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On Behalf of the Association of the
Bar of the City of New York

UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

STATE OF OREGON, Plaintiff, & RICHARD HOLMES; KARL STANSELL; JAMES ROMNEY; JANE DOE #1; PETER A. RASMUSSEN, M.D.; and DAVID MALCOME HOCHHALTER, PhD, Plaintiffs-Intervenors, v. JOHN ASHCROFT, in his official capacity as United States Attorney; ASA HUTCHINSON, in his official capacity as Administration of the Drug Enforcement Administration; KENNETH W. MAGEE, in his official capacity as Director of the	No. CV01-1647-JO ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK'S AMICUS BRIEF IN SUPPORT OF OREGON'S MOTION FOR SUMMARY JUDGMENT

Drug Enforcement Administration, Portland Office;) UNITED STATES OF AMERICA; UNITED) STATES DEPARTMENT OF JUSTICE; and) UNITED STATES DRUG ENFORCEMENT) ADMINISTRATOR,)
)
Defendants.)

INTRODUCTION

This brief is being submitted on behalf of the Association of the Bar of the City of New York (the "Association"). As set forth below, the Association objects to the unprecedented action of Attorney General John Ashcroft to proclaim, in his November 8, 2002 directive (the "Ashcroft Directive"), that he has the authority to determine what is a "legitimate medical purpose" in the context of Oregon's Death with Dignity Act. The Association does not take a position regarding the merits of the Oregon statute. Instead, the Association focuses on the impermissible action of the Attorney General to usurp the traditional authority of the individual states to regulate the practice of medicine within their own borders, and the negative implications the Ashcroft Directive will have on patients and healthcare practitioners. The Ashcroft Directive would have the effect of precluding the use of federally controlled substances even if lawful under the Oregon Death With Dignity Act.

First, the Association objects to the Attorney General's interpretation of the Controlled Substances Act ("CSA") – an act created to address illegal drug trafficking in the United States – as giving him the authority to decide what is a "legitimate medical purpose." Second, the Ashcroft Directive is objectionable because it exposes patients, medical practitioners, and the public at large to the personal philosophy of the individual appointee who holds the office of Attorney General at any particular time. Third, the Association objects to the Attorney General's failure to comply with publication and comment requirements of the Administrative Procedures Act in issuing the Ashcroft Directive. Fourth, the Association objects to the Ashcroft Directive because it will have far reaching adverse implications for healthcare practitioners, and their patients, across the country. Fifth, the Association objects to General Ashcroft's action as being inconsistent with the traditional deference given to the states to make

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determinations regarding the legitimate practice of medicine.

BACKGROUND

Controlled Substances Act

Attorney General Ashcroft alleges that he is vested with the authority to declare physician-assisted suicides illegal (if assisted by controlled substances) based on the authority granted to him under "The Controlled Substances Act" (the "CSA"). The CSA sets forth the regulatory scheme whereby the federal government regulates the use and administration of controlled substances.[1] It was established by Congress for the specific purpose of prohibiting and controlling "[t]he illegal importation, manufacture, distribution, possession and improper use of controlled substances [that] have a substantial and detrimental effect on the health and general welfare of the American people." At the same time, the CSA expressly recognizes that many controlled substances have useful and legitimate medical purposes, for which they may appropriately be used to "maintain the health and general welfare of the American people."[2]

The CSA is enforced by the federal Drug Enforcement Administration (the "DEA"), which is "responsible for controlling abuse of narcotics and dangerous drugs, while ensuring adequate supplies for legitimate medical purposes. . . . DEA accomplishes its objectives through coordination with state, local, and other federal officials in . . . regulation of legitimate controlled substances."[3] Clearly, the DEA's focus is on illegal drug trafficking, not regulation of the legitimate practice of medicine. But now, as a direct result of recent action taken by the Attorney General, the DEA's role may change to improperly encompass the regulation of the practice of medicine.

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[1] 21 U.S.C.S. Section 801, et seq.

[2] 21 U.S.C.S. Section 801.

[3] Fed. Reg., Vol. 66, No. 232, Monday, December 3, 2001 (publication of Department of Justice Statement of Regulatory Priorities).

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Oregon's Death with Dignity Act
And Subsequent Federal Legislation

Underlying the instant litigation is Oregon's Death with Dignity Act. In 1994 the people of Oregon, through a public referendum, enacted the Death with Dignity Act (the "Oregon Act"). In 1997, the Oregon Act went into effect after a referendum to repeal the Oregon Act was rejected by the Oregon voters.[4] The Oregon Act, permits, under certain conditions, providers to prescribe medications in dosages that will assist terminally-ill patients to "end his or her life in a humane and dignified manner."[5] The Oregon Act is the only statute of its kind in the United States.

For obvious reasons, the Oregon Act has generated much debate. In 1998 (following the effective date of the Oregon Act), former Attorney General, Janet Reno, "concluded that adverse action against a physician who has assisted in a suicide in full compliance with the Oregon Act would not be authorized by the CSA."[6] This conclusion overruled an earlier opinion by the head of the DEA. Attorney General Reno's ruling was met with strong opposition. Representative Henry Hyde introduced two bills in the House of Representatives condemning Attorney General Reno's endorsement of the Oregon statute, and prohibiting physicians from prescribing controlled substances for assisting in suicide.

The first bill, the Lethal Drug Abuse Prevention Act of 1998, would have amended the CSA to directly authorize the suspension or revocation of a practitioner's DEA registration if the registrant intentionally dispensed or distributed a controlled substance for the purpose of assisting the suicide or euthanasia of another individual.[7] The second bill, the Pain Relief Promotion Act, attempted to clarify the CSA to provide that the alleviation of pain is a legitimate medical purpose, but that the CSA did not

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[4] ORS 127.800 through 127.995.

[5] ORS 127.800 (7), 127.800 (11), 127.805 (1), 127.815 (1)(k); 127.830.

[6] *Statement of Attorney General Janet Reno on Oregon's Death with Dignity Act* (visited Mar. 4, 2002) <http://www.usdoj.gov/opa/pr/1988/June/259ag.htm.html> (emphasis added).

[7] Lethal Drug Abuse Prevention Act of 1998, H.R. 4006, 105th Cong. (1998).

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permit the use of controlled substances to cause death or assist in a suicide.[8] While the second bill passed the House, neither bill passed the Senate, nor was either signed into law.

The Ashcroft Directive

Accordingly, the Oregon Act generated substantial debate at the federal level, but Congress has not definitively responded to it. Nonetheless, the current Attorney General, on his own initiative and without notice or formal rule-making, reversed the prior position of the Department of Justice with respect to the Oregon Act. He did so by issuing an "interpretive rule" which states that prescribing federally controlled substances to assist in an individual's suicide will subject a physician's DEA registration to possible suspension or revocation as being "inconsistent with the public interest," even if this activity is authorized by the Oregon Act.[9]

This is an unbridled attempt to define the "legitimate" practice of medicine -- without the benefit of congressional action, without the benefit of empirical findings, and without the benefit of formal rule-making. For the reasons set forth below, the Attorney General's directive must not withstand judicial scrutiny.

ARGUMENT

POINT I

THE ATTORNEY GENERAL CANNOT CIRCUMVENT THE NEED FOR LEGISLATIVE ENACTMENT OR FORMAL RULE-MAKING BY ISSUING A MEMORANDUM THAT LIMITS THE STATES' ABILITY TO DETERMINE WHAT CONSTITUTES "A LEGITIMATE MEDICAL PURPOSE"

A. The Potential Political Nature Of The Ashcroft Directive

The Ashcroft Directive exposes patients, medical providers, medical/pharmacy regulators, and the public at large to the personal philosophy, subjectivity and whim of the individual political "appointee"

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[8] Pain Relief Promotion Act, H.R. 2260, 106th Cong. (1999).

[9] Fed. Reg., Vol. 66, No. 218, Friday, November 8, 2001 (publication of the Ashcroft Directive as an "interpretive rule").

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who then holds the office of United States Attorney General. As such, this kind of action holds potential for abuse, from which Americans are entitled, and expect, to be protected. While the Ashcroft Directive politicizes a narrow medical-practices issue concerning physician-assisted suicide as presently legalized by statute in the State of Oregon, this kind of rule-making, as a precedent, allows this Attorney General, or any future Attorney General, to politicize any other aspect of medical practice - regardless of whether a treatment or practice is conventional or controversial, whether the implications are narrow or broad, and whether or not it involves end-of-life decisions. The Ashcroft Directive is devoid of any reference to medical, empirical or other objective analysis or data while, at the same time, in the context of the evolving area of palliative care, it purports to create a bright line distinguishing between the appropriate use of controlled substances to manage pain (which in some instances may increase the risk of death), and an inappropriate use of controlled substances to assist in a suicide.[10]

The Ashcroft Directive has the effect of defining the term "legitimate medical purpose" where Congress, in enacting the CSA, elected to remain silent. Further, without the benefit of public hearings, or the apparent input of state medical and pharmacy licensing boards, hospice care providers, pain or mental health specialists, patients or affected members of the public, the Ashcroft Directive authorizes, and is designed to expose otherwise-licensed and qualified physicians to, possible suspension or revocation of their DEA registration to prescribe controlled substances in the practice of their profession. While the Department of Justice might typically be called upon to offer enforcement guidance in connection with a federal statute, Attorney General Ashcroft's action crosses the line from guidance to legislation.

In contrast, former Attorney General Reno, when faced with precisely the same issue, declined to legislate a definition of "legitimate medical purpose," where Congress had failed to do so. In her June 5, 1998 statement, Attorney General Reno acknowledged that she was bound by the CSA, and concluded that the CSA did not authorize the imposition of her personal, and political philosophy on Americans

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[10] *Id.*

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(notwithstanding the stated position of the Clinton administration against physician-assisted suicide).[11]

The affirmative intent of Congress not to nullify Oregon's Death with Dignity Act was further evidenced and reinforced in its failure after public hearings to pass the Pain Relief Promotion Act of 1999 (the "PRPA")[12] - which was introduced and considered after Oregon's legislation and Attorney General Reno's 1998 statement. Under the proposed PRPA, the CSA would have been amended by, among other things, adding to Section 303 of 21 U.S.C. 823 the following:

> "Notwithstanding any other provision of this Act, in determining whether a registration is consistent with the public interest under this Act, the Attorney General shall give no force and effect to State law authorizing or permitting assisted suicide or euthanasia."

Moreover, Rep. Henry J. Hyde, Chairman of the Committee conducting the House hearings on June 24, 1999, acknowledged, in addressing his colleague Rep. Barney Frank, that "But we are trying to establish a national standard where you can know what the law is from State to State, and that is the effort."[13] By not enacting the Pain Relief Promotion Act of 1999, Congress specifically declined the opportunity to nullify Oregon's statute and/or to create a national standard on the issue.[14]

B. *Need For Formal Rule-Making*

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[11] *Statement of Attorney General Janet Reno on Oregon's Death with Dignity Act* (visited Mar. 4, 2002) <http://www.usdoj.gov/opa/pr/1988/June/259ag.htm.html>.

[12] *Pain Relief Promotion Act of 1999: Hearing on H.R. 2260 Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 106th Cong. (1999) [hereinafter *House Comm. Hearings*]; *Pain Management and Improving End of Life Care: Hearing on S. 1272 Before S. Comm. on Health, Education, Labor and Pensions*, 106th Cong. (1999) [hereinafter *Senate Hearings*].

[13] *House Comm. Hearings*, *supra* note 12, at 111.

[14] One of the expressed objections to the PRPA was that it would politicize medical standards and nullify the will of the people:

> PRPA would nullify the will of the people of Oregon as expressed through two ballot referenda ... Congress and the courts have long recognized the importance of the laboratory of State experimentation on complicated matters of social policy. . . .a side effect of this contravention of federalism is the politicization of medical standards, which currently are decided on a State-by-State basis. In effect, the federal government, through the Justice Department and the Drug Enforcement Administration, would come closer to establishing itself as a 'national medical board.'

H.R. Rep. No. 378, 106th Cong., 1st Sess., pt. 1, p.33 (1999) (emphasis added).

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The Administrative Procedure Act ("APA") requires agency-created rules to be subject to public criticism before they are "chiseled into bureaucratic stone."[15] Under the APA, notice of proposed rule-making must be published in the Federal Register, and interested parties must be given an opportunity to comment and participate in the rule-making process.[16] In *Alcaraz v. Block*, the court, in describing the APA's informal, notice and comment rule-making, stated:

> "This framework creates a pre-publication dialogue which allows the rule-making agency to educate itself on the full range of interests the rule affects, and reintroduces a representative public voice, thus ensuring fairness to affected parties after governmental authority has been delegated to unrepresentative agencies, through sensitive efficient governmental decision making."[17]

However, there is an exception to the public notice and comment requirements for "interpretive rules, general statements of policy, or rules of agency organization, procedure or practice."[18] In an effort to circumvent the rule-making process, the Ashcroft Directive has been labeled an "interpretative rule" by the Defendants. As an interpretive rule, Defendants contend that they properly dispensed with the APA's public notice and comment requirements.

While there is no bright-line distinction between substantive "legislative rules" (which require notice and comment) and "interpretive rules,"[19] interpretative rules have been defined, generally, to:

> "merely clarify or explain existing laws or regulations, and do not foreclose alternate courses of action or conclusively affect rights of private parties." [20]

The Ashcroft Directive does not fall under this definition of an interpretative rule. Rather, the Ashcroft Directive is an attempt by the Department of Justice to intrude into the area of medical regulation

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[15] *Alcaraz v. Block*, 746 F.2d 593, 610-611 (9th Cir. 1984).

[16] 5 U.S.C. §553(b) and (c).

[17] *Alcaraz v. Block,* 746 F.2d 593, 611 (9th Cir. 1984).

[18] 5 U.S.C. §553(b)(A).

[19] *Alcaraz*, 746 F.2d at 613.

[20] *Malone v. Bureau of Indian Affairs* 38 F.3d 433, 438 (9th Cir. 1994), *quoting, Powderly v. Schweiker,* 704 F.2d 1092, 1098 (9th Cir. 1983) and *Linoz v. Heckler*, 800 F.2d 871, 877 (9th Cir. 1986).

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by deciding what constitutes a legitimate medical purpose. It is not a clarification of existing federal law or policy. The Ashcroft Directive attempts to preempt existing state law, and substantially affects the rights of Oregon medical practitioners and patients.

For these simple reasons alone, the Ashcroft Directive cannot be construed as an interpretative rule, and must be invalidated because it was promulgated without public notice and comment, in violation of APA requirements.

POINT II

FAR-REACHING NEGATIVE CONSEQUENCES OF THE ASHCROFT DIRECTIVE ON PRACTITIONERS AND PATIENTS

A. *Practitioner Implications*

The ability of the Attorney General to determine the legitimacy of a particular medical practice is extremely dangerous. The practice of medicine is based on state standards, and doctors, until now, were assured that they would not be subject to liability if they practiced within the confines of those standards.

The potential loss of a DEA registration is of no small consequence to a practitioner. Revocation or suspension of DEA registration may subject a practitioner to investigation by state licensing or medical boards.[21] Whenever a practitioner is called into question by a state medical board, that physician runs the risk of losing his or her license to practice medicine.[22] Any adverse action by a state medical board also threatens a practitioner's ability to participate in Medicare, Medicaid and other federally funded programs.[23] Should a practitioner be excluded from participation in such federal programs, that practitioner is likely to find himself unable to practice in most hospitals and medical institutions, which rely on such federal funding..

The practitioner is faced with a Hobson's choice between practicing in accord with the Oregon

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[21] N.Y. EDUC LAW § 6530 (McKinney. 2001); N.Y. PUB. HEALTH § 3390 (McKinney. 2001); ORS 677.190.

[22] *Id.*

[23] 42 CFR §1001.501 (2001).

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state law and standards, and federal law and standards as articulated in the Ashcroft Directive. This issue was articulated in the Congressional debate over the proposed PRPA: One of the dissents in a House Committee Report on the proposed PRPA almost seemed to anticipate the Ashcroft Directive, in writing that the PRPA would allow federal law enforcement agents to "second-guess the considered medical judgment of physicians, pharmacists, and patients," threaten medical professionals "with long prison sentences and strict liability," and "inhibit physicians from aggressively treating pain."[24]

B. *Patient Implications*

The Ashcroft Directive also allows unprecedented federal intrusion into the protected relationship between patients and their physicians. Fear of federal investigation and prosecution will make physicians hesitant to make decisions and prescribe drugs according to their best medical judgment. This result will undoubtedly harm patient care because the Ashcroft Directive's intrusion into state medical practice under cover of the CSA has implications for pain management generally, not just in the context of physician-assisted suicide..

For example, while the trend in medical education is to provide adequate pain management to terminally ill patients, patients will no longer be likely to receive adequate pain treatment. But, in reality, if a practitioner exercises his or her professional judgment in prescribing a pain medication to a terminally ill patient, and that patient succumbs to death, there is absolutely nothing to prevent that practitioner's medical judgment from being second-guessed by the DEA. In fact, there has already been testimony before the United States Senate Committee on Health, Education, Labor and Pensions that "some clinicians are reluctant to use sufficient dosages of opioids to relieve pain because they fear that this may hasten death and that the clinically appropriate use of pain medications could be confused with physician-assisted suicide."[25] The fear of investigation and penalties will erode progress in the evolving area of life

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[24] H.R. Rep. No. 378, 106th Cong., 1st Sess., pt. 1, p. 31 (1999).

[25] *Senate Hearings, supra* note 12, (written testimony of Joseph J. Fins, M.D., F.A.C.P., Associate Professor of Medicine in Psychiatry, Weill Medical College of Cornell University and Director of Medical Ethics, New York Presbyterian Hospital - Cornell Campus).

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care and pain management and cause dying patients and their families to needlessly suffer.[26] By allowing the Attorney General and the DEA to make decisions which involve the practice of medicine and science, the balance that Congress established between the federal objective to regulate the abuse of controlled substances and the states' ability to regulate medical practice, will be upset.[27] "When balance in controlled substance policy is upset, the chances for conflict between law enforcement and medicine increases, as does the likelihood that patient care will be harmed."[28]

The Ashcroft Directive, should it be permitted to stand, also sets the stage for future federal intrusions aimed at curtailing other medical practices and procedures that are viewed as objectionable by the current Attorney General or Administration.[29]

For example, if the Attorney General can declare the use of certain controlled substances to hasten the death of a terminally-ill patient's death to be an illegal, non-legitimate medical practice, then it is fair to assume that the Attorney General, if so inclined, can issue another directive declaring the use of certain anesthetics to perform late-term abortions to be an illegal, non-legitimate medical practice.[30] While some states have laws banning late-term abortions under certain conditions,[31] and others are still

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[26] *Id.*

[27] *Senate Hearings, supra* note 12, (testimony of David E. Joranson, Senior Scientist and Director of the Pain Studies Group, University of Wisconsin Comprehensive Cancer Center, Madison).

[28] *Id.*

[29] "The directive establishes a clear precedent by putting the Attorney General's office in the position of regulating the practice of medicine. If the provisions of the memorandum are permitted to stand, Ashcroft or a future Attorney General could decide to use this precedent to justify restrictions on other medically approved drugs or practices viewed as objectionable." Edward Lowenstein, M.D., *The U.S. Attorney General's Intrusion Into Medical Practice*, 346 New England Journal of Medicine, 447, 447-448 (2002).

[30] On April 10, 1996 President Clinton vetoed the proposed federal "Partial-Birth Abortion Ban Act of 1995," which would have banned partial-birth abortions. A new Attorney General cannot be allowed to override prior President veto by declaring the use of controlled substances in connection with this procedure to be a non-legitimate medical practice – effectively banning the procedure. If this were allowed, this nation's system of checks and balances would be seriously jeopardized.

[31] Ala. Code § 26-23-1 to 26-23-6 (2001); Ariz. Rev. Stat. Ann § 13-3603.01 (2001); Ga. Code Ann. § 16-12-144 (2001); N.J. Stat. Ann. § 2A: 65A-6 (2001); Ohio Rev. Code Ann. §

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debating the issue,[32] the Attorney General may conceivably ban this controversial procedure without any regard to existing or proposed state laws regulating the procedure.[33]

Given the above serious negative implications to practitioners and their patients, the Ashcroft Directive cannot be permitted to stand.

POINT III

THE ATTORNEY GENERAL DOES NOT HAVE THE AUTHORITY TO DETERMINE WHAT CONSTITUTES A "LEGITIMATE MEDICAL PURPOSE,"A FUNCTION TRADITIONALLY LEFT TO THE STATES TO DECIDE

A. *Deference Is Traditionally Given To States Concerning Regulation Of The Practice of Medicine*

For obvious reasons, the practice of medicine is a highly regulated profession. However, the practice of medicine is regulated generally by state law, not federal law.[34] Each state has its own medical licensing board, standards of professional conduct and licensing requirements.[35]

State sovereignty with respect to the regulation of medicine is well-established, and for that reason, Congress has not created a national standard for the practice of medicine. To the contrary, the

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2919.15.

[32] NY A.B. 3688, 224th Legis. Sess. (N.Y. 2001); NY A.B. 2826, 224 Legis. Sess. (N.Y. 2001); OR S.B. 750, 71st Legis. Assemb. (OR 2001).

[33] Another example concerns the use of misoprotol, which has been recognized as an effective abortifacient in combinations with other FDA-approved drugs. This legitimate medical use of misoprotol may be jeopardized if the Ashcroft Directive is allowed to stand because "it would be a simple matter of using his memorandum as a precedent to declare illegitimate this or any other off-label use of an approved medicine," which are common and recognized by the FDA. Edward Lowenstein, M.D., *The U.S. Attorney General's Intrusion Into Medical Practice*, 346 New England Journal of Medicine, 447, 447-448 (2002).

[34] In *Linder v. United States*, the United States Supreme Court stated that "[o]bviously, direct control of medical practice in the states is beyond the power of the federal government." 268 U.S. 5, 18, 45 S.Ct. 446, 449 (1925).

[35] States are authorized to regulate medicine by setting up licensing boards and may determine the qualifications of who may practice medicine in the state. *See Peckman v. Thompson*, 745 F. Supp. 1388, 1391 (C.D. Ill. 1990); *See also Dent v. West Virginia*, 129 U.S. 114, 122, 9 S.Ct. 231, 233 (1889) (deferring to state medical licensing laws and stating that the "nature and extent of the qualifications required [to practice medicine] must depend primarily upon the judgment of the state as to their necessity").

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United States Supreme Court has held that a state's ability to regulate medicine within its borders is "elemental" and vital to the state's police powers.[36] The Supreme Court has also consistently given deference to physicians' medical judgments.[37]

B. In Enacting the CSA, Congress Did Not Intend To Determine What Constitutes a "Legitimate Medical Purpose"

The Ashcroft Directive effectively usurps the well-established authority of the states to regulate the practice of medicine. In place of physicians and medical experts, the Attorney General, having no medical expertise, will now be able to determine whether a particular medical treatment or practice is, or is not, legitimate.

This result was not intended by Congress when it enacted the CSA. The CSA was enacted by Congress for the specific purpose of combating illegal manufacturing, dispensing and distributing of controlled substances.[38] Because Congress recognized that many of these substances have legitimate medical uses, the CSA contains an elaborate registration and reporting scheme that enables registered practitioners to legally prescribe and dispense controlled substances without fear of prosecution.[39] Under the CSA's registration and reporting scheme, physicians and pharmacists apply to the DEA for a federal license to prescribe and administer controlled substances. Any prescription for a controlled substance "must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of

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[36] *Barsky v. Bd. of Regents*, 347 U.S. 442, 449, 74 S.Ct. 650 (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. It is vital to the state's police powers.").

[37] *See, e.g., Parham v. J.R.*, 442 U.S. 584, 608, 99 S.Ct. 2493, 2507 (1979) (mode and procedure of medical diagnostic procedures is not the business of judges); *Addington v. Texas*, 441 U.S. 418, 429, 99 S.Ct. 1804, 1811 (1979) (whether a person is mentally ill turns on the meaning of facts which must be interpreted by psychiatrists and psychologists); *Youngberg v. Romeo*, 457 U.S. 307, 322-23, 102 S.Ct. 2452, 2461-62 (1982) (deference to medical judgment requires that physicians be permitted to consider factors that the medical community accepts as relevant in the making of such judgments.).

[38] 21 U.S.C. § 801. *See e.g., United States v. Moore,* 423 U.S. 122, 135, 96 S.Ct. 335, 342 (1975); *United States v. Rosenberg,* 515 F.2d 190, 193 (9th Cir. 1975), *cert. denied,* 423 U.S. 1031, 96 S.Ct 562 (1975).

[39] 21 U.S.C. §§ 821-830.

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his professional practice . . . ."[40] Only when a registered practitioner's "activities fall outside the usual course of professional practice," may he or she be prosecuted under the CSA.[41]

However, the CSA and its implementing regulations do not define or address what constitutes the "usual course of professional practice" or "legitimate medical purpose." This was not an oversight by Congress, but rather a choice by Congress not to intrude into an area traditionally regulated by the states. The intent of Congress to defer to the states on issues of medical practice was confirmed by a 1997 Act of Congress that restricts the use of federal funds to furnish services in support of assisted suicide, euthanasia and mercy killing, while expressly recognizing that such activities, "because of recent developments, may still become lawful in areas of the United States."[42]

C. *The Supreme Court Has Deferred To The States To Explore The Issue of Physician-Assisted Suicide*

The Supreme Court has already considered two state laws – one enacted by New York and the other by Washington – declaring physician-assisted suicides illegal.[43] While the Supreme Court found both of these state laws to be constitutional, the Court did not hold that a state law legalizing physician-assisted suicide is necessarily unconstitutional.

In *Washington v. Glucksburg*, five justices joined in the opinion of the Court written by Chief Justice Rehnquist, who wrote:

> "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[44]

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[40] 21 C.F.R. § 1306.04.

[41] *United States v. Moore,* 423 U.S. 122, 124, 96 S.Ct. 335, 337 (1975); *U.S. v. Ekinci*, 101 F.3d 838 (2d Cir.1996).

[42] *See*, Assisted Suicide Funding Restriction Act of 1997, 42 U.S.C. § 14401(a)(2)-(3).

[43] *Washington v. Glucksburg,* 521 U.S. 702, 117 S.Ct. 2258 (1997); *Vacco v. Quill*, 521 U.S. 793, 117 S.Ct. 2293 (1997).

[44] *Glucksburg*, 521 U.S. at 735, 117 S.Ct. at 2275 . Justice Rehnquist also noted that States are already engaged in "serious, thoughtful examinations of physician-assisted suicides and other issues." 521 U.S. at 719, 117 S.Ct. at 2267.

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Similarly, Justice O'Connor (joined by Justice Ginsburg and Justice Breyer, in part) agreed that the decision on this issue should be "entrusted to the 'laboratory' of the States in the first instance."[45] In the companion case of *Vacco v. Quill*, dealing with the issue of physician-assisted suicide, the Supreme Court agreed with the district court's determination that "[u]nder both the U.S. Constitution and the federal system it establishes, the resolution of this issue is left to the normal democratic processes within the state."[46]

Given the Supreme Court's decision urging continued debate by the states on this issue, it is not appropriate for the Attorney General to resolve such debate by administrative fiat.

CONCLUSION

For the foregoing reasons, we respectfully request the Court to issue an order granting Plaintiff's motion for summary judgment.

Dated: March 7, 2002

THE ASSOCIATION OF THE
BAR OF THE CITY OF NEW YORK

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issues." 521 U.S. at 719, 117 S.Ct. at 2267.

[45] *Glucksburg*, 521 U.S. at 737, 117 S.Ct. at 2303.

[46] *Vacco v. Quill*, 521 U.S. at 798, 117 S.Ct. at 2297.

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CERTIFICATE OF SERVICE

I hereby certify that I served the foregoing *ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK'S AMICUS BRIEF IN SUPPORT OF OREGON'S MOTION FOR SUMMARY JUDGMENT* on the following party(ies):

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by mailing a true and correct copy by first class mail thereof to said party(ies) on the date stated below.

DATED this 7th day of March, 2002.

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On behalf of the Association of the Bar of the City of New York

UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

STATE OF OREGON Plaintiff, & RICHARD HOLMES; KARL STANSELL; JAMES ROMNEY; JANE DOE #1; PETER A. RASMUSSEN, M.D.; and DAVID MALCOME HOCHHALTER, PhD, Plaintiffs-Intervenors, v. JOHN ASHCROFT, in his official capacity as United States Attorney; ASA HUTCHINSON, in his official capacity as Administration of the Drug Enforcement Administration; KENNETH W. MAGEE, in his official capacity as Director of the Drug Enforcement Administration, Portland Office; UNITED STATES OF AMERICA; UNITED STATES DEPARTMENT OF JUSTICE; and UNITED STATES DRUG ENFORCEMENT ADMINISTRATOR, Defendants.	Case No. CV01-1647-JO MOTION OF ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK TO FILE AMICUS CURIAE MEMORANDUM EXPEDITED CONSIDERATION REQUESTED DECISION REQUESTED BEFORE MARCH 7, 2002

L.R. RULE 7.1 CERTIFICATION

The parties made a good faith effort through personal or telephone conferences to resolve the dispute, and each of the parties has consented to this motion, with the exception of the defendants. One letter, one e-mail, two voice mails, and a message left with the secretary for Joseph W. LaBue, U.S. Justice Department, Senior Trial Counsel, have gone unanswered.

MOTION

The Association of the Bar of the City of New York ("ABCNY") is aligned with the position of the State of Oregon and the Plaintiffs-Intervenors in this case. The ABCNY is prepared to file its amicus curiae memorandum by March 7, 2002, the deadline set by the court for such submissions. The ABCNY respectfully requests that the court expedite its consideration of this motion for leave to appear as amicus curiae, and issue an order before March 7, 2002.

Based on the inherent powers of the Court, the ABCNY requests that the Court allow the submission of an amicus curiae memorandum in the above-captioned matter. The ABCNY believes that it has unique and helpful information that will assist the Court in ruling on this important case.

The ABCNY was founded in 1870 and has grown to more than 22,000 members. Since its formation it has engaged in public policy and reform of the law, working through its committees, which presently are 180 in number.

Through the work of its Health Law Committee, the ABCNY seeks to file an amicus brief. The Health Law Committee is the bar association's committee that addresses legal and policy issues affecting health care and public health. The Health Law Committee, as is the case with other ABCNY committees, routinely prepares position statements and, on occasion, amicus briefs (in both state and federal courts, at all levels), on issues that it believes are relevant to members of the legal profession and in the public interest.

This Committee has noted the potential relevance of the subject matter of Attorney General Ashcroft's recent directive with regard to the Controlled Substances Act and its application to Oregon law. It further has noted the potential impact that this directive, or similar directives in this area, may

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have on medical practitioners, patients, and the regulation of medical practice in the states.

Accordingly, the ABCNY seeks permission to present its position, which focuses to a large extent on these issues of state medical practice and state medical regulation, and believes that this should be a part of any consideration of the issues at hand.

Dated: March 1, 2002

Respectfully submitted,

LINDSAY, HART, NEIL & WEIGLER LLP

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CERTIFICATE OF SERVICE

I hereby certify that I served the foregoing MOTION OF THE ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK TO FILE AMICUS CURIAE MEMORANDUM on the following party(ies):

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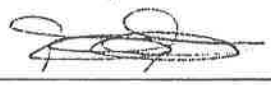
by mailing a true and correct copy by first class mail thereof to said party(ies) on the date stated below.

DATED this 1st day of March, 2002.



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