# The Pain Relief Promotion Act of 1999 and Physician-Assisted Suicide: A Call for Congressional Self-Restraint*

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## I. INTRODUCTION

Physician-assisted suicide is gaining prominence in our social consciousness as patients and physicians, legislatures and courts wrestle with how best to resolve the profound differences of opinion regarding its practice. This Comment addresses the legal and structural arguments surrounding whether the decision to permit or prohibit physician-assisted suicide should be made by Congress or by the states.

In *Washington v. Glucksberg*,[1] the 1997 landmark decision upholding a state ban on assisted suicide, the Supreme Court provided Congress and the American people with the following guidance: "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding *permits this debate to continue, as it should in a democratic society*."[2] In direct opposition to this sage advice, Congress is seeking to foreclose the physician-assisted suicide debate through its "heavy-handed"[3] amendment to the Controlled Substances Act of 1970.[4] This amendment, deceptively called the Pain Relief Promotion Act of 1999,[5] will effectively nullify the only law in the United States permitting physician-assisted suicide[6]—Oregon's Death with Dignity Act[7]—and

1. 521 U.S. 702 (1997).

2. *Id.* at 735 (emphasis added).

3. In a letter dated October 20, 1999, addressed to Rep. Henry Hyde (R-Ill.), the bill's chief sponsor, Assistant Attorney General Robert Raben wrote that imposing the penalties contemplated under the bill "would affirmatively interfere with state policy-making in a particularly heavy-handed way." Dave Hogan & Mark O'Keefe, *Anti-Suicide Bill Draws New Fire: A U.S. Justice Department Letter Says a House Measure to Block Oregon's Law Affects Other States' Rights to Make Their Own Policy*, THE OREGONIAN, Oct. 21, 1999, at A1.

4. In particular, the proposed bill amends 21 U.S.C. §§ 823 and 872(a) (1994). The Controlled Substances Act, 21 U.S.C. §§ 801–904 (1994), provides a uniform national standard for the control of potentially dangerous drugs, and empowers the Drug Enforcement Administration to enforce its provisions and penalties. H.R. REP. NO. 106-378, pt. 1, at 2 (1999). Section 841 of the Controlled Substances Act makes it "unlawful for any person [to] knowingly or intentionally . . . distribute, or dispense . . . a controlled substance" "[e]xcept as authorized by this [Control and Enforcement] subchapter." 21 U.S.C. § 841(a). The subchapter creates an exception allowing physicians to distribute or dispense controlled substances, provided the physician has applied for and received a federal prescribing license from the Attorney General. 21 U.S.C. § 823(f). *See also* H.R. REP. NO. 106-378, pt. 1, at 2 (1999).

5. H.R. 2260, 106th Cong. (1999); S. 1272, 106th Cong. (1999).

6. The Oregon physician-assisted suicide law is the only law of its kind in the world. Sam Howe Verhovek, *Oregon Reporting 15 Deaths in 1998 Under Suicide Law*, N.Y. TIMES, Feb. 18, 1999, at A1. The Northern Territory of Australia legalized assisted suicide for a period between July 1996 and March 1997. *Id.* In the Netherlands, assisted suicide is technically illegal, but it is rarely prosecuted. *Id.* It is important to note that

abrogate this debate in other states contemplating physician-assisted suicide legislation.[8] It is important to note that physician-assisted suicide refers to the voluntary self-administration of lethal drugs legally prescribed by a physician to provide aid in dying.[9] It is *not* active euthanasia, which would entail a physician directly ending the life of a patient.[10] The Pain Relief Promotion Act would prevent physician-assisted suicide in two respects, both of which are indirect.[11] First, the proposed bill subjects physicians who prescribe certain controlled substances to a terminally ill patient, for the purpose of hastening death, to revocation of their license to prescribe controlled substances, civil penalties, and up to twenty years imprisonment.[12] These controlled

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because physician-assisted suicide is, in a practical sense, not governed by law in the Netherlands, there is some evidence that cases of both voluntary and involuntary euthanasia are taking place. *Id.* Under Oregon law neither form of euthanasia is possible because of the strict controls placed on patient competency and because the lethal prescription is provided directly to the patient who self-administers the drugs. *See infra* note 36 (describing restrictions and safeguards of the Oregon law).

7. OR. REV. STAT. §§ 127.800–127.897 (Supp. 1998).

8. Maine voters considered, and ultimately rejected, a physician-assisted suicide referendum in November, 2000, after the Maine Legislature rejected a similar bill in 1998. Glenn Adams, *Right-to-Die Advocates File Referendum Petitions: Assisted Suicide Question May Go to Voters in 2000*, BANGOR DAILY NEWS, Sept. 27, 1999, at B1; *Suicide Voted Down*, WALL ST. J., Nov. 10, 2000, at A18. In California, AB 1592, legislation similar to Oregon's Death with Dignity Act, lapsed on inactive file on Feb. 3, 2000. *AB 1592 Assembly Bill—History*, *at* http://www.leginfo.ca.gov/pub/bill/asm/ab_1551-1600/ab_1592-20000203_history.html (last visited Feb. 11, 2000).

9. "Assisted suicide" is the "intentional act of providing a person with the medical means or the medical knowledge to commit suicide." BLACK'S LAW DICTIONARY 1447 (7th ed. 1999).

10. "Euthanasia" is the "act or practice of killing or bringing about the death of a person who suffers from an incurable disease or condition, [especially] a painful one, for reasons of mercy. Euthanasia is sometimes regarded by the law as second-degree murder, manslaughter, or criminally negligent homicide." *Id.* at 575. "Active euthanasia" is "[e]uthanasia performed by a facilitator ([usually] a physician) who not only provides the means of death but also carries out the final death-causing act." *Id.*

11. The tension between whether the Pain Relief Promotion Act directly or indirectly preempts Oregon state law is illustrated in the reports of two House Committees: the Committee on the Judiciary and the Committee on Commerce. The House Committee on the Judiciary reports: "H.R. 2260 does not preempt Oregon's law legalizing assisted suicide in specified circumstances. Its only legal effect is to forbid the use of those drugs which are federally controlled for this purpose." H.R. REP. NO. 106-378, pt. 1, at 11 n.45 (1999). However, the House Committee on Commerce reports that this bill does preempt Oregon law. "[Directing the Attorney General to give no force and effect to state law] would be a preemption of the Oregon 'Death with Dignity Act' because it would limit the options available to doctors acting under that state law." H.R. REP. NO. 106-378, pt. 2, at 9–10 (1999).

12. Revocation of a physician's national prescribing license means that the

substances, particularly barbiturates, are the only drugs that efficiently end a person's life without suffering.[13] Second, terminally ill patients desiring the assistance of a physician to help them die would necessarily have to resort to medications not controlled by the government,[14] none of which are as effective or reliable as the controlled substances, raising the specter of botched suicide attempts.

The Pain Relief Promotion Act is not yet federal law. At the time of this writing, the bill had passed the House of Representatives in 1999 but failed to come up for a vote in the Senate before the 106th Congress adjourned.[15] While in office, President Clinton publicly opposed physician-assisted suicide[16] but refrained from openly supporting the Pain Relief Promotion Act because it so blatantly interferes with states'

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physician is no longer permitted to prescribe certain substances controlled under 21 U.S.C. §§ 801–904 (1994). H.R. REP. NO. 106-378, pt. 1, at 3 n.4 (1999). "The Attorney General may deny an application for such registration if he determines that the issuance of such registration would be inconsistent with the public interest." 21 U.S.C. § 823(f) (1999). Factors to be considered in making this determination include recommendations of state licensing boards or professional disciplinary authority; the physician's experience in dispensing or conducting research regarding controlled substances; the physician's conviction record regarding dispensing controlled substances; compliance with local, state, and federal laws; and "[s]uch other conduct which may threaten the public health and safety." *Id.* Civil and criminal penalties for violation of the Controlled Substances Act can range up to life imprisonment and a fine up to four million dollars depending upon the substance in question. *Id.* § 841(b).

13. The drugs recommended for use under the Oregon physician-assisted suicide law are "high dose, short acting barbiturates, an anti-emetic, beta-adrenergic blocker and alcohol." THE CENTER FOR ETHICS IN HEALTH CARE, THE OREGON DEATH WITH DIGNITY ACT: A GUIDEBOOK FOR HEALTH CARE PROVIDERS 34 (Kathleen Haley & Melinda Lee eds., 1998).

14. Revocation of the prescribing license does not preclude the physician from practicing medicine or from prescribing substances that are not controlled by the federal government. However, revocation of one's national prescribing license is only one of several possible penalties to which physicians could be subjected under the Controlled Substances Act and the Pain Relief Promotion Act. 21 U.S.C. § 841(b). *See also infra* note 64 (discussing penalties for violation of the Controlled Substances Act).

15. On October 27, 1999, House Bill 2260 passed the House of Representatives by a vote of 271 to 156. *House Votes to Ban Doctor-Assisted Suicide*, L.A. TIMES, Oct. 28, 1999, at A14. Senator Don Nickles (R-Okla.) was unsuccessful in his attempt to get the bill passed through the Senate in the final days of December, 2000. Jim Barnett, *Nickles Will Continue Suicide Fight*, THE OREGONIAN, Dec. 8, 2000, at A6; John Giglio, *PRPA Not Passed as Congress Adjourns!*, *at* http://www.stopprpa.org/frame-intro.htm (last modified Dec. 19, 2000).

16. President Clinton signed the Federal Assisted Suicide Funding Restriction Act of 1997, 42 U.S.C. §§ 14401–14408 (1994), which prohibits the use of federal funds in support of physician-assisted suicide. Upon signing this bill, President Clinton commented that it "will allow the Federal Government to speak with a clear voice in opposing these practices," and warned that "to endorse assisted suicide would set us on a disturbing and perhaps dangerous path." Statement by President William Jefferson Clinton on Signing the Assisted Suicide Funding Restriction Act of 1997, 33 WEEKLY COMP. PRES. DOC. 617 (Apr. 30, 1997).

rights.[17] Although the legislation has been defeated for the moment, the bill will likely be reintroduced this year in the 107th Congress.[18]

Aside from explaining the provisions and proposed operation of the Pain Relief Promotion Act, this Comment will not attempt to argue its merits *per se*, that is, whether physician-assisted suicide should be permitted or prohibited.[19] On the contrary, this Comment is confined to exploring the constitutionality of Congress's attempt to regulate in a manner deliberately designed to overturn the will of Oregon voters, and how that regulation impinges upon the principles of federalism underlying the United States Constitution. Essentially, this Comment argues that physician-assisted suicide is an issue that should be decided state by state, not by Congress as a matter of national policy.

Part II sets out the specific provisions of Oregon's Death with Dignity Act, and its procedures and safeguards. This law was twice passed by Oregon voters.[20] In addition, the first two years of physician-assisted suicide under the Death with Dignity Act show that the law is working very well; contrary to the slippery slope fears of opponents, there has been no evidence to support the notion that the Act will lead to abuse or mistakes.[21]

Part II also examines the first, hasty congressional attempt to block Oregon's physician-assisted suicide law, the Lethal Drug Abuse

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17. *House Votes to Ban Doctor-Assisted Suicide*, *supra* note 15. President Clinton, in a speech on federalism, stated:

> [W]e've had this history of believing from the time of our founders that the national government would never have all the answers, and that the states should be seen as our friends and our partners because they could be laboratories for democracy. They could always be out there pushing the envelope of change. And certain things would be possible politically in some places that would not be possible in others.

President William Jefferson Clinton, *Remarks by the President to Forum of Federation Conference*, in Mont-Tremblant, Canada (Oct. 8, 1999), *at* http://www.pub.whitehouse.gov/uri-res/I2R?urn:pdi://oma.eop.gov.us/1999/10/8/18.text (visited Feb. 4, 2000).

18. Giglio, *supra* note 15.

19. There is an abundance of literature on this point. *See, e.g.*, Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases*, 82 MINN. L. REV. 895 (1998); Edward J. Larson, Essay, *Prescription for Death: A Second Opinion*, 44 DEPAUL L. REV. 461 (1995); Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1 (1985); Timothy Quill, *Physician Assisted Death: After the U.S. Supreme Court Ruling*, 75 U. DET. MERCY L. REV. 481 (1998); Thomas F. Schindler, *Assisted Suicide and Euthanasia: Ethical Dimensions of the Public Debate*, 72 U. DET. MERCY L. REV. 719 (1995); Patrick M. Curran, Jr., Note, *Regulating Death: Oregon's Death with Dignity Act and the Legalization of Physician-Assisted Suicide*, 86 GEO. L.J. 725 (1998).

20. *See infra* Part II.A.

21. *See infra* Part II.B.

Prevention Act of 1998.[22] The significance of this bill, although it failed to garner sufficient support for passage, is that it clearly shows the fundamental purpose of its successor bill, the Pain Relief Promotion Act of 1999.[23] Both bills, at their core, specifically seek to punish physicians for conduct that is legal under Oregon state law: dispensing controlled substances to competent and informed, terminally ill patients who voluntarily request such medication in order to hasten death. The effect of this legislation, if it becomes law, will be to deny Oregon voters the benefit of their state law.

Part III examines potential constitutional arguments that could be raised to prevent Congress's interference, through the Pain Relief Promotion Act, with Oregon state law. Several points will be made. First, Congress, through its Commerce Clause power, has the constitutional authority to regulate the medical use of controlled substances in the states.[24] Second, a constitutional argument that Congress may not regulate state medical practices, based on traditional state dominance in that area, is insufficient to limit Congress's commerce power.[25] Third, Congress may exercise its commerce power based on moral and social policy motives.[26] Finally, individual rights claims, under the First Amendment and the Due Process Clause, will likewise be insufficient to limit Congress's power to regulate controlled substances in the states.[27]

Part IV argues that, although Congress has and should have the power necessary to regulate some intrastate activity (such as how physicians prescribe controlled substances), in the area of physician-assisted suicide Congress should refrain from exercising this authority. Based on the important principles of federalism that apply in this debate, Congress should allow states to determine their own policy. First, physician aid in dying is a profound, personal decision, and policy governing it should be made as close to voters as practical. Because voters have more influence in, and greater opportunities to participate in, policy decisions at the state level than at the national level, states should determine for themselves whether physician-assisted suicide is an appropriate social policy.[28] Second, the importance of electoral accountability supports the argument that this social policy should be made by the decision-makers

22. H.R. 4006, 105th Cong. (1998). *See infra* Part II.C.
23. H.R. 2260, 106th Cong. (1999); S. 1272, 106th Cong. (1999). *See infra* Part II.C.
24. *See infra* Part III.A.
25. *See infra* Part III.B.
26. *See infra* Part III.C.
27. *See infra* Part III.D.
28. *See infra* Part IV.B.

most accountable to state voters.[29] Oregon voters have decided for themselves to permit physician-assisted suicide; members of Congress, all but seven unaccountable to Oregon voters, should not override that decision. Finally, federalism provides the opportunity for states to innovate in solving local issues. Through debate and experimentation, states mold and polish solutions uniquely tailored to the needs of their citizens. These solutions can then be borrowed and adapted, or rejected, by other states according to their needs.[30] However, when Congress preempts state law, as it proposes to do in this case, such innovation becomes a one-size-fits-all national social policy. This kind of federal approach to social policy denies the diversity of attitudes and beliefs strongly held by voters in different areas of the country. States should be permitted to choose or reject physician-assisted suicide based on the will of state voters, not forced to accept the dictates of a distant Congress.

## II. THE OREGON LAW AND CONGRESS'S RESPONSE

### *A. The Oregon Experiment*

In November, 1994, Oregon voters approved a ballot measure to legalize physician-assisted suicide.[31] Following a failed court challenge,[32] Oregon voters once again approved physician-assisted suicide by rejecting a proposal to repeal the Death with Dignity Act.[33] Finally, on October 27, 1997, the nation's first physician-assisted suicide

29. *See infra* Part IV.C.
30. *See infra* Part IV.D.
31. Oregon voters approved Ballot Measure 16, the Death with Dignity Act, by a 51% to 49% margin. H.R. REP. NO. 106-378, pt. 1, at 5 (1999).
32. On November 27, 1994, immediately following approval by voters of the Death with Dignity Act, a lawsuit was filed challenging the Act on equal protection and due process grounds. Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995), *rev'd*, Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997). The district court issued a preliminary injunction preventing implementation of the Act pending resolution of the case. H.R. REP. NO. 106-378, pt. 1, at 5 n.16. On August 3, 1995, the district court held the law to be unconstitutional as a violation of the Equal Protection Clause. *Lee*, 891 F. Supp. at 1437. However, on February 27, 1997, the Ninth Circuit Court of Appeals overturned the ruling because the plaintiffs lacked standing. *Lee*, 107 F.3d at 1386, 1391. The case was dismissed, and the district court was ordered to lift the injunction. *Id.*
33. This second affirmation of the Death with Dignity Act (i.e., the rejection of the repeal attempt) passed by 60% to 40% on November 4, 1997. H.R. REP. NO. 106-378, pt. 1, at 5 n.18.

law, the Oregon Death with Dignity Act,[34] went into effect.

The Death with Dignity Act provides a terminally ill patient the opportunity to request and receive from his or her physician a prescription for medication that may be used, at the discretion of the patient, for the purpose of ending the patient's life in a "humane and dignified manner."[35] There are a number of safeguards incorporated into the Oregon law to ensure that such medication is prescribed only to a person who is terminally ill, competent, and informed, and who has voluntarily requested the lethal medication.[36]

### *B. Results of the First Two Years Under the Death with Dignity Act*

The 1998 and 1999 annual reports of the Oregon Health Division, reported in the New England Journal of Medicine,[37] clearly show that during the first two years of legalized physician-assisted suicide, the Oregon law worked extremely well. In 1998, a total of twenty-three people received prescriptions for lethal medication under the law.[38] Of those, fifteen people chose to take the medication, six died from the

34. OR. REV. STAT. §§ 127.800–127.897 (Supp. 1998).

35. *Id.* § 127.805.

36. Patient eligibility under the Death with Dignity Act is restricted to adult, Oregon residents who have a medically confirmed terminal illness, defined as "an incurable and irreversible disease" that "will, within reasonable medical judgment, produce death within six (6) months." *Id.* §§ 127.800, 127.805. The eligible patient must request the medication to end her life by completing and signing a written form, witnessed by two persons, one of whom must not be (a) related to the patient by blood, marriage, or adoption, (b) entitled to any portion of the patient's estate, or (c) connected with a health care facility. *Id.* §§ 127.805, 127.810, 127.897. The two witnesses must attest that "the patient is capable, acting voluntarily, and is not being coerced to sign the request." *Id.* § 127.810. Following submission of the written request to the patient's attending physician, the eligible patient is referred to a consulting physician for confirmation that the patient is terminally ill, is acting voluntarily, and is not suffering from "a psychiatric or psychological disorder, or depression causing impaired judgment." *Id.* §§ 127.815, 127.820, 127.825. Both the attending and consulting physicians are charged with ensuring that the patient is acting voluntarily and with informed consent. *Id.* The eligible patient must make three voluntary requests for the lethal medication: an oral request, the written and witnessed request, and a final oral request which must be made not less than fifteen days following submission of the written request. *Id.* § 127.840. The attending physician must inform the patient of her opportunity to rescind the request at any time and in any manner, and must repeat this opportunity to rescind at the end of the fifteen-day waiting period. *Id.* §§ 127.815, 127.845, 127.850. The attending physician must again verify that the patient is making an informed and voluntary decision immediately prior to writing the prescription for medication. *Id.* § 127.815.

37. For the 1998 report, see Arthur E. Chin et al., *Legalized Physician-Assisted Suicide in Oregon—The First Year's Experience*, 340 NEW ENG. J. MED. 577 (1999). For the 1999 report, see Amy D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon—The Second Year*, 342 NEW ENG. J. MED. 598 (2000).

38. Chin et al., *supra* note 37, at 578.

underlying disease, and two were still alive on January 1, 1999.[39] In 1999, a total of thirty-three people received prescriptions for lethal medication: twenty-six took the medication, five died from the underlying disease, and two were still alive on January 1, 2000.[40] Death from the lethal medication represented only 6 out of 10,000 deaths in Oregon in 1998 and 9 out of 10,000 deaths in Oregon in 1999.[41] Patients who chose physician assistance to die were not disproportionately poor, less educated, or lacking in insurance or access to hospice.[42] Opponents' fears that this law would be forced upon or chosen by a disproportionate number of the poor, uneducated, and uninsured[43] proved unfounded.[44] Most importantly, in terms of this Comment, the controlled substances used to induce death—the very substances Congress is attempting to prohibit for this use—provided every one of the patients who used them a peaceful and uncomplicated death. Each patient fell into a coma within thirty minutes, and most patients died within one hour.[45] Without these medications[46] to facilitate a dignified death, physician-assisted suicide will cease to exist, or will revert to the use of covert acts by the physician to facilitate death[47] (at great personal risk to the physician and

39. *Id.* Of the two persons still alive on January 1, 1999, both died in 1999: one from ingestion of the lethal medication and the other from the underlying disease. Sullivan et al., *supra* note 37, at 599.

40. Sullivan et al., *supra* note 37, at 599.

41. *Id.* at 600.

42. Chin et al., *supra* note 37, at 582; Sullivan et al., *supra* note 37, at 602. In a comparison with all Oregon residents who died of similar diseases in the same year, patients who died by physician-assisted suicide were actually better educated than, but "otherwise demographically similar to," the control group. Sullivan et al., *supra* note 37, at 603. All but one of the patients who died by physician-assisted suicide were insured for major medical expenses. Chin et al., *supra* note 37, at 581; Sullivan et al., *supra* note 37, at 603. Finally, close to three-quarters of the patients who died by physician-assisted suicide were receiving hospice care at the time of death. Chin et al., *supra* note 37, at 581; Sullivan et al., *supra* note 37, at 603.

43. Washington v. Glucksberg, 521 U.S. 702, 732 (1997) (discussing the "risk of subtle coercion and undue influence in end-of-life situations" and the fear that "many might resort to [physician-assisted suicide] to spare their families the substantial financial burden of end-of-life health-care costs").

44. Chin et al., *supra* note 37, at 582; Sullivan et al., *supra* note 37, at 602.

45. Chin et al., *supra* note 37, at 578–79; Sullivan et al., *supra* note 37, at 599.

46. The medications prescribed were either secobarbital or pentobarbital. Chin et al., *supra* note 37, at 578. Prescriptions were also written for nonlethal medications to be used in conjunction with the above-mentioned drugs. *Id.*

47. Because directly inducing a patient's death is illegal, doctors are unwilling to openly discuss this practice. However, the group Compassion in Dying acknowledges that, prior to passage of the Oregon Death with Dignity Act, they would refer terminally ill patients "to doctors willing to covertly prescribe lethal doses of drugs." William

perhaps without the informed consent of the patient), or physicians and patients will be desperate enough to attempt assisted suicide with less effective and more dangerous drugs or other devices.[48]

### C. *The Road to Undermining Oregon's Law*

On November 5, 1997, within days of Oregon's physician-assisted suicide law going into effect, Thomas Constantine of the Drug Enforcement Administration (DEA), in reply to an inquiry from the House Committee on the Judiciary, took the official position that doctors prescribing controlled substances under the Oregon Death with Dignity Act would be violating the Controlled Substances Act, which would result in revocation of their national prescribing licenses.[49] The importance of this sanction should not be underestimated. The Controlled Substances Act requires physicians who dispense any of the specified controlled substances, from barbiturates to Tylenol with

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Claiborne, *In Oregon, Suicide Option Brings a Kinder Care*, WASH. POST, Apr. 29, 1998, at A1.

48. Several individuals and groups have taken action in an attempt to make the means of suicide more available to terminally ill patients. For example, Dr. Jack Kevorkian, now serving a 10- to 25-year prison term for second-degree murder, claims to have assisted in the deaths of over 100 seriously ill persons. Jim Irwin, *Right-to-Die Activists Continue Work with Kevorkian in Prison*, GRAND RAPIDS PRESS, Jan. 3, 2000, at B3. In addition, Derek Humphry and his Euthanasia Research & Guidance Organization sponsored a "Self-Deliverance New Technology Conference" in Seattle in late 1999 to promote development of technology to aid in do-it-yourself suicide. Carol M. Ostrom, *New Devices Evolve in Search for a Way to Die*, NEW ORLEANS TIMES-PICAYUNE, Dec. 19, 1999, at B2. One such device is the "debreather," which uses calcium hydroxide and sodium hydroxide to remove carbon dioxide from air breathed through a mask, thereby avoiding the "panic" reflex as the person peacefully dies of lack of oxygen. *Id.* Humphry, a founder of the Hemlock Society, also produced a 34-minute "how-to" program for committing suicide that was aired on cable television in Oregon in February, 2000. Kim Murphy, *Graphic How-To Program on Suicide to Air on TV in Oregon, Sparking Debate*, L.A. TIMES, Feb. 1, 2000, at A13. This program, "Final Exit," showed how a person could use ordinary workshop hardware to construct a device to produce death quickly and painlessly. *Id.* Moreover, Dr. Philip Nitschke of Australia is attempting to develop a "suicide pill" or potion that can be assembled easily from common ingredients that the government cannot ban. Ostrom, *supra.* These are extreme measures taken by serious individuals with the goal of producing the means to commit suicide safely and painlessly, and in a manner which the government will be unable to control.

49. Letter from The Honorable Thomas K. Constantine, Administrator of the Drug Enforcement Administration of the United States, to Chairman Henry J. Hyde, Committee on the Judiciary, U.S. House of Representatives, dated November 5, 1997 ("[D]elivering, dispensing, or prescribing a controlled substance with the intent of assisting a suicide would not be under any current definition a legitimate medical purpose."), *quoted in* H.R. REP. NO. 106-378, pt. 1, at 7 & nn.24–25 (1999). *See also* Steve Suo et al., *DEA Deems Suicide Law Illegal: Oregon Doctors Could Lose Their Right to Prescribe Some Drugs If They Assist in a Suicide*, THE OREGONIAN, Nov. 8, 1997, at A1.

codeine, to obtain a registration (or prescribing license) from the Attorney General.[50] Without this registration it is unlawful for a physician to dispense such substances,[51] meaning she could easily be put out of business. Moreover, the drugs regulated under the Controlled Substances Act are necessarily the very drugs that make suicide in a humane and dignified manner possible.[52]

Following a seven-month Justice Department investigation, events took an abrupt turn. Attorney General Janet Reno released a ruling that prescriptions for controlled substances for the purpose of causing death are to be considered part of the ordinary practice of medicine in Oregon.[53] Therefore, such prescriptions do constitute a "legitimate medical purpose,"[54] and the DEA lacks the authority to revoke the prescribing license of a physician utilizing the Oregon law.[55] This is the current state of the law: physicians in Oregon, and only Oregon, may dispense controlled substances to qualified patients, allowing those patients to self-administer the substances for the purpose of hastening

50. 21 U.S.C. § 822(2) (1994).

51. 21 U.S.C. § 841(a) (1994).

52. Ingestion of the lethal dose of a short-acting barbiturate (controlled substance) is expected to produce unconsciousness within five to fifteen minutes and death within five hours. THE CENTER FOR ETHICS IN HEALTH CARE, *supra* note 13, at 33.

53. Letter from The Honorable Janet Reno, Attorney General of the United States, to Chairman Henry J. Hyde, Committee on the Judiciary, U.S. House of Representatives, dated June 5, 1998 ("Adverse action against a physician who has assisted in a suicide in full compliance with the Oregon Act would not be authorized by the [Controlled Substances Act]."), *quoted in* H.R. REP. NO. 106-378, pt. 1, at 7–8 & nn. 26–28.

54. The critical issue in the controversy surrounding the Pain Relief Promotion Act is the interpretation given to the phrase "legitimate medical purpose." The underlying principle that allows a prescription for a controlled substance to be legal and valid is the requirement that it be "issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 C.F.R. § 1306.04(a) (2000). Attorney General Janet Reno ruled that because physician-assisted suicide is permitted under Oregon law, it is to be considered part of the ordinary practices of medicine in Oregon and therefore constitutes a "legitimate medical purpose." *See supra* note 53. The Pain Relief Promotion Act would override this position, requiring the Attorney General to "give no force and effect to State law authorizing or permitting assisted suicide." H.R. 2260, 106th Cong. § 101 (1999); S. 1272, 106th Cong. § 101 (1999). If this bill is enacted, prescribing controlled substances for the purpose of causing death would no longer be considered a "legitimate medical purpose"; physicians who did so would be in violation of the Controlled Substances Act and subject to its civil and criminal penalties. H.R. REP. NO. 106-378, pt. 2, at 6 (1999) ("[P]hysicians must be prepared to explain to DEA officials their use of these drugs, and they lose their registration and even risk criminal penalties if they prescribe such drugs for any purpose other than a 'legitimate medical purpose.'").

55. H.R. REP. NO. 106-378, pt. 1, at 7 (citing letter from The Honorable Janet Reno).

death.[56]

In an attempt to override the Attorney General's ruling, Rep. Henry Hyde (R-Ill.) and Sen. Don Nickles (R-Okla.) immediately introduced, in their respective chambers, the Lethal Drug Abuse Prevention Act of 1998.[57] This bill would have amended the Controlled Substances Act to effectively reinstate the DEA's original position, that is, to permit revocation of the prescribing license of any physician dispensing or distributing controlled substances for the purpose of assisting a patient to die. Although its sponsors declined to bring the bill to a House or Senate vote—the bill lacked crucial support from the American Medical Association[58]—the proposed Lethal Drug Abuse Prevention Act is important because it was the first incarnation of the Pain Relief Promotion Act of 1999.

In order to garner support among the medical community,[59] the bill's name was changed to the Pain Relief Promotion Act and several appealing provisions were added, such as protections for physicians who, in alleviating a patient's pain, may inadvertently cause the patient's death,[60] and funding for new palliative care research programs.[61] These

56. H.R. REP. NO. 106-378, pt. 1, at 24 ("As it currently stands, under both Oregon and federal law, it is acceptable for doctors in Oregon to use federally controlled substances for the purposes set forth in state law.").

57. H.R. 4006, 105th Cong. (1998); S. 2151, 105th Cong. (1998).

58. H.R. REP. NO. 105-683, pt. 1, at 24 (1998) ("[T]he American Medical Association strongly opposes the legislation.").

59. The Pain Relief Promotion Act gained the express support of the American Medical Association, National Hospice Organization, Hospice Association of America, American Academy of Pain Management, American Society of Anesthesiologists, Physicians for Compassionate Care, Christian Medical and Dental Society, Catholic Health Association, Hope Hospice and Palliative Care (Florida), Americans for Integrity in Palliative Care, American College of Osteopathic Family Physicians, Coalition of Concerned Medical Professionals, and the Oklahoma State Medical Association. H.R. REP. NO. 106-378, pt. 1, at 2 n.1.

In contrast, many other groups either formally oppose or have significant concerns about the proposed Pain Relief Promotion Act, including the American Alliance of Cancer Pain Initiatives, the American Pain Foundation, the American Pharmaceutical Association, the American Society of Health-System Pharmacists, the American Society of Pain Management Nurses, the American Academy of Family Physicians, the Oregon Medical Association, the Oregon Hospice Association, the San Francisco Medical Society, the Rhode Island Medical Society, and the Hospice Federation of Massachusetts. *Id.* at 32. Also opposed to the proposed bill are the California Medical Association, the American Nurses Association, the Oncology Nursing Society, and the National Association of Orthopaedic Nurses. H.R. REP. NO. 106-378, pt. 2, at 17.

60. The Pain Relief Promotion Act states that "alleviating pain or discomfort in the usual course of professional practice is a legitimate medical purpose for the dispensing, distributing, or administering of a controlled substance that is consistent with public health and safety, even if the use of such a substance may increase the risk of death." H.R. 2260, 106th Cong. § 101 (1999); S. 1272, 106th Cong. § 101 (1999).

61. The proposed bill allocates five million dollars to palliative care research and training. H.R. 2260, 106th Cong. § 202(b)(2) (1999); S. 1272, 106th Cong. § 202(b)(2)

enticing provisions were sufficient to sway the American Medical Association[62] and others despite the fact that the bill's sights remain trained on Oregon's physician-assisted suicide law. The Pain Relief Promotion Act states, "Nothing in this section authorizes intentionally dispensing, distributing, or administering a controlled substance for the purpose of causing death or assisting another person in causing death."[63] A significant difference between this version of the bill and the proposed Lethal Drug Abuse Prevention Act is that now the penalty for violation is not simply revocation of the physician's prescribing license but could also include life imprisonment for the physician.[64]

Given the controversial nature of physician-assisted suicide, consideration must be given to the legal arguments surrounding this

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(1999).

62. The American Medical Association (AMA) adamantly opposes physician-assisted suicide. Susan Duerksen, *AMA Backs Regulation of Pain Relievers: Divisive Vote Supports U.S. Bill Aimed at Doctor-Assisted Suicide*, SAN DIEGO UNION-TRIB., Dec. 9, 1999, at B3. AMA delegates met in San Diego, California, in December, 1999, where they voted to support the Pain Relief Promotion Act. *Id.* Concern over the possible "chilling effect" the legislation may have on physicians (that is, causing hesitation in prescribing adequate pain medication because of possible criminal penalties involved if the patient dies) prompted the AMA to seek changes in the legislation; however, the delegates also voted to support the bill even if changes were not made. *Id.* Of particular interest to the AMA is the bill's explicit acknowledgment that drugs can be appropriately used and still hasten death. *Id.* Interestingly, the AMA delegates also issued a statement that "henceforth our AMA will oppose any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties." *Id.*

63. H.R. 2260, 106th Cong. § 101 (1999); S. 1272, 106th Cong. § 101 (1999).

64. Depending on the particular controlled substance dispensed, the penalties under § 841(b) of the Controlled Substances Act can range up to "a term of imprisonment of not more than 20 years and if death or serious bodily injury results from the use of such substance shall be sentenced to a term of imprisonment of not less than twenty years or more than life," and a fine of up to one million dollars. 21 U.S.C. § 841(b)(1)(C) (1994).

The House Committee on the Judiciary reports, under Dissenting Views: "Because no provision in H.R. 2260 provides any authority negating the criminal law provisions provided in current law under § 841 of the [Controlled Substances Act], it is clear that the same criminal law penalties will apply to persons who dispense drugs which result in death." H.R. REP. NO. 106-378, pt. 1, at 34. Furthermore, the "Supreme Court has held affirmatively that the Government can use § 841 to criminally prosecute physicians registered under the [Controlled Substances Act] for misuse of controlled substances." *Id.* at 34 n.27 (citing United States v. Moore, 423 U.S. 122, 124 (1975)). Interestingly, the House Judiciary Committee voted down an amendment proposed by Rep. Howard L. Berman (D-Cal.) to insert the following provision: "Nothing in this section shall constitute any criminal liability other than that already existing." *Id.* at 19. This would seem to suggest a potential for increasing the criminal liability of physicians deemed to have dispensed controlled substances for the purpose of assisting suicide.

debate. Part III addresses the constitutional issue of whether Congress has the authority to regulate the prescription of medications and medical practices, the latter being an area traditionally regulated by the states. A related issue is whether congressional authority extends to moral and social causes or is confined to strictly economic regulation. Finally, constitutionally protected individual rights are explored as a potential limit on Congress's authority to regulate the prescription of medication. Following this discussion, Part IV examines federalist arguments advocating state determination, rather than congressional fiat, of the physician-assisted suicide issue.

## III. CONSTITUTIONAL ARGUMENTS

Our system of federalism requires that Congress act only in accordance with the specific enumerated powers granted to it by the Constitution.[65] Those legitimate governmental powers not granted to the federal government are expressly reserved to the States.[66] The question here is whether regulation of physicians' prescribing practices lies within the federal grant of power or is a power reserved to the States.

The main thrust of the Pain Relief Promotion Act is to amend 21 U.S.C. § 823 of the Controlled Substances Act by adding:

> (i)(1) For purposes of this Act and any regulations to implement this Act, alleviating pain or discomfort in the usual course of professional practice is a legitimate medical purpose for the dispensing, distributing, or administering of a controlled substance that is consistent with public health and safety, even if the use of such a substance may increase the risk of death. Nothing in this section authorizes intentionally dispensing, distributing, or administering a controlled substance for the purpose of causing death or assisting another person in causing death.
>
> (2) Notwithstanding any other provision of this Act, in determining whether a registration is consistent with the public interest under this Act, the Attorney General shall give no force and effect to State law authorizing or permitting assisted suicide or euthanasia.[67]

Does the Constitution provide Congress with sufficient authority to do so? To begin this discussion, we look to the constitutional authority invoked by Congress to regulate controlled substances under the Pain Relief Promotion Act and the Controlled Substances Act.

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65. U.S. CONST. art. I, § 8 (explicitly listing the powers of Congress). James Madison wrote: "The powers delegated by the proposed Constitution to the Federal Government, are few and defined. Those which are to remain in the State Governments are numerous and indefinite." THE FEDERALIST NO. 45, at 313 (James Madison) (Jacob E. Cooke ed., 1961).

66. U.S. CONST. amend. X ("The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.").

67. H.R. 2260, 106th Cong. § 101 (1999); S. 1272, 106th Cong. § 101 (1999).

### *A. The Commerce Power*

The main source of Congress's claimed authority to regulate local physicians' prescription of controlled substances is the Commerce Clause,[68] which states: "The Congress shall have Power . . . [t]o regulate Commerce . . . among the several States . . . ."[69] Congress invokes this power in its findings and declarations section of the Controlled Substances Act, which states: "A major portion of the traffic in controlled substances flows through interstate and foreign commerce."[70] As to those purely local or intrastate incidents of traffic in controlled substances, the congressional findings state that such activities "nonetheless have a substantial and direct effect upon interstate commerce" because many controlled substances are "transported in interstate commerce."[71] Are these claims sufficient to bring regulation of prescription of particular substances within the power of Congress?

#### *1. Categories of Activities That May Be Regulated*

According to the Supreme Court's recent clarification of Commerce Clause doctrine in *United States v. Lopez*,[72] Congress may regulate three

68. The House Committee on Commerce finds constitutional authority for the Pain Relief Promotion Act in Article I, Section 8, Clause 3 ("The Congress shall have Power . . . [t]o regulate Commerce . . . among the several States . . . ."). H.R. REP. NO. 106-378, pt. 2, at 10 (1999). In addition to this clause, the House Committee on the Judiciary also finds constitutional authority for this bill in Article I, Section 8, Clause 1 ("The Congress shall have Power [t]o . . . provide for the . . . general Welfare of the United States . . . ."), and Clause 18 ("The Congress shall have Power . . . [t]o make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof."). H.R. REP. NO. 106-378, pt. 1, at 25 (1999).

69. U.S. CONST. art. I, § 8, cl. 3.

70. 21 U.S.C. § 801(3) (1994).

71. *Id.*

72. 514 U.S. 549 (1995). *Lopez* marks the first time in sixty years that the Supreme Court has held a federal statute invalid as beyond Congress's commerce power. The Gun-Free School Zones Act of 1990 made it a federal offense "for any individual knowingly to possess a firearm at a place that the individual knows, or has reasonable cause to believe, is a school zone." *Id.* at 551 (quoting 18 U.S.C. § 922(q)(1)(A) (Supp. V 1988)). The defendant was a 12th-grade student who carried a .38-caliber handgun and ammunition onto high school grounds in San Antonio, Texas. *Id.* In striking down the statute, the Court emphasized that the statute "by its terms has nothing to do with 'commerce' or any sort of economic enterprise, however broadly one might define those terms." *Id.* at 561. *See also* discussion *infra* notes 84–85, 99, and accompanying text.

broad categories of activities under its commerce power.[73] These categories are: (a) the use of the "channels" of interstate commerce, such as highways, waterways, and air traffic; (b) the "instrumentalities" of interstate commerce, such as people, machines, and "things" used in effecting interstate commerce; and (c) activities which have a "substantial relation" to interstate commerce, meaning "those activities that substantially affect interstate commerce."[74] The congressional findings section of the Controlled Substances Act, therefore, claims that Congress is empowered to act under the Commerce Clause because controlled substances flow through, or are transported in, interstate commerce, thus substantially affecting interstate commerce. Once an activity is found to be within the sphere of Congress's commerce power, Congress has great latitude in its ability to regulate the activity.[75] The main question, then, is whether prescribing medication is an activity that substantially affects interstate commerce.

### 2. *Commercial Versus Noncommercial Activity*

The Controlled Substances Act regulates the supply of designated substances in the marketplace.[76] Prescribing or dispensing[77] these substances directly affects their demand in the marketplace. Furthermore, the act of prescribing medication is a commercial act in that the physician performs this service in return for compensation.[78] Therefore, the act of prescribing medication is a commercial activity. Before moving to the second question—whether this commercial activity substantially affects interstate commerce—we must examine the significance of finding that prescribing medication is a commercial,

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73. *Lopez*, 514 U.S. at 558–59.

74. *Id.*

75. The Supreme Court held that the commerce power "is the power to regulate; that is, to prescribe the rule by which commerce is to be governed. This power, like all others vested in congress, is complete in itself, may be exercised to its utmost extent, and acknowledges no limitations, other than are prescribed in the constitution." Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 196 (1824).

76. 21 U.S.C. §§ 822–830 (1994).

77. 21 U.S.C. § 802(10) (1994) ("The term 'dispense' means to deliver a controlled substance to an ultimate user . . . by, or pursuant to the lawful order of, a practitioner, including the prescribing and administering of a controlled substance . . . . The term 'dispenser' means a practitioner who so delivers a controlled substance to an ultimate user . . . .").

78. Prescribing medication is one of the many services performed by a physician, for which she is paid by the patient, by an insurer, or through a government program. The rare circumstance in which a physician prescribes medicine on a completely voluntary and uncompensated basis is not considered here. Furthermore, it is unrealistic to think that physicians could circumvent the Controlled Substances Act by merely giving away such controlled substances.

rather than noncommercial, activity.

The narrow majority in *Lopez*,[79] in invalidating a federal statute, emphasized that the statute at issue was regulating a *noncommercial* activity, possession of a gun within a school zone.[80] Writing for the Court, Chief Justice Rehnquist remarked: "The [Gun-Free School Zones] Act neither regulates a commercial activity nor contains a requirement that the possession be connected in any way to interstate commerce."[81] Justice Kennedy, in his concurrence, wrote: "[U]nlike the earlier cases to come before the Court here neither the actors nor their conduct has a commercial character, and neither the purposes nor the design of the statute has an evident commercial nexus."[82] Justice Thomas, concurring, wrote: "[T]here was no question that activities wholly separated from business, such as gun possession, were beyond the reach of the commerce power."[83]

The recent decision in *United States v. Morrison*[84] affirmed the *Lopez* framework in holding that the commerce power does not extend to providing civil remedies to victims of crimes of violence motivated by gender because such crimes "are not, in any sense of the phrase, economic activity."[85] Whether the activity being regulated is commercial

79. *Lopez* was decided with a five-member majority; the opinion was written by Chief Justice Rehnquist. Justices Kennedy (with whom Justice O'Connor joined) and Thomas filed separate concurring opinions, while Justices Stevens, Souter, and Breyer (with whom Justices Stevens, Souter, and Ginsburg joined) filed dissenting opinions. Obviously, any change in the Court's membership could represent a substantial departure on the *Lopez* reasoning and outcome.

80. *See supra* note 72 (discussing background of *Lopez*). It is noteworthy that Justice Breyer, with whom Justices Stevens, Souter, and Ginsburg joined, in his dissent rejects the "critical distinction between 'commercial' and noncommercial 'transaction[s].'" *Lopez*, 514 U.S. at 627 (Breyer, J., dissenting) (quoting 514 U.S. at 561) (alteration in original). Such an approach "would distinguish between two local activities, each of which has an identical effect upon interstate commerce, if one, but not the other, is 'commercial' in nature." *Id.* This, Justice Breyer warns, is to return to the disreputable approach of determining Congress's commerce power based on formulas such as "production" or "indirect" effects. *Id.* at 627–28 (quoting Wickard v. Filburn, 317 U.S. 111, 120 (1842)). However, Justice Breyer goes on to add that "if a distinction between commercial and noncommercial activities is to be made, this is not the case in which to make it," because of the close link he finds between gun possession in school zones and education, itself a commercial activity. *Id.* at 628.

81. *Lopez*, 514 U.S. at 551.

82. *Id.* at 580 (Kennedy, J., concurring).

83. *Id.* at 599 (Thomas, J., concurring).

84. 120 S. Ct. 1740 (2000).

85. *Id.* at 1751. The Court declared: "[T]hus far in our Nation's history our cases have upheld Commerce Clause regulation of intrastate activity only where that activity is economic in nature." *Id.*

or noncommercial[86] turns out to play an important role in satisfying the second question: whether the activity regulated substantially affects interstate commerce so that it may be regulated by Congress rather than by the states.

### 3. *Aggregation of Intrastate Commercial Activity*

Turning to this second question, we ask: Does the prescription of medication substantially affect interstate commerce? Looking at the situation most favorable to states' rights, how is interstate commerce substantially affected when a patient visits her local physician to request a prescription for medication that is locally manufactured and distributed? After all, the Supreme Court has declared that "commerce, which is completely internal, which is carried on between man and man in a state, or between different parts of the same state, and which does not extend to or affect other states" is not within Congress's commerce power.[87] Congress, in its findings and declarations section of the Controlled Substances Act, states that strictly local dispensing of controlled substances has a substantial and direct effect upon interstate commerce because (a) the substances dispensed usually have been transported in interstate commerce;[88] (b) "[l]ocal distribution . . . contribute[s] to swelling the interstate traffic in such substances";[89] (c) since there is no differentiation between substances locally manufactured and distributed and interstate substances, it is not feasible to control the substances differently;[90] and (d) federal control of local dispensing of controlled substances is essential to controlling interstate dispensing.[91] These claims appeal to the Supreme Court's 1942 decision in *Wickard v. Filburn*,[92] permitting Congress to regulate purely intrastate activities that, when aggregated with like activities, substantially affect interstate commerce.

In *Wickard*, regarding a single wheat farmer's production of wheat for

86. For an interesting perspective on Commerce Clause analysis, see Grant S. Nelson & Robert J. Pushaw, Jr., *Rethinking the Commerce Clause: Applying First Principles to Uphold Federal Commercial Regulations but Preserve State Control Over Social Issues*, 85 IOWA L. REV. 1, 11–12 (1999) (advocating a decisive distinction between commercial and noncommercial activities and proposing the existence of congressional authority to regulate all commercial activities that affect more than one state but no congressional authority, through the Commerce Clause, to regulate noncommercial activities).

87. Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 194 (1824).

88. 21 U.S.C. § 801(3) (1994).

89. *Id.* § 801(4).

90. *Id.* § 801(5).

91. *Id.* § 801(6).

92. 317 U.S. 111 (1942).

his own home consumption, the Court held: "That [the farmer's] own contribution to the demand for wheat may be trivial by itself is not enough to remove him from the scope of federal regulation where, as here, his contribution, *taken together with that of many others similarly situated*, is far from trivial."[93] Although the Court in *Lopez* referred to the *Wickard* holding as "perhaps the most far reaching example of Commerce Clause authority over intrastate activity,"[94] the Court did not cut back on the holding. Instead the Court distinguished *Lopez* from *Wickard* on the basis of commercial versus noncommercial activity, noting that *Wickard* "involved economic activity in a way that the possession of a gun in a school zone does not."[95] This distinction proved critical to the decision in *Lopez*. Because possessing a gun in a particular place is not itself a commercial activity, the Court held that:

> [The Gun-Free School Zones Act] is not an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated. It cannot, therefore, be sustained under our cases upholding regulations of activities that arise out of or are connected with a *commercial transaction*, which viewed in the aggregate, substantially affects interstate commerce.[96]

The *Lopez* Court also hinted that perhaps its decision might have gone the other way if Congress had included an interstate commerce component to the gun possession, such as requiring that the gun in issue had been transported in interstate commerce.[97] However, absent this "express jurisdictional element which might limit its reach to a discrete set of firearm possessions that additionally have an explicit connection with or effect on interstate commerce,"[98] the regulation of this noncommercial activity failed to satisfy the substantial effects test and

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93. *Id.* at 127–28 (emphasis added).
94. United States v. Lopez, 514 U.S. 549, 560 (1995).
95. *Id.*
96. *Id.* at 561 (emphasis added).
97. *Id.* at 561–62. Specifically, the Court stated:

> [The Gun-Free School Zones Act] contains no jurisdictional element which would ensure, through case-by-case inquiry, that the firearm possession in question affects interstate commerce. For example, in United States v. Bass, 404 U.S. 336 (1971), the Court interpreted former 18 U.S.C. § 1202(a), which made it a crime for a felon to 'receive[e], posses[s], or transpor[t] in commerce or affecting commerce . . . any firearm.' The Court interpreted the possession component of § 1202(a) to require an additional nexus to interstate commerce . . . .

*Id.* (citation omitted) (alterations in original).
98. *Id.* at 562.

was therefore beyond Congress's commerce power.

In summary, where the activity regulated is a commercial activity, Congress may aggregate purely local acts in determining whether the sum of such acts substantially affects interstate commerce. However, where the activity is noncommercial, this aggregation may not be permitted.[99] For the purposes of this Comment, because the act of prescribing and dispensing medication is generally a commercial activity,[100] the aggregation of even purely intrastate incidents of dispensing locally manufactured and distributed drugs can be found to have a "substantial affect" on the interstate commerce of the substances Congress intends to control. In meeting the substantial effect requirement, the Court's interpretation of the Commerce Clause provides Congress with great latitude in regulating that commercial activity. Therefore, Congress has the constitutional authority to regulate the prescription and dispensing of controlled substances. In reality, Congress should have the authority to regulate such substances; if not, the bulk of our federal drug laws would be nullified. The real issue involves how Congress uses this constitutional authority. It is better that Congress has the power to regulate controlled substances, but that it do so with due respect for the demonstrated will of state voters.

### *B. Traditional State Dominance in Medical Regulation*

A second possible constitutional argument against the Pain Relief Promotion Act concerns implied limits on congressional authority due to traditional state dominance in regulating medical practices. In *United States v. Lopez*,[101] the Supreme Court defended state sovereignty by rejecting the Government's argument that Congress could regulate gun possession in a school zone.[102] The Court stated that if Congress were permitted to so regulate, "it is difficult to perceive any limitation on federal power, even in areas such as criminal law enforcement or education where States historically have been sovereign."[103] This statement seems to indicate that federalism will protect state sovereignty in certain historically state-dominated areas. In addition to criminal law enforcement and education, regulation of state medical practices is such an area where states historically have been sovereign.

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99. United States v. Morrison, 120 S. Ct. 1740, 1754 (2000) ("We accordingly reject the argument that Congress may regulate noneconomic, violent criminal conduct based solely on that conduct's aggregate effect on interstate commerce.").

100. *See supra* notes 76–78 and accompanying text.

101. 514 U.S. 549 (1995).

102. *See supra* note 72 and accompanying text.

103. *Lopez*, 514 U.S. at 564.

In *Linder v. United States*,[104] the Court explicitly stated: "Obviously, direct control of medical practice in the States is beyond the power of the Federal Government."[105] *Linder* concerned the Harrison Narcotic Law[106] through which Congress used its taxing authority[107] to regulate, among other things, the dispensing of controlled substances. The Court went on to confine Congress's power to interfere in state medical practices, declaring: "Incidental regulation of such [medical] practice by Congress through a taxing act cannot extend to matters plainly inappropriate and unnecessary to reasonable enforcement of a revenue measure."[108] In other words, Congress may not use its authority, here through its power to tax, to unnecessarily interfere with state-sanctioned medical practices.

Second, Congress itself has declared its intention to proscribe federal interference with state medical practices. The preamble to the Health Insurance for the Aged Act, better known as Medicare, states:

> *Prohibition against any Federal interference.* Nothing in this subchapter 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* . . . or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.[109]

Why, then, is Congress, through the Pain Relief Promotion Act, preempting Oregon law with respect to its medical practices, that is, legitimate prescription of medications to patients? The answer again turns on the fact that prescribing medication is not exclusively a matter of medical practice but is also a commercial act.[110] In the line of cases recently recognizing areas of state sovereignty based on traditional state

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104. 268 U.S. 5 (1925).
105. *Id.* at 18.
106. The Harrison Narcotic Law, approved in 1914, required persons who "produce, import, manufacture, compound, deal in, dispense, sell, distribute, or give away opium or coca leaves," or their derivatives to register with the "Collector of Internal Revenue" and pay a special tax. *Id.* at 12. The law prohibited the use or possession of these drugs, with one relevant exception: "the dispensing or distribution of any of the aforesaid drugs to a patient by a physician . . . registered under this Act in the course of his professional practice." *Id.* at 13.
107. U.S. CONST. art. I, § 8, cl. 1 ("The Congress shall have Power To lay and collect Taxes . . . .").
108. *Linder*, 268 U.S. at 18.
109. 42 U.S.C. § 1395 (1994) (emphasis added).
110. *See supra* notes 76–78 and accompanying text (discussing the commercial aspect of prescribing medication).

dominance, none involved regulation of a commercial act.[111] As discussed earlier,[112] once an activity is found to be within the commerce power, Congress's authority to regulate it is plenary. This power "is complete in itself, may be exercised to its utmost extent, and acknowledges no limitations [other] than are prescribed in the constitution."[113] Therefore, traditional state dominance would seem to protect the noncommercial aspects of regulating medical practices, such as licensing physicians. However, when a commercial aspect of medical practice, such as prescribing medication, is found to substantially affect interstate commerce, then Congress has the constitutional authority to regulate it, regardless of traditional state dominance in regulating that activity.

### *C. Congress's Motive Is Moral and Social, Not Purely Economic*

A third argument that Congress's Commerce Clause power should be limited in the case of physician-assisted suicide concerns the moral and social motive behind Congress's proposed regulation. The Commerce Clause authorizes Congress to regulate interstate commerce,[114] but overriding Oregon's physician-assisted suicide law is a moral and social policy decision, not an economic decision.[115] Should Congress be permitted to extend its Commerce Clause authority to preempt state laws for moral and social preferences? The answer is a bittersweet "Yes." On the one hand, history has shown several instances in which federal intervention was necessary to protect the civil rights of individuals from the parochial interests of the states.[116] Without such authority much of

111. *See* Printz v. United States, 521 U.S. 898 (1997) (holding that Congress lacks the power to require state law enforcement officers to conduct background checks on prospective gun purchasers); New York v. United States, 505 U.S. 144 (1992) (holding that Congress lacks the power to force a state to enact particular legislation of Congress's choosing regarding "tak[ing] title" to low-level radioactive waste generated in a state); Gregory v. Ashcroft, 501 U.S. 452 (1991) (holding that Congress lacks the power to interfere with a state's mandatory retirement provisions for state judges through its Age Discrimination in Employment Act).

112. *See supra* Part III.A.

113. Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 195 (1824).

114. U.S. CONST. art. I, § 8, cl. 3 ("The Congress shall have Power . . . [t]o regulate Commerce . . . among the several states . . . .").

115. Tom Stacy, *Whose Interests Does Federalism Protect?*, 45 U. KAN. L. REV. 1185, 1185 n.5 (1997) ("The overriding aim of the Commerce Clause is to give Congress authority to foster an effective interstate economy. This aim is apparent in the text and overall structure of Article I." (citation omitted)).

116. Barry Friedman, *Valuing Federalism*, 82 MINN. L. REV. 317, 367 (1997) ("Calhoun's nullification movement in response to the tariff, slavery, the Civil War followed by Reconstruction, Jim Crow, and the struggle over civil rights are all events in which southern states made choices that ultimately led the national government to take power from the states.").

our federal civil rights legislation would be unconstitutional.[117] In *Heart of Atlanta Motel, Inc. v. United States*,[118] the Supreme Court upheld Title II of the 1964 Civil Rights Act[119] as it applied to the racially discriminatory practices of a modest downtown Atlanta motel. The Court stated:

> In framing Title II of this Act Congress was also dealing with what it considered a moral problem. But that fact does not detract from the overwhelming evidence of the disruptive effect that racial discrimination has had on commercial intercourse.... Congress was not restricted by the fact that the particular obstruction to interstate commerce with which it was dealing was also deemed a moral and social wrong.[120]

This reasoning was also applied in *Katzenbach v. McClung*,[121] the companion case to *Heart of Atlanta Motel*, in which a small family-owned restaurant refused to seat African-Americans inside the restaurant; that is, African-Americans could only purchase take-out food.[122] Despite the fact that there was not even a claim that interstate travelers ate at the restaurant,[123] Congress was permitted to apply Title II of the Civil Rights Act[124] to end this racially discriminatory practice. The Court ultimately resorted to a finding that, since forty-six percent of the meat served in the restaurant was procured from out-of-state sources[125]—a commercial activity that can be aggregated—Congress was empowered to make a moral and social policy determination regarding where African-Americans were permitted to sit in a restaurant.

The scope of the Commerce Clause is indeed broad. This point was summarized in *United States v. Darby*:[126] "The motive and purpose of a

117. Joseph D. Grano, *Teaching the Commerce Clause*, 78 B.U. L. REV. 1163, 1174 (1998) ("In basing the 1964 Civil Rights Act on the Commerce Clause, for example, Congress may have been concerned more with morality and human dignity than with the disruptive effects of discrimination on the economy.").

118. 379 U.S. 241 (1964).

119. Pub. L. No. 88-352, § 201, 78 Stat. 243 (codified as amended at 42 U.S.C. § 2000a (1994)). Title II of the 1964 Civil Rights Act provides that "[a]ll persons shall be entitled to the full and equal enjoyment of the goods, services... and accommodations of any place of public accommodation... without discrimination or segregation on the ground of race, color, religion, or national origin." 42 U.S.C. § 2000a(a) (1994).

120. *Heart of Atlanta Motel*, 379 U.S. at 257.

121. 379 U.S. 294 (1964).

122. *Id.* at 296.

123. *Id.* at 298.

124. *See supra* note 119 (discussing Title II of the 1964 Civil Rights Act).

125. *McClung*, 379 U.S. at 296.

126. 312 U.S. 100 (1941).

regulation of interstate commerce are matters for the legislative judgment upon the exercise of which the Constitution places no restriction and over which the courts are given no control."[127] This clearly illustrates that Congress can exercise its immense commerce power to restrict the use of controlled substances for the explicit purpose of nullifying the legitimate practice of physician-assisted suicide in Oregon.

In sum, where the activity being regulated falls within Congress's commerce power, the moral and social motives spurring the regulation are immaterial, and Congress has the power to so regulate. Such motives become truly influential during the process of deciding whether Congress *should* so regulate. With respect to the Pain Relief Promotion Act, the Dissenting Views section of the House Committee on the Judiciary reports:

> While there have been instances in our Nation's history where it was appropriate for Federal law to supercede State law in order to fulfill constitutional imperatives, such as the realm of civil rights, this is not one of those occasions. States historically have regulated the medical profession, and the Federal Government has no constitutional authority or imperative to do so now.[128]

Should this argument fall on deaf ears in Congress, a constitutional argument based on motive will not limit Congress's power to enact the Pain Relief Promotion Act.

### *D. Individual Rights Arguments*

Two additional arguments have been asserted in defense of patients' rights, and may be used to argue in favor of limiting Congress's power to interfere with physician-assisted suicide. First, an argument could be made that the First Amendment protects the physician–patient relationship such that Congress may not interfere with a doctor's advice to the patient.[129] A second argument is that an individual right or liberty

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127. *Id.* at 115.

128. H.R. REP. NO. 106-378, pt. 1, at 38 (1999).

129. A related argument is that the Pain Relief Promotion Act is unconstitutionally vague because of the difficulty in determining a physician's intent in prescribing large doses of pain relieving medication. A statute is void for vagueness if it fails to give "the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly." Grayned v. City of Rockford, 408 U.S. 104, 108 (1972). Under the Pain Relief Promotion Act, a physician may legitimately prescribe controlled substances with the intent to alleviate pain, "even if the use of [such a substance] may increase the risk of death." H.R. 2260, 106th Cong. § 101 (1999). However, the same physician prescribing the same medication to the same patient but with the intent to hasten death is subject to severe penalties. *See supra* note 64. The chilling effect this ambiguity creates for physicians is described in the House Committee on Commerce

interest exists under the Due Process Clause that allows a patient to hasten his or her own death. However, both of these arguments to date have been unsuccessful in curbing Congress's power.

### *1. First Amendment Protection of Physician–Patient Relationship*

How much protection does the First Amendment afford to the physician–patient relationship? In an area closely analogous to Congress's attempt to nullify Oregon's physician-assisted suicide law, the DEA and Congress took action to prohibit physicians from prescribing marijuana for medical use[130] after voters in California and Arizona overwhelmingly passed initiatives authorizing such use.[131] In *Conant v. McCaffrey*,[132] plaintiffs (physicians, patients, and nonprofit organizations) brought action against the United States government, seeking a preliminary injunction to prevent the DEA from revoking the national prescribing registration of, and instituting criminal actions against, physicians who advise their patients regarding the medical use

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report:

> [T]his bill raises the prospect of the Drug Enforcement [Administration] (DEA) "second guessing" a physician or a health care professional's intent in prescribing and using large doses of opiates for patients who are in severe pain. Title I of the bill could turn the DEA into a medical oversight body charged with investigating the "intent" and "purpose" of a physician's care for a patient. The threat of investigation alone could scare health care professionals away from providing quality care to the neediest patients.

H.R. REP. NO. 106-378, pt. 2, at 17 (1999).

130. The Drug Enforcement Administration, in conjunction with the Clinton Administration, issued "Administration Response to Arizona Proposition 200 and California Proposition 215," describing specific sanctions it intended to impose on physicians who recommend marijuana, a Schedule I controlled substance, to patients. Notice, 62 Fed. Reg. 6164 (Feb. 11, 1997). For its part, Congress proposed, and ultimately failed to pass, the Drug Abuse Prevention Act of 1997, S. 40, 105th Cong. (1997), which would have subjected a physician who advised a patient regarding the medical use of marijuana to revocation of her national prescribing license, criminal penalties, and fines.

131. Eric E. Sterling, *Drug Policy: A Smorgasbord of Conundrums Spiced by Emotions Around Children and Violence*, 31 VAL. U. L. REV. 597, 643 (1997). In November, 1996, California voters approved, by a 55% margin, Proposition 215, which provides "for a medical use defense to a prosecution of marijuana possession, distribution, or cultivation." *Id.* at 628. Arizona voters passed, by more than 65%, Proposition 200, which authorizes physicians to prescribe marijuana, as well as other Schedule I controlled substances under the Arizona Controlled Substances Act, to seriously ill or terminally ill patients. *Id.* at 629.

132. 172 F.R.D. 681 (N.D. Cal. 1997).

of marijuana,[133] as permitted by the California Compassionate Use Act.[134] The district court observed that the physician–patient relationship is a protected relationship for First Amendment purposes: "Although the Supreme Court has never held that the physician–patient relationship, as such, receives special First Amendment protection, its case law assumes, without so deciding, that the relationship is a protected one."[135] As such, the District Court held that the First Amendment protects physician–patient communication regarding the medical use of marijuana, but only up to the point at which the physician's recommendation makes her liable for aiding and abetting or conspiracy to violate federal or state drug laws.[136] The crucial difference between physicians advising patients on the medical use of marijuana (a controlled substance) and physicians' conduct under the Oregon physician-assisted suicide law is that in Oregon physicians step beyond merely advising patients to actually prescribing barbiturates (controlled substances). A First Amendment protected speech[137] argument is insufficient here.[138]

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133. *Id.* at 685–87. The court also granted plaintiffs class certification, defined as follows:

> (1) All licensed physicians practicing in the State of California who treat patients diagnosed with HIV/AIDS, cancer, glaucoma, and/or seizures or muscle spasms associated with a chronic, debilitating condition, and who, in the context of a bona fide physician–patient relationship, discuss, approve, or recommend the medical use of marijuana for these patients based on the physician's best medical judgment; and
>
> (2) All patients in the State of California diagnosed with HIV/AIDS, cancer, glaucoma, and/or seizures or muscle spasms associated with a chronic, debilitating condition, who, in the context of a bona fide physician–patient relationship, communicate with their physicians about the medical use of marijuana.

*Id.* at 693.

134. California voters passed the initiative known as Proposition 215 or the Compassionate Use Act of 1996 in November, 1996. The Act provides, in pertinent part, that:

> seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.

CAL. HEALTH & SAFETY CODE § 11362.5(b)(1)(A) (West Supp. 2000).

135. *Conant*, 172 F.R.D. at 694. *See also* Planned Parenthood v. Casey, 505 U.S. 833, 884 (1992) (finding that the "doctor–patient relation does not underlie or override . . . the right to make family decisions and the right to physical autonomy"); City of Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416, 445 (1983) (discussing relationship of trust between patient and doctor).

136. *Conant*, 172 F.R.D. at 700.

137. *See* U.S. CONST. amend. I ("Congress shall make no law . . . abridging the freedom of speech . . . .").

138. However, the *Conant* decision is instructive in its interpretation of the DEA's authority to revoke a physician's prescribing license under the Controlled Substances

### 2. *Liberty Interest Under the Due Process Clause*

In *Washington v. Glucksberg*,[139] plaintiffs (physicians, terminally ill patients, and a nonprofit organization) challenged a Washington statute banning physician-assisted suicide on the grounds that such a ban violated the Fourteenth Amendment's Due Process Clause.[140] The Supreme Court, in a long line of cases, has held that "liberty" in the Due Process Clause protects such personal and intimate matters as the rights to marry,[141] to have children,[142] to direct the education and upbringing of one's children,[143] to marital privacy,[144] to use contraception,[145] to bodily integrity,[146] and to abortion.[147] In a closely analogous case, *Cruzan v. Director, Missouri Department of Health*,[148] the Court held that the Constitution granted competent persons a "constitutionally protected right to refuse lifesaving hydration and nutrition."[149] From this, the plaintiffs in *Glucksberg* asserted the argument that the broad, individualistic principles reflected in these cases protect the "liberty of competent, terminally ill adults to make end-of-life decisions free of undue government interference."[150] The Court in *Glucksberg*, however,

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Act. In particular, the Controlled Substances Act provides for revocation of the prescribing license in the event the physician's conduct is "inconsistent with the public interest." 21 U.S.C. § 823(f) (1994). The district court in *Conant* held that the term "public interest," as used in 21 U.S.C. § 823, encompasses "only actual violations of state and federal drug law." *Conant*, 172 F.R.D. at 699. On the one hand, this interpretation limits the potentially broad application of "[s]uch other conduct which may threaten the public health and safety." 21 U.S.C. § 823(f)(5). On the other hand, if the Pain Relief Promotion Act succeeds in making the prescription of controlled substances for the purpose of assisting suicide a violation of federal law, physicians will be subject to the penalties of the Controlled Substances Act.

139. 521 U.S. 702 (1997).

140. *Id.* at 705–06. *See* U.S. CONST. amend. XIV, § 1 ("[N]or shall any State deprive any person of life, liberty, or property, without due process of law . . . .").

141. *See* Loving v. Virginia, 388 U.S. 1 (1967).

142. *See* Skinner v. Oklahoma *ex rel.* Williamson, 316 U.S. 535 (1942).

143. *See* Meyer v. Nebraska, 262 U.S. 390 (1923); Pierce v. Society of Sisters, 268 U.S. 510 (1925).

144. *See* Griswold v. Connecticut, 381 U.S. 479 (1965).

145. *See* Eisenstadt v. Baird, 405 U.S. 438 (1972).

146. *See* Rochin v. California, 342 U.S. 165 (1952).

147. *See* Planned Parenthood v. Casey, 505 U.S. 833 (1992).

148. 497 U.S. 261 (1990).

149. *Id.* at 279.

150. Washington v. Glucksberg, 521 U.S. 702, 724 (1997) (quoting Brief for Respondents 10). In addition, plaintiffs emphasized the statement in *Casey*: "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define

disagreed. In distinguishing *Glucksberg* from *Cruzan*, the Court stated:

> The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct. In *Cruzan* . . . we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide.[151]

The decision in *Glucksberg* is notable in two respects. First, its holding clearly denies constitutional protection for any "right" to assistance in committing suicide.[152] Second, the same decision also provides the encouragement to allow the physician-assisted suicide debate to continue "as it should in a democratic society."[153]

In summary, the act of prescribing medication is a commercial activity that, when viewed in the aggregate, substantially affects the interstate commerce of controlled substances. As such, this activity falls within Congress's Commerce Clause power, which is plenary. This commerce power cannot be limited by either state sovereignty based on traditional regulation of medical practices or the argument that Congress's motive is moral rather than economic. Constitutionally protected individual rights—privacy and freedom of speech and association—are also insufficient to limit Congress here. Therefore, Congress possesses the power, through the Commerce Clause, to regulate the prescription of controlled substances and thereby enact the Pain Relief Promotion Act which will preempt Oregon's physician-assisted suicide law. If there is to be any protection for Oregon's law—that Congress should not exercise its commerce power—that protection must come from a structural argument that federalism demands congressional restraint here. Part IV examines the federalism arguments favoring state determination of the physician-assisted suicide issue.

## IV. FEDERALISM ARGUMENTS

### *A. Why Federalism Matters*

In designing the Constitution, the Framers sought to ensure protection

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the attributes of personhood were they formed under compulsion of the State." *Id.* at 726–27 (citing Brief for Respondents 12, quoting *Casey*, 505 U.S. at 851).

151. *Glucksberg*, 521 U.S. at 725–26 (citation omitted).

152. *Id.* at 728 ("[T]he asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause.").

153. *Id.* at 735 ("Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.").

of the rights of the people by creating two governments rather than one. As James Madison explained:

> In the compound republic of America, the power surrendered by the people, is first divided between two distinct governments, and then the portion allotted to each, subdivided among distinct and separate departments. Hence a double security arises to the rights of the people. The different governments will [control] each other; at the same time that each will be [controlled] by itself.[154]

Thus, the power to govern was divided between the national government and the states. Powers of the national government are limited and enumerated; the remaining powers are reserved to the states.[155] However, many factors have served over the years to expand the scope of national power at the expense of state sovereignty.[156] Yet there are important benefits of federalism that are lost when power is centralized in the national government. In particular, retaining government authority at the subnational level fosters greater political participation, and increased accountability, and state governments can be more innovative as they experiment with solutions.[157] Part IV looks at each of these benefits of federalism in arguing that the issue of physician-assisted suicide is better decided at the state level rather than by Congress and, therefore, that the Pain Relief Promotion Act should not become law.[158]

### *B. Greater Political Participation in Democracy*

State government is closer to the people and provides a greater opportunity for voters to influence and participate in the decisions that affect their everyday lives.[159] As Justice Powell noted in *Garcia v. San*

154. THE FEDERALIST NO. 51, at 351 (James Madison) (Jacob E. Cooke ed., 1961).

155. *See* U.S. CONST. art I, § 8; *id.* amend. X ("The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.").

156. Friedman, *supra* note 116, at 367–78 (arguing that greater centralization of government at the national level is the result of several factors: historical discontent with state positions on civil rights, the expansion of technology, the breakdown in judicial formalistic barriers, judicial deference to political actors, the political economy benefits of central decision-making, and the importance of trade).

157. *Id.* at 389–400.

158. If the Pain Relief Promotion Act is enacted, the Supremacy Clause requires that state laws to the contrary are void. U.S. CONST. art. VI, cl. 2 ("This Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land . . . .").

159. Friedman, *supra* note 116, at 390 ("[S]tate and local government does provide

*Antonio Metropolitan Transit Authority*,[160] "The Framers recognized that the most effective democracy occurs at local levels of government, where people with firsthand knowledge of local problems have more ready access to public officials responsible for dealing with them. This is as true today as it was when the Constitution was adopted."[161] Even more democratic is the initiative and referendum process,[162] through which the citizens of Oregon asked their fellow voters to decide the issue of physician-assisted suicide for their state. Oregon voters approved—not once, but twice—the Death with Dignity Act,[163] which allows physicians to prescribe lethal medication to qualified terminally ill patients.[164] This is direct democracy in action. The voters of Oregon have themselves made physician-assisted suicide the law in their state.

This is by no means an argument that all states should approve physician-assisted suicide. Rather, states should be free to decide for themselves whether physician-assisted suicide is an appropriate social policy for its citizens. Indeed many states have chosen to ban physician-assisted suicide.[165] The point is that physician aid in dying is a controversial issue upon which intelligent, well-meaning people have differing views, and these views are better represented by state-level policy choices than by a single federal law. To illustrate this concept, Michael McConnell offers this example:

> [A]ssume that there are only two states, with equal populations of 100 each. Assume further that 70 percent of State A, and only 40 percent of State B, wish

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many more avenues for citizen participation than does the national government."). *See also* DAVID L. SHAPIRO, FEDERALISM: A DIALOGUE 93–94 (1995) ("[T]o the extent that the democratic ideal is more fully realized on a municipal or town level, the states are in a far better position to respond to local pressures for home rule than is a more remote and centralized government." (citation omitted)).

160. 469 U.S. 528 (1985).

161. *Id.* at 575 n.18 (Powell, J., dissenting) (citations omitted).

162. *See* Daniel B. Rodriguez, *Turning Federalism Inside Out: Intrastate Aspects of Interstate Regulatory Competition*, 149 YALE L. & POL'Y REV. 149, 168 (1996) ("[T]he initiative system allows issues to be considered by the populace and not by elected officials with their own, particular self-interests. . . . [I]nitiative lawmaking empowers a type of constituency that is represented very differently in a more republican form of government.").

163. *See supra* notes 31–33 and accompanying text (discussing election results).

164. *See supra* note 36 (discussing safeguards of the Death with Dignity Act).

165. Currently, assisted suicide is prohibited in forty-five states, either through statutes or common law. Thirty-nine states prohibit assisted suicide through statutes: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, and Wisconsin. H.R. REP. NO. 106-378, pt. 1, at 4 n.11 (1999). Six states criminalize assisted suicide through common law: Alabama, Idaho, Massachusetts, Nevada, Vermont, and West Virginia. *Id.*

> to outlaw smoking in public buildings. The others are opposed. If the decision is made on a national basis by a majority rule, 110 people will be pleased, and 90 displeased. If a separate decision is made by majorities in each state, 130 will be pleased, and only 70 displeased.[166]

This concept recognizes the diversity of attitudes, experiences, and beliefs of people in different parts of the country and endeavors to more fully represent that diversity through state-determined social policies.[167] The one-size-fits-all approach of federal legislation necessarily destroys this diversity of social choice. Physician-assisted suicide is a social policy choice that should be determined by state voters, not by distant members of Congress.[168]

This is not to say that there is no place for Congress to regulate activities in a state; there are many issues, such as cross-border pollution, that require a federal response, because states may be incapable of fashioning a satisfactory solution. But issues that are truly local, that do not affect the activities or environment of another state, should be left to state control. Physician-assisted suicide, as practiced in Oregon, is such a strictly local issue. Oregon law requires that a person requesting lethal medication be diagnosed with a terminal disease, meaning the patient has less than six months to live.[169] In addition, the patient must satisfy the law's residence requirement.[170] Thus, residents of other states will not flock to Oregon to die; there are no externalities

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166. Michael W. McConnell, *Federalism: Evaluating the Founders' Design*, 54 U. CHI. L. REV. 1484, 1494 (1987).

167. *See* Nelson & Pushaw, *supra* note 86, at 118. Nelson and Pushaw assert:

> [I]n the noncommercial sphere, we object to federal standards because they wipe out all differences of opinion on social, cultural, or moral issues—regional, state, and local. We believe that such diversity of views is healthy and should be encouraged, and that the only practical means to do so is through state and local legislation.

*Id.*

168. Indeed, only 7 of the 535 Members of Congress (2 Senators and 5 Representatives) represent Oregon voters.

169. OR. REV. STAT. §§ 127.800, 127.805 (Supp. 1998).

170. The Death with Dignity Act's residency requirement states:

> Only requests made by Oregon residents under ORS 127.800 to 127.897 shall be granted. Factors demonstrating Oregon residency include but are not limited to:
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> (1) Possession of an Oregon driver license;
> (2) Registration to vote in Oregon;
> (3) Evidence that the person owns or leases property in Oregon; or
> (4) Filing of an Oregon tax return for the most recent tax year.

*Id.* § 127.860 (1999), Oregon State Legislature, *available at* http://www.leg.state.or.us/ors/127.html.

about which other states should legitimately be concerned. Whether to allow or prohibit physician-assisted suicide is a local issue that should be decided by local voters.

### *C. Accountability*

Closely related to public participation is the concept that government officials should be held accountable to voters for their decisions.[171] When decisions are made at state and local levels—and most especially by popular referendum—the decision-makers actually live in the localities impacted by the policies.[172] When decisions concerning Oregonians are made in Washington, D.C., at most only the representatives from Oregon (five Congressmen and two Senators) can be held accountable by Oregon voters.[173] In this case, the Oregon voters themselves have decided to permit physician-assisted suicide. Yet Members of Congress who are not electorally accountable to Oregonians are trying to override their law.

Furthermore, Congress is eluding accountability on this issue in a second respect. The Pain Relief Promotion Act is deceptive in that its main function is to nullify physician-assisted suicide under the guise of promoting pain relief.[174] As Governor John Kitzhaber of Oregon, a physician, explains, this bill will result in a reduction in the use of controlled substances to relieve pain, not an increase.

> In its zealous effort to block Oregon's law, Congress has passed a bill that would have a chilling effect on the use of controlled substances in palliative care for the terminally ill. It does this by making it illegal for physicians to knowingly prescribe drugs to aid in a death.... Faced with the specter of investigation by the Drug Enforcement Administration, prison or loss of their

171. SHAPIRO, *supra* note 159, at 111 ("The political integrity of a republican form of government does center on the accountability of elected representatives to their electorate....").

172. Friedman, *supra* note 116, at 395.

173. Oregon voters may also hold the President accountable. However, with elections four years apart, and given the diversity of issues on which voters elect a president, there is limited presidential electoral accountability on this issue.

174. In considering action by the House Committee on the Judiciary, Rep. Melvin L. Watt (D-N.C.) proposed two amendments which, by their defeat, illustrate the purpose of this bill. H.R. REP. No. 106-378, pt. 1, at 15 (1999). Rep. Watt proposed to insert language that would "authorize the dispensing of a controlled substance for the purpose of causing death or assisting in causing death when in compliance with applicable State, Federal or local laws." *Id.* The second proposal was to strike the language requiring the Attorney General "to give no force or effect to State law authorizing or permitting assisted suicide or euthanasia." *Id.* Both proposed amendments were voted down by a majority of members of the House Committee on the Judiciary. *Id.* at 15–16. Had either of these proposals been included in the provisions of the Pain Relief Promotion Act, there would be no doubt that Congress was concerned primarily with palliative pain relief rather than overriding Oregon state law.

> practice, many doctors will treat pain less aggressively than is required for full relief, in order to defend themselves.[175]

If Congress wants to outlaw physician-assisted suicide, it should enact a straight prohibition against it. Congress should not deflect its accountability for this effect by appealing to an unrealistic and unworkable,[176] but universally desirable, ideal of greater pain relief for terminally ill patients.

### *D. States as Laboratories for Social Experimentation*

Federalism affords each state government the flexibility to innovate in reaching solutions to local problems. The notion of states as laboratories for social experimentation provides that the best innovations will be adopted by other governing bodies facing similar problems, maximizing successful results with a minimum of risk.[177] State experimentation, or

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175. John A. Kitzhaber, *Congress's Medical Meddlers*, WASH. POST NAT'L WKLY. EDITION, Nov. 8, 1999, at 26. *See also supra* note 129 (discussing the chilling effect this legislation may have on physicians' decisions regarding the amount of pain medication to prescribe).

176. The Dissenting Views section of the House Committee on the Judiciary report states:

> This legislation represents an unnecessary intrusion into the sensitive relationship between terminally-ill patients and their physicians and would empower Federal law enforcement agents to second-guess the considered medical judgment of physicians, pharmacists, and patients. Moreover, by threatening medical professionals with long prison sentences and strict liability, this bill would inhibit physicians from aggressively treating pain, limit patient access to palliative care, and make death more painful.

H.R. REP. NO. 106-378, pt. 1, at 31 (1999). Furthermore:

> Not only does the bill contort the purpose of the [Controlled Substances Act], it also would lead to the establishment of a new and burdensome oversight mechanism whereby the DEA would be expected to police every prescription that every healthcare worker, distributor, and manufacturer in the country dispenses. Moreover, the DEA could monitor such activities only by imposing vast new paperwork requirements on all regulated parties or through a network of healthcare workers reporting on each other, the likes of which would be unprecedented and fundamentally destructive to the proper functioning of the practice of medicine. All of this would occur even though the DEA has no expertise whatsoever in medical care.

*Id.* at 38.

177. *See* SHAPIRO, *supra* note 159, at 85. Shapiro observes:

> The notion of the states as "laboratories" has two aspects: . . . after thorough testing in a variety of contexts, a national solution will emerge that is suitable for implementation in every state. A related form—rooted in notions of pluralism and relativism—recognizes that given the wide variation in conditions and preferences in a country as diverse as ours, different solutions

innovation, is an "evolutionary process."[178] That is, as governments in various states innovate to solve similar problems, the most attractive solutions can be adopted by other states, while the less attractive or problematic solutions can be discarded.[179] Better solutions evolve as we learn from our mistakes and the experiences of others. The classic formulation of this concept is from Justice Brandeis:

> To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It 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.[180]

Indeed, it is just this sort of continued state-by-state social experimentation the Supreme Court called for in *Washington v. Glucksberg*:[181] "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[182] Yet, Congress would end this debate and annul Oregon's law.

In Oregon, physician-assisted suicide has been and continues to be extensively debated, as proponents and opponents together search for a safer and more responsive law. In June 1999, Governor John Kitzhaber signed Oregon Senate Bill 491, which amends and clarifies specific provisions of the Death with Dignity Act.[183] The most important aspect of Senate Bill 491 is that it is the product of a collaborative effort involving proponents of the Act as well as many groups that had fought to repeal the physician-assisted suicide law.[184] Some of the compromises worked out by these various groups include clarification of the Oregon residency requirement, definition of providers covered by immunity, definition of a physician's counseling requirement, clarification of a health care provider's right to have policies prohibiting participation in the Act and to sanction physicians who violate the provider's policies, and limitations on those sanctions.[185] These refinements to the

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may be best for different states.

*Id.*

178. Friedman, *supra* note 116, at 399.

179. *Id.* at 399–400.

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

181. 521 U.S. 702 (1997).

182. *Id.* at 735.

183. *Oregon Legislature Votes to Strengthen Death With Dignity Law*, OR. REP. (Or. Death With Dignity Legal Def. and Educ. Ctr., Portland, Or.), Spring/Summer 1999, at 1.

184. *See id.*

185. *Senate Bill 491: How It Clarifies the Oregon Death With Dignity Law*, OR.

physician-assisted suicide law, which strengthen the law and prevent unwanted expansion, would not have come about had the debate regarding physician-assisted suicide been foreclosed by Congress.

It is clear from the first two years of physician-assisted suicide in Oregon that the fears of its opponents were unfounded.[185] There is no indication that patients who chose physician-assisted suicide were concerned about the financial burden of their illnesses or that they were disproportionately poor, uneducated, or uninsured.[187] The safeguards embedded in Oregon's Death with Dignity Act have worked well to permit aid in dying to a small number of competent, terminally ill patients.[188] With no evidence of abuse, the fears of opponents are merely speculative. The Oregon law provides the first real opportunity to perform a comprehensive study of physician-assisted suicide:[189] why patients choose assistance to die, the effects of physician-assisted suicide on physicians and health care providers, the efficacy of lethal medications, and how society can better attend to the needs of the dying. Oregonians should be permitted to utilize physician-assisted suicide, to continue to refine its guidelines and safeguards, and to monitor its results; this will allow the rest of the nation to better understand this issue and its consequences from an empirical standpoint (rather than from fearful speculation), and then to determine—on a state-by-state basis—its appropriateness as a social policy.

## V. CONCLUSION

Why do some terminally ill patients utilize physician assistance to die? It is not fear of intractable pain or concern about the financial impact of their illnesses.[190] Those patients who chose physician assistance to die in the first two years under Oregon's Death with Dignity Act did so out of concern for their autonomy and personal

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REP. (Or. Death With Dignity Legal Def. and Educ. Ctr., Portland, Or.), Spring/Summer 1999, at 1.

186. *See supra* Part II.B.

187. Chin et al., *supra* note 37, at 582; Sullivan et al., *supra* note 37, at 602.

188. *See supra* note 36 (discussing safeguards of the Death with Dignity Act).

189. Chin et al., *supra* note 37, at 577 ("Although there have been many studies of physician-assisted suicide, there are no data on the experiences of patients and physicians when the practice is legal.").

190. *Death With Dignity Law Works Perfectly for First Year*, OR. REP. (Or. Death With Dignity Legal Def. and Educ. Ctr., Portland, Or.), Winter/Spring 1999, at 1.

control.[191] Their devastating illnesses would take their lives; they simply wanted to control the manner in which they died.[192] It is this very aspect of autonomy and personal control that Congress proposes to take from these terminally ill patients by prohibiting physicians from prescribing the medications that will efficiently aid patients in dying without suffering. In its attempt to pass the Pain Relief Promotion Act, Congress also attacks the autonomy and sovereignty of states. The Act requires the Attorney General to "give no force and effect to State law authorizing or permitting assisted suicide."[193] Physician assistance to die is an intensely personal choice and a social policy that should be made as close to the voter as possible—at the state rather than national level. Most particularly, when voters have used the initiative and referendum process to make this important social policy themselves, this decision should not be overridden by politicians in Washington, D.C., who are largely unaccountable and often unresponsive to these state voters.

Under the Supreme Court's Commerce Clause interpretation, Congress has the power to annul Oregon's physician-assisted suicide law. As Justice O'Connor succinctly stated: "[A]ll that stands between the remaining essentials of state sovereignty and Congress is the latter's underdeveloped capacity for self-restraint."[194] Congress should muster the self-restraint to allow state voters to decide for themselves whether physician-assisted suicide is an appropriate social policy in their state.

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191. *Id.*; Sullivan et al., *supra* note 37, at 601.

192. *Death With Dignity Law Works Perfectly for First Year*, OR. REP. (Or. Death With Dignity Legal Def. and Educ. Ctr., Portland, Or.), Winter/Spring 1999, at 1.

193. H.R. 2260, 106th Cong. § 101 (1999); S. 1272, 106th Cong. § 101 (1999).

194. Garcia v. San Antonio Metro. Transit Auth., 469 U.S. 528, 588 (1985) (O'Connor, J., dissenting).