

***Gonzales v. Oregon* and the Normative Constitution of American Health Care**

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[Note to Georgetown readers: This is very much a work in progress, and I welcome your comments large and small. Please forgive the incomplete footnoting throughout. I look forward to discussing this and related topics with you on April 7th]

I. Introduction

Health law issues and strong-form constitutional doctrine¹ intersect only rarely in the pages of the U.S. Supreme Court reports. Notwithstanding (or perhaps *because of*) the unquestionable importance of health care in the United States economy and in the attitudes of American citizens, the Supreme Court has over the past several decades generally declined to create new constitutional law touching on health issues. This consistent pattern of restraint in the health law field has held even during a half-century in which the Court has constructed and maintained new doctrines of constitutional law in other issue areas to a greater extent than it had in a century and a half of prior history. Even during this era of flourishing judicial rights-creation, the Supreme Court has rejected invitations to constitutionalize rights to receive, or to refuse, particular medical procedures with the notable exception of abortion jurisprudence. The Court displayed a version of this deferential jurisprudential dynamic over a century ago when the *Lochner*-era Court found no individual right to refuse state-mandated vaccinations², and only a decade ago when the Rehnquist Court squarely rejected terminal patients' claims of

¹ I borrow Mark Tushnet's vocabulary here, using "strong-form" to mean a declarative judicial statement of constitutional doctrine that exerts a trumping effect on the normal operation of ordinary law and politics.

² See *Jacobsen v. Massachusetts*.

individual right to physician-assisted suicide under both substantive due process and equal protection clause rationales.³ Even the abortion cases themselves, which still protect a woman's limited individual right to elect that medical procedure, have steadily since *Roe* become less solicitous of individual physician discretion and less sensitive to the norms of medical practice.⁴ Other key recent constitutional law decisions, such as *Gonzales v. Raich*'s declaration that the federal commerce power extended to criminalize the medical use of marijuana under a physician's prescription, display a general lack of judicial interest in the particular norms of medical judgment which might have produced a different result, or at least a different rationale, if taken seriously.⁵

All of this merely highlights the uncontroversial point that the construction of modern constitutional doctrine and the rise of the modern healthcare system have largely proceeded along separate legal lines of inquiry. This is not to say the current system of allocating and regulating healthcare is unconstitutional in any meaningful respect. As Larry Gostin and others have illuminated in comprehensive strokes, the current legal and political framework of medical care provisions and public health regulation is deeply rooted in the historical constitutional infrastructure and the shared role of the states and federal government in that enterprise.⁶ Similarly, this disconnect with formal constitutional law hardly means that other forms of law are absent or irrelevant in the modern health care system. To the contrary, health care in the United States is situated

³ See *Washington v. Glucksberg* and *Vacco v. Quill*, discussed *infra*.

⁴ I have explored this pattern of "demedicalization" of the abortion right since *Roe* in other works. See, e.g., Theodore W. Ruger, *Health Law's Coherence Anxiety*, 96 *Geo. L. J.* 625 (2008). For an incisive analysis of this trend with a particular focus on the internal Court memoranda and debates at the time of the *Roe* decision, see Nan D. Hunter, *Justice Blackmun, Abortion, and the Myth of Medical Independence*, 72 *Brook. L. Rev.* 147, 177-88 (2006).

⁵ 545 U.S. 1 (2005) (rejecting argument that physician prescription requirement for personal medical use served to diminish potential for diversion, and noting without empirical evidence that "our cases have taught us that there are some unscrupulous physicians who overprescribe.").

⁶ See e.g., L. Gostin, *Power, Duty Restraint* volume (2nd ed. 2008); see also Robert Field.

within – and dramatically shaped by – a dense thicket of state, federal and private law rules, but legal rules that are generally “ordinary” law instead of black-letter constitutional doctrine.

It is tempting to extend this analysis about the lack of intersection between health law and judge-made constitutional doctrine to reach the more sweeping conclusion that the constitution of the United States has nothing to say about health law or health care. On this view, the multifaceted legal regime that governs the provision of medical care in the United States is entirely a creature of historical path dependence, interest group politics, and public policy optimization. But this conclusion follows only if one accepts the conventional Supreme Court-centered vocabulary of “constitutional law.” What we mean in the conventional account when we say there is little “constitutional law” relating to American health care is that the uniquely preferred institution for creating canonical constitutional law (the U.S. Supreme Court) has not used a particular mode of jurisprudential action (the creation and application of explicitly trumping constitutional doctrines) to constrain the resolution of political disputes in this particular area. Under that precise formulation of canonical judicial doctrine it is certainly accurate to state that health law and constitutional law are largely separate endeavors.

New developments in constitutional theory, however, invite a reconsideration of this basic assumption. One of the unique contributions of a large group of legal scholars over the past decade or more has been to broaden the institutional and operational conception of the American “constitution” to embrace a variety of actors other than the Supreme Court, and a variety of modalities of constitutional interpretation and application other than formal judicial doctrine. Central to much of this newer scholarship

is the proposition that constitutional interpretation – or more fundamentally, “the Constitution” itself – is more complex and decentralized than the classical Court-centered model has maintained.⁷ This conceptual broadening presents rich theoretical opportunities for scholars of health law to explore anew the connections between constitutional structures and health law rules. There are at least two lines of analysis under this broadened notion of constitutionalism with clear relevance for health law inquiry: the first focuses on constitutional actors other than the Supreme Court, the second looks to the Court itself but at the Court’s normative commitments in cases like *Gonzales v. Oregon* do not represent classical constitutional doctrine.

The first idea is institutionally eclectic, reflecting an effort to deemphasize the interpretive exclusivity of the Supreme Court on questions of constitutional meaning. Numerous scholars have contributed to this rich literature over the past decade or more, with emphasis on the crucial role in specifying constitutional meaning played by Congress, the federal Executive, state courts and legislatures, and even “the People Themselves.”⁸ In the health law context, this institutional catholicity opens up fruitful avenues for exploring the intersection of constitutional norms and pressing questions of health law and policy. Though the Court has been relatively silent in applying the constitutional doctrine in this area, Congress has made various foundational choices that are arguably constitutional in nature: in framing an incomplete right to healthcare for the

⁷ Leading exemplars include Bruce Ackerman, *The Living Constitution* 120 Harv. L. Rev. 1737, 1761 (describing the “landmark statutes of the 1960s as functionally equivalent to the constitutional amendments of the 1860s” and thus deserving of “a central place in the constitutional canon”) (2007); William N. Eskridge, Jr. & John Ferejohn, *Super-Statutes*, 50 Duke L. J. 1215, 1266-67 (2001) (arguing that super-statutes represent “something more than ordinary law-making” and are “quasi-constitutional” in nature); see also Siegel, Kramer, Tushnet, Katyal and others.

⁸ The quoted phrase is from one major work in the field, Larry Kramer’s “The People Themselves”.

aged⁹, some of the poor¹⁰, and for those in emergency circumstances¹¹, and by continuing to enforce a durable allocational norm that leaves significant discretion over health policy in the hands of state governments.¹²

I explore some of these dimensions of legislative constitutionalism and the American health care system in a different historical work. However, my focus in this essay remains with the Supreme Court itself, but on a different jurisprudential mode than the Justices' creation and explication of above-board constitutional doctrine. In the health law field, there is ample evidence that constitutional norms and judicial interpretation intersect not through the creation and application of black-letter constitutional doctrine but through more subtle norms of interpretation that manifest as substantive norms of construction in contested statutory cases. Scholars have long recognized the important role that substantive canons of construction play in statutory interpretation, and often such canons are explicitly derivative of constitutional values.

This paper examines several entrenched normative commitments that occasionally – perhaps often – appear to guide judicial statutory interpretation in cases involving health law questions. Though I will discuss other Rehnquist and Roberts Court cases later, my primary focus is on one recent case that is fast becoming one of the early Roberts Court greatest hits, at least judged by the amount of scholarly commentary. *Gonzales v. Oregon* forced the Court to consider the question of whether the Attorney General was authorized to interpret the Controlled Substances Act in a manner that prohibited Oregon physicians from fulfilling their role under valid state law in assisting

⁹ Medicare

¹⁰ Medicaid

¹¹ EMTALA

¹² See *infra* Part III-B for a collection of such statutes. See also Lars Noah, *Ambivalent Commitments to Federalism in Controlling the Practice of Medicine*, 53 U. Kan. L. Rev. 149 (2004).

certain terminal patients to commit suicide. Given that the Supreme Court only a decade before had declined to affirmatively constitutionalize an individual right to assisted suicide¹³, the case outcome was highly uncertain in the months prior to decision. That the Court ultimately found against the Attorney General’s authority reflects an exercise in “standard” statutory construction that was steeped in various underlying substantive norms. The question of which precise substantive values were important to the Justices, and the manner in which they intersected to produce the six-Justice majority in the case, is the subject of a robust scholarly debate that I join in this paper.

I examine three separate substantive commitments that arguably operated on the Court’s analysis in Oregon. The first of these rests on the Court’s expertise-based rationale that the Attorney General was the *wrong* federal official to make a determination about medical practice. Noting the greater involvement of the Secretary of Health and Human Services on medical practice issues generally, and the fact that the CSA delegates authority to multiple agencies, the Court found the Attorney General insufficiently expert on medical practice issues to justify any deference to his interpretive rule. Jody Freeman and Adrian Vermeule have assessed this dimension of the Oregon ruling in the context of a broader work on “expertise-forcing” in the Court’s statutory interpretation decisions.¹⁴ Their claim, and to an extent that of the majority opinion itself in Oregon, is that the Court will grant greater deference to executive officials who exercise scientific or technical expertise instead of raw political judgment.

This expertise-forcing norm operated simultaneously with at least one different allocational norm in the *Oregon* decision. Recognizing the longstanding primacy of the

¹³ See *Washington v. Glucksberg* and *Vacco v. Quill*, discussed *infra*.

¹⁴ See Jody Freeman and Adrian Vermeule, *Massachusetts v. EPA: From Politics to Expertise* (working paper, 2008 – add forthcoming information).

states in regulating the medical profession, the Court applied a version of a clear statement rule to presume that Congress did not intend by the CSA to reorder the basic allocation of authority over the medical profession. The federalism norm on display in Oregon has likewise already featured in broader secondary literature.¹⁵ As I explain below, the Court has displayed a similar pattern of deference to state legislative reform in several other cases involving health law issues and claims of federal preemption. This substantive preference against trumping of state policy is clearly consistent with durable principles of vertical devolution in health regulation. Though in the Oregon case as presented the federalism norm operated congruently with the expertise norm mentioned above, it is possible to imagine different facts on which the norms would cut in different directions, and I explore that latent tension below.

Finally, I maintain that a third norm, that I call a “democracy-forcing” canon, was also at work in the *Oregon* opinion. This norm rests on the accurate historical proposition that “legitimacy” in the practice of medicine is a fundamentally deobjectified concept, determined through the operation of normal politics and existing professional structures which are preferred in the outcomes of those political contests. There is no independent or extrapolitical dimension to “legitimacy” in medicine of the sort that would lend itself to bureaucratic or scientific analysis. Given that such political debate is ongoing in the states on the threshold legitimacy of assisted suicide (and the Oregon Court recognized as much in the first paragraph of its opinion), this third norm overlaps heavily with the more general federalism norm (except in some other health and safety preemption cases I discuss). But it is clearly in tension with the expertise-forcing norm as it applies to the definition of “legitimate” medical practice. After a brief discussion of

¹⁵ See, e.g., Ernest Young, *The Constitution Outside the Constitution*, 117 Yale L.J. 408 (2007).

the *Oregon* decision itself, I will describe all of these normative commitments and their connection to the Court's opinion below.

As suggested by this introduction, an additional claim is that these substantive patterns of governance are sufficiently durable and entrenched as to be fairly considered part of the "constitution" of American health law. The fact that these norms appear not as above-board constitutional doctrine but rather as norms of statutory construction renders them a distinct (and ultimately weaker) form of constitutional law, but does not deprive them of all features of constitutional commitment. Moreover, the fact that the Court is occasionally inconsistent in its adherence to these norms and unclear in their specification does not in itself obviate their existence or their "constitutional" quality, any more so than unclear and inconsistent application of formal doctrine (Establishment Clause jurisprudence, anyone?) can be said to existentially negate the operation of that form of constitutionalism. Before returning to these questions, however, I will first describe the case itself and then explore the particular normative commitments that mattered to the Court.

II. The *Gonzales v. Oregon* Decision

The origins of the dispute that culminated in the Supreme Court opinion of interest here began with Oregon's adoption in 1994 of the "Oregon Death With Dignity Act." That state regime permitted physician-assisted suicide for some terminal patients under tightly regulated circumstances.¹⁶ The Oregon system had operated successfully and without federal intrusion from 1994 until 2001, when the new U.S. Attorney General John Ashcroft sought to prohibit the use of federally-approved drugs to carry out such

¹⁶ Ore. Rev. Stat. sec. 127.800 *et seq.*

assisted suicides, a ban that would effectively end the practice in Oregon. The litigation that reached the Supreme Court resulted from Oregon's legal challenge to the Attorney General's action. Strictly speaking, the case was not one about "constitutional law" in terms of the doctrinal grounds on which Oregon challenged the federal prohibition. Oregon did not assert any inherent constitutional right to suicide on its citizens' behalf, nor in the Supreme Court did it directly challenge the federal government's basic authority to regulate practice of medicine under the 21st-century Commerce Clause. The former claim would have failed under *Washington v. Glucksberg* and *Vacco v. Quill*¹⁷, and any questions about the latter issue were foreclosed a year earlier by the Supreme Court's decision in *Gonzales v. Raich*¹⁸, which held that the federal government's Commerce Clause authority was expansive enough to permit regulation of individual medicinal marijuana transactions. The question in *Gonzales v. Oregon*, then, was not whether the federal government could in theory regulate (or ban) assisted suicide, but a set of narrower issues of statutory interpretation and administrative law.

Central to the dispute in *Oregon* was the judicial interpretation of the powers Congress had delegated to the Attorney General when it enacted the Controlled Substances Act of 1970 (CSA) and subsequent amendments.¹⁹ Attorney General Ashcroft sought to promulgate his novel interpretation of the CDA by issuing an "interpretive directive" that purported to add specification to a much older administrative interpretation of the CSA. On November 9, 2001, Attorney General Ashcroft published an interpretive rule in the Federal Register in which he stated that "assisting suicide is not a 'legitimate medical purpose' within the meaning of 21 CFR § 1306.04," and therefore

¹⁷ 521 U.S. 793 (1997).

¹⁸ 545 U.S. 1 (2005).

¹⁹ 21 U.S.C. sec. 801 et seq.

that “prescribing, dispensing, or administering federally controlled substances to assist suicide violates the CSA.”²⁰ Because such federally-scheduled pharmaceuticals were the standard means that Oregon physicians used in assisting patients in ending their lives – and arguably the only acceptable means of doing so – the Attorney’s General’s interpretation would if enforced have effectively ended Oregon’s limited experiment with assisted suicide.

The focal point of the dispute in the Supreme Court as in the lower courts was the Attorney General’s authority to so interpret the CSA. The Act makes it unlawful to “manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense” any controlled substance, “[e]xcept as authorized by [21 U.S.C. 801-904].”²¹ It provides for substances to be classified in one of five schedules, each with different regulatory implications.²² The drugs used by physicians in Oregon for assisted suicide purposes were Schedule II substances, which are dispensible only by doctors who obtain a special registration from the federal Attorney General. To dispense controlled substances lawfully, a physician or other practitioner must “obtain from the Attorney General a registration.”²³ The CSA authorizes the Attorney General to deny or revoke the registration of a practitioner “if he determines that the issuance of such registration would be inconsistent with the public interest.”²⁴ In determining the “public interest” for registration purposes, the Attorney General is directed to consider a number of factors, including the registrant’s compliance with federal, state, and local laws relating to controlled substances and “such other conduct which may threaten the public health and

²⁰ See 66 Fed. Reg. 56,607 (2001).

²¹ 21 U.S.C. 841(a)(1).

²² 21 U.S.C. 812.

²³ 21 U.S.C. 822(a)(2).

²⁴ 21 U.S.C. 823(f).

safety.”²⁵ The CSA also expressly contemplates a role for the DOJ in promulgating rules for interpretation. Section 821 gives the Attorney General the authority to issue “rules and regulations . . . relating to the registration and control of the manufacture, distribution, and dispensing of controlled substances.”²⁶ A separate subsection of the Act confirms the Attorney General’s regulation-drafting authority, making it “unlawful for any person to distribute” certain controlled substances except pursuant to an order form issued by the Attorney General in accordance with “regulations prescribed by him.”²⁷

The above language indicates a clear delegation to the Attorney General to exercise some interpretive authority over the Act’s enforcement scheme. Certainly the relevant sections of the CSA presume some rulemaking authority, and the mandate is a broad one: to all rules “relating to the registration and control of the manufacture, distribution, and dispensing of controlled substances.” Dispensing is permissible only by prescription, and Oregon physicians who participated in the assisted suicide scheme would have necessarily written prescriptions that were within the overall ambit of the CSA’s regulatory coverage. To the extent the Attorney General issued interpretive statements “relating to” the dispensing of the Schedule II substances used in the Oregon assisted suicide cases, the CSA appears to authorize such action.

It was this delegated interpretive authority that John Ashcroft invoked when in 2001 he issued an “Interpretive Rule” declaring that “assisting suicide is not a ‘legitimate medical purpose’” under the CSA, and that physicians prescribing or administering Schedule II substances for that purpose in Oregon would have their federal registrations revoked. Because scheduled drugs are prescribed in many contexts beyond assisted

²⁵ 21 U.S.C. 823(f).

²⁶ 21 U.S.C. 821.

²⁷ 21 U.S.C. 828(a).

suicide, such revocation of federal privileges would be devastating to the Oregon doctors' ability to practice medicine.

The face of the statute presents a strong argument that the Ashcroft interpretive directive was authorized by the statutory mandate to issue regulations "relating to the registration and control of the manufacture, distribution, and dispensing of controlled substances." The majority opinion stated that the CSA ought not be read so broadly, claiming that the Attorney General's "control" authority was limited by a provision earlier in the statute, which defines "control" as: "to add a drug or other substance ... to a schedule under part B of this subchapter."²⁸ But Justice Scalia's dissent persuasively argues that since the control provisions of subsection 821 discussed above is found in Part C of the subchapter, the specific definition of control found in section 805 is inapplicable, and instead a more ordinary meaning ought control. And the ordinary meaning of "control" certainly embraces some law enforcement discretion over lawful and unlawful prescription activity by physicians under the Act.²⁹

Beyond the language of the CSA itself, two different theories of deference would, if applied by the Supreme Court, have operated to bolster the Attorney General's authority to interpret the CSA to prohibit the use of these substances for the purposes of assisted suicide in Oregon. First, since the Attorney General (and his subordinate delegate the DEA administrator) were charged with primary responsibility for enforcing the CSA, it is strongly arguable that ordinary *Chevron* deference ought to have applied in the case.³⁰ Second, a more particularized form of *Auer* deference³¹ might have applied

²⁸ 21 U.S.C. 805.

²⁹ See also *Moore* opinion.

³⁰ *Chevron U.S.A. Inc. v. NRDC, Inc.*, 467 U.S. 837, 843-844 (1984). See also *See Alliance for Cannabis Therapeutics v. DEA*, 930 F.2d 936, 939 (D.C. Cir. 1991) ("neither the statute nor its legislative

to the Ashcroft interpretive directive which itself construed a prior regulation implementing the CSA. In 1971, shortly after the CSA's original enactment, DEA's predecessor (the Bureau of Narcotics and Dangerous Drugs) issued regulations to implement the Act through notice-and-comment rulemaking. One of those regulations required that a prescription for a controlled substance "must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."³² *Auer* states that deference ought be given to an implementing agency's interpretation of its own valid regulations – and might have ordinarily been expected to apply here.

In sum, Justice Scalia's heated claims in dissent about the proper application of textual interpretation and ordinary deference principles appear to have more than a little merit. The unadorned text of the CSA arguably supports the authority of the Attorney General to interpret "legitimate medical purpose" and enforce subsidiary restrictions on physicians who deviate from such a standard. And multiple theories of deference make such a conclusion even stronger.

That the six-Justice majority of the Court in *Oregon* nonetheless found that Ashcroft's interpretive directive exceeded his authority suggests that other normative values influenced the Court's decision. Writing for a majority of six, Justice Kennedy emphasized that the CSA delegated interpretive authority not only to the Attorney General, but also to the Secretary of Health and Human Services, stating that "the

history precisely defines the term 'currently accepted medical use'; therefore, we are obliged to defer to the Administrator's interpretation of that phrase if reasonable").

³¹ See *Auer v. Robbins*, 519 U.S. 452, 461-63 (1997) (holding that an administrative rule interpreting the issuing agency's own regulation may receive substantial deference).

³² 21 C.F.R. 1306.04(a)

Attorney General does not have the sole delegated authority under the CSA.”³³ Justice Kennedy went on to note the HHS Secretary’s greater comparative expertise on questions of medical policy, which to the Court’s majority suggested that Congress did not intend to grant the Attorney General the sweeping authority that Ashcroft had claimed. That the “interpretive rule” barring Schedule II drugs from use in assisted suicides was grounded in the Attorney General’s determination about the legitimacy of the medical purpose was important to the Supreme Court majority, which reasoned that such medical decision-making power was vested instead in HHS: “The CSA allocates decision-making powers among statutory actors so that medical judgments, if they are to be decided at the federal level and for the limited objects of the statute, are placed in the hands of the Secretary.” Later the Court reasoned that Congress intentionally directed the consideration of medical judgment to the relatively more “expert” HHS Secretary.³⁴ According to the Court, “[t]he structure of the CSA . . . conveys unwillingness to cede medical judgments to an Executive official who lacks medical expertise.”

The federalism norm was similarly evident on the face of the majority opinion. Justice Kennedy stressed the traditional role of state governments in regulating medical practice, and declined to infer a Congressional intent to transfer such regulatory authority from the states to the federal Attorney General without a clearer expression in the statutory text. Ultimately, said the Court, “the text and structure of the CSA show that Congress did not have this far-reaching intent to alter the federal-state balance and the congressional role in maintaining it.” In sum, the Court’s opinion was a sweeping rejection of Attorney General Ashcroft’s effort to interfere with the operation of Oregon’s

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³⁴ *Id.* at 266.

assisted suicide regime. It was grounded not merely in “standard” principles of statutory construction, but also heavily freighted with the influence of several overlapping substantive norms.

III. Overlapping Substantive Commitments Behind the *Oregon* Decision

Gonzales v. Oregon is a case that fascinates because it operates on multiple layers of interpretation and analysis. Beyond the “standard” interpretive referents of statutory text, structure, history, the Court appears to have applied more than multiple substantive norms of statutory construction that were extrinsic to the specific facts of the case before it. It is not an unusual phenomenon for the Supreme Court to apply “substantive canons” in the course of statutory interpretation, and the list of such canons that the Court and lower federal courts have applied in recent decades is long and highly varied.³⁵ In many cases, however, the substantive content of such norms are agreed-upon *ex ante* and easily identifiable – the rule of lenity which operates in favor of criminal defendants is one such canon. With such well-established substantive norms there is no question of identification, but instead only questions over the norm’s application (e.g., is this the right kind of case, with the requisite ambiguity, to apply the rule of lenity?) and implication (e.g., does the rule of lenity operate as a mere tiebreaker, or exert a somewhat stronger hydraulic force on interpretation?).

In *Gonzales v Oregon* it strongly appears that some other substantive norm or norms drove the majority opinion in the case, but neither the Court’s opinion itself nor the burgeoning commentary on the case is in consistent agreement about what these

³⁵ See Eskridge, Frickey & Garrett, *Legislation: Cases and Materials on Statutes and the Creation of Public Policy*, Appendix B (4th ed. 2008).

underlying values are. Anyone who views the case (as I do) as involving the influence of underlying substantive norms bears an explanatory burden of identifying and specifying these normative commitments. I will discuss three different norms that may have interacted and contributed to the Court’s ultimate outcome and rationale in the case. All of these are in evidence to a greater or lesser extent on the face of the Court’s opinion. The first two are readily identifiable and have already generated competing academic commentary: an “expertise-forcing” norm that emphasized the Attorney General’s lack of particularized bureaucratic experience with medical practice, and a federalism norm that stressed the longstanding structural priority of the states in defining and regulating medical practice. These norms operated in congruence in *Oregon*, but it is easy to imagine possible cases of cross-cutting tension between the expertise and the federalism norms, and I address that possible conflict below. Finally, I suggest that a third normative idea unique to the health care context may have contributed to the Court’s rejection of the Attorney General’s interpretive directive – the recognition that legitimacy in medical practice has historically been a construct of positive law, contested and mediated through the legitimate institutions by which the polity resolves disputes over public norms. That John Ashcroft sought to trump the operation of normal democratic politics on the question of assisted suicide, and foreclose the “earnest and profound debate”³⁶ that Americans were having on the subject, was an additional mark against his decision. Obviously this democracy-forcing norm overlaps with the federalism norm since such debates primarily are taking place in the realm of state politics. But here too one can find instances where the two values conflict – such as

³⁶ Id. at 249 (quoting *Washington v. Glucksberg*, 521 U.S. 702 (1997)).

when the federalism preference in health and safety is operationalized by an institution that many of the Justices view as inadequately democratic, namely lay juries. In those cases (e.g. the recent device preemption case of *Riegel v. Medtronic*) the Court has been more than willing to trump state policy by construing broad preemption rules.

I will now examine all three of these norms singly, and with an eye toward possible conceptual tension in future cases.

A. Expertise-Forcing and the Attorney General

The majority opinion in *Oregon* was quite clear that it regarded the Attorney as the wrong federal official to issue a declarative statement on the medical legitimacy of assisted suicide. Throughout its analysis the Court repeatedly stressed the relative inexperience of the Attorney General in making such determinations. Justice Kennedy's opinion reasoned that "[t]he structure of the CSA . . . conveys unwillingness to cede medical judgments to an Executive official *who lacks medical expertise*." (emphasis added). Earlier the opinion made clear its view that "the CSA allocates decision-making powers among statutory actors so that medical judgments . . . are placed in the hands of the Secretary," who has a comparative expertise advantage over the Attorney General on such matters.³⁷

Other scholars have noted this dynamic in *Oregon* and connected it with the Justices' decision-making in other recent cases. In a forthcoming work subtitled "From Politics to Expertise," Jody Freeman and Adrian Vermeule posit that the Supreme Court is increasingly like to refuse deference to administrative action that lacks indicia of

³⁷ *Id.* at 266.

bureaucratic and scientific expertise.³⁸ In their analysis the *Oregon* holding is analogous to the Court's more recent rebuke to the executive branch in *Massachusetts v. EPA* (2007) – both involved the Justices “forcing” agencies to channel decisions to expert officials and to make decisions that leveraged their relative institutional expertise rather than impermissible (political) factors.

I do not doubt that the expertise-forcing norm is powerful, and some sense particularly so on the current court. One can identify recent cases where it appears to trump the deeply rooted federalism norm where the two values conflict. In a recent line of drug and device preemption cases the Supreme Court and lower federal courts have been increasingly likely to find preemptive force for the FDA's administrative actions in ambiguous statutory language (see *Riegel v. Medtronic*) or to imply regulatory preemption in the face of statutory silence (drug labeling preemption cases, see, e.g. *Wyeth v. Levine*). In these cases the Justices here are clearly operationalizing their own conception of comparative institutional expertise -- the FDA is more expert and appropriate on drug safety than a collection of lay juries – but at dramatic costs to the traditional role of states in protecting consumers and affording avenues for relief to those injured by prescription drugs in devices. All of this suggests the expertise-forcing norm is alive and well on the current Supreme Court, and manifests in a variety of cases cutting across issue areas.

In the *Oregon* case, of course, no such clash of normative values was necessary: both the expertise-forcing norm and the federalism norm pushed in the same direction, and both pushed against the Attorney General's authority. This makes it impossible to

³⁸ See Jody Freeman and Adrian Vermeule, *Massachusetts v. EPA: From Politics to Expertise* (working paper, 2008 – add forthcoming information).

precisely regress out the independent effect of these overlapping norms in the case (although this imprecision does not dampen my willingness to speculate on the question). My own reading of the case leads me to think that the expertise-forcing norm was not the primary driver of the result in *Oregon v Gonzales*, even as it remains important in a variety of other contexts. This assessment is grounded both in the fundamental conceptual nature of “legitimacy” in medical practice, coupled with the related institutional inexperience of HHS itself in directly regulating the practice of medicine.

At bottom, medical legitimacy is not a concept that lends itself to scientific or technical analysis. As I explain in more detail below, throughout history contests over legitimacy in medical practice have historically been resolved in the political arena. That the resolution of such contests often entail delegation of self-regulatory authority to an expert professional elite ought not obscure the fact that judgments of legitimacy or acceptability in medical practice remain heavily freighted with normative value-laden choices. In this sense determinations of medical legitimacy are wholly different from the kinds of technical determinations many federal safety agencies make, such as the FDA’s determination of the relative safety and efficacy of a new drug, or the EPA’s assessment of air or water quality or the metrics of global warming. To be sure, the ultimate policy choice that follows from those determinations might be heavily political, so that the decision to approve (or not approve) a drug with a given risk-benefit profile cannot be answered solely or primarily by technical criteria. But that ultimate regulatory decision is overlaid on a spectrum of analysis that is essentially scientific and technical. This is not true of medical legitimacy. We can demonstrate, for instance that one new drug is relatively safer than another, even as we argue over whether to approve both, but it would

be difficult to precisely map the relative legitimacy of two different contested medical procedures.³⁹

For these reasons Justice Scalia was correct when he argued in dissent that “the contested “scientific and medical” judgment at issue [about the legitimacy of assisted suicide] ultimately rests, not on ‘science’ or ‘medicine,’ but on a naked value judgment.”⁴⁰ The implication that Justice Scalia draws from this otherwise reasonable conceptual assessment is wrongheaded: he reasons that the statute’s “use of the word ‘legitimate’ connotes an objective standard of ‘medicine’” that can be ascertained and enforced by a single federal official.⁴¹ But the error in that conclusion arises from his overly robust conception of objectivity in specifying legitimate medical practice, not from any misunderstanding of the fundamentally normative character of the legitimacy determination.

Beyond this conceptual point about the incompatibility of legitimacy judgments and technocratic expertise, there is the institutional fact that HHS and its predecessor agencies have for decades explicitly disclaimed any special regulatory mandate to regulate the practice of medicine. Even if medical legitimacy is susceptible to expert analysis, HHS and the federal government more generally has not displayed interest or experience in developing and applying such expertise. The FDA, for instance, has for decades stated that it does not regulate “the practice of medicine” in exercising its statutory role to assess the safety or efficacy of prescription drugs. This is an immense

³⁹ There are limits to my claim, of course: there are some medical procedures that are so established that no one would question their legitimacy – my point about relativism applies as between two procedures whose legitimacy is contested. Likewise, it is of course possible to technically measure and compare the relative safety of medical procedures in the same manner as pharmaceutical safety comparisons, but that is a very different inquiry than legitimacy itself.

⁴⁰ 546 U.S. 243, at 296 (Scalia, J., dissenting).

⁴¹ *Id.*, at 285.

void in the FDA’s regulatory mandate, permitting doctors to use drugs in dosages, durations, and combinations that the FDA never contemplated when making its initial approval decision. Yet so powerful is this disinclination to regulate specific medical use that even the Bush FDA which has made new preemptive claims about state tort law has nonetheless reiterated that “its role is not to regulate medical practice.”⁴² Likewise the HHS itself has repeatedly and consistently espoused a “general position of deferring to State laws regulating the practice of pharmacy and the practice of medicine,” and expressly recognized “the fundamental Federalism principles” undergirding such federal deference.⁴³ Elsewhere the HHS Secretary has pointedly “acknowledge[d] the authority within State government to regulate the practice of medicine.”⁴⁴

These administrative statements are closely related to, perhaps largely compelled by, the federalism norm that was also crucial in the *Oregon* majority opinion. And there is nothing new about these recent proclamations -- federal agencies have historically disclaimed authority and expertise over medical practice precisely because states have asserted primary authority in such areas.

This leads back to the ultimate question of the last several paragraphs about the relative strength of the federalism norm and the expertise-forcing norm in the *Oregon* analysis. In *Oregon* the Court was not forced to choose between these values – what would have happened if such a choice had been forced? It is not hard to imagine a scenario: assume (counterfactually) that the new Bush-appointed HHS Secretary had,

⁴² 70 Fed. Reg. 17,168, 17,181 (Apr. 4, 2005). *See also* 70 Fed. Reg. 6,256, 6,258 (Feb. 4, 2005) (“It is also important to remember that we [the FDA] do not regulate the practice of medicine.”).

⁴³ 68 Fed. Reg. 63,692, 63,704 (Nov. 7, 2003).

⁴⁴ 66 Fed. Reg. 4,076, 4,081-82 (Jan. 17, 2001).

upon reaching office in 2001, broken with prior practice and issued an interpretive statement that matched the Attorney General's finding that assisting in suicide for a terminally ill patient is not "legitimate medical practice." Would the Court then have upheld the federal executive branch's unified collective interpretation of the CSA? Certainly the face of the *Oregon* opinion, with its focus on the Attorney General as the "wrong" official to determine medical legitimacy suggests it might have. But I find that implausible given other statements in the Court's opinion about the vertical allocation of authority between the federal government and the states. In the context of the longstanding primacy of states on this topic, and the related inexperience of HHS in broadly defining medical legitimacy, an HHS statement on the topic would have been hardly more "expert" than John Ashcroft's actual directive.

B. The Federalism Norm in *Oregon* and Other Cases

Even in a 21st-century world of massive federal government involvement in the health care enterprise, individual states retain primacy over the regulation of physicians' practice of medicine. The role of the federal government and of private employers and insurers in financing and regulating many features of the system is immense, of course, but still the basic authority to define and enforce standards of medical practice resides with the states. There was a time when medical practice was not considered to be "commerce", so that this pattern of vertical devolution of regulatory authority was mandated by the formal doctrinal constitution. Indeed, among the first key federalism debates that Congress engaged in during the 1790s involved the validity of a proposed federal quarantine law. After heated debate over the constitutional reach of the

Commerce Power in this area proponents of a federal scheme backed down, leaving authority over quarantines even at ports and borders to the state governments. It would not be until almost a century later, near the end of the nineteenth century, that a federal quarantine law was enacted, again generating explicit debate over the relative constitutional authority of the states and the national government.

Importantly, the vast expansion of the federal commerce power that occurred after 1940 has altered, but pointedly not subverted or overturned the traditional primacy of the states in medical regulation. The fact that the first-order constitutional pressure has receded has not brought an end to the institutional and normative structures that were constructed around the older constitutional limiting principle. Moreover, to a much greater extent than in other regulatory areas Congress repeatedly and pointedly disclaimed its intention to exercise the full extent of its Commerce Clause authority over the practice of medicine. For instance, Congress since 1938 has rigorously regulated the safety of prescription drugs and (more recently) medical devices. But both Congress and the Food and Drug Administration have repeatedly disclaimed the authority to regulate how physicians *use* drugs once approved, on the grounds that this would constitute regulation of medical practice. Likewise, the Medicare statute commits the federal government as a substantial purchaser of medical services, but nonetheless states that “[n]othing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided.”⁴⁵ Congress similarly disclaimed any intent to regulate medical practice despite becoming a major funder of new hospitals in the Hill-Burton Act in the 1940s, providing that “nothing in this title shall be construed as conferring on any

⁴⁵ Pub. L. No. 89-97, § 102(a), 79 Stat. 290, 291 (1965).

Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any hospital with respect to which any funds have been or may be expended under this title.”⁴⁶ More recent 21st-century amendments to these and other federal health programs repeat such disclaiming language.

What emerges from this mass of legislation is a relatively consistent Congressional practice of exercising something less than the full extent of its judicially-specified commerce power. To be sure, there are exceptions to this norm: the federal Partial Birth Abortion Act which selects and prohibits a specific medical procedure directly interferes with physician discretion. But the exceptions are notable precisely because of their incongruence with the general norm. This pattern of regulation suggests that Congress is operationalizing a variable commerce authority which is at odds with the formal judicial Commerce Clause doctrine. The Supreme Court has long treated Congress’s commerce authority as plenary; it does not wax or wane depending on the specific substantive object of regulation (save for the new categorical requirement in *Lopez* and *Morrison* that the underlying behavior be “economic”). But Congress in its own regulatory behavior appears to be adopting a more variegated and finely-grained conception of its authority, tending to avoid legislating in certain areas (medical practice) that are unquestionably within its judicially-defined authority over commerce. The longstanding durability of this pattern of behavior and its clear connection to structures of constitutional federalism make it possible to claim that Congress is engaged in a type of legislative constitutionalism with respect to medical practice, and one that maintains the

⁴⁶ See Hospital Survey & Construction Act, Pub. L. No. 79-725, § 2, 60 Stat. 1040, 1049 (1946).

traditional regulatory primacy of the states even though no longer required to do so by judicial doctrine.

I will leave this first-order discussion of legislative behavior behind and focus on its implications for judicial statutory construction. The consistent Congressional practice described here might impact judicial interpretation of statutes in at least two ways. First, this entrenched commitment to federalism on health care matters might affect the normative position of Justices themselves, who may internalize this view and bring that perspective to the resolution of close questions. More formally, Congressional practice in this issue area can be used to construct an inference about legislative intent which is overlaid on statutes that might ambiguously implicate medical practice. In this view the longstanding commitment to federalism which is express in so many acts of Congress becomes a clear statement principle where the text is silent: the Court will presume against federal regulation of medical practice unless Congress clearly indicates it wishes to regulate. It is obvious that this norm was present in *Oregon*, and Justice Kennedy's opinion says as much on its face. His opinion stressed the fact that "the structure and operation of the CSA presume and rely upon a functioning medical profession regulated under the States' police powers." In the absence of a clear statement from Congress to overturn this presumption, the Court would not interpret the CSA to "effect a radical shift of authority from the States to the Federal Government to define general standards of medical practice," and nor would it permit the Attorney General to so interpret it. Other commenters have already made much of this federalism norm at work in the *Oregon* opinion. One notable example is Ernest Young's article on "The Constitution Outside the Constitution," which describes the operation of the federalism norm in *Oregon* as a prime

example of the kind of “constitutive . . . statutory boundaries [that] have come to dominate the structure of American federalism.”⁴⁷ I have no doubt that this federalism norm was a crucial driver of the Court’s opinion in *Oregon*, and as explained earlier I think it is relatively more important here than the alternative expertise-forcing norm. In the next few pages I will assert a broader claim, namely that this federalism-protective norm of statutory construction is also evident in a number of other cases involving health care regulation, and is uniquely important to the Court in this issue area.

This claim of comparative deference to states on health law matters requires a quick assessment of the baseline: in general terms the Rehnquist and now Roberts Courts have *not* been particularly protective of state regulatory authority – this has been an assertively preemptive Court whether applying standard preemption law analysis, the trumping values of the Dormant Commerce Clause, or other statutory or constitutional provisions with potential preemptive scope. For all its rhetorical solitude for state “sovereignty” and “dignity” in a few high-profile constitutional cases, the Court in the past two decades has not actually shown significant deference to state lawmaking. Various empirical studies support this point. For instance, in their comprehensive empirical treatment of hundreds of Supreme Court cases that reviewed state action in some form or another, Ruth Colker and Kevin Scott assessed the Court’s solicitude for affirmative state activity. Their title—“Dissing States”⁴⁸—reveals their conclusion: the Rehnquist Court was not been particularly deferential to state sovereignty in its active rather than passive form. The Rehnquist Court was as likely as any in history to find reasons to invalidate affirmative state regulatory or enforcement activity. Colker and

⁴⁷ Ernest A. Young, *The Constitution Outside the Constitution*, 117 Yale L. J. 408, 432 (2008).

⁴⁸ Ruth Colker & Kevin Scott, *Dissing States?: Invalidation of State Action During the Rehnquist Era*, 88 Va. L. Rev. 1301 (2002).

Scott found that the Court has invalidated state action in 54.7% of the cases where a state activity allegedly clashed with a federal constitutional norm.⁴⁹ By comparison, the reputedly more “activist” Warren Court invalidated state action at a rate of 53.6%.⁵⁰

Against this jurisprudential backdrop of assertive uniformity-promotion across many issue areas, the Court’s treatment of state authority in several contested health law cases over the past decade is interesting and potentially important. In a number of cases involving ERISA-preemption claims and related issues, the Court appears to have been relatively more deferential to state policy experimentation on matters of physician regulation and health insurance and finance than it has been in similar areas outside the health context.

A few ERISA-preemption cases help make this point. ERISA is a major federal law governing employee benefits, that has dramatic (and almost certainly unforeseen) applicability to state regulation of employee-provided health insurance and analogous benefits to employment. [more detail and citation to be added]. ERISA contains a broad preemption clause, trumping all state laws that “relate to” employee benefits, but then a savings clause which exempts from preemption any state law “which regulates insurance.” This has led to significant judicial confusion as applied to employer-provided insurance, and there the Court’s paths with respect to health insurance regulation on the one hand, and life insurance regulation on the other, have diverged.

The Court’s prioritization of national uniformity in life insurance regulation was particularly pronounced in its decision in *Egelhoff v. Egelhoff ex rel. Breiner*.⁵¹ That case involved a Washington law providing, quite reasonably according to some leading

⁴⁹ *Id.* at 1308.

⁵⁰ *Id.*

⁵¹ 532 U.S. 141 (2001)

legal academics,⁵² that a retirement plan designation of a spouse as beneficiary was terminated as a matter of law upon divorce. Retirement plan administrators claimed that the state law was preempted by the Employee Retirement Income Security Act (ERISA), and the Supreme Court agreed. In construing broadly the preemptive scope of ERISA's text, the Court placed great weight upon a policy rationale of uniformity in national regulation. The Court stressed that uniformity was a major goal of ERISA, and stated that "[u]niformity is impossible . . . if plans are subject to different legal obligations in different States."⁵³ Such uniformity concerns were exacerbated where "the employer is located in one State, the plan participant lives in another, and the participant's former spouse lives in a third," such that "administrators might find that plan payments are subject to conflicting legal obligations."

This relative preference for national uniformity over affirmative state regulation, and perhaps more generally a broad deregulatory bent, is manifest in other Supreme Court cases that implicate similar preemption concerns. But this general pattern appears much weaker in the context of state health insurance and health finance regulation, perhaps because it conflicts with the countervailing norm of state primacy over medical issues. In contradistinction to the *Egelhoff* case enforcing uniformity over life insurance regulation, the Court in several ERISA-preemption cases involving health insurance in the past decade and a half has displayed a greater deference to state lawmaking, and a greater willingness to construe the statutory provisions of ERISA to permit multimodal policy experimentation in this area.

⁵² See, e.g., John Langbein, *The Nonprobate Revolution and the Future of the Law of Succession*, 97 HARV. L. REV. 1108, 1135 (1984).

⁵³

One case which signaled that the Court might regard preemption of state health plan regulation differently than other ERISA preemption cases was *Rush Prudential HMO v. Moran*.⁵⁴ *Rush Prudential* involved a challenge to an Illinois statute requiring health maintenance organizations (HMOs) to provide independent review of disputes between a primary care physician and an HMO, and to cover treatments deemed “medically necessary” by the independent reviewer. *Rush Prudential* was a hard case, not just under ordinary ERISA preemption principles which preempt state laws “relating to” an employee benefit plan but also under ERISA’s exclusive remedial provisions. It was possible to plausibly read ERISA as preempting the Illinois statute at issue, as illustrated by the district court opinion and the minority opinion of three justices (Rehnquist, Thomas and Kennedy) in the case. But the majority of the Court in *Rush Prudential* sought to avoid preemption in reasoning very different in tone than its *Egelhoff* opinion. The Court stressed a baseline norm of nonpreemption of state enactments, stating that it “had no choice but to temper the assumption” that the ordinary meaning of a statute “expresses the legislative purpose . . . with the qualification “that the historic police powers of the States were not [meant] to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.”⁵⁵ Writing for the Court, Justice Souter noted the “inevitable” regulatory disuniformity that would result from the Court’s ruling, but explained that the Court would not imply preemption of state enactments in the health care field: “[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose.”

⁵⁴ 536 U.S. 355 (2002)

⁵⁵ *Rush Prudential*, at __ (citations and internal quotation marks omitted).

Rush sent an important signal to observers unsure about how the Supreme Court, with its general lack of deference to state regulation, would treat state enactments in the health care area. And *Rush* may reflect a judicial disinclination to find preemption in close cases in the health law field even as the Court is willing to do so in other areas of regulation.⁵⁶ The Court in 2003 sustained another important state law against a claim of ERISA preemption in *Kentucky Association of Health Plans v. Miller*, a challenge to that state’s “any-willing-provider” law. The Court unanimously ruled in favor of the validity of the state provision, and justified that result as a clear application of its earlier *Rush* decision. As a simple matter of law the *Miller* result does seem to follow from *Rush* in fairly straightforward fashion, but some implications of any willing provider laws for the economics of managed care might have ordinarily led this Court to take a closer look. Any-willing-provider laws facially allow membership in a health insurance network to any provider who “meets the terms” that the network has offered to in-network providers. But one of these negotiated terms that in-network providers may value, implicitly if not explicitly, is exclusivity itself, and the negotiated price terms may be lower to reflect this exclusivity benefit.⁵⁷ One purpose of any-willing-provider laws is to pierce this exclusivity barrier, but in so doing they may significantly alter the landscape of private ordering in this field, and perhaps hinder the formation of new networks or threaten the stability of existing ones.

Given that the Court had expressly incorporated discussion of such economic concerns and burdens on industry in some of its other rulings in favor of federal preemption (*Geier, Egelhoff*), its reluctance to do so in *Miller* is notable. A choice in

⁵⁶ See *Egelhoff v. Egelhoff*, *supra*; see also *Geier v. American Honda*.

⁵⁷ Add citations to health economics literature.

favor of any-willing-provider laws is in an important sense a health policy decision, forcing a choice between a preference for enhanced consumer/provider choice and a preference for facilitation of managed care and cost containment. To be sure, that the Court found no preemption meant that it simply left this policy choice to the Kentucky (and 49 other) state legislatures rather than making it itself, and such judicial deference in an area of great social and political importance is praiseworthy. Moreover, there are good reasons discussed below why such deference may be appropriate, both based on the specific text and precedent of ERISA but also the more general history and policy of health related regulation.

Another important recent case involving the role of ERISA in the modern health care industry is *Pegram v. Herdrich*.⁵⁸ In *Pegram* the Court considered—and rejected—a patient’s claim that ERISA imposed a fiduciary duty on treating physicians such that a breach of that duty gave rise to a cause of action. The Court held that ERISA imposed no such duty on physicians. *Pegram* may seem an odd fit with the line of cases upholding regulation of health plans I have been discussing, for in that case the Court ruled *against* a patient and *against* the creation of a new court-created regulation on medical care provision. By declining to create a new federal cause of action for fiduciary duty, the *Pegram* holding can be viewed as “deregulatory” in a manner that contrasts with the cases discussed above.

Nonetheless, the manner in which the Court reached its *Pegram* result demonstrates consistency with the Court’s deferential attitude toward state health care regulation discussed above, particularly since the *Pegram* rationale was articulated by Justice Souter (also the *Rush* author), who as much as any Justice appears to be the

⁵⁸ 530 U.S. 211 (2000).

architect of the Court’s emerging jurisprudence involving regulation of the health care industry. The Court stressed that its ruling was not grounded in any strong policy of insulating physicians from stringent duties of care generally—rather the Court’s concern was that neither it nor Congress acting implicitly should oust the states from their traditional role in defining such physician duties. Accordingly, the Court was strongly disinclined to “federalize malpractice litigation in the name of fiduciary duty.”⁵⁹

The Court’s relative deference to state experiments in health policy is also evident in a different type of jurisprudential preemption analysis – namely that required by the current Dormant Commerce Clause doctrine. *Pharmaceutical Research and Manufacturers of America v. Walsh*,⁶⁰ involved a challenge to Maine’s mandatory prescription drug pricing program for Medicaid recipients, which represented both a major health policy choice similar to that considered by several other states, and a major threat to drug maker’s profits. The plaintiff PhRMA brought a lawsuit alleging preemption (by HHS regulation) as well as a claim that the Maine law transgressed the “dormant” component of the federal Commerce Clause, which precludes laws that discriminate against or unduly burden interstate commerce. The Court rejected both claims, and in so doing confirmed its reluctance to interfere with state health policy choices.⁶¹ Even more so than the occasionally vague preemption doctrine, the malleability of dormant commerce clause doctrine invites judicial policymaking, as judges can—and frequently do—strike down state laws that they regard as unduly

⁵⁹ *Pegram*, 530 U.S. at 236.

⁶⁰ 123 S.Ct. 1855 (2003).

⁶¹ The Court’s reluctance to itself interfere was strengthened also by presence of the latent ability (not yet exercised, in the Court’s view) of the Secretary of Health and Human Services to preempt the Maine plan by federal administrative regulation under the Medicaid statute.

burdensome or restrictive.⁶² The potential for judicial discretion inherent in dormant commerce clause doctrine has led some Justices (e.g., Scalia) to expressly disfavor it and some commentators (e.g., Vermeule) to likewise argue for its inappropriateness. Nonetheless, the Supreme Court in the past half-century has become a robust protector of the “federal free trade unit”⁶³ through its dormant commerce clause jurisprudence, and the recent Court has continued this trend, generally ruling against state laws that were subject to such scrutiny. That it found no such problem in the Maine drug plan only confirms the point of the foregoing preemption discussion: the Supreme Court appears more comfortable with letting stand rigorous (and even burdensome) state regulation of the health care industry than it was with respect to otherwise similar regulation of economic activity generally.

[NOTE: I need to expand on an important qualifier here. There is an important institutional exception to this general pattern of deference to states on health policy issues: the Court *has not* shown any inclination to defer when state policy is operationalized by state juries as opposed to the legislature or administrative bodies. This was evident in a major ERISA case that preempted Texas’s managed care liability statute (*Aetna v Davila*) and also in the Court’s recent medical device preemption case (*Riegel v Medtronic*) In other words, state legislatures appear to get deference from the Court on health law matters, but not juries. This may reflect the interaction of the generalized federalism norm with the 2 other normative commitments discussed here: juries get less deference because they are less expert (the expertise-forcing norm), and/or because their

⁶² See, e.g., *Kassel v. Consolidated Freightways*, 450 U.S. 662 (1991).

⁶³ See *H.P. Hood & Sons, Inc. v. Du Mond*, 336 U.S. 525, 538 (1949).

verdicts have less democratic pedigree than a law enacted by referendum or by state legislature (the democracy-forcing norm)]

Having described the general patterns of the Supreme Court's relatively robust deference to state policymaking in the health law area, I wish to spend a few paragraphs defending the desirability of this federalism norm as applied to questions of health policy. A number of possible rationales, both historical and functional, support the maintenance of significant health regulatory authority in the states. Since the earliest days in the nation's history courts have recognized, and affirmed, the states' special power to regulate in the health and safety area.⁶⁴ This is generally true even in eras, like the current one, where the Supreme Court has shown an inclination to strike down legislation in other policy areas. Even the *Lochner*-era Court acknowledged the state's police power authority to regulate health concerns. Such a uniquely permissive attitude toward health regulation has historically applied to congressional enactments as well.

Another ground supporting the Rehnquist's Court's deferential health law jurisprudence also relates to an American federalism, but in a theoretical rather than historical sense. Federalism is textually and historically embedded in the American constitutional tradition (to what extent, of course, is subject to much debate). But it is also supported in some circumstances by public policy and utilitarian rationales, such that many polities that lack American-style textual federalism nonetheless occasionally opt for analogous decentralized policy-making regimes. Such decentralization is desirable where, for instance, public attitudes on a given issue vary geographically—in such circumstances permitting regional variation can increase aggregate public satisfaction.

⁶⁴ *Barnes v. Glen Theatre, Inc.*, 501 U.S. 560, 569 (1991) ("The traditional police power of the States is defined as the authority to provide for the public health, safety, and morals...").

Similarly, in a field like health care where rapid innovation in technology and economic organization can strain existing regulatory structures, decentralized federalism facilitates experimentation with multiple policy responses to emerging issues, which in turn can hasten the development of desirable regulatory solutions.⁶⁵

Justice Brandeis famously made this point about policy experimentation almost a century ago, explaining that "[i]t is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."⁶⁶ And it is a model of particular force in the health care area. Congress has recognized this in the basic structure of the Medicaid system, which expressly decentralizes to the states important decisions about program funding levels and organization. American demography suggests that many significant policy problems such relating to the cost, quality, and allocation of care will only become more acute as the population ages, so that encouraging policy ferment at the state level should be encouraged. Innovative state policies like the Maine prescription drug pricing plan, Oregon's Medicaid rationing experiment, Illinois' "independent review" provision, and Kentucky's any-willing-provider laws may or may not provide desirable solutions to these health policy problems, but at the very least such state experimentation creates a body of policy experience that future regulators, state or federal, can draw upon. The Supreme Court has cooperated in this venture in the area of health policy, by rarely foreclosing states from pursuing innovative regulatory options. This is a normatively appealing posture,

⁶⁵ See William N. Eskridge, Jr. & John Ferejohn, *Structuring Lawmaking to Reduce Cognitive Bias: A Critical View*, 87 CORNELL L. REV. 616 (2002) ("Federalism permits American governance to engage in mistake-filled experiments without paying too high a social cost."). See also Akhil Reed Amar, *Of Sovereignty and Federalism*, 96 YALE L.J. 1425 (1987).

⁶⁶ *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

and consistent with good policy and constitutional structure. As Justice Breyer has stated, “in today's world, filled with legal complexity, the true test of federalist principle may lie, not in the occasional constitutional effort to trim Congress' commerce power at its edges, or to protect a State's treasury from a private damages action, but rather in those many statutory cases where courts interpret the mass of technical detail that is the ordinary diet of the law.”⁶⁷

Oregon's experiment with assisted suicide itself appears exemplary in this rationale. The Court in *Glucksberg* and *Vacco* preserved space for policy experimentation on assisted suicide by refusing to create a uniform individual right against the states, but said nothing to preclude individual states from implementing regimes. And as an “experiment” the Oregon system has already provided useful data. With more than a decade of empirical experience with the Oregon Death with Dignity Act, many of these concerns about widespread abuse and/or patient coercion that the Court expressed in 1994 in *Glucksberg* have been greatly ameliorated. Various amici and the state of Oregon made this clear to the Justices in the *Gonzales v Oregon* briefing, and it almost certainly impacted their overall normative assessment of the case.

[Add paragraph: what's more, for all of its importance, health policy differentiation by states creates relatively few tangible interstate externalities, as compared for instance with environmental regulation]

A different kind of political theory argument also supports a reduced judicial role in the oversight of state health care regulation. One of the hallmarks of Supreme Court jurisprudence in the past half-century has unique solicitude for “discrete and insular minorities” who are uniquely disadvantaged by majoritarian legislation. The Court seems

⁶⁷ *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001) (Breyer, J., dissenting).

most willing to upset settled legislative solutions when such laws disadvantage a particular group or groups that were unable to meaningfully participate in the political process that generated the laws. This vision of the Court’s active role was famously articulated in the famous *Carolene Products* footnote four,⁶⁸ and can be found—implicitly in explicitly—in a number of recent decisions that struck down state enactments viewed as hostile to minority religions,⁶⁹ homosexuals,⁷⁰ and racial minorities.

For the most part, no such special judicial vigilance is conceptually required with respect to legislative health policy choices. Health care is a special good in part because all in society might need it, and in large quantities, and all persons are at least somewhat uncertain about how much and what kind of health care we might require. This uncertainty creates something of a Rawlsian veil—we are all potential patients—that gives a broad majority of Americans some interest in enacting policies that promote high quality care, to a much greater extent than most American care about, say, welfare policy or the rights of criminal defendants. We can thus expect a high degree of public discourse and debate on health policy topics, and recent experience bears this out. To the extent policy concerns about health care are felt particularly in older Americans, who tend to be more politically active, this dynamic is even more acute. Similarly, the health care industry is well-organized and politically active, and although a numerical “minority” in the debate over patient protection statutes, certainly not a minority in need of special judicial protection. The Supreme Court understandably might think that the political process functions reasonably well in striking a balance between patient interests

⁶⁸ *United States v. Carolene Products Co.*, 304 U.S. 144, 152-53 n.4 (1939).

⁶⁹ *Church of the Lukumi Babalu Aye v. City of Hialeah*, 508 U.S. 520 (1993).

⁷⁰ *Romer v. Evans*, 517 U.S. 620 (1996).

and corporate interests in this area, and accordingly show a high level of deference to state legislative solutions.

[Note to Georgetown readers: This last section about the third norm involved in Oregon, the “democracy-forcing” norm, remains incomplete, both in this draft but also—in all candor -- in my own thinking. In outline form here I sketch out some major points, and look forward to exploring this further in the seminar discussion next week]

C. The “Democracy-Forcing” Norm of Positivism in Defining the Practice of Medicine

A central question in *Gonzales v Oregon* was whether physician assisted suicide constitutes “legitimate” medical practice. This question implicates centuries of history, as debates over medical legitimacy and authorized practice of medicine have a long pedigree. One theme that emerges from this history is that the resolution of such contested questions is typically and relentlessly positivist. That is, I maintain that there is no such thing as “legitimate” medical practice separate from the coercive power of the state to specify and enforce boundary lines. In the American experience this positivism has two features, however – first a democratic character, the people in their state political regimes have set the basic framework and continue to do so. Second, the resolution typically produced has entailed another allocational assumption: that physicians and medical experts are vested with substantial professional authority in defining what acceptable medical practice is. In the context of the federalism discussion above this is a kind of double devolution in the American constitutional structure: regulation of medicine is primarily vested in the states, which in turn repose substantial regulatory discretion in the profession itself. So entrenched and durable is this professional self-

regulation model that it is possible to neglect its antecedent, the democratic politics that produces a regime that devolves authority to the profession to set boundaries. In the American context this has been largely obscured during a stable twentieth century, but was in full display in all of its raw democratic fervor in the middle of the nineteenth century. [Discussion of constitutional debates over medical practice in Jacksonian era]

Moreover, the history of contestation over legitimacy of medical practice illustrates the difficulty of imposing a single neutral objective standard of what constitutes “legitimate” medical practice. Even within this regime of state power that has existed for over a century, and which delegates standard-setting authority to the profession itself, variations among states and within states persist. Medicine consistently resists efforts to impose a single uniform or “objective” standard of the best practice of medicine. I return here to Scalia’s claim that the definition of legitimacy in medicine is not susceptible to scientific definition. He is unquestionably correct in that, but equally incorrect in his posterior assumption that therefore a non-medical federal official (the Attorney General) may therefore determine and enforce a single uniform “objective” standard of medical legitimacy.

If “legitimacy” in medicine cannot be objectified, it ought normatively be situated where it has long been – in the normal operation of democratic politics. The Oregon Court appears to recognize as much, noting up front that “Americans are engaged in an earnest and profound debate about the *morality, legality, and practicality* of physician-assisted suicide.” (emphasis added) The italicized text belies the Court’s own expertise-enforcing rationale that it later expressed in the opinion – what special competence does the Secretary of HHS have as to the “morality” and “legality” of assisted suicide? But the

full quotation clearly represents an allocational preference: resolution of the question of assisted suicide ought take place in the realm of ordinary democratic politics. The Court itself situated this debate in that political realm a decade before by declining to create an individual right against the state, and Oregon can be seen as a bookend to those earlier decisions, reflecting the Court's strong view that democratic politics ought answer the question.

In this light we can regard the majority opinion in significant part as resting on the belief that the Ashcroft directive was profoundly undemocratic to the extent it sought to truncate this ongoing debate. More strongly, by referencing failed attempts in Congress to expressly preempt the Oregon Death With Dignity Act, the Court suggests its view that opponents of assisted suicide were attempting to accomplish through bureaucratic back channels what they failed to win in the halls of Congress. The Court hints as much in a line that is utterly gratuitous except as justification for this democracy-forcing theory, noting that "Mr. Ashcroft had supported efforts to curtail assisted suicide while serving as a Senator." In other words, what he couldn't achieve as a Senator he sought to effect as Attorney General. The Court's dim view of the democratic legitimacy of Ashcroft's action is similarly reflected in the following factual characterization: "On November 9, 2001, without consulting Oregon or apparently anyone outside his Department, the Attorney General issued an Interpretive Rule announcing his intent to restrict the use of controlled substances for physician-assisted suicide."

In sum, I think a large driver of the Court's decision can be regarded as "democracy forcing" in the sense that it regarded Ashcroft's action as fundamentally corrosive of the ongoing civic debate on assisted suicide. The harder question I haven't

worked out is whether, and how, this is meaningfully independent from the federalism norm discussed earlier in the paper.

Finally, to return to some of the themes of the introduction, I will want to discuss on April 7 the manner in which any or all of the normative values discussed here can fairly be regarded as “constitutional”. Certainly they are durable and longstanding, but also certainly they are inconsistently enforced and incompletely specified.

Thanks in advance for your comments!