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Notes

OREGON V. ASHCROFT: THE ATTORNEY GENERAL'S ATTEMPT
TO OVERRIDE STATE CONTROLLED MEDICAL PRACTICECasey Kaufman^{al}

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JASON EWING HAS had cancer for four years, and now death is imminent.¹ He has gone through all the standard and experimental treatments, but now even his most optimistic doctor has agreed time is very short. While this tragedy may be commonplace for the elderly, Jason is only 35. In high school and college Jason was a track star, an athlete in top shape. But now, he is starting to notice the effects of the cancer and shortness of breath is severely limiting his activities. Sadly, Jason's symptoms will worsen to the point where asphyxiation will cause his death. The doctors inform him that he has no medical options--radiation and chemotherapy have failed--and surgery is out of the question.

Jason does not want his wife and children to be burdened with the last stages of death. He wants their lasting image of him to be one of strength and poise. In most states, Jason would have to experience each aspect of dying, progressive and agonizing, until the disease caused him to stop breathing. However, Jason lives in Oregon and wants to take advantage of a recently-passed state law that allows him to avoid this painful end of life by taking control of the situation. Oregon's Death With Dignity Act ("Oregon Act"),² allows for physician-assisted suicide ("PAS"), giving Jason the option to end his life humanely, without forcing his wife and family to watch him deteriorate.

***1066** Many other individuals with different diseases, characteristics, and circumstances find themselves in positions similar to Jason. An alternative for some, PAS is a heavily debated topic today, and many states have addressed it with legislation, criminalizing PAS. Oregon was the first state to allow its citizens an option aside from the natural course of a terminal disease.³ In response to the Oregon Act, Attorney General John Ashcroft issued a directive ("Ashcroft Directive") ordering the Drug Enforcement Administration ("DEA") to prosecute doctors that prescribe life-ending medicine.⁴

Part I of this Note examines the Oregon Act, the Controlled Substances Act, and the Ashcroft Directive. Part II scrutinizes Oregon v. Ashcroft, the state of Oregon's attempt to enjoin the enforcement of the Ashcroft directive. That section will identify the parties, their arguments, and the basis of the district court opinion. Although this Note concurs with the District Court's decision, Part III will suggest an alternate route for the Ninth Circuit to decide its upcoming appeal. Specifically, Part III focuses on principles of federalism and state controlled medical practice, which require the appeals court to strike the Ashcroft Directive as a violation of the Tenth Amendment.

I. Background

The Oregon Act provides a detailed procedure by which a mentally competent, terminally ill patient can request medication "for the purpose of ending his or her life in a humane and dignified manner."⁵ The Oregon Act allows patients to use medications, such as secobarbital or pentobarbital,⁶ which are listed as schedule II drugs under the Federal Controlled Substances Act ("CSA") to end their life.⁷ The CSA was enacted by Congress to address the problem of drug abuse and illegal trafficking

of drugs and organizes drugs from aspirin to heroin into schedules with different levels of regulation.⁸ After the Oregon Act took effect, the Attorney General issued a directive (“Ashcroft Directive”) which declared that PAS is a practice which ***1067** directly violates the CSA.⁹ In response to the Ashcroft Directive, the state of Oregon sought to enjoin the order in Oregon v. Ashcroft¹⁰ --the subject of this Note.

A. The Oregon Act

1. Statutory Provisions of the Oregon Act

The Oregon Act was a citizen's initiative, first passed in 1994 with a vote of 51% in favor and 49% opposed.¹¹ Doctors, patients, and residential care facilities immediately sought an injunction to prevent the Oregon Act from taking effect.¹² A permanent injunction was granted on Equal Protection grounds, because the Oregon Act lacked sufficient safeguards against preventing suicide of people that were not terminally ill.¹³ On appeal, the Ninth Circuit reversed the injunction and dismissed the complaint for lack of jurisdiction.¹⁴ In November 1997, Measure 51¹⁵ was placed on the general election ballot to give Oregon voters a chance to repeal the Oregon Act.¹⁶ Voters chose to keep the PAS option for Oregon citizens, this time with a 60% vote.¹⁷

The Oregon Act allows physicians to prescribe lethal medications to terminally ill Oregon residents.¹⁸ A capable¹⁹ adult resident of Oregon, who has been diagnosed with a terminal disease and has voluntarily expressed his or her wish to die, may make a written request for lethal medication²⁰ from a licensed Oregon physician.²¹ The patient must make a simultaneous oral and written request and then, 15 days ***1068** later, an additional oral request to the physician to write the prescription for life-ending medication.²² The physician must, along with other requirements, verify that the patient has a terminal disease,²³ the request was voluntary, and the doctor informed the patient of feasible alternatives, including hospice care and pain control.²⁴ Lastly, the physician must verify that the patient's disease is indeed terminal, and a second consulting physician must confirm that opinion.²⁵

The patient must self-administer the medication; no physician or other individual may end the patient's life by lethal injection, mercy killing, or active euthanasia.²⁶ In addition, any person acting in accordance with the Oregon Act is not considered to have committed suicide or to have assisted a suicide.²⁷ The Oregon Act also exempts a patient and their family from experiencing typical life insurance policy conditions: if a qualified patient takes advantage of the Oregon Act, the method of their death shall not have any effect upon insurance or annuity policies.²⁸

2. The Oregon Act's Demographics

From 1998 through 2001, ninety-one people took lethal medications prescribed under the Oregon Act and died.²⁹ In 2001, thirty-three physicians gave forty-four patients life-ending medication.³⁰ Of these forty-four patients, nineteen died from medication ingestion, fourteen died from their underlying disease, and eleven remained alive at the end of 2001.³¹ Twenty-one patients actually ingested the lethal medications that year,³² while 6,365 others died in Oregon from similar underlying causes, without performing PAS.³³ Demographically, those who took advantage of the Oregon Act were slightly more likely to be women, have college degrees, and be divorced.³⁴ “Although ***1069** the number of prescriptions written for [PAS] has increased during the past four years, the number of terminally ill patients ingesting lethal medication has remained small, with fewer than 1/10 of one percent of Oregonians dying by [PAS].”³⁵

B. The Federal Controlled Substances Act

Congress intended the CSA “to keep legally available controlled substances within lawful channels of distribution and use.”³⁶ It establishes five schedules of controlled substances according to their potential for abuse, their current medical use in the United States, and the psychological and physical effects of abuse.³⁷ Congress derives its power to control such substances through the Commerce Clause.³⁸ Congress made an express finding that controlled substances are creatures of interstate commerce; after manufacturing, they usually travel through interstate and foreign commerce, and interstate and intrastate controlled substances cannot be distinguished.³⁹ In *United States v. Tisor*,⁴⁰ the Ninth Circuit found that Congress has power under the Constitution to regulate these substances through the Commerce Clause.⁴¹

The CSA requires physicians and pharmacists to register with the DEA for authorization to dispense controlled substances.⁴² The CSA specifies procedures by which the Attorney General may delegate any of his functions under the CSA to other employees or officers of the Department of Justice (“DOJ”).⁴³ The Attorney General delegated to the Administrator of the DEA the task of drafting formal regulations to implement the CSA.⁴⁴

It is a DEA regulation that is central to the issues raised in *Oregon v. Ashcroft*.⁴⁵ Specifically, the Attorney General may suspend or revoke the registration of a physician or pharmacist if that registration is inconsistent *1070 with the “public interest.”⁴⁶ In addition, the regulation states that “[a] prescription for a controlled substance . . . must be issued for a legitimate medical purpose . . . in the usual course of . . . professional practice.”⁴⁷ Attorney General Ashcroft interpreted the “legitimate medical practice” language from the DEA regulation in conjunction with the “public interest” language from the CSA to muster authority for the Ashcroft Directive.⁴⁸ The Directive said PAS was not a legitimate medical practice and was against public interest, and therefore physicians or pharmacists that took part in a PAS should have their licenses revoked.

C. The Federal Response to the Oregon Act

Prior to the Oregon Act enactment in 1997, Illinois Representative Hyde and Utah Senator Hatch wrote a letter to then-DEA Administrator Constantine, requesting a determination as to whether the CSA prohibited the use of controlled substances for the purpose of assisting suicide.⁴⁹ The Congressmen asserted that assisting suicide through either prescribing or dispensing a controlled substance was not a legitimate medical purpose in light of DEA regulations, “especially when the practice is not reasonable and necessary to the diagnosis and treatment of disease and injury, legitimate health care, or compatible with the physician's role as healer.”⁵⁰ Constantine agreed with that view, indicating that PAS did not constitute a legitimate medical purpose under DEA regulations, and performing PAS violated the CSA.⁵¹

Enforcement of Constantine's interpretation would have nullified the Oregon Act by intimidating doctors and pharmacists through fear of reprisal. Had Constantine declared PAS to be a violation of the *1071 CSA, the DEA could have revoked doctor or pharmacist registration required to prescribe or distribute medication, effectively stripping their ability to work as medical professionals. In addition, the DEA could have also had them criminally prosecuted and possibly incarcerated.

On June 5, 1998, former United States Attorney General Janet Reno reversed Constantine's interpretation of the Oregon Act.⁵² The United States Attorney General is in command of many executive branch agencies within the Department of Justice, including the DEA.⁵³ Therefore, any DEA action or decision could be overturned by the Attorney General. Reno found no evidence indicating that Congress intended the CSA to “displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice.”⁵⁴ She further pointed out that “the CSA is essentially silent with regard to regulating the practice of medicine

that involves legally available drugs.”⁵⁵ The Federal Government's pursuit of Oregon physicians who comply fully with the Oregon Act would be “beyond the purpose of the CSA.”⁵⁶ Reno concluded, “the CSA does not authorize DEA to prosecute, or to revoke the DEA registration of, a physician who has assisted in a suicide in compliance with Oregon law.”⁵⁷

Subsequently, between 1998 and 2000, Congress twice attempted to pass legislation to outlaw PAS.⁵⁸ Congress's first attempt, The Lethal Drug Abuse and Prevention Act of 1998,⁵⁹ failed to reach the floor of either the House or the Senate.⁶⁰ The second attempt, The Pain Relief Promotion Act of 1999,⁶¹ passed the House,⁶² but failed to reach the Senate floor.⁶³ Had it passed, the Pain Relief Promotion Act would have banned the practice of intentionally dispensing a controlled *1072 substance for the purpose of death.⁶⁴ In addition, the Pain Relief Promotion Act stated that “the Attorney General shall give no force and effect to [s]tate law authorizing or permitting assisted suicide or euthanasia.”⁶⁵

D. Attorney General Ashcroft's Memorandum: The Ashcroft Directive

Instead of waiting for legislation to proceed through congressional pathways, Ashcroft issued the Ashcroft Directive to DEA Administrator Hutchinson on November 6, 2001.⁶⁶ Ashcroft determined that assisting suicide is not a “legitimate medical purpose” under DEA regulation.⁶⁷ Ashcroft based his memorandum on a brief prepared at his request by the Office of Legal Counsel (“OLC”),⁶⁸ and the Ashcroft Directive explicitly cited to it for legal support of its conclusions.⁶⁹

One argument directly addressed former Attorney General Reno's reasoning that the DEA lacked the authority to determine legitimate medical practices.⁷⁰ Concerning that issue, the OLC first conceded that “Congress did not intend to assign to the DEA the role of resolving the national debate over [PAS].”⁷¹ Instead, according to the Ashcroft Directive, Congress intended to give the Attorney General authority to devise regulations “relating to the . . . dispensing of controlled substances and control of regulated persons.”⁷² The regulation at issue here states that a controlled substance may only be distributed for a legitimate medical purpose.⁷³ The OLC opined that “it was well within the scope of the DEA's authority to determine how that regulation *1073 was to be applied to the use of controlled substances in [PAS].”⁷⁴ In sum, this argument made by the OLC proposed the controversial and disturbing notion that an agency with authority can pass a regulation and then interpret it in a way that might not be aligned with the congressional intent behind the grant of authority.

Another OLC argument specifically addressed the federalism principle that “[s]tates are the . . . primary regulators of the practice of medicine.”⁷⁵ Conversely, the OLC argued that CSA legislative history expanded the authority given to the Attorney General and the DEA into the arena of regulating medicine.⁷⁶ Federal regulation in the medical arena has centered on the dispensing of controlled substances since the Harrison Narcotics Act of 1914,⁷⁷ the predecessor of the CSA which was enacted in 1970.⁷⁸ In a 1984 amendment to curb deaths from prescription drug abuse,⁷⁹ Congress expanded the Attorney General and DEA authority under the CSA to refuse or revoke registration of any “physician who has committed acts ‘inconsistent with the public interest.’”⁸⁰ Prior to this amendment, registration was granted unless the physician's state license was revoked or the physician was convicted of a felony.⁸¹ The amendment listed five factors to be considered for determining the public interest:

- (1) The recommendation of the . . . [s]tate licensing board or professional disciplinary authority.
- (2) The applicant's experience . . . with respect to controlled substances.
- (3) The applicant's conviction record . . . relating to the manufacture, distribution, or dispensing of controlled substances.
- (4) Compliance with applicable [s]tate, [f]ederal, or local laws relating to controlled substances.
- (5) Such other conduct which may threaten the public health and safety.⁸²

The OLC declared that the inclusion of the phrase, “inconsistent with the public interest,” mandated a “standard . . . more demanding than the standard of a physician's licensing [s]tate.”⁸³ The brief then stated that the Attorney General and DEA were now authorized “to *1074 enforce the CSA against medical practitioners who prescribe controlled substances in a manner that ‘endangers public health or safety’ contrary to the ‘public interest’ notwithstanding . . . state law.”⁸⁴ The OLC concluded that the public interest standard authorized suspension or revocation of the DEA registration if a practitioner assisted in a suicide, regardless of a state law that permitted such action.⁸⁵

Using the OLC brief, Ashcroft concluded that PAS was not a legitimate medical practice and stated that the DEA registration of a physician who utilized the Oregon Act would be “inconsistent with public interest.”⁸⁶ The Ashcroft Directive reversed Reno's position, reinstated the original DEA interpretation, and directed the DEA to enforce a ban on PAS in Oregon.⁸⁷ With one memorandum, the Attorney General did something that Congress failed to do over two sessions: outlaw PAS.⁸⁸

II. The Oregon v. Ashcroft Case

On November 7, 2001, Oregon initiated this action by filing a complaint in the United States District Court of Oregon for declaratory and injunctive relief and a motion for a temporary restraining order to halt the enforcement of the Ashcroft Directive.⁸⁹ Defendants were John Ashcroft, as United States Attorney General, Administrator Hutchinson, the Director of the DEA's Portland office, the United States, the United States Department of Justice, and the United States DEA.⁹⁰ The district court granted the temporary restraining order and a full hearing on the merits was conducted on March 22, 2002 to determine if a permanent injunction should be issued.⁹¹ The substantive issue in the case was whether the CSA and DEA regulations authorized the Ashcroft Directive.⁹² As the head of the prosecutorial arm of the federal executive branch, the “mission of the Office of the Attorney General is to supervise and direct the administration and operation of the Department of Justice, including the . . . [DEA].”⁹³ The Ashcroft *1075 Directive was not a legally binding instrument, but rather an instruction to both the DOJ and the DEA to disallow PAS through either revocation of physician and pharmacist professional licenses or criminal prosecution.⁹⁴

A. The Plaintiffs' Arguments

The state of Oregon advanced four different arguments against the validity of the Ashcroft Directive.⁹⁵ First, Oregon contended that it was invalid for failing to issue public notice or solicit commentary as required by the Administrative Procedures Act.⁹⁶ The Administrative Procedures Act requires public notice and comment before adoption of substantive, or “legislative-type,” regulations; however, there is no such requirement for “interpretive rules.”⁹⁷ Neither public notice nor invitations for outside commentary were issued by the Attorney General in conjunction with the Ashcroft Directive.⁹⁸ A finding that it was in fact a substantive regulation would invalidate the directive.⁹⁹ Oregon admitted that the substantive/interpretive distinction “is notoriously hazy,” but examination of the numerous ongoing debates regarding PAS and possible ramifications of the Ashcroft Directive indicated a substantive rule issued without the requisite notice and commentary.¹⁰⁰

Second, Oregon contended that the Attorney General violated President Clinton's [Executive Order 13,132](#) which promoted federalism among executive agencies.¹⁰¹ This Executive Order commanded federal agencies to follow fundamental federalism principles and provided rules for formulating and implementing policies with federalism implications.¹⁰² The Executive Order thoroughly defined federalism, and asserted that “it is rooted in the belief that issues that are not national in scope or significance are most appropriately addressed by the level of government closest to the people.”¹⁰³ Oregon contended *1076 that the

Ashcroft Directive defied the order's general intent as well as the prescribed guidelines. The Ashcroft Directive, therefore, was invalid.¹⁰⁴

Third, Oregon argued that the Attorney General violated the Supreme Court's "clear statement"¹⁰⁵ rule regarding congressional intent and the agency authority because the Ashcroft Directive did the following: (1) "invoked" the outer limits of Congress's power under the Commerce Clause, (2) permitted federal encroachment into a traditional state power, and (3) did so without a "clear statement" of this intent from Congress.¹⁰⁶ If the Attorney General utilized the CSA in a way that violated the Commerce Clause, the CSA could be found unconstitutional. Congress did not intend, or delegate the authority to preempt states regulating the practices of doctors or pharmacists with either the enactment or 1984 amendment to the CSA.¹⁰⁷ Oregon deduced that without the requisite congressional intent, the Ashcroft Directive was an unauthorized use of power.¹⁰⁸

Finally, in the event the court found the Ashcroft Directive authorized by the CSA, Oregon argued the CSA exceeded constitutional authority.¹⁰⁹ First, citing *Linder v. United States*¹¹⁰ and its supporting decisions, Oregon declared that the Supreme Court previously held that "regulation of medical practices is a matter of state" and not federal concern.¹¹¹ Second, Oregon argued the Ashcroft Directive violated the Commerce Clause because it regulated PAS, a non-economic, intrastate activity.¹¹² Oregon further argued that even if the Ashcroft Directive was a rightful exercise of the Attorney General's authority under the Commerce Clause, it violated the Tenth Amendment protection of state sovereignty by nullifying Oregon's policy choice regarding a subject reserved to the states.¹¹³ Any of these constitutional violations would render the CSA invalid and therefore the Ashcroft Directive would have no force against the Oregon Act.

***1077** Patient plaintiffs raised arguments similar to those introduced by Oregon, and asserted one additional Constitutional claim.¹¹⁴ They contended that the Ashcroft Directive contravened their Fifth Amendment right to palliative care, up to and including, terminal sedation.¹¹⁵ They were afraid that physicians would be discouraged "from prescribing pain management drugs out of fear that such action could be viewed after the fact, by DEA agents . . . as an 'intentional' effort to end a patient's life."¹¹⁶ This "chilling effect," patient plaintiffs contended, would make physicians reluctant to prescribe sufficient medication when people needed aggressive pain management most--"at the end of life when death is near and pain is intractable."¹¹⁷

B. The Defendants' Arguments

The defendants first asserted that the CSA did not authorize the dispensing of controlled substances for assisted suicide.¹¹⁸ Rather, the defendants argued that the memorandum addressed the intent of the CSA to regulate controlled substances and the validity of the DEA regulation requiring controlled substances to be used only for legitimate medical purposes.¹¹⁹ Defendants drew support for their contentions from the OLC brief, addressed earlier in this Note, and concluded that the Attorney General was fully authorized by the CSA to determine PAS was not a legitimate medical practice.¹²⁰

Defendants then addressed the issues concerning the Administrative Procedures Act's notice and comment requirements for substantive rules.¹²¹ The defendants asserted that the Ashcroft Directive is an interpretive rule, one issued to "advise the public of the agency's construction of rules it administers."¹²² They supported this finding with four relevant "conclusions" reached by Ashcroft:

***1078** [1] . . . assisting suicide is not a "legitimate medical purpose" within the meaning of [the DEA regulation], . . . [2] prescribing, dispensing, or administering federally controlled substances to assist suicide violates the CSA[,] [3] [s]uch conduct by a physician registered to dispense controlled substances may "render his registration . . . inconsistent with the public interest" and therefore subject to possible suspension or revocation . . . [, and] [4] [t]his conclusion applies regardless of whether state law authorizes or permits such conduct¹²³

Defendants then proceeded to refute plaintiffs' constitutional claims by legitimizing the constitutionality of the CSA.¹²⁴ They claimed the CSA was a valid exercise of its power under the Commerce Clause, basing its support on congressional claims and findings in section 801 of the CSA that expounded the interstate nature of controlled substances.¹²⁵ Defendants also claimed the CSA did not violate the Tenth Amendment because it did not force states or state officers to administer federal regulation.¹²⁶

In response to the patient plaintiffs' Fifth Amendment claim, the Attorney General contended that the Ashcroft Directive affirmatively promoted pain management.¹²⁷ In addition, defendants cited numerous decisions which held there was no Fifth Amendment right to any specific type of drug or treatment.¹²⁸ Lastly, the Attorney General refuted President Clinton's Executive Order argument by citing a portion of the order that the plaintiffs' motion did not address.¹²⁹ Specifically, the defendants' brief cited section 11 of the order, entitled "Judicial Review," which stated that "[t]his order is intended only to improve the internal management of the executive branch, and is not intended to create any right or benefit, substantive or procedural, enforceable at law by a party against the United States, its agencies, its officers, or any person."¹³⁰ The Attorney General relied on cases addressing the binding affect of Executive Orders to conclude that [Executive Order 13132](#) only created obligations within the executive branch and did not supply a right that private parties or states may enforce.¹³¹

***1079 C. The District Court Opinion**

The district court analyzed the issue at bar via statutory interpretation.¹³² It scrutinized the plain language of the CSA and found no explicit or implicit support that the CSA delegated authority to the Attorney General or the DEA to decide the question of whether PAS constitutes a legitimate medical purpose or practice.¹³³

The court then turned to the legislative history of the CSA and found no suggestion that Congress intended the CSA to restrict prescriptions for controlled substances that might be used legitimately under state law to assist suicide.¹³⁴ The court found that the core objective of the CSA was to permit federal prosecution of drug dealers, drug abusers, and practitioners who engage in the illegal diversion and distribution of drugs.¹³⁵

With regard to federalism issues, the court opined that determination of what constitutes a legitimate medical purpose has traditionally been left to the individual states.¹³⁶ States determine medical standards that specifically and clearly define what is lawful.¹³⁷ Here, the court found that "the Oregon voters have made the legal, albeit controversial, decision that such a practice is legitimate in this sovereign state."¹³⁸

The district court concluded the opinion with a general appraisal of the events that led to the suit.¹³⁹ It noted the failure of Congress to pass two acts that would have limited PAS.¹⁴⁰ The court recognized the efforts of certain congressional leaders to "get through the administrative door that which they could not get through the congressional door, seeking refuge with the newly-appointed Attorney General whose ideology matched their views."¹⁴¹ As a final thought, the opinion stated that legislative action attempting to control matters traditionally left to the state may raise Constitutional concerns.¹⁴² A ***1080** permanent injunction was entered, on April 17, 2002, enjoining the Ashcroft Directive from application.¹⁴³

III. Analyses and Criticisms

Attorney General Ashcroft appealed the issue of whether he had “permissibly construed the Controlled Substances Act and its implementing regulations to prohibit the prescription of controlled substances for suicide.”¹⁴⁴ *Oregon v. Ashcroft* is currently pending before the Ninth Circuit. This Note will examine two avenues, aside from statutory interpretation, by which the Ninth Circuit should decide *Oregon v. Ashcroft* in order that the Oregon Act remains in effect for the citizens of Oregon. First, the traditional state right to determine legitimate medical practices will be examined via the United States Supreme Court case, *Linder v. United States*. It held that state law, not federal law, controls questions of medical practice.¹⁴⁵ Although decided in 1925, the *Linder* case is legally and factually similar to how a DEA prosecution of a doctor in light of the Ashcroft Directive would occur. Its opinion, rooted in principles of federalism, should control the Ninth Circuit's *Oregon v. Ashcroft* decision.¹⁴⁶ Second, this Note will examine Tenth Amendment jurisprudence to expand the argument that the Ashcroft Directive is commandeering state sovereign power.¹⁴⁷

A. Federalism and *Linder v. United States*

Federalism is “[t]he relationship and distribution of power between the national and regional governments within a federal system of government.”¹⁴⁸ Clinton's Executive Order explained that:

The nature of our constitutional system encourages a healthy diversity in the public policies adopted by the people of the several [s]tates according to their own conditions, needs, and desires. In the search for enlightened public policy, individual [s]tates and communities are free to experiment with a variety of approaches to public issues. One-size-fits-all approaches to public policy can inhibit the creation of effective solutions to those problems.¹⁴⁹

***1081** The Framers of the Constitution instituted the sovereign state system through the form and structure of the Constitution.

1. The *Linder* Case

Linder recognized that “direct control of medical practice in the States is beyond the power of the Federal government.”¹⁵⁰ The Supreme Court in *Linder* examined the conviction of Dr. Linder under the Harrison Narcotic Law (Narcotic Law) for dispensing morphine and cocaine to a known drug addict.¹⁵¹ Dr. Linder was accused of violating section 2 of the Narcotic Law that stated that any use, sale, or distribution of drugs taxed by the Narcotic Law must be in the lawful and legitimate practice of his profession.¹⁵² Dr. Linder was indicted based upon the finding that distributing one tablet of morphine and three tablets of cocaine to an addict was a violation of the Narcotic Law.¹⁵³

The Narcotic Law required the registration of persons that produce, dispense, sell, or distribute opium or coca leaves and their derivatives with the Internal Revenue Service (“IRS”) for the purpose of imposing a special tax.¹⁵⁴ Under the law, a doctor had to be registered with the IRS, which Dr. Linder was.¹⁵⁵ The declared intent of the Narcotic Law was to provide revenue; it says nothing of “addicts” and did not undertake to regulate any type of medical treatment.¹⁵⁶

The Supreme Court overturned Dr. Linder's conviction because he did nothing that violated the Narcotic Law, and the holding raised issues pertinent to *Oregon v. Ashcroft*.¹⁵⁷

Obviously, direct control of medical practice in the States is beyond the power of the Federal Government. Incidental regulation of such practice by Congress through a taxing act cannot extend to matters plainly inappropriate and unnecessary to reasonable enforcement of a revenue measure The enactment . . . may regulate medical practice in the States only so far as reasonably appropriate for or merely incidental to its enforcement.¹⁵⁸

***1082** The Court also said, “Congress cannot, under the pretext of executing delegated power, pass laws for the accomplishment of objects not entrusted to the Federal Government.”¹⁵⁹

The Linder Court dealt with two different issues, taxation and state-controlled medical practice. How congressional taxation and spending power has changed since Linder is not of concern in this Note. Instead, this Note relies upon Linder's holding that the state controls medical practice, which has been reinforced repeatedly since the decision was issued.¹⁶⁰

2. Legal and Factual Analogies to Oregon v. Ashcroft

The factual similarities between Linder and Oregon v. Ashcroft are uncanny, especially considering that more than seventy-five years has elapsed between the two cases. In both Linder and Oregon v. Ashcroft the DOJ prosecutors attempted to attack a specific state-allowed medical practice by way of federal law. However, Congress did not implement either of these underlying Congressional acts with the intent to regulate these medical practices. There are three strong similarities between the two cases. Both situations concern physicians performing medical practices that were legal under their state laws. Both concern physicians in compliance with the underlying federal legislation. Lastly, the intents of the underlying Congressional acts would be similarly misconstrued to support the federal interest of prosecution.

First, in Linder, Dr. Linder's act of giving morphine and cocaine to a known addict was not actually a violation of Washington state law.¹⁶¹ Similarly, in the state of Oregon, the Death With Dignity Act was established to allow PAS.¹⁶² Therefore, in both cases, physicians ***1083** performed medical practices legal under state law. Linder held that states are to decide what a medical practice is and that this determination is beyond the legislative territory of the federal government.¹⁶³ Applying Linder's federalism holding to the situation in Oregon v. Ashcroft, the Oregon Act would trump the Ashcroft Directive and support state determination of whether PAS is a legitimate medical practice.

Second, Dr. Linder was properly registered with the IRS and in compliance with the Narcotic Act at the time of his alleged violation.¹⁶⁴ Likewise, doctors in Oregon could properly register with the DEA and comply with the CSA but still be in violation of the Ashcroft Directive. Therefore, in both situations, a physician could comply fully with the underlying federal legislation and still be targeted for prosecution. The fact that a doctor in full compliance with the CSA can still violate the Ashcroft Directive crystallizes the misguided application of the CSA by the Attorney General.

Lastly, the explicit congressional intent behind the Narcotic Law was to raise revenue through taxation.¹⁶⁵ The explicit congressional intent of the CSA was to curb drug abuse and illegal drug trafficking.¹⁶⁶ In both cases, the DOJ twisted congressional intent of the underlying legislation to further an agenda of federal control over what constitutes a medical practice within a state. “Federal power is delegated [from the Constitution], and its prescribed limits must not be transcended even though the end seem[s] desirable.”¹⁶⁷

3. Current Views of Federalism

Current attitudes towards federalism reveal support for Oregon's sovereign right to pass a law condoning PAS.

a. The Supreme Court and Federalism

The Supreme Court continues to support the Linder ideal that states determine what constitutes legitimate medical practices. PAS was addressed at length in Washington v. Glucksberg,¹⁶⁸ which concerned the constitutionality of Washington's ban on assisted suicide.¹⁶⁹ Refusing unwanted lifesaving medical treatment is considered ***1084** a fundamental right under the

Fourteenth Amendment,¹⁷⁰ and Glucksberg addressed whether the right included “a right to commit suicide which itself include[d] a right to assistance in doing so.”¹⁷¹

The Court refused to recognize a constitutional right to assisted suicide.¹⁷² Chief Justice Rehnquist's opinion remarked upon the complexity of the issue: “[t]hroughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of [PAS] . . . as it should [be] in a democratic society.”¹⁷³ Furthermore, the Court refused to weigh the various state interests in a ban, holding that “Washington's ban on assisted suicide is at least reasonably related to their promotion and protection.”¹⁷⁴ In her concurrence, Justice O'Connor asserted that when deciding such sensitive issues such as the debate surrounding PAS, “the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the ‘laboratory’ of the States.”¹⁷⁵ “The Court declined to ‘strike down the considered policy choice’ of the State of Washington, deferring instead to that state's resolution of the debate.”¹⁷⁶ Implied in the Court's holding is that the state may resolve the PAS issue according to their own state interests, even if the state legalizes PAS, despite the fact there is no constitutional right to assisted suicide.

b. The Ninth Circuit and Federalism

Conant v. Walters,¹⁷⁷ decided by the Ninth Circuit in 2002, revealed that court's attitude towards states' rights. Although it was decided on an issue not applicable to *Oregon v. Ashcroft*, the opinion is important, nonetheless. *Conant v. Walters* resolved a First Amendment issue regarding the ability of doctors to recommend the use of marijuana to their patients.¹⁷⁸ California passed the Compassionate Use Act of 1996 (“California Act”)¹⁷⁹ which stated that “no physician in this state shall be punished, or denied any right or privilege, for having *1085 recommended marijuana to a patient for medical purposes.”¹⁸⁰ In response to the California Act, the federal government issued a policy (“Federal Marijuana Policy”) that stated that a “practitioner's action of recommending or prescribing Schedule I controlled substances is not consistent with the ‘public interest’ . . . and will lead to administrative action . . . to revoke the practitioner's registration.”¹⁸¹ The Federal Marijuana Policy was an executive branch response aimed at nullifying properly enacted state legislation and is analogous to the Ashcroft Directive.

Patients, physicians, and organizations brought action against the Federal Marijuana Policy in early 1997.¹⁸² A permanent injunction was issued, enjoining the government from revoking the DEA registration of certain physicians who recommended the use of marijuana.¹⁸³ It also enjoined the DEA from initiating any investigation of those physicians on the basis of that recommendation.¹⁸⁴

Conant addressed physician recommendations for marijuana use, whereas a separate but related case, *United States v. Oakland Cannabis Buyers' Coop*,¹⁸⁵ dealt with the actual distribution of marijuana for medical purposes.¹⁸⁶ *Oakland Cannabis* addressed whether federal law prohibiting marijuana distribution preempted the California Act.¹⁸⁷ The main difference between *Conant* and *Oakland Cannabis* is whether the CSA applies to their respective practices. In *Oakland Cannabis*, the issue was whether a cooperative could manufacture and distribute marijuana to patients.¹⁸⁸ Manufacture and distribution of marijuana is validly regulated by the CSA.¹⁸⁹ In *Conant*, the issue was whether physicians could recommend the use of marijuana to their patients.¹⁹⁰ The *1086 Ninth Circuit did not address the applicability of the CSA to recommendations of marijuana use, and instead held that the federal policy barring physician recommendations of medical marijuana use to patients violated the First Amendment.¹⁹¹

The *Conant* court's understanding of federalism should control the appellate decision in *Oregon v. Ashcroft* because of the applicability of *Conant*'s findings to the situation posed in *Oregon v. Ashcroft*. In the *Conant* majority opinion, the Ninth Circuit Court of Appeals stated its view of medical practice regulation:

Our decision today is consistent with principles of federalism that have left states as primary regulators of professional conduct. See *Whalen v. Roe* [citation omitted] (recognizing states' broad police powers to regulate the administration of drugs by health professionals); *Linder v. United States* [citation omitted] ('direct control of medical practice in the states is beyond the power of the federal government'). We must 'show[] respect for the sovereign States that comprise our Federal Union. That respect imposes a duty on federal courts, whenever possible, to avoid or minimize conflict between federal and state law, particularly in situations in which the citizens of a State have chosen to serve as a laboratory in the trial of novel social and economic experiments without risk to the rest of the country.' ¹⁹²

This opinion provides unwavering support of state regulated medical practice. The statement declaring the Ninth Circuit's pro-states' rights views appeared at the end of the Conant opinion, after a thorough analysis and holding with respect to the First Amendment. ¹⁹³ This Note contends that the above statement was not idle rambling; rather, it was to provide pro-states' rights advice for the court to rely upon when deciding *Oregon v. Ashcroft*.

The court's reference to federalism case law is also more relevant to the issues in *Oregon v. Ashcroft* than *Conant*. It cites to *Whalen v. Roe* and *Linder v. United States* for their support regarding state control of medical practice. ¹⁹⁴ Prior to handing down the *Conant* decision, the Supreme Court found any distribution of marijuana illegal, so the *Conant* court was not citing these cases to support state-sanctioned marijuana distribution. This Note further contends that the *Conant* court was citing *Whalen* and *Linder* to restate the Ninth Circuit's support for their state controlled medical practice holdings. The court's "laboratory" view of the states is precisely why Oregon could pass the Oregon *1087 Act, and the Ninth Circuit should decide *Oregon v. Ashcroft* based on that principle.

B. The Ashcroft Directive Commandeers the Oregon Legislature

Tenth Amendment jurisprudence is also instructive, addressing the federal government's inability to commandeer states or state officials into enforcing federal legislation. ¹⁹⁵ In *New York v. United States*, ¹⁹⁶ the Supreme Court overturned federal legislation that attempted to obligate states to dispose of low-level radioactive waste produced within their borders. ¹⁹⁷ The Court recognized that the Constitution "divides power among sovereigns and among branches of government precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day." ¹⁹⁸ In striking down the Low-Level Radioactive Waste Policy Amendments Act of 1985, the Supreme Court noted that "the [f]ederal [g]overnment may not compel the [s]tates to enact or administer a federal regulatory program." ¹⁹⁹

Later, in *Printz v. United States*, ²⁰⁰ the Supreme Court addressed the Federal Brady Handgun Violence Prevention Act. The Act was an attempt to regulate the distribution of guns throughout the country by establishing a national instant background check system. ²⁰¹ It contained an interim provision mandating prospective gun purchasers to file a form with their local chief law enforcement officer. ²⁰² The officer would then have to make a reasonable effort to perform a background check to determine if the sale to that buyer would violate the law. ²⁰³ The Court found the act unconstitutional because it required state police officers to conduct federally mandated background checks on prospective handgun purchasers. ²⁰⁴

This Note contends that the Ashcroft Directive violates this Tenth Amendment doctrine by excessively interfering with Oregon's sovereignty. The Oregon Act was properly enacted by voters and concerns *1088 an area of traditional state power. The Ashcroft Directive can be likened to the federal acts struck down in *Printz* and *New York*, with the similarities lying in the federal effort to control a sovereign state action. In effect, the Ashcroft Directive compels Oregon and its legislature to outlaw PAS by undermining that State's ability to pass the Oregon act.

Coincidentally, Judge Kozinski authored a concurring opinion in *Conant* that addressed this vein of Supreme Court Tenth Amendment jurisprudence.²⁰⁵ He stated that “[i]n the circumstances of this case, however, I believe the federal government’s policy runs afoul of the ‘commandeering’ doctrine announced by the Supreme Court in *New York v. United States* . . . and *Printz v. United States*”²⁰⁶ Judge Kozinski quoted part of the following, from *Printz*:

The Federal Government may neither issue directives requiring the States to address particular problems, nor command the States’ officers, or those of their political subdivisions, to administer or enforce a federal regulatory program. It matters not whether policymaking is involved, and no case-by-case weighing of the burdens or benefits is necessary; such commands are fundamentally incompatible with our constitutional system of dual sovereignty.²⁰⁷

Judge Kozinski applied *Printz* by stating that the Federal Marijuana Policy would violate the commandeering doctrine by forcing a state to “criminalize behavior it has chosen to make legal.”²⁰⁸ Furthermore, “allowing the federal government, already nearing the outer limits²⁰⁹ of its power, to act through unwilling state officials would ‘obliterate the distinction’ [between federal and state government] entirely.”²¹⁰

Applying Judge Kozinski’s views to *Oregon v. Ashcroft*, a state sovereignty argument crystallizes. The Ashcroft Directive attempts to commandeer Oregon by abolishing the state law decriminalizing PAS, just as the Federal Marijuana Policy attempted to commandeer California into abolishing a state law decriminalizing recommendations to use medical marijuana. In a sense, Ashcroft commandeers the Oregon *1089 legislative process by rendering a citizen’s ability to pass a law concerning a traditional area of state sovereignty impotent.

Ashcroft’s actions are exactly what Judge Kozinski feared: the Ashcroft Directive criminalizes behavior that the state of Oregon chooses to make legal. Through his directive, Attorney General Ashcroft effectively commands Oregon lawmakers to repeal a law with which he disagrees. This situation is what the *New York* and *Printz* courts avoided by striking down their respective federal acts. In deciding the appeal, the Ninth Circuit should address Ashcroft’s attempt to commandeer the Oregon democratic process in violation of the Tenth Amendment.

Conclusion

This Note examines Oregon’s law allowing PAS and Attorney General John Ashcroft’s attempt to criminalize it. This Note urges the Ninth Circuit to preserve the determination of medical practices to the states, which is the proper arena for a decision regarding the legality of the medical practice of PAS. The court should follow *Linder* and *Conant* as applicable legal precedent, and find the Ashcroft Directive an unconstitutional application of the CSA.

Returning to Mr. Ewing’s dilemma, Oregon followed the recommended avenue of debate and democratic legislation to legalize PAS. The court should not allow the Attorney General to commandeer the Oregon legislature and take away his ability to perform PAS.

Footnotes

^{a1} Class of 2004. The author wishes to thank Professor John Adler for his insight and enthusiasm and his family and fiancée Sierra for their love, encouragement, and unwavering support.

¹ Jason Ewing is a fictional character.

² Or. Rev. Stat. §§ 127.800-127.897 (2001).

- 3 See Alexandra Dylan Lowe, [Facing the Final Exit: The U.S. Supreme Court Has Left the Issue of Physician-Assisted Suicide Up to the States. Now the Question is How Law and Society Will Deal with the Debate.](#), 83 A.B.A.J. 48, 51 (1997).
- 4 See [Dispensing of Controlled Substances to Assist Suicide](#), 66 Fed. Reg. 56,607, 56,608 (Nov. 9, 2001).
- 5 Or. Rev. Stat. § 127.805(1).
- 6 See Arthur E. Chin et al., Or. Dep't of Human Res., 1998 Annual Report of Oregon's Death With Dignity Act: The First Year's Experience 5 (1999).
- 7 See [Oregon v. Ashcroft](#), 192 F. Supp. 2d 1077, 1082 (D. Or. 2002).
- 8 See [id.](#) at 1080.
- 9 See [Dispensing of Controlled Substances to Assist Suicide](#), 66 Fed. Reg. at 56,608.
- 10 192 F. Supp. 2d at 1077.
- 11 See Chin et al., *supra* note 6, at 1.
- 12 See [Lee v. Oregon](#), 869 F. Supp. 1491 (D. Or. 1994).
- 13 See [Lee v. Oregon](#), 891 F. Supp. 1429 (D. Or. 1995). Specifically, the court held that the Oregon Act violated the Equal Protection Clause of the United States Constitution as it “provide[d] a means to commit suicide to a severely overinclusive class who may be competent, incompetent, unduly influenced, or abused by others.” [Id.](#) at 1437.
- 14 See [Lee v. Oregon](#), 107 F.3d 1382, 1392 (9th Cir. 1997).
- 15 This measure was placed on the ballot for a special election. It was sponsored by the Oregon House of Representatives Committee on Judiciary in H.B. 2954, 69th Leg. Assem., Reg. Sess. (Or. 1997).
- 16 See Chin et al., *supra* note 6, at 1.
- 17 See [id.](#)
- 18 See [id.](#)
- 19 “‘Capable’ means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.” Or. Rev. Stat. § 127.800(3) (2001).
- 20 See [id.](#) § 127.805(1).
- 21 See Chin et al., *supra* note 6, at 1.
- 22 See Or. Rev. Stat. § 127.840.
- 23 “‘Terminal disease’ means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.” [Id.](#) § 127.800(12) (2001).
- 24 See [id.](#) § 127.815.
- 25 See [id.](#) § 127.805(1).
- 26 See [id.](#) § 127.880.
- 27 See [id.](#)
- 28 See [id.](#) § 127.875.

- 29 See Katrina Hedberg, Or. Dep't of Human Res., Fourth Annual Report on Oregon's Death With Dignity Act 3 (2002).
- 30 See *id.*
- 31 See *id.*
- 32 See *id.*
- 33 See *id.*
- 34 See *id.*
- 35 *Id.* at 4.
- 36 Janet Reno, U.S. Dep't of Justice, Statement of Attorney General Reno on Oregon's Death With Dignity Act, at <http://www.usdoj.gov/opa/pr/1998/June/259ag.htm.html> (last accessed June 1, 2003).
- 37 See 21 U.S.C. § 812 (2002).
- 38 U.S. Const. art. I, § 8, cl. 3.
- 39 See 21 U.S.C. § 801.
- 40 96 F.3d 370 (9th Cir. 1996).
- 41 See *id.* at 375.
- 42 See 21 U.S.C. § 822.
- 43 See *id.* § 871(a).
- 44 See *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077, 1081 (D. Or. 2002).
- 45 See *id.* at 1083.
- 46 *Id.* § 824(a)(4). The following factors should be considered when 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; or (5) such other conduct which may threaten the public health and safety. *Id.* § 823.
- 47 21 C.F.R. § 1306.04(a) (2002).
- 48 See *Dispensing of Controlled Substances to Assist Suicide*, 66 Fed. Reg. 56,607, 56,608 (Nov. 9, 2001).
- 49 See Sheldon Bradshaw & Robert J. Delahunty, [Whether Physician-Assisted Suicide Serves a "Legitimate Medical Purpose" Under the Drug Enforcement Administration's Regulations Implementing the Controlled Substances Act](#), 17 *Issues L. & Med.* 269, 270 (2002).
- 50 *Id.* at 270 n.4 (citation omitted).
- 51 See *id.* at 270.
- 52 See generally Janet Reno, U.S. Dep't of Justice, Statement of Attorney General Reno on Oregon's Death With Dignity Act, at <http://www.usdoj.gov/opa/pr/1998/June/259ag.htm.html> (last accessed June 1, 2003).
- 53 See <http://www.usdoj.gov/dojorg.htm> (last accessed June 1, 2003).
- 54 *Id.*
- 55 *Id.*

- 56 Id.
- 57 Id.
- 58 See [Oregon v. Ashcroft](#), 192 F. Supp. 2d 1077, 1083 (D. Or. 2002).
- 59 See H.R. Rep. No. 106-378, pt. 2, at 8 (1999).
- 60 See [Ashcroft](#), 192 F. Supp. 2d at 1083 n.6.
- 61 See H.R. 2260, 106th Cong. (1999).
- 62 See 145 Cong. Rec. H10903 (daily ed. Oct. 27, 1999).
- 63 See *id.*
- 64 See H.R. 2260, 106th Cong. (1999).
- 65 Id.
- 66 See [Dispensing of Controlled Substances to Assist Suicide](#), 66 Fed. Reg. 56,607, 56,608 (Nov. 9, 2001).
- 67 See [Oregon v. Ashcroft](#), 192 F. Supp. 2d 1077, 1083 (D. Or. 2002).
- 68 See Bradshaw & Delahunty, *supra* note 49, at 269-70.
The Assistant Attorney General in charge of the Office of Legal Counsel assists the Attorney General in his function as legal advisor to the President and all of the executive branch agencies. The Office drafts legal opinions of the Attorney General and also provides its own written opinions and oral advice in response to requests from the Counsel to the President, the various agencies of the executive branch, and offices within the [DOJ].
U.S. Dep't of Justice, Office of Legal Counsel, at <http://www.usdoj.gov/olc/> (last accessed June 1, 2003).
- 69 See Bradshaw & Delahunty, *supra* note 49.
- 70 See *id.* at 289-292.
- 71 Id. at 290.
- 72 Id.
- 73 See 21 C.F.R. § 1306.04 (2002); see discussion *infra* Part I.B.
- 74 Bradshaw & Delahunty, *supra* note 49, at 290.
- 75 Id. at 284.
- 76 See *id.* at 288-289.
- 77 See *id.* at 284 n.27.
- 78 See *id.*
- 79 See *id.* at 286 n.34 (citing 130 Cong. Rec. 25851 (1984) (statement of Rep. Rodino) (“[P]rescription drugs are responsible for close to 70 percent of the deaths and injuries due to drug abuse”).
- 80 Id. at 286.
- 81 See *id.*
- 82 21 U.S.C. § 823 (2002).

- 83 Bradshaw & Delahunty, *supra* note 49, at 287.
- 84 *Id.*
- 85 *See id.*
- 86 Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607, 56,608 (Nov. 9, 2001).
- 87 *See Oregon v. Ashcroft*, 192 F. Supp. 2d 1077, 1083 (D. Or. 2002).
- 88 *See id.* at 1079.
- 89 *See id.* at 1084.
- 90 *See id.* at 1077.
- 91 *See id.* at 1084.
- 92 *See id.* at 1087.
- 93 *See* <http://www.usdoj.gov/jmd/manual/ag.htm#ag> (last accessed June 1, 2003).
- 94 *See* Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607, 56,608.
- 95 *See* Oregon's Memorandum in Support of Motion for Summary Judgment, *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077 (D. Or. 2002) (No. CV 01-1647-JO) [hereinafter Memorandum].
- 96 *See id.* at 20-23.
- 97 *Id.* at 20.
- 98 *See Ashcroft*, 192 F. Supp. 2d 1077, 1084 (D. Or. 2002).
- 99 *See* Memorandum, *supra* note 95, at 10-14.
- 100 *Id.* at 20.
- 101 *See id.* at 23.
- 102 *See* Exec. Order No. 13,132, 64 Fed. Reg. 43,255 (Aug. 10, 1999).
- 103 *Id.*
- 104 *See* Memorandum, *supra* note 95, at 23.
- 105 “Where an administrative interpretation of a statute invokes the outer limits of Congress’ power, we expect a clear indication that Congress intended that result....” *Solid Waste Agency v. Army Corps of Eng’rs*, 531 U.S. 159, 172-173 (2001).
- 106 Memorandum, *supra* note 95, at 24.
- 107 *See id.* at 25-31.
- 108 *See id.* at 31.
- 109 *See id.* at 31-37.
- 110 268 U.S. 5 (1925).
- 111 *Supra* note 95, at 32.
- 112 *See id.* at 33-35.

- 113 See id. at 35-36.
- 114 See Patient Plaintiffs' Brief in Support of Their Motion for Partial Summary Judgment and in Opposition to Defendants' Motion to Dismiss or in the Alternative for Summary Judgment, [Oregon v. Ashcroft](#), 192 F. Supp. 2d 1077 (D. Or. 2002) (No. CV 01-1647-JO) [hereinafter Plaintiffs' Brief].
- 115 See id. at 27.
- 116 Id. at 28.
- 117 Id. at 28-29.
- 118 See Memorandum in Support of Defendants' Motion to Dismiss or in the Alternative for Summary Judgment and in Opposition to Plaintiffs' Motions for Summary Judgment at 12-36, [Oregon v. Ashcroft](#), 192 F. Supp. 2d 1077 (D. Or. 2002) (No. CV 01-1647-JO).
- 119 See id. at 13-21.
- 120 See id. at 32-35.
- 121 See id. at 44-52.
- 122 Id. at 44 (quoting [Gunderson v. Hood](#), 268 F.3d 1149, 1154 (9th Cir. 2001)).
- 123 Id. at 45 (citation omitted).
- 124 See id. at 36-44.
- 125 See id. at 36-40.
- 126 See id. at 41-42.
- 127 See id. at 42.
- 128 See id.
- 129 See id. at 52-54.
- 130 Exec. Order No. 13,132, 64 Fed. Reg. 43,255, 43,259 (Aug. 10, 1999) [hereinafter Executive Order].
- 131 See Plaintiffs' Brief, *supra* note 114, at 52-54.
- 132 See [Oregon v. Ashcroft](#), 192 F. Supp. 2d 1077, 1093 (D. Or. 2002).
- 133 See id. at 1089.
- 134 See id. at 1089-90.
- 135 See id. at 1090.
- 136 See id. at 1092.
- 137 See id.
- 138 Id.
- 139 See id. at 1092-1093.
- 140 See id. at 1093.
- 141 Id.

- 142 See *id.*
- 143 See *id.*
- 144 Brief for Appellants at 2, [Oregon v. Ashcroft](#), 192 F. Supp. 2d 1077 (D. Or. 2002) (No. 02-35587).
- 145 See *id.* at 18.
- 146 See discussion *infra* Part IV.A.
- 147 See discussion *infra* Part IV.B.
- 148 Black's Law Dictionary 627 (7th ed. 1999).
- 149 Executive Order, *supra* note 130 at 13,259.
- 150 [Linder](#), 268 U.S. 5, 18 (1925).
- 151 See *id.* at 10-16.
- 152 See *id.* at 13.
- 153 See *id.* at 10.
- 154 See *id.* at 12.
- 155 See *id.* at 10.
- 156 *Id.* at 17-18.
- 157 See *id.* at 22.
- 158 *Id.* at 18.
- 159 *Id.* at 17.
- 160 See [Semler v. Or. State Bd. of Dental Exam'rs](#), 294 U.S. 608, 611 (1935) (“That the state may regulate the practice of dentistry, prescribing the qualifications that are reasonably necessary, and to that end may require licenses and establish supervision by an administrative board, is not open to dispute.”); [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. It is a vital part of a state's police power. The state's discretion in that field extends naturally to the regulation of all professionals concerned with health.”); [Bigelow v. Virginia](#), 421 U.S. 809, 827 (1975) (“The State, of course, has a legitimate interest in maintaining the quality of medical care provided within its borders.”); [Whalen v. Roe](#), 429 U.S. 589, 603 n.30 (1977) (“It is, of course, well settled that the State has broad police powers in regulating the administration of drugs by the health professions.”); [Conant v. Walters](#), 309 F.3d 629, 639 (9th Cir. 2002) (“Our decision is consistent with principles of federalism that have left states as primary regulators of professional conduct.”).
- 161 See [Linder](#), 268 U.S. at 10-12.
- 162 See [Oregon v. Ashcroft](#), 192 F. Supp. 2d 1077, 1081-1082 (D. Or. 2002).
- 163 See [Linder](#), 268 U.S. at 18.
- 164 See *id.* at 22.
- 165 See *id.* at 17.
- 166 See [Ashcroft](#), 192 F. Supp. 2d at 1080.
- 167 [Linder](#), 268 U.S. at 22.

- 168 521 U.S. 702, 735 (1997).
- 169 See *id.* at 705-706.
- 170 See *id.* at 720.
- 171 *Id.* at 723.
- 172 See *id.*
- 173 *Id.* at 735. Justices O'Connor, Scalia, Kennedy, and Thomas joined in the majority.
- 174 *Id.* at 728-733.
- 175 *Id.* at 737. (O'Connor, J., concurring). Justices Ginsburg and Breyer joined in this portion of the concurrence.
- 176 [Oregon v. Ashcroft](#), 192 F. Supp. 2d 1077, 1079 (D. Or. 2002) (citing [Glucksberg](#), 521 U.S. at 737).
- 177 309 F.3d 629 (9th Cir. 2002).
- 178 See [Conant](#), 309 F.3d at 632.
- 179 Cal. Health & Safety Code § 11362.5 (West 2003).
- 180 *Id.* § 11362.5(c).
- 181 Administration Response to Arizona Proposition 200 and California Proposition 215, 62 Fed. Reg 6164-01 (Feb. 11, 1997).
- 182 See [Conant](#), 309 F.3d at 633.
- 183 See *id.* at 634.
- 184 See *id.* at 634.
- 185 532 U.S. 483 (2001).
- 186 See *id.* The Supreme Court has held that there is no medical necessity exception in the CSA for manufacturing or distributing marijuana. [United States v. Oakland Cannabis Buyers' Coop.](#), 532 U.S. at 494. Marijuana is a Schedule I drug, for which Congress has found no legitimate medical use; this will not influence *Oregon v. Ashcroft* because the drugs used for PAS are found in Schedule II, for which there are legitimate medical purposes. See U.S. Dep't of Justice, Drug Scheduling, at <http://www.usdoj.gov/dea/pubs/scheduling.html> (last accessed June 1, 2003).
- 187 See [Oakland Cannabis Buyers' Coop.](#), 532 U.S. 486-489.
- 188 See *id.* at 487.
- 189 See *id.* at 486.
- 190 See [Conant](#), 309 F.3d 629, 632 (9th Cir. 2002).
- 191 See *id.* at 634-639.
- 192 *Id.* at 639 (citation omitted).
- 193 See *id.*
- 194 See [Oakland Cannabis Buyers' Coop.](#), 532 U.S. 483.
- 195 See generally [New York v. United States](#), 505 U.S. 144 (1992) and [Printz v. United States](#), 521 U.S. 898 (1997).
- 196 505 U.S. 144 (1992).

- 197 See *id.* at 144.
- 198 *Id.* at 187.
- 199 *Id.* at 188.
- 200 521 U.S. 898 (1997).
- 201 See *id.* at 902.
- 202 See *id.* at 902-903.
- 203 See *id.* at 903.
- 204 See *id.*
- 205 See *Conant v. Walters*, 309 F.3d 629, 639 (9th Cir. 2002) (Kozinski, J., concurring).
- 206 *Id.* at 645 (Kozinski, J., concurring).
- 207 *Printz*, 521 U.S. at 935.
- 208 *Conant*, 309 F.3d at 646 (Kozinski, J., concurring).
- 209 The Ashcroft Directive lies at the “outer limits” of federal power insofar as many authors feel that the Ashcroft Directive would not pass muster under the Commerce Clause. See Lindsay R. Kandra, Comment: [Questioning the Foundation of Attorney General Ashcroft's Attempt to Invalidate Oregon's Death With Dignity Act](#), 81 Or. L. Rev. 505, 539-542 (2002). In addition, that author opined that the Ashcroft Directive violated the Supremacy Clause; see Kandra, *supra* at 536-539.
- 210 *Id.* (citing *United States v. Lopez*, 514 U.S. 549, 557 (1995)).

37 USFLR 1065