

2000

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Recommended Citation

Joy Fallek, *The Pain Relief Promotion Act: Will It Spell Death to "Death With Dignity" Or Is It Unconstitutional?*, 27 Fordham Urb. L.J. 1739 (2000).

Available at: <https://ir.lawnet.fordham.edu/ulj/vol27/iss6/1>

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THE PAIN RELIEF PROMOTION ACT: WILL IT SPELL DEATH TO “DEATH WITH DIGNITY” OR IS IT UNCONSTITUTIONAL?

Joy Fallek *

INTRODUCTION

There is no evidence that Congress, in the CSA [Controlled Substances Act], intended to displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice.¹

In writing these words to Representative Henry Hyde, Chairman of the House of Representatives' Judiciary Committee, United States Attorney General Janet Reno may have had no idea that she was throwing down the gauntlet, daring House conservatives to act.² The year was 1998, and Reno was offering her ruling on whether the latest of several efforts to derail Oregon's Death with Dignity Act by amending the Controlled Substances Act (“CSA”) could prevent Oregon doctors from prescribing controlled substances for terminally ill patients who wished to commit suicide.³ The right to physician-assisted suicide in limited circumstances, supported by Oregonians both in a voter initiative election and later in a referendum,⁴ had strong opponents in the House of Rep-

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1. Letter from Janet Reno, Attorney General of the United States, to Chairman Henry J. Hyde, Committee on the Judiciary, U.S. House of Representatives (June 5, 1998) (available at the Internet address of the Committee on the Judiciary, U.S. House of Representatives (visited Mar. 21, 2000) <<http://house.gov/judiciary/at-tygen.htm>>) [hereinafter Reno Letter].

2. Senate Assistant Majority Leader Don Nickles is an Oklahoma Republican who is open about how his political views are shaped by Catholicism and a “Christian world view.” *Assisted Suicide: A New Attack*, THE OREGONIAN, Sept. 8, 1999, at A8. He described Reno's letter as a “challenge” and proposed legislation to meet this challenge. 145 CONG. REC. S14774 (daily ed. Nov. 18, 1999).

3. See Reno Letter, *supra* note 1.

4. See *infra* Part I.

representatives. Henry Hyde responded to Janet Reno's de facto endorsement of the Oregon Act by proposing new legislation, the Lethal Drug Abuse and Prevention Act of 1998 ("LDAP Act"), which would clarify that doctors could not prescribe controlled substances for suicide.⁵ When the LDAP Act stalled in Congress, a new bill, the Pain Relief Promotion Act of 1999 ("PRPA") was crafted.⁶ The PRPA, passed by the House of Representatives on October 27, 1999,⁷ explicitly states that controlled substances may not be dispensed intentionally to assist suicide or to cause death, and that the Attorney General must give no force or effect to any state law that authorizes assisted suicide.⁸

There is little doubt that should the PRPA become law, supporters of Oregon's assisted-suicide law will challenge the Act as unconstitutional. This Note examines possible constitutional claims that opponents of the PRPA may bring. Part I discusses the creation, structure, and implementation of the Oregon Death with Dignity Act. It then discusses two congressional responses, the LDAP Act and the PRPA, intended to limit the ability of Oregonians to implement physician-assisted suicide. Part II examines areas of controversy created by the PRPA. Part III will discuss recent constitutional decisions, both those on physician-assisted suicide and others that show the federalist leanings of the current Supreme Court. Furthermore, it will look at several constitutional provisions as well as the concept of provisional adjudication, all of which are applicable to an analysis of the constitutionality of the PRPA. Part IV will argue why the Supreme Court should rule the PRPA unconstitutional. This Note concludes that the PRPA is a premature attempt by opponents of physician-assisted suicide to cut off experimentation and debate on a controversial social issue and that the Supreme Court should prevent this limitation on state experimentation.

I. THE DEATH WITH DIGNITY ACT AND THE PAIN RELIEF PROMOTION ACT

A. Oregon Votes For Physician-Assisted Suicide

It is perhaps not surprising that Oregon has been the first state in the Union to tackle the contentious assisted-suicide issue. Ore-

5. See H.R. REP. NO. 106-378, pt. 2, at 5-6 (1999) (referring to the Lethal Drug Abuse Prevention Act, H.R. 4006, 105th Cong. (1998)).

6. See H.R. 2260, 106th Cong. (1999).

7. See 145 CONG. REC. H10903 (daily ed. Oct. 27, 1999).

8. See H.R. 2260.

gon's founders have been described as a group of "rugged and robust individuals" with "highly moral as well as irreverent views" who wished to create "a free society unfettered by the governmental imposition of some people's views of morality on the free expression of others."⁹ Oregonians are mavericks on many social issues. They legalized abortion years before *Roe v. Wade*¹⁰ and were among the first to decriminalize the use of marijuana and approve its medical uses.¹¹ They were also the first to conduct an election entirely by mail¹² and, in fact, mailed ballots to their citizens to vote on assisted suicide.¹³

Oregon's state constitution permits voter initiatives, proposed legislation introduced by private citizens that is later voted on by the electorate.¹⁴ The Death with Dignity Act began with just such an initiative. Elvin Sinnard, an Oregon man who had secretly helped his terminally-ill wife die after she had suffered for eighteen months from a debilitating heart disease, hated having to act surreptitiously.¹⁵ Working with a group of doctors and lawyers, the future members of Oregon Right to Die, Sinnard drafted the initiative.¹⁶

In their 1994 election, Oregon citizens approved Ballot Measure 16, the Oregon Death with Dignity Act, legalizing physician-assisted suicide in limited circumstances.¹⁷ The election had a 68% turnout, with 51.3% in support of the right of terminally-ill adults to obtain prescriptions for lethal drugs and 48.7% in opposition.¹⁸ Any pleasure that the victors may have felt after their narrow victory was soon to fade. On November 23, 1994, fifteen days before

9. *State v. Henry*, 732 P.2d 9, 16 (Or. 1987).

10. 410 U.S. 113 (1973) (recognizing a right to abortion grounded in a Fourteenth Amendment privacy right).

11. See Sam Howe Verhovek, *Oregon Chafes at Measure to Stop Assisted Suicides*, N.Y. TIMES, Oct. 29, 1999, at A1.

12. See *id.*

13. See Erin Hoover, *Pain Medication Hastens Some Patients' Death*, THE OREGONIAN, Oct. 10, 1997, at A1.

14. See OR. CONST. art. IV, § 1(2)(a) ("The people reserve to themselves the initiative power, which is to propose laws and amendments to the Constitution and enact or reject them at an election independently of the Legislative Assembly.").

15. See Carol A. Pratt, *Efforts To Legalize Physician-Assisted Suicide in New York, Washington and Oregon: A Contrast Between Judicial and Initiative Approaches — Who Should Decide?*, 77 OR. L. REV. 1027, 1032 (1998).

16. See *id.*

17. See *Physician Assisted Suicide: In the United States* (last modified Oct. 31, 1999) <http://www.religioustolerance.org/euth_us.htm>.

18. See *Hearings on H.R. 4006 Before the Subcomm. on the Const. of the House Comm. on the Judiciary*, 105th Cong. (1998) (statement of John A. Kitzhaber, M.D., Governor of Oregon) [hereinafter Kitzhaber statement].

the Act was to take effect, various doctors, patients and health facilities filed a class action suit complaining that the Act violated their Fourteenth Amendment Equal Protection and Due Process rights, First Amendment free exercise of religion and free association rights, and Americans with Disabilities Act rights.¹⁹ The federal district court found that the Act violated the Equal Protection Clause and on August 3, 1995, issued a permanent injunction against its implementation.²⁰ This ruling was appealed.²¹ Before the Ninth Circuit could rule, however, the Oregon legislature passed H.B. 2954-A repealing the 1994 statute on assisted suicide and ordering a referendum on the issue.²² Opponents waged an extensive campaign, spending close to four million dollars.²³ Supporters of assisted suicide raised only \$800,000 and were \$300,000 in debt by the election.²⁴ On November 4, 1997, Oregonians rejected the referendum asking them to repeal the Death with Dignity Act by a margin of sixty percent to forty percent and the measure became effective.²⁵

The next day, at the request of two conservative members of Congress, Senator Orrin Hatch and Representative Henry Hyde, a Federal Drug Enforcement Administration ("DEA") administrator wrote a policy statement threatening to charge any doctor participating in the Oregon Act with a violation of the CSA.²⁶ Later, in June 1998, Attorney General Janet Reno would issue her ruling nullifying the DEA policy,²⁷ stating that drug laws had not been intended "to assign DEA the novel role of resolving the earnest and profound debate about the morality, legality and practicality of physician-assisted suicide."²⁸ Meanwhile, in February 1997, the Ninth Circuit decided that it lacked jurisdiction to hear the plaintiff's earlier constitutional claims and dismissed the complaint.²⁹ In October, prior to the November 1997 referendum, Federal District

19. See *Lee v. Oregon*, 869 F. Supp. 1491 (D. Or. 1994).

20. See *Lee v. Oregon*, 891 F. Supp. 1439 (D. Or. 1995).

21. See *Lee v. Oregon*, 107 F.3d 1382, 1386 (9th Cir.), *cert. denied*, 522 U.S. 927 (1997).

22. See Kitzhaber statement, *supra* note 18.

23. See *Physician Assisted Suicide in the United States*, *supra* note 17.

24. See *id.*

25. See *id.*

26. See THE OREGON REPORT ON THE RIGHT TO DIE (Oregon Death with Dignity Legal Defense and Education Center, Portland, Or.), Spring/Summer 1998, at 4.

27. See *id.*

28. Reno Letter, *supra* note 1.

29. See *Lee v. Oregon*, 107 F.3d 1382, 1392 (9th Cir.), *cert. denied*, 522 U.S. 927 (1997).

Judge Michael Hogan vacated the injunction placed in 1994 on Measure 16.³⁰ Physician-assisted suicide was now legal in Oregon.

1. *Provisions of the Death with Dignity Act*

The Oregon Death with Dignity Act allows a mentally capable Oregon adult resident to make a written request for medication that can be used to end his life if physicians have determined that he is suffering from a terminal disease (defined as having six months to live), and he has voluntarily expressed a wish to die.³¹ The Act was amended on June 30, 1999 by state Senate Bill 491, which makes subtle, but significant, changes.³² The Senate Bill, which was passed with strong bipartisan support, represented a collaborative effort by disparate groups that had originally opposed or supported the Act.³³

The amended Act has many safeguards. First, it states that no person qualifies under these provisions simply because of age or disability.³⁴ Second, unlike the original Act, the amended Act defines "capable."³⁵ A person is capable if either a court, his doctor, a consulting physician, psychiatrist or psychologist finds that the patient can make and communicate health care decisions to health care providers.³⁶ Third, a written request to the patient's doctor must have been preceded by two oral requests, separated in time by at least fifteen days.³⁷ The written request must be witnessed, in the patient's presence, by at least two people who attest that they believe the patient to be competent and acting voluntarily.³⁸ At least one of these witnesses must not be (1) a relative by blood, marriage, or adoption, (2) a future heir, (3) the owner, operator or employee of a health facility treating the patient, and (4) the patient's physician.³⁹

The amended Act has other provisions to try to ensure that patients are making well thought out decisions. If a patient requests help with dying, a physician must determine that the patient has a

30. See THE OREGON REPORT ON THE RIGHT TO DIE (Oregon Death with Dignity Legal Defense and Education Center, Portland, Or.), Fall/Winter 1997, at 1.

31. See OR. REV. STAT. § 127.800(2.01) (Supp. 1998).

32. See S. 491 (Or. 1999).

33. See THE OREGON REPORT ON THE RIGHT TO DIE (Oregon Death with Dignity Legal Defense and Education Center, Portland, Or.), Spring/Summer 1999, at 1.

34. See 1999 Or. Laws 423 § 127.805(2.01)(2).

35. See *id.* § 127.800(1.01)(3).

36. See *id.*

37. See OR. REV. STAT. § 127.840(3.06) (Supp. 1998).

38. See *id.* § 127.810(2.02)(1).

39. See *id.* (2.02)(2)(a)-(c), (3).

terminal illness, is competent and has made the request voluntarily.⁴⁰ The doctor must discuss the following subjects with the patient: diagnosis and prognosis; risks of taking the medication to be prescribed; and feasible alternatives, such as hospice care and pain control.⁴¹ The patient must be referred to a consulting physician who confirms the diagnosis and agrees that the patient is capable and acting voluntarily.⁴² If the doctor or consulting physician believes that the patient is suffering from a mental disorder or depression, she must refer the patient for counseling.⁴³ The amended Act defines counseling as "one or more consultations as necessary between a state-licensed psychiatrist or psychologist and a patient" to determine that the patient is capable and not suffering from a disorder or depression impairing judgment.⁴⁴ "No medication to end a patient's life in a humane and dignified manner" can be prescribed as long as a patient suffers from a disorder that impairs judgment.⁴⁵

The amended Act recommends that the patient be counseled about the importance of having someone else present when the medication is taken.⁴⁶ The patient must be informed that he can rescind the request at any time, and the doctor should reiterate this offer at the end of the fifteen day waiting period.⁴⁷ The amended law suggests two options for giving medication. First, the doctor can dispense medicines directly to minimize patient discomfort, provided he is registered with the Board of Examiners as a dispensing physician and has a current DEA certificate.⁴⁸ A second option allows the physician, with the patient's written consent, to contact a pharmacist to inform him of the prescription, and to deliver the prescription personally or mail it to the pharmacy.⁴⁹ In the latter case, the pharmacist will give the medications either to the patient, the doctor or an expressly identified third party.⁵⁰ The doctor must file copies of the dispensing record with the Oregon Health Division, the state health department.⁵¹

40. See 1999 Or. Laws 423 § 127.815(3.01)(1).

41. See *id.* § 127.815(3.01)(1)(c)(A), (B), (C), (E).

42. See *id.* (3.01)(1)(d).

43. See *id.* § 127.825(3.03).

44. *Id.* § 127.800(1.01)(5).

45. *Id.* § 127.825(3.03).

46. See *id.* § 127.815(3.01)(1)(g).

47. See *id.* (3.01)(1)(h).

48. See *id.* (3.01)(1)(k)(A).

49. See *id.* (3.01)(1)(k)(B).

50. See *id.*

51. See *id.* § 127.865(3.11)(1)(b).

Finally, the amended Act adds several provisions to satisfy institutions, such as hospitals, that do not wish to participate in assisted suicide. These institutions may impose sanctions on staff who, while acting in the course and scope of employment with the institution, violate an institutional policy against participating in physician-assisted suicide.⁵² A physician will neither be subject to civil or criminal penalties or professional disciplinary actions for participating in physician-assisted suicide, nor be punished for refusing to participate in the practice.⁵³

2. *Initial Outcomes After Implementation of the Death with Dignity Act*

The Oregon Health Division, published reports following the first and second years of the Act's implementation.⁵⁴ Epidemiologists collected information from doctors of patients who received prescriptions of lethal medication in 1998.⁵⁵ The study found that twenty-three people had received prescriptions; fifteen died after ingesting medication; six died from their illnesses; and two were still alive on January 1, 1999.⁵⁶ The average age of the fifteen who took medication was sixty-nine.⁵⁷ Eight were male, all were white, and twelve were high school graduates.⁵⁸ Participants disproportionately appeared to be unmarried; thirteen were widowed, divorced or never married.⁵⁹ The researchers suggested, however, that one must be cautious in assuming that the unmarried individuals were socially isolated.⁶⁰ The report stated that patients who chose assisted suicide were not disproportionately poor, unedu-

52. *See id.* § 127.885(4.01)(5).

53. *See id.* (4.01)(1), (2).

54. *See* Arthur E. Chin et. al., *Legalized Physician-Assisted Suicide in Oregon—The First Year's Experience*, 340 NEW ENG. J. MED. 577 (1999); Amy Sullivan, Ph.D., M.P.H. et. al., *Oregon's Death with Dignity Act: The Second Year's Experience*, Department of Human Services, Oregon Health Division, Center for Disease Prevention and Epidemiology (Feb. 23, 2000) <<http://www.ohd.hr.state.or.us/cdpe/chs/pas/ar-index.htm>>.

55. *See* Chin, *supra* note 54, at 578.

56. *See id.* The report listed 22 prescriptions written and 15 deaths. The report of the second year corrected this figure to 23 prescriptions written and 16 deaths. In the second year under the Act, twenty-seven patients with a median age of 71, the majority of whom had terminal cancer, ended their lives by assisted death. *See* Sullivan, *supra* note 54, at 3.

57. *See* Chin, *supra* note 54, at 580.

58. *See id.*

59. *See id.*

60. *See* Arthur E. Chin et. al., *Letter to Editor*, NEW ENG. J. MED. (visited Oct. 4, 1999) <<http://www.nejm.org/content/1999/0341/0003/0212.asp>>.

cated, uninsured, fearful of financial circumstances or lacking end of life care.⁶¹ Interestingly, the majority placed significantly more importance on autonomy and personal control, rather than pain, as the factors motivating their decision to die.⁶²

By the standards of supporters, the first year of experimentation with assisted suicide had been a success,⁶³ but for opponents, it did nothing to lessen their resolve to oppose this Act. They decided to mobilize on a federal level.

B. The House of Representatives Acts to Thwart the Death with Dignity Act

Members of the House of Representatives responded to the Death with Dignity Act by proposing legislation that would make the Act virtually impossible to implement.

1. The Lethal Drug Abuse and Prevention Act

On June 5, 1998, the date of Janet Reno's letter permitting Oregon doctors acting in compliance with state law to write lethal prescriptions without fear of DEA investigation, Henry Hyde proposed new legislation, the LDAP Act.⁶⁴ Senator Don Nickles introduced a companion bill in the Senate.⁶⁵ In a statement before the House, Hyde portrayed assisted suicide as a natural result of the "culture of death" and of the "slippery slope" entered when the Supreme Court "sanctified abortion [as a] preferred option."⁶⁶ He characterized the bill as one that would prevent the killing of the

61. See Chin, *supra* note 54, at 582.

62. See *id.*

63. The second year could be characterized as a success by supporters as well. In the second year, 33 prescriptions were written and 27 patients died (representing a rate of six per ten thousand of all Oregon deaths) from ingesting the medication. The median age of patients was 71, almost all were white, 12 were married and 16 were male. Seventeen patients had end-stage cancer (representing a rate of twenty per ten thousand of Oregon cancer deaths). All patients had health insurance and 21 were receiving hospice care. Once again, according to reports by doctors and relatives, patients' main concern was loss of autonomy. Patients' other most significant fears were "decreasing ability to participate in activities that make life enjoyable," losing bodily functions, and physical suffering. Sullivan, *supra* note 54, at 3, 10.

64. H.R. 4006, 105th Cong. (1998).

65. See S. 2151, 105th Cong. (1998). Both bills followed in the wake of the Assisted Suicide Funding Restriction Act of 1997, 42 U.S.C. § 14403 (1997). That law prohibits the use of federal funds to cause a patient's death. It received unanimous Senate support and was approved by a vote of 398-16 in the House. President Clinton signed it into law. See H.R. REP. NO. 106-378, pt. 1, at 5-6 (1999).

66. *Hearings on H.R. 4006 Before the Subcomm. on the Const. of the House Judiciary Comm.*, 105th Cong. (1998) (statement of Rep. Henry J. Hyde).

"elderly, the infirm, the sick, the disabled," those who are "unwanted."⁶⁷ Senator Nickles spoke before the Senate on the need for the legislation to reaffirm doctors' right to relieve pain while clarifying that this right does not extend to assisted suicide.⁶⁸ In his opinion, the Oregon Death with Dignity Act places the DEA in a position of regulating controlled substances for the purpose of assisted suicide.⁶⁹ It compels the DEA to follow two standards, one in Oregon under which assisted suicide is a "legitimate medical purpose" and a second in the rest of the country under which it is not.⁷⁰ This bill would remedy that situation and provide one standard.⁷¹

The LDAP Act sought to amend the CSA by clarifying that federal law prohibits a doctor from dispensing or distributing controlled substances with the intention of causing a suicide.⁷² Under the LDAP, the Attorney General would deny registration to prescribe controlled substances to a doctor who had "intentionally dispensed or distributed a controlled substance with a purpose of causing, or assisting in causing, the suicide or euthanasia of any individual"⁷³ The Act would not apply to doctors prescribing medications with the sole purpose of alleviating pain or discomfort even if death should follow.⁷⁴ The burden would rest on the Attorney General to prove by clear and convincing evidence a physician's intent to cause death.⁷⁵ The Attorney General would create a medical review board that could, at a doctor's request, review any decision to deny, revoke or suspend registration.⁷⁶

Some believed that the LDAP Act would make doctors fear prescribing adequate pain relief for suffering patients.⁷⁷ Significantly, it was opposed by the American Medical Association ("AMA") and by more than forty medical groups.⁷⁸ This opposition was tell-

67. *Id.*

68. See *Drugs, Dignity, and Death: Physician Assisted Suicide?: Hearings on S. 2151 Before the Senate Judiciary Comm.*, 105th Cong. 7-14 (1998) (statement of Sen. Don Nickles).

69. See *id.*

70. *Id.*

71. See *id.*

72. See H.R. 4006, 105th Cong. (1998).

73. *Id.* § 2(b)(1)(B).

74. See *id.*

75. See *id.* § 2(c)(2).

76. See *id.*

77. See Pratt, *supra* note 15, at 1108.

78. See *id.* at 1107 n.434. The AMA viewed "expanding the DEA's authority in this matter [as an] unacceptable federal intrusion over matters of state law regarding the practice of medicine." *Lethal Drug Abuse Prevention Act of 1998: Hearings on*

ing and, although H.R. 4006 was referred out of committee, the House took no further action.⁷⁹ Stating that it would be one of his top priorities to counteract the "misguided ruling by the Attorney General" and clarify that controlled substances could only be used for legitimate medical purposes and not for assisted suicide, Senator Nickles vowed to revisit the issue in the next Congress.⁸⁰

2. *The Pain Relief Promotion Act*

True to his word, Nickles introduced the PRPA in the Senate on June 17, 1999,⁸¹ concurrently with Representative Henry Hyde who introduced the bill in the House.⁸² In Nickles' view, the Act would "respond to the Attorney General's challenge, by clarifying that the intentional misuse of [controlled substances] to cause patients' death is not authorized by Congress in any state nor has it ever been."⁸³ Henry Hyde, writing for the majority of the House Judiciary Committee, stated that the Act is necessary to ensure that all states will regard the use of controlled substances in assisted suicide as "inconsistent with public health and safety [as it was regarded] prior to the Attorney General's 1998 ruling."⁸⁴ Although agreeing that states are the "first line of defense" in monitoring prescription drug use, he wrote that the federal government has an obligation to step in if a state refuses to follow federal standards.⁸⁵ Congressional supporters wished to make a strong statement that the CSA does not permit assisted suicide and also improves end of

H.R. 4006 Before the Subcommittee on the Constitution Committee of the House Committee on the Judiciary, 105th Cong. (July 14, 1998) (statement of Thomas R. Reardon, M.D.). Furthermore, the AMA stated that federal action was not needed since states were already addressing the issue of assisted suicide and "state legislatures, through the police powers . . . determine the scope of medical practice." *Id.* Making "the DEA an arbiter of the practice of medicine" was "unacceptable." *Id.* In its initial support of subsequent legislation, H.R. 2260, the AMA appeared to have rethought these concerns. *See infra* note 145 and accompanying text.

79. *See* 144 CONG. REC. H. 8083 (daily ed. Sept. 18, 1998).

80. Senator Don Nickles, *Nickles Pledges to Revisit Physician-Assisted Suicide Issue Next Year* (visited Feb. 3, 2000) <[http://www.senate.gov/~nickles/legislative /releases/suicid98.cfm](http://www.senate.gov/~nickles/legislative/releases/suicid98.cfm)>.

81. *See Timeline*, THE OREGONIAN, Sept. 8, 1999, at A8.

82. Nickles would be frustrated as his bill stalled in the Senate Health, Education, Labor and Pensions Committee. *See* 199 U.S. S.B. 1272 (SN). (State Net Bill tracking). Henry Hyde would be rewarded with victory. *See* Robert Pear, *House Backs Ban on Using Medicine to Aid in Suicide*, N.Y. TIMES, Oct. 28, 1999, at A1.

83. 145 CONG. REC. S14775 (daily ed. Nov. 18, 1999).

84. H.R. REP. NO. 106-378, pt. 1, at 11 (1999). Actually, 38 states prohibit assisted suicide through statutes and six through common law. *See id.* at 4 n.11.

85. *Id.* at 12.

life care by promoting pain control.⁸⁶ Representative Tom Bliley, writing for the House Commerce Committee, stressed the need for the Attorney General to use uniform standards.⁸⁷ He wrote that Janet Reno's previous ruling improperly rendered federal law on assisted suicide "subordinate to and a mere function of state law and policy."⁸⁸

The PRPA differs significantly from its predecessor. It amends Section 303 of the CSA by stating, for the first time, 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."⁸⁹ In direct response to Janet Reno's contention that the CSA could not "override a state's determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice,"⁹⁰ the Act states that "[n]othing 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," and further stipulates that "the Attorney General shall give no force and effect to state law authorizing or permitting assisted suicide or euthanasia."⁹¹ Doctors violating the Act by using controlled substances for assisted suicide would lose their registration, have to give up any controlled substances in stock, and be held criminally liable.⁹² A doctor faces a twenty year mandatory minimum sen-

86. See, e.g., 145 CONG. REC. H10869 (daily ed. Oct. 27, 1999) (statement of Rep. John Linder); 145 CONG. REC. H10875 (daily ed. Oct. 27, 1999) (statement of Rep. Jerry Moran).

87. See H.R. REP. NO. 106-378, pt. 2, at 6 (1999).

88. *Id.* Federal law on assisted suicide, the Assisted Suicide Funding Restriction Act of 1997, 42 U.S.C. § 14401 (1997), is not actually made subordinate to state law by the Death with Dignity Act since Oregon complies with its provision not to use federal funds for assisted suicide.

89. H.R. 2260, 106th Cong. § 101(i)(1) (1999).

90. Reno Letter, *supra* note 1.

91. H.R. 2260 § 101(i)(1).

92. See H.R. REP. NO. 106-378, pt. 2, at 10 (1999). Speaking before the House on the day of the vote on the PRPA, Representative Peter De Fazio of Oregon quoted the Justice Department on the issue of criminal penalties:

By denying authorization under the Controlled Substances Act, H.R. 2260 would make it a Federal crime for a physician to dispense a controlled substance to aid a suicide. However, a physician who prescribes the controlled substances most commonly used to aid a suicide, because he or she necessarily intends death to result, or may have intended death to result, or should have known that death should have resulted, would face a 20-year mandatory minimum sentence in Federal prison.

tence when death results from the distribution of a schedule II substance.⁹³

Next, the Act requires that law enforcement personnel be offered education and training "on the necessary and legitimate use of controlled substances in pain management and palliative care" and on how, in their investigations, they "may accommodate such use."⁹⁴ The Act also amends Title IX of the Public Health Service Act⁹⁵ by requiring the administrator to "develop and advance scientific understanding of palliative care" and to distribute protocols on pain management and palliative care to medical programs and practitioners.⁹⁶ Finally, the Act allocates \$5,000,000 for grants to health profession schools, hospices or other organizations to educate and train health professionals in palliative care.⁹⁷

II. THE PRPA STIRS UP CONTROVERSY

Opponents of the PRPA have expressed many concerns that highlight the controversial nature of the legislation. They fear the legislation's effects on the quality of health care available to people in pain, challenge a perceived intrusion into states' rights, and question possible punitive effects of the PRPA on physicians.⁹⁸

A. General Reactions to the PRPA

Democrats on the Judiciary Committee, in an impassioned dissent from the committee's majority report, raised both medical and constitutional concerns.⁹⁹ Their major medical concern, one shared by many doctors, was that the bill would inhibit adequate pain relief, making doctors afraid to treat pain aggressively lest they come to the notice of the DEA.¹⁰⁰ Representative Steven Rothman, a

145 CONG. REC. H10872 (daily ed. Oct. 27, 1999) (statement of Rep. Peter De Fazio).

93. See 21 U.S.C. § 841(b)(i)(C) (1994). A schedule II substance is a drug accepted for medical use that a physician may prescribe under DEA licensure, but which has a high potential for abuse. See 21 U.S.C. § 812(b)(2) (1994); see also *United States v. Moore*, 423 U.S. 122, 124 n.1 (1975).

94. H.R. 2260, 106th Cong. § 102(3) (1999).

95. 42 U.S.C. § 299 (1994).

96. H.R. 2260, § 906(a)(1), (2). Palliative care is defined as "active total care of patients whose prognosis is limited due to progressive, far-advanced disease. The purpose of such care is to alleviate pain and other distressing symptoms and to enhance the quality of life, not to hasten or postpone death." *Id.* § 906 (b).

97. See *id.* § 754(a), (c)(2).

98. See *infra* § II(A), (B).

99. See H.R. REP. NO. 106-378, pt. 1, at 31-39.

100. See *id.* at 34-35. The dissenters quoted parts of a letter from William H. Goodson, III, M.D., President of the San Francisco Medical Society, to Representative Nancy Pelosi, Aug. 20, 1999:

non-committee member and opponent of physician-assisted suicide, spoke of doctors under-prescribing because of their present fear of civil medical malpractice lawsuits.¹⁰¹ He expressed concern that an emphasis on criminal penalties would make doctors even less eager to treat pain effectively.¹⁰² Other members of Congress feared the effect of federal agents "second-guessing" doctors and intruding on the sensitive doctor-patient relationship.¹⁰³

The response of supporters to this concern was rather surprising. In essence, both Hyde¹⁰⁴ and Nickles¹⁰⁵ said that such worries were unfounded because only a small number of Oregon doctors, rather than doctors as a whole, would receive increased DEA scrutiny under this Act. Representative Hyde's Judiciary Committee report stated that in Oregon, the DEA would simply subpoena records of those doctors who had prescribed medications for suicide and then complied with Oregon's recording laws; other Oregon doctors would have nothing to fear.¹⁰⁶ Similarly, the Commerce Committee wrote in its report on the costs of enforcing the Act that since "the bill would affect only doctors in Oregon, the costs . . . would fall below the \$100 million . . . threshold."¹⁰⁷

Senator Nickles, speaking before the Senate, said that the Act would not have a "chilling effect" on doctors because it would not

In an era when a concerted and long-overdue effort is being made to lessen physicians' fears of prescribing appropriate amounts of medications for pain, we do not need to send a frightening and mixed message of increased investigation, criminalization, and politicization of what should be a private matter between patients and their physicians.

Id. at 35. A more horrible prospect was raised by Assistant Attorney General Robert Raben when he suggested that H.R. 2260 could make state-authorized suicides more painful. "H.R. 2260's prohibitions would only reach controlled substances, which are most often used as sedatives and not as the actual agents of death. As a result, H.R. 2260 might well result in physician assisted suicides that do not use sedatives and pain-controlling substances that are accordingly more painful." Letter from Robert Raben, Assistant Attorney General, U.S. Department of Justice, Office of Legislative Affairs, to Henry Hyde, Chairman, House Committee on the Judiciary (Oct. 19, 1999) (on file with the author).

101. See 145 CONG. REC. H10870 (daily ed. Oct. 27, 1999) (statement of Rep. Steven Rothman).

102. See *id.* "Patient" has the Latin root *patior*, meaning "to endure pain or suffering." Ben A. Rich, *A Prescription for the Pain: The Emerging Standard of Care for Pain Management*, 26 WM. MITCHELL L. REV. 1, 28 (2000). "To note this . . . is merely to highlight the persistent ambivalence of the medical profession toward pain and suffering as an aspect of the experience of illness." *Id.*

103. 145 CONG. REC. H10870.

104. See H.R. REP. NO. 106-378, pt. 1, at 13.

105. See 145 CONG. REC. S14775-776 (daily ed. Nov. 18, 1999).

106. See H.R. REP. NO. 106-378, pt. 1, at 13.

107. H.R. REP. NO. 106-378, pt. 2, at 10 (1999).

“increase [by] one iota the authority of the DEA to investigate the misuse of controlled substances to assist suicide outside of Oregon.”¹⁰⁸ The DEA would simply subpoena and look at records required by Oregon law so there would be “no question of murky intentions or ambiguity.”¹⁰⁹ Even Oregon doctors would not have to fear increased scrutiny if they were only prescribing medications for pain relief.¹¹⁰ Nickles expected the DEA to follow its “long-standing practice of generally deferring to state authorities” on these issues.¹¹¹ The Act could only benefit the vast majority of doctors by providing “a more explicit ‘safe harbor’ for the practice of pain control.”¹¹²

Scientist David Joranson, testifying before the House Judiciary Subcommittee on the Constitution, commented on how extraordinary he found it that Congress would “single out States with controversial policies on important societal issues, issues . . . nevertheless within their authority, and then, because there is an (albeit tenuous) relation to the use of controlled substances, amend the CSA to contravene the policy of that State.”¹¹³ Mr. Joranson’s perception of the motives of at least some representatives was borne out by the comments of Representative Ron Paul of Texas before the House when he said “[T]he Pain Relief Promotion Act of 1999 . . . is designed for one purpose. It is to repeal the State of Oregon’s law dealing with assisted suicide and euthanasia.”¹¹⁴

Opponents of the legislation also raised federalism concerns. First, they saw this bill as a violation of the Supreme Court’s decision encouraging states to experiment with resolutions to the issue of physician-assisted suicide.¹¹⁵ Viewing the motives of sponsors of H.R. 2260 as primarily to “nullify an Oregon referendum,” they found them counter to a fundamental aspect of federalism, “that the States are free to act as independent laboratories of democ-

108. 145 CONG. REC. S14775-776 (daily ed. Nov. 18, 1999).

109. *Id.* at 14775.

110. *See id.* at 14776.

111. *Id.*

112. *Id.*

113. *Hearings on H.R. 2260 Before the Subcomm. on the Const. of the House Judiciary Comm.* 106th Cong. 1999 WL 427145 (F.D.C.H.) (July 24, 1999) (testimony of David E. Joranson, Senior Scientist and Director of the Pain & Policy Studies Group at the Comprehensive Cancer Center at the University of Wisconsin) [hereinafter Joranson testimony].

114. 145 CONG. REC. H10870 (daily ed. Oct. 27, 1999) (statement of Rep. Ron Paul). Representative Paul supported this goal but not this bill.

115. *See* H.R. REP. NO. 106-378, pt. 1, at 32-33 (1999).

racy.”¹¹⁶ Responding to Henry Hyde’s call for uniform national standards, Representative Barney Frank stated that “[t]he existence of a right of assisted suicide in Oregon has no effect in Massachusetts or Oklahoma or Washington State . . . [b]ut clearly the need for uniformity simply reflects a desire of people here to impose their moral views on the people of Oregon who have been found to be morally deficient in this particular regard.”¹¹⁷ The *Washington Post* noted federalism concerns with the PRPA in an editorial:

Federalism is only meaningful if members of Congress exercise restraint even when they disagree with state policies. To argue that states should be free to experiment with policy only when their experiments reflect a national democratic consensus—rather than the preferences of their own populations—is really to argue that the states themselves are only nominally more than administrative districts of the national government.¹¹⁸

Even Representative Ron Paul, who is strongly against abortion and physician-assisted suicide, took issue with the Act because, like *Roe v. Wade*, it attempted to find a national solution to an issue that should be handled by states.¹¹⁹ He expressed fear that the ultimate result could be disastrous for pro-life forces.¹²⁰ “[T]here is nothing to say that once we further establish this principle, that the federal government . . . will be used to repeal the very laws that exist in 49 states . . . that prohibit euthanasia.”¹²¹ He expressed the danger of “[introducing] the notion that our federal congresses and our federal courts have the wisdom to tell all the states how to achieve the goals of protecting life and liberty.”¹²²

In a letter to Henry Hyde, Robert Raben, Assistant Attorney General of the Department of Justice, decried the heavy handed interference with state policy that would “effectively preclude States from adopting . . . [even] carefully drafted provisions designed to protect the terminally ill.”¹²³ Raben wrote, “When an issue turns solely on ethics, not science, it is reasonable to allow individual states to reach their own conclusions, rather than impose

116. *Id.* at 32

117. *Id.*

118. Editorial, *The Assisted Suicide Ban*, WASH. POST, Nov. 1, 1999, at A26.

119. See 145 CONG. REC. H10869-10870 (daily ed. Oct. 27, 1999) (statement of Rep. Ron Paul).

120. See *id.*

121. *Id.*

122. *Id.*

123. Raben, *supra* note 100.

a uniform national standard through implied preemption of state medical standards."¹²⁴

Supporters responded that federalism was not at issue. "I have long been a strong advocate of states' rights and the limited role of the federal government," Senator Nickles told the Senate Judiciary Committee when discussing the original LDAP Act.¹²⁵ He went on to explain that the legislation simply clarifies that longstanding federal law does not allow the use of controlled substances for assisted suicide.¹²⁶

The Democrats in dissent complained further that this bill was more punitive than H.R. 4006; the PRPA could impose criminal penalties on doctors whereas its predecessor only revoked doctors' licenses.¹²⁷ They disagreed with proponents' contention that this Act would not lead to criminal liability by noting that amendments proposed by Democrats to modify the Act were rejected along strict party lines.¹²⁸ For example, when Representative Howard Berman suggested an amendment to remove criminal penalties from the Act, it was rejected.¹²⁹ The majority also rejected two amendments proposed by Representative John Conyers that would have required the government to prove a doctor's intention to cause death and also would have allowed an affirmative defense of no intent.¹³⁰ The dissenters expressed concern that the only language permitting doctors to give pain relief, even if it has the unintended consequence of causing death, appears in the Act's introduction and is not "written in an operative manner."¹³¹ The language could "leave physicians exposed to penalties 'even if their subjective intent was to provide palliative care.'"¹³² The minority on the Commerce Committee lamented the lack of subcommittee

124. *Id.*

125. *Pain Management and End of Life Care: Hearing on S. 1272 Before the Senate Judiciary Comm.*, 106th Cong. (1999) (statement of Sen. Don Nickles).

126. *See id.*

127. *See* H.R. REP NO. 106-378, pt. 1, at 34-35 (1999).

128. *See id.* at 35.

129. *See id.*

130. *See id.* at 37.

131. *Id.* at 36. The dissenters believe that the language of intent stated in the introduction to the PRPA only states the bill's purpose but does not compel prosecutors to abide by any set standard. *Id.* at 36-37. They argued that "the weight of legal authority supports the view that the bill may result in strict liability for physicians . . . [leaving doctors] exposed to penalties[.]" regardless of whether their only intention was to provide pain relief. *Id.* at 37.

132. *Id.* at 37 (quoting from Letter from Nicholas W. van Aelstyn, Heller Ehrman White & McAuliffe, to the Honorable Ron Wyden (D-Or.), U.S. Senator (July 21, 1999)).

hearings or markup of the bill on such a complicated and controversial issue.¹³³ They decried the prospect of DEA agents second-guessing doctors and suggested that the Act would make doctors afraid to prescribe sufficient pain medication, thereby increasing suicides by patients unable to bear their pain.¹³⁴

Supporters denied that the PRPA would expand the investigatory or enforcement powers of the DEA.¹³⁵ They believed that it would only reinforce powers already present and allow doctors to use pain medications effectively. "[W]e are drawing a clear line of distinction there that gives the physician the guidance they need, it takes the discretion away from a DEA agent, and it follows the same path that we have handled in our cases under the Controlled Substances Act for decades and decades," Representative Asa Hutchinson of Arkansas said on the floor of the House.¹³⁶

Opponents agreed that the Act would reinforce powers already present and concluded that the Act is redundant. They suggested that the legislation was unnecessary to insure adequate pain relief because the law¹³⁷ clearly states that "[t]his section is not intended to impose any limitation on a physician . . . to administer or dispense narcotic drugs to persons with intractable pain in which no relief or cure is possible."¹³⁸ In its 1974 regulations and again in its 1990 Physicians' Manual, the DEA had clarified that doctors may prescribe opioids for intractable pain.¹³⁹ They urged support for

133. See H.R. REP. NO. 378, pt. 2, at 17 (1999).

134. See *id.*

135. See, e.g., 145 CONG. REC. H10874 (daily ed. Oct. 27, 1999) (statement of Rep. Bart Stupak; statement of Rep. Asa Hutchinson).

136. *Id.* at H10874 (statement of Rep. Asa Hutchinson).

137. 21 CFR § 1306.07 (1999) (discussing the administering or dispensing of narcotic drugs).

138. 21 CFR § 1306.07(c) (1999).

139. See Joranson testimony, *supra* note 113. The 1990 DEA Physician's Manual states that

[c]ontrolled substances and, in particular, narcotic analgesics, may be used in the treatment of pain experienced by a patient with a terminal illness or chronic disorder. These drugs have a legitimate clinical use and the physician should not hesitate to prescribe, dispense or administer them when they are indicated for a legitimate medical purpose.

DEA Physician's Manual at 21 *cited in* letter from John A. Gilbert, Jr., Attorney, Hymen, Phelps & McNamara, to James A. Guest, Executive Director, American Pain Foundation (Oct. 20, 1999) (on file with author).

The AMA Code of Medical Ethics also already advises doctors that "[p]hysicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death." Rich, *supra* note 102, at 35 (quoting American Medical Association, Code of Medical Ethics 40 (1996)).

other legislation such as the Advance Planning and Comprehensive Care Act of 1999¹⁴⁰ or the Conquering Pain Act of 1999,¹⁴¹ both of which concern palliative care but not assisted suicide.

B. Physicians' Reactions to the PRPA

The PRPA stirred up immediate controversy among doctors as well. The AMA, which opposed the LDAP Act, initially supported H.R. 2260 but subsequently experienced dissent among members.¹⁴² Medical groups lined up on both sides of this issue. In addition to the AMA, supporters included the National Hospice Organization, American Academy of Pain Management, American Association of Anesthesiologists, and the Catholic Health Association.¹⁴³ Opponents included the Oregon Medical Association, the American Alliance of Cancer Pain Initiatives, American Pain Foundation, American Academy of Family Physicians and the Oregon Hospice Association.¹⁴⁴ Dr. Yank Coble, representing the AMA, expressed support of the PRPA because: it acknowledges that adequate pain relief may cause death (the principle of the "double effect"), provides for coordination of systems of pain management, funds education in palliative care, and opposes physician-assisted suicide.¹⁴⁵ In addition, the AMA believes that the bill provides new protection for physicians who provide aggressive pain

140. See S. 628, 106th Cong. (1999). This bill, proposed by Senator Rockefeller on March 16, 1999 to amend the Social Security Act, would develop standards to assess end of life care, expand advance directives, provide a hotline for end of life decision-making, and provide Medicare coverage for self-administered medications for chronic pain amongst other goals.

141. See S. 941, 106th Cong. (1999). This bill, proposed by Senator Ron Wyden on May 3, 1999 to amend the Public Health Service Act, would set guidelines for treatment of pain, for quality improvement and for improved palliative care. It would provide education programs on pain management and study reimbursement barriers to adequate pain relief.

142. See H.R. REP. NO. 106-378 pt. 1, at 2 n.1 (1999). In December 1999, the AMA House of Delegates asked its parent body to lobby to eliminate those parts of the bill that would allow DEA agents to second-guess doctors and impose criminal sanctions. President Reardon expressed optimism that a compromise could be worked out with Senator Nickles such as allowing state medical societies to be part of the process. See Mark O'Keefe, *AMA Seeks Major Changes in Pain Bill*, THE OREGONIAN, Dec. 9, 1999, at A1.

143. See H.R. REP. NO. 106-378, pt. 1, at 2 n.1.

144. See *id.* at 32.

145. *Pain Management and End of Life Care: Hearings on S. 1272 Before the Comm. on Health, Education, Labor and Pensions of the Senate*, 106th Cong. (Oct. 13, 1999) (statement of Yank D. Coble, M.D., member, AMA).

relief at the end of life, thus reducing a physician's chance of being criminally prosecuted for a legitimate medical practice.¹⁴⁶

Opponents noted the problems inherent in the concept of the DEA interpreting a physician's intent. In a letter to Senator Wyden, an attorney wrote:

[T]his notion of *intent*, and the unclear manner in which it is used in S. 1272, creates troubles for physicians *in all states*, whether or not they plan to engage in physician-assisted suicide. Legally, *intent* is considered to be established where there is knowledge that the death is substantially certain to occur as a result of the conduct; however, *intent* also can be found where death should have been reasonably expected to occur as a result of the conduct. The PRPA would mandate that the criminal process resolve those difficult subjective questions after the fact.¹⁴⁷

Opponents note that a physician thus could be liable even if he merely should have known the dosage he administered was lethal.¹⁴⁸ The DEA would be compelled to make difficult judgments it might prefer not to make. The DEA Deputy Administrator has acknowledged that there is no consensus among doctors regarding the appropriate use of controlled substances in the treatment of intractable pain, which puts the "DEA . . . in a difficult position, for it is asked to determine the appropriate prescribing practices in the treatment area in which the medical profession is not in accord [It] is not the DEA's role to resolve this disagreement. It remains the role of treating physicians to make medical decisions"¹⁴⁹

Ultimately, on October 28, 1999, the House passed the Pain Relief Promotion Act of 1999 by a vote of 271-156.¹⁵⁰ Oregonians were angered. *The New York Times* reported one day after the PRPA passed that Oregon congressional members, including those who had voted against the Death with Dignity Act twice, were united in their determination to stop this bill from becoming law.¹⁵¹ Senator Ron Wyden, an opponent of assisted suicide, said he

146. *American Medical Association's position on the "Pain Relief Promotion Act of 1999"* (visited Mar. 4, 2000) <<http://www.ama-assn.org/ama/basic/article/0,1059,199-483-1,00.html>>.

147. Letter from Nicholas W. van Aelstyn, Attorney, Heller Ehrman White & McAuliffe, to Senator Ron Wyden (Oct. 1, 1999) (on file with author).

148. *See id.*

149. 64 Fed. Reg. 25,073, 25079 (1999).

150. *See* Pear, *supra* note 82.

151. *See* Sam Howe Verhovek, *Oregon Chafes at Measure to Stop Assisted Suicide*, N.Y. TIMES, Oct. 29, 1999, at A1.

would filibuster if the bill reached the Senate floor.¹⁵² On January 24, 2000, he notified the minority leader that he had placed a hold on H.R. 2260.¹⁵³ Governor Kitzhaber said he would explore possible legal challenges if the PRPA becomes law.¹⁵⁴ Thus, it is likely that opponents of the PRPA will challenge the amendment in the Supreme Court if it is passed by the Senate in the next Congress and signed into law.

III. CONSTITUTIONAL CONSIDERATIONS RELATED TO THE PRPA

In advance of Section IV, which will evaluate the PRPA in light of constitutional provisions, this section reviews recent U.S. Supreme Court rulings that may influence its holdings. In addition, it examines constitutional grants or limitations of power that may have an impact on the constitutional discussion. Finally, it considers the concept of provisional adjudication that might provide a prudent rationale for postponing final resolution of this issue.

A. The Supreme Court Rules on Assisted Suicide

In 1997, the Supreme Court considered the constitutionality of two state laws that made physician-assisted suicide illegal.¹⁵⁵ The Court, while finding no constitutional right to assisted suicide, suggested in *Washington v. Glucksberg*¹⁵⁶ that states and the democratic process have appropriate roles to play in forming policy on this issue.¹⁵⁷

The Supreme Court upheld a statute forbidding assisted suicide in *Vacco v. Quill*.¹⁵⁸ There, the question was whether New York State's statute prohibiting assisted suicide violated the Equal Protection Clause of the Fourteenth Amendment.¹⁵⁹ Respondents¹⁶⁰ claimed that although the right to refuse life-sustaining treatment is not distinguishable from the right to physician-assisted suicide, the

152. *See id.*

153. A "hold" means that he is asking to be notified if the bill reaches the Senate floor, presumably because he would wish to be there to filibuster.

154. *See* Verhovek, *supra* note 151.

155. *See* *Vacco v. Quill*, 521 U.S. 793 (1997); *Washington v. Glucksberg* 521 U.S. 702 (1997).

156. 521 U.S. 702.

157. *See id.* at 716.

158. *See Quill*, 521 U.S. at 809.

159. *See id.* at 796.

160. Respondents were three practicing physicians who would have prescribed lethal medications to competent, terminally ill patients but for the statute, and three patients who had died by the time of the decision. *See id.* at 797.

law treats these choices differently.¹⁶¹ They contended that this disparity violates the Equal Protection Clause.¹⁶² The Court rejected the lower court's conclusion that withdrawal of life-sustaining treatment is essentially assisted suicide.¹⁶³ In the Court's opinion, a patient who refuses life-sustaining treatment may not intend death, even though he dies from his underlying disease, whereas a person ingesting lethal drugs intends to die and is killed, not by disease, but by medication.¹⁶⁴ Furthermore, a doctor who withdraws treatment at a patient's request intends only to follow the patient's wishes and to cease futile care, whereas a doctor who assists a suicide "must, necessarily and indubitably, intend primarily that the patient be made dead."¹⁶⁵ The Court also saw no parallel between providing palliative care to someone who then dies more quickly (the so called "double effect") and physician-assisted suicide.¹⁶⁶ Since the Court found New York's decision to ban assisted suicide in order to preserve life, prevent suicide, protect vulnerable people and avoid a possible slide towards euthanasia legitimate,¹⁶⁷ the Court found the statute constitutional.

In a second case, *Washington v. Glucksberg*, respondents were physicians who treated terminally ill patients and who declared that they would help some patients die were it not for the Washington ban on assisted suicide.¹⁶⁸ The Court unanimously ruled that Washington's law did not violate the Constitution, and five justices joined in the opinion of the Court written by Chief Justice Rehnquist.¹⁶⁹ Rehnquist found that although the nation has moved from

161. *See id.* at 798.

162. *See id.*

163. *See id.*

164. *See id.* at 800-01. In a contrasting view, in *Cruzan v. Director, Mo. Dep't of Health*, Justice Scalia, who voted with the majority in *Glucksberg* and *Quill*, argued that refusing treatment which results in death is suicide. 497 U.S. 261, 296 (1990). "Starving oneself to death is no different from putting a gun to one's temple as far as the common-law definition of suicide is concerned; the cause of death in both cases is the suicide's conscious decision to 'put an end to his own existence.'" *Id.* at 296-97 (citations omitted).

165. *Quill*, 521 U.S. at 801-02.

166. *See id.* at 807 n.11.

167. *See id.* at 808-09.

168. *See id.* at 707. They were joined by three terminally ill patients who had died by the time the Court heard arguments and by the organization Compassion in Dying. *See id.* at 707-08.

169. *See id.* at 704. For Chief Justice Rehnquist, this issue may have held special significance because of his wife's death in 1991 after a protracted fight with ovarian cancer. Also, Justice Breyer's wife counseled terminally ill children and their parents at a cancer institute at the time of the case. *See* PETER FILENE, *IN THE ARMS OF OTHERS: A CULTURAL HISTORY OF THE RIGHT TO DIE IN AMERICA* 199 (1998).

a punitive stance on suicide to one of greater understanding, it has retained a strong condemnation of assisted suicide.¹⁷⁰ Though the Court had previously read the liberty interest of the Due Process Clause to include the right to protection against government actions in matters of family and personal privacy, the Court hesitated to extend these rights to this issue, one that more properly should be part of "the arena of public debate and legislative action."¹⁷¹ Chief Justice Rehnquist found that Washington's ban was rationally related to legitimate government interests in preserving human life, preventing suicide, protecting the integrity and ethics of doctors, protecting vulnerable groups who might be coerced into choosing suicide, and preventing a slide down the "slippery slope" towards voluntary or involuntary euthanasia.¹⁷² The ban on assisted suicide was found not to violate the Fourteenth Amendment on its face or as applied to competent terminally ill patients.¹⁷³ The Court wrote that since "Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide," this holding will allow the "debate to continue, as it should in a democratic society."¹⁷⁴

Thus, while finding no constitutional right to physician-assisted suicide, Justice Rehnquist urged that the debate on assisted suicide continue in our democratic society. Justice O'Connor (joined by Justice Ginsberg and Justice Breyer, in part)¹⁷⁵ and Justice Souter¹⁷⁶ deferred to the states to explore this issue further, and Justice

170. See *Glucksberg*, 521 U.S. at 710-719.

171. *Id.* at 720.

172. *Id.* at 733 n.23.

173. See *id.* at 735. Justice Rehnquist agreed with Justice Stevens that another plaintiff might prevail in a more particularized challenge, but said the claim would have to differ greatly from that of *Glucksberg*. See *id.* at 735 n.24.

174. *Id.* at 735.

175. In her concurrence, Justice O'Connor, made the point that, in New York and Washington, any terminally ill patient suffering great pain can obtain medication legally from a doctor to relieve his suffering even though unconsciousness or death may ensue. See *id.* at 736 (O'Connor, J., concurring). Thus, to avoid the "slippery slope" dangers, the Court should not rule assisted suicide constitutional. See *id.* at 737. She agreed that this issue should be left to the democratic processes and the "laboratory of the States." *Id.*

176. Justice Souter concurred in the judgment of the Court for two reasons. First, he argues that the state had a powerful enough interest in protecting vulnerable people and in preventing the potential slide into legal euthanasia to defeat the respondents' claim. See *id.* at 782-83 (Souter, J., concurring). Second, he reasoned that state legislatures are the appropriate forum for consideration of this issue. See *id.* at 788. Souter wrote that "[t]he experimentation that should be out of the question in constitutional adjudication displacing legislative judgments is entirely proper, as well as

Stevens suggested that a ban on assisted suicide might fail in some particular circumstances.¹⁷⁷

B. Federalism and the Court

1. *A Federalist Court*

A majority of the justices on the current Supreme Court have shown a strong commitment to the federalist principle of protecting state sovereignty, which may influence how they view the impact of the PRPA on Oregon's law. The Framers, who believed that "freedom was enhanced by the creation of two governments, not one,"¹⁷⁸ forged a system wherein power would be shared by the federal and state governments. As they fashioned a new form of government, the Framers determined that "[t]he powers delegated by the proposed Constitution to the federal government [would be] few and defined" whereas the states' powers would be "numerous and indefinite."¹⁷⁹ While the federal government would be concerned with such issues as "war, peace, negotiations and foreign commerce," the states could control issues concerning "the lives, liberties and properties of the people; and the internal order, improvement and prosperity of the State."¹⁸⁰

Ideally, in allocating power to the federal government or to the states, the analysis would center on which arrangement could result in the most effective government.¹⁸¹ For example, the national government is likely to be better at defense, foreign policy, trade, large-scale transportation infrastructure such as interstate highways, and national currency.¹⁸² It has the power to make laws that can control negative externalities that one state may impose on an-

highly desirable, when the legislative power addresses an emerging issue like assisted suicide." *Id.* at 789.

177. Justice Stevens, although joining the opinion, appeared to favor physician-assisted suicide in some circumstances and foresaw that a mentally competent person seeking assisted suicide might "prevail in a more particularized challenge." *Id.* at 741, 750 (Stevens, J., concurring). He wrote that some state intrusions on people's decisions on how to die are intolerable. *See id.* at 745. Stevens saw "no absolute right to physician-assisted suicide" but believed that people who are near death should be able to decide "how . . . a critical threshold [that is, the threshold to death] shall be crossed." *Id.* The state's interests will not have the same force when a patient is terminally ill. *See id.* at 745-46.

178. *United States v. Lopez*, 514 U.S. 549, 576 (1995).

179. *FEDERALIST* NO. 45 at 303 (James Madison) (Clinton Rossiter ed., 1961).

180. *Id.*

181. *See* Erwin Chemerinsky, *Formalism and Functionalism in Federalism Analysis*, 13 GA. ST. U. L. REV. 959, 960 (1997).

182. *See* Steven G. Calabresi, "A Government of Limited and Enumerated Powers": In Defense of *United States v. Lopez*, 94 MICH. L. REV. 752, 780, 787 (1995).

other through its activities.¹⁸³ Furthermore, the federal government can protect unpopular minorities, whereas a homogeneous state government might be unwilling to act.¹⁸⁴

States, on the other hand, can meet the particular needs of their constituents. Chief Justice Rehnquist has written of the traditional services that states provide their citizens, such as "fire prevention, police protection, sanitation, public health, and parks and recreation."¹⁸⁵ Professor Steven Calabresi has noted that the United States has four major and distinct regions, (the Northeast, the Midwest, the South and the West), each of which "vote[s] very differently . . . and . . . disagree[s] on matters of religion, culture, and to some extent, on race and ethnicity."¹⁸⁶ The "libertarian" West may favor policies such as physician-assisted suicide that are abhorrent to the "religious, more culturally conservative" South.¹⁸⁷ Acting on their distinctive cultural, social and political mores, states can experiment with new ideas that may ultimately influence their neighbors. In 1932, Justice Brandeis stated that "[i]t is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."¹⁸⁸ Seconding this value of federalism, Justice O'Connor has noted that women's suffrage, begun in Wyoming in 1890, preceded national suffrage by thirty years¹⁸⁹ and that unemployment insurance, minimum wage laws for women and minors, and no-fault automobile insurance all began as state initiatives.¹⁹⁰ No doubt other experiments were tried and abandoned but at no risk to the nation at large.

Furthermore, Justice O'Connor has cautioned that "[c]itizens . . . cannot learn the lessons of self-government if their local efforts are devoted to reviewing proposals formulated by a faraway national legislature [C]itizens must retain the power to govern, not merely administer, their local problems."¹⁹¹ The Court's federalists

183. See *id.* at 781.

184. See *id.* at 784.

185. *National League of Cities v. Usery*, 426 U.S. 833, 851 (1976), *overruled by Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528 (1985).

186. Calabresi, *supra* note 182, at 766.

187. *Id.* at 767.

188. *New State Ice Co. v. Liebman*, 285 U.S. 262, 386-87 (1932) (Brandeis, J., dissenting).

189. See *Federal Energy Regulatory Comm'n v. Mississippi*, 456 U.S. 742, 788 (1982) (O'Connor, J., concurring in part, dissenting in part).

190. See *id.* at 788-89.

191. *Id.* at 790.

seek to “zealously protect [the] distinctions” between state and federal power lest we “[upset] the balance of power that buttresses our basic liberties.”¹⁹² Responding to an increase in federal crimes, Chief Justice Rehnquist wrote that

[t]he trend to federalize crimes that traditionally have been handled in state courts . . . threatens to change entirely the nature of our federal system. The pressure in Congress to appear responsive to every highly publicized societal ill . . . needs to be balanced with an inquiry into whether . . . we want most of our legal relationships decided at the national rather than local level.¹⁹³

Thus, this Court weighs the balance of power between states and the federal government with care and seeks to protect federalist values. The Court has held at least twenty federal laws unconstitutional since the 1994-1995 term¹⁹⁴ and has displayed a renewed emphasis on protecting state sovereignty.¹⁹⁵ This philosophy may influence how the Court rules on the constitutionality of the PRPA.

192. *Id.*

193. William H. Rehnquist, *The 1998 Year-End Report of the Federal Judiciary*, 11 FED. SENT. R. 134 (Nov./Dec. 1998).

194. See The Committee on Federal Legislation, *The New Federalism*, 54 THE RECORD (Association of the Bar of the City of New York) 712 (1999).

195. The Supreme Court has followed a pendulum's swing over the many years of its judgments. In *McCulloch v. Maryland*, 17 U.S. (4 Wheat) 316 (1819), the Court held the federal government supreme in power to the states when it allowed Congress to charter a national bank and forbade Maryland to follow its practice of taxing banks not chartered by the state. In 1824, Chief Justice Marshall gave broad powers to Congress to legislate under the Commerce Clause, allowing it to legislate with respect to all commercial intercourse that concerns more than one state. See *Gibbons v. Ogden*, 22 U.S. (9 Wheat) 1, 194 (1824).

The period from 1887-1937 is generally described as one in which the Court reversed direction and found much congressional action unauthorized by its Commerce Clause power. Laurence Tribe points out, however, that the Court ruled against Congress on only eight occasions. LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 810 (3d ed. 2000). Nevertheless, these eight rulings had great impact. “Like the proverbial sword of Damocles, they exert[ed] their influence simply by hanging overhead and not falling.” *Id.* The Court's construction of the term “commerce” was narrow, allowing Congress to regulate trade, but not permitting it to regulate such activities as mining or manufacturing even if the resulting products would enter interstate commerce. See *id.*

The pendulum swung again with *United States v. Darby*, 312 U.S. 100 (1941). Here, the Court found that Congress' power “extends to those activities intrastate which so affect interstate commerce . . . as to make regulation of them appropriate means to the attainment of [Congress' granted interstate commerce power].” *Id.* at 118. The Court ruled that the Tenth Amendment, which “states but a truism that all is retained which has not been surrendered,” offered no barrier to Congress' authority over interstate commerce. *Id.* at 124. Following *Darby*, the Court continued to show deference to federal power until the present period of renewed federalism.

2. *The Rebirth of Tenth Amendment Rights*

Although subsequently overruled, *National League of Cities v. Usery*¹⁹⁶ marked the beginning of the Court's federalist revival after many years of deference to Congress. Writing for the Court, Justice Rehnquist held that Congress could not, within its Article I powers, "directly displace the States' freedom to structure integral operations in areas of traditional governmental functions."¹⁹⁷ Accordingly, the Court invalidated the 1974 Amendments to the Federal Labor Standards Act, which extended minimum wage and hour laws to state municipal workers.¹⁹⁸ Permitting Congress to dictate terms under which the State hired its workers, the Court held, would intrude upon "integral governmental functions"¹⁹⁹ and make it harder for states to work effectively in a federal system.²⁰⁰ Permitting Congress to prevent states from making "those fundamental employment decisions upon which their systems for performance of [the traditional functions of state governments] must rest . . . we think there would be little left of the States' 'separate and independent existence.'"²⁰¹

National League of Cities was overturned by *Garcia v. San Antonio Metropolitan Transit Authority*,²⁰² which found the previous "attempt to draw the boundaries of state regulatory immunity in terms of 'traditional government function' . . . unworkable . . ."²⁰³ Acknowledging the important place of states in the constitutional system, the Court nevertheless believed that the political system would "[ensure] that laws that unduly burden the states will not be promulgated."²⁰⁴ Justice Rehnquist may have been dismayed by this ruling, but the confidence revealed in his dissent that the Court would change its views again was soon vindicated.²⁰⁵

*Gregory v. Ashcroft*²⁰⁶ signified the beginning of that change.²⁰⁷ Justice O'Connor began her opinion with a description of the val-

196. 426 U.S. 833 (1976), *overruled by* *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528 (1985).

197. *Id.* at 852.

198. *See id.* at 837-38.

199. *Id.* at 851.

200. *See id.* at 852.

201. *Id.* at 851 (quoting *Coyle v. Oklahoma*, 221 U.S. 559, 580 (1911)).

202. 469 U.S. 528 (1985).

203. *Id.* at 531.

204. *Id.* at 556.

205. *See id.* at 580 (Rehnquist, J. dissenting).

206. 501 U.S. 452 (1991).

207. The issue in *Gregory* was whether Missouri was violating the Age Discrimination in Employment Act of 1967 ("ADEA") by requiring state judges to retire at age

ues of federalism, noting how a “healthy balance of power” between the federal government and the states could “reduce the risk of tyranny” and how the Tenth Amendment permits States to “retain substantial sovereign authority.”²⁰⁸ “In the tension between federal and state power,” O’Connor contended, “lies the promise of liberty.”²⁰⁹ The Court refused to read the Age Discrimination in Employment Act of 1967 (“ADEA”) as covering judges without a clear statement from Congress to that effect.²¹⁰ Furthermore, the Court ruled that if Congress intends to change the constitutional balance between the federal government and the states, it must do so with a clear statement of intent.²¹¹ Finding no such statement within this Act, the Court decided that the ADEA could not supersede the Missouri law.²¹² The Court appeared to be returning to the methodology of *National League of Cities*, defining areas of state activity that Congress could not regulate.²¹³ It began by reaffirming the importance of federalism, moved on to defining an area that should remain within state control and then “erected the plain statement rule to either completely protect or at least partially shield this delineated area of state sovereignty from federal regulation.”²¹⁴

Federalism continued its recovery with *New York v. United States*.²¹⁵ The Court defined the issue as one of “discerning the proper division of authority between the Federal Government and

seventy. See *id.* at 455-57. The ADEA included the states as employers but excluded elected officials, personal staff of elected officials, appointees on the policymaking level, or legal advisers from the term “employee.” See 29 U.S.C. § 630(f) (1967).

208. *Gregory*, 501 U.S. at 457-460. The Tenth Amendment states, “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.” U.S. CONST. amend. X.

209. *Id.* at 459.

210. See *id.* at 467.

211. See *id.* at 460-61 (citing *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 243 (1985)).

212. See *id.* at 473.

213. See John C. Yoo, *The Judicial Safeguards of Federalism*, 70 S. CAL. L. REV. 1311, 1339 (1997). Over the years, the Court has moved between two interpretations of the Tenth Amendment. Either it is seen as a reminder that Congress can act within its express or implied authority and no law in Congress’ power will be invalidated as invading states’ rights, or, as it appears in *Gregory*, the Tenth Amendment “reserves a zone of activities to the states” which Congress may not enter even while exercising its Article I power. Chemerinsky, *supra* note 181, at 971.

214. Yoo, *supra* note 213, at 1339.

215. 505 U.S. 144 (1992). The case analyzed the constitutionality of the “take title” provision of the Low-Level Radioactive Waste Policy Amendments Act of 1985, which compelled states that did not meet a deadline to develop plans for disposal of low-level radioactive waste to take possession of the waste and become liable for any damages it caused. See *id.* at 153 (describing 42 U.S.C. § 2021e(d)(2)(C)).

the States, [a] constitutional question . . . as old as the Constitution."²¹⁶ Justice O'Connor, writing for the majority, declared the "take title" provision unconstitutional because it sought to "compel the States to enact or administer a federal regulatory program."²¹⁷ In an interesting analysis of the Tenth Amendment, Justice O'Connor explained that "Congress exercises its conferred powers subject to [constitutional] limitations."²¹⁸ Although Congress might legitimately regulate publishers under the Commerce Clause, it could be limited in that power by the First Amendment.²¹⁹ Similarly, other powers granted to Congress by the Constitution might be limited by the state sovereignty granted by the Tenth Amendment.²²⁰ In *New York*, the Court determined that "an incident of state sovereignty is protected by a limitation on an Article I power."²²¹

In *Printz v. United States*,²²² the Court reaffirmed that Congress may not compel a state to "enact or enforce a federal regulatory program," and extended the prohibition to direct "conscripting of the States' officers."²²³ Sheriffs challenged amendments to the "Brady Bill" on Tenth Amendment grounds.²²⁴ The government argued that it could ask state officials for limited assistance in enforcing federal law that regulates private conduct because the government would not be asking the states to make policy, as in *New York*.²²⁵ Justice Scalia rejected the distinction between "'policymaking' and mere 'implementation'" as impossible to draw and stated that "an imprecise barrier against federal intrusion upon state authority is not likely to be an effective one."²²⁶ Furthermore, Scalia contended that a state's independence and autonomy is less undermined when it can make policy than when it is simply compelled to follow federal directives.²²⁷ In following a federal di-

216. *Id.* at 149.

217. *Id.* at 188.

218. *Id.* at 156.

219. *See id.*

220. *See id.* at 157.

221. *Id.*

222. 521 U.S. 898 (1997).

223. *Id.* at 935. Amendments to the Federal Gun Control Act (commonly called the "Brady Bill") temporarily required the chief law enforcement officer in local jurisdictions to conduct background checks on people seeking to buy guns to insure that potential purchaser did not fall into prohibited categories. *See id.* at 903.

224. *See id.* at 904-05.

225. *See id.* at 926-27.

226. *Id.* at 927-28.

227. *See id.*

rective, states will also be “put in the position of taking the blame for the directive’s burdensomeness and defects.”²²⁸

Justice Stevens’s dissent contended that the Commerce Clause in conjunction with the Necessary and Proper Clause²²⁹ granted the power to regulate the sale of guns and thus validated Congress’ right to legislate in the Brady Bill. Justice Scalia’s majority opinion offered the following analysis:

When a “[l]a[w] . . . for carrying into Execution” the Commerce Clause violates the principle of state sovereignty reflected in the various constitutional provisions we mentioned earlier . . . it is not a “[l]a[w] . . . proper for carrying into Execution the Commerce Clause,” and is thus, in the words of The Federalist, “merely [an] ac[t] of usurpation” which “deserve[s] to be treated as such.”²³⁰

Furthermore, Justice Scalia contended that because “numerous constitutional provisions” reflect “our system of dual sovereignty . . . [i]t is not at all unusual for our resolution of a significant constitutional question to rest upon reasonable implications.”²³¹

The Court has continued to render decisions that show a commitment to protecting state sovereignty.²³² This trend may influence how the Court rules on the constitutionality of the PRPA.

228. *Id.* at 930.

229. U.S. CONST. art. I § 8, cl. 18. “The Congress shall have the Power . . . To make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers” *Id.* Justice Stevens argued that such powers include regulation of commerce in guns. See *Printz*, 521 U.S. at 941 (Stevens, J. dissenting).

230. *Id.* at 923-24 (quoting THE FEDERALIST NO. 33 (Alexander Hamilton)). Scalia cited the following constitutional provisions earlier in *Printz*: the Guarantee Clause; the Tenth Amendment; the prohibition on involuntary reduction of a State’s territory, Art. IV, § 3; the Judicial Power Clause, Art III, § 2; the Privileges and Immunities Clause, Art. IV, § 2, speaking of the “Citizens” of the States; and the amendment provision, Article V. See *id.* at 919.

231. *Id.* at 923-24 n.13 (citations omitted).

232. See, e.g., *City of Boerne v. Flores*, 521 U.S. 507 (1997) (striking down the Religious Freedom Restoration Act, which required compelling state interests should the government attempt to burden the exercise of religious rights. Congress cannot create new constitutional rights, and its powers under § 5 of the Fourteenth Amendment extend only to enforcing the rights already guaranteed by the Fourteenth Amendment); *Seminole Tribe of Fla. v. Florida*, 517 U.S. 44 (1996) (holding that the Commerce Clause does not give Congress the power to override a State’s immunity under the Eleventh Amendment); *College Savings Bank v. Florida Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666 (1999) (holding that the Eleventh Amendment precludes suits of states in federal courts for their trademark infringements, and striking down the Trademark Remedy Clarification Act, 15 U.S.C. § 1122, which permitted such suits); *Alden v. Maine*, 527 U.S. 706 (1999) (disallowing suit in state or federal court for violations of provisions of the Fair Labor Standards Act, 29 U.S.C. § 216(b), which required the State to give its employees overtime pay).

3. *The Guarantee Clause and Federalism*

The Guarantee Clause²³³ provides another area for judicial review in deciding the constitutionality of the PRPA. This Clause provides that “[t]he United States shall guarantee to every State in this Union a Republican Form of Government”²³⁴ The Guarantee Clause has been an integral part of federalism, allowing states a federal guarantee to experiment with various forms of government.²³⁵ As Professor Deborah Jones Merritt suggested, states can only have a republican form of government if the federal branches permit them the autonomy to initiate and preserve their own forms of government.²³⁶

The Guarantee Clause has two principle aspects: states may not adopt non-republican forms of government; and, if states adhere to republican principles, the federal government may not act in ways that would destroy this republican character.²³⁷ In tracing the history of the Clause, Merritt notes that “although the original impulse behind the Clause might have been a desire to protect the states from the dangers of aristocratic government or internal rebellion, the broad language of the Clause secured the states against any threat to ‘republican’ government [including] intrusions by the federal government.”²³⁸

Voter initiatives would seem to be a novel way for states to experiment with their form of government. However, as soon as initiatives were introduced, they were attacked as not fitting a republican form.²³⁹ Oregon’s 1902 constitutional amendment per-

233. U.S. CONST. art. IV, § 4.

234. *Id.* .

235. See William T. Mayton, *Direct Democracy, Federalism & the Guarantee Clause*, 2 GREEN BAG 2D, 269, 270 (1999).

236. Deborah Jones Merritt, *The Guarantee Clause and State Autonomy: Federalism for a Third Century*, 88 COLUM. L. REV. 1, 2 (1988).

237. See *id.* at 25. There are several valuable effects when states have their appropriate share of power under the federal system and are spared federal intrusion. First, states can “check national power by serving as a wellspring of political force”. *Id.* at 5. They can lobby the federal government, sue it or regulate in areas the federal government has ignored. See *id.* at 5-6. Second, citizens can participate more readily in state and local government. See *id.* at 6. This creates the secondary benefits of training citizens in democracy, giving voters trust in the democratic system and compelling local officials to be accountable. See *id.* Third, allocating power to states allows different social and political climates to flourish in different communities. See *id.* at 8. Finally, this allocation of power creates opportunities for the creation of new ideas and programs as fifty states attempt to craft solutions for their individual pressing issues. See *id.* at 4.

238. *Id.* at 35.

239. See Mayton, *supra* note 235, at 273.

mitting voter initiatives was tested in *Kadderly v. City of Portland*.²⁴⁰ The Oregon Supreme Court held that the amendment did not violate the Guarantee Clause.²⁴¹ “The people have simply reserved to themselves a larger share of legislative power, but they have not overthrown the republican form of the government, or substituted another in its place.”²⁴²

Historically, the Guarantee Clause has not played a major part in Supreme Court jurisprudence. The Court refused to rule in an 1849 Guarantee Clause case, *Luther v. Borden*,²⁴³ because the case turned on “political rights and political questions.”²⁴⁴ Justice O’Connor has complained that an initially “limited holding” by the Court has “metamorphosed into the sweeping assertion” that violations of the Guarantee Clause are nonjusticiable.²⁴⁵ O’Connor noted that the Court in *Reynolds v. Sims* suggested that some Guarantee Clause claims are justiciable when it stated that “some questions raised by the Guarantee Clause are nonjusticiable.”²⁴⁶ More recently, the Court has mentioned the Guarantee Clause as relevant to the power of states to “determine the qualifications of their most important government officials”²⁴⁷ and as indicative that the states retain sovereignty and reserved rights.²⁴⁸

C. The Commerce Clause

1. *United States v. Lopez*

Article I, Section 8, of the Commerce Clause, allows Congress “[t]o regulate Commerce . . . among the several States.”²⁴⁹ As noted previously, Congress’ powers under the Commerce Clause

240. See 44 Or. 118 (1903).

241. See *id.* at 144.

242. *Id.* at 145.

243. 48 U.S. (7 How.) 1 (1849).

244. Mayton, *supra* note 235, at 275. This was a case where conflicting groups each attempted to establish themselves as the legitimate governments of Rhode Island. One group, the Dorrites, eventually lost the contest and their leader, Dorr, was arrested for treason by the group in power, the Charter government. See *id.* Several years later, when the issue was basically moot, the Supreme Court was asked to rule whether Dorr’s arrest had been unlawful because, it was argued, his party had been the legitimate governors of the state at the time of Dorr’s arrest. See *id.* Thus the Court had to decide if the Dorrites had established themselves as the rightful state government under the Guarantee Clause. See *id.* The court refused to rule on this issue. See *id.*

245. *New York v. United States*, 505 U.S. 144, 184 (1992).

246. *Id.* at 185 (quoting *Reynolds v. Sims*, 377 U.S. 533, 582 (1964)).

247. *Gregory v. Ashcroft*, 501 U.S. 452, 463 (1991).

248. See *Printz v. United States*, 521 U.S. 898, 917 (1997).

249. U.S. CONST. art. 1, § 8, cl. 3.

have waxed and waned.²⁵⁰ In *United States v. Lopez*,²⁵¹ a case with great import in evaluating the constitutionality of the PRPA, the Court reined in Congress' greatly expanded Commerce Clause powers.²⁵² *Lopez* was a twelfth grade student who had been arrested on school premises carrying a handgun and bullets.²⁵³ State charges for firearm possession on school premises were dismissed after federal agents charged Lopez under the Gun Free School Zones Act of 1990 ("GFSZA").²⁵⁴ This Act made it a federal offense for a person "knowingly to possess a firearm at a place that the individual knows, or has reasonable cause to believe, is a school zone."²⁵⁵

The District Court found Lopez guilty, but the Court of Appeals for the Fifth Circuit reversed, finding that Congress had exceeded its powers under the Commerce Clause.²⁵⁶ The Supreme Court affirmed.²⁵⁷ Writing for the majority, Chief Justice Rehnquist began with a statement, "[w]e start with the first principles," and continued with a description of the benefits of federalism and the judicial history of the Commerce Clause.²⁵⁸ He determined that Congress has the right to regulate the channels and instrumentalities of interstate commerce, and also "those activities having a substantial relation to interstate commerce."²⁵⁹ The Court found that the GFSZA regulated activity that was neither part of commerce nor an "essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated."²⁶⁰ Nor did the statute contain a jurisdictional element to ensure thorough analysis of each case that the firearm possession in question actually affected interstate commerce.²⁶¹ By criminalizing conduct already criminalized by most states and infringing on an area in which states have primary authority, Congress was disturbing a sensitive balance between federal and state

250. See *supra* note 195.

251. 514 U.S. 549 (1995).

252. See *id.* at 561.

253. See *id.* at 551.

254. See *id.*

255. *Id.* (quoting 18 U.S.C. § 922(g)(1)(A)(Supp. V 1988).

256. See *id.* at 552.

257. See *id.*

258. *Id.* at 552-562.

259. *Id.* at 558-59.

260. *Id.* at 561.

261. See *id.*

power.²⁶² Gun possession could not be considered an economic activity affecting interstate commerce even if many people possessed guns.²⁶³ “To uphold the Government’s contentions here,” Rehnquist continued, “we would have to pile inference upon inference in a manner that would bid fair to convert congressional authority under the Commerce Clause to a general police power of the sort retained by the States.”²⁶⁴

The following two principles emerge from *Lopez*: (1) Congressional power is limited and extends only to those activities that substantially affect interstate commerce;²⁶⁵ and (2) the Court will be less deferential when reviewing congressional powers than it has been in the past, subjecting them to a stronger rational basis standard.²⁶⁶ Congress may not “use a relatively trivial impact on commerce as an excuse for broad general regulation of state or private activities.”²⁶⁷ The Court found that two types of laws substantially affect interstate commerce: those that regulate an intrastate commercial activity that substantially affects interstate commerce when viewed in the aggregate; and those that “include a jurisdictional element allowing ‘case by case inquiry’ to ensure that specific applications of the law do in fact substantially affect interstate commerce.”²⁶⁸ One can also distinguish *Lopez* by the following factors which may not often arise in Commerce Clause cases: Congress was entering two spheres traditionally left to the states, education and crime; it was legislating a national solution where none was needed; and it was regulating an activity that had only a tenuous connection to interstate commerce.²⁶⁹

262. See *id.* at n.3. Responding to the government’s contention that violent crime has negative effects on education, travel and commerce, the Court stated that “[u]nder the [Government’s] theories . . . 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.” *Id.* at 564.

263. See *id.* at 567.

264. *Id.* In his concurrence, Justice Kennedy also found no evident commercial nexus in the statute and criticized it for preventing State experimentation in an area of traditional state concern “to which States lay claim by right of history and expertise.” *Id.* at 583.

265. See Deborah Jones Merritt, *Commerce!*, 94 MICH. L. REV. 674, 677 (1995).

266. See *id.*

267. *Lopez*, 514 U.S. at 558 (quoting *Maryland v. Wirtz*, 392 U.S. 183, 197 n.27 (1968)).

268. Douglas W. Kmiec, *Is the Violence Against Women Act a Valid Exercise of Congressional Power?*, 4 PREVIEW 210 (Dec. 20, 1999).

269. David B. Kopel & Glenn H. Reynolds, *Taking Federalism Seriously: Lopez and the Partial-Birth Abortion Ban Act*, 30 CONN. L. REV. 59, 107 (1997). The particular circumstances of *Lopez* may explain why there have been few lower court decisions limiting Congressional Commerce Clause action. The most significant reliance

Professor Deborah Jones Merritt has designed a series of criteria to help determine if an activity is more likely to be considered interstate commerce by the Court.²⁷⁰ An activity is more likely to be interstate commerce if it is commercial or economic, if it falls in an area where national regulation is needed, and if it is connected to the workplace and concerns employer-employee conduct.²⁷¹ An activity is less likely to be interstate commerce, and thus not within Congress' authority to regulate, if it concerns an area, like education, that is traditionally regulated by the states, if it regulates private property, if it seeks to regulate a crime already punishable by state law, or if it appears to so broadly grant congressional power that permitting this law would allow congressional regulation of all sorts of conduct.²⁷² Furthermore, if the statute in question fails to provide a jurisdictional element that links the activity to interstate commerce and lacks explicit congressional findings connecting the law to commerce, the Court is less likely to find that the statute

on *Lopez* has been *Brzonkala v. Virginia Polytechnic Inst. and State Univ.*, 169 F.3d 820 (4th Cir.), *cert. granted*, 60 U.S. L.W. 3175 (U.S. Sept. 28, 1999) (No. 99-5, 99-29). The Fourth Circuit found that Congress lacked authority under the Commerce Clause to pass § 13981 of the Violence Against Women Act of 1994. Pub. L. No. 103-322 §§ 40001-40703, 108 Stat. 1796, 1902-55 (1994). This section was one part of a multifaceted federal response to crimes of violence against women and created "a private cause of action against any 'person . . . who commits a crime of violence motivated by gender,'" allowing the victim "to obtain compensatory damages, punitive damages, and injunctive, declaratory, or other appropriate relief." *Brzonkala*, 169 F.3d at 827.

In 1995, Christy Brzonkala filed a case under this section against two male students at her college, alleging that they had forcibly raped her in a dormitory room and then made coarse public statements indicating gender animus. *See id.* Applying *Lopez*, the Fourth Circuit Court of Appeals found that § 13981 concerned crimes that arise from gender hatred, "a type of crime relatively unlikely to have any economic character at all." *Id.* at 834. Nor would such crimes in the aggregate substantially affect interstate commerce. *See id.* The court said that "the federal patchwork of antidiscriminatory laws can hardly be characterized as a single, interdependent regulatory scheme aimed at commercial or economic activity." *Id.* Like the Court in *Lopez*, the Fourth Circuit refused to extend federal protection to traditional areas of state control. *See id.* at 844. Even if Congress was responding to a failure by states to act in this area of criminal law, Congress erred by providing a remedy against criminals rather than one against states. *See id.* at 842. By doing so, Congress "encroached upon the States' ability to determine when and how violent crime will be punished . . . [and] blurred the boundary between federal and state responsibility for the deterrence and punishment of such crime." *Id.* Shortly before this Note went to press, the Supreme Court affirmed the Fourth Circuit's ruling in a five to four majority opinion that strongly reaffirmed the *Lopez* analysis of the Commerce Clause powers. *See United States v. Morrison*, 120 S. Ct. 1740 (2000).

270. *See* Deborah Jones Merritt, *supra* note 265, at 746.

271. *See id.*

272. *See id.*

regulates interstate commerce.²⁷³ Finally, if competition among states will probably lead to positive outcomes on a particular legal issue, the Court will find that federal legislation is not required or permitted.²⁷⁴ Merritt explains that national legislation may be needed when competition between states causes each to lower its standards in a 'race to the bottom,' but is not needed when states are competing to attract citizens, either by offering services and laws desired by the public at large, or by offering "progressive regulations that appeal to some segments of the citizenry."²⁷⁵

2. *The Commerce Clause and Drug Regulation*

Of interest in this Note is how Congress' Commerce Clause powers relate to its right to regulate those drugs that might be prescribed by a doctor in assisting a suicide.

a. *Congress' History of Drug Regulation*

Congress has shown an active interest in drug regulation for more than ninety years. The Pure Food and Drug Act of 1906, which forbade the interstate shipment of adulterated or mislabeled food and drugs, represented Congress' first attempt to regulate the sale and distribution of drugs it considered dangerous.²⁷⁶ Subsequently, in 1914, Congress passed the Harrison Act²⁷⁷ and in 1922, the Narcotic Drugs Import and Export Act,²⁷⁸ two initiatives intended to regulate addictive drug consumption which remained in place until 1970. The enactment of fifty laws since 1914 regulating narcotics and dangerous drugs had led to a "confusing and often duplicative approach" to the regulation of legitimate drugs and control of the illegal drug trade.²⁷⁹ Noting that the country's problems with illicit drug use had worsened, Congress favored the creation of one piece of legislation which could unite existing laws

273. *See id.*

274. *See id.*

275. *Id.* at 706-07 (quoting William L. Cary, *Federalism and Corporate Laws: Reflections Upon Delaware*, 83 YALE L.J. 663, 705 (1974)).

276. *See* ch. 3915, 34 Stat. 768 (repealed 1938).

277. *See* ch. 1, 38 Stat. 785 (repealed 1970).

278. *See* ch. 9, 38 Stat. 275 (repealed 1970).

279. H.R. REP. NO. 91-1444 (1970). The Marijuana Tax Act of 1937 defined marijuana as a controlled substance; it was followed by other anti-drug laws such as the Opium Poppy Control Act, the Narcotic Manufacturing Act of 1960, and the 1965 amendments to the Federal Food, Drug and Cosmetic Act which targeted hallucinogens, barbiturates, and tranquilizers. *See* Kathleen F. Brickey, *Criminal Mischief: The Federalization of American Criminal Law*, 46 HASTINGS L. J. 1135, 1149 (1995).

and court rulings into one instrument.²⁸⁰ Both statutes were repealed in 1970 and replaced with the Comprehensive Drug Abuse Prevention and Control Act of 1970, also known as the Controlled Substances Act ("CSA").²⁸¹

The CSA requires every person who manufactures, distributes or dispenses any controlled substance to register with the United States Attorney General so as to obtain authority to continue his work.²⁸² Anyone who unlawfully manufactures, distributes, dispenses or possesses controlled substances is subject to criminal penalties that include imprisonment, fines or both.²⁸³ A registered physician, however, may lawfully give a patient a prescription for a controlled substance if the medical purpose is legitimate, and if he is acting "in the usual course of his professional practice."²⁸⁴ The responsibility for correctly prescribing and dispensing drugs lies with the practitioner.²⁸⁵

280. H.R. REP. NO. 91-1444 (1970).

281. See 21 U.S.C. §§ 801-904 (1970). The principal purpose of the CSA was to counter a "growing menace of drug abuse" through a three-pronged approach of prevention and rehabilitation, strengthened law enforcement for abuse prevention and control and balanced penalties for drug crimes. See H.R. REP. NO. 91-1444. The law was intended primarily to counter drug abuse, particularly the use of drugs for their "stimulant, depressant, or hallucinogenic effect on the central nervous system." Reno Letter, *supra* note 1 (quoting 21 U.S.C. § 811(f)). Congress believed that "[f]ederal control of the intrastate incidents of the traffic in controlled substances is essential to the effective control of the interstate incidents of such traffic." 21 U.S.C. § 801(6) (1970). It intended the CSA to create a "'closed' system of drug distribution for legitimate handlers of such drugs" to counter the widespread diversion of prescription drugs into "illicit channels." H.R. REP. NO. 91-1444. The House Report noted that in 1965, it was estimated that half of the nine billion amphetamines and barbiturates produced legally in the United States found their way to the illegal market. See *id.* The CSA created five categories of controlled substances ranked according to their abuse potential as well as accepted medical use. See Brickey, *supra* note 279, at 1149.

282. See 21 U.S.C. § 822.

283. See *id.* at § 841(a)-(b).

284. 21 C.F.R. § 1306.04 (1974).

285. See *id.* It has been argued that the war on drugs has made doctors reluctant to prescribe opioids and has provided a significant barrier to adequate palliative care. See Rich, *supra* note 102, at 43. Doctors fear that their patients may become addicted and furthermore, fear that even if the DEA finds no irregularities in their prescribing practices, state medical licensing boards, "many . . . themselves afflicted with the same prejudices, fears, myths, and misinformation about the use of narcotics for pain relief as those they regulate" will censure their actions as unprofessional. *Id.* at 48, 54.

While prior to 1999 there had been no disciplinary action against a physician for inadequate provision of pain relief, there had been many accusations of over-prescribing analgesics. See *id.* at 58. In 1999, the Oregon Medical Board censured a physician for allowing six patients to suffer pain unnecessarily. See Erin Hoover Barnett, *Case marks big shift in pain policy*, THE OREGONIAN, Sept. 2, 1999 at A1. Although pain can be relieved in 90% of cases, there is evidence that 80% of patients do not receive adequate pain relief. See Rich at 39 n.219 (citing Betty R. Ferrell & Michelle Rhiner,

Doctors who violate the Controlled Substances Act can incur penalties as severe as those imposed on drug dealers. In *United States v. Moore*,²⁸⁶ a physician was convicted of “knowing and unlawful distribution and dispensation of methadone” because he had prescribed large doses of methadone to patients, charging them according to the number of pills prescribed, and providing inadequate physical examinations or other appropriate medical care.²⁸⁷ The Supreme Court overturned a lower court holding that registered physicians, because of their status as registrants, could be subject only to sections of the law carrying lower penalties²⁸⁸ and could not be liable under § 841(a)(1) of the Controlled Substances Act, a section carrying the most severe penalties.²⁸⁹ As is typical in cases where physicians are convicted under the CSA, the Court viewed Moore as a “large scale ‘pusher’ not as a physician.”²⁹⁰

b. The Right of Congress to Regulate Drugs Under the Commerce Clause

Shortly after Congress enacted the CSA, several federal court cases tested the Act’s constitutionality.²⁹¹ In two cases relating specifically to physicians, defendants contended that the Act violated the Tenth Amendment.²⁹² In *United States v. Collier*,²⁹³ a physician authorized to dispense controlled substances was convicted of illegally distributing methadone “while not acting in the

High-Tech Comfort: Ethical Issues in Cancer Pain Management for the 1990’s, 2 J. CLIN. ETHICS 108, 108 (1991)).

286. 423 U.S. 122 (1975).

287. *Id.* at 125.

288. *See id.* at 128. The Court of Appeals believed that doctors could only be subject to §§ 842 and 843. *See id.* Section 842 makes it unlawful for a “registrant to distribute a controlled substance . . .” *Id.* at 129 n.5. The penalty is at most one year imprisonment and/or a fine of \$25,000. *See id.* at 129 n.6. Section 843 makes it unlawful for a registrant knowingly and intentionally to distribute a schedule I or II substance in the course of his legitimate business “except pursuant to an order or an order form . . .” *Id.* at 129 n.5. The penalty for violation is a maximum of four year imprisonment and/or a fine of not more than \$30,000. *See id.* at 129 n.6. Section 841 (a) (1) makes it illegal for “‘any person’ knowingly or intentionally to distribute or dispense a controlled substance except as authorized by the CSA.” *Id.* at 122. By contrast, violations of § 841 carry a maximum sentence of fifteen years and/or a fine of up to \$25,000. *See id.* at 129 n.6.

289. *See id.* at 131.

290. *Id.* at 143.

291. *See United States v. Lopez*, 459 F.2d 949 (5th Cir. 1972); *United States v. Scales*, 464 F.2d 371 (6th Cir. 1972); *United States v. Collier*, 478 F.2d 268 (5th Cir. 1973); *United States v. Rosenberg*, 515 F.2d 190 (9th Cir.), *cert. denied*, 423 U.S. 1031 (1975).

292. *See Collier*, 478 F.2d at 272; *Rosenberg*, 515 F.2d at 198.

293. 478 F.2d 268.

usual course of his professional practice.”²⁹⁴ Dr. Collier contended that the statute, by invading states’ residual police powers²⁹⁵ to control the practice of medicine,²⁹⁶ violated the Tenth Amendment.²⁹⁷ The Fifth Circuit rejected this claim. The court held that the Tenth Amendment did not apply when Congress was exercising its rightful power under the Commerce Clause.²⁹⁸ Under the CSA, Congress was permissibly regulating drugs which, when uncontrolled, could pass freely from state to state through illegitimate channels.²⁹⁹ Congress, therefore, had a responsibility to insure that doctors who have legitimate access to drugs did not divert them to the illicit market.³⁰⁰

In *United States v. Rosenberg*,³⁰¹ Dr. Rosenberg appealed his conviction on twenty-seven counts of unlawful distribution, not in the course of professional practice, of a controlled substance.³⁰² The seventy-five year old doctor had sold prescriptions for Dexedrine, Seconal, and Miltown to several undercover federal agents.³⁰³ The court noted that the federal government had to regulate the legitimate channels of the intrastate market to control interstate incidents of drug trafficking.³⁰⁴ Quoting *United States v. Darby*,³⁰⁵ the court noted that the Tenth Amendment does not prevent Congress from “resort[ing] to all means for the exercise of a

294. *Id.* at 270.

295. “Police power” refers to “[a]n authority conferred by the American constitutional system in the Tenth Amendment . . . upon the individual states . . . through which they are enabled to . . . secure generally the comfort, safety, morals, health and prosperity of its citizens” BLACK’S LAW DICTIONARY 1156 (6th ed. 1990).

296. In *Linder v. United States*, the Court stated that “[o]bviously, direct control of medical practice in the states is beyond the power of the federal government.” 268 U.S. 5, 18 (1925). States are authorized to regulate medicine by setting up licensing boards and may determine the qualifications of who may practice medicine in the state. See *Peckman v. Thompson*, 745 F. Supp. 1388, 1391 (C.D. Ill. 1990); see also *Dent v. West Virginia*, 129 U.S. 114, 122 (1889) (deferring to state medical licensing laws and stating that the “nature and extent of the qualifications required [to practice medicine] must depend primarily upon the judgment of the state as to their necessity”).

297. See *Collier*, 478 F.2d at 272.

298. See *id.* This interpretation differs from the one apparently favored by the present Supreme Court that the Tenth Amendment “reserves a zone of activities to the states” that Congress may not enter even while exercising its Article I powers. See *Chemerinsky*, *supra* note 181.

299. See *Collier*, 478 F.2d at 273.

300. See *id.*

301. See 515 F.2d 190 (9th Cir.), *cert. denied*, 423 U.S. 1031 (1975).

302. See *id.* at 191.

303. See *id.* at 192 n.1.

304. See *id.* at 194.

305. 312 U.S. 100 (1941).

granted power which are appropriate and plainly adapted to the permitted end.”³⁰⁶ The court found the statute constitutional.³⁰⁷ Courts have continued to reaffirm Congress’ Commerce Clause power to regulate controlled substances in several cases which followed *United States v. Lopez*.³⁰⁸

D. Equal Protection Amendment Challenge

The Fifth Amendment is another provision that applies to the constitutionality of the PRPA. It prescribes that “[n]o person shall be . . . deprived of life, liberty, or property, without due process of law.”³⁰⁹ Although the Amendment does not mention equal protection specifically as is the case with the Fourteenth Amendment,³¹⁰ it has been understood to encompass equal protection.³¹¹ In its simplest terms, the Amendment guarantees that people who are similarly situated will be treated similarly.³¹² A challenge under the Fourteenth Amendment would center on whether the PRPA might have the inadvertent effect of making pain care less accessible to some. The challenge would be based on a right hinted at by the Court in *Washington v. Glucksberg*³¹³—the right to adequate pain relief at life’s end.³¹⁴ Justice O’Connor appears to suggest that there may be a constitutional right for terminally ill patients who are suffering pain at the end of their lives to receive palliative care.³¹⁵ Justice Breyer has written that “were state laws to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life—then the law’s

306. See *Rosenberg*, 515 F.2d at 198. The *Darby* vision of the federal/state balance of power differs from the views of the present Court. See Chemerinsky, *supra* note 181.

307. See *Rosenberg*, 515 F.2d at 198.

308. See, e.g., *United States v. Genao*, 79 F.3d 1333 (2d Cir. 1996). There, a cocaine dealer who sold drugs interstate, challenged the CSA as exceeding Congress’ commerce power authority. See *id.* at 1334. The court stated that Congress could regulate intrastate drug sales because this obviously economic activity, combined with like activity, affects interstate commerce. See *id.* at 1335, 1337. The court wrote that “because narcotics trafficking represents a type of activity that Congress reasonably found substantially affected interstate commerce, the actual effect that each drug conspiracy has on interstate commerce is constitutionally irrelevant.” *Id.* at 1336.

309. U.S. CONST. amend. V.

310. See *id.* amend. XIV, § 1 (“No State shall . . . deny to any person . . . the equal protection of the laws.”)

311. See *Bolling v. Sharpe*, 347 U.S. 497, 499 (1954); see also *Buckley v. Valeo*, 424 U.S. 1, 93 (1976).

312. See LAWRENCE TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1438 (2d ed. 1988).

313. 521 U.S. 702 (1997).

314. See *id.* at 737 (O’Connor, J., concurring).

315. See *id.*

impact upon serious and otherwise unavoidable physical pain (accompanying death) would be more directly at issue.”³¹⁶ Justice Stevens wrote that “ensuring the availability of adequate pain treatment is of utmost importance.”³¹⁷

E. Provisional Adjudication

Professor Michael Dorf advocates for provisional adjudication when the Court is confronted with complex issues, such as assisted suicide, that are addressed differently in different states.³¹⁸ Provisional adjudication refers to a practice of postponing decision-making or making a provisional decision until an issue has “ripened.”³¹⁹ Dorf posits that since five justices in *Glucksberg* and *Quill* seemed to believe that they might find a right to assisted suicide in a properly framed future case, “[it] is thus reasonable to suppose that the possibility of state experimentation was a critical factor in the Court’s rejection of” this right in the cases it judged.³²⁰

Assuming that Congress could, under its Commerce Clause power, legitimately outlaw lethal prescriptions and thus endanger a State’s ability to experiment with assisted suicide, Dorf suggests that this separation between “the jurisprudence of congressional power and the jurisprudence of individual rights” may lead to wrong solutions.³²¹ Rather, the Court should supplement federal jurisprudence with rights jurisprudence. “When . . . the possibility of experimentation by the states plays a substantial role in the provisional decision to deny recognition to a right, the Court ought to limit the federal government’s ability to adopt a uniform national solution before there has been a substantial period for experimentation.”³²² Although the Court has, since *Martin v. Hunter’s Lessee*,³²³ striven for uniform application of federal law, the Court has also deferred judgment on some novel issues so that they can

316. *Id.* at 792 (Breyer, J., concurring).

317. *Id.* at 747 (Stevens, J., concurring).

318. Michael C. Dorf, *Foreward: The Limits of Socratic Deliberation*, 112 HARV. L. REV. 4, 60-63 (1998).

319. *See id.* at 65.

320. *Id.* at 62-63.

321. *Id.* at 63.

322. *Id.* at 64.

323. 14 U.S. (1 Wheat) 304 (1816) (stating the “necessity of uniformity in decisions throughout the whole United States on all subjects within the purview of the constitution” and claiming that “deplorable” “public mischief” would result if the Court could not “control these jarring and discordant judgments and harmonize them into uniformity”). *Id.* at 347-48.

“percolate.”³²⁴ There are, in fact, several occasions on which members of the Court denied certiorari or made statements based on the conviction that some issues deserve a period of experimentation before the Court can make final judgments.³²⁵ Thus, precedent exists to delay judgment on controversial issues like assisted suicide.

This section has reviewed aspects of the Tenth Amendment, the Guarantee Clause, the Commerce Clause, and the Fifth Amendment, as well as the concept of provisional adjudication, all of which are relevant in evaluating the constitutionality of the PRPA. Section IV analyzes the PRPA in light of these provisions.

IV. THE SUPREME COURT SHOULD FIND THE PRPA UNCONSTITUTIONAL

A. Application of federalist principles under the Tenth Amendment and the Guarantee Clause

Ironically, the natural supporters of physician-assisted suicide, people on the “Left,” traditionally have been advocates of strong federal government legislation on such social concerns as abortion, gun control or violence against women. Perhaps recalling the role of states’ rights in the oppression of black citizens, they fear a return to federalism.

Equally ironically, those who are usually strong supporters of states’ rights—people on the “Right” on many social issues—favor federal law opposing physician-assisted suicide. Supporters of assisted suicide may need to shed their aversion to federalist positions and argue that, in our highly heterogeneous society, some divisive social, cultural and religious issues require state experimentation. It is not inconsistent to favor federal abortion rights but to oppose federal legislation that precludes assisted suicide. A

324. Dorf, *supra* note 318, at 65.

325. See, e.g., *Arizona v. Evans*, 514 U.S. 1, 23 n.1 (1995) (Ginsburg, J., dissenting) (“We have in many instances recognized that when frontier legal problems are presented, periods of ‘percolation’ in, and diverse opinions from, state and federal appellate courts may yield a better informed and more enduring final pronouncement by this Court.”); *Smith v. Robbins*, - U.S. -, 120 S. Ct. 746, 758-59 (2000) (stating that “it is more in keeping with our status as a court, and particularly with our status as a court in a federal system, to avoid imposing a single solution on the States from the top down We will not cavalierly ‘imped[e] the States’ ability to serve as laboratories for testing solutions to novel legal problems.”); *McCray v. New York*, 461 U.S. 961, 963 (1983) (Stevens, J., respecting denial of certiorari) (“In my judgment it is a sound exercise of discretion for the Court to allow the various States to serve as laboratories in which the issue receives further study before it is addressed by this Court.”).

federal right to abortion grants choice: no one is compelled to avail herself of this right and no one is precluded from defining her own destiny as it relates to pregnancy. By contrast, a federal ban on assisted suicide would eliminate choice for people who live in states that allow terminally ill people to have some say in the manner of their deaths. Thus, there are good reasons for supporters of physician-assisted suicide to favor analysis of the PRPA under federalist principles.

A federalist analysis would center on finding the correct balance of power between the federal government and the states, as well as on specific constitutional provisions such as the Tenth Amendment and the Guarantee Clause.

1. *The Tenth Amendment*

The Tenth Amendment states, "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."³²⁶ The Court vacillates between two interpretations of the Tenth Amendment: reading it as a reminder that Congress can act within its express or implied authority so that no law in Congress' power will be invalidated as invading states' rights; or finding that the Tenth Amendment "reserves a zone of activities to the states" and protects this zone from congressional regulation.³²⁷ The majority on the present Supreme Court appears to favor the latter reading as more consistent with federalist principles. Although *National League of Cities v. Usery*³²⁸ was overturned, it provided then Justice Rehnquist with the opportunity to express his belief that there are "areas of traditional government function" (including regulation of public health) that a state can direct without federal government intervention.³²⁹ Similarly, in *Gregory v. Ashcroft*,³³⁰ the Court appeared to be returning to the methodology of *Usery*, defining areas of state activity that Congress could not regulate.³³¹

Applying *Gregory*, the Court might find that regulation of public health and doctors' medical practice is a state function that falls within states' police powers. States already monitor doctors through state medical boards.³³² The State of Oregon has chosen

326. U.S. CONST. amend. X.

327. Chemerinsky, *supra* note 213.

328. 426 U.S. 833 (1976).

329. *Id.* at 852.

330. 501 U.S. 452 (1991).

331. See *supra* notes 213-214 and accompanying text.

332. See *supra* note 296.

to define assisted suicide as part of the normative practice of medicine within its borders. It has created regulations and procedures to monitor physician-assisted suicide. The Court might decide that the federal government should not override the decision-making power of the state in this area. In *New York v. United States*,³³³ Justice O'Connor wrote that a state's Tenth Amendment rights to sovereignty could supersede Article I powers granted to Congress.³³⁴ Justice Scalia, in *Printz v. United States*,³³⁵ stated that even a law enacted by Congress under Commerce Clause powers may be void if it violates the right of states to sovereignty widely alluded to in several clauses of the Constitution.³³⁶ Thus, even though Congress has the general power under the Commerce Clause to regulate doctors' prescribing of controlled substances, the right of the State of Oregon to sovereignty may supersede Congress' power in this narrow instance.

More recent Tenth Amendment cases concern whether the federal government can compel states or state officials to enact policy or administer federal programs.³³⁷ The PRPA does not appear to require that the states help the federal government implement its new regulations. If the PRPA requires state officials to perform some of the work of the DEA, the court may find a Tenth Amendment violation. Justice Scalia rejected the government's argument in *Printz* that state officials could be asked for limited help in enforcing federal laws that regulate private conduct because the federal government would not be compelling state governments to make policy in such an instance.³³⁸ He believed that it would be difficult to draw a distinction between policymaking and implementation and that states, acting without choice or authority in the matter, would nevertheless be blamed by their constituents for any negative consequences of the regulation.³³⁹ This lack of choice and authority would threaten their sovereignty.³⁴⁰

Finally, Justice O'Connor noted an additional limitation on congressional power when she wrote of the plain statement rule in

333. 505 U.S. 144 (1992)

334. *See id.* at 156-57 (1992).

335. 521 U.S. 898 (1997).

336. *See id.* at 923-24 (quoting *THE FEDERALIST* NO. 33 at 204 (Alexander Hamilton)).

337. *See New York v. United States*, 505 U.S. 144 (1992); *Printz v. United States*, 521 U.S. 898 (1997).

338. *See Printz*, 521 U.S. at 927.

339. *See id.* at 928, 930.

340. *See id.* at 928.

Gregory.³⁴¹ The Court stated that if Congress intends to change the constitutional balance between the federal and state governments, it must make this intention clear with a plain statement.³⁴² It can be argued that the PRPA's statement that "the Attorney General shall give no force and effect to State law authorizing or permitting assisted suicide or euthanasia"³⁴³ is such a plain statement. Conversely, this statement can be seen as vague rather than clear notice that Congress intends to enter the arena of regulation of medical practice generally allocated to the states. If interpreted that way, this Act would violate the plain statement rule.

2. *The Guarantee Clause*

The Guarantee Clause allows states to experiment with various forms of republican government.³⁴⁴ Professor Deborah Jones Merritt has explained that the clause has two elements: (1) states may not adopt non-republican forms of government; and (2) once states have chosen a republican form of government, the federal government may not sabotage the states' choice.³⁴⁵ By preventing federal intrusion into state governance choices, the Guarantee Clause becomes an integral part of federalism.³⁴⁶

Recently, the Court has recognized the power of the Guarantee Clause to protect state sovereignty.³⁴⁷ Voter initiatives, such as the one that introduced the Death with Dignity Act to Oregon voters, were first acknowledged as a legitimate way to experiment with a republican form of government in Oregon³⁴⁸ and have become common in several states. Voter initiatives can get voters directly and enthusiastically involved in self-governance, a goal that Justice O'Connor has praised.³⁴⁹ Conversely, in Oregon, where voters have twice expressed their desire to experiment with a new social policy, through voter initiative and then referendum, and now face the prospect of having their will thwarted by national representatives who disagree with their policy choice, citizen involvement in the democratic process is likely to fade. Naturally, if voters choose

341. See 501 U.S. 452, 460 (1991).

342. See *id.* at 473.

343. H.R. 2260 § 101, 106th Cong. (1999).

344. See *supra* note 235 and accompanying text.

345. See *supra* note 237 and accompanying text.

346. See *supra* note 235 and accompanying text.

347. See *Gregory v. Ashcroft*, 501 U.S. 452, 463 (1991); *Printz v. United States*, 521 U.S. 898, 919 (1997).

348. See *Kadderly v. City of Portland*, 74 P. 710 (Or. 1903).

349. See *Federal Energy Regulatory Comm'n v. Mississippi*, 456 U.S. 742, 790 (1982) (O'Connor, J., concurring in part, dissenting in part).

to approve an unconstitutional law through a voter initiative proposal, the Court would be correct in overturning that proposal.³⁵⁰ That, however, is not the case with Oregon's assisted suicide law. The Supreme Court has not made a judgment that a law allowing physician-assisted suicide is unconstitutional; rather it has decided that states are not violating the Constitution when they ban assisted suicide since the right to choose the manner of one's death is not a fundamental right.

In examining a Guarantee Clause claim relating to the PRPA, the court might adopt a narrow view, contending that there is no violation of the Guarantee Clause because Oregonians retain the right to voter initiatives whether the PRPA stands or falls. In fact, the Death with Dignity Act would still stand on the books under the PRPA even if it would become most difficult to implement with the elimination of the use of controlled substances. Nevertheless, a more functional analysis, exploring how best to apportion power to promote democracy, might find that although the voter initiative would remain a right available to Oregonians, it would become a hollow right if citizens' knew their votes could be overturned by Congress. The assisted suicide right that would remain would not be the right sixty percent of Oregonian voters chose. Chilling voters' enthusiasm to take an active part in decisions that affect their community cannot advance the causes of federalism or democracy. Similarly, when a state has chosen the voter initiative as a form of republican government, its right to "retain substantial sovereign authority"³⁵¹ is damaged if the results of an initiative are treated as insignificant. As the *Washington Post* noted, "[t]o argue that states should be free to experiment with policy only when their experiments reflect a national democratic consensus—rather than the preferences of their own populations—is really to argue that the states themselves are only nominally more than administrative districts of the national government."³⁵²

B. The PRPA and the Commerce Clause

In an effort to stop the "Death with Dignity" movement before it gained momentum, congressional opponents of physician-as-

350. See, e.g., *Romer v. Evans*, 517 U.S. 620 (1996) (holding that no legitimate state interest was served by a Colorado constitutional amendment, approved by state referendum, that would have prevented the state or any of its cities from giving certain protections to homosexuals and finding the amendment unconstitutional).

351. *Gregory*, 501 U.S. at 461 (1991).

352. See Editorial, *The Assisted-Suicide Ban*, WASH. POST., Nov. 1, 1999, at A26.

sisted suicide had two choices: to draft national legislation outlawing assisted suicide or to tack an amendment weakening the right to assisted suicide onto legislation already recognized as regulating in an area of legitimate congressional power. Opponents may have hesitated to do the former, because the Supreme Court had stated quite explicitly that it wished debate to continue on this issue and several justices had expressed a preference for state-by-state resolution of the controversy.³⁵³ Therefore, amending the CSA was preferable because the regulation of controlled substances has long been recognized as falling within Congress' Commerce Clause powers.³⁵⁴ Because Congress wanted to counter the widespread diversion of prescription drugs into illicit channels,³⁵⁵ and because drugs travel interstate in trade, Congress was within its rights to "regulate [this] commerce among the several states."³⁵⁶ Cases following *United States v. Lopez*³⁵⁷ continued to support Congress' right to regulate in this area.³⁵⁸

Several principles emerge from *Lopez*, however, that suggest that Congress has overstepped its Commerce Clause powers in drafting this legislation. Professor Deborah Jones Merritt's criteria on evaluating whether an activity is likely to be interstate commerce³⁵⁹ provide an excellent platform from which to begin an analysis. First, if an activity is commercial or economic, it is likely to be interstate commerce and subject to congressional regulation. In *Lopez*, mere possession of a firearm, even in the aggregate, was not deemed to be a commercial activity.³⁶⁰ In the context of the CSA, drugs that are bought and sold and enter the illicit drug market are part of commercial activity. Prescription drugs that travel from manufacturers to pharmacies to doctors and finally to patients are also part of commerce. Accordingly, Congress and the Court rationally can conclude that assisted suicide prescriptions affect interstate commerce and Congress can regulate in this area. The PRPA would thus be constitutional under the Commerce Clause. A more complex analysis of the issues at stake here suggests an alternate conclusion, however, which this Note will examine after further exploration of Merritt's criteria.

353. See *supra* notes 174-177 and accompanying text.

354. See *supra* Part III.C.

355. See *supra* note 281 and accompany text.

356. U.S. CONST. art. 1, § 8, cl. 3.

357. 514 U.S. 549 (1995).

358. See *supra* note 308.

359. See *supra* notes 271-275 and accompanying text.

360. See 514 U.S. at 567.

Merritt's second criterion is that, to be "interstate commerce," an activity must fall within an area where national regulations are needed.³⁶¹ In *Lopez*, the Court was being asked to override state decisions in two areas traditionally left to the states, education and crime.³⁶² The Court believed that the federal government would upset a sensitive balance between state and federal powers by criminalizing conduct already criminal in most states.³⁶³ In the area of physician-assisted suicide, thirty-eight states already prohibit assisted suicide through statute and six more prohibit it through common law.³⁶⁴ Whether the Court would find national regulation of assisted suicide necessary would turn on whether it would find that the country needs one national standard on this issue. By noting that their holding would allow the "debate to continue, as it should in a democratic society" on the "morality, legality and practicality of physician-assisted suicide,"³⁶⁵ the Court in *Washington v. Glucksberg* appeared to reject one universal, national solution. If the PRPA is providing one national standard when none is needed, it is less likely to fall under Congress' right to regulate interstate commerce.

Third, if an activity is connected to workplace employer-employee conduct, it is considered interstate commerce.³⁶⁶ Although the gun in *Lopez* was brought onto school premises—a workplace—possession of that gun did not relate to employer/employee conduct. It is arguable whether a regulation of a doctor's intention when he administers medication falls under this measure.

Fourth, according to Merritt, an activity is less likely to be commerce if it regulates an area traditionally left to the states,³⁶⁷ such as schools or crime. Justice Kennedy criticized the government in *Lopez* for preventing state experimentation in an area of traditional state concern claimed by "history and expertise."³⁶⁸ The PRPA, allying itself with the CSA and thus purporting to regulate traffic in illegal drugs, is actually regulating physician medical decisions. Medicine is traditionally an area of state regulation. As the Court stated in *Linder v. United States*,³⁶⁹ "[o]bviously direct con-

361. See Deborah Jones Merritt, *supra* note 265, at 746.

362. See Kopel & Reynolds, *supra* note 269, at 107.

363. See *Lopez*, 514 U.S. at 561 n.3.

364. See *supra* note 84.

365. 521 U.S. 702, 735 (1997).

366. See Deborah Jones Merritt, *supra* note 265, at 746.

367. See Deborah Jones Merritt, *supra* note 265, at 746.

368. *Lopez*, 514 U.S. at 583.

369. 268 U.S. 5, 18 (1925).

trol of medical practice in the states is beyond the power of the federal government."³⁷⁰ Nevertheless, the Court has allowed regulation of doctor's behavior in the area of administering drugs. The Supreme Court found prosecution of a doctor under the CSA proper in *United States v. Moore* because the doctor was acting as a "drug pusher."³⁷¹ Other cases where convictions of physicians under the CSA were upheld all concerned doctors introducing large quantities of narcotic drugs into the stream of commerce for profit rather than because of medical necessity.³⁷² Illicit drug traffic is not at issue in the Oregon law, however. A doctor writing a prescription for a terminally ill patient is not selling drugs for profit in the manner proscribed in *Moore*. Oregon, through the voice of its citizens, has chosen to define physician-assisted suicide as a normative aspect of professional medical practice. Medical practices are regulated by state medical boards that license doctors and determine appropriate medical standards.³⁷³ Such licensing and overseeing is not a federal function. Thus, the PRPA is less likely to be regulating interstate commerce because it is attempting to regulate a traditional state function.

Fifth, an activity is less likely to be interstate commerce if the statute fails to provide a jurisdictional element that links the element to interstate commerce.³⁷⁴ Had the statute in *Lopez* stated that a gun that has traveled in interstate commerce may not be possessed within a thousand feet of a school, the Court might have upheld the statute. A statute is also less likely to be found as regulating interstate commerce if it lacks explicit findings connecting the law to commerce. The PRPA makes no jurisdictional statement and has no findings, perhaps because the drafters believed the amendment could rest on the findings of its parent statute. The Court should require findings as well as an explicit jurisdictional element tying particular prescriptions to interstate commerce.

Next, an activity is less likely to be interstate commerce if competition among states on this issue will probably lead to positive outcomes rather than a race to lower standards.³⁷⁵ Regulation is not needed when states are offering progressive laws that appeal to some segments of the citizenry, leading them to wish to live in that

370. *Id.*

371. 423 U.S. 122, 143 (1975).

372. See *supra* notes 292-307 and accompanying text.

373. See *supra* note 296.

374. See Deborah Jones Merritt, *supra* note 265, at 746.

375. See Deborah Jones Merritt, *supra* note 265, at 746.

state. Regulation is needed if one state's negative practices—such as permitting unregulated pollution, child labor, or marijuana use—will contaminate other states.³⁷⁶ However, the right to physician-assisted suicide in one state can only contaminate other states if their citizens come to believe that it is a right they want for their own and “the Commerce Clause does not allow Congress to legislate against such infection.”³⁷⁷ Furthermore, Oregon's law has existed for two years, causing no disruption in other states. Thus, the PRPA is less likely to be regulating interstate commerce here because it is attempting to prevent a state from meeting the needs of citizens drawn to its innovative policy.

Returning to the question of whether the PRPA regulates a commercial activity, there is a rational argument that writing a prescription for a controlled substance is a commercial activity that Congress may regulate. Conversely, one might frame the argument that Congress is not regulating commerce in the PRPA as follows: while drugs travel in interstate commerce, a terminally ill patient's decision to ask a doctor for a prescription to end his life and a doctor's decision to comply are medical rather than commercial decisions. Because the PRPA permits doctors to prescribe controlled substances as long as their intent is not to assist suicide, the Act is regulating the only significant variable, a doctor's intent. Or, to put it differently, if Doctor A gives patient B ten morphine tablets for pain and she dies, and Doctor C gives patient D ten morphine tablets intending to help her die, only doctor C will be prosecuted. While both doctors might be participating in interstate commerce by prescribing medication, only their intentions would be monitored under the PRPA, and a doctor's intent is not a commercial activity. In *Lopez*, the Court found that although guns might travel in interstate commerce, mere possession of a gun was not a commercial activity.³⁷⁸

Furthermore, the relatively small number of assisted suicides in Oregon does not have a substantial effect on interstate commerce even in the aggregate (and aggregation would be allowed only if the decision to commit suicide or the doctor's intent were commercial activities).³⁷⁹ The small subset of Oregonians availing themselves of the right to prescriptions for terminal doses of medication

376. See Charles Fried, Op-Ed, *Leave the Personal to the States*, N.Y. TIMES, Oct. 29, 1999, at A35.

377. *Id.*

378. 514 U.S. 549, 567 (1995).

379. See *supra* note 268 and accompanying text.

(twenty-three prescriptions written in 1998; thirty-three written in 1999) under highly controlled and regulated circumstances does not upset the war on drugs. Congress' regulatory scheme to limit the sale and use of illegal drugs is in no way hindered by allowing Oregon's law to remain vital. Moreover, medical regulation touches an area of traditional state control. *Lopez* precludes the federal government from invading areas of traditional state regulation. Upheld, this statute might open the door to federal intervention into other areas of medicine traditionally regulated by the states.³⁸⁰ Overall, the Court may find that, in drafting the PRPA, Congress is "[using] a relatively trivial impact on commerce as an excuse for broad general regulation of state private activities."³⁸¹

C. Application of the Fifth Amendment to the PRPA

As implemented, the PRPA may tread on the rights of both doctors and patients to equal protection under the law.

1. *The Rights of Patients to Adequate Pain Care*

Patients bringing a Fifth Amendment Equal Protection claim would argue that they have a fundamental right to pain relief but cannot receive equal access to that right under this law because doctors are intimidated by a vague "intent" standard. In *Glucksberg*, several justices implied that there may be a fundamental right to receive medication for pain relief, particularly at the end of life. Justice O'Connor (joined by Justices Ginsberg and Breyer) appeared to rest her decision that there is no fundamental right to assisted suicide on the fact that terminally ill patients who are suffering great pain have access, in New York and Washington, to medication even if this medication might hasten death.³⁸² If patients could not readily obtain opioids for pain relief, she might rule differently. Justice Breyer wrote that if state law prevented adequate provision of pain relief at the end of life, he would reconsider the physician-assisted suicide issue.³⁸³ Justice Stevens, who wrote that providing adequate pain relief is of the utmost impor-

380. The analysis above was inspired by David Kopel and Glenn Reynolds' analysis of partial-birth abortion in the context of the Commerce Clause. See Kopel & Reynolds, *supra* note 269, at 104.

381. *Lopez*, 514 U.S. at 558 (quoting *Maryland v. Wirtz*, 392 U.S. 183, n.27 (1968)).

382. See *Washington v. Glucksberg*, 521 U.S. 702, 736 (1997).

383. See *id.* at 792.

tance, might also see the right to adequate pain relief at the end of life as fundamental.³⁸⁴

Opponents of the PRPA contend that, although the amendment may be intended to expand pain relief, it may have the opposite effect. Our nation's war on drugs, which has engendered negative attitudes towards narcotic medications, has made many doctors hesitant to prescribe these medications in dosages that can effectively control severe pain.³⁸⁵ Doctors fear turning patients into addicts and, furthermore, are not willing to risk scrutiny by, and possible civil or criminal penalties from, the DEA or state medical licensing boards.³⁸⁶ Until 1999, doctors had been investigated only for over-prescribing narcotic medications.³⁸⁷ Although amendments to the PRPA were proposed to increase doctor's due process rights by requiring the government to prove a doctor's intention to cause death, or by allowing a doctor an affirmative defense of no intent, these amendments were rejected.³⁸⁸ Doctors who are ambivalent about narcotics and fear the expensive and time-consuming process of defending themselves in an investigation by authorities would have every incentive to under-prescribe.

Supporters of the PRPA would argue that, on the contrary, doctors will feel more free to prescribe pain medication because this amendment clarifies that doctors are fully within their rights to prescribe large doses of pain medication, even if it hastens death. Only doctors who give medication with the intention of assisting a suicide are not within the Act and may be prosecuted. Following this understanding, the DEA, and probably state medical boards, would have to judge a doctor's intent after the fact. Intent is difficult to gauge. Furthermore, lawyers have stated that intent can be established not only where the doctor knew his prescription would lead to death, but also where he should reasonably have assumed so.³⁸⁹ Accepting this definition of "intent," it would be difficult legally to distinguish between the culpability of a doctor who gave a prescription to a patient intending that the patient die, and one who says that he did not intend that the patient die, yet he reasona-

384. *See id.* at 747.

385. *See supra* note 285.

386. *See id.*

387. *See id.* In 1999, in an unusual occurrence that may become more common in the future, the Oregon Medical Board censured a physician for under-prescribing medication for people in great pain. The Board was newly sensitized to the issue of pain because of widespread discussion over the Death with Dignity Act. *See id.*

388. *See supra* note 130 and accompanying text.

389. *See supra* note 147 and accompanying text.

bly could have assumed that this high level of medication would kill the patient. The DEA has stressed its reluctance to make judgments on appropriate prescribing practices since even doctors are in stark disagreement.³⁹⁰ Although law enforcement personnel would, under the PRPA, receive education on the necessary and legitimate use of controlled substances for pain management,³⁹¹ their education could hardly achieve the level of highly trained physicians who have reached no consensus in this area.

Thus, a Fifth Amendment claim would center on the vague "intent" provision of the PRPA. Theoretically, the Court could be presented with terminally ill respondents who could show that they have received inadequate pain relief because of their doctors' fear of DEA investigation and the threat of criminal prosecution. They should argue that this Act, by creating a hard to interpret standard of "intent," has lead to erratic application of the right granted doctors to prescribe pain medication because some doctors feel they are protected while others fear they are now at risk of increased scrutiny. If the Court judges pain control at the end of life to be a fundamental right, it would apply strict scrutiny to the provision that endangers this right. The Court should find that the PRPA, as applied, robs patients of their right to equal protection of their fundamental right to pain relief and is unconstitutional. If the Court finds that there is no fundamental right to pain relief and applies a lesser standard than strict scrutiny, it could also find that the patient's right to adequate pain control supersedes any interest the government may have in limiting the right to physician-assisted suicide through the PRPA.

2. *Physicians' Rights to Equal Protection*

Representative Hyde and Senator Nickles offer assurances that the DEA would continue to defer to state medical boards after passage of the PRPA, and that the issue of intent would arise only in Oregon.³⁹² There, it would be easy for DEA officials to gauge a doctor's intent to assist a suicide because the doctor, complying with state law, would fill out forms documenting his participation in the death.³⁹³ It seems unlikely, however, that a national law would be implemented in one state only. If this were so, Oregon doctors would have an equal protection claim that the law as im-

390. See *supra* note 149 and accompanying text.

391. See *supra* note 94 and accompanying text.

392. See *supra* notes 106-108 and accompanying text.

393. See *supra* note 109 and accompanying text.

plemented applies standards to only a few doctors whereas the majority of physicians need not comply. It is likely that such an argument would prevail, particularly if the doctors could show widespread prescription of large doses of opioids in other states.

D. Provisional Adjudication

By finding the PRPA unconstitutional, the Court can continue to study the effects of physician-assisted suicide in Oregon. Provisional adjudication allows the Court to postpone decision making until time has passed to allow observation of how a policy has worked.³⁹⁴ Although congressional supporters of the PRPA have stressed the need for uniform standards³⁹⁵ and the Court has sought that aim as well,³⁹⁶ precedent also exists to let issues ripen.³⁹⁷ For example, in the case of Oregon's Death with Dignity Act, the Court refused in 1997 to review a Ninth Circuit Court of Appeals decision that allowed the law to be implemented.³⁹⁸ Chief Justice Rehnquist has stated that debate should continue on this issue.³⁹⁹ The Court expressed fear in *Glucksberg* and *Quill* of voluntary or involuntary euthanasia and the potential injury to vulnerable populations were assisted suicide to be permitted.⁴⁰⁰ They might have wished to see whether a state could craft a law that could prevent abuses, in which case the Court might recognize a limited right to this choice at some future date. Professor Michael Dorf has written that "it is reasonable to suppose that the possibility of state experimentation was a critical factor in the Court's rejection of" a right to assisted suicide in *Glucksberg* and *Quill*.⁴⁰¹

Provisional adjudication could not be applied directly in the case of the PRPA because applying it would require the Court to let that law stand. Rather, the Court could apply the philosophy underlying provisional adjudication by overturning the PRPA but noting that on a future occasion, if the assisted-suicide experiment fails, the Court might allow a limitation on the right to assisted suicide in a properly crafted bill. Two years has not been enough time to evaluate whether Oregon's law is working well. It appears

394. See *supra* note 319 and accompanying text.

395. See *supra* note 87 and accompanying text.

396. See *Martin v. Hunter's Lessee*, 14 U.S. 304 (1816), discussed *supra* note 323.

397. See *supra* note 325.

398. See *Lee v. Oregon*, 107 F.3d 1382, 1392 (9th Cir.), *cert. denied*, 522 U.S. 927 (1997).

399. See *Washington v. Glucksberg*, 521 U.S. 702, 735 (1997).

400. See *Vacco v. Quill*, 521 U.S. 793, 808-09 (1997); *Glucksberg*, 521 U.S. at 733.

401. See *supra* note 320 and accompanying text.

that only a small number of people avail themselves of the right to die and that they are not disproportionately poor, uneducated, uninsured or lacking in end of life care.⁴⁰² A strong motive for their choice of assisted suicide appears to be a desire for autonomy and personal control.⁴⁰³ Oregon might be viewed by some as a "courageous state . . . [willing to] serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."⁴⁰⁴ The nation can benefit from allowing this experiment to continue.

CONCLUSION

It is understandable that in our heterogeneous society, people of good conscience can disagree on the wisdom of physician-assisted suicide. This issue touches on people's fundamental beliefs about life, death, religion, autonomy and dignity. It is precisely when an issue arises that lacks national consensus, that one state's desire to experiment responsibly with a novel solution should be respected. The PRPA is a premature attempt by opponents of physician-assisted suicide to cut off experimentation and debate on a controversial social issue, an issue of passionate importance to most Oregonians. Although the PRPA would not overrule the Death with Dignity Act entirely, it would severely limit its effectiveness by proscribing the most common method of allowing patients a gentle death. The majority in the Supreme Court, as supporters of state sovereignty and an equitable balance between federal and state powers, should overrule the PRPA and allow the Oregon experiment to continue. Such a decision would not only be fair to Oregon but also would benefit all states by enabling them to continue to observe whether, in certain circumstances, physician-assisted suicide is just, proper and manageable.

402. *See supra* note 61 and accompanying text.

403. *See supra* note 62 and accompanying text.

404. *New State Ice Co. v. Liebman*, 285 U.S. 262, 386-87 (1932) (Brandeis, J., dissenting).