historical tradition, the weight of professional medical opinion, and the laws of all states except Oregon suggest that the Attorney General’s interpretation is not “plainly erroneous.”⁹¹

Concluding Observations

The Supreme Court’s forthcoming decision in *Oregon* is not expected to settle the contentious debate over physician-assisted suicide. Rather, its decision may determine whether Oregon physicians who prescribe controlled substances for the purpose of hastening the death of terminally ill patients will lose their prescription privileges and/or be subject to prosecution. As this report has discussed, the dispute in *Oregon* is a complicated legal one involving several overlapping considerations: statutory interpretation of the CSA, federalism issues, and the degree of judicial deference accorded to administrative agency interpretations. The Supreme Court has an opportunity to address many of these arguments in determining whether the Attorney General exceeded his authority when he proclaimed that it is not a legitimate medical purpose under the CSA for physicians to prescribe controlled substances in order to facilitate an individual’s death.

⁹⁰ 66 Fed. Reg. 56,608.

⁹¹ *Oregon*, 368 F.3d at 1145-46 (Wallace, J., dissenting).