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Supreme Court's Decision in *Gonzales v. Oregon*: *High Court Rejects Federal Regulation of Physician-Assisted Suicide*

On January 17, 2006, the Supreme Court ruled that the 1970 Controlled Substances Act (CSA) does not give the U.S. attorney general the authority to prohibit Oregon doctors from prescribing lethal doses of drugs to certain terminally ill patients who want to end their own lives. The court's decision in *Gonzales v. Oregon* resolves a conflict between the state's Death with Dignity Act (DWDA) and the attorney general's interpretation of the federal drug statute. Oregon is currently the only state that has an assisted-suicide law.

When the Oregon law was first enacted in 1994, the Justice Department, under then-Attorney General Janet Reno, determined that the law did not violate the CSA. In 2001, however, then-Attorney General John Ashcroft reversed this finding and issued a ruling designed to halt the practice of physician-assisted suicide under Oregon's law. The "Ashcroft Directive," as it came to be known, stated that physician-assisted suicide was not a "legitimate medical purpose," as defined by the CSA. Thus, any prescriptions written for that purpose would be unlawful and expose the offending medical practitioner to civil, or even criminal, sanctions. Ashcroft's successor, Attorney General Alberto Gonzales, also endorsed the Directive.

The Supreme Court, by a 6-3 vote, ruled that the Directive exceeded the powers that Congress granted to the attorney general under the CSA. The court thus affirmed a ruling by the U.S. Court of Appeals for the Ninth Circuit that had held the Directive "unlawful and unenforceable." Dissenting in the case were Justices Antonin Scalia and Clarence Thomas, as well as Chief Justice John Roberts, who cast his first dissenting vote since joining the court on Sept. 29, 2005.

The immediate legal impact of the court's ruling is clear: Oregon physicians may prescribe drugs under the Death with Dignity Act without fear of federal penalty. The broader legal significance of the ruling, however, is less clear. Although other states may be encouraged to adopt similar provisions, those who oppose physician-assisted suicide will likely continue to try to use the CSA to impede the practice. Opponents may also attempt to press Congress to enact a nationwide

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assisted-suicide ban, although past efforts to pass such legislation have come to naught.

As explained below, the court in *Gonzales v. Oregon* did not completely close the door to federal regulation of physician-assisted suicide. In fact, it may not even have foreclosed administrative regulation of the practice under the CSA. If federal executive branch agencies, through their own processes for adopting administrative rules, end up remedying the defects identified by the court in *Gonzales v. Oregon*, the state's victory could be fleeting. If, however, the defects identified by the court relate to the more basic issue of the distribution of authority between state and federal government, then overcoming the court's decision will, at a minimum, require congressional action — action that, as already noted, Congress thus far has declined to take.

Gonzales v. Oregon

Gonzales v. Oregon represents the third time in the last 15 years that the Supreme Court has tackled end-of-life issues. In its first ruling, *Cruzan v. Director, Missouri Department of Health* (1990), the court held that patients have a “liberty interest” in declining unwanted medical treatment. But the court also held that states may impose reasonable conditions on the exercise of that interest — such as a requirement that the patient's wishes be in writing — in order to protect the vulnerable. Seven years later, the court decided a pair of cases, *Washington v. Glucksberg* and *Vacco v. Quill* (1997), that directly addressed the question of assisted suicide. In both cases, plaintiffs argued that their respective states' statutory prohibitions on physician-assisted suicide violated the federal Constitution. Although federal appellate courts had agreed with the plaintiffs, a unanimous Supreme Court ruled in both cases that no provision of the U.S. Constitution guarantees to an

individual the assistance of a physician in ending his or her life.

During this same period, many states enacted legislation that established procedures for individuals to provide specific directions for their end-of-life medical care and to designate surrogates to exercise additional choices. Several states, including California, Washington and Oregon, considered broader proposals that would authorize physicians to assist certain terminally ill patients to end their own lives. Oregon alone adopted such a measure, the Death with Dignity Act. First enacted through a voter initiative in 1994, the law did not become effective until 1997, after it survived a second vote by the state's electorate.

Soon after the law took effect, some members of Congress began to pressure Attorney General Reno to exercise her authority under the CSA and prohibit Oregon doctors from prescribing controlled substances for the purpose of assisting terminal patients who might wish to end their lives. Under the federal drug statute, no person may “manufacture, distribute or dispense” a controlled substance except under certain conditions. The law provides for a system, controlled by the attorney general, for registering those permitted to prescribe or dispense covered substances. The law also establishes a schedule listing restrictions on specific drugs and requires that any prescription must be “issued for a legitimate medical purpose.”

Despite pressure from lawmakers, Reno determined that the CSA did not give the attorney general the broad authority advocated by the legislators, and declined to take any action with respect to the DWDA. Then-Senator John Ashcroft (one of the legislators who had urged Reno to act) introduced legislation in 1998 and 1999 to amend the CSA to prohibit the prescription of controlled substances for assisted suicide, but neither bill passed. By 2001, however, Ashcroft had replaced

Reno as attorney general, and he quickly moved to reverse her ruling on the DWDA. Most importantly, he asserted the attorney general's authority to determine the meaning of "legitimate medical purpose" under the federal drug statute, and then defined the phrase to exclude the practice of physician-assisted suicide contemplated by the Oregon law.

Almost immediately, Oregon doctors and pharmacists, and later patients and the state itself, filed suit to block enforcement of the Ashcroft Directive. The plaintiffs argued that the attorney general lacked the authority to regulate the practice of medicine as determined by Oregon's Death With Dignity Act. A divided panel of the U.S. Court of Appeals for the Ninth Circuit agreed with the plaintiffs, holding that the CSA does not give the attorney general the broad authority over medical practice claimed by the Directive. The attorney general then asked the Supreme Court to review the appellate court's decision; the court agreed, and heard oral argument in the case on October 5, 2005.

The Court's Opinion

Although the morally charged context of end-of-life decision-making permeates the case, the court's resolution of the core issues in *Gonzales v. Oregon* turned on more prosaic, if equally complex, questions of administrative law. In the end, the case came down to one deceptively simple question: How much deference, if any, did the court owe to the attorney general's interpretation of the phrase "legitimate medical purpose" under the CSA? Over the past half-century, federal courts have developed a spectrum across which

various degrees of deference can be plotted. In some situations, courts treat a government agency's determination as virtually dispositive; in others, the agency determination receives no more weight than any other source of relevant information, whether legal or scientific.

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In *Gonzales v. Oregon*, the federal government argued that, under the principles of administrative law, the attorney general's Directive deserved significant deference because an agency has the right to interpret its own rules or to interpret ambiguities in statutes that apply to it, such as the

CSA. The plaintiffs argued that the Ashcroft Directive was not only a misreading of the CSA, but that it pushed, and perhaps even exceeded, the limits of congressional power with respect to areas traditionally reserved to the states. Thus, they argued, the Directive merited intense judicial scrutiny, not deference.

Writing for the majority, Justice Anthony Kennedy — joined by Justices Stephen Breyer, Ruth Bader Ginsburg, Sandra Day O'Connor, David Souter and John Paul Stevens — stated that the Directive reflected neither an interpretation of the Justice Department's own rules nor the exercise of interpretive authority delegated to the department under any statute. The attorney general's statutory role under the CSA, Kennedy reasoned, focused on two core tasks: maintaining the register of those who are permitted to prescribe or dispense controlled substances; and establishing safeguards against the diversion of controlled substances from their permitted medical purposes. Rulemaking or interpretation focused on either of these two tasks, he argued, would deserve substantial deference. But the Directive

sought to define the practice of medicine well beyond the range of those contexts, Kennedy determined, and thus lost the presumption of validity it enjoyed with respect to the core tasks of registration and control.

Although the court majority rejected the federal government's claim of deference, it also — if less explicitly — rejected the plaintiffs' claim that the Directive unconstitutionally encroached on a domain reserved to the states, i.e., the physician-patient relationship. The court acknowledged the important roles that states play in creating and enforcing standards of professional medical conduct. The court concluded, however, that "there is no question that the federal government can set uniform standards in these areas." The only relevant question for this case was whether the attorney general possessed the authority, under the CSA, to establish such standards with respect to physician-assisted suicide.

To answer that question, the court turned to a standard of judicial review drawn from *Skidmore v. Swift & Co.* (1944). Under the *Skidmore* standard, the Directive receives neither the strong presumption of validity that attaches under the court's deferential review of agency rulemaking nor the suspicion of invalidity that applies when agencies act near the boundaries of federal authority. Instead, the Directive must stand or fall on its own merits. Using the *Skidmore* standard, a court will consider the quality of the agency's decisionmaking process — the coherence and consistency of its legal interpretations, its collection and consideration of relevant information and the reasonableness of its judgments based on that information. If, using the

Skidmore standard, the reviewing court finds the agency interpretation to be persuasive and not inconsistent with the meaning of the statute, then the reviewing court is free to adopt the agency's interpretation as authoritative. If, however, the court decides that the agency's interpretation is not persuasive, then the court is free to reject the agency's interpretation. Using the *Skidmore* standard, the court in *Gonzales v. Oregon* concluded that

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the attorney general's interpretation of the CSA was not persuasive. It offered three reasons to justify this conclusion.

First, and most importantly, the court determined that Congress intended the CSA to address the problems of addiction and recreational drug abuse, and the trafficking in controlled substances that facilitate such use. It did not create the CSA as a vehicle for developing national standards for medical practice. Thus, the court determined, specific provisions of the act, including the phrase "legitimate medical purpose," should be read in light of those intentions.

Second, the court criticized the process through which the attorney general reached his conclusions in the Directive. Ashcroft failed to consult the secretary of Health and Human Services, even though the CSA explicitly delegates certain judgments about medical issues to that official. The attorney general also failed to consult any officials from the State of Oregon, despite attempts by state officials to meet with him before the rule was issued. Finally, the attorney general implied that he intended to disregard the physician registration procedure laid out in the statute. Taken together, the court found, these factors significantly undermine confidence in the reliability of the attorney general's judgment.

Finally, the court held that the Directive claimed an authority over states that the attorney general did not possess. In part, this holding reflects the court's judgment that the Directive failed to accord the states appropriate respect. As already noted, the attorney general declined to consult with state officials before issuing the Directive. And he announced procedures related to physician registration that seemed to ignore state licensing agencies.

In striking down the Ashcroft Directive, however, the court did not follow the lead of the Ninth Circuit, which had rested its decision in this case on a strong claim of federalism. The doctor-patient relationship, the lower court had determined, stands at the edge, and perhaps just beyond the reach of, congressional power under the Commerce Clause. In its view, courts should not presume that federal law was intended to reach into such relationships unless that intent is "clearly stated" in the applicable legislation. But the Supreme Court, while finding nothing in the CSA that would grant the attorney general authority over Oregon doctors, nevertheless determined that Congress clearly has the right to legislate in this area.

Dissenting Opinions

Justice Scalia wrote a dissenting opinion in the case and was joined by the other two dissenters, Thomas and Chief Justice Roberts. Justice Thomas also wrote a separate dissenting opinion, which was not joined by the other two dissenting justices.

Justice Scalia's dissent directly engaged the majority's administrative law argument. He determined that the CSA grants the attorney general an expansive role in the administration and interpretation of the statute. Hence, Scalia argued, the Ashcroft Directive deserved substantial deference, either as

the agency's interpretation of its own rule or as the agency's use of delegated congressional authority to interpret the statute.

Even if the court rejects that specific argument for deferential review, Scalia argued, the attorney general's position is more than persuasive under the Skidmore standard of review. Scalia pointed to the widespread condemnation of physician-assisted suicide by other jurisdictions and professional societies of medical practitioners. He argued that from that evidence, the attorney general could reasonably conclude that prescribing drugs to assist a patient's suicide is not a "legitimate medical purpose" under the CSA. Moreover, Scalia examined the history of the CSA and concluded that revisions made to the statute in 1984 authorized the attorney general to act independently of state regulators with respect to physician registration. The idea of uniform standards of medical practice and the exercise of administrative authority under the CSA to enforce the standards are intrinsic to the statute, Scalia argued.

Thomas' dissent came as something of a surprise. The previous term, he had dissented in *Gonzales v. Raich* (2005), a case that involved the intrastate possession of medical marijuana, which was permitted under California law but prohibited under the CSA. In that case, the majority ruled that under the CSA, federal authorities may determine and restrict the "manner" in which controlled substances are used, notwithstanding a state's approval of medical practices authorizing a different or broader range of uses. In his dissent, Thomas argued that the majority's ruling in *Raich* reflected overreaching by the federal authority. In his view, congressional power under the Commerce Clause must arise from the movement of goods or services in interstate commerce. Intrastate growing and use of small quantities of medical marijuana, he asserted, failed to meet that jurisdictional threshold.

In *Gonzales v. Oregon*, however, Thomas dissented from the majority's finding that the CSA did not give the federal government authority over the Oregon law, a finding based at least in part on the same Commerce Clause grounds to which Thomas had appealed in his *Raich* dissent. Thomas reconciled the two opinions through the doctrine of precedent: "I agree with limiting the applications of the CSA in a manner consistent with the principles of federalism But that is now water over the dam." In other words, even if the court's reasoning in *Raich* was wrong, Thomas argued, it is now law and must be accorded jurisprudential respect.

The Next Chapter

Those who support the right of the terminally ill to end their own lives have portrayed *Gonzales v. Oregon* as a significant victory; a contrary result would certainly have severely limited the movement's legal options. With the cloud now removed from the Oregon law, activists and legislators may renew efforts to have similar practices adopted in other states. Indeed, California legislators have already announced their intention to revive a measure that closely mirrors the Oregon law. But the Bush administration and members of Congress opposed to the practice have also signaled their intention to continue their opposition, and the court's opinion in *Gonzales v. Oregon* leaves them with some footing on which to stand.

The legal issue resolved by *Gonzales v. Oregon* is a relatively narrow one. The court asked: Does the federal government have authority under the CSA to regulate Oregon physicians' practice of medicine under the terms of the state's assisted-suicide law? For the reasons given above, the majority

answered in the negative, concluding that the attorney general lacked authority over Oregon physicians' practice of medicine.

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While it is important to understand what the court resolved in *Gonzales v. Oregon*, it is equally important to understand what the Supreme Court did not decide. To begin with, the court rejected the claim, put forth by Oregon and accepted by the Ninth Circuit, that the Commerce Clause restricts

the power of Congress to determine a uniform national standard for medical practice. Kennedy's opinion for the majority underscores the interdependence of the federal and state regulatory schemes under the CSA, but the court never suggests that the federal legislation "pushes up against the limits" of federal power. Although states' interests merit appropriate respect, that deference does not imply a robust notion of state independence from federal authority.

In addition, the court left open the possibility that Congress could amend the CSA to establish normative standards in specific areas of medical practice that displace inconsistent state regulations — as Congress has already done in the field of substance abuse treatment. This suggests that Congress has the legal authority to adopt an amendment to the CSA that is substantially identical in content to the Ashcroft Directive. As noted earlier, however, such legislation has been introduced several times, but has failed to pass.

Finally, and most importantly, the decision leaves open the possibility that the executive branch could, without congressional action, take steps that would allow it to use the CSA to regulate physician-assisted suicide. Such a prospect, while by no means assured, exists because a significant part of the court's critique of the Ashcroft Directive is focused on the attorney general's decision-making

process. In particular, the court emphasized three issues that could be addressed internally by the federal executive branch. First, it challenged the attorney general's usurpation of authority and responsibility that more properly belonged to the secretary of Health and Human Services, a fellow officer in the president's cabinet who has greater expertise in health care. As both officers serve at the president's pleasure, their cooperation should not be unduly burdensome to achieve, and should address the court's concern about the attorney general's lack of technical expertise.

Second, the court criticized the attorney general's failure to consult with Oregon state officials before imposing the Directive. Because the

Skidmore standard turns on the quality of the agency decision-making process, the collection of information from all relevant sources — and Oregon officials certainly represented a relevant source — takes on special importance, and would appear to be an easily remedied defect.

And finally, the court determined that the attorney general's directive ignored the proper procedure for registering or de-registering physicians, a procedure that requires consideration of state legal and policy issues, as well as broader national concerns. A commitment to follow this procedure when applying the CSA to the Oregon law could well allay some of the court's concerns about the attorney general's exercise of his authority under the act.

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1615 L STREET, NW SUITE 700 WASHINGTON, DC 20036-5610
202 419 4550 TEL 202 419 4559 FAX WWW.PEWFORUM.ORG

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