THE PEW FORUM ON RELIGION & PUBLIC LIFE

Supreme Court Considers Challenge to Oregon's Death with Dignity Act

Gonzales v. Oregon and the Right to Die

On October 5, 2005, the Supreme Court will hear oral argument in *Gonzales v. Oregon*, a case arising from the conflict between Oregon's Death with Dignity Act (DWDA) and the U.S. attorney general's interpretation of the federal Controlled Substances Act of 1970 (CSA). The federal law controls the distribution of drugs by regulating those who are registered to prescribe and dispense them, and by assigning drugs to categories of risk or medical usefulness. Oregon's Death with Dignity Act permits physicians to prescribe a lethal dose of drugs to certain terminally ill patients, who may then choose to end their own lives. The law was initially enacted in 1994 through a voter initiative, but a court injunction delayed its implementation until 1997, when voters again approved the measure in a second referendum. The court then lifted the injunction. Almost immediately, federal legislators and executive branch officials focused on the Oregon law's potential conflict with the federal Controlled Substances Act.

The administrator of the federal Drug Enforcement Administration (DEA) initially determined that physician-assisted suicide is not a "legitimate medical purpose" under the CSA. But then-Attorney General Janet Reno overruled that determination and found that the statute "does not authorize [the DEA] to prosecute, or to revoke registration [under the CSA] of, a physician who has assisted in a suicide in compliance with Oregon law." In 1998 and 1999, federal legislators, led by then-Senator John Ashcroft, introduced two bills designed to amend the CSA to state explicitly that physician-assisted suicide is not a "legitimate medical purpose," and that the registration of a doctor prescribing controlled substances for that purpose may be revoked. Neither bill passed, and Oregon doctors and pharmacists were left free to prescribe and fill prescriptions under the DWDA without fear of losing their registrations under the CSA.

By 2001, however, the legal landscape had changed dramatically; John Ashcroft was now attorney general. Using his authority under the CSA and its regulations, Ashcroft reversed Janet Reno's position on the Death with Dignity Act. In a ruling known as the "Ashcroft Directive," he determined that physician-assisted suicide is not a "legitimate medical purpose." Any doctor who

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prescribes drugs for the purpose of assisting a patient's suicide — and any pharmacist who fills a prescription written for that purpose — is likely to violate the CSA, the attorney general ruled, and risks loss of his or her privilege to prescribe drugs or fill prescriptions as well as possible criminal penalties.

An Oregon doctor and pharmacist, joined by patients and the state of Oregon, immediately filed suit to block enforcement of the Ashcroft Directive. The plaintiffs contended that the Directive exceeds the attorney general's authority under the CSA. The law was intended to combat the illegal traffic in narcotics, they argued, not to regulate the practice of medicine, which is an area traditionally left to state control. A federal district judge enjoined enforcement of the Ashcroft Directive, and the attorney general appealed. On May 26, 2004, the U.S. Court of Appeals for the Ninth Circuit ruled in favor of the plaintiffs and held the Ashcroft Directive "unlawful and unenforceable." Attorney General Ashcroft petitioned the U.S. Supreme Court to hear the case in its 2005-06 term. By the time the court agreed to hear the case, in February 2005, Ashcroft had been replaced by Alberto Gonzales.

Gonzales v. Oregon arises out of the morally charged debates and lawsuits surrounding end-of-life decision-making, seen most recently in the nationwide controversy involving Terri Schiavo. These debates and the cases that accompanied them are the focus of the first section of this backgrounder. Although these controversies ensure that *Gonzales v. Oregon* will generate much public interest, the case will not be resolved on broad moral, political or even constitutional terms. Instead, as is described in the second section of this backgrounder, the Supreme Court's decision will likely involve technical legal questions about statutory interpretation and the deference courts should accord to certain decisions of federal administrative officials.

The End-of-Life Debate

The debate over the legal, ethical and political implications of death and dying is a relatively recent phenomenon. Prior to the scientific and technological revolutions of the 19th and 20th centuries, most people died at home, often quite rapidly from viral or bacterial infections or various other diseases for which there were no effective treatments.

The idea of using drugs or other means to hasten someone's painful end, while not unheard of, was frowned upon at all levels of American society. Traditional Jewish and Christian teachings consider taking one's own life to be a grave sin. Moreover, the ancient Hippocratic Oath and other medical codes of conduct have long prohibited doctors from assisting in the taking of life, even if the patient wants to die prematurely.

The modernization of health care in the 20th century dramatically changed the character of death and dying. People began to routinely die in hospitals. More importantly, new technologies, such as the artificial respirator, allowed doctors to prolong life, often for substantial periods of time.

By the 1950s, a small body of writers and thinkers in the United States and Europe began to argue in favor of voluntary euthanasia. These arguments gained wider acceptance in the 1960s as the civil rights movement, the sexual revolution and other social movements helped to expand notions of

personal freedom. In 1967, the first "right to die" bill was introduced in the United States — in the Florida legislature. It failed, as did a similar measure in the Idaho legislature in 1969.

In the 1970s the end-of-life debate vaulted onto the national stage, thanks in large part to the highly publicized case of Karen Ann Quinlan. Quinlan, a 21-year-old New Jersey woman, fell into a coma in April 1975, possibly due to mixing valium and alcohol. Despite efforts to resuscitate her, she never regained consciousness. Quinlan was later judged to be in a "chronic persistent vegetative state," a condition in which the patient is judged to have no remaining cognitive functions. She was surviving with the assistance of an artificial respirator.

Several months after Karen's hospitalization, her father and legal guardian, Joseph Quinlan, determined that she would not want to be kept alive in her present condition. When he directed the hospital to remove her respirator, her treating physician refused, prompting Mr. Quinlan to sue in state court for the right to remove his daughter's life support. After a highly publicized trial, the court ruled against Quinlan.

The decision was overturned on appeal to the New Jersey Supreme Court, and Joseph Quinlan was granted the right to remove his daughter from the respirator. Writing for a unanimous court in *In re Quinlan*, New Jersey Chief Justice Richard J. Hughes found that Karen's (and by extension Joseph's) right to terminate her life support was grounded in the U.S. Constitution's unwritten right to privacy. That right had solidified in the years just before *Quinlan*, notably in two landmark Supreme Court cases, *Griswold v. Connecticut* (1965) and *Roe v. Wade* (1973).

In *Griswold*, the Supreme Court found that specific provisions of the Bill of Rights, when taken together, create certain privacy protections. This idea — that privacy protections "emanate" from the Bill of Rights — was affirmed in *Roe*, which expanded the privacy sphere to create a right to abortion.

Griswold specifically concerns the right of married couples to seek contraception counseling. But, as Chief Justice Hughes noted, the privacy right enumerated in *Griswold* "is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions," as in *Roe*.

Ironically, Karen Quinlan continued to live after her respirator was removed. She did not die until 1985, nine years after the case had been resolved.

In the years following the *Quinlan* decision, many state legislatures passed living will statutes. Living wills were conceived in 1969 by human rights lawyer Louis Kutner as a way to allow patients to refuse life-sustaining treatment in cases where they are no longer able to communicate their wishes. State courts also weighed in during this time with a variety of decisions on end-of-life issues, including a 1985 New Jersey Supreme Court ruling allowing a hospital to remove a feeding tube from a patient in the last stages of terminal cancer.

In 1990 the right-to-die debate reached the Supreme Court, when it took up *Cruzan v. Director, Missouri Department of Public Health*. The case involved Nancy Cruzan, a Missouri woman who was left in a persistent vegetative

state following a car accident in 1983. Five years after her accident, Cruzan's condition had not improved and her parents asked that her feeding tube be removed. But the Missouri Department of Health refused, prompting the family to challenge the decision in state court.

The case worked its way to the Missouri Supreme Court, which ruled in favor of the state, arguing that the state has a strong interest in preserving life, an interest embodied in its laws, including the criminalization of homicide. Given this state interest, and Nancy's lack of a living will, the court ruled that the Cruzan family could only terminate life support if there was "clear and convincing evidence" that she would have wanted such treatment withdrawn. The Cruzan family presented evidence that Nancy had stated her desire not to live as a "vegetable," but that evidence was judged to be insufficient by the state's high court.

The Supreme Court upheld the state court's rationale by a vote of 5-4. Writing for the majority, then-Chief Justice William Rehnquist agreed that the Due Process Clause of the 14th Amendment gives Nancy Cruzan and other patients a "liberty interest" in declining treatment. But, he continued, in cases like this, where the patient is not competent to make decisions for herself and must rely on family members to do so, states have the right to establish procedures to ensure that decisions made by surrogates conform, as best as possible, to the wishes expressed by the patient when still competent. What's more, Rehnquist argued, "Missouri may legitimately seek to safeguard the personal element of [these decisions] through the imposition of heightened evidentiary standards." In sum, requiring "clear and convincing evidence" of the patient's intent before life support is withdrawn did not violate Cruzan's constitutional right to terminate treatment.

In a concurring opinion, Justice Antonin Scalia couched his support for Missouri in completely different terms, arguing that end-of-life questions should be left to state legislatures, not federal courts. "American law has always accorded the State the power to prevent, by force if necessary, suicide — including suicide by refusing to take appropriate measures necessary to preserve one's life," he wrote. Moreover, Scalia argued, "the point at which life becomes 'worthless,' and the point at which the means necessary to preserve it become 'extraordinary' or 'inappropriate,' are neither set forth in the Constitution nor known to the nine justices of this Court any better than they are known to nine people picked at random from the Kansas City phone directory."

Writing for the dissent, Justice William Brennan argued that Nancy Cruzan's liberty rights outweighed the state's obligation to protect her wishes or life in general. This argument was echoed and expanded upon in a separate dissent by Justice John Paul Stevens, who concluded that "the meaning and completion of her life should be controlled by persons who have her best interests at heart — not by a state legislature concerned with only the 'preservation of human life.' "

In spite of the fractured character of the *Cruzan* decision, the Supreme Court for the first time implicitly recognized the right to refuse treatment in extraordinary circumstances. Indeed, when the case was remanded back to the state courts for retrial, a judge determined that the Cruzan family had met the "clear and convincing" standard and allowed Nancy to be disconnected from her feeding tube and to die.

In some ways, *Cruzan* presaged another high-profile case, that of Terri Schiavo, the severely brain-damaged Florida woman whose situation became a national media story from 2003 until her death in 2005. But in striking contrast to *Cruzan*, state courts in the *Schiavo* case consistently affirmed the right of Michael Schiavo, Terri's husband and legal guardian, to remove her feeding tube and allow her to die. Moreover, federal courts, including the Supreme Court, were unwilling to intervene in the case, even after Congress passed a law authorizing the federal judiciary to intervene.

In the years immediately following *Cruzan*, a number of states held referenda on legalizing physician-assisted suicide for certain terminally ill patients. In Washington state in 1991 and then in California the next year, voters rejected these measures. Even when voters in Oregon approved the Death with Dignity Act in 1994, it did not come into legal force until 1997, owing to court challenges and a second state referendum that unsuccessfully sought to nullify the Act.

The Oregon law only applies to patients who are terminally ill and likely to die within six months, a diagnosis that must be confirmed by two physicians. In addition, eligible patients must possess the mental capacity to give informed consent, cannot suffer from depression and must sign a written declaration in front of two witnesses stating that they are competent and acting voluntarily. Finally, while doctors may prescribe the lethal drugs, the dose must be administered by the patient.

Glucksberg *and* Quill

While states on the West Coast were grappling with right-to-die referenda, several challenges to state laws prohibiting physician-assisted suicide were working their way to the Supreme Court. Two suits, *Washington v. Glucksberg* and *Vacco v. Quill*, were filed on the grounds that a law prohibiting doctors or others from assisting terminally ill patients to prematurely end their lives violates the liberty interest under the 14th Amendment's Equal Protection Clause. In both cases, federal appeals courts agreed and declared the laws — from Washington state in *Glucksberg* and New York in *Quill* — to be unconstitutional. In *Quill*, for instance, the Court of Appeals for the Second Circuit ruled that since New York allowed terminally ill patients to remove life-support systems in order to quickly end their lives, it should also allow dying patients other means to hasten death, including physician-assisted suicide.

But the Supreme Court rejected these arguments in twin unanimous decisions issued in 1997, ruling that state laws prohibiting assisted suicide are constitutional. Writing for the majority in *Glucksberg*, Chief Justice Rehnquist argued that in order for something to be specially protected by the Due Process Clause, it must be "deeply rooted in this nation's history and tradition," such as the right to marry and raise children. Neither marriage nor child rearing are specifically guaranteed by the Bill of Rights, but both have been deemed a liberty interest, protected by the Due Process clause.

According to Rehnquist, the right to physician-assisted suicide does not rise to the level of a deeply rooted historical right. Indeed, he argued, states have traditionally outlawed the practice and continue to do so. In this context, Rehnquist wrote, physician-assisted suicide cannot be compared with the removal of life support. The right to refuse medical treatment

has a long history in the nation's traditions and laws, he argued, and was deemed to be constitutionally protected in *Cruzan*.

Finally, the chief justice looked at the constitutionality of Washington state's law prohibiting physician-assisted suicide. Although the right to assisted suicide is not protected under the Due Process Clause, he wrote, the law prohibiting it must still advance a legitimate state interest in order to be constitutional. In this case, Rehnquist argued, Washington state's prohibition met a number of legitimate interests, including the state's broad interest in preserving life and protecting the depressed and mentally ill.

A number of justices issued concurring opinions in *Glucksberg*. Justice Sandra Day O'Connor, while agreeing that the Constitution offered no broad right to suicide, left open the possibility that someone "experiencing great suffering" might have a constitutional right to control "the circumstances of his or her imminent death."

In his concurrence, Justice Stevens took O'Connor's rationale a step further, writing that there are times when hastening death "is entitled to constitutional protection." Stevens essentially argued that the court's earlier decision in *Cruzan* is a counterweight to *Glucksberg*, requiring constitutional boundaries on right-to-die issues to stand somewhere between the two decisions. "Although there is no absolute right to physician-assisted suicide," Stevens wrote, "*Cruzan* makes it clear that some individuals who no longer have the option of deciding whether to live or to die because they are already on the threshold of death have a constitutionally protected interest that may outweigh the State's interest in preserving life at all costs."

The opinions in *Quill* largely paralleled those in *Glucksberg*. Once again, Rehnquist wrote for the unanimous majority, with O'Connor, Stevens and others concurring. And once again, the majority rejected the argument that physician-assisted suicide was a constitutionally protected right. While *Glucksberg* and *Quill* upheld prohibitions on physician-assisted suicide, they did not in any way address the question of whether a law like Oregon's Death with Dignity Act would be constitutional. Neither will the upcoming *Gonzales* case.

Gonzales v. Oregon

Under the Controlled Substances Act, no person may "manufacture, distribute or dispense" a controlled substance except in conformity with the conditions established by the law. The Controlled Substances Act requires physicians to register with the attorney general in order to prescribe controlled substances, and then restricts such prescriptions to those that are "issued for a legitimate medical purpose." A prescription issued by a physician that lacks a legitimate medical purpose is legally indistinguishable from a prescription drug dispensed by a non-physician. Both fall outside the CSA's rules for distributing controlled substances. The law also gives the attorney general the authority to revoke a physician's registration for violations of the CSA or other acts "inconsistent with the public interest."

Soon after Oregon voters re-approved the Death with Dignity Act in 1997, then-DEA

Administrator Thomas Constantine determined that the CSA prohibited the use of controlled substances as envisioned by the Oregon law, because a prescription for a lethal dose does not constitute a "legitimate medical purpose." Several months later, however, then-Attorney General Reno overruled the DEA determination. She concluded that Congress enacted the CSA to address the traffic in illegal and unauthorized drugs and to address problems of substance abuse. Congress, she reasoned, did not intend "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." Moreover, Reno found that the law's legislative history in no way indicates that Congress meant for the attorney general to resolve the complex moral and legal questions of physician-assisted suicide.

The Ashcroft Directive

On Nov. 9, 2001, then-Attorney General Ashcroft issued an interpretive rule, known as the Ashcroft Directive, that reversed his predecessor's legal analysis of the conflict between the DWDA and the CSA. The Ashcroft Directive relies on an opinion written by the Department of Justice Office of Legal Counsel, which analyzes the legal framework of the CSA and the attorney general's authority under the Act, along with the broad policy and legal context of assisted suicide. The Ashcroft Directive's ruling contains three main elements.

First, the Directive asserts the authority of the attorney general to identify and establish a uniform national definition of "legitimate medical purpose," as used in the CSA and its implementing regulations. An important decision of the Supreme Court that year, *United States v. Oakland Cannabis Buyers' Coop.* (2001), lends weight to the Directive. In *Oakland Cannabis*, a California grower-distributor of marijuana claimed that its cooperative enterprise was exempt from the reach of the CSA because it provided the drug only to those eligible to use it under California's "medical marijuana" statute, enacted in 1996. When the DEA filed suit to stop these activities, the grower asked the court to recognize a "medical necessity" exception to the CSA, one that would permit those charged with improper use of drugs to defend themselves against the charge by showing the medical usefulness of the drug.

The U.S. Court of Appeals for the Ninth Circuit ruled in favor of the grower, but the U.S. Supreme Court reversed the lower court's ruling. The high court held that the CSA assigns expressly to the attorney general or Congress the authority to determine which drugs are listed. In this case, Congress specifically determined that marijuana was one of those drugs with "no currently accepted medical uses." Once such a determination is made, the Court held, only Congress or the attorney general may revise the drug's status and declare such medical uses to exist. Neither states nor private entities possess the authority to decide, for purposes of the CSA, whether marijuana or any other drug has a medical use, the court said.

Second, the Office of Legal Counsel opinion, on which the Ashcroft Directive relies, asserts that the Oregon law represents a significant departure from the legal and ethical norms governing medical care. The office surveyed a broad range of state laws and professional standards for health care practitioners. It concluded that across all other U.S. jurisdictions, and among virtually all the major organizations of

medical professionals, physician-assisted suicide is uniformly regarded as outside the range of "legitimate medical purposes" for which controlled substances may be prescribed.

Third, the Ashcroft Directive declares the attorney general's intention to sanction non-complying practitioners, and instructs DEA officials to monitor compliance in Oregon. Specifically, the Directive states that Oregon's legalization of physician-assisted suicide is not a defense to those who violate the terms of the CSA by prescribing or dispensing drugs for purposes of assisting in a patient's suicide.

The day after the Ashcroft Directive was issued, Oregon filed suit in federal district court to block its enforcement. Health care providers and terminally ill patients soon joined the state's lawsuit against the attorney general. Although the district court granted the plaintiffs' motion to enjoin the Directive, it lacked jurisdiction to hear the suit and transferred the case to the U.S. Court of Appeals for the Ninth Circuit, which asserted jurisdiction over the case and continued the injunction.

On May 26, 2004, a divided panel of the Ninth Circuit struck down the Ashcroft Directive, holding that the attorney general's rule "violates the plain language of the CSA, contravenes Congress' express legislative intent and oversteps the bounds of the attorney general's statutory authority." In dissent, Judge J. Clifford Wallace argued that the court should have applied ordinary standards of administrative law to the case, which would have accorded far greater deference to the Ashcroft Directive and its determination of "legitimate medical purpose" under the CSA. The attorney general sought review of the Ninth Circuit's decision in the Supreme Court, and the high court agreed to hear the case in its October 2005 term.

Arguments in Gonzales

Although its context is morally and politically charged, *Gonzales v. Oregon* presents the court with a common, though doctrinally convoluted, question of administrative law and statutory interpretation. Should courts defer to agency interpretations of a regulation or statute, or should they review such interpretations with a more critical eye? More concretely, should courts defer to the attorney general's interpretation of "legitimate medical purpose" as used under the CSA and its regulations, or should they apply greater scrutiny to the attorney general's ruling in the Ashcroft Directive?

Answers to that question fall across a broad spectrum of judicial deference to agency interpretations, from substantial deference (with very little judicial scrutiny) on one side, to virtually no deference (with intense judicial scrutiny of the agency interpretation) at the other. In *Gonzales v. Oregon*, the parties have advanced three distinguishable approaches to the issue of judicial deference, one falling toward each end of the spectrum and another lying in the middle.

1. No Deference — Federalism and the Clear Statement Rule

In their most ambitious argument, which prevailed in the Ninth Circuit, the respondents — those who are challenging the Ashcroft Directive — contend that the Directive merits no judicial deference because the attorney general lacked the legal authority to issue such a rule. This argument rests on the claim that the CSA reflects a "delicate balance between federal regulation of

controlled substances and state control of medical practice." Although control of drug distribution clearly falls within federal power under the Constitution's Commerce Clause, respondents argue, the same cannot be said of the doctor-patient relationship or medical practice more generally. More intrusive federal regulation of the doctor-patient relationship pushes up against the limits of federal power under the Commerce Clause. "By attempting to regulate physician-assisted suicide," the Ninth Circuit held, "the Ashcroft Directive invokes the outer limits of Congress' power by encroaching on state authority to regulate medical practice."

When faced with a regulation that "invokes the outer limits" of Congress' constitutional authority, courts engage in a two-part analysis. First, they demand that an agency show that Congress has clearly authorized it to push these limits. If an agency does not show that it has clear congressional authority, the regulation is deemed invalid. Second, even if the agency can make that showing, the regulation may still be invalid, because the court may ultimately find that Congress exceeded the "outer limit" of its authority under the Constitution.

Respondents in *Gonzales* argue that granting authority to the attorney general under the CSA to determine a national standard of "legitimate medical purposes" for which drugs may be prescribed would inevitably lead to federal encroachment on the state's power to regulate the doctor-patient relationship, and raise serious concerns under the Commerce Clause. In other words, such a grant would "push up against," and quite possibly exceed, the limits of Congress' constitutional authority. Given this, respondents contend, courts should scrutinize the CSA to find a clear statement granting the attorney general that authority. Finding none, the court should decline to recognize (or defer to) the attorney general's definition of "legitimate medical purpose," at least as applied to the practice of physician-assisted suicide. Therefore, the attorney general's interpretive rule should be deemed invalid, and the court would have no reason to move to the second part of the analysis, and decide whether or not Congress actually exceeded its constitutional authority.

Although the Ninth Circuit Court agreed with respondents' argument, and held that the Ashcroft Directive lacked legal authority because Congress did not clearly grant such authority to the attorney general, the Supreme Court is unlikely to reach the same conclusion. The demand for a clear statement of congressional authority rests on a prior conclusion that the challenged regulation or interpretation "invokes the outer limits" of federal authority, and the Supreme Court is likely to conclude that the Ashcroft Directive falls well within those limits. Earlier this year, the Supreme Court, in *Gonzales v. Raich* (2005), concluded that Congress has authority under the Commerce Clause to prohibit even the intrastate, personal growing and possession of marijuana for medical use. If Congress may regulate the personal possession of marijuana, it follows that it may also regulate the prescription of drugs by doctors, since doctors are normally paid and the drugs are virtually always purchased through channels of interstate commerce. Therefore, the Ashcroft Directive is not likely to "invoke the outer limits" of federal authority under the Commerce Clause, so the Supreme Court will not require a clear statement of the attorney general's authority to make the challenged determination.

2. Substantial Deference to Agency Interpretations of Agency Regulations

In *Gonzales* the attorney general argues that the Supreme Court should accord the Ashcroft Directive "substantial deference" because it only interprets a regulation made by the agency, not the CSA statute itself. The Supreme Court, in an earlier case, *Seminole Rock v. Bowles* (1945), ruled that courts must defer to the agency's interpretation of its own rules "unless it is plainly erroneous or inconsistent with the [agency's own] regulation." The Ashcroft Directive interprets the phrase "legitimate medical purposes" in the context of a regulation that defines the purpose for which a lawful prescription may be issued. Thus, the attorney general contends, the Supreme Court should accept the Directive's definition of that phrase unless the respondents show that the definition is "erroneous or inconsistent with the regulation."

If the Supreme Court accepts the attorney general's argument that the Ashcroft Directive merits the substantial deference of *Seminole Rock*, the respondents will have a virtually insurmountable burden of proving defects in the attorney general's definition of "legitimate medical purpose." Nothing in the CSA or its regulations forbids the attorney general from making rules governing medical purposes, and the substance of the definition chosen — that assisted suicide is not a "legitimate medical purpose" — cannot reasonably be deemed an erroneous determination, since all states but Oregon follow such a rule.

3. Intermediate Deference to Agency Interpretations of Statutes

Although the Ashcroft Directive seems to interpret an agency regulation, and thus would warrant application of the *Seminole Rock* standard of review, it is possible that the Supreme Court will analyze the Directive under a less deferential standard, drawn from *Skidmore v. Swift & Co.* (1944), which applies to certain agency interpretations of statutes. The *Skidmore* standard is far more contextual than either the clear statement rule used by the Ninth Circuit or the *Seminole Rock* standard. *Skidmore* requires courts to consider the "thoroughness evident in the [agency's] consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade."

If the Supreme Court follows *Skidmore* in analyzing the Ashcroft Directive, it is likely to focus on two features of the Directive. The first is its apparent inconsistency with the CSA and prior administrative practice. As former Attorney General Reno concluded in her 1998 opinion letter, Congress intended the CSA primarily to combat the illegal trade in drugs, including prescription drugs diverted out of the legitimate chain of distribution. All regulations and enforcement actions prior to the Ashcroft Directive focused on this illegal traffic in drugs. The Directive, however, departs from that focus, and attempts to regulate conduct that a state has brought within the bounds of lawful medical practice. Respondents contend that the Directive's novel reach reflects its lack of statutory authority. Yet the attorney general argues that the respondents' claim is no different from that of doctors or patients in California who wish to prescribe or use medical marijuana, a drug categorically prohibited by the CSA. In each context, the CSA gives the attorney general the authority to regulate doctors' prescriptions of a drug.

Second, the Court is likely to find significant the attorney general's evaluation — largely contained in the 2001 Office of Legal Counsel

opinion — of broad public and professional understandings of "legitimate medical purposes." In ruling that Oregon's Death with Dignity Act, with its permission to prescribe drugs for assisted suicide, falls outside the range of legitimate medical purposes, the attorney general cited the current professional codes of virtually all healthcare professions, along with a wide range of opinion polls. Unlike the clear statement rule or the *Seminole Rock*standard, however, the contextual character of the *Skidmore* analysis renders uncertain any prediction about its outcome.

Although *Gonzales v. Oregon* involves the highly charged context of assisted suicide, its resolution will turn on routine considerations of the relationships between federal and state law; Congress and the executive branch; and reviewing courts and executive branch interpretations of law. The fact that the health professions have, for the most part, repudiated assisted suicide may, however, influence at the margin some of the Court's judgments about these relationships. In that way, ethical and social considerations about assisted suicide may creep back into what is otherwise a question of interest only to lawyers.

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