reaffirm that the United States Constitution protects the marriage rights of all individuals and that neither the states nor Congress can simply abridge these rights without justification.

BRIEF OF THE AMERICAN COLLEGE OF LEGAL MEDICINE IN OREGON v. ASHCROFT

Miles J. Zaremski* & Maxwell J. Mehlman**

In 1994, Oregon voters by referendum adopted the Oregon Death with Dignity Act, and after surviving challenges in the courts and from voters, the act went into effect in 1997. The law establishes a detailed procedure whereby physicians may prescribe lethal oral doses of controlled substances for terminally ill Oregon residents. Approximately 129 Oregonians have availed themselves of the relief provided for by the act.

Physician-assisted suicide is not supported by some segments of society, including the American Medical Association and the right-to-life movement. The Oregon law has provoked efforts to block its operation not only in Oregon but at the federal level. One approach opponents have used is to interpret the Controlled Substances Act (CSA) to prohibit physicians from prescribing controlled substances to facilitate patient suicide. In 1997, the administrator of the Drug Enforcement Administration, the unit in the Justice Department that enforces the CSA, issued such an interpretation, only to have it reversed by Attorney General Janet Reno. But after the Bush administration took office, Attorney General John Ashcroft re-issued this interpretation. By memorandum dated No-

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2. 112 S.Ct. 2127, 2132 (2002).
November 6, 2001, he directed the DEA to revoke permission for physicians to prescribe controlled substances if they complied with the Oregon Death with Dignity Act. Mr. Ashcroft based his action on the ground that physician-assisted suicide was not a "legitimate medical purpose," and therefore the use of controlled substances for this purpose violated the CSA. The State of Oregon filed a complaint for declarative and injunctive relief in the U.S. District Court for the District of Oregon, and on April 17, 2002, Judge Robert E. Jones granted the requested relief. Mr. Ashcroft has appealed to the Ninth Circuit, and this appeal is now pending.

The American College of Legal Medicine is comprised primarily of persons who hold both M.D. and J.D. degrees. It filed the following amicus brief in the Ninth Circuit in support of the State of Oregon. There are two major issues in the case. One is whether, as a matter of federalism, the federal government can override a state's interpretation of what constitutes the legitimate practice of medicine. The other is whether the attorney general of the United States has the authority to determine what is and what is not a "legitimate medical purpose" in the manner employed by Mr. Ashcroft. Given the unique qualifications of its membership, the amicus brief of the American College of Legal Medicine addresses the latter question.

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Now comes the American College of Legal Medicine ("ACLM"), by and through its legal counsel, Miles J. Zaremski, Esq., and Maxwell J. Mehlman, Esq., and submits this brief as amicus curiae in support of Plaintiffs-Appellees in this case.

Consent of the Parties

The ACLM has received consent from all parties to file this brief.

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7 Id. at 265-66.
9 The following amicus curiae brief is reprinted with permission by the Houston Journal of Health Law & Policy.

I. INTEREST OF AMICUS

The American College of Legal Medicine is uniquely qualified to advise the Court on this subject. Founded in 1960, the American College of Legal Medicine (ACLM) is a non-profit organization dedicated to scholarship, education and policy in law, medicine, and healthcare. The ACLM is the only organization in the United States where the majority of its 1,300 Fellows and members possess both medical and juris doctor degrees. These healthcare and legal professionals' diverse education, training, and experience enable the ACLM to promote interdisciplinary cooperation and an understanding of issues where law and medicine converge.

II. ARGUMENT

In a Directive to the Department of Drug Enforcement on 6 November 2001, the Attorney General of the United States declared that the use of Schedule II controlled substances under Oregon's Death with Dignity Act was not a "legitimate medical purpose," and that therefore physicians who complied with that act were violating the Controlled Substances Act ("CSA"). 66 Fed. Reg. 5,607, 5,608 (Nov. 9, 2001). A key issue in this case consequently is the meaning of the term "legitimate medical purpose," and more importantly, what process the CSA and the law in general require for establishing what is and is not a legitimate medical use.

The Attorney General takes the position that he can declare what is and is not a legitimate medical purpose under the CSA. This is plainly contrary to the CSA. In the District Court's opinion in this case, Judge Robert E. Jones held that nothing in the CSA grants the Attorney General "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. 1077, 1089 (D. Ore. 2002). We concur.

The CSA does not give the Attorney General the power to unilaterally decide what is and is not a currently accepted medical use for scheduling purposes. Controlled substances are scheduled according to whether they have a "currently accepted medical use" or "no currently accepted medical use," with varying levels of restrictions. 21 USC § 812(b). But 21 USC § 811(b) provides:

The Attorney General shall, before initiating proceedings under subsection (a) of this section to control a drug or other substance or to remove a drug or other substance entirely from the
schedules, and after gathering the necessary data, request from the Secretary a scientific and medical evaluation, and his recommendations, as to whether such drug or other substance should be so controlled or removed as a controlled substance. . . .

The recommendations of the Secretary shall include recommendations with respect to the appropriate schedule, if any, under which such drug or other substance should be listed. . . .

The recommendations of the Secretary to the Attorney General shall be binding on the Attorney General as to scientific and medical matters, and if the Secretary recommends that a drug or other substance not be controlled, the Attorney General shall not control the drug or other substance.

Thus, according to the CSA, a determination of what is and is not a currently accepted medical use can only be made by the Attorney General based on a scientific and medical evaluation from the Secretary of Health and Human Services (HHS). The Secretary of HHS must also include recommendations as to where a substance should be scheduled. The recommendations of HHS are binding on the Attorney General as to scientific and medical matters, including where a drug is scheduled and whether or not a drug ought to be controlled. In short, the CSA does not give the Attorney General the authority to declare sua sponte what is and is not a currently accepted medical use. Instead, he must defer to the expert medical judgment of the Department of Health and Human Services, embodied in a "scientific and medical evaluation."

The only relevant discretion the Attorney General is given under the CSA is to determine whether to schedule a derivative drug in the same schedule or a higher numerical schedule than its immediate precursor, 21 USC § 811(e) and, if there is an imminent hazard to public safety, to move a controlled substance to schedule I (no currently accepted medical use) for no more than eighteen months, 21 USC § 811(b). Neither of these decisions involves a determination of what is or is not a legitimate medical use. The former relates to the potential for abuse, while the latter involves the much less precise judgment that a substance has no legitimate medical use at all. These limited exceptions to the Attorney General's power under the CSA emphasize his lack of competence to determine on his own what the legitimate medical uses are for a controlled substance that has some legitimate medical use (i.e., not Schedule I).

The CSA does not provide a definition of "legitimate medical purpose" in its extensive definitions. Court decisions, however, uniformly confirm the notion that the Attorney General must defer to expert medical judgment in determining what is and is not a legitimate medical use. The Attorney General relies on two cases in his brief, U. S. v. Rosenberg, 515 F.2d 190 (9th Cir. 1975) and U. S. v. Moore, 423 U.S. 122 (1975) for the proposition that the CSA prohibits physicians from prescribing drugs except for legitimate medical purposes. Both cases demonstrate that expert medical judgment is required in order to determine what is and is not a legitimate medical purpose. In Rosenberg, the Ninth Circuit held that Dr. Rosenberg violated the CSA by prescribing Schedule II, III, and IV controlled substances to patients he had not examined, or in some cases not met, because expert medical testimony showed that this was outside the "usual course of professional practice." Rosenberg 515 F.2d at 193. Moore was relied on by the Attorney General, 66 Fed. Reg. 5,607, 5,608 (Nov. 9, 2001), and by the Office of Legal Counsel ("OLC") of the Office of Legal Counsel of the United States Department of Justice's Memorandum on which he based his directive (OLC Memo, June 27, 2001, pp.5-6).

In Moore, a physician prescribed methadone, a Schedule II controlled substance, in large quantities, charging by the pill, to patients not in detoxification or maintenance programs. U. S. v. Moore, 505 F.2d 426, 447 (D.C. Cir. 1974) (dissent). Reversing the Court of Appeals, the Supreme Court held that the physician could be held liable for failing to use controlled substances within the course of professional practice and for legitimate medical purposes. U. S. v. Moore, 423 U.S. at 142. What is significant is that expert medical testimony was necessary to prove that this was not legitimate medical practice and therefore violated the CSA.

In fact, case law makes it clear that expert medical knowledge is required in all jurisdictions to determine legitimate medical use for purposes of proving that a physician has violated the CSA in the course of professional practice. "The general rule is that the propriety or impropriety of particular medical treatment can be established only by expert medical testimony." Church v. Bloch, 182 F.2d 241, 245 (Cal. 1947). See, e.g., U. S. v. Boettjer, 569 F.2d 1078, 1079 (9th Cir. 1978) ("The testimony of the government's expert witness supported the conclusion that Dr. Boettjer had dealt with the investigator-patients in an unprofessional manner without the application of sound medical criteria and the prescriptions were not issued for legitimate medical purposes."); Farney v. Anderson, 372 N.E.2d 151, 154 (Ill. 1978) ("The method employed by Farney might be the accepted one for treating addicts; perhaps not, but it is not for a layman, uneducated in medicine, to say. Expert testimony, whether coming down on the positive or negative side of Farney's
treatment, is essential.") See also U.S. v. Tran Trong Cuong, M.D., 18 F.3d 1132,1137-38 (4th Cir. 1994) ("In making a medical judgment concerning the right to treatment for an individual patient physicians have discretion to choose among the wide range of available options. Therefore, in determining whether defendant acted without a legitimate medical purpose, you should examine all the defendant's actions and the circumstances surrounding them..."). An examination of [expert medical] testimony and the other evidence presented convinces us that Dr. Tran's actions in dispensing narcotics and other controlled substances violated the criminal standard and were outside the bounds of his professional medical practice."); White v. United States, 399 F.2d 813, 819-20 (8th Cir. 1968) (It would seem that no one whose area of expertise is the study of the beneficial and harmful effects of drugs within the human body is in an especially advantageous position to testify as to the relationship which should exist between a doctor and patient, or what a doctor should know about his patient before prescribing a particular drug. He, as a student of drugs, can evaluate their potential effect in the human body. His testimony is along a line not generally known to laymen and jurors. Consequently, Dr. Burton is a proper expert and his testimony was within the range of his expertise.").

A requirement that the Attorney General defer to expert medical judgment is consistent with the manner in which the law establishes what is and is not a legitimate medical use in contexts outside of the CSA as well. The Supreme Court, in Davis v. Virginia Railway Company, 361 U.S. 354 (1960), articulated the standard for proof of malpractice as requiring two elements of evidence, "evidence as to the recognized standard of care of the medical community in the particular kind of case, and a showing that the physician in question negligently departed from this standard in his treatment of the plaintiff." 361 U.S. at 356 (1960). Expert medical testimony is necessary to prove both elements. See also State v. Warden, 813 P.2d 1146,1151 (Utah 1991) ("Since the negligence occurred in the context of medical treatment, it is necessary to view the circumstances from the viewpoint of a member of the medical profession. Expert testimony established that Warden, by not examining Young prior to the time birth was imminent and not hospitalizing the infant immediately after the birth, deviated from the standard of care which physicians using ordinary care exercise in the delivery and care of newborns."); People v. Kivna, 15 Cal.Rptr.2d 512, 536 (1992) (Expert medical testimony was necessary "on the prevailing standards of obstetrical care and what knowledge a person with Dr. Kivna's medical training and experiences would be expected to possess."); Rudick v. Prineville Memorial Hospital, 319 F.2d 764 (9th Cir. 1963) (holding that the dismissal of appellee radiologist was improper because there was no expert testimony that he had acted negligently or improperly or in any way not in conformity with the medical practice of experts in his specialty).

Expert medical knowledge, whether from outside experts or based on the physician board members' own expertise, is also necessary to determine what is and is not a legitimate medical use in disciplinary hearings before state medical boards. E.g. Dotson v. Texas State Bd. of Medical Examiners, 612 S.W.2d 921 (Tex. 1981) ("The problem is that there is no expert testimony to support the Board's factual conclusion that these drugs were non-therapeutic in the manner such drugs were prescribed by either of these doctors. It should be recognized at the outset that each of these controlled drugs (Preludin, Valium, Ritalin and Elavil) is a legitimately manufactured prescription drug authorized for use by the Food and Drug Administration and that both doctors were authorized to prescribe each."); Loffredo v. Sobol, 195 A.D.2d 757, 759 (N.Y. 1993) ("[Expert medical] testimony adequately supported the finding of gross negligence with respect to patient A. The contrary medical evidence presented by petitioner merely created a credibility issue which respondents were free to and did resolve against him."); McKay v. State Board of Medical Examiners, 86 P.2d 232, 236 (Colo. 1938) ("In the case before us there is no expert testimony disclosed in the record that proves or tends to prove a failure properly to diagnose or to treat the disease of the various persons with respect to whom malpractice was charged. It is not enough that the board may be composed of experts who applied their knowledge of diagnosis and treatment to the case in which malpractice is alleged."); Smith v. Department of Registration, 106 N.E.2d 722, 730-31 (Ill. 1952) ("This court possesses neither medical learning nor powers of telepathy. We are, therefore, unable to medically evaluate the testimony in this record or to know what scientific appraisal of it was made by the medical committee."); Cf. Arlen v. State Medical Board, 399 N.E.2d 1251, 1254 (Oh. 1980) ("[Expert testimony as to a standard of practice is not mandatory in a license revocation hearing and the board may rely on its own expertise to determine whether a physician failed to conform to minimum standards of care.").

Indeed, the Attorney General appears to recognize the appropriateness of deferring to expert medical judgment when he refers to the views of the American Medical Association on the Oregon
Death with Dignity Act. "The American Medical Association and the American Nurses Association . . . regard the practice of assisted suicide as 'fundamentally inconsistent with the physician's role as healer,'" and have informed the Supreme Court that '[t]he ethical prohibition against physician-assisted suicide is a cornerstone of medical ethics." Defendants' Memorandum In Support of Motion to Dismiss, p. 34, (citing OLC Memo at 11). Yet it is important to realize that the AMA's and ANA's views themselves do not settle the question of what is a legitimate medical use. The law recognizes that the practice of medicine is complex and that reasonable physicians may differ on what is legitimate and appropriate. The law is thus careful to allow room for disagreement among reasonable practitioners, as reflected, for example in the "respectable minority doctrine," which recognizes medical practices that are not the norm, but are nonetheless a legitimate medical use, in that they are acceptable and supported by a school of expert medical thought. See In re Williams, 60 Ohio St.3d 85, 86 (1991) (overturning a State Medical Board determination that the physician had failed to meet the minimum standards of medical practice because the two medical experts who testified stated that, although they supported the majority opinion on the duration of prescription stimulants for weight loss, "Dr. Williams's application of the 'minority' protocol was not a substantial medical practice."); Chambler v. McChere, 505 F.2d 489,492 (6th Cir. 1974) ("Where two or more schools of thought exist among competent members of the medical profession concerning proper medical treatment for a given ailment, each of which is supported by responsible medical authority, it is not malpractice to be among the minority in a given city who follow one of the accepted schools."); Downer v. Veilleux, 322 A.2d 82, 87 (Me. 1974) ("A physician does not incur liability merely by electing to pursue one of several recognized courses of treatment. It is incumbent upon the plaintiff to show by expert testimony that the treatment pursued by the defendant was something other than that which the average and reasonably skilled physician would have employed.").

In fact, a substantial percentage of Oregon physicians, including the governor of Oregon, John A. Kitzhaber, MD, believe that the Oregon Death with Dignity Act reflects legitimate medical practice. A survey for the Journal of the American Medical Association, for example, found that 51% of responding physicians (66% of practicing Oregon physicians) strongly support or support the Death with Dignity Act and legalization of physician-assisted suicide. Linda Ganzini, MD, et al., Oregon Physicians' Attitudes About and Exper-
only with the aid of medical expertise or by states making considered choices about public policy. Therefore, the ACLM respectfully requests that the Court affirm the decision below.