Order Code RL33120

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

Updated February 7, 2006

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Summary

The state of Oregon's Death with Dignity Act (ODWDA) is the first and only state law in the nation that legalizes physician-assisted suicide. The ODWDA 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" potentially subjected Oregon doctors who prescribed drugs pursuant to the ODWDA to criminal prosecution for violating the CSA and to a loss of the privilege to prescribe controlled substances.

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 January 17, 2006, the U.S. Supreme Court in *Gonzales v. Oregon* affirmed the judgment of the Ninth Circuit, ruling that the Directive is not entitled to the traditional judicial deference customarily accorded to a federal agency's interpretation of a regulation or statute, and, furthermore, that the Directive is unenforceable because the CSA does not authorize the Attorney General to prohibit the distribution of federally controlled substances for the purposes of facilitating an individual's suicide.

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Introduction

The circumstances giving rise to *Gonzales v. Oregon*[1] involved the emotionally charged political and moral debate over physician-assisted suicide and end-of-life decision making.[2] However, the matter in controversy did not require the U.S. Supreme Court to weigh in on the merits of physician-assisted suicide or the constitutionality of the Oregon statute that sanctioned and regulated such practice. Rather, it presented the Court with a question concerning the scope of authority granted by a federal statute: Whether the Controlled Substances Act (CSA) and its implementing regulations authorized the Attorney General to prohibit the distribution of federally controlled substances for the purpose of facilitating an individual's suicide, regardless of the state of Oregon's law that permits such distribution.

Writing the opinion of the Court, which was joined by five other justices, Associate Justice Anthony M. Kennedy relied on a statutory interpretation of the CSA to determine that the Attorney General had exceeded his authority under the CSA when he issued a rule declaring the use of controlled substances for physician-assisted suicide to be a violation of the CSA.[3] As a consequence of this decision, a physician acting pursuant to the Oregon Death with Dignity Act to hasten the death of a terminally ill patient does not commit a per se violation of the CSA — thus he or she cannot be subjected to federal criminal prosecution on this particular ground, nor can the physician's authority to prescribe controlled substances be revoked on this basis.

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[1] 546 U.S. __ , 126 S. Ct. 904 (2006).

[2] For a discussion concerning the "right to die" and assisted suicide, *see* CRS Report 97-244A, *The "Right to Die": Constitutional and Statutory Analysis,* by (name redacted).

[3] It is important to note that this decision did *not* explicitly uphold the constitutionality of the Oregon Death with Dignity Act, as that matter was not at issue before the Court. The outcome of the decision determines the possible legal sanctions under federal law that an Oregon physician might face if he or she prescribes controlled substances to facilitate a patient's death in compliance with the Oregon law.

Background

The Controlled Substances Act. Congress enacted the CSA as Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970.[4] 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, which have no currently accepted medical use in treatment and can only be used in very limited circumstances, to substances in Schedules II, III, IV, and V, which have recognized medical uses and may be manufactured, distributed, and used in accordance with the CSA.[5]

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.[6] No controlled substance in Schedules II, III, IV, and V may be dispensed without a prescription.[7] According to a regulation promulgated by the Attorney General in 1971, 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."[8]

The CSA authorizes[9] 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."[10] In determining the public interest, the Attorney General is required to consider the following factors:[11]

- 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 and state laws relating to the manufacture, distribution, and dispensing of controlled substances.

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

[5] *See* 21 U.S.C. § 812.

[6] 21 U.S.C. §§ 822, 841(a)(1).

[7] 21 U.S.C. § 829.

[8] 21 C.F.R. § 1306.04(a).

[9] While the Attorney General is empowered by the CSA to deny, suspend, or revoke a DEA registration, this action is not mandatory: "A [DEA] registration ... *may* be suspended or revoked by the Attorney General..." 21 U.S.C. § 824(a) [emphasis added].

[10] 21 U.S.C. § 824(a)(4).

[11] 21 U.S.C. § 823(f).

- Compliance with applicable state, federal, and local laws relating to controlled substances.
- Such other conduct that may threaten the public health and safety.

Oregon's Death with Dignity Act. The Oregon Death with Dignity Act (ODWDA) is the first and only state law in the nation that legalizes physician-assisted suicide.[12] The ODWDA 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."[13] 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."[14] The patient's written request must be signed and dated in the presence of at least two witnesses who attest that the patient is competent and acting voluntarily.[15]

Under the ODWDA, an Oregon physician may prescribe, but not administer, lethal doses of medication to enable the patient to end his or her life.[16] 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.[17] Between 1998 and 2004, 208 persons in Oregon chose to take their lives pursuant to the ODWDA.[18] The most frequently given reasons for terminally ill patients making prescription requests under the ODWDA are a decreasing ability to participate in activities that make life enjoyable, loss of autonomy, and a loss of dignity.[19]

The Ashcroft Directive. In 1997, in reaction to a congressional inquiry, the DEA Administrator issued an opinion letter stating 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 ODWDA to prescribe or dispense controlled substances.[20] However, on June 5, 1998, after conducting "a thorough and careful review of the issue," then-Attorney General Janet

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[12] 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.

[13] OR. REV. STAT. § 127.805(1).

[14] OR. REV. STAT. § 127.800(12).

[15] OR. REV. STAT. § 127.810(1).

[16] *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 ODWDA may provide physical assistance to the patient.").

[17] Oregon v. Ashcroft, 368 F.3d 1118, 1123 n.5 (9th Cir. 2004); Oregon v. Ashcroft, 192 F.Supp. 2d 1077, 1082 (D. Or. 2002).

[18] 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].

[19] *Id.* at 15.

[20] *Oregon*, 368 F.3d at 1132 (Wallace, J., dissenting).

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."[21] 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."[22]

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."[23] The Lethal Drug Abuse and Prevention Act of 1998[24] would have required the Attorney General to determine that a physician's DEA registration is 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.[25] The Pain Relief Promotion Act of 1999[26] 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.[27]

After John Ashcroft became the new Attorney General, the Department of Justice's interpretation of the CSA changed. On November 9, 2001, Attorney General Ashcroft issued a memorandum to the DEA Administrator that reversed the legal analysis of his predecessor. This interpretive rule, known as the "Ashcroft Directive," states that the Attorney General has determined that

> "[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

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[21] 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].

[22] *Id.*

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

[24] H.R. 4006, 105th Cong., 2nd Sess. (1998).

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

[26] H.R. 2260, 106th Cong., 1st Sess. (1999).

[27] *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 (name redacted).

practitioners or others and regardless of the condition of the person whose suicide is assisted.[28]

This Directive thus attempts to accomplish three specific things:[29]

- declaring that the phrase "legitimate medical purpose," as it appears in a regulation that interprets the CSA, does not include physician-assisted suicide;
- determining that prescribing, dispensing, or administering federally controlled substances to assist suicide is a *violation* of the CSA; and
- cautioning that assisting in suicide *may* render a physician's registration "inconsistent with the public interest" and thus subject to suspension or revocation.

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. A federal district court in Oregon in 2002 entered a permanent injunction against the Directive's enforcement,[30] and the U.S. Court of Appeals for the Ninth Circuit in 2004 determined that the Directive was invalid.[31] 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.[32]

The Supreme Court Opinion in *Gonzales v. Oregon*

By a vote of 6-3, the U.S. Supreme Court affirmed the judgment of the Court of Appeals. The majority opinion, written by Justice Anthony M. Kennedy, was joined by Justices John Paul Stevens, Sandra Day O'Connor, David H. Souter, Ruth Bader Ginsburg, and Stephen G. Breyer. Justice Antonin Scalia wrote the dissent, signed by Chief Justice John G. Roberts, Jr., and Justice Clarence Thomas, who also wrote a separate dissent.

Majority Opinion. At the outset, Justice Kennedy identified the Court's primary task that would provide a resolution to the case: "interpreting a federal statute to determine whether Executive action is authorized by, or otherwise

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[28] 66 Fed. Reg. 56,608.

[29] *Gonzales,* 126 S. Ct. at 926 (Scalia, J., dissenting).

[30] Oregon v. Ashcroft, 192 F.Supp. 2d 1077 (D. Or. 2002).

[31] Oregon v. Ashcroft, 368 F.3d 1118 (9th Cir. 2004). The Court of Appeals provided two independent reasons for finding the Directive unlawful and unenforceable: (1) The Directive altered the "usual constitutional balance between the States and the Federal Government" in the absence of a "clear statement" by Congress that the CSA authorizes such action, and (2) The Directive is contrary to the plain language of the CSA, which is limited to combating conventional drug abuse and requires the Secretary of Health and Human Services, not the Attorney General, to make decisions on medical policy. *Id.* at 1124-1129.

[32] Gonzales v. Oregon, 125 S.Ct. 1299 (2005).

consistent with, the enactment."[33] In the opinion of the Court, Attorney General Ashcroft had exceeded his statutory authority under the CSA when he issued the Directive, and his determination excluding physician-assisted suicide as a "legitimate medical purpose" under the prescription requirement of the CSA is entitled to no judicial deference.

Standards of Judicial Deference. As a framework for analyzing the Attorney General's Directive throughout the opinion, the Court considered several different standards of judicial deference that might be applicable and ultimately concluded that only one would be appropriate. Judicial deference is the degree to which a court will uphold and respect the validity of a federal agency's interpretive rules during judicial review of such agency decisions. The Court described the inquiries that determine the level of judicial deference accorded, as they had been explained in earlier Supreme Court jurisprudence:

- *Auer v. Robbins*:[34] if the administrative rule interprets the issuing agency's own ambiguous *regulation*, a court must accord "substantial deference," meaning that the interpretation is binding on the court unless it is plainly erroneous or inconsistent with the regulation.
- *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*:[35] if the administrative rule interprets an ambiguous *statute*, the interpretation *may* receive substantial deference.
- *United States v. Mead Corp.*:[36] if the administrative rule interprets an ambiguous statute, *and* it appears that Congress has delegated authority to the agency generally to make rules carrying the force of law, *and* the interpretation was promulgated in the exercise of that authority, then the *Chevron* substantial deference standard is warranted.
- *Skidmore v. Swift & Co.*:[37] if the administrative rule interprets an ambiguous statute, *but* Congress did *not* confer upon the agency authority to promulgate the rules or regulations, the interpretation is respected by the court only to the extent that it is persuasive.

As these standards indicate, the degree of deference to which an agency's rule is entitled depends on two threshold matters: (1) whether the interpretation at issue construes statutory text or the regulations promulgated by the agency charged with administering the statute and (2) whether Congress had empowered the agency to issue the interpretive rule in the first place. This determination dictates how a court will likely resolve any challenges to an administrative agency's rules, and, indeed,

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[33] *Gonzales,* 126 S. Ct. at 911.

[34] 519 U.S. 452 (1997).

[35] 467 U.S. 837 (1984).

[36] 533 U.S. 218 (2001).

[37] 323 U.S. 134 (1944).

the *Gonzales* Court relied on this analysis to guide its opinion to the outcome it reached.

The Relevant Statutory Text and Regulations. The Court examined the following statutory provisions of the CSA and the regulation at issue:

- 21 U.S.C. § 829(a): No controlled substance in Schedule II may be dispensed without the written prescription of a practitioner.
- 21 C.F.R. § 1306.04(a): To be effective, a prescription for a controlled substance must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.
- 21 U.S.C. § 824(a)(4): The Attorney General may deny, suspend, or revoke a physician's DEA registration if the physician's registration would be "inconsistent with the public interest."

The first provision was part of the CSA as it had been enacted in 1970. The second provision is a regulation promulgated by the Attorney General in 1971, interpreting the word "prescription" as it appears in 21 U.S.C. § 829. The third provision was added to the CSA by amendments made to the law in 1984.

"Parroting" Regulation. The Government in *Gonzales* claimed that the Ashcroft Directive, issued in 2001, is an interpretation of the term "legitimate medical purpose" in the regulation 21 C.F.R. § 1306.04(a). Under the government's position, the Ashcroft Directive would appear to be entitled to the *Auer* substantial deference standard, as a purported interpretation of an agency regulation rather than of a statute. However, the *Gonzales* Court declined to accord the *Auer* standard of deference to the Directive. In its view, the agency regulation 21 C.F.R. § 1306.04(a) "does little more than restate the terms of the statute itself."[38] Because the language of the Directive "comes from Congress, not the Attorney General," this "near-equivalence of the statute and the regulation" renders *Auer* deference inappropriate. The Court thus announced a new principle for judicial review of agency rules and deference standard selection:

> [T]he existence of a parroting regulation does not change the fact that the question here is not the meaning of the regulation but the meaning of the statute. An agency does not acquire special authority to interpret its own words when, instead of using its expertise and experience to formulate a regulation, it has elected merely to paraphrase the statutory language.[39]

Because the Court majority believed that the regulation at issue was a mere paraphrase of the statutory language, it examined whether the Ashcroft Directive was entitled to receive *Chevron* deference as an interpretation of the CSA.

Rule Not Authorized. Applying the *Mead* analysis, the Court refused to accord *Chevron* deference to the Directive after concluding that it was not

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[38] *Gonzales,* 126 S. Ct. at 915.

[39] *Id.* at 916.

promulgated pursuant to the authority that Congress delegated to the Attorney General.[40] The Court made the determination that the CSA fails to provide the Attorney General with the authority to issue this particular rule "carrying the force of law," after examining the language, structure, and purpose of the CSA. First, the Court explained that the CSA delegates to the Attorney General the power to make rules relating to "registration" and "control" of the manufacture, distribution, and dispensing of controlled substances,[41] as well as other rules he deems "necessary and appropriate for the efficient execution of his functions" under the statute.[42] The Court noted, however, that the Attorney General's powers under the CSA are expressly limited to those functions and responsibilities, and that nothing in the CSA authorizes the Attorney General "to make a rule declaring illegitimate a medical standard for care and treatment of patients that is specifically authorized under state law."[43]

The Directive was issued in excess of the Attorney General's authority to make regulations for the "control" of drugs, since the Court's majority determined that "control" is a "term of art" that is defined in the statute: "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."[44] Because the Directive does not address the scheduling of drugs, the Court found that it cannot be considered a valid exercise of the Attorney General's power to "control" drugs through the making of regulations.[45] In apparent response to the *Gonzales* dissenting opinion that questioned the applicability of the statutory definition of "control" to the Attorney General's authority to promulgate the Directive (and which argued instead for the use of a dictionary definition of "control"), the majority opinion rejected giving "control" a more expansive meaning, stating that

> Even if "control" in [21 U.S.C.] § 821 were understood to signify something other than its statutory definition, it would not support the [Ashcroft Directive]. The statutory references to "control" outside the scheduling context make clear that the Attorney General can establish controls "against diversion" ... but do not give him authority to define diversion based on his view of legitimate medical practice. ... [T]he CSA's express limitations on the Attorney General's authority, and other indications from the statutory scheme, belie any notion that the Attorney General has been granted this implicit authority.[46]

The Directive is also not authorized under the Attorney General's powers to register a physician to prescribe controlled substances, or to revoke or suspend an

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[40] *Id.*, citing *Mead*, 533 U.S. at 226-27.

[41] 21 U.S.C. § 821.

[42] 21 U.S.C. § 871(b).

[43] *Gonzales*,126 S. Ct. at 916.

[44] 21 U.S.C. § 802(5).

[45] *Gonzales*, 126 S. Ct. at 917.

[46] *Id.*

existing registration, in conformity with "the public interest."[47] The Court asserted that the Directive failed to undertake the five-factor analysis required by the statute in determining consistency with the public interest.[48] More importantly, the Directive reaches beyond the subject of registration to interpret substantive federal requirements for what constitutes a valid prescription and, in effect, "declare[s] that using controlled substances for physician-assisted suicide is a crime, an authority that goes well beyond the Attorney General's statutory power to register or deregister."[49] The Court expressed concern about this "unrestrained" and "extraordinary" authority claimed pursuant to the Attorney General's deregistration power, since it criminalizes the actions of physicians who engage in conduct that the Attorney General deems is illegitimate.[50] Furthermore, the Court was unwilling to find that the CSA implicitly delegates to the Attorney General the broad authority to interpret the "legitimate medical purpose" provision: "Congress ... does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions — it does not, one might say, hide elephants in mouseholes."[51]

Finally, the Court noted that the authority claimed by the Attorney General to promulgate the Directive is in tension with the overall structure and design of the CSA, which allocates decision-making powers between the Attorney General and the Secretary of Health and Human Services. Medical judgments are to be made by the Secretary, who presumably possesses medical expertise and competence beyond that of the Attorney General, and the Attorney General is required to defer to those decisions.[52] While the government had argued that the Ashcroft Directive reflects a legal, not a medical, decision, the Court disagreed, noting that the Directive itself relies upon medical judgments and the views of the medical community.[53]

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[47] 21 U.S.C. §§ 823(f), 824(a)(4).

[48] See the factors listed in 21 U.S.C. § 823(f) in the "Background" section of this Report. The government argued, however, that the Directive merely provides notice to physicians that facilitating a patient's death *could* potentially constitute being "inconsistent with the public interest" within the meaning of 21 U.S.C. § 824(a)(4), although this determination is *not* mandatory and, in any event, cannot be made until there is an enforcement proceeding against a physician to revoke or suspend his or her DEA registration. The *Gonzales* dissenting opinion agreed with this characterization. *Gonzales,* 126 S. Ct. at 938 (Scalia, J., dissenting) ("It would be improper — indeed, *impossible* — for the Attorney General to 'undertake the five-factor analysis' ... outside the context of an actual enforcement proceeding. But of course the Attorney General may issue regulations to clarify his interpretation of the five factors, and to signal how he will apply them in future enforcement proceedings.") [Emphasis in original.]

[49] *Gonzales,* 126 S. Ct. at 918.

[50] *Id.*

[51] *Id.* at 921 (citations omitted).

[52] *Id.* at 920, citing 21 U.S.C. § 811(b) ("The recommendations of the Secretary to the Attorney General shall be binding on the Attorney General as to such scientific and medical matters [concerning the scheduling of any drug or other substance].").

[53] *Gonzales,* 126 S. Ct. at 909.

Skidmore *Deference Applies.* The remaining question facing the Court was whether the Ashcroft Directive was a correct interpretation of the CSA and its regulations, in case the Attorney General chooses to rely on the interpretation "only for guidance in deciding when to prosecute or deregister" physicians.[54] Because the Ashcroft Directive was not promulgated pursuant to the authority the CSA vests in the Attorney General, the Court explained that the interpretive rule only receives *Skidmore* deference:

> 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.[55]

The Court first noted that its willingness to accord judicial respect for the Directive is "tempered" by the fact that the Attorney General lacks the medical expertise to decide what physician practices constitute a "legitimate medical purpose" and that there had been an "apparent absence of any consultation with anyone outside the Department of Justice who might aid in a reasoned judgment" concerning this issue.[56] Then the Court, applying the *Skidmore* analysis, ruled that it did not find the Directive persuasive, and thus the Court was not required to uphold its validity.

In assessing the validity of the Ashcroft Directive's reasoning, the Court considered whether the CSA can be read as prohibiting physician-assisted suicide. Two recent Supreme Court cases are arguably relevant to this analysis: *United States v. Oakland Cannabis Buyers' Cooperative*[57] and *Gonzales v. Raich*.[58] 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.[59] The Supreme Court ruled in *Raich* that Congress has the power under the Commerce Clause to prohibit the cultivation or possession of marijuana for medical purposes, despite a California law that permitted it. Thus, federal authorities could prosecute medical marijuana users as violating the CSA.

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[54] *Id.* at 922.

[55] *Skidmore,* 323 U.S. at 140.

[56] *Gonzales,* 126 S. Ct. at 922.

[57] 532 U.S. 483 (2001). 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 (name redacted).

[58] __ 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 (name redacted).

[59] *Oakland Cannabis,* 532 U.S. at 491.

The *Gonzales* majority opinion did not expressly attempt to distinguish the use of controlled substances for facilitating physician-assisted suicide from the medical marijuana issue considered in *Oakland Cannabis* and *Raich*. This omission is perhaps explained, in part, by the fact that the *Gonzales* Court was presented with "a question of statutory interpretation, and not the extent of constitutionally permissible federal power."[60] However, the Court noted that Congress has made an "express determination that marijuana ha[s] no accepted medical use" by categorizing it as a Schedule I controlled substance.[61] In contrast, physicians acting pursuant to the Oregon Death With Dignity Act prescribe Schedule II controlled substances to facilitate their patients' deaths; drugs classified in this schedule have accepted medical uses, such as alleviating pain, if prescribed in lower dosages.

Examining the CSA's text and design, the Court concluded that the CSA was intended to regulate "medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood."[62] With a nod towards the principle of federalism, the Court observed that the CSA still permits the states to have a considerable role in regulating the practice of medicine under their traditional police powers. This intent to preserve, rather than displace, the states' regulation of the health and safety of their citizens is evidenced by the inclusion of a nonpreemption provision in the CSA:

> No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together.[63]

In the opinion of the Court, the Oregon Death with Dignity Act is an example of a state law concerning a medical practice that Congress has not enacted explicit language to regulate.[64] The Court rejected the government's assertion that the CSA impliedly criminalizes physician-assisted suicide, since the CSA is largely silent on the practice of medicine and includes the nonpreemption provision that permits continued state regulation of the medical profession.[65]

Prescription Requirement as an Insufficient Basis of Authority. The Court was unpersuaded by the government's argument that the CSA's "prescription"

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[60] *Gonzales,* 126 S. Ct. at 941 (Thomas, J., dissenting).

[61] *Gonzales,* 126 S. Ct. at 923.

[62] *Id.* Justice Thomas' separate dissenting opinion criticized the "hasty retreat" of the Court in narrowly interpreting the purpose of the CSA after having reached far broader conclusions about the scope of the same statute only seven months earlier in *Raich. Id.* at 939-40 (Thomas, J., dissenting).

[63] 21 U.S.C. § 903.

[64] *Gonzales*, 126 S. Ct. at 923.

[65] *Id.* at 924.

requirement provides sufficient legal support for the Ashcroft Directive. The CSA prohibits the dispensing of any Schedule II drug without the written prescription of a practitioner.[66] As noted earlier in this report, a regulation promulgated by the Attorney General in 1971 interpreted the term "prescription" to mean one issued for a "legitimate medical purpose."[67] Thus, according to the government, a Schedule II drug may only be prescribed to a patient for a legitimate medical purpose.[68] In the government's judgment, the term "medical" connotes healing, curing, treatment, or prevention of disease, and therefore necessarily excludes "the intentional hastening of a patient's death."[69] The Government also offered the opinion and positions of prominent professional medical organizations and the 49 other states that have not legalized physician-assisted suicide as evidence that such medical practice is not a "legitimate" one.[70]

Although the Court conceded the "reasonableness" of this characterization of physician-assisted suicide, the majority opinion rejected the government's reliance on the prescription requirement as an independent basis for such an expansive federal authority to regulate medicine practices:

> The primary problem with the Government's argument, however, is its assumption that the CSA impliedly authorizes an Executive officer to bar a use simply because it may be inconsistent with one reasonable understanding of medical practice. Viewed alone, the prescription requirement may support such an understanding, but statutes "should not be read as a series of unrelated and isolated provisions."[71]

The Court noted that the legislative history and statutory scheme of the CSA suggests "a more limited understanding" of the prescription provision.[72] First, the CSA's legislative history reveals that Congress intended to limit the CSA to problems associated with drug abuse and addiction.[73] The CSA statutory text requires that the Attorney General's decisions to classify a substance in Schedules II through V must be based, in part, on a substance's psychological or physical dependence and abuse potential.[74] The prescription provision must be considered in its context, the Court

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[66] 21 U.S.C. § 829(a).

[67] 21 C.F.R. § 1306.04.

[68] *Gonzales,* 126 S. Ct. at 924.

[69] *Id.*

[70] *Id.*

[71] *Id.* (quoting Gustafson v. Alloyd Co., 513 U.S. 561, 570 (1995)).

[72] *Id.* at 925.

[73] 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 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).

[74] 21 U.S.C. § 811(c)(7).

stated, and thus it is "a provision that ensures patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse."[75]

The Court agreed with the Ninth Circuit's opinion that prescriptions for physician-assisted suicide is not a "drug abuse," but rather should be considered a general medical practice to be regulated by the states.[76] Attempting to characterize physician-assisted suicide as a "drug abuse," the Court asserted, is "discordant with the phrase's consistent use throughout the statute, not to mention its ordinary meaning."[77] The Court refused to believe that Congress had the "far-reaching intent" for the prescription requirement to delegate authority "to a single Executive officer the power to effect a radical shift of authority from the States to the Federal Government to define general standards of medical practice in every locality."[78]

Dissenting Opinion. Justice Scalia, joined by Chief Justice Roberts and Justice Thomas, would have reversed the Ninth Circuit's opinion and upheld the validity of the Ashcroft Directive on three independently sufficient grounds:[79]

- The Attorney General's Directive was entitled to deference under the *Auer* standard, because it is a valid interpretation of the "legitimate medical purpose" phrase that is used in the Attorney General's 1971 regulation, 21 C.F.R. § 1306.04.
- Even if the Directive is entitled to no judicial deference, the validity of the interpretation is correct because "it is by far the most natural interpretation of the Regulation."
- Even if the Attorney General's interpretation of the regulation is incorrect, his interpretation of the CSA's statutory phrases "public interest" and "public health and safety" are entitled to *Chevron* deference.

First, Justice Scalia believed that this case should have been resolved with a "straightforward application" of the *Auer* standard of judicial deference.[80] He questioned the majority's actions in creating a "parroting" exception to the *Auer* rule, without which *Auer* would have determined the judicial treatment of the case — requiring the Court to respect the Attorney General's Directive "unless plainly erroneous or inconsistent with the regulation."[81] Despite objecting to the newly announced "parroting" rule, Justice Scalia asserted that the rule would not even apply in this case. He observed that the regulation at issue, 21 C.F.R. § 1306.04, does *not* merely "paraphrase the statutory language" as the majority claimed. The regulation clarifies the undefined term "prescription" as it appears in the statutory language of

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[75] *Gonzales,* 126 S. Ct. at 925.

[76] *Ashcroft,* 368 F.3d at 1125-26.

[77] *Gonzales,* 126 S. Ct. at 925.

[78] *Id.*

[79] *Gonzales,* 126 S. Ct. at 926 (Scalia, J., dissenting).

[80] *Id.* at 927.

[81] *Id.* (quoting *Auer*, 519 U.S. at 461.)

21 U.S.C. § 829(a), by explicitly stating that any prescription, to be valid under the CSA, may only be issued for a "legitimate medical purpose." This regulation "significantly clarifies the meaning of an otherwise ambiguous statutory provision," adds content to the statutory text, and thus "is not a 'parroting' regulation..."[82] Justice Scalia thus concluded that since the regulation is not a mere duplication of the statutory text, and since the Directive is the Attorney General's interpretation of the regulation, then the *Auer* deference standard is applicable. Using this standard, Justice Scalia stated that the Directive is "controlling" on the Court because he did not find the interpretation to be plainly erroneous or inconsistent with the regulation;[83] indeed, he opined that the Directive is a "perfectly valid" construction of "legitimate medical purpose" that is within the Attorney General's authority under the CSA to make.[84]

Even if he were to accept the application of the "antiparroting canon" to this case, Justice Scalia argued that the Directive would still be entitled to deference under *Chevron*. He rejected as "manifestly erroneous" the Court's use of the CSA's definition of "control" as it appears in one part of the statute, 21 U.S.C. § 802(5), to restrict the Attorney General's powers to control the manufacture, distribution, and dispensing of controlled substances under 21 U.S.C. § 821.[85] He stated that

> We do not force term-of-art definitions into contexts where they plainly do not fit and produce nonsense. What is obviously intended in § 821 is the ordinary meaning of "control" — namely, "[t]o exercise restraining or directing influence over; to dominate; regulate; hence, to hold from action; to curb..."[86]

Justice Scalia reasoned that if the Court had not incorrectly adopted the artificially narrow definition of "control," the Directive would likely have been deemed to be within the Attorney General's interpretive authority and thus worthy of receiving *Chevron* deference. Unlike the majority of the Court, Justice Scalia was not concerned that the Directive effectively created a criminal sanction for physician-assisted suicide; this was an inevitable consequence of the CSA's "prescription" requirement: Since the Directive declared that assisting suicide is not a legitimate medical purpose for a controlled substance prescription, the writing of such

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[82] *Id.* at 928.

[83] *Id.* at 929.

[84] *Id.* at 931.

[85] 21 U.S.C. § 802(5) provides that, as used "in this title," 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. [Emphasis added.] As Justice Scalia correctly observed, Section 821 is *not* included in part B of the CSA subchapter, but rather is located in part C. Thus, Justice Scalia argued, the majority opinion should not have made the definition of "control" applicable to the Attorney General's powers under Section 821. *Gonzales*, 126 S. Ct. at 929 (Scalia, J., dissenting).

[86] *Id.* (citations omitted)

prescriptions could subject the physician to prosecution for engaging in conduct that violates the CSA.[87]

Second, Justice Scalia opined that even in the absence of any judicial deference to it, the Directive is "the most reasonable" interpretation of the regulation and of the statute, and is valid upon de novo review.[88] His conclusion relied on the "overwhelming weight of authority" that has excluded intentionally assisting suicide from the definition of "legitimate medical purpose."[89] In addition, "virtually every medical authority from Hippocrates to the current American Medical Association (AMA) confirms that assisting suicide has seldom or never been viewed as a form of 'prevention, cure, or alleviation of disease,'" which is the typical dictionary definition of *medicine*.[90] Furthermore, Justice Scalia declared in dicta that "[i]f the term '*legitimate* medical purpose' has any meaning, it surely excludes the prescription of drugs to produce death."[91]

He also criticized the majority's efforts to limit the scope of the CSA to only "addiction and recreational abuse." Although conceding that drug abuse is a *principal* concern of the statute, he argued that such purpose is not its *exclusive* concern.[92] The majority opinion correctly noted that the CSA requires that the Attorney General must consider a drug's addictive properties in making scheduling determinations,[93] but Justice Scalia asserted that the Court had failed to discuss another factor that the Attorney General must evaluate: "[w]hat, if any, risk there is to the public health."[94] In addition, the Attorney General may refuse to register a physician to prescribe controlled substances if such registration "would be inconsistent with the public interest;"[95] in determining the "public interest," the Attorney General must consider "[s]uch other conduct which may threaten the public health and safety."[96] In his view, the majority opinion erred when it apparently disregarded these public interest, public health, and public safety objectives in

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[87] *Id.* at 931.

[88] *Id.*

[89] *Id.* at 932.

[90] *Id.*

[91] *Id.* at 939.

[92] *Id.* at 933 [emphasis in the original]. Justice Scalia explained: "We have repeatedly observed that Congress often passes statutes that sweep more broadly than the main problem they were designed to address. '[S]tatutory prohibitions often go beyond the principal evil to cover reasonably comparable evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed.'" *Id.* (quoting Oncale v. Sundowner Offshore Servs., Inc., 523 U.S. 75, 79 (1998)).

[93] 21 U.S.C. §811(c)(7).

[94] 21 U.S.C. § 811(c)(6).

[95] 21 U.S.C. § 823(f).

[96] 21 U.S.C. § 823(f)(5).

determining that the Attorney General's authority under the CSA's prescription requirement applies only in the context of preventing drug abuse.[97]

Justice Scalia points out that the CSA's nonpreemption clause does not support the Court's declaration that the CSA contemplates a role for the states in regulating controlled substances; rather, the clause "merely disclaims field pre-emption, and affirmatively *prescribes* federal pre-emption whenever state law creates a conflict."[98] Furthermore, the Ashcroft Directive does not preempt the Oregon state law because the Oregon law does not *require* assisted suicide; rather, the Directive interprets the CSA to prohibit conduct that is permitted under Oregon law.[99]

Finally, Justice Scalia explained that even if the Attorney General's interpretation of "legitimate medical purpose" is incorrect, *Chevron* deference should still be applied to the Directive under yet another independent basis — the Attorney General's authority to interpret the term "public health and safety" as it is used in the CSA's grant of power to him to deregister physicians for conduct that is inconsistent with the public interest.[100] He criticized the Court's *Mead* analysis that had resulted in applying *Skidmore* deference to the Directive rather than *Chevron*. Justice Scalia suggested that Congress, by leaving the terms "public interest" and "public health and safety" ambiguous in the CSA, implicitly empowered the Attorney General to interpret those factors.[101] Although such delegation of authority to interpret these terms may not be explicit in the statute, in his judgment, *Chevron* would be warranted because even an implicit delegation of authority could still entitle an agency interpretation to substantial deference,[102] and in any event, the CSA explicitly delegates to the Attorney General the power to promulgate rules and regulations regarding the registration and control of the manufacture, distribution, and dispensing of controlled substances.[103]

That the design of the CSA divides decision-making authority between the Attorney General and the Secretary of Health and Human Services failed to convince Justice Scalia of the majority's claim that the Attorney General has no role in making determinations concerning the legitimacy of medical practices. Charged with the power to register and deregister physicians for prescribing and dispensing controlled substances, and the power to prosecute those who violate the CSA, the Attorney General should have discretion over the substantive standards by which such a

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[97] *Gonzales*, 126 S. Ct. at 933 (Scalia, J., dissenting) ("All of these provisions, not just those selectively cited by the Court, shed light upon the CSA's repeated references to the undefined term 'abuse.'").

[98] *Id.* at 934 [emphasis in the original].

[99] *Id.* [emphasis in the original].

[100] *Id.* at 935-36.

[101] *Id.* at 936.

[102] *Id.* ("The Court's exclusive focus on the explicit delegation provisions is, at best, a fossil of our pre-*Chevron* era; at least since *Chevron*, we have not conditioned our deferral to agency interpretations upon the existence of explicit delegation provisions.")

[103] 21 U.S.C. § 821.

decision is made, he reasoned. Such a determination "ultimately rests, not on 'science' or 'medicine,' but on a naked value judgment."[104] He explained:

> Far from establishing a general principle of Secretary supremacy with regard to all scientific and medical determinations, the fact that Congress granted the Secretary specifically defined authority in the areas of scheduling and addiction treatment, without otherwise mentioning him in the registration provisions, suggests, to the contrary, that Congress envisioned no role for the Secretary in that area — where, as we have said, interpretive authority was both implicitly and explicitly conferred upon the Attorney General.[105]

Concluding Observations

However accurate as a matter of statutory interpretation and administrative law that he felt his dissenting opinion may have been, Justice Scalia evidently failed to convince the six Justices voting in the majority. Justice Kennedy's opinion represents the judgment of the Court in *Gonzales v. Oregon*, holding that the Attorney General exceeded his legal authority when he proclaimed that it is not a legitimate medical purpose under the Controlled Substances Act for physicians to prescribe controlled substances to facilitate an individual's death. As noted earlier, the Court's opinion did not rule on the constitutionality of the Oregon law that authorizes physician-assisted suicide practices.[106] The Court also did not address the question of whether Congress had the power to override such a state law. The narrow legal inquiry answered by the Court was the authority of the Attorney General under the Controlled Substances Act to make a decision that interferes with a medical practice sanctioned by state law. Perhaps influenced in part by principles of federalism and the recognition that states have traditionally enjoyed the independent, sovereign power to regulate the practice of medicine, the Court rejected an executive action that, in its view, was beyond the authority that Congress had granted to the Attorney General.[107]

However, Justice Scalia in dissent observed the following: "The Court's decision today is perhaps driven by a feeling that the subject of assisted suicide is none of the Federal Government's business. It is easy to sympathize with that position." In *Washington v. Glucksberg*, the Court had stated that "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

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[104] *Gonzales*, 126 S. Ct. at 937 (Scalia, J., dissenting).

[105] *Id.*

[106] In *Washington v. Glucksberg*, 521 U.S. 702 (1997), the Supreme Court held that the *right* to assisted suicide is not a fundamental liberty interest protected under the Due Process Clause of the Fourteenth Amendment.

[107] The concerns of the Court are evidenced by the words chosen to describe the powers claimed by the Attorney General in promulgating the Directive: "extraordinary authority" and "unrestrained" power. *Gonzales*, 126 S. Ct. at 918.

debate to continue, as it should in a democratic society."[108] Former Justice Sandra Day O'Connor offered a concurrence in that opinion, in which she stated that

> 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."[109]

The *Gonzales* Court also permits the debate over physician-assisted suicide to continue. It is uncertain what role the federal government may play in the "democratic process" that resolves this contentious issue, but the *Gonzales* Court made it clear that the Controlled Substances Act, as it is currently written, cannot be used as a basis for the Attorney General to act unilaterally to prohibit this medical practice authorized by the state of Oregon.

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[108] *Glucksberg*, 521 U.S. at 735.

[109] *Id.* at 737 (O'Connor, J., concurring) [citations omitted].