No. 04-623

IN THE
Supreme Court of the United States

ALBERTO R. GONZALES, Attorney General, *et al.*,

Petitioners,

v.

STATE OF OREGON, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF MEMBERS OF THE OREGON CONGRESSIONAL DELEGATION AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF THE *AMICI CURIAE*

Amici are Members of Congress representing the people of the State of Oregon.[1] *Amicus* Ron Wyden has the honor of serving Oregon in the United States Senate. *Amici* Earl Blumenauer, Peter DeFazio, Darlene Hooley, and David Wu have the honor of serving Oregon in the United States House of Representatives. As members of Congress, *amici* are directly concerned with the need to carefully circumscribe within constitutional and statutory limits the authority of the Executive Branch to preempt the considered policy judgments made by the states and their citizens.

While serving in the United States Congress, *amici* have taken the lead in helping to defeat attempts at legislative preemption of Oregon law. Though he voted twice as a private citizen against the Oregon ballot measures that approved Oregon's Death With Dignity Act ("Dignity Act"), Or. Rev. Stat. §§ 127.800-127.995 (2001), Senator Wyden also has twice testified before the Senate Judiciary Committee, as well as once before the Senate Committee on Health, Education, Labor, and Pensions, in opposition to bills seeking amendments to the Controlled Substances Act ("CSA"), 21 U.S.C. §§ 801 *et seq.* (2000), that would have preempted the decision of the citizens of Oregon reflected in the Dignity Act. Similarly, Representative DeFazio—who has a masters degree in gerontology and has counseled seniors on end-of-life issues—testified before the House Judiciary Committee in opposition to the legislation seeking to overturn the Dignity Act.

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1. Consents to the filing of this *amici curiae* brief are on file with the Clerk of the Court pursuant to Rule 37(3) of the Rules of the Supreme Court of the United States. Pursuant to Rule 37(6), counsel for *amici* certifies that no counsel for a party authored this brief in whole or in part and that no person, other than *amici* or their counsel, made a monetary contribution to the preparation or submission of this brief.

Representatives DeFazio, Blumenauer, Hooley, and Wu each fought against passage of the "Pain Relief Promotion Act," H.R. 2260, 106th Cong. (1999), in order to protect from federal preemption Oregon's thoughtful approach to giving terminally-ill patients more control over difficult end-of-life issues.

Congresswoman Hooley, representing Oregon's Fifth Congressional District, despite personal opposition to the practice of physician-assisted suicide, joined her Republican colleague from Connecticut, Representative Nancy Johnson, in introducing the "Conquering Pain Act," H.R. 2188, 106th Cong. (1999), coauthored by Senator Wyden, as a substitute for the Pain Relief Promotion Act in order to improve palliative care without overturning Oregon law.

Similarly, Representative Wu, representing Oregon's First Congressional District, actively opposed the Pain Relief Promotion Act in the 106th Congress, and joined his colleagues in sending a letter to former President Clinton urging him to oppose any legislation that would overturn Oregon's law. Likewise, during the 107th Congress, he joined the Oregon delegation in requesting a meeting with President Bush and Attorney General Ashcroft before the Administration considered any action regarding Oregon's Dignity Act. Representative DeFazio joined more than fifty health and hospice related organizations to defeat attempts to overturn the Oregon law.

Because of their experience with the CSA and the policy debate about physician-assisted suicide during their time in the United States Congress, *amici* Senator and Representatives can offer a unique insight into the CSA's legislative purpose and history, into the Congressionally-drawn demarcation between the role of the states and the role of the Attorney General under the CSA, and into the proper relationship between the CSA and Oregon's Death With Dignity Act. In addition, Senator Wyden served in the United States House of Representatives at the time

of the 1984 amendments to the CSA, and thus can bring his perspective on the purpose of the 1984 amendments to an analysis of the CSA.

SUMMARY OF ARGUMENT

All parties and *amici* agree that regulation of the practice of medicine, including matters of medical ethics, has traditionally been the province of the states. Nothing in the CSA alters state primacy in this area. The statute, which was enacted for the purpose of controlling drug trafficking and abuse, does not authorize the Attorney General to preempt state law on issues regarding the ethical practice of medicine.

ARGUMENT

I. The Attorney General Has Acted Outside The Scope Of The Power Delegated By Congress In The CSA.

Congress enacted the Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236, to "deal in a comprehensive fashion with the growing menace of drug abuse in the United States." H.R. Rep. No. 91-1444 (Sept. 10, 1970), *reprinted in* 1970 U.S.C.C.A.N. 4566, 4567. Title II of the Act, dealing with "control and enforcement," was designated the Controlled Substances Act. *Id*. at 4569. From its inception in 1970, its amendment in 1984, and its consistent construction and application over three decades, the CSA directed the Attorney General to enforce a closed system of drug distribution and dispensing as a means of curbing drug abuse and controlling drug trafficking. Nothing in the language, history, or application of the original or amended CSA authorized the Attorney General to use his law enforcement powers to proscribe as illegitimate those medical practices that fail to conform to his moral convictions.

In an unprecedented expansion of his role under the CSA, the Attorney General in his 2001 Interpretive Rule asserted that he is authorized to prohibit physicians from prescribing drugs in accordance with the Dignity Act. *See* Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607, 56,608 (Nov. 9, 2001) (the "Interpretive Rule"). He found that authority in a DEA regulation supplying the criteria for what constitutes an effective prescription for a controlled substance under the CSA. *Id*. Promulgated in 1971, that regulation provides that a "prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 C.F.R. 1306.04(a) (2004). The Attorney General declared in his Interpretive Rule that he had "determined that assisted suicide is not a 'legitimate medical purpose' within the meaning of 21 CFR 1306 (2001), and that prescribing, dispensing, or administering federally controlled substances to assist suicide violates the Controlled Substances Act." 66 Fed. Reg. at 56,608. Thus, thirty years after its promulgation, this heretofore unremarkable regulation has become the vehicle by which the nation's chief law-enforcement officer seeks to become arbiter of the legitimacy of medical practices, to usurp the traditional state prerogative of regulating the practice of medicine, and to derogate the outcome of Oregon's political process acting within the core of its traditional competency.

Viewed in light of the language and purpose of the statute under which it was promulgated, the 1971 regulation simply does not provide the Attorney General with the broad authority to preempt state law that he seeks. The CSA cannot sustain such a dramatic expansion of the Attorney General's limited authority under that statute. To the contrary, the terms and legislative history of the CSA demonstrate the will of Congress to respect the traditional prerogative of the states to regulate the practice of medicine. *See Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988) ("It is axiomatic that an administrative

agency's power to promulgate legislative regulations is limited to the authority delegated by Congress.").

A. As Originally Enacted, The CSA Protected The Historical Prerogative Of States To Regulate The Practice Of Medicine And Denied The Attorney General Any Discretion To Regulate Medical Use Of Approved Controlled Substances.

The terms and history of the CSA as originally enacted belie the claim that Congress gave the Attorney General, a law-enforcement officer, final word as to which state-sanctioned medical practices are "legitimate." The CSA was "designed to improve the administration and regulation of the manufacturing, distribution, and dispensing of controlled substances by providing for a 'closed' system of drug distribution for legitimate handlers of such drugs." H.R. Rep. 91-1444, 1970 U.S.C.C.A.N. at 4589. Congress authorized the Attorney General to exercise several law-enforcement functions intended to keep controlled substances from escaping the closed system and flowing to illicit channels. Congress never delegated any power or discretion to the Attorney General to make judgments about the proper medical use of controlled substances. Those matters were left to state law—which traditionally has regulated the practice of medicine—or, in specific, limited circumstances, to federal officials with expertise in medical and scientific matters.

As part of its effort to regulate drug distribution and prevent diversion to illicit channels, Congress in the CSA required that medical practitioners wishing to prescribe controlled substances register with the Attorney General. Pub. L. No. 91-513, 302(a), 84 Stat. 1236, 1253. Under the CSA as originally enacted, practitioner "registration would be as a matter of right where the individual or firm is engaged in activities involving these drugs which are authorized or permitted under state law." H.R. Rep. 91-1444, 1970 U.S.C.C.A.N. at 4590. The Attorney

General was required to register practitioners "if they are authorized to dispense . . . controlled substances under the law of the State in which they practice." Pub. L. No. 91-513, § 303(f), 84 Stat. 1253 (1970).[2] When it enacted the CSA, therefore, Congress unquestionably intended to leave solely to the states the power to license and discipline medical practitioners regarding the use of controlled substances, and gave the Attorney General no leeway to override the state regulators' determinations or otherwise to exercise discretion regarding medical issues.[3]

To be sure, Congress in the original CSA provided for a limited federal role in medical issues relating to use of controlled substances. That federal role, however, was highly circumscribed and directly related to the core concern of the Act, *i.e.*, maintaining a closed system for distribution of potentially dangerous drugs. Further, that limited federal medical role was entrusted to federal officials with medical expertise at the Department of Health, Education, and Welfare, not to federal officials with law enforcement expertise at the Department of Justice.

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2. This provision was amended in 1984. As demonstrated *infra*, at Part I.B., and contrary to the assertions of the Attorney General and various *amici*, the 1984 amendments to the CSA's registration provisions did not abandon the requirement of deference to state regulation of the practice of medicine.

3. This Court's recent decision in *Gonzales v. Raich*, 125 S. Ct. 2195 (2005), is not to the contrary. *Raich* addressed a commerce-clause challenge to the decision of Congress to prohibit the local use of locally-grown marijuana, and did not consider the Attorney General's authority under the CSA. Also, *Raich* concerned federal authority under the drug-scheduling, rather than the physician-licensing, authority conferred by the CSA. While scheduling decisions involve medical determinations, Congress in the CSA expressly entrusted those decisions to federal officials with medical expertise (or in some cases made the decision itself). *See infra* at 7.

Accordingly, the CSA vested the Secretary of Health, Education, and Welfare (now, the Secretary of Health and Human Services)—not the Attorney General—with authority over medical and scientific determinations relating to the scheduling of controlled substances. *See* 21 U.S.C. § 811(b) (2000) (determinations of the Secretary "shall be binding on the Attorney General as to such scientific and medical matters"). Likewise, Congress granted the Secretary of Health, Education, and Welfare the authority to determine national standards for the use of methadone and other narcotics in the treatment of addicts. Pub. L. No. 91-513, Tit. I, § 4, 84 Stat. 1236, 1241.

The Narcotic Addict Treatment Act of 1974, Pub. L. No. 93-281, 88 Stat. 124, which amended the CSA to set forth procedures governing practitioner registration to conduct addiction treatment programs, provides further evidence of the Congressional will to withhold from the Attorney General discretionary authority over medical determinations. The legislative history of the 1974 amendments demonstrates that Congress intended to "preserve . . . the distinctions found in the Controlled Substances Act between the functions of the Attorney General and the Secretary of Health, Education and Welfare." H.R. Rep. No. 93-884 (1974), *reprinted in* 1974 U.S.C.C.A.N. 3029, 3034. Congress intended that "[a]ll decisions of a medical nature are to be made by the Secretary. . . . Law enforcement decisions respecting the security of stocks of narcotic drugs and the maintenance of records on such drugs are to be made by the Attorney General." *Id.*

As even the *amici* federal legislators who support the Attorney General recognize, "Congress never intended to displace the states as primary regulators of physicians, and the CSA was never intended to result in a wholesale nationalizing of the practice of medicine." *Amicus Curiae* Brief of Senators Rick Santorum, et al., at 19 ("Santorum Br."). Prior to the Interpretive Rule, attempts by the federal government to regulate the practice of medicine under the CSA dealt principally with

the use of narcotics in addiction treatment, which directly relates to the central purpose of the CSA.[4] It is not surprising that Congress wanted a federal role in defining the manner in which narcotics were placed in the hands of addicts, the most likely vehicles for diversion from proper to illicit channels. Congress, however, granted this limited authority not to the Attorney General, but to "the principal health agency of the federal government." H.R. Rep. 91-1444, 1970 U.S.C.C.A.N. at 4581. Given this statutory scheme, it is absurd to suggest that Congress implicitly vested the Attorney General with the uncabined authority to declare illegitimate state-sanctioned medical practices unrelated to the evils to which the CSA was directed. While uniform guidelines for the methods by which physicians place narcotics in the hands of addicts serve the anti-diversion goals of the CSA, a national standard regulating the medical purposes that physicians may legitimately pursue serves no such goal.

Despite this clear indication of Congressional intent to defer to the states, the Attorney General and certain *amici* insist that, even under the original CSA, the Attorney General had the authority to override a state's decisions as to the legitimacy of particular medical purposes. Two arguments are raised in support of this position, but neither holds water.

First, the Attorney General and certain *amici* insist that the federal drug-control laws that preceded the CSA "created a

4. The government points to the DEA's 1986 policy statement concerning non-FDA-approved uses of the drug Marinol as the sole exception. Gov. Br. at 30. This reliance is misplaced because, as the government concedes, the purpose of the DEA's policy was to prevent "attempt[s] to justify illegal or improper distribution or dispensing" of a drug that resembles the principal psychoactive substance in marijuana. *Id.* (quoting 51 Fed. Reg. 17,476, 17,477 (1986)). The Marinol policy statement thus reflects an effort by the DEA to prevent diversion of a particular controlled substance into illicit channels rather than an attempt to effectuate the Attorney General's personal views on what constitutes a legitimate medical practice.

federal standard for determining what constitutes a legitimate medical practice," and that the CSA was intended to "clarify that *federal* standard, not to cloud that standard by overlaying potentially disparate state standards." Brief for the Petitioners at 33 ("Gov. Br.") (emphasis in original); *see also* Santorum Br. at 18-19. This argument is grounded on a gross mischaracterization of the legislative history. The Attorney General relies on the Report of the House Committee On Interstate And Foreign Commerce, but that Report in fact demonstrates that Congress deliberately *denied* federal law-enforcement personnel discretion to make medical and scientific judgments with respect to addiction treatment. *See* H.R. Rep. 91-1444, 1970 U.S.C.C.A.N. at 4581. The House Committee recognized that previous federal drug laws had led to the problem of prosecutors indicting practitioners for their practices in treating addiction, thereby in effect exercising discretion as to the propriety of methods used to treat addiction. *Id.* Congress specifically intended to withdraw any discretion in this area from federal prosecutors and instead to authorize the Secretary of Health, Education, and Welfare (now the Secretary of Health and Human Services) to issue guidelines for prescribing narcotics to treat addicts.

The Attorney General's assertion that Congress had always intended to allow the Attorney General to define appropriate medical practice is based on partial, out-of-context quotations from the House Report. The passage in full, however, makes clear that the Committee was describing with disfavor the situation created by the Justice Department's overbroad assertion of authority under pre-1970 federal narcotics legislation in the specific area of addiction treatment.[5] Placed in context, the

5. In full, with *italics* indicating the portions the Attorney General omitted in his selective excerpt, the passage reads:

> *The Committee expects that the determinations made by the Secretary of Health, Education, and Welfare will clarify*

(Cont'd)

passage demonstrates that Congress sought to avoid any intervention in medical matters by prosecutors and other medically-unqualified federal law-enforcement officials. H.R. Rep. 91-1444, 1970 U.S.C.C.A.N. at 4581.

Second, the Attorney General (Gov. Br. at 31), and the legislative *amici* who support him (Santorum Br. at 10), argue that this Court's decision in *United States v. Moore*, 423 U.S. 122 (1975), recognized the Attorney General's authority to declare uniform federal standards for permissible prescriptions under the CSA. In *Moore*, however, this Court did not address the issue whether the CSA empowers the Attorney General to determine the legitimacy of particular medical purposes. Instead, the physician defendant in *Moore* had been found to be acting as a methadone pusher rather than as a physician and thus could not claim immunity from prosecution under the more severe provisions of the CSA. *Id.* at 133. To the extent that the holding depended on the existence of a federal standard for appropriate

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(Cont'd)

> *for the medical profession the conditions under which narcotic drugs may be prescribed for the medical treatment of narcotic addicts*. Although the Committee is concerned about the appropriateness of having federal officials determine the appropriate method of the practice of medicine, it is necessary to recognize that for the last 50 years this is precisely what has happened, through criminal prosecution of physicians whose methods of prescribing narcotic drugs have not conformed to the opinions of federal prosecutors of what constitutes appropriate methods of professional practice. *In view of this situation, this section will provide guidelines, determined by the principal health agency of the federal government, after consultation with appropriate national professional organizations. Those physicians who comply with the recommendations made by the secretary will no longer jeopardize their professional careers by accepting addicts as patients.*

H.R. Rep. 91-1444, 1970 U.S.C.C.A.N. at 4581.

practice, the Court looked only to the "particularly clear" limits on practices relating to methadone treatment, the articulation of which the 1970 Act expressly committed to the Secretary of Health, Education, and Welfare. *Id.* at 144. Neither the Attorney General nor any of the fifteen *amici* briefs in support of his position has identified a single instance in which the federal government has based a prosecution or license revocation on a finding of an illegitimate medical purpose other than conduct amounting to "pill pushing."[6]

B. The 1984 Amendments To The CSA Did Not Expand The Attorney General's Limited Statutory Authority.

Although based primarily on the Attorney General's interpretation of the phrase "legitimate medical purpose" in the 1971 regulation now found at 21 C.F.R. 1306.04(a) (2004), the Interpretive Rule also purports to rely on the 1984 amendments to the CSA to support the threat of enforcement action against physicians prescribing controlled substances pursuant to the Dignity Act.[7] *See* 66 Fed. Reg. at 56,608; *see also* Gov. Br. at

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6. *Hugh I. Schade, M.D., Denial of Application*, 60 Fed. Reg. 56,354 (Nov. 8, 1995), cited in Santorum Br. at 24 n.7, is not such a case. In that proceeding, the DEA simply found it appropriate to deny a physician's application for registration due to the physician's having been convicted in state court of involuntary manslaughter in connection with the death of a patient and having been found by the DEA to be in violation of numerous regulations concerning the keeping of controlled substances. The decision did not involve any determination of the legitimacy of physician-assisted suicide or otherwise federalize the issue of what constitutes the legitimate practice of medicine.

7. If the Attorney General's interpretation of 21 C.F.R. 1306.04 stands, practitioners acting pursuant to the Dignity Act also would potentially be subject to criminal penalties under 21 U.S.C. § 841. *See United States v. Moore*, 423 U.S. 122, 136 (1975); *see also* Memorandum

(Cont'd)

34-35. Likewise, the Attorney General invokes the 1984 amendments as support for the proposition that Congress intended to depart from its traditional deference to state regulation of medical practice. The substance and history of the 1984 amendments support neither of these assertions. To the contrary, the 1984 amendments reaffirmed the Act's fundamental division of authority.

The 1984 amendments began as the "Dangerous Drug Diversion Control Act" and later were incorporated into the Comprehensive Crime Control Act of 1984. Pub. L. No. 98-473, 98 Stat. 1837 (1984). As the original bill title reflects, Congress intended the 1984 legislation to address a specific issue: the "problem of diversion of drugs of legitimate origin into the illicit market." S. Rep. No. 98-225, *reprinted in* 1984 U.S.C.C.A.N. 3182, 3442; *see also id.* at 3444. Although the CSA's original registration provisions had proven effective in "meeting the diversion problem at the manufacturer and distributor levels," Congress was concerned that "the same strong regulatory authority to maintain a 'closed' distribution chain does not exist at the practitioner level." *Id.* at 3443.

Toward the limited end of sealing leaks in the closed distribution system, Congress made applicable to the registration of practitioners a standard comparable to that already applicable to the registration of manufacturers and distributors of controlled substances. *See id.* at 3449 (citing 21 U.S.C. §§ 823(a), (b), (d), (e)). Whereas the CSA had previously required the Attorney General to register any practitioner authorized to distribute controlled substances by that practitioner's state, the 1984

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from Deputy Assistant Attorney General Sheldon Bradshaw to Hon. John Ashcroft, Whether Physician-Assisted Suicide Serves a "Legitimate Medical Purpose" Under the Drug Enforcement Administration Regulations Implementing the Controlled Substances Act (June 27, 2000), *reprinted in* 17 Issues L. & Med. 269, 271-72 (2002).

amendment authorized the Attorney General to deny or revoke a practitioner's DEA registration upon a finding that such registration is contrary to the "public interest." 21 U.S.C. § 824(a)(4) (added by Pub. L. No. 98-473, § 512(2), 98 Stat. 1837).

While giving the Attorney General a limited basis for denying or revoking the registration of state-licensed physicians in order to better combat illegal diversion of drugs, the 1984 amendment did not, contrary to the Attorney General's position, upset two-hundred years of tradition by vesting the nation's chief law-enforcement officer with unfettered discretion over how medical practitioners do their work. Indeed, Congress intended that the Attorney General would be required to "continue to give deference to the opinions of State licensing authorities." S. Rep. No. 98-225, *reprinted in* 1984 U.S.C.C.A.N. at 3449. In light of the purpose and substance of the 1984 amendments, the grant of authority to the Attorney General cannot be read as an open-ended invitation to block as "illegitimate" state-sanctioned medical practices of which he disapproves.

First, in the 1984 amendments, Congress expanded the authority of the Attorney General with respect to practitioner registration for a single purpose: to strengthen federal controls against diversion of controlled substances to illicit channels. *See, e.g.*, 130 Cong. Rec. H9680 (daily ed. Sept. 18, 1984) ("The most serious diversion problem today exists at the retail level. State policing of these activities, as well as peer review within the profession, have not been adequate control measures."); H.R. Rep. No. 98-1030 (1984), *reprinted in* 1984 U.S.C.C.A.N. 3182, 3443 (the "strong regulatory authority to maintain a 'closed' distribution system does not exist at the practitioner level"); 130 Cong. Rec. S758 (daily ed. Feb. 2, 1984) (statement of Senator Strom Thurmond) (arguing that the amendment was appropriate given that "80 to 90 percent of current diversion of drugs into illicit markets takes place" at

the practitioner level); *see also* Santorum Br. at 13 ("The theme of needing to better control the distribution of controlled substances through physicians by shoring up weaknesses at the state level pervades the legislative history [of the 1984 amendments].").

The 1984 amendments do not support the Attorney General's authority to make registration determinations based on a definition of the "public interest" that has no relationship to that Congressional goal. The "public interest" provision was meant to strengthen federal enforcement of the closed system, not to authorize federal regulation of the practice of medicine. As with any regulatory statute, the term "public interest" must be construed in light of the statutory purpose. *See, e.g.*, *NAACP v. Federal Power Comm'n*, 425 U.S. 662, 669 (1976) ("The use of the words 'public interest' in a regulatory statute . . . take meaning from the purposes of the regulatory legislation."); *see also Business Roundtable v. S.E.C.*, 905 F.2d 406, 413-14 (D.C. Cir. 1990) (rejecting SEC's attempt to invoke statute's "public interest" mandate to assert authority in an area of "firmly established" state jurisdiction and noting that affirming this "advance into an area not contemplated by Congress would circumvent the legislative process that is virtually the sole protection for state interests").

Second, the term "public interest" does not stand alone in the amended CSA. Instead, section 824(a)(4) allows the Attorney General to revoke or suspend a registrant upon a finding that the registrant "has committed such acts as would render his registration *under section 823* of this title inconsistent with the public interest *as determined under such section.*" 21 U.S.C. § 824(a)(4) (emphasis added). The provision on which the Attorney General relies cannot be read apart from the provision on which it explicitly depends. It is under 21 U.S.C. § 823 that the meaning of "inconsistent with the public interest" is determined.

Section 823 provides an exclusive list of the factors that the Attorney General may consider in determining the "public interest":

> (1) The recommendation of the appropriate State licensing board or professional disciplinary authority.
>
> (2) The applicant's experience in dispensing, or conducting research with respect to controlled substances.
>
> (3) The applicant's conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.
>
> (4) Compliance with applicable State, Federal, or local laws relating to controlled substances.
>
> (5) Such other conduct which may threaten the public health and safety.

21 U.S.C. § 823(f). Nothing about these five factors—and certainly nothing in the legislative history of the 1984 amendments—suggests that Congress intended to upset the fundamental principle it had established in 1970: that the regulation of medical practice be left to the states other than as necessary to prevent diversion of controlled substances into illicit markets, and that any federal intrusion into medical and scientific matters must be specifically authorized, delegated to federal health officials, and off-limits for the Attorney General.

The Attorney General does not purport to rely on the first three factors, and for good reason. The first factor reaffirms the primacy of state regulators in determining the eligibility of

practitioners for CSA registration. As the 1984 Senate Report made clear, the amended registration provisions require that the Attorney General "continue to give deference to the opinions of state licensing authorities, since their recommendations are the first of the factors to be considered with respect to practitioner applicants." S. Rep. No. 98-225, *reprinted in* 1984 U.S.C.C.A.N. 3182, 3449.[8] This requirement of deference to state officials only serves to highlight the fallacy in the Attorney General's suggestion (Gov. Br. at 35) that the CSA prescribes exclusively federal standards for regulating use of controlled substances by medical practitioners. Nothing in the 1984 amendments or their legislative history suggests that such national uniformity was one of Congress's goals.

The second and third factors, meanwhile, are objective considerations that have nothing to do with the scientific or ethical legitimacy of particular medical purposes.

The Attorney General is thus left with the fourth and fifth factors. As to factor four, whether a physician who prescribes a controlled substance to assist suicide in a manner consistent with Oregon law fails to comply with "applicable . . . Federal . . . laws relating to controlled substances," 21 U.S.C. § 823(f)(4), begs the question currently before the Court.

The fifth factor permits the Attorney General to consider "[s]uch other conduct which may threaten the public health and safety." 21 U.S.C. § 823(f)(5). The term "public health and safety," however, does not provide the Attorney General with discretion to define the legitimate practice of medicine. The phrase must be construed in light of the purpose and structure of the CSA itself, which is directed toward preventing the diversion of controlled substances to illicit channels and

8. As the Ninth Circuit found, "[i]t is undisputed that the Attorney General made no effort to solicit input from the State of Oregon before issuing his Directive, notwithstanding an express promise to do so by his subordinates." *Oregon v. Ashcroft*, 368 F.3d 1118, 1129 (9th Cir. 2004).

which reserves medical determinations to the states and (in limited instances) to federal health officials.[9] It would be odd, indeed, for Congress to have departed so radically from the basic structure of the CSA in such a "back door" manner.

As this Court has observed of similar statutory provisions, section 823(f)(5) "calls for the application of the maxim *ejusdem generis*, the statutory canon that '[w]here general words follow specific words in a statutory enumeration, the general words are construed to embrace only objects similar in nature to those objects enumerated by the preceding specific words.'" *Circuit City Stores, Inc. v. Adams*, 532 U.S. 105, 114-15 (2001) (quoting 2A N. Singer, *Sutherland on Statutes and Statutory Construction* § 47.17 (1991)). None of the four enumerated factors preceding section 823(f)(5) involves anything remotely similar to a major policy determination defining the legitimate practice of medicine based on considerations of morality, or a wholesale preemption of matters that are the historical province of the states.

In sum, the 1984 amendments to the CSA's registration provisions did not alter the goals or basic structure of the Act.[10]

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9. *See Brotherhood of Locomotive Engineers v. Atchison, Topeka & Santa Fe Railroad Co.*, 516 U.S. 152, 157 (1996) (recognizing that, where a statute's objective is apparent, statutory terms "must be understood in accord with that objective").

10. Insistence by *amici* federal legislators that, in the event of affirmance in this case, "Oregon will merely have carved out of the CSA a specific purpose for controlled substances (i.e., assisting suicides) that is governed solely by state law," Santorum Br. at 21, misses the mark. Regulation of particular medical purposes has never been within the ambit of the CSA. Affirmance would thus restore the status quo in which the Attorney General lacked discretion to carve out specific purposes from those for which a prescription could be written. Under that status quo, state standards were pivotal—rather than anathema—to the enforcement of the CSA's registration provisions.

The amendments enhanced the federal government's authority to act to maintain the closed system for distribution of controlled substances. They did not, however, effect the sea change in federal policy towards the regulation of the practice of medicine that the Attorney General urges.[11]

II. Congress Has Manifested Its Understanding That The Attorney General Lacks Authority To Preempt State Regulation Of Physician-Assisted Suicide.

Since the enactment of Oregon's Dignity Act, Congress has three times considered bills dealing with assisted suicide. The Congressional proponents and opponents of these legislative efforts understood that federal authority under the CSA did not reach physician-assisted suicide and that, at a minimum, new federal legislation would be required to defeat the Dignity Act.

A. Congress Has Recognized That The CSA Does Not Authorize Federal Preemption Of State Law Regarding The Legitimacy Of Physician-Assisted Suicide.

In 1998, opponents of the Dignity Act introduced H.R. 4006, entitled the "Lethal Drug Abuse Prevention Act," 105th Cong. (1998), which would have authorized the Attorney General to suspend or revoke the registration of a physician prescribing lethal doses of drugs to terminally ill patients to assist suicide, even if authorized by state law. The bill failed. In 1999, the opponents made another attempt at preempting the Oregon law in H.R. 2260, the "Pain Relief Promotion Act," 106th Cong.

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11. The strong bipartisan support for the amendments identified by *amici*, *see* Santorum Br. at 15, is not consistent with the theory that the 1984 amendments were intended to radically alter the balance of state and federal power in the area of regulation of medical practice.

(1999), which also failed.[12] Implicit in these attempts is the recognition that the CSA does not preempt, or authorize the Attorney General to preempt, state law in this area.

While failed legislative proposals generally are accorded limited weight in statutory interpretation, in appropriate contexts rejected attempts at amending a statute may provide valuable guidance in determining the scope of the unamended legislation. *See New York Tel. Co. v. New York State Dep't of Labor*, 440 U.S. 519, 544-45, 544 n.44 (1979) (finding that two instances in which Congress considered and failed to approve attempts to expressly preempt state power indicated lack of preemption). This is such a case, because the context in which Congress considered these failed bills is particularly helpful in delineating the scope of the Attorney General's authority under the CSA in its present form.

First, the amendments to the CSA were proposed in the wake of this Court's observation in *Washington v. Glucksberg* that "Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society." 521 U.S. 702, 735 (1997). In light of this observation, the sponsors of the failed bills recognized that this debate would continue in the states unless Congress stepped in to amend the CSA to preempt the Oregon, and any similar state, law. The CSA, however, was not so amended.

Second, Congress failed to amend the CSA despite Attorney General Reno's 1998 interpretation of the CSA as *not*

12. Both proponents and opponents of the bills acknowledged that the amendments targeted the Dignity Act. *See, e.g.*, S. Rep. No. 106-299, at 7, 18 (2000) (Senate Judiciary Committee Report on H.R. 2260); *id*. at 54-55 (minority views); H.R. Rep. No. 106-378, at 5 (1999) (House Judiciary Committee Report on H.R. 2260); H.R. Rep. No. 105-683, at 6 (1998) (House Judiciary Committee Report on H.R. 4006).

authorizing preemption of state law on physician-assisted suicide. *Cf. United States v. Hunter*, 101 F.3d 82, 85 (9th Cir. 1996) (presuming that Congress is aware of, and acquiesces to, existing interpretations of its laws when it subsequently enacts amendments). After "thorough and careful review of the issue," Attorney General Reno explained her conclusion that "[t]here is no evidence that Congress, in the CSA, intended to displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice." Letter from Hon. Janet Reno, Attorney General of the United States, to Hon. Henry Hyde, Chairman on the Judiciary, United States House of Representatives (June 5, 1998), *available at* http://www.usdoj.gov/opa/pr/1998/June/259ag.htm.html. At virtually every stage in Congress's consideration of the two bills, both proponents and opponents mentioned Attorney General Reno's interpretation.[13] The failure of these attempts to override Attorney General Reno's interpretation of the CSA, while lacking the force of an affirmative legislative enactment, should carry great weight in assessing whether the CSA in its present form empowers the current Attorney General to preempt state law.

When asked to interpret federal statutes as preempting state law, this Court has held that courts should "start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996). Given the lack of any evidence that Congress ever intended the CSA to substantially preempt state regulation of the practice of medicine, Congress's recent refusals

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13. *See, e.g.*, S. Rep. No. 106-299, at 12, 42 (2000) (Senate Judiciary Committee Report on H.R. 2260); *id.* at 52-53 (minority views); H.R. Rep. No. 106-378, at 6 (1999) (House Judiciary Committee Report on H.R. 2260); H.R. Rep. No. 105-683, at 6 (1998) (House Judiciary Committee Report on H.R. 4006).

to "eviscerate the states' well-established power to regulate medical practices," S. Rep. No. 106-299, at 61 (Senate Judiciary Committee minority views on H.R. 2260), are significant.

B. Congress Has Recognized That Federal Law Leaves The Regulation Of Physician-Assisted Suicide To The States.

In 1997, Congress passed the Assisted Suicide Funding Restriction Act ("Funding Act"), Pub. L. No. 105-12, 111 Stat. 23, which prohibits the use of federal funds in assisted suicide. *Amici* refer to the Funding Act as evidence that "the position of the federal government has consistently been that it will not facilitate suicide." Santorum Br. at 25. This proposition, however, is beside the point.[14] The decision not to provide federal funds for physician-assisted suicide does not imply an authorization for federal officials to prohibit, or to preempt state laws authorizing and regulating, physician-assisted suicide. Indeed, when Congress enacted the Funding Act, it did so with the explicit understanding that the power to regulate assisted suicide remained with the states.

Then-Senator Ashcroft, speaking as a cosponsor of the Senate version of the bill, explained that the legislation would alter only allocation of federal funding:

> [The bill] *does not in any way forbid a State to legalize assisted suicide or even to provide its own funds for assisted suicide*. It simply says Federal resources are

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14. The authority upon which *amici* relies—a Medicare Benefit Policy Manual—is particularly unavailing as support for a claim of federal policy antagonistic to state law. The Medicare statute provides that "[n]othing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." 42 U.S.C. § 1395 (2000).

> not to be used to promote or conduct assisted suicides. After passage of this bill, *States might choose to legalize or fund assisted suicide*, but they would not be able to draw on Federal resources normally drawn upon in joint efforts between the State and the Federal Government for the provision of health services.

143 Cong. Rec. S3249, S3250 (1997) (emphasis added); *see also* 143 Cong. Rec. H1397, H1402 (1997) (statement of Rep. Bilirakis). Thus, at the time of the Funding Act, Congress understood that federal law—which, of course, included the CSA—left to the states the policy decision whether to permit physician-assisted suicide.

Far from demonstrating congressional understanding that physician-assisted suicide was inconsistent with federal law, the enactment of the Funding Act demonstrates Congress's recognition that state legislatures might choose to authorize assisted suicide. Otherwise, there would be no need to prohibit use of federal funds. The original sponsor of the bill in the House, Representative Ralph Hall, explained: "If assisted suicide is legalized by the Supreme Court or in any individual State, all it would take [for federal funds to be used] is for one district court judge to rule that assisted suicide fits under the State's Medicare guidelines." 143 Cong. Rec. H1397, H1403 (1997). This concern was echoed verbatim by a cosponsor of the Senate bill. 143 Cong. Rec. S3249, S3258 (1997) (statement of Sen. Nickles). The Funding Act thus demonstrates the Congressional recognition that states could and might legalize physician-assisted suicide and that, absent federal legislation, the federal government might be forced to fund the practice.

III. The Regulation Of Physician-Assisted Suicide Is Within The Core Of The States' Power And Competence.

The absence of authorization in the CSA for federal officials to regulate physician-assisted suicide is not a coincidence. Policy decisions respecting physician-assisted suicide sit at the crossroads of moral judgment and medical regulation. Tradition and constitutional doctrine recognize that decisions in these areas are properly entrusted to the states.

A. Regulation Of The Practice Of Medicine And Related Issues Of Medical Ethics Has Traditionally Fallen To The States.

As this Court has recognized, "States have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests, they have broad power to establish standards for licensing practitioners and regulating the practice of professions." *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 792 (1975). The compelling interest that each state has in regulating professionals operating within its borders has particular force in the field of medicine, where the conduct of professionals relates directly to the core of state police power—the public health. *See Watson v. Maryland*, 218 U.S. 173, 176 (1910) ("There is perhaps no profession more properly open to [state] regulation than that which embraces the practitioners of medicine.").

The uniquely strong interest of states in the regulation of the practice of medicine is consistent with this Court's frequent recognition that such regulation has traditionally been the province of the states. *See Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) (health care is "a subject of traditional state regulation"); *Hillsborough County v. Automated Med. Labs.*,

471 U.S. 707, 719 (1985) ("the regulation of health and safety matters is primarily, and historically, a matter of local concern"); *Barsky v. Bd. Of Regents*, 347 U.S. 442, 449 (1954) ("It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there."). Congress has similarly deferred to the traditional primacy of state regulation of medicine by providing in several statutes pertaining to medical matters that nothing in those statutes should be construed to authorize federal officials "to exercise supervision or control over the practice of medicine or the manner in which medical services are provided." 42 U.S.C. § 1395 (2000) (Medicare); *see also* 42 U.S.C. § 263a-2(i)(1) (2000) (Fertility Success Rate Certification Act of 1992); 21 U.S.C. § 396 (2000) (Food and Drug Administration Modernization Act of 1997); 21 U.S.C. § 823(g)(2)(H)(i) (2000) (Drug Addiction Treatment Act of 2000). So strong is the Congressional recognition of the centrality of state regulation in this area that Congress requires physicians serving in the United States military to subject themselves to state licensing regimes. 10 U.S.C. § 1094 (2000). Even *amici* writing in support of the Attorney General have been forced to acknowledge that regulation of the practice of medicine "had always been considered primarily a state responsibility." Santorum Br. at 18.

The Attorney General, however, seeks to evade the issue of which entity has traditionally been empowered to make decisions with respect to the appropriateness of particular medical practices. Instead of addressing this issue, the Attorney General attempts to reframe the question as whether a particular medical practice has traditionally been authorized by states. *See* Gov. Br. at 39. So framed, the question lacks meaningful content. The power to authorize only medical practices that have been traditionally authorized is no power at all. This approach, moreover, would freeze medical practice as it has existed at some point in the past, and could jeopardize the advancement of medicine through the use of initially controversial practices.

Similarly, the attempt by the Attorney General and certain *amici* to characterize the Dignity Act as inconsistent with a national consensus on physician-assisted suicide is both inaccurate and inapposite. To begin, statements of ethical policy by the American Medical Association—of which approximately 30% of physicians are members[15]—and similar organizations cannot be treated as establishing a national medical consensus against physician-assisted suicide.[16] In fact, a recent national survey of physicians reveals that 71% of physicians support the legalization of physician-assisted suicide, at least under some circumstances.[17] Another recent national poll of the general public indicates that, far from reflecting a radical departure from national norms, authorizing doctors to participate in physician-assisted suicide for terminally ill patients is consistent with the policy preference of nearly three-quarters of the public.

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15. *See* AMA, *Frequently Asked Questions In Ethics*, http://www.ama-assn.org/ama/pub/category/5105.html.

16. The Attorney General is quite selective in his reliance on the AMA position. The AMA Code of Ethics also prohibits physician participation in legally authorized executions, including by administering or overseeing lethal injection. AMA, *Code of Ethics* § E-2.06, *available at* http://www.ama-assn.org/ama/pub/category/8419.html. Despite the existence of identical authority in support of a supposed "national" consensus, the Attorney General has not invoked the CSA to declare such participation contrary to the public interest as he has with respect to physician-assisted suicide. Nor would he agree that the AMA position represents a national consensus on the illegitimacy of execution by lethal injection.

17. The survey was conducted by the Louis Finkelstein Institute for Social and Religious Research and HCD Research. A plurality (41%) of physicians endorse legalization of physician-assisted suicide under a wide range of circumstances, and another 30% support legalization in "a few cases." *Poll: Majority of Doctors Support Ethics of Physician Assisted Suicide*, Business Wire (Mar. 3, 2005).

See 15 CQ Researcher 421, at 428 (May 13, 2005).[18] Reflective of these evolving views on this issue, the California legislature is currently debating a bill virtually identical to Oregon's Dignity Act. *See* California Compassionate Choice Act, 2005-06 Cal. AB No. 654 (Cal. 2005); Nancy Vogel, *Oregon Law Fuels Debate on Suicide*, L.A. Times, May 24, 2005, at A1. The question is being debated in other states as well. *Id*.

In any event, even if a strong national consensus against physician-assisted suicide did exist—and it clearly does not—the opinions of the rest of the country have nothing to do with whether each state has the presumptive authority to reach its own decision. That is, after all, the very point—and the genius—of our federal system.

B. This Court Has Recognized That Resolution Of The Difficult Moral, Practical, And Ethical Questions Associated With Physician-Assisted Suicide Is Appropriately Entrusted To The States.

A mere eight years ago, this Court acknowledged that the difficult questions surrounding physician-assisted suicide could not easily be resolved. "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician assisted suicide. Our holding permits this debate to continue, as it should in a democratic society." *Washington v. Glucksberg*, 521 U.S. 702, 735 (1997).

As Justice Brandeis famously observed in his dissent in *New State Ice Co. v. Liebman*, 285 U.S. 262, 311 (1932),

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18. This Gallup poll, too, reflects evolving attitudes toward the issue. In 1950, only 26% of Americans supported physician-assisted suicide for terminally-ill patients; in 2003, 72% of Americans voiced support.

"[i]t is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." *See Glucksberg*, 521 U.S. at 737 (O'Connor, J., concurring) ("States are presently undertaking extensive and serious evaluation of physician assisted suicide and other related issues. In such circumstances, 'the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the States . . . in the first instance.'" (quoting *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 292 (1990) (O'Connor, J., concurring))).

As the current debate in California and debates in other states throughout the country make clear, the wisdom of authorizing physicians to assist terminally-ill patients in hastening their deaths is a matter on which reasonable minds can and do differ. The Attorney General should not be permitted to deprive the people of Oregon and the nation of the opportunity to benefit from the ultimate outcome of the "earnest and profound debate" in which they are engaged.

CONCLUSION

Amici urge this Court to affirm the decision below.

Respectfully submitted,

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