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Stacy A. Tromble

University at Buffalo School of Law

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A Dialogue on Death & Deference: *Gonzales v. Oregon*

STACY A. TROMBLE†

INTRODUCTION

Oscar Wilde once said that “life is far too important a thing to ever talk seriously about.”¹ Until rather recently, the same thing could be said about America’s approach to death and end of life decision-making. The protracted legal battle surrounding Terri Schiavo² has brought many of these issues to the forefront of the political, social, and legal agenda. The unprecedented flurry of midnight legislation crafted by Congress and subsequently signed by the President in that case underscores the struggle that can ensue when legitimate state interests clash with individual autonomy.³ The *Schiavo* case presented some unique issues, principally because Ms. Schiavo was in a persistent vegetative state and unable to make her own healthcare decisions.⁴ While end of life decision-making for the mentally incompetent raises unsettled and complex legal questions, the latest legal battle centers around a bold Oregon law that permits mentally competent, terminally ill

† J.D. Candidate, State University of New York at Buffalo, 2007; M.S.W., State University of New York at Buffalo, 2007. I would like to thank the members of the Buffalo Law Review and my sister, Jennifer Tromble, for editorial assistance. I would also like to thank my husband, James Bartoszczyk, for his unwavering support and encouragement. This Note is dedicated to my parents, Gerard and Carol Tromble, who lived and died with dignity.

1. Oscar Wilde, *Lady Windermere’s Fan* 6 (Dover Publications 1998) (1893).

2. See generally Manuel Roig-Franzia, *Long Legal Battle Over as Schiavo Dies*, WASH. POST, April 1, 2005, at A1.

3. For an excellent discussion of the *Schiavo* case, see generally WILLIAM H. COLBY, UNPLUGGED: RECLAIMING OUR RIGHT TO DIE IN AMERICA (2006); see also Jack M. Beermann, *Federal Court Self-Preservation and Terri Schiavo*, 54 BUFF. L. REV. 553 (2006).

4. See *id.*

adults to end their lives. Oregon's Death With Dignity Act⁵ is the first and only legislation in the country that permits physician-assisted suicide. It is a carefully tailored piece of legislation which closely delimits the circumstances whereby an individual may seek a lethal dose of prescription medication from their physician.⁶ The legislation has weathered several legal challenges. The latest challenge was an Interpretive Rule,⁷ issued by then Attorney General John Ashcroft, that announced that pursuant to provisions of the Controlled Substances Act, physicians that write a prescription pursuant to the Oregon Death With Dignity Act could lose their prescription-writing privileges. The Interpretive Rule would effectively nullify the Oregon law. The litigation that resulted wound its way to the Supreme Court in *Gonzales v. Oregon*,⁸ the subject of this Note.

In order to grasp the significance of this case, the reader must first understand the factual and legal context that gave rise to it. Accordingly, this Note begins with a discussion of Supreme Court precedents that set the stage for the current debate. The next section gives an overview of the Oregon Death With Dignity Act and the Controlled Substances Act, the two pieces of legislation that collide in this case. Next, the majority and dissenting opinions are summarized in some depth, with an emphasis on the Court's deference arguments. Finally, the Note concludes with a discussion of the prospects for a continued dialogue on the substantive issues of end of life decision making given the long history of congressional attempts to prohibit physician-assisted suicide and the reluctance of other states to join the conversation.

5. The Oregon Death With Dignity Act, OR. REV. STAT. §§ 127.800-.995 (2005).

6. *See id.*

7. Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607 (Nov. 9, 2001).

8. *Gonzales v. Oregon*, 126 S.Ct. 904 (2006).

I. CAUSATION & INTENT AT THE END OF LIFE: A
JURISPRUDENTIAL LINE IN THE SAND

American courts are much more willing to support the withdrawal or refusal of life-sustaining treatment than to advocate for physician-assisted suicide (PAS).⁹ An individual's right to refuse treatment has its roots in the common law action of trespass¹⁰ and now enjoys constitutional protection. In the landmark case *Cruzan v. Director, Missouri Department of Health*,¹¹ the Supreme Court held that a mentally competent adult has a constitutionally protected liberty interest in refusing unwanted medical treatment or in removing life-sustaining medical care.¹² The Court also recognized that, under certain conditions, a surrogate could substitute his or her judgment in the best interests of an incapacitated individual, if that individual's wishes were unknown.¹³ While this liberty interest in refusing or removing life-sustaining treatment is grounded in the Fourteenth Amendment, it is not an absolute right. It is subject to a balancing test that weighs the individual's interests against those of the State.¹⁴

Once an individual's liberty interest in refusing or withdrawing life-sustaining treatment was firmly established, proponents of an affirmative right to die sought judicial sanction of physician-assisted suicide. In 1997, *Washington v. Glucksberg*¹⁵ and its companion case, *Vacco*

9. See generally Kristine Karnezis, *Patient's Right to Refuse Treatment Allegedly Necessary to Sustain Life*, 93 A.L.R.3d 67 (1979).

10. The common law action of trespass and the legal maxim of patient autonomy were well established in the United States as early as 1914. In *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129 (1914), Justice Cardozo stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault"

11. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

12. See *id.*

13. See *id.* at 273.

14. See *id.* at 279; see also *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982); *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30 (1905) (Court balancing the individual's refusal to take a smallpox vaccine against State's interest to prevent the spread of disease).

15. 521 U.S. 702 (1997).

v. Quill,¹⁶ reached the Supreme Court. In both cases, terminally ill patients and their physicians sought to overturn state statutes that prohibited PAS. Both attempts failed. Respondents in both cases claimed that there was little, if any, distinction between the removal of life-sustaining medical treatment and PAS.¹⁷ The Court responded that while "the decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, . . . it has never enjoyed similar legal protection."¹⁸

In *Vacco v. Quill*, the Court held that the difference between the well-recognized liberty interest in refusing or removing treatment and PAS is one of causation and intent.¹⁹ The jurisprudential line in the sand was thus drawn by distinguishing between *letting* a patient die and *causing* a patient to die. In both *Glucksberg* and *Quill*, the Court took pains to articulate the myriad of State interests involved in a decision to prohibit PAS.²⁰ It would be a mistake, however, to deem either opinion as a blanket rejection of the practice. Instead, the Court suggested that the statutes prohibiting PAS in both Washington and New York are constitutional because their legislatures—the popularly elected representatives of the people—have rationally related the ban on PAS to legitimate government interests.²¹ Under this paradigm, when a state—either by referendum or by legislation—chooses to legalize PAS, the law is not inherently unconstitutional. Instead of ending the important dialogue around PAS, the Court expressed a desire that its holding "permit [the] debate to continue, as it should in a democratic society."²²

16. 521 U.S. 793 (1997).

17. See *Glucksberg*, 521 U.S. at 725; *Quill*, 521 U.S. at 798.

18. *Glucksberg*, 521 U.S. at 725.

19. *Quill*, 521 U.S. at 794.

20. These legitimate government interests include "prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice and psychological pressures to end their lives; and avoiding a possible slide towards euthanasia." *Id.* at 808-09.

21. See *id.*

22. *Glucksberg*, 521 U.S. at 735.

It is against this legal landscape that the Oregon Death With Dignity Act and the latest legal challenge to its existence must be viewed.

II. COLLIDING LEGISLATION

A. *The Oregon Death With Dignity Act*

The Oregon Death With Dignity Act (“ODWDA” or “the Act”) allows a mentally competent Oregon resident who is over the age of eighteen and whose terminal illness will result in death within six months to request a lethal prescription from their physician.²³ If a resident chooses to end his or her life in accordance with the Act’s provisions, the resulting death is not considered suicide under Oregon law.²⁴

Physicians acting pursuant to the ODWDA prescribe controlled substances for the express purpose of helping their terminally ill patients to end their lives.²⁵ Oregon residents are only eligible for the lethal prescription if several criteria are met.²⁶ First, their attending physician must certify that they have a terminal and irreversible illness which will, in their reasonable medical judgment, result in death within six months, and a consulting physician must concur.²⁷ Physicians must ensure that the request for medication is voluntary and informed;²⁸ patients who might be suffering from a psychiatric illness such as

23. See OR. REV. STAT. § 127.805 (2005). For a succinct summary of the Act’s provisions, see OREGON DEP’T OF HUMAN SERVICES, EIGHTH ANNUAL REPORT ON OREGON’S DEATH WITH DIGNITY ACT (2006), <http://www.oregon.gov/DHS/ph/pas/docs/year8.pdf>.

24. See OR. REV. STAT. § 127.880 (2005).

25. OREGON DEP’T OF HUMAN SERVICES, *supra* note 23, at 7.

26. These criteria include, among other things, two oral requests, a written request signed in the presence of two witnesses, and a waiting period. Physicians are mandated to inform their patients of alternatives to assisted suicide including hospice services. Physicians can also request, but cannot require, that the patient’s next-of-kin be notified of the prescription request. See *id.* at 7-8.

27. See OR. REV. STAT. § 127.820 (2005).

28. See *id.* § 127.830.

depression must be referred to counseling.²⁹ A second consulting physician must also examine the patient and medical records to confirm the primary physician's findings.³⁰ All physicians operating under the Act must be registered with the Oregon State Board of Medical Examiners and the Federal Drug Enforcement Administration.

In *Gonzales v. Oregon*, the Attorney General challenged the ODWDA by invoking his powers under the Controlled Substances Act (CSA) to threaten deregistration of physicians who prescribe controlled substances for the purpose of assisting a suicide. Accordingly, before proceeding to the holding and reasoning of the case, a brief discussion of the CSA is in order.

B. *The Controlled Substances Act*

The Controlled Substances Act,³¹ Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, is the legal foundation of the government's fight against drug abuse. The CSA categorizes all regulated controlled substances into one of five schedules, with the placement of drugs on a particular schedule being governed by an assessment of the substance's medicinal value, harmfulness, and potential for abuse or addiction. Schedule I³² is reserved for the most dangerous drugs that have no recognized medical use, while Schedule V³³ is the classification used for the least dangerous drugs. Proceedings to add, delete, or change the schedule of a drug or other substance may be initiated by the Drug Enforcement Administration (DEA), the Department of Health and Human Services (HHS), or by petition from any

29. *See id.* § 127.825.

30. The Death With Dignity Act requires doctors to extensively document the patient's diagnosis and prognosis as well as all requests made by, and evaluations of, the terminally ill patient. Copies of these forms are available at <http://egov.oregon.gov/DHS/ph/pas/index.shtml>. For a complete list of physician responsibilities, see OR. REV. STAT. § 127.815 (2005).

31. Comprehensive Drug Abuse Prevention and Control Act, 21 U.S.C. §§ 801-971 (2000) [hereinafter CSA].

32. 21 U.S.C. § 812 (2000).

33. *Id.*

interested party.³⁴ When a petition is received by the DEA, the agency begins its own investigation of the drug. Once the DEA has collected the necessary data, the DEA Administrator, by authority of the Attorney General, requests that HHS provide a scientific and medical evaluation and a recommendation on whether the drug should be controlled. If HHS recommends that a drug be controlled, the Department must also recommend which schedule the drug should be categorized under.³⁵ In this process, the HHS Secretary can solicit information from the Food and Drug Administration, the National Institute on Drug Abuse, and the scientific and medical community at large.³⁶ The Secretary's medical and scientific evaluations bind the DEA with respect to scientific and medical matters.³⁷

The CSA regulates both the controlled substances and those who handle them. Accordingly, the legislation reaches actors along the entire chain of distribution, from the manufacturers who produce the substances, right down through the physicians who prescribe them, and the pharmacists who ultimately distribute them. In order to prescribe controlled substances under the CSA, physicians must be registered with the DEA and comply with protocols for the prescription and dispensing of controlled substances to patients. Like many complex regulatory schemes, Congress defined many terms used throughout the statute. For instance, physicians are considered practitioners under the CSA if they prescribe controlled substances in the "course of professional practice."³⁸ Similarly, a "valid prescription" is one "issued for a legitimate medical purpose."³⁹ A 1971 federal regulation promulgated by the Attorney General pursuant to delegated powers under the CSA further stated that all prescriptions must be issued "for a legitimate medical purpose by an individual

34. *Id.* § 811(a)(2).

35. *See id.* § 811(b).

36. *See id.* § 823(H)(i).

37. *See id.*

38. *Id.* § 802(21); *see also* 21 C.F.R § 1306.04(a) (2006).

39. 21 U.S.C. § 830(b)(3)(A)(ii) (2000).

practitioner acting in the usual course of his professional practice."⁴⁰

Practitioners prescribing controlled substances for other than legitimate medical purposes are subject to deregistration. Prior to 1984, physician registration under the CSA was little more than a formality if a physician was licensed by their state medical board. The process of deregistration could only be commenced under very narrow circumstances—where the physician had his state license revoked or was convicted of a felony in relation to controlled substances.⁴¹ In 1984, however, the CSA was amended to permit the Attorney General to deny or revoke a physician's registration upon a finding that such registration would be "inconsistent with the public interest."⁴² The amendment provided that in determining whether a physician's registration under the CSA was inconsistent with the public interest, the Attorney General shall consider the following criteria: (1) the recommendations of the physician's state licensing or disciplinary board; (2) the physician's experience in dispensing or conducting research with controlled substances; (3) the physician's conviction record under both state and federal laws related to controlled substances; (4) compliance with state, federal, or local laws related to controlled substances; and finally (5) any other conduct which may threaten the public health and safety.⁴³

C. The ODWDA and the CSA: From Legislation to Litigation

Oregon's Death With Dignity Act first passed in 1994 when fifty-one percent of Oregon voters approved the measure,⁴⁴ but an injunction delayed the implementation of the law until October 1997.⁴⁵ In July of 1997, as Oregonians were weighing the merits of the legislation in their own state in preparation for a ballot measure that sought to

40. 21 C.F.R. § 1306.04(a) (2006).

41. See 21 U.S.C. §§ 824(a)(2)-(3) (2000).

42. *Id.* § 824(a)(4).

43. *Id.* § 824(f).

44. Joseph Cordaro, *Who Defers to Whom? The Attorney General Targets Oregon's Death with Dignity Act*, 70 *FORDHAM L. REV.* 2477, 2483-84 (2002).

45. See *id.* at 2484.

repeal the Act, both houses of Congress overwhelmingly passed, and President Clinton signed, the Assisted Suicide Funding Restriction Act (ASFRA)⁴⁶ which became effective on July 25, 1997. ASFRA, introduced in the U.S. Senate by Senators Byron Dorgan and John Ashcroft, prohibited the use of federal funds for any health care item or service that is furnished for the purpose of causing or assisting a suicide.⁴⁷

Perhaps spurred by the momentum of ASFRA, Senator Orrin Hatch and Representative Henry Hyde, Chairmen of the Senate and House Judiciary Committees respectively, wrote to the Chief Administrator of the DEA, Thomas A. Constantine, in July of 1997. The letter asked for his opinion as to whether State legislation, like that in Oregon which authorizes the prescription and dispensing of controlled substances for the express purpose of assisting suicide, would violate the CSA.⁴⁸ The letter went on to cite various sources ranging from the American Medical Association to the Health Care Financing Organization in support of their view that "assisting in a suicide by prescribing or filling a prescription for a controlled substance cannot be a 'legitimate medical purpose.'"⁴⁹ In response, Mr. Constantine—relying on "a number of cases, briefs, law review articles, and state law,"⁵⁰ as well as a review of prior administrative cases in which physicians were deregistered for dispensing scheduled substances for other than legitimate medical purposes—concluded that delivering, dispensing, or prescribing a controlled substance with the intent of assisting a suicide would not qualify as a legitimate medical purpose under "any current definition."⁵¹ While Constantine apologized for the delay in his response, it is noteworthy that the letter is dated on November 5, 1997, exactly one day after Oregon voters defeated a second

46. Assisted Suicide Funding Restriction Act, 42 U.S.C. §§ 14401-08 (2000).

47. *See id.* This includes Medicare and Medicaid appropriations.

48. *See* Letter from Senator Orrin Hatch and Representative Henry Hyde to Thomas A. Constantine, Chief Adm'r, DEA (July 29, 1997), *in* S. REP. NO. 105-372, at 7 & n.6 (1998).

49. *Id.*

50. Letter from Thomas A. Constantine, Chief Adm'r, DEA, to Senator Orrin Hatch (Nov. 5, 1997), *in* S. REP. NO. 105-372, at 8-9 & n.9 (1998).

51. *See id.*

ballot measure that sought to repeal the ODWDA by a margin of sixty percent to forty percent.⁵²

On April 2, 1998, after the ink had dried on the Oregon ballots and after a barrage of letters from Congress urging both support and resistance for the enforcement of the CSA against physicians who assist in suicides pursuant to state law, then-Attorney General Janet Reno took the position that "the federal government's pursuit of adverse actions against Oregon physicians who fully comply with that state's Death With Dignity Act would be beyond the purpose of the CSA."⁵³ Attorney General Reno's refusal to commence deregistration actions against Oregon physicians rested on her conclusion that nothing in the CSA evinces a congressional intent 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 in the absence of a federal law prohibiting that practice."⁵⁴

Following Attorney General Reno's decision not to enforce the CSA against Oregon, legislation known as the Lethal Drug Abuse Prevention Act of 1998⁵⁵ was introduced in Congress. This bill, if passed, would have effectively preempted the ODWDA. When it failed to reach the floor of either the House or Senate, another bill known as the Pain Relief Promotion Act (PRPA)⁵⁶ was introduced. The PRPA would have amended the CSA to provide increased funding and support for palliative care, while prohibiting the use of controlled substances for the "purpose of causing death or assisting another person in causing death."⁵⁷ Moreover,

52. The total number of votes against repeal of the Oregon Death with Dignity Act was 666,275, while the total number of votes for repeal was 445,830. The vote totals on State Measure 51 are available from the Oregon Secretary of State online at <http://www.sos.state.or.us/elections/nov497/other.infor/m51abst.htm>.

53. Letter from Janet Reno, Att'y Gen., to Senator Orrin Hatch, Chairman of the Senate Judiciary Comm. (June 5, 1998), in S. REP. NO. 105-372, at 10 (1998).

54. *Id.*

55. The Lethal Drug Abuse Prevention Act of 1998, H.R. 4006, 105th Cong. (1998); S. 2151, 105th Cong. (1998).

56. Pain Relief Promotion Act of 1999, H.R. 2260, 106th Cong. (1999); S. 1272, 106th Cong. (1999).

57. S. 1272, at 2.

PRPA directed the Attorney General to give no “force and effect to State law authorizing or permitting assisted suicide”⁵⁸ when determining what uses of a controlled substance are in the public interest. The Act passed the House,⁵⁹ but never reached the floor of the Senate for a vote.

By November 2001, the country had a new President and a new Attorney General, John Ashcroft. On November 6, 2001, just about four years to the day that Oregon voters approved the ODWDA, Attorney General Ashcroft issued his Interpretive Rule that provided in pertinent part that: Assisting suicide is not a “legitimate medical purpose” within the meaning of 21 CFR § 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 practitioners⁶⁰

This Interpretive Rule supported the DEA’s 1997 conclusion that controlled substances may not be prescribed and dispensed to assist suicides and directly contradicted his predecessor’s conclusion that “adverse action against a physician who has assisted in a suicide in full compliance with the Oregon Act would not be authorized by the CSA.”⁶¹ The Interpretive Rule encouraged the DEA to undertake immediate enforcement, and even suggested that the process could be expedited by using Oregon’s own state provisions under the ODWDA to “identify cases in which federally controlled substances are used to assist suicide.”⁶²

58. *Id.*

59. The Pain Relief Promotion Act of 1999 passed the House by a vote of 237-174.

60. Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607, 56,608 (Nov. 9, 2001).

61. Letter from Janet Reno, Att’y Gen., *supra* note 53, at 9.

62. Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607, 56,608 (Dep’t of Justice Nov. 9, 2001). In the Attorney General’s opinion, using Oregon’s own records would make the process more expedient and could give the DEA the information it needed “without having to review patient medical records or otherwise investigate doctors.” *Id.*

On November 7, 2001, the State of Oregon commenced an action in U.S. district court for declaratory and injunctive relief to enjoin the enforcement of the Interpretive Rule. Judge Jones held that the CSA does not authorize the U.S. Justice Department to effectively overturn the Oregon law through the interpretation of an administrative statute that attempts to define the meaning of "legitimate medical purpose."⁶³ Citing the failure of the Lethal Drug Abuse Prevention Act or its successor the Pain Relief Prevention Act, Judge Jones characterized the Interpretive Rule as an attempt to "get through the administrative door that which they [opponents of the ODWDA and physician-assisted suicide] could not get through the congressional door."⁶⁴

Attorney General Ashcroft filed a timely appeal with the Ninth Circuit Court of Appeals. A three-judge panel held that the Interpretive Rule was unlawful and unenforceable because it "lacks clear congressional authority"⁶⁵ and "violates the plain language of the CSA."⁶⁶ After the Ninth Circuit declined to rehear the case en banc, the Attorney General filed a petition for certiorari with the U.S. Supreme Court. He announced his retirement that afternoon.

III. THE SUPREME COURT'S DECISION IN *GONZALES V. OREGON*

The substantive issues surrounding physician-assisted suicide in *Gonzales v. Oregon* take a back seat to the narrow question of whether the Attorney General has permissibly construed the Controlled Substances Act and its implementing regulations to prohibit the distribution of federally controlled substances for the purpose of assisting suicides. In a six-three decision, the Supreme Court held that the CSA does not authorize the Attorney General to

63. *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077, 1087 (D. Or. 2002).

64. *Id.* at 1093.

65. *Oregon v. Ashcroft*, 368 F.3d 1118, 1125 (9th Cir. 2004).

66. *Id.*

prohibit physicians from prescribing scheduled drugs under the Oregon Death With Dignity Act.

A. Summary of the Majority Opinion

The majority opinion authored by Justice Kennedy and joined by Justices Stevens, O'Connor, Souter, Ginsburg, and Breyer, began with a careful statement that narrowed the decisional grounds. The Court announced that while the dispute that gave rise to the suit was a product of "political and moral debate,"⁶⁷ the resolution was one of straightforward statutory interpretation.

The Court first pointed out that the ODWDA was enacted pursuant to a voter referendum and survived a ballot measure to repeal the legislation. Having thus established the legislation's popular roots, the Court briefly recounted the factual history with considerable space devoted to the fact that, in a span of just four years, two Attorney Generals had come to two disparate conclusions regarding whether the CSA permitted deregistration of physicians who prescribed controlled substances for the purpose of assisting suicide pursuant to Oregon law. Where Attorney General Reno found that the CSA did not authorize her office 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 practices,"⁶⁸ Attorney General Ashcroft unequivocally found that "assisting suicide is not a 'legitimate medical purpose' within the meaning of 21 C.F.R. 1306.04 (2001),"⁶⁹ an administrative regulation promulgated under the CSA.

The Court defined two questions that needed to be decided to resolve the present dispute between the Federal Government and the State of Oregon. The first was what degree of deference, if any, should be afforded the Attorney General's substantive conclusions about the meaning of "legitimate medical purposes" within the meaning of 21 CFR 1306.04 (2001) (the "Regulation"). The second question, and arguably the more fundamental one, was

67. *Gonzales v. Oregon*, 126 S. Ct. 904, 911 (2006).

68. Letter from Janet Reno, Att'y Gen., *supra* note 53, at 10.

69. *Dispensing of Controlled Substances to Assist Suicide*, 66 Fed. Reg. 56,607, 56,608 (Nov. 9, 2001).

whether the Regulation that the Interpretive Rule purports to further define is authorized by the statutory provisions of the CSA.

The Government first argued that the Attorney General's Interpretive Rule was an elaboration on a 1971 Attorney General Regulation that required all prescriptions be issued for a "legitimate medical purpose,"⁷⁰ and as such was entitled to considerable deference in accordance with the Supreme Court's decision in *Auer v. Robbins*.⁷¹ At issue in *Auer* was whether a class of law enforcement officers were due overtime pay in accordance with the Fair Labor Standards Act of 1938. The Secretary of Labor wrote an amicus brief to the Court stating that the officers were exempt from overtime pay because they met the "salary basis test" that had been set out in a previous regulation promulgated by the Secretary.⁷² The Court found the Secretary's interpretation controlling because the salary basis test was a "creature of the Secretary's own regulations"⁷³ and his interpretation of that test represented the "considerable experience and expertise the Department of Labor had acquired over time with respect to the complexities of the Fair Labor Standards Act."⁷⁴

The Court reasoned that unlike the Secretary of Labor's interpretation of the salary basis test in *Auer*, the Attorney General's interpretation of what constituted a "legitimate medical purpose" pursuant to the Regulation was not controlling because the language in that Regulation did not give specificity to the CSA's statutory scheme, or reflect the considerable experience of the Department of Justice.⁷⁵ Instead, the Court found that the Regulation's decree that prescriptions only be issued "for a legitimate medical purpose by an individual practitioner acting in the usual

70. 21 C.F.R. § 1306.04 (2006).

71. 519 U.S. 452 (1997).

72. *See id.* at 454.

73. *Id.* at 461.

74. *Gonzales v. Oregon*, 126 S. Ct. 904, 915 (2006).

75. *See id.*

course of his professional practice”⁷⁶ did little more than “restate the terms of the statute itself.”⁷⁷

The Court also found that the Attorney General’s Interpretive Rule was not entitled to *Auer* deference because his authority to issue the Rule, and thus deregister physicians whose registration runs contrary to the public interest, was not granted until 1984, nearly thirteen years after the Regulation was originally promulgated.⁷⁸ As the Attorney General could not have foreseen this deregistration authority in 1971 when he originally issued the Regulation, the 1999 Interpretive Rule cannot be said to embody the intent of the Attorney General at that time.

With *Auer* deference thus foreclosed, the Court turned to whether the Interpretive Rule was entitled to *Chevron*⁷⁹ deference. Such deference is appropriate only when Congress has delegated rulemaking authority to an agency and the rule in question is promulgated pursuant to that authority. The Court found that rather than delegating broad rulemaking authority to the Attorney General, Congress chose instead to strictly limit his authority to “registration”⁸⁰ and “control.”⁸¹ According to the Court’s reading of the statutory text, the words “control” and “registration” are severely limited and not subject to their colloquial definitions. The Court interpreted the statute to define “control” as the ability 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.”⁸² The Court conceded that the word “control” is used outside the scheduling context and that the Attorney General was given the authority to establish

76. 21 C.F.R. § 1306.04 (2006).

77. *Gonzales v. Oregon*, 126 S. Ct. at 915.

78. *Id.* at 916 (citing *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994) for the proposition that *Auer* deference is not warranted when a current interpretation of a regulation is counter to intent at the time of regulation’s promulgation).

79. *Chevron U.S.A., Inc. v. Natural Res. Def. Council*, 467 U.S. 837 (1984).

80. *See* 21 U.S.C. § 821 (2000).

81. *See id.*

82. *Id.* § 802(5).

controls "against diversion."⁸³ This power, however, cannot be said to give the Attorney General the expansive authority to define diversion by reference to his own views on what does and does not constitute legitimate medical practice.⁸⁴ Therefore, the Interpretive Rule, which endeavors to do just that, cannot be entitled to *Chevron* deference.

Similarly, the registration provisions that permit the Attorney General to deregister physicians whose registration does not accord with the public interest,⁸⁵ does not confer broad discretion. In determining whether a physician's registration is in the public interest, the Attorney General must undertake a five factor analysis⁸⁶ that includes the licensing state's recommendations, compliance with federal, state, and local laws concerning controlled substances, as well as public health and safety. The Interpretive Rule declared prescribing practices that are legal under Oregon law to be a federal crime. Because this power far exceeded the Attorney General's authority, it was not deserving of any judicial deference. The Court reasoned that it would be inconsistent for Congress to have "so painstakingly described the Attorney General's limited authority to deregister a single physician or schedule a single drug, but to have given him, just by implication, authority to declare an entire class of activity outside 'the course of professional practice,' and therefore a criminal violation of the CSA."⁸⁷

The Court found no argument with the fact that the Attorney General's deregistration power carries an implication of criminal enforcement. This enforcement, however, would only be triggered if a physician dispensed a controlled substance after he was deregistered. The problem for the Court was that the Interpretive Rule works "in the opposite direction"⁸⁸ by declaring certain conduct criminal and thus triggering deregistration. The fatal flaw

83. *Id.* § 823(a)(1).

84. *See Gonzales v. Oregon*, 126 S. Ct. 904, 916 (2006).

85. *See* 21 U.S.C. § 823(f) (2000).

86. *See id.* §§ 823(f)(1)-(5).

87. *Gonzales v. Oregon*, 126 S. Ct. at 918.

88. *Id.*

with the Interpretive Rule was that it presumed that the Attorney General, on his own, could decide what constitutes a violation of the CSA. If this were true, the Court reasoned, the Attorney General could not only determine compliance with the law, but could also interpret what the law is. While the Court did not say so explicitly, it seems clear that such sweeping power would infringe on the traditional province of the judiciary to interpret the law.⁸⁹

The majority decision also rested heavily on the overall structure of the CSA. The Court viewed the CSA as setting up a bifurcated regulatory scheme that involves both the Attorney General and the Secretary of Health, with authority over legal and medical issues respectively. Put another way, the division of labor was squarely drawn, with the Secretary making medical decisions and the Attorney General making legal decisions.⁹⁰ The Court found evidence for this conclusion throughout the CSA, but singled out the provision that gives the Secretary of Health and Human Services the authority to determine the acceptable methods of professional practice in the medical treatment of drug addiction.⁹¹

The majority also found that congressional commentary following the enactment of the CSA did not support the Attorney General's claimed authority to regulate medical practice. When debating ratification of the United Nations Convention on Psychotropic Substances, Congress decided that the Convention would have to be integrated into the CSA's procedures and that "nothing in the Convention will interfere with ethical medical practice in this country as determined by the Secretary"⁹² Importantly, the Secretary of Health and Human Services, not the Attorney General, is delegated the task of ascertaining the ethics of professional medical practice.

Also unavailing was the Government's argument that the Attorney General's decision to deregister physicians

89. See *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803).

90. See *Gonzales v. Oregon*, 126 S. Ct. at 920.

91. See 21 U.S.C. § 823(g) (2000) (stating that the Attorney General shall register practitioners who dispense drugs for the treatment of narcotics addictions upon a determination by the Secretary that the applicant is so qualified).

92. 21 U.S.C. § 801a(3) (2000).

who prescribe controlled substances in accordance with ODWDA is a legal rather than a medical one. Here, the Court's reasoning rests on the Attorney General's substantial reliance on medical judgments in concluding that prescribing controlled substances to assist suicide is not a legitimate medical purpose.⁹³ The Court pointed out that the Office of Legal Counsel Memorandum that the Attorney General appended to his Interpretive Rule extensively discussed "Federal medical policy"⁹⁴ against physician-assisted suicide.⁹⁵ This memorandum also made medical distinctions between pain management and actively assisting suicide. The very fact that the Attorney General had to undertake such research demonstrates that his claimed authority is both "beyond his expertise and incongruous with the statutory purposes and design."⁹⁶ The Court maintained that if Congress intended the Attorney General to have such broad authority over the national medical policy, they would not have done so in such vague terms. "Congress," the Court declared, "does not hide . . . elephants in mouseholes."⁹⁷ As Congress never delegated such authority, nothing in the Attorney General's Interpretive Rule was deserving of *Chevron* deference.

The Attorney General's lack of authority to define the scope of legitimate medical practice made the Interpretive Rule non-binding on the Court. While not controlling, the Interpretive Rule might nonetheless have deserved of some deference under the Court's decision in *Skidmore*⁹⁸ to the extent that such Rule was thoroughly considered, validly reasoned, consistent with earlier and later agency pronouncements, and was otherwise persuasive.⁹⁹ The Court declined to find the Rule persuasive under *Skidmore* for a number of reasons.

93. The Attorney General's Interpretive Rule relied heavily on the Office of Legal Counsel Memorandum he sought prior to issuing his directive to the DEA.

94. *Gonzales v. Oregon*, 126 S. Ct. at 921.

95. *See id.*

96. *Id.*

97. *Id.* (quoting *Whitman v. Am. Trucking Ass'n*, 531 U.S. 457, 468 (2001)).

98. *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944).

99. *Id.* at 140.

First, the Interpretive Rule did not align with the overarching goals behind the CSA, a piece of legislation that the Court said embodies congressional intent to “conquer drug abuse and to control the legitimate and illegitimate traffic in controlled substances.”¹⁰⁰ Congress sought to regulate medical practice in the CSA *only* to the extent that it prohibits physicians from utilizing their prescription privileges to aid drug trafficking, and manifested no intent to regulate medicine generally, or physician-assisted suicide specifically. Congress, in fact, cautioned against concluding that the CSA displaced the states’ regulation of the medical profession by expressly stating that nothing in the Act should be “construed as indicating an intent on the part of the Congress to occupy the field”¹⁰¹

The Court found that the ODWDA is “an example of the state regulation of medical practice that the CSA presupposes”¹⁰² in the non-preemption clause. The Court carefully pointed out that Congress is certainly free to set uniform standards of medical practice, notwithstanding the fact that such regulation has been traditionally left to the states.¹⁰³ The question, the Court reiterated, was not whether Congress *can* regulate a physician’s ability to issue prescriptions for the purpose of assisting suicide, but rather whether Congress *did* in fact do so. The Court read the CSA’s silence on the practice of physician-assisted suicide, its general delegation of medical judgments to the Secretary of Health, and the non-preemption clause together to conclude that the Interpretive Rule was “difficult to defend”¹⁰⁴ and therefore lacked the power to persuade.

The Court concluded by stating that it was unnecessary to reach the clear statement arguments because their conclusion—that Congress would not grant the Attorney General the sweeping authority to regulate medical practice

100. *Gonzales v. Oregon*, 126 S. Ct. at 922 (citing *Gonzales v. Raich*, 545 U.S. 1, 12 (2005)).

101. 21 U.S.C. § 903 (2000).

102. *Gonzales v. Oregon*, 126 S. Ct. at 923.

103. *See id.*

104. *Id.* at 924.

through “muffled hints”¹⁰⁵— is fundamentally predicated on plain old “commonsense.”¹⁰⁶

B. *Summary of the Dissenting Opinion: Justice Scalia*

The dissent, authored by Justice Scalia and joined by Chief Justice Roberts and Justice Thomas, argued that there are three independent grounds for upholding the Attorney General’s Interpretive Rule.

First, the dissent contended that the Attorney General’s interpretation of “legitimate medical purpose” was deserving of *Auer* deference and is, therefore, “controlling unless ‘plainly erroneous or inconsistent with the regulation.’”¹⁰⁷ The attack on the majority’s reasoning started with its creation of an anti-parroting canon which, the dissent maintained, was wholly unsupported by precedent.¹⁰⁸

The dissent then assumed, *arguendo*, that even if an anti-parroting doctrine exists, its application would be misplaced in this instance because the Regulation represents the Attorney General’s interpretation and clarification of the word “prescription” above and beyond what is included in the original statute.¹⁰⁹ In an attempt at humor, the dissent argued that the regulation did not “run afoul”¹¹⁰ of the anti-parroting canon and therefore the Interpretive Rule based on that regulation was controlling unless it was “plainly erroneous or inconsistent.”¹¹¹ Here, the dissent maintained that the Attorney General’s conclusion that prescriptions require a medical purpose that is legitimate under a federal standard is reasonable, in part, because they came to the same conclusion as the Court did in *Webb v. United States*.¹¹² At issue in *Webb* was

105. *Id.* at 925.

106. *Id.*

107. *Auer v. Robbins*, 519 U.S. 452, 461 (1997) (quoting *Robertson v. Methow Valley Citizen Council*, 490 U.S. 337, 359 (1989)).

108. *See Gonzales v. Oregon*, 126 S. Ct. at 927 (Scalia, J., dissenting).

109. *Id.*

110. *Id.*

111. *Id.*

112. 249 U.S. 96 (1919).

whether an order for morphine, written to maintain the recipient's "customary use," was a prescription under the Harrison Act,¹¹³ a predecessor to the CSA. The Court found that "to call such an order for the use of morphine a physician's prescription would be so plain a perversion of meaning that no discussion of the subject is required."¹¹⁴ For Justice Scalia and the other dissenters, there appeared to be little difference between the facts in *Webb* and issuing prescriptions to assist terminally-ill patients to end their lives under the ODWDA.

The dissent dismissed the majority's narrow definition of "control" as used in the statutory text. "Control" within the meaning of the CSA does not mean solely the Attorney General's ability to add or remove a substance from a schedule. While this definition of control is consistent with § 802, it is incompatible with §§ 821-30, sections that deal with the "Registration of Manufacturers, Distributors, and Dispensers of Controlled Substances,"¹¹⁵ the specific areas of the Act that the Interpretive Rule addresses. In that context, the word "control" must necessarily take on its ordinary meaning—"to exercise restraining or directing influence over."¹¹⁶ Once the everyday meaning of "control" is adopted, the Attorney General's conclusion that the prescription requirement of § 829 "relates to the . . . control of the . . . dispensing of controlled substances"¹¹⁷ under § 821 is at least reasonable.

The dissent maintained that even if the Attorney General's Interpretive Rule was not entitled to deference under the Court's *Auer* or *Chevron* precedents, his interpretation of the regulation was nonetheless the most reasonable under any objective inquiry. This reasonableness was demonstrated by the extensive third-party authority that supports the proposition that assisting suicide is "fundamentally incompatible with a physician's

113. *See id.* at 99.

114. *Id.*

115. 21 U.S.C. §§ 821-30 (2000).

116. *Gonzales v. Oregon*, 126 S. Ct. at 930 (citing WEBSTER'S NEW INTERNATIONAL DICTIONARY 580 (2d ed. 1950)).

117. 21 U.S.C. § 821 (2000).

role as a healer.”¹¹⁸ According to the dissent, the majority erred in indulging a normative inquiry into what the parameters of medical practice *should be* rather than what they *are*.¹¹⁹

The dissent also took issue with the Court’s “lipservice”¹²⁰ to state autonomy. While appearing to reject the argument that the CSA creates a uniform federal standard for the legal distribution of controlled substances, the Court also rejected the opposite argument that any medical practice authorized by state law is legitimate within the meaning of CSA. The Court’s conclusion that “legitimate medical purpose,” as used in the CSA, refers to all uses of drugs unrelated to “addiction and recreational abuse” is in fact based on a “hazily defined *federal* standard,” extracted selectively from the legislation to serve the Court’s ends.¹²¹ This narrow definition of the CSA is not a result of sound reasoning, but rather the Court’s purposeful decision to work backward from its desired result—staking out a middle ground between sweeping federal standards and unbridled state experimentation.

In the alternative, even if the primary purpose of the CSA is to curtail drug abuse, there is nothing in the legislation that suggests this is its singular goal. If that were the case, the dissent posited, why would Congress have amended the Act in 1984 to authorize the Attorney General to deny a physician’s registration when such registration would be “inconsistent with the public interest”?¹²² In support of a broader reading of the CSA that encompasses public health and safety objectives, the dissent pointed to the Anabolic Steroids Control Act of 1990¹²³ that classified anabolic steroids as controlled drugs under Schedule III of the CSA. If the majority’s conclusion was correct, and the CSA’s sole purpose was to curtail addiction

118. *Gonzales v. Oregon*, 126 S. Ct. at 931 (citing *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997)).

119. *Id.* at 932.

120. *Id.* at 933.

121. *See id.*

122. 21 U.S.C. § 823(f) (2000).

123. The Anabolic Steroids Control Act classified anabolic steroids as controlled drugs and placed them in Schedule III of the CSA. *See* 21 U.S.C. § 812 (2000).

and recreational abuse, the control of these bodybuilding drugs would have been impermissible.

Finally, the dissent argued that even if the Attorney General's Interpretive Rule was an incorrect reading of the regulation, his *independent* conclusion that "prescribing, dispensing, or administering federally controlled substances . . . by a physician . . . may 'render his registration . . . inconsistent with the public interest' and therefore subject to possible suspension or revocation"¹²⁴ was entitled to deference under *Chevron* because the CSA clearly confers on the Attorney General the authority to interpret the statutory phrase "public interest" and "public health and safety."

Congress, the dissent argued, gave the Attorney General broad discretion to register or deregister physicians under the CSA. The only limit on this expansive power can be found in § 823(f), which enumerates five factors which the Attorney General must weigh.¹²⁵ The fifth and broadest factor explicitly states that the Attorney General shall consider "such other conduct which may threaten the public health and safety."¹²⁶ The dissent took issue with what they saw as the majority's apparent insistence that all five factors are to be read in the conjunctive rather than the disjunctive. Instead, the addition of this fifth factor should be read to provide the Attorney General with the authority to interpret the broad phrase "public interest" and exclude assisted suicide as contrary to such interest. The majority's conclusion that such a broad delegation cannot encompass setting a federal standard for medical practice, an argument grounded on the statute's division of labor between the Attorney General and the Secretary of Health, was dismissed by the dissent as untenable.¹²⁷ The fact that Congress gave the Secretary explicit responsibilities in the area of scheduling and addiction treatment, but not in the sections of the statute that pertain to the registration of physicians, leads to the unassailable conclusion that Congress "envisioned no role for the Secretary in that

124. Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607, 56,608 (Nov. 9, 2001).

125. See 21 U.S.C. § 823(f) (2000).

126. *Id.*

127. See *Gonzales v. Oregon*, 126 S. Ct. 904, 937 (2006).

area.”¹²⁸ The Attorney General, having been charged by Congress with the sole responsibility to register physicians in accordance with the public interest, is well within his authority to give notice to those physicians that a decision to prescribe controlled substances to assist suicides could make their further registration under the CSA contrary to public interest, the dissent concluded.

C. Summary of the Dissenting Opinion: Justice Thomas

Justice Thomas wrote a separate dissent that was sympathetic to the position that the CSA should be limited by federalism principles. Nonetheless, he ultimately concluded that such arguments were now “water over the dam”¹²⁹ given the Court’s decision just last term in *Gonzales v. Raich*.¹³⁰ In *Raich*, the Court held that the CSA authorized the Attorney General to prohibit the purely intrastate possession of marijuana that was legal under California law.¹³¹ According to Justice Thomas, the majority’s characterization of the scope of the CSA in this case differed markedly from the Court’s characterization of the same legislation in *Raich*. The statute had been somehow been transformed from a broad and “comprehensive regulatory regime specifically designed to regulate which controlled substances can be utilized for medicinal purposes, and in what manner,”¹³² to a statute of limited reach concerned primarily with “drug abuse”¹³³ as it relates to “addiction or abnormal effects on the nervous system.”¹³⁴

While Justice Thomas found the expansive scope of the CSA and the Attorney General’s sweeping powers therein

128. *Id.*

129. *Id.* at 941 (Thomas, J., dissenting).

130. 545 U.S. 1 (2005).

131. *See id.* at 7. Prior to *Raich*, the California Compassionate Use Act allowed physicians to prescribe marijuana. The state deemed the use of marijuana for documented medical purposes was legitimate even though the substance was listed on Schedule I of the CSA as having no such legitimate medical use.

132. *See id.* at 27 (emphasis added).

133. *Gonzales v. Oregon*, 126 S. Ct. at 940.

134. *Id.*

“troubling,”¹³⁵ such results, he lamented, are “merely the inevitable and inexorable consequence of the Court’s *Commerce Clause* and separation-of-powers jurisprudence.”¹³⁶ In the final analysis, Justice Thomas dissented not because he is a proponent of unchecked federal power, but because he believed that the majority was now furthering the same constitutional arguments, albeit under the “guise of statutory interpretation,”¹³⁷ that the Court found wanting only a mere seven months ago in *Raich*.

IV. A DIALOGUE ON DEFERENCE

The Supreme Court’s refusal to defer to the Attorney General’s Interpretive Rule represents a departure from the modern tendency of the Court to afford a high degree of deference to administrative rulemaking. In fact, one commentator has pointed out that in its final term of the twentieth century, the Court consistently sounded “a steady drum beat; a drum beat of deference.”¹³⁸ The decisions on which this characterization is based run the gamut of subject matter and include everything from an agency’s right to have the first chance to review constitutional challenges to its regulations,¹³⁹ to upholding a government decision to seize range fixtures from ranchers and their creditors.¹⁴⁰ Leading the charge in favor of agency deference is Justice Scalia, the author of the primary dissent, who has shown a willingness to do away with *Skidmore* deference entirely, and to expand *Chevron* deference beyond traditional notice-and-comment rulemaking, to any authoritative agency ruling including letters, decisions, and even no-action notices published in the federal register.¹⁴¹

135. *Id.* at 940.

136. *Id.* (citing *Gonzales v. Raich*, 545 U.S. 1 (2005) and *Whitman v. Am. Trucking Ass’n*, 531 U.S. 457 (2001)).

137. *Id.* at 941.

138. Allen E. Shoenberger, *October Term, 1999: The Supreme Court’s Last Term of the Twentieth Century, Increasing Deference to Administrative Agencies*, 21 J. NAT’L ASS’N ADMIN. L. JUDGES 213, 234 (2001).

139. *See Sims v. Apfel*, 530 U.S. 103 (2000).

140. *See City of Chicago v. Morales*, 527 U.S. 41 (1999).

141. *See Christiensen v. Harris County*, 529 U.S. 576, 589 (2000).

Many of the Court's recent decisions in support of agency deference tend to be close five-four majorities¹⁴² and are highly technical. While the spread on the *Gonzales v. Oregon* decision was six-three, the Court's analysis is characteristically technical and largely devoted to detailed interpretation of statutory language and its implications. Behind the technical language and the pages of close statutory analysis aimed at ascertaining the meaning of words such as "prescription" and "public interest," lies a simple idea—that the federalism-inspired clear statement rule should trump agency deference. While the Court finds that Congress would not "hide elephants in mouseholes"¹⁴³ by conferring on the Attorney General the broad authority to set national medical policy through vague CSA registration provisions, the Court makes only a passing reference to the structural federalism concerns that are also clearly implicated. The Court devotes only a mere paragraph at the end of a thirteen page opinion to what it calls the "background principles of our federal system" which "belie the notion that Congress would use such an obscure grant of authority to regulate areas traditionally supervised by the States' police power."¹⁴⁴ Rather than elaborate on the point, the Court simply makes the statement that "it is unnecessary even to consider the application of clear statement requirements."¹⁴⁵ The Court's seeming reluctance to make an explicit federalism argument in favor of a sometimes excruciating dialogue on deference leaves one to wonder if the Court is hiding a few elephants of its own.

In failing to deal explicitly with the clear statement requirement, the Court mirrored the Ninth Circuit's approach below. When Oregon sought injunctive relief from enforcement of the Attorney General's Interpretive Rule, the Ninth Circuit granted that request in part because it found that the Rule "interferes with Oregon's authority to regulate medical care within its borders,"¹⁴⁶ and thus "alters the 'usual constitutional balance between the States

142. Shoenberger, *supra* note 138, at 213.

143. *Gonzales v. Oregon*, 126 S. Ct. 904, 921 (2006).

144. *Id.* at 925.

145. *Id.*

146. *Oregon v. Ashcroft*, 368 F.3d 1118, 1124 (9th Cir. 2004).

and the Federal Government.”¹⁴⁷ In short, because the Attorney General’s interpretation of the CSA gave rise to federalism concerns, Judge Tallman, writing for the majority, invoked the “clear statement rule,” holding that Congress must be “unmistakably clear” when it intends to trespass on areas traditionally left to states’ police power.¹⁴⁸ Thus, while the Ninth Circuit’s decision rested in large part on the conclusion that the CSA failed to evince a clear statement from Congress regarding their intention to regulate physician-assisted suicide, the implicit arguments that such a clear statement requirement overrides agency deference “remained no more than an unspoken assumption.”¹⁴⁹

While the Court declined to put forward a clear statement argument in any detail, it is quite apparent that if Congress intends the CSA to sweep broadly enough to prohibit physician-assisted suicide, it must say so explicitly, either by directly prohibiting the practice or by empowering the Attorney General with such authority. The Court admitted that there is “no question that the Federal Government can set uniform national standards”¹⁵⁰ of health and safety despite the traditional entrustment of those matters to the states. What they cannot do, however, is alter the CSA’s scope to prohibit physician-assisted suicide through “muffled hints.”¹⁵¹ Whether Congress will speak louder on the matter is yet to be seen.

A. The Future of the Oregon Experiment: Prospects for Congressional Action

In the wake of the Supreme Court’s decision there is certainly a temptation to get overly sanguine about the future of the national dialogue on physician-assisted suicide specifically, and end of life issues more generally. Such

147. *Id.* (citing *Gregory v. Ashcroft*, 501 U.S. 452, 461 (1991)).

148. *See id.* at 1125.

149. *Recent Case: Administrative Law—Ninth Circuit Holds that Attorney General’s Directive Criminalizing Physician-Assisted Suicide Exceeded Authority Under the Federal Controlled Substances Act*, 118 HARV. L. REV. 1371, 1375 (2005).

150. *Gonzales v. Oregon*, 126 S. Ct. at 923.

151. *Id.* at 925.

optimism would likely be premature given the history of congressional attempts to defeat the Oregon Death With Dignity Act and the reluctance of state legislatures to engage in a dialogue about PAS legislation. Importantly, the Interpretive Rule that gave rise to *Gonzales v. Oregon* was only issued after several attempts to pass federal law prohibiting physician-assisted suicide failed to gain momentum.

1. *The Lethal Drug Abuse Prevention Act*. On June 5, 1998, the same day that then-Attorney General Janet Reno announced that the CSA did not permit the DEA to prohibit doctors acting pursuant to ODWDA from writing lethal prescriptions to assist terminally-ill individuals with ending their lives, Representative Henry Hyde proposed new legislation, the Lethal Drug Abuse Prevention Act of 1998 (LDAPA).¹⁵² Senator Nickles, Senator Lott, and eleven other senators introduced a companion bill in the Senate.¹⁵³ In a statement before the House, Representative Hyde portrayed assisted suicide as a natural result of the "slippery slope" entered into when the Supreme Court "sanctified abortion [as a] preferred option."¹⁵⁴ Senator Nickles stated before the Senate that the enactment of the LDAPA would ensure that federal authorization to prescribe DEA-regulated drugs does not include the authority to prescribe such drugs to cause death.¹⁵⁵ The LDAPA would have amended § 303 and § 304 of the Controlled Substances Act to provide for the suspension or revocation of a physician's license if that physician had "intentionally dispensed or distributed a controlled substance with a purpose of causing, or assisting in

152. H.R. 4006, 105th Cong. (1998).

153. See S. 2151, 105th Cong. (1998). Both the House and Senate bills followed on the heels of the Assisted Suicide Funding Restriction Act of 1997, 42 U.S.C. § 14403 (2000), legislation which prohibits the use of federal funds for assisting a suicide, mercy killing, or euthanasia.

154. *Lethal Drug Abuse Prevention Act of 1998: Hearing on H.R. 4006 Before the Subcomm. on the Constitution of the Comm. on the Judiciary*, 105th Cong. 1 (1998) (statement of Rep. Henry J. Hyde, Chairman Pro Tempore, Subcomm. on the Constitution of the Comm. on the Judiciary).

155. See *Drugs, Dignity, and Death: Physician-Assisted Suicide? Hearing on S. 2151 Before the Comm. on the Judiciary*, 105th Cong. 14 (1998) (statement of Sen. Don Nickles).

causing, the suicide or euthanasia of any individual.”¹⁵⁶ License revocation would not apply where a physician prescribed or distributed a controlled substance for “the purpose of alleviating pain or discomfort (even if the use of the controlled substance may increase the risk of death), so long as the controlled substance is not also dispensed or distributed for the purpose of causing, or assisting in causing, the death of an individual for any reason.”¹⁵⁷ The Attorney General would have had to prove by clear and convincing evidence that a physician *intended* to cause death.¹⁵⁸ This approach is consistent with the tendency of U.S. Courts to make distinctions between pain management that may inadvertently end a life and actions taken with the express intent to hasten death.¹⁵⁹ Significantly, the legislation was opposed by the American Medical Association (AMA), in part because of fears that doctors would be reluctant to prescribe adequate pain relief for suffering patients.¹⁶⁰ The legislation was sent to committee and never emerged.

2. *The Pain Relief Promotion Act.* The battle to end the Oregon experiment did not stop with the failure of the Lethal Drug Abuse Prevention Act. Senator Nickles introduced the Pain Relief Promotion Act (PRPA) in the Senate¹⁶¹ in June of 1999, concurrently with Representative Hyde who introduced the bill in the House.¹⁶² Senator Nickles testified before the Senate Judiciary Committee that the PRPA legislation was designed to respond to the concerns of the medical community that arose with the

156. Lethal Drug Abuse Prevention Act of 1998, H.R. 4006, 105th Cong. § 2(b)(4) (1998).

157. *Id.*

158. *See id.* § 2(a)(2).

159. *See* David Orentlicher, *The Supreme Court and Physician-Assisted Suicide: Rejecting Assisted Suicide but Embracing Euthanasia*, 337 NEW ENG. J. MED. 1236, 1237 (1997); *see also* Brett Kingsbury, *A Line Already Drawn: The Case for Voluntary Euthanasia After the Withdrawal of Life-Sustaining Hydration and Nutrition*, 38 COLUM. J.L. & SOC. PROBS. 201, 236-38 (2004).

160. *See, e.g.,* David Orentlicher & Arthur Caplan, *The Pain Relief Promotion Act of 1999: A Serious Threat to Palliative Care*, 283 J. AM. MED. ASS'N 255, 258 (2000).

161. *See* Pain Relief Promotion Act of 1999, S. 1272, 106th Cong. (1999).

162. *See* Pain Relief Promotion Act of 1999, H.R. 2260, 106th Cong. (1999).

introduction of the Lethal Drug Abuse Prevention Act.¹⁶³ Accordingly, PRPA had three main goals: (1) to make clear that the Controlled Substances Act prohibited the use of federally controlled substances to assist suicides; (2) to promote greater understanding of pain management and palliative care in the medical and law enforcement community; and (3) to gain the support of the National Hospice Association and the American Medical Association who had voiced opposition to the LDAPA.¹⁶⁴ The Act consisted of two major titles. Title I amended the Controlled Substances Act to prohibit physician-assisted suicide, while Title II was designed to promote palliative care, education, and research. The Pain Relief Promotion Act attempted to differentiate between the practice of prescribing drugs that may have the incidental effect of hastening death and the practice of prescribing drugs for the express purpose of causing death by making clear that “alleviating pain or discomfort in the usual course of professional practice is a legitimate medical purpose for which dispensing, distributing, or administering a controlled substance that is consistent with public health and safety, even if the use of such a substance may increase the risk of death.”¹⁶⁵

Unlike its predecessor, the Pain Relief Promotion Act succeeded in gaining the support of both the AMA and the National Hospice Association. The AMA undertook an independent legal analysis of the legislation and concluded that it would be “incorrect to suggest that the ‘Pain Relief Promotion Act of 1999’ is no different than the bill introduced by the same sponsors in the last Congress, the ‘Lethal Drug Abuse Prevention Act of 1998.’”¹⁶⁶ This analysis went on to point out that while the latter bill “cited participation in physician-assisted suicide as a reason to revoke a physician’s Drug Enforcement Administration (DEA) registration, and specifically permitted revocation or denial of registration if the DEA believed there was reason

163. *The Pain Relief Promotion Act: Hearing on H.R. 2230 Before the S. Judiciary Comm.*, 106th Cong. (2000) (testimony of Sen. Don Nickles).

164. *See id.*

165. Pain Relief Promotion Act of 1999, H.R. 2260, 106th Cong. § 101 (1999).

166. AMERICAN MEDICAL ASSOCIATION, ANALYSIS OF S.1272 / H.R. 2260—THE NICKLES/HYDE “PAIN RELIEF PROMOTION ACT OF 1999” (1999), <http://www.ama-assn.org/ama/upload/mm/399/leg1099.pdf>.

to suspect a physician's intention was to assist a suicide," PRPA, "explicitly acknowledges the medical legitimacy of the 'double effect' in the CSA and provides a new and important statutory protection for physicians prescribing controlled substances for pain, particularly for patients at the end of life."¹⁶⁷ The AMA goes on to assure its members that this "significant improvement to the CSA largely rectifies the AMA's concern about last year's bill [the Lethal Drug Abuse Prevention Act of 1998] regarding the potential to chill appropriately aggressive prescribing for pain management."¹⁶⁸

This official support notwithstanding, some state medical societies dissented from the AMA, stating that the legislation would actually have a chilling effect on pain management because physicians—concerned over increased scrutiny over pain management—would be reluctant to aggressively treat pain management in the terminally-ill.¹⁶⁹ Particularly troublesome was section 102 of the Act, which provided for the training of law enforcement "on the necessary and legitimate use of controlled substances in pain management and palliative care"¹⁷⁰ Giving law enforcement officers with no clinical education on medical decision making would, according to one advocacy group, invite "misunderstanding and misidentification of violations."¹⁷¹ Dr. David Orentlicher of the Center of Law and Health at Indiana University and former director of the AMA's Division of Medical Ethics, testified before the House Judiciary Committee, that the passage of PRPA would likely discourage pain management rather than encourage it, stating "[n]o matter how many words you attempt to write into this Act to define and encourage good pain management and palliative care, the reality of the practice of medicine all over the country is that doctors would rather

167. *Id.*

168. *Id.*

169. See *Pain Relief Promotion Act: Hearing on S. 1272 Before the S. Judiciary Comm.*, 106th Cong. (Apr. 25, 2000) (statement of Sen. Patrick Leahy, Ranking Member, S. Judiciary Comm.), available at <http://leahy.senate.gov/press/200004/000427e.html>.

170. Pain Relief Promotion Act, S. 1272, 106th Cong. § 102 (1999).

171. Steven J. Baumrucker, *Should We Fear the Pain Relief Promotion Act?* AM. J. HOSPICE & PALLIATIVE CARE, July-Aug. 2000, at 224, 225 (quoting the American Academy of Family Practice).

avoid risk, interrogation, and investigation at all costs.”¹⁷² Dr. Orentlicher had previously expressed concern that the legislation required law enforcement officers to ascertain, after the fact, what a physician’s intent was when prescribing pain medication and opined that “physicians must worry that law enforcement officers will see a criminal intent where none existed.”¹⁷³

The disparate goals of the legislation probably contributed to its demise. Even commentators that applauded the legislation’s support of palliative care were skeptical of the decision to promote pain management and prohibit physician-assisted suicide in the same piece of legislation.¹⁷⁴ It appeared as though Congress was attempting to strike down a single law in a single state by exposing doctors all over the country to enhanced scrutiny and quite possibly criminal prosecution.¹⁷⁵ This killing a fly with a sledge hammer approach proved too much. At the beginning of the 2000 congressional session, passage of PRPA in the Senate appeared imminent, but opponents rallied for a further examination of the bill’s costs and objectives.¹⁷⁶ The result was that the legislation failed to reach the floor for a full vote before the session adjourned.

B. *The Future of Oregon’s Experiment: Prospects for State Action*

Perhaps contributing to congressional acquiescence thus far, is the reluctance of most states to introduce or pass legislation that would legalize physician-assisted suicide. Oregon is not the first state to attempt to legalize PAS, but it is the first to succeed. The states of Washington,

172. *Pain Relief Promotion Act: Hearing on H.R. 2260 Before the Subcomm. on the Constitution of the H. Judiciary*, 106th Cong. (1999) (statement of David Orentlicher, Professor, Indiana University School of Law).

173. Orentlicher & Caplan, *supra* note 160, at 255.

174. One commentator noted that it seemed as if “the palliative care aspects were merely tacked on to make a bill striking down the Oregon law more palatable (and thereby ‘passable’).” Baumrucker, *supra* note 171, at 225.

175. *Id.*

176. See generally 106 CONG. REC. S13156 (daily ed. Oct. 26, 1999) (statement of Sen. Wyden).

California, and Michigan¹⁷⁷ all attempted to pass referendums on PAS before Oregon, and all failed. In 1991, Washington became the first state to hold a referendum on the practice. The legislature introduced Proposition 119 which attempted to amend the state's 1979 Natural Death Act (the nation's second living-will legislation).¹⁷⁸ The question on the ballot was plainly, "[s]hall adult patients who are in a medically terminal condition be permitted to request and receive from a physician aid-in-dying?"¹⁷⁹ The ambiguous phrase "aid-in-dying," together with what opponents called a lack of "safeguards," likely contributed to the Proposition's defeat.¹⁸⁰ When the final tally was taken, the Proposition garnered forty-six percent of the 1.5 million votes cast.¹⁸¹ On January 24th, shortly after *Gonzales v. Oregon* was handed down, Senator Thibaudeau and other senators introduced the "Washington Death With Dignity Act," a bill patterned on the Oregon Death With Dignity Act.¹⁸² It died in committee.

In 1992, California became the second state to attempt to pass some version of a physician-suicide law by referendum. The first proposition—California's Proposition 161—was authored by the Hemlock Society,¹⁸³ the same organization that created Washington's Proposition 119, but this time the proposition spelled out the meaning of "aid-in-dying." Interestingly, the definition left room for PAS and active euthanasia. Proposition 161 notably established some safeguards that were missing from the Washington Proposition, including the requirement that

177. The State of Michigan held a referendum on PAS in 1998 and the measure failed by a seventy-one percent to twenty-nine percent margin. State of Michigan, Department of State, Official 1998 Election Results for State Proposal B, <http://miboecfr.nicusa.com/election/results/98gen/90000002.html> (last visited Feb. 25, 2007).

178. Natural Death Act, WASH. REV. CODE ANN. §§ 70.122.010-.905 (2005).

179. George Annas, *Death by Prescription: The Oregon Initiative*, 331 NEW ENG. J. MED., 1240, 1240 (1994).

180. *See id.*

181. Rob Carson, *Washington's I-119*, HASTINGS CTR. REP. Mar.-Apr. 1992, at 7, 7.

182. *See* S.B. 6843, 59th Leg. (Wash. 2006).

183. The Hemlock Society has since changed its name to "Compassion and Choices." *See* Compassion and Choices, <http://www.compassionandchoices.org/aboutus/themovement.php> (last visited Feb. 25, 2007).

written directives be witnessed and that records on the program be regularly transmitted to the California State Department of Health Services.¹⁸⁴ The California Proposition was defeated by a margin of fifty-four percent to forty-six percent.¹⁸⁵

Since Proposition 161 was defeated, California has made several other attempts to pass PAS legislation. The state's most recent attempt at legalizing the practice is entitled the "Compassionate Choice Act."¹⁸⁶ The legislation is patterned on the Oregon Death With Dignity Act and if passed, would allow a physician to prescribe a self-administered, life-ending drug to an adult who requested it, had been found by two doctors to be mentally competent, and was within six months of death. The bill was introduced in the Assembly in February 2005, and passed by a vote of 48-30 in May of that same year.¹⁸⁷ On June 27, 2006, the California Senate Judiciary Committee voted down the legislation, assuring that the legislation would not have a hearing in front of the full Senate.¹⁸⁸

Washington and California are not alone in persevering to pass physician-assisted suicide legislation. The states of Arizona, Maine, Hawaii, Rhode Island, Vermont, and Wisconsin have also introduced Death With Dignity legislation. Two states, Vermont and Hawaii, have long histories of entertaining PAS legislation. In Vermont, legislation patterned on the Oregon Death With Dignity Act was introduced in 2003, 2005, and 2007.¹⁸⁹ The 2007

184. See Annas, *supra* note 179, at 1240-41.

185. Patrick M. Curran, Jr., *Regulating Death: Oregon's Death with Dignity Act and Legalization of Physician-Assisted Suicide*, 86 GEO. L.J. 725, 727 (1998).

186. A.B. 651, 2005-06 Leg. Sess. (Ca. 2005).

187. The California Assembly vote tally for A.B. 651 is available at the California State Legislature webpage, http://www.leginfo.ca.gov/pub/05-06/bill/asm/ab_0651-0700/ab_0651_bill_20061130_history.html (last visited Feb. 25, 2007).

188. The California Senate Judiciary vote tally is available at the California State Senate webpage, http://info.sen.ca.gov/pub/05-06/bill/asm/ab_0651-0700/ab_651_vote_20060627_000003_sen_comm.html (last visited Feb. 25, 2007).

189. In 2003, Vermont's legislature considered several measures on both sides of the issue. Two bills (S. 112 and S. 181) would have made PAS legal, one bill (H. 275) would have prohibited the practice. In 2005, the "Vermont Death With Dignity Act" (H. 168) was introduced and died in committee.

legislation is entitled "Patient Choice and Control at the End of Life" and is now being considered by the Human Services Committee.¹⁹⁰ Similarly, PAS legislation was introduced in Hawaii in 2002, 2003, 2005, 2006, and 2007.¹⁹¹ Hawaii's 2007 Death With Dignity legislation was introduced concurrently in the House on January 22nd and in the Senate on January 24th.¹⁹²

In the eight years since the Supreme Court issued an invitation to the states to continue the democratic debate around the right to die,¹⁹³ no state outside of Oregon has legalized the practice of physician-assisted suicide. In fact, with the addition of Maryland in 1999,¹⁹⁴ forty states now explicitly prohibit assisting a suicide by statute while still others forbid the practice by operation of common law.¹⁹⁵ Interestingly, most of these states, including Maryland, continue to couple physician-assisted suicide with assisted suicide in general, failing to make any principled distinction between the two. This trend, together with the inability of state legislatures to move Death With Dignity legislation out of committee in the wake of the *Gonzales v. Oregon* decision, suggests that a large scale national debate on the wisdom or imprudence of physician-assisted suicide will remain illusive.

CONCLUSION

The profound moral, legal, and ethical issues that surround the end of human life are deeply felt and strongly argued as evidenced in events that culminated in the

190. H. 0044, 2007 Leg. Sess. (Vt. 2007).

191. For a comprehensive history on Death With Dignity legislation for Hawaii and other states see, Professor Valerie Vollmar's Physician Assisted Suicide Website, <http://www.willamette.edu/wucl/pas/> (last visited Feb. 25, 2007).

192. See S.B. 1995, 24th Leg. Sess. (Ha. 2007); H.B. 675, 24th Leg. Sess. (Ha. 2007).

193. *Washington v. Glucksberg*, 521 U.S. 702, 797 (1997). The Court noted that their decision "permits this debate to continue as it should in a democratic society." *Id.*

194. See 21 MD. CODE ANN. § 416 (2007).

195. See Nightingale Alliance, *Chart of Legal Status of Assisted Suicide/Euthanasia in the United States*, http://www.nightingalealliance.org/pdf/state_grid.pdf (last visited Feb. 25, 2007).

Supreme Court's decision in *Gonzales v. Oregon*. The emergence of the Oregon model has confronted the American people with the issue of physician-assisted suicide, and more broadly with the issue of dignity at the end of life. To say that the conversation has proved uncomfortable would be an understatement. This discomfort with the substance of the conversation is reflected in seemingly small matters such as syntax. For example, in Oregon, the advocacy group Compassion and Choices has expended energy persuading the state to remove the word "suicide" from all references to the Death With Dignity Act, while other advocates have lobbied the Associated Press to make "aid in dying" the preferred phrase in its stylebook.¹⁹⁶ Given Congress's inability to pass legislation prohibiting physician-assisted suicide and the reluctance of other states to join the conversation, Oregon is still, for now, the only one talking.

The continuation of the Oregon dialogue has its advantages, not the least of which is that it affords Americans the opportunity to listen, albeit from a distance. The process of physician-assisted suicide in Oregon is highly regulated and the Oregon Department of Human Services produces a plethora of data about which terminally-ill patients are seeking to end their lives and why they are making that choice.¹⁹⁷ The importance of this data cannot be understated. In fact, much of the data that has been compiled in the nine years since the law was enacted undermines the parade of horrors often relied upon by opponents of physician-assisted suicide.¹⁹⁸ Future data from Oregon promises to assist bio-ethicists,

196. See Patty Fisher, 'Aid in Dying' Kinder Image Than Suicide, SAN JOSE MERCURY TIMES, Nov. 19, 2006, at 1B.

197. The Oregon Department of Human Services is legally required to collect information regarding compliance with the Act and make information available on a yearly basis. See OR. REV. STAT. § 127.865 (2005). All annual reports can be found at www.oregon.gov/DHS/ph/pas.

198. Opponents of physician-assisted suicide often suggest that the process will be over utilized and will become a means by which to rid society of those who are poor, uneducated, and uninsured. To date, 246 Oregonians have availed themselves of the practice and according to the Oregon Department of Human Services, since 2002 the ratio of PAS deaths to total deaths has remained stable. Additionally, participation rates in PAS are higher among those with more years of formal education and those with private insurance. See OREGON DEP'T OF HUMAN SERVICES, *supra* note 23 at 4, 19-24.

legislators, medical professionals, and the public in parsing out the facts from the fiction surrounding PAS, but only if this experiment in end of life choice is allowed to continue unabated by federal intervention.

