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 THE AMERICAN CIVIL LIBERTIES UNION AND THE ACLU OF OREGON AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

STEVEN R. SHAPIRO
The Americans Civil Liberties Union Foundation
125 Broad Street
New York, NY 10004

CHARLES F. HINKLE
ACLU Foundation of Oregon
Stoel Rives LLP
900 S.W. Fifth Avenue
Portland, OR 97204

ANDREW L. FREY
Counsel of Record
DAVID M. GOSSETT
KRISTINA SILJA BENNARD
Mayer, Brown, Rowe & Maw LLP
1909 K Street, N.W.
Washington, DC 20006
(202) 263-3000

Counsel for The American Civil Liberties Union and The ACLU of Oregon

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BRIEF OF THE AMERICAN CIVIL LIBERTIES UNION AND THE ACLU OF OREGON AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

INTEREST OF AMICI CURIAE

The American Civil Liberties Union ("ACLU") is a nationwide, nonprofit, nonpartisan organization with more than 400,000 members dedicated to the principles of liberty and equality embodied in the Constitution and this nation's civil rights laws. The ACLU of Oregon is one of its statewide affiliates. The personal autonomy issues raised by this case and discussed in this brief have been central to the ACLU's concerns for many years. Of particular note, the ACLU represented the petitioner in *Cruzan* v. *Missouri Department of Health*, 497 U.S. 261 (1990), and submitted an amicus brief in *Washington* v. *Glucksberg*, 521 U.S. 702 (1997). The ACLU of Oregon supported passage of Oregon's Death with Dignity Act, directly represented Intervenors-Defendants Levin and Schuck in a constitutional challenge to the statute (*Lee* v. *Oregon*, 107 F.3d 1382 (9th Cir. 1997)), and submitted an amicus brief in the district court supporting the state's defense of the statute.[1]

INTRODUCTION AND SUMMARY OF ARGUMENT

In *Washington* v. *Glucksberg*, 521 U.S. 702 (1997), the Court declined to strike down a statute prohibiting physician-assisted suicide as facially unconstitutional, but left open the possibility that there could be situations in which blocking a terminally ill, mentally competent patient from obtaining pre-

[1] Pursuant to Rule 37.6, amici affirms that no counsel for a party authored this brief in whole or in part and that no person other than amici and its counsel made a monetary contribution to its preparation or submission. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office.

scription drugs to end his or her life would transgress the Constitution's guarantee of liberty and privacy. Although the various opinions in *Glucksberg* differed as to the exact contours of that constitutional boundary, taken together these opinions provide a general outline of the circumstances in which obstructing access to physician-assisted suicide would have constitutional implications.

Oregon's Death with Dignity Act ("DWDA"), Or. Rev. Stat. § 127.800 *et seq.*, fits that outline. The carefully drawn statute has built-in safeguards against abuse, ensuring that only patients whose claim to physician-assisted suicide is at its constitutional zenith may invoke the statute's provisions. This case, however, does not require the Court to resolve whether impeding terminally ill Oregonians from making their own end-of-life decisions under the DWDA would in fact violate the liberty and privacy interests protected by the Fourteenth Amendment. It is enough that the Attorney General's construction of the Controlled Substances Act ("CSA"), 21 U.S.C. § 801 *et seq.*, which would effectively nullify the DWDA, raises serious constitutional doubts under the Fourteenth Amendment.[2] When the Court reads the CSA

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[2] While the Ashcroft Directive purports to leave Oregon's DWDA intact — because it only prohibits the use of Schedule II narcotics for physician-assisted suicide — the Directive blocks access to what physicians consider to be the safest and most effective means of ending one's life. See, *e.g.*, *Oregon* v. *Ashcroft*, 368 F.3d 1118, 1123 n.5 (9th Cir. 2004). Indeed, 204 of the 208 individuals who have ended their lives under the DWDA used Schedule II drugs. See Oregon Dep't of Human Services, *Seventh Annual Report on Oregon's Death with Dignity Act*, at 24 (Table 4) (March 10, 2005), available at http://egov.oregon.gov/DHS/ph/pas/docs/year7pdf. It is at best a cruel rejoinder that under the Ashcroft Directive terminally ill individuals still would have available to them other, less effective, less safe, and, perhaps, less gentle measures to end their lives. See, *e.g.*, *Oregon* v. *Ashcroft*, 368 F.3d at 1135 (Wallace, J., dissenting) ("Oregon physicians may

"in the light of the Constitution's demands" (*Zadvydas* v. *Davis*, 533 U.S. 678, 689 (2001)), as it must, it will see that only a construction that does not undermine Oregon's DWDA passes constitutional muster. Accordingly, the Attorney General's reading of the CSA must be rejected.

The DWDA permits physicians to prescribe drugs that will enable certain terminally ill, mentally competent Oregonians to end their lives. See pp. 10-12, *infra*. The statute has already withstood direct constitutional challenge (*Lee* v. *Oregon*, 107 F.3d 1382 (9th Cir. 1997)) and a later anti-DWDA ballot measure.[3] This case arose when Attorney General Ashcroft adopted a policy in 2001 designed to thwart the decision of Oregon voters to permit physician-assisted suicide under carefully controlled circumstances. Rejecting his predecessor's reading of the CSA — a statute designed to counter drug trafficking and diversion — he determined that the use of Schedule II prescription drugs, *i.e.*, those overwhelmingly used by terminally ill individuals under the DWDA, lacked the "legitimate medical purpose" required by the CSA. See Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607 (Nov. 9, 2001) (hereinafter "Ashcroft Directive"). Thus, the Attorney General's reading of the CSA allows him not only to prosecute any physician who writes a DWDA prescription in accordance with Oregon's law, but also to revoke that physician's ability to write any prescriptions for substances regulated by the CSA.

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continue to assist suicide by other means" such as with "carbon monoxide"); Amicus Br. of Int'l Task Force on Euthanasia and Assisted Suicide, at 7 ("A physician could write a prescription for the type of assisted suicide appliance made from plastic tubing to be used with substances that are not federally controlled.").

[3] In 1997, Oregon voters convincingly rejected a ballot measure that would have repealed the DWDA.

Oregon brought suit in federal court to block enforcement of the Ashcroft Directive.[4] The U.S. District Court for the District of Oregon permanently enjoined the Ashcroft Directive, finding that nothing in "the CSA * * * demonstrates or even suggests that Congress intended to delegate to the Attorney General or the [Drug Enforcement Administration ("DEA")] the authority to decide, as a matter of national policy, a question of such magnitude as whether physician-assisted suicide constitutes a legitimate medical purpose or practice." *Oregon* v. *Ashcroft*, 192 F. Supp. 2d 1077, 1089 (D. Or. 2002).

On appeal, the Ninth Circuit affirmed, also grounding its decision on interpretation of the CSA. *Oregon* v. *Ashcroft*, 368 F.3d 1118 (9th Cir. 2004). The court held that "[t]he Ashcroft Directive is invalid because Congress has provided no indication * * * that it intended to authorize the Attorney General to regulate the practice of physician assisted suicide." *Id.* at 1125. In the course of analyzing the case, the Ninth Circuit identified a potential constitutional problem with the Attorney General's reading of the CSA: the Ashcroft Directive — "by encroaching on state authority to regulate medical practice" — might exceed Congress's authority under the Commerce Clause, from which Congress's authority to enact the CSA is derived. *Ibid.* Absent an "unmistakably clear expression of intent to alter the usual constitutional balance," the court held that it was bound to interpret the CSA "to preserve rather than destroy the States' substantial sovereign powers." *Ibid.* (quotation marks omitted).

In our view, the Attorney General's interpretation of the CSA raises another substantial constitutional issue that provides additional grounds for affirming the decision below. See S. Ct. Rule 37.1. Specifically, the Ashcroft Directive

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[4] Later, a group of terminally ill Oregonians, a physician and a pharmacist moved to intervene.

raises serious constitutional problems in light of the suggestion by a majority of the *Glucksberg* Court that the Fourteenth Amendment may well protect the right of mentally competent, terminally ill patients — who may be experiencing great suffering — to physician-assisted suicide with safe and effective prescription drugs in order to ease their suffering and to control the circumstances of their imminent death.

Under well-established principles of statutory construction, this Court should reject an interpretation of the CSA that gives rise to such constitutional doubts. See Part A, *infra*. As set forth more fully below, the DWDA is a narrowly drawn, comprehensive statute designed to permit physician-assisted suicide for only those mentally competent, terminally ill individuals who have the most compelling constitutional claim to protection under the Fourteenth Amendment. See Part B, *infra*. And as we explain in Part C, *infra*, the existence of extreme pain-relief measures does nothing to lessen the constitutional doubt that arises from denying these individuals the shelter they seek in the DWDA.

Although this case does not itself present a direct constitutional challenge to the Ashcroft Directive, there is a reasonable interpretation of the CSA that will enable the Court to avoid having to confront that constitutional question in the future. Given the strained nature of the Attorney General's interpretation of the CSA, that is clearly the correct outcome here.

ARGUMENT

THE ATTORNEY GENERAL'S INTERPRETATION OF THE CSA SHOULD BE REJECTED BECAUSE IT RAISES SERIOUS CONSTITUTIONAL DOUBTS UNDER THE FOURTEENTH AMENDMENT.

When interpreting federal statutes, this Court has long adhered to the view that, whenever reasonably possible, a construction should be adopted that will avoid the need to

decide constitutional questions. *E.g.*, *Ashwander* v. *Tennessee Valley Auth.*, 297 U.S. 288, 341 (1936) (Brandeis, J., concurring). Accordingly, it is a "'cardinal principle' of statutory interpretation" that "'th[e] Court will first ascertain whether a construction of the statute is fairly possible by which the question may be avoided.'" *Zadvydas*, 533 U.S. at 689 (quoting *Crowell* v. *Benson*, 285 U.S. 22, 62 (1932)). Accord *Edward J. DeBartolo Corp.* v. *Florida Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 575 (1988); *United States* v. *Clark*, 445 U.S. 23, 31 (1980). This principle of statutory interpretation has a long pedigree of guarding against erosion of individual constitutional rights, including religious liberty (*N.L.R.B.* v. *Catholic Bishop of Chicago*, 440 U.S. 490, 507 (1979)), free speech (*DeBartolo Corp.*, 485 U.S. at 575-576), due process (*Zadvydas*, 533 U.S. at 682, 690), and equal protection (*Clark*, 445 U.S. at 33-34).[5]

In order to apply the doctrine of constitutional doubt, the Court need not decide that the interpretation of the CSA contained in the Ashcroft Directive would, in fact, lead that statute to be unconstitutional — only that such an interpretation would "raise[] a serious doubt as to [the statute's] constitutionality." *Zadvydas*, 533 U.S. at 689 (quotation marks omitted).[6] So long as one interpretation of the statute is

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[5] The doctrine of constitutional doubt is well established. Some commentators trace it back to the earliest days of the Republic. *E.g.*, Note, *The Avoidance of Constitutional Questions and the Preservation of Judicial Review: Federal Court Treatment of the New Habeas Provisions*, 111 HARV. L. REV. 1578, 1585 (1998) (tracing doctrine back to *Murray* v. *Schooner Charming Betsey*, 6 U.S. (2 Cranch) 64 (1804)); Adrian Vermeule, *Saving Constructions*, 85 GEO. L. J. 1945, 1948 (1997) (tracing doctrine back to *Mossman* v. *Higginson*, 4 U.S. (4 Dall.) 12 (1800)).

[6] See also Erwin Chemerinsky, *Raising Constitutional Doubts*, 38-Jan. TRIAL 68, 70 (2002) (to create constitutional doubt, "a lawyer need not convince a court that a law is unconstitutional,"

reasonable — and, as we discuss in Part A, Oregon's interpretation of the CSA is in fact persuasive — courts must avoid any other interpretation that may raise a significant constitutional problem. As we demonstrate in Part B, the interpretation of the CSA contained in the Ashcroft Directive clearly threatens to transgress constitutional bounds, and thus must be rejected.

A. Oregon's Interpretation Of The CSA, Under Which That Statute Would Permit The Continued Operation Of The DWDA, Is Clearly Reasonable.

The first stage of a constitutional-doubt analysis is to determine whether there is a plausible reading of a statute that raises no constitutional issue. While a court cannot "press statutory construction 'to the point of disingenuous evasion' * * * to avoid a constitutional question" (*United States* v. *Locke*, 471 U.S. 84, 96 (1985) (quoting *Moore Ice Cream Co.* v. *Rose*, 289 U.S. 373, 379 (1933))), it should not reach constitutional questions that a plausible reading of the statute would avoid. *Zadvydas*, 533 U.S. at 689.

There can be little doubt that Oregon's reading of the CSA, which permits the continued operation of the DWDA, is — at the very least — "fairly possible" (*id*. at 689 (quotation marks omitted)). Oregon's reading is "not at odds with fundamental legislative purposes" and "appears fair and reasonable in light of the language, purpose, and history" of the CSA. *Clark*, 445 U.S. at 31. And certainly nothing in the text of the CSA *compels* the interpretation of "legitimate medical purpose" asserted by the Attorney General. See *Locke*, 471 U.S. at 96 (declining to apply doctrine of constitutional doubt where statutory language did not permit an interpretation that "avoid[ed] a constitutional question"). The use Oregon

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but rather must "only persuade the court that there are important constitutional issues with uncertain resolutions").

makes of physicians in the DWDA scheme, described more fully below, is important to assure that the carefully circumscribed limitations on access to the Act's protections are effectively enforced; non-physicians simply could not administer the statute's safeguards as competently. It takes no linguistic contortions to find that the role assumed by physicians under Oregon's scheme serves a "legitimate medical purpose."

This conclusion is resoundingly reaffirmed when consideration is give to the congressional goals in enacting the CSA. That statute unquestionably was designed to prevent drug abuse and trafficking — not to prevent physicians from prescribing drugs to help their patients deal with the physical pain and mental anguish of advanced terminal illness, where no link to trafficking or abuse is even suggested. The statute itself explains that its purpose is to "increase[] research into, and prevention of, drug abuse and drug dependence * * * and to strengthen existing law enforcement authority in the field of drug abuse." Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236 (1970) (codified at 21 U.S.C. §§ 801-904). Similarly, the House Report accompanying the Act explained that "[t]his legislation is designed to deal in comprehensive fashion with the growing menace of drug abuse in the United States." H.R. Rep. No. 91-1444, reprinted in 1970 U.S.C.C.A.N. 4566, 4567. And this Court recognized just last Term that "[t]he main objectives of the CSA were to conquer drug abuse and to control the legitimate and illegitimate traffic in controlled substances." *Gonzales* v. *Raich*, 125 S. Ct. 2195, 2203 (2005).

In fact, even the Attorney General does not — indeed, cannot — point to any language in the CSA indicating that the statute was meant to bar drug use of the kind authorized by the DWDA (see U.S. Br. at 18-20). His amici, too, concede that the legislative history of the CSA contains not one hint that in enacting that legislation, Congress had in mind —

let alone sought to restrict — physician-assisted suicide. See, *e.g.*, Amicus Br. of Sen. R. Santorum, et al., at 3, 21-22.[7]

Thus, it is no surprise that Attorney General Reno determined that the CSA did not preclude the continued operation of Oregon's DWDA because "[t]he particular drug abuse that Congress sought to prevent was that deriving from the drug's 'stimulant, depressive, or hallucinogenic effect on the central nervous system.'" Stmt. of Attorney General Reno on Oregon's Death with Dignity Act (June 5, 1998), available at http://www.usdoj.gov/opa/pr/1998/June/259ag.htm.html (quoting 21 U.S.C. § 811(f)).

In short, reading the CSA to avoid interference with the DWDA is eminently reasonable — and, we submit, correct. Most importantly, however, unlike the Ashcroft Directive, Oregon's interpretation "avoids a serious constitutional question" (*Clark*, 445 U.S. at 31), the issue to which we now turn.

B. Preventing Physicians From Prescribing Lethal Dosages Of Schedule II Medications To Individuals Who Qualify Under The DWDA Would Raise Serious Constitutional Concerns.

Notwithstanding differing views on the scope and strength of substantive due process, this Court has recognized that, under certain circumstances, a patient's claim to physician-assisted suicide could assume constitutional dimensions. Although in *Washington* v. *Glucksberg*, 521 U.S. 702 (1997), this Court held that there was no general Fourteenth Amendment right to physician-assisted suicide, the Court explicitly left open the possibility that a mentally competent

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[7] A more detailed discussion of the text, history, and purpose of the CSA appears in the Ninth Circuit's opinion (368 F.3d at 1127-1129) and, we presume, in the respondents' briefs. This truncated discussion suffices here in that the doctrine of constitutional doubt requires only a showing that Oregon's reading of the CSA is plausible. *E.g.*, *Zadvydas*, 533 U.S. at 689.

individual — who may be experiencing great suffering — may have a constitutionally cognizable interest in controlling the circumstances of her death by means of physician-assisted suicide with scheduled narcotics. *Id.* at 735 n.24, 736-737 (O'Connor, J., concurring), 751-752 (Stevens, J., concurring in the judgment), 782 (Souter, J., concurring in the judgment), 789 (Ginsburg, J., concurring in the judgment), 792 (Breyer, J., concurring in the judgment).

It is now eight years after *Glucksberg* and eight years into Oregon's experiment with the DWDA. In marked contrast to *Glucksberg*, in which the contours of and limits on the asserted right to physician-assisted suicide were unknown, here, a terminally ill individual must clear several specific and carefully constructed hurdles before qualifying under the DWDA. These strict requirements insure that only mentally competent individuals in the most dire situations are eligible. A majority of the Court in *Glucksberg* strongly suggested that circumstances like those facing patients who meet DWDA's requirements would, in fact, give rise to constitutional protection. See pp. 14-17, *infra*.

1. ***Oregon's DWDA is narrowly drawn and carefully applied.***

The DWDA's built-in safeguards ensure that only patients in constitutionally compelling circumstances are permitted to invoke the statute. For example:

- Among other qualifications, the patient must be a terminally ill Oregon resident with a life expectancy of less than six months (OR. REV. STAT. §§ 127.800(12), 127.805(1)),[8] and must be capable of

[8] A patient is "terminally ill" if he or she has "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months." Or. Rev. Stat. § 127.800(12).

making and communicating health care decisions (*id.* § 127.815).

- To ensure that an individual has fully considered her decision, she must make two oral requests for a lethal prescription to her physician, separated by at least 15 days. *Id.* § 127.840.
- The patient must also provide a written request that is signed in the presence of two witnesses — at least one of whom is not related to the patient — who will attest that the patient is competent and acting voluntarily (*id.* §§ 127.810, 127.840).
- The physician must inform the patient of the available alternatives to assisted suicide, such as hospice care. *Id.* §§ 127.815(1)(c)(E), 127.830.
- A second physician must confirm the patient's diagnosis and prognosis, as well as the first physician's determination of the patient's mental competence. *Id.* §§ 127.815(1)(d), 127.820.
- If either physician has any doubts about a patient's mental state, he or she must refer the patient for a psychiatric or psychological evaluation. *Id.* § 127.825.
- There is then another 48-hour waiting period after the patient's written request before the physician actually may write the prescription. *Id.* § 127.850.
- The patient must be capable of taking the medication orally — no one else is permitted to administer the prescription. *Id.* § 127.880.
- Oregon closely monitors the DWDA. Physicians must report to the Oregon Health Division all prescriptions that they write for lethal medication and describe the characteristics of the patient. *Id.* §§ 127.815(1)(j),

127.855.[9] The state collects this data and publishes it in an annual report. *Id.* § 127.865. It is intended that detailed information regarding the use of the DWDA be abundant and accessible.

In short, the DWDA establishes a comprehensive framework designed to permit only patients facing the greatest hardships to invoke its provisions.

2. ***Experience shows that the DWDA is, in fact, applied only in the most severe cases and is not being abused by unscrupulous doctors, incapable patients, or uncaring family members.***

Oregon's experience with the DWDA has proven to be quite at odds with the oft-repeated and familiar parade of horribles one hears from opponents of physician-assisted suicide. The data gathered by Oregon demonstrates that "[t]he law has not had the dire social consequences that some opponents predicted." Susan Okie, M.D., *Physician-Assisted Suicide — Oregon and Beyond*, 352:16 NEW ENG. J. MED. 1627, 1628 (April 21, 2005). In fact, "[t]here is no evidence that it has been used to coerce elderly, poor, or depressed patients to end their lives, nor has it caused any significant migration of terminally ill people to Oregon." *Ibid.* See also Brian Boyle, *The Oregon Death With Dignity Act: A Successful Model or a Legal Anomaly Vulnerable to Attack?*, 40 HOUS. L. REV. 1387, 1388 (2004) (noting that DWDA "has operated relatively quietly and modestly since its inception in 1997") (footnote omitted). The data thus belie the doomsday prophesies made when the DWDA took effect.

Between 1998 and 2004, 326 patients received prescriptions for drugs intended to hasten their deaths; 208 of those individuals, or 64%, actually used them. See Oregon Dep't of

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[9] Doctors are under no obligation to write a lethal prescription. OR. REV. STAT. § 127.885(4).

Human Services, *Seventh Annual Report on Oregon's Death with Dignity Act* (March 10, 2005), available at http://egov.oregon.gov/DHS/ph/pas/docs/year7.pdf (hereinafter "*Seventh Annual Report*"). Of the 208 who ingested their prescription, 86% of them were enrolled in hospice care (*id.* at 24 (Table 4)), and, remarkably, 99% had some form of health insurance at the time of their death. *Ibid.*

Moreover, it is clear that robust end-of-life care and physician-assisted suicide are not mutually exclusive. Since the DWDA took effect, commentators have noted "[e]vidence of concomitant improvements in end-of-life care in Oregon," including "increased hospice referrals, morphine prescription per capita among the highest in the United States," and "increased physician attendance at palliative care conferences." Timothy E. Quill, M.D. & Christine K. Cassel, M.D., *Professional Organizations' Position Statements on Physician-Assisted Suicide: A Case for Studied Neutrality*, 138:3 ANNALS OF INTERNAL MED. 208, 209 (Feb. 4, 2003). Accord Robert Steinbrook, *Physician-Assisted Suicide in Oregon – An Uncertain Future*, 346:6 NEW. ENG. J. MED. (Feb. 7, 2002), available at 2002 WLNR 5896 ("there is evidence that the overall quality of care for dying patients in the state has improved"; "[b]etween 1997 and 2000, morphine use increased by about 50 percent in Oregon").

Indeed, after just two years of DWDA's existence, 76% of Oregon physicians who cared for terminally ill patients reported having improved their knowledge of pain treatment and their recognition of psychiatric disorders such as depression. *Seventh Annual Report*, at 17; Okie, *supra*, at 1629. And, as noted above, Oregon physicians now refer patients to hospice *more* frequently than before enactment of the DWDA. *Seventh Annual Report*, at 17; Okie, *supra*, at 1629; Quill & Cassel, *supra*, at 209.

3. *The DWDA — by its express terms and in practice — addresses the legitimate concerns expressed in* **Glucksberg** *regarding physician-assisted suicide.*

Although the opinions in *Glucksberg* provided varying degrees of detail about the factors that could give rise to a constitutional right to physician-assisted suicide, certain concerns permeate every Justice's opinion in that case. The DWDA guards against these potential pitfalls and establishes a comprehensive framework that not only permits careful analysis but also ensures that "recognizing [the] due process right" of individuals covered by DWDA would not "leave a court with no principled basis to avoid recognizing another." *Glucksberg*, 521 U.S. at 785 (Souter, J., concurring in the judgment).

a. Oregon's law includes multiple safeguards to ensure that "those who are not truly competent or facing imminent death, or those whose decisions to hasten death would not truly be voluntary," cannot invoke its provisions. *Id.* at 737 (O'Connor, J., concurring).

As outlined above, the DWDA requires a terminally ill patient to make his or her request for a lethal prescription multiple times over at least a 15-day period and in the presence of two witnesses. OR. REV. STAT. §§ 127.810, 127.840. A second independent physician must confirm the patient's diagnosis, prognosis, and mental competence to make health care decisions. *Id.* §§ 127.815(1)(d), 127.820.[10] If either phy-

[10] Of course, a doctor's informed judgment as to a terminally ill patient's life expectancy cannot be made with 100% certainty. However, the DWDA guards against abuse by requiring two physicians to agree on a patient's diagnosis and prognosis. Moreover, the term "terminal condition" is used (and defined) in "living will" statutes in effect in most states. *E.g.*, VA. CODE ANN. § 54.1-2984; MONT. CODE ANN. § 50-9-101. So, while the term is not free from difficulty, it has proved workable.

sician suspects that a patient is suffering from depression or other psychiatric impairments, they must refer the patient to a mental health expert for analysis. *Id.* § 127.825. Thus, the DWDA is able to "strike the proper balance between the interests of the terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure." *Glucksberg*, 521 U.S. at 737 (O'Connor, J., concurring).

In addition, only the "knowing and responsible" qualify under the DWDA. *Glucksberg*, 521 U.S. at 787 (Souter, J., concurring in the judgment). Because physicians are required to advise patients about other end-of-life options, including comfort care and hospice, the DWDA covers only "individual[s] adequately informed of the[ir] care alternatives." *Id.* at 748 (Stevens, J., concurring in the judgment). For these informed and competent individuals who "might make a rational choice for assisted suicide," "the State's interest in preventing potential abuse and mistake is only minimally implicated." *Ibid.*

Further lessening any fears that a terminally ill patient may face coercion or undue pressure — or, as the Attorney General's amici suggest, "a duty to die" (*e.g.*, Amicus Br. of Focus on the Family, at 23) — it is important to note that *all* Oregon residents have access to hospice care, regardless of their ability to pay,[11] and Medicare covers hospice for pa-

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[11] Oregon's Health Plan covers hospice care (OR. ADMIN. R. 410-142-0040(1)), and "Oregon's hospices support universal access to hospice care [and] will not turn dying Oregonians and their families away because they cannot pay for its services." Oregon Hospice Ass'n, at http://www.oregonhospice.org/endoflifecare_legal.htm (last visited July 14, 2005). See also Central Oregon Home Health & Hospice (will "not refuse care to anyone for lack of ability to pay"), at http://www.cohospice.org/hospicecare.htm (last visited July 10, 2005); Providence Hospice (same), at

tients with less than six months to live (42 C.F.R. §§ 418.20, 418.22(b), 418.24). Thus, worries about being unable to afford end-of-life-care or about burdening family members need not affect the decisions of terminally ill patients. Finally, only the patient herself may administer the drug — no doctor or family member may assist. OR. REV. STAT. § 127.880.

b. There is also no indication that the DWDA has disproportionately impacted vulnerable groups in Oregon. In fact, quite the opposite: "[a] higher level of education was strongly associated with the use of PAS" and those who invoked the DWDA were on average younger than those in Oregon dying of natural causes. *Seventh Annual Report*, at 13, 22 (Table 2). Almost an equal number of men and women have used the DWDA. *Ibid.* And, as noted above, 99% of patients who availed themselves of the DWDA had some form of health insurance at the time of their death, and 86% were receiving hospice care. See page 13, *supra*.

c. Moreover, there is no indication that the DWDA has impeded advancements in end-of-life and palliative care. To the contrary, since 1997 *more* terminally-ill Oregonians have been referred to hospice, doctors have increased their knowledge of palliative care options, and prescriptions for pain relief medications have increased. See page 13, *supra*. Oregon is also one of the few states to begin disciplining doctors for the *under*-treatment of pain. See Joseph P. Pestaner, *End-of-Life Care: Forensic Medicine v. Palliative Medicine*, 31 J. L. MED. & ETHICS 365, 369 (2003); Erin Hoover Barnett, *Case Marks Big Shift in Pain Policy*, OREGONIAN, Sept. 2, 1999, at A1.[12]

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http://www.providence.org/Oregon/Programs_and_Services/Hospice/about.htm (last visited July 14, 2005)).

[12] Along these lines, in 2003, Oregon passed a measure that requires the state's health-professional regulatory boards to "encour-

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As Justice Souter recognized in *Glucksberg*, "events could overtake [the Court's] assumptions, as experimentation in some jurisdictions confirm[] or discredit[] the concerns about progression from assisted suicide to euthanasia." 521 U.S. at 787 (Souter, J., concurring in the judgment). Eight years of experience suggests that the DWDA has adequately addressed these fears. Unlike *Glucksberg* — where the particulars of the asserted right were undefined and it was unknown how a regime of physician-assisted suicide would operate in practice — here the Court has before it an actual statute that establishes defined, detailed boundaries, that has been in use since 1997, and about which detailed data is available for evaluation.[13] In this context, the constitutional claim to a right of physician-assisted suicide is at its zenith. Any interpretation of the CSA that interferes with such a right should be avoided if at all possible.

C. The Existence Of Extreme Pain-Relief Measures Does Not Resolve The Constitutional Problems With The Attorney General's Interpretation Of The CSA.

In an apparent, though unspoken, attempt to convince this Court that *Glucksberg* was wrong to suggest that there might, in certain cases, be a constitutionally protected right to physician-assisted suicide — and, as a result, that our constitutional doubt argument is irrelevant — several of petitioners'

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age the development of state-of-the-art multidisciplinary pain management services and the availability of these services to the public." S. 434 (S.B. 434-A), 72nd Leg. (Or. 2003).

[13] See Bryan Hilliard, *Evaluating the Dissent in* State of Oregon v. Ashcroft: *Implications for the Patient-Physician Relationship and the Democratic Process*, 33 J. L. MED. & ETHICS 142, 144 (2005) ("The Oregon Act details quite explicitly the requirements patients have to meet and the responsibilities physicians must fulfill in order for a prescription to be written and for death to be hastened.").

amici assert that advances in pain-relief treatments have, in essence, mooted any right to physician-assisted suicide in any circumstance. That argument does not withstand scrutiny.

In particular, petitioners' amici argue that the existence of measures to ameliorate the pain of terminally ill individuals in almost all instances demonstrates that the DWDA is not necessary to ensure those individuals a pain-free death. *E.g.*, Amicus Br. of Am. United for Life, at 5-10; Amicus Br. of Physicians for Compassionate Care Educ. Found., at 7-9; Amicus Br. of U.S. Conference of Catholic Bishops, et al., at 12-24. From this premise, the amici would presumably argue that even if there were a right to a pain-free death protected by the Fourteenth Amendment (see *Glucksberg*, 521 U.S. at 737-738 (O'Connor, J., concurring)), the availability of pain relief for all terminally ill individuals negates any constitutional claim to physician-assisted suicide that patients eligible for the DWDA might otherwise have.

This is a myopic view of an individual's final days and fails to take into account the mental, emotional, and spiritual hardships that attend one's exit from this world — any one of which could lead a patient to seek the relief provided by the DWDA. A terminally ill patient's constitutional claim to invoke the DWDA is based on more than his or her interest in a pain-free death. Indeed, the majority of Oregonians who have used the DWDA have given as their reasons for doing so loss of autonomy and loss of dignity. *Seventh Annual Report*, at 15, 24 (Table 4).

Members of this Court have similarly rejected a single-minded focus on physical pain. *Glucksberg*, 521 U.S. at 743 (Stevens, J., concurring in the judgment); *id.* at 779, 781 (Souter, J., concurring in the judgment); *id.* at 790 (Breyer, J., concurring in the judgment). And, a majority of the Court has implicitly recognized a right to palliative care (521 U.S. at 737-738 (O'Connor, J., concurring)) — of which pain-

relief is only one facet. The existence of the range of pain-relief measures identified by amici — some of which reasonable and thoughtful individuals would find to be outright repugnant, as we explain below — therefore does not remove the constitutional doubt engendered by the Ashcroft Directive. For the same reasons, the fact that the Attorney General would still permit physicians to prescribe "sufficient dosages of pain medication necessary to eliminate or alleviate pain" (U.S. Br. at 8 n.5) does not save his reading of the CSA.[14]

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[14] Moreover, the government's assertion in this regard rings hollow in light of the DEA's current practice of targeting for investigation and prosecution doctors who prescribe opiates for treatment of chronic pain. Commentators have referred to this practice as "[t]he DEA's war on prescription painkillers," and attribute to it a worsening of the already widespread problem of undertreated or untreated chronic pain. See, *e.g.*, Ronald T. Libby, CATO Institute Policy Analysis No. 545, *Treating Doctors as Drug Dealers: The DEA's War on Prescription Painkillers* (June 6, 2005), available at http://www.cato.org/pub_display.php?pub_id=3778; ABC News Report, *When Medicine Clashes With the Law* (May 11, 2005), available at http://abcnews.go.com/Health/PainManagement/story?id=749207&page=1. Relying upon the very same reading of the CSA's language that is at issue in this case — the requirement that scheduled narcotics be prescribed only for a "legitimate medical purpose" in the "usual course of professional practice" — the federal government has waged a nationwide campaign against doctors specializing in pain treatment — prosecuting 50 last year and 42 thus far this year — which has significantly reduced the availability of pain medication to chronic pain patients. Recently, the National Association of Attorneys General ("NAAG") sent a letter, signed by 31 Attorneys General, to the head of the DEA expressing concern about the chilling effect of DEA's enforcement policies on the willingness of physicians to treat patients who are in pain. Letter, Attorneys General Express Concern with DEA Action and Prescription Pain Medication Policy (Jan. 19, 2005), available at http://www.naag.org/news/pdf/so-20050119-prescription-pain-med.pdf.

1. The right to physician-assisted suicide is grounded on more than pain relief.

In *Glucksberg*, members of this Court recognized that a right to assisted suicide could be based on *more* than one's liberty or privacy interest in a pain-free death. 521 U.S. at 743 (Stevens, J., concurring in the judgment); *id.* at 779, 781 (Souter, J., concurring in the judgment); *id.* at 790 (Breyer, J., concurring in the judgment). A dying individual's basic "freedom" includes an "interest in dignity, and in determining the character of the memories that will survive long after her death." *Id.* at 743 (Stevens, J., concurring in the judgment). This kind of "[p]ersonal control over the manner of death" (*id.* at 790 (Breyer, J., concurring in the judgment)) is an essential component of one's right to die with dignity. See also *Cruzan* v. *Missouri Dep't of Health*, 497 U.S. 261, 287 (1990) (O'Connor, J. concurring) ("our notions of liberty are inextricably entwined with our idea of * * * self-determination").

As the United States itself recognized in its amicus brief in *Glucksberg*,

> a competent, terminally ill adult has a constitutionally cognizable liberty interest in avoiding the kind of suffering experienced by the plaintiffs in this case. *That liberty interest encompasses an interest in avoiding not only severe physical pain, but also the despair and distress that comes from physical deterioration and the inability to control basic bodily or mental functions in the terminal state of an illness*.

U.S. Amicus Br. in *Washington* v. *Glucksberg*, 1996 WL 663185, at *8 (Nov. 12, 1996) (emphasis added).

Indeed, "[t]he choice between life and death is a deeply personal decision." *Cruzan*, 497 U.S. at 281. Thus, access to pain-relief measures, while vital, does not end the inquiry into the constitutional protections afforded to the terminally

ill individuals who qualify for the DWDA. As such, it does not render the Attorney General's interpretation of the CSA any less constitutionally suspect.

*2. **Palliative care seeks to provide relief from the entire spectrum of a terminally ill patient's suffering.***

A majority of the Court in *Glucksberg* implicitly recognized a constitutional right for terminally ill individuals to receive palliative care to ease their suffering, even if that care would hasten death. 521 U.S. at 737-738 (O'Connor, J., concurring). As anyone who has experienced emotional hardship knows, however, suffering can be more than just physical pain. It also includes "the despair that accompanies physical deterioration and a loss of control of basic bodily and mental functions." *Id.* at 736 (O'Connor, J., concurring).

In recognition of this reality, palliative care encompasses *more* than just pain management — rather, it is meant to ensure that one has a gentle, dignified death. See Growth House Inc., *Palliative Care, Professional Resources* at www.growthhouse.org/palliat.html (last visited July 14, 2005) ("Palliative care, also called comfort care, is primarily directed at providing relief to a terminally-ill person through symptom management and pain management. The goal is not to cure, but to provide comfort and maintain the highest possible quality of life for as long as life remains.").

"Well-rounded palliative care programs also address mental and spiritual needs" of the patient. *Id.* Accord Beth Packman Weinman, *Freedom From Pain*, 24 J. LEGAL MED. 495, 517 (2003) ("palliative care encompasses much more than simply pain management"); OR. ADMIN. R. 410-142-0020(23) (Oregon Dep't of Human Servs., Hospice Services Rulebook) (defining "Palliative Services" as "[c]omfort services of intervention that focus primarily on reduction or abatement of the physical, psychosocial and spiritual symptoms of terminal illness").

The hospice care movement also regards control of physical pain as but one part of its mission of supporting terminally ill patients; thus, hospice care also includes "services provided to meet the physical, psychosocial, spiritual and other special needs of the patient/family unit during the final stages of illness." OR. ADMIN. R. 410-142-0020(18) (Oregon Dep't of Human Servs., Hospice Services Rulebook).

3. ***Some of the alternative forms of care proposed by petitioner's amici are inconsistent with the goals of palliative care.***

As Justice Souter wrote in *Glucksberg*, terminally ill individuals often seek

> not only an end to pain (which they might [obtain], although perhaps at the price of stupor), but an end to their short remaining lives with a dignity that they believe[] would be denied them by powerful pain medication, as well as by their consciousness of dependency and helplessness as they approached death.

521 U.S. at 779 (Souter, J., concurring in the judgment).

The palliative care "options" proposed by petitioners' amici might address the physical pain a terminally ill patient can experience, but many of those "options" ignore the other purposes of palliative care — particularly insuring a gentle and dignified death. Extreme, uncomfortable, and/or invasive palliative measures such as "sedation to a sleep-like state," "surgically denervat[ing] painful areas," "anesthetic interventions to block nerve transmission" (Amicus Br. of Am. United for Life, at 9 & n.17), and "spinal infusion pumps" (Amicus Br. of Physicians for Compassionate Care Educ. Found., at 8), might render a terminally ill patient pain-free, but at the cost of eviscerating the last bit of liberty, privacy, and dignity that patient has in his final days.

Even less drastic means of pain relief carry with them potentially undesirable side effects that a patient reasonably

might wish to avoid experiencing in his or her final days. Whether it is terminal sedation, surgery to cut one's nerves, or simply large doses of strong pain medication that affect patients' mental and physical processes, there must come a point at which terminally ill individuals can decline these measures that "burden[] [their] liberty, dignity, and freedom to determine the course of [their] own treatment" (*Cruzan*, 497 U.S. at 289 (O'Connor, J., concurring)), without, as a consequence, losing all means of escaping their suffering and experiencing a gentle quitting of life. "Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny." RONALD DWORKIN, LIFE'S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM 217 (1993).

"How [a person] dies will affect how that life is remembered." *Cruzan*, 497 U.S. at 344 (Stevens, J., dissenting). The constitutional interests of a patient in his or her final days are greater — and far more nuanced — than being free of pain. As such, the availability of pain-relief measures does not render the Ashcroft Directive any less of a threat to the constitutional rights of the individuals eligible for Oregon's DWDA.

* * * * *

While we believe that the individuals eligible for the DWDA have a liberty, privacy, and dignity right to physician-assisted suicide protected by the Fourteenth Amendment, this Court need not resolve that question today. Rather, under the doctrine of constitutional doubt, it is enough that such individuals have a serious claim to constitutional protection.

CONCLUSION

For the reasons stated, the judgment of the court of appeals should be affirmed.

Respectfully submitted.

STEVEN R. SHAPIRO
The Americans Civil Liberties Union Foundation
125 Broad Street
New York, NY 10004

CHARLES F. HINKLE
ACLU Foundation of Oregon
Stoel Rives LLP
900 S.W. Fifth Avenue
Portland, OR 97204

ANDREW L. FREY
Counsel of Record
DAVID M. GOSSETT
KRISTINA SILJA BENNARD
Mayer, Brown, Rowe & Maw LLP
1909 K Street, N.W.
Washington, DC 20006
(202) 263-3000

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