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THE OREGON DEATH WITH DIGNITY ACT: REVERSAL OF THE DEPARTMENT OF JUSTICE'S POSITION ON PHYSICIAN ASSISTED SUICIDE AND THE ENSUING COURT BATTLE

INTRODUCTION

The concept of death confronts everyone at some point during his life. Difficult decisions must be made when the prospect of dying is encountered. For example, technological advances have extended life expectancy well beyond what was thought possible only twenty years ago. Grandparents are receiving hip replacement surgery, people are overcoming cancer, and the list goes on and on. But, when is enough, enough? Medicine and technology cannot be relied upon to extend our lives forever. The inevitable will occur and that day has become the center of much attention.

Some individuals do not feel that their lives are worth living, or more to the point of this article, that living has become too burdensome. Intolerable pain, loss of autonomy, and negative affects on one's family weigh heavily on individuals as they approach death. Doctor Jack Kevorkian has said that, "You can pass any law against assisted suicide and euthanasia and I will disobey it. . .because it is immoral medically. When the law itself is intrinsically immoral, there is a greater duty to violate the law."¹ Doctor Kevorkian's statement may represent one end of the spectrum, but it does raise an interesting proposition. Can a terminally ill patient with full mental capacity choose to die?

A person may take his own life without question. Physician-assisted suicide, however, has sparked controversy throughout the world. After years of heated debate, Oregon successfully passed the Oregon Death with Dignity Act (the Act).² The Act permits physicians to prescribe controlled substances to qualified individuals so that the individual may take his own life.³ Oregon is the only state in the United States, which permits physician-assisted suicide. Maine, California, Michigan, and Arizona have all attempted unsuccessfully to follow in Oregon's footsteps. Amid protests and legal challenges, the Act has prevailed to date, yet it now confronts its greatest challenge, the federal government.

1. See *The Hemlock Society USA*, at www.hemlock.org/changing_laws.htm (last visited April 20, 2002).

2. Or. Rev. Stat. § 127.800- 127.897 (1999).

3. *Id.*

Attorney General John Ashcroft recently stated that DEA agents are required to prosecute physicians in Oregon who perform physician-assisted suicides.⁴ This is a departure from the decision by former Attorney General Janet Reno who declared the Oregon Death with Dignity Act did not necessitate a federal response. The day after the pronouncement by Attorney General Ashcroft, the state of Oregon filed suit, challenging the ruling. The ensuing court battle questions the purpose and scope of the Controlled Substance Act and the validity of Attorney General Ashcroft's ruling. Possessing the requisite standing, Oregon will successfully challenge Attorney General Ashcroft's ruling on the grounds that it goes beyond the scope of the Controlled Substance Act and it violates the principles of federalism set out in the Constitution and reiterated by President Clinton in a 1999 Executive Order.

The argument in this Article proceeds as follows: Part I provides a brief history of physician-assisted suicide and the Oregon Death with Dignity Act to acquaint the reader with a general understanding of the issues on both sides of the argument; Part II introduces important and relevant case law; Part III discusses the effect of Attorney General Ashcroft's pronouncement; Part IV sets up the arguments on both sides of the current court battle; and Part V explains why Oregon will be allowed to continue its practice of physician assisted suicide.

I. THE OREGON DEATH WITH DIGNITY ACT

A. *History*

The Oregon Death with Dignity Act (the Act), approved by voter ballot in 1994 and enacted in October 1997,⁵ legalized physician-assisted suicide for competent, terminally ill persons residing in Oregon.⁶ The Act grants an attending physician the authority to prescribe a lethal dose of medication to a qualifying patient for the purpose of self-administration.⁷ A qualifying patient must be a capable adult⁸ with a terminal illness⁹ who resides in Oregon.¹⁰

4. Memorandum for Asa Hutchinson, Administrator, The Drug Enforcement Administration, from John Ashcroft, Attorney General, Department of Justice Press Release (Nov. 6, 2001).

5. See Attorney General Hardy Myers to Take Legal Action to Protect Oregon's Physician-Assisted Suicide Law, Dept. of Justice, available at www.doj.state.or.us/releases/rel110701.htm (after the Act was approved by ballot in 1994 it was immediately challenged in the courts. This prompted the Oregon legislature to put the Oregon Death with Dignity Act on the ballot again in 1997.).

6. Or. Rev. Stat. § 127.800 (1999).

7. Or. Rev. Stat. § 127.815 (1999).

8. Or. Rev. Stat. § 127.800(3) (1999) ("in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has

Before the physician may prescribe the medication, the Act places a great deal of responsibility upon her to guarantee that the patient has made an informed and well thought out decision.

The physician must discuss with the patient, his medical diagnosis, prognosis, and potential risks.¹¹ Alternative options, like hospice care and comfort care, must also be brought to the patient's attention.¹² These safeguards are designed to ensure the patient understands his medical future so the best decision regarding that future can be made. After the physician discusses the procedure, all possible alternatives, and Oregon residency is determined, a second physician is consulted to confirm that the attending physician fulfilled her duties to the patient.¹³

If either physician feels it is necessary, the patient may also be referred to a counselor¹⁴ for a determination as to whether or not the patient comprehends the ramifications of his decision. If the counselor does not believe the patient is capable of making an informed decision the patient will not be allowed to proceed with physician-assisted suicide. Finally, the patient is encouraged to contact next of kin¹⁵ and a waiting period gives the patient fifteen days to contemplate his decision before a final decision must be made.¹⁶

The Act was designed to offer individuals an opportunity to take a more active role in determining the outcome of their remaining life. Terminally ill patients who feel there is no chance or opportunity for survival, are provided the means to end their lives. The patient receives a medical prescription which will end his life, instead of possibly enduring medical procedures that will prolong death but inflict greater pain and discomfort. In essence, the Act was initiated to provide terminally ill patients the opportunity to die as they had live, with dignity.

B. Scope and Effect of the Oregon Death with Dignity Act

the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available").

9. Or. Rev. Stat. § 127.800(12) (1999) ("an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six 6 months").

10. Or. Rev. Stat. § 127.860 (1999).

11. Or. Rev. Stat. § 127.815(c) (1999).

12. Or. Rev. Stat. § 127.815(c)(E) (1999).

13. Or. Rev. Stat. § 127.815(d) (1999).

14. Or. Rev. Stat. § 127.825 (1999).

15. Or. Rev. Stat. § 127.815(f) (1999).

16. Or. Rev. Stat. § 127.840 (1999) (the patient must be given the opportunity to rescind his request for physician-assisted suicide up until and including the day the final decision must be made).

By implication, the Act has been challenged theoretically on equal access grounds. In 1999, a man diagnosed with amyotrophic lateral sclerosis requested and received life ending medication from his physician.¹⁷ Controversy surrounded the event when the man had problems taking the medication himself.¹⁸ Reports indicated that the man's brother-in-law helped him carry out the intended act.¹⁹ The brother-in-law remained tight-lipped regarding his actions causing people to speculate about how he "helped" the dying man.²⁰ Because the body was cremated before an autopsy could be performed, no one will ever know for sure the brother-in-law "helped."²¹

Supporters of the Act say "there are no plans to attempt to expand the law to allow lethal injections or other means so those with disabilities can access the law [but] other's [say] it is only a matter of time."²² The fact remains that neither active euthanasia, lethal injection, nor mercy killing are acknowledged by the Act as acceptable means of physician-assisted suicide. Furthermore, immunity from prosecution is only granted to those physicians complying in good faith with the provisions of the Act.²³ The Act does not protect individuals from illegally assisting an individual's suicide, nor was it intended to. While the Act is open to challenge from the American with Disabilities Act²⁴ no such challenge has created a change in the Act's original scope.

A study performed at the University of California in San Francisco, by R. Jeffery Kohlwes, designed to evaluate physician responses to requests for assisted suicide, showed "that patient requests for physician-assisted suicide are a relatively common clinical occurrence."²⁵ How physicians deal with such inquiries differs as much between physicians as it does between states. No other state is as progressive as Oregon in terms of allowing physician-assisted suicide, therefore a comparison cannot be made, but Oregon's Death with Dignity Act has led to 69 Oregonians optioning for physician-assisted suicide.²⁶

17. Diane M Gianelli, *Oregon Death Tests Assisted-Suicide Law*, American Medical News, Apr. 5, 1999, at 10.

18. *Id.*

19. *Id.*

20. *Id.*

21. *Id.*

22. *Id.*

23. Or. Rev. Stat. § 127.885(1) (1999).

24. This subject goes beyond the scope of this article.

25. R. Jeffery Kohlwes, *Physicians' Responses to Patients' Requests for Physician Assisted Suicide*, THE J. AM. MED. ASS'N, June 12, 2001, at 2838.

26. See *Oregon Death with Dignity*, at http://www.dwd.org/pdf/odwd_report.pdf (last visited April 20, 2002) (data is compiled from 1998-2000 statistics).

According to an executive director for Compassion in Dying, the Act is working exactly as the intended, without any failures and or abuses.²⁷ In 1998, only fifteen individuals accepted physician assistance to end their lives.²⁸ “Some suggested that the numbers were lower than they otherwise may have been because of the cloud in the form of proposed federal legislation – that hung over the law for much of the year.”²⁹ Despite the fear that the number of people choosing physician-assisted suicide would increase dramatically, the number has remained relatively constant.

In both 1999 and 2000, 27 people received medical assistance to end their lives. In 2000, of those 27, the “median age was 69, and 21 had end-stage cancer. All had health insurance, and 23 were in hospice care before their deaths.”³⁰ An inference can be drawn from this data that the majority of persons requesting and receiving physician assistance in committing suicide, were near the end of their lives in terms of both age and health, and they possessed the means to continue receiving treatment via insurance had they desired. This being the case, the system does not appear to be exploiting nor taking advantage of persons seeking physician assistance.

Those opposed to physician-assisted suicide have enumerated a litany of reasons detailing their opposition. The most prevailing concern is that the doctor will advocate assisted suicide when she should be acting within the traditional guidelines as a healer; this situation would potentially destroy the doctor-patient relationship.³¹ Another fear is that the dual role thrust upon doctors would lead to an increase in unnecessary deaths.³² Opponents also believe “physician-assisted suicide would lead to a decreased incentive to research and develop new methods of providing palliative care and life sustaining treatments.”³³

Proponents, on the other hand, advocate physician-assisted suicide for the dignity and autonomy it can restore to a terminally ill patient at the end of his life.³⁴ They also believe that physician-assisted suicide should be available to anyone capable of exercising free choice.³⁵ The foundation of these beliefs is

27. Diane M. Gianelli, *Oregon Suicide Report Contains Some Surprises*, American Medical News, March 8, 1999, at 9.

28. *Id.*

29. *Id.* (the *Lethal Drug Abuse Prevention Act (H.R. 4006/S. 2151)* would have hampered physicians from practicing by taking away their DEA license if they performed physician-assisted suicides).

30. *Oregon Suicide Law Used by 27*, Drug Topics, March 5, 2001, at 10.

31. Rena Patel, *Physician-assisted Suicide: Is It Time?*, 35 Cal. W. L. Rev. 2, 333 (1999).

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.*

that a patient's rights should outweigh all other interests.³⁶ For example, when first put on the agenda in Oregon, pain and suffering were the two biggest reasons for legalizing physician-assisted suicide.³⁷ Yet, of all of the persons who died in 1998 from physician-assisted suicide in Oregon, only one of the patients said pain control was a concern. Most cited concerns over loss of autonomy or loss of control of bodily function.³⁸

II. IMPORTANT AND RELEVANT CASE LAW

A. *Conflict between the States*

Advocates believed that the combination of relatively low physician-assisted suicides and lack of reported abuses in Oregon would lead to the adoption of similar statutes in other states.³⁹ No state has yet adopted anything resembling Oregon's Death with Dignity Act. Some have tried, but they have all failed. Although Oregon has opened the door to a major shift in health care ethics, it has been a constant uphill battle for assisted-suicide proponents.

Five states did place physician-assisted suicide on the ballot, but each initiative failed: Washington in 1992, California in 1993, Michigan in 1998, and Maine in 2000.⁴⁰ Beyond the above states, which put physician-assisted suicide to a vote, 24 other states initiated bills that would have legalized it; the measure failed in each state.⁴¹ State courts have also been less than supportive of individuals seeking the same right to physician-assisted suicide as experienced in Oregon.

In *Sampson v State*, Sampson and Doe, two mentally competent and terminally ill persons, challenged Alaska's criminal statute against physician-assisted suicide, alleging that their physicians should not be prosecuted under the manslaughter statute for helping end their lives.⁴² The Alaska Superior Court granted summary judgment against Sampson and Doe. The court concluded that "the Alaska Constitution's guarantees of privacy and liberty do not afford terminally ill patients the right to a physician's assistance in committing suicide and that Alaska's manslaughter statute did not violate

36. *Id.*

37. See *The Hemlock Society USA*, at <http://www.hemlock.org/background.htm> (last visited April 20, 2002).

38. See *Death with Dignity*, at <http://www.dwd.org/fss/impact.asp> (last visited April 20, 2002).

39. Diane M. Gianelli, *Will Oregon Data Spur Other States to Try Assisted Suicide?*, *American Medical News*, March 15, 1999, at 11.

40. See *Death with Dignity Initiatives*, at <http://www.dwd.org/law/statutes.asp> (last visited 4-20-02).

41. Gianelli, *supra* note 39, at 11.

42. *Sampson v. State*, 31 P.3d 88, 89 (Alaska 2001).

Sampson and Doe's right to equal protection."⁴³ The cry of personal autonomy has not been enough to legalize physician-assisted suicide. Opposition has fought advocates of legalized suicide at every turn and to the advocates' dismay, increasingly harder.

The latest opposition has come in the form of anti-assisted suicide legislation. In two unanimous decisions, the U.S. Supreme Court upheld physician-assisted suicide bans in New York and Washington.⁴⁴ In *Vacco v. Quill*, the plaintiffs alleged that the ban on physician-assisted suicides violated the Fourteenth Amendment's Equal Protection Clause. The plaintiffs challenged the law based upon the premise that physician-assisted suicide was comparable to withdrawing life-sustaining treatment.⁴⁵

The Court ultimately reaffirmed its position that a distinction exists between ceasing medical treatment and assisted suicide as enunciated in *Cruzan v. Director, MO Dept. of Health*. In *Cruzan*, the Court concluded that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from [their] prior decisions."⁴⁶ The Court's doctrine enunciating a right to refuse treatment is based on the notion that patients have a personal liberty right to freedom from unwanted touching.⁴⁷

In *Washington v. Glucksberg*, the Court once again held that terminally ill patients have no legal right to medical help in committing suicide.⁴⁸ This ruling prevented individuals in Washington from claiming a constitutional right to physician-assisted suicide, but it did not adversely affect the Act. Nor did the decision begin to resolve the moral and ethical questions many Americans ponder physician-assisted suicide. Chief Justice William Rehnquist wrote that the Court's decision "permits this debate to continue, as it should in a democratic society."⁴⁹ In her concurrence, Justice O'Connor insinuated that the best result may occur if the debate takes place on the state level. She noted that "States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues."⁵⁰ In which case, "the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the States . . . in the first instance."⁵¹

43. *Id.* at 95, 100 (both Sampson and Doe died before the case was decided).

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

45. *Vacco*, 521 U.S. at 794-99.

46. *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 278 (1990).

47. *Id.* at 278-279.

48. *Washington*, 521 U.S. 702.

49. *Id.*

50. *Id.* at 737 (citing 521 U.S. at 716-718).

51. *Id.* (citing *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 292 (1990) (Justice O'Connor, concurring)).

B. Case Law

For years, the medical profession attempted to prolong life through medical means. Sometimes these efforts kept people alive longer than otherwise natural. In 1976, the landmark case of *In re Quinlan* (Quinlan) turned the tide toward accepting death as opposed to prolonging life as long as possible.⁵² Twenty-one year old Karen Quinlan was put on life support by her doctors after she stopped breathing; she remained in a permanent vegetative state, supported only through the assistance of machines.⁵³ A court battle ensued when Karen's father wanted to remove the machines keeping Karen alive.⁵⁴ Karen's doctors and the hospital opposed this proposition as interfering with medical judgment in route to murder.⁵⁵

The New Jersey Supreme Court sided with Karen's father, holding that removal of life-sustaining technology is a constitutionally protected right.⁵⁶ The court rationalized that the 14th Amendment would have allowed Karen as a competent adult to relinquish her life.⁵⁷ Unfortunately for Karen, given her vegetative state, she could not give her consent to the physician. Considering this situation, the court determined that a legal guardian would also possess the right to reject life-sustaining technology for the patient.⁵⁸ Later courts also upheld similar cases on the basis of patient's informed consent.⁵⁹ The decision in *In re Quinlan* marked a tremendous victory for end of life treatment. Patients were given a larger say in how they were going to be medically treated during the end of their lives. Starting with *In re Quinlan*, courts began to recognize that patients possess an inherent right to consent to any and all medical treatment.⁶⁰ Included in a patient's right to consent is also the right to reject unwanted treatment. The Court, however, has drawn a distinction between patient consent and assisted suicide.

Fourteen years later, the US Supreme Court recognized *In re Quinlan* and other similar state court decisions in *Cruzan v. Director, MO Dept. of Health*.⁶¹ *Cruzan* was *In re Quinlan* all over again with the exception that *Cruzan* was being tried before the US Supreme Court. *Cruzan* was in a vegetative state and

52. *In re Quinlan*, 355 A.2d 647 (NJ 1976).

53. *Id.* at 653-655.

54. *Id.* at 651.

55. *Id.*

56. *Id.* at 671.

57. *Id.* at 663.

58. *Id.*

59. *See, e.g., In re Conroy*, 486 A.2d 1209 (N.J. 1985); *see In re Torres*, 357 N.W.2d 332 (Minn. 1984).

60. *Quinlan*, 355 A.2d 647 (NJ 1976).

61. *Cruzan*, 497 U.S. 261.

received life-sustaining assistance with the help of medical technology.⁶² The Court ruled that Cruzan was able to choose to reject or remove life-sustaining assistance if she was competent or if her legal guardian agreed.⁶³ The Court did note that it was permissible for the state to require ‘clear and convincing’ evidence that the patient would be unable to live without technological assistance before removal was permitted.⁶⁴ The Court affirmed *Cruzan* in 1997, but it continued to prohibit assisted suicide.⁶⁵

III. THE ATTORNEY GENERAL’S POSITION

A. Oregon’s Breakthrough

On June 5, 1998, then Attorney General Janet Reno issued a press release detailing the Department of Justice’s position on Oregon’s Death with Dignity Act. The press release stated that “the Department has conducted a thorough and careful review of the issue of whether the Controlled Substance Act (CSA) authorizes adverse action against a physician who prescribes a controlled substance to assist in a suicide in compliance with Oregon’s Death With Dignity Act.”⁶⁶ The Department stated that as long as a physician adheres to Oregon law, “adverse action” would not be sought against the physician.⁶⁷

The strict guidelines and narrow circumstances under which physicians may legally assist patient suicide convinced the Department the state of Oregon was not acting in violation of federal laws.⁶⁸ Further, “the Department concluded that the CSA does not authorize DEA to prosecute, or to revoke the DEA registration of, a physician who has assisted in a suicide in compliance with Oregon law.”⁶⁹ As long as physicians act in accordance with Oregon law, the DEA has no grounds for prosecution; however, should someone stray from these particular circumstances, prosecution may be sought. A few examples include: “where a physician assists in a suicide in a state that has not authorized the practice under any conditions, or where a physician fails to comply with state procedures in doing so.”⁷⁰

62. *Id.*

63. *Id.* at 262.

64. *Id.* at 261.

65. *Washington*, 521 U.S. 702 (Court held the right to refuse medical treatment did not extend to the ingestion of poison).

66. Statement of Att. Gen. Reno on Oregon’s Death with Dignity Act (on file with author) (June 5, 1998).

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.*

B. *Setback*

November 6, 2001 marked a dramatic change in the Attorney General's position on Oregon's Death with Dignity Act. Citing a Supreme Court decision, Ashcroft stated federal regulation of controlled substances, may not be superceded by state legislation.⁷¹ "Upon review of the *Oakland Cannabis* decision and other relevant authorities, [Ashcroft] concluded that the DEA's original reading of the CSA - that controlled substances may not be dispensed to assist suicide - was correct."⁷² The effect of this ruling would be to strip doctors in Oregon of the ability to assist terminally ill patients in committing suicide. Doctors who prescribe federally controlled substances to assist patient suicide could have their DEA registration revoked or suspended.⁷³ Revocation or suspension of a doctor's DEA registration prohibits him or her from prescribing drugs, effectively eliminating the doctor's ability to practice medicine.⁷⁴

Ashcroft's position would effectively eliminate an Oregon doctor's ability to assist his or her patient in committing suicide by requiring DEA agents to police and punish doctors who assist patient suicides by prescribing controlled substances. Oregon was unique in allowing physician assisted suicide. No other state in the entire United States allowed physicians to participate in assisted suicides. Ashcroft knew Oregon would be the only state affected when he reversed Attorney General Reno's position. What affect does the ruling have on Oregon? Oregon is currently challenging Ashcroft's decision in the federal courts.⁷⁵

IV. THE ENSUING COURT BATTLE

Attorney General Ashcroft's press release has raised several legal issues. They include: whether Oregon has standing to challenge the Attorney General's position, whether the Controlled Substance Act applies to the current situation, and whether federalism is being infringed upon. Each will now be discussed in turn.

A. *Standing*

71. *U.S. v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483 (2001).

72. Memorandum for Asa Hutchison, *supra* note 4.

73. *Id.*

74. *Id.*

75. *Oregon v. Ashcroft*, No. 01-CV-1647, 65-66, (D. Ore. filed Nov. 7, 2001); *see* <http://www.dwd.org/pdf/transcript.pdf> (a temporary injunction was issued by the District Court of Oregon on November 8, 2001).

Standing is required to litigate in federal court. Standing is composed of three essential elements: an “injury in fact,”⁷⁶ a “causal connection,”⁷⁷ and the injury complained of is likely to be redressed.⁷⁸ The injury in fact must be “concrete and particularized.”⁷⁹ That is to say that there must be an invasion of a legally protected interest and no citizen suits of general grievance are allowed. The injury in fact must also be “actual or imminent.”⁸⁰ For the causal connection to be satisfied, “the injury must be fairly traceable to the challenged action of the defendant and not the result of some independent action of a third party.”⁸¹ In order to be redressable, it “must be likely and not speculative that the injury will be redressed by a favorable Court decision.”⁸²

The injury Oregon alleges is an intrusion upon its sovereign and regulatory interests. Oregon wants to protect its sovereignty by ensuring that its properly enacted state laws remain free from federal encroachment.⁸³ Oregon is also fearful that the new position taken by the Department of Justice infringes upon state regulatory interests by prohibiting Oregon’s Board of Medical Examiners, Board of Pharmacy, and Department of Human Services from duly performing their functions.⁸⁴ Standing was granted in similar situations when existing state statutes conflicted with new federal legislation. In *New York v. United States*, the Court heard New York’s challenge of a new federal law.⁸⁵ New York challenged Congress’ ability to enact a federal law, which set guidelines for the disposal of radioactive waste, where New York already had its own policy.⁸⁶ Similarly, in *Ohio v. Department of Transportation*, “since Ohio [was] litigating the constitutionality of its own statute, duly enacted by the Ohio General Assembly, Ohio [had] a sufficient stake in the outcome of this litigation to give it standing.”⁸⁷

This case may look like an example of *parens patriae*⁸⁸ but it is not. On the surface, the federal government is merely construing its own statute. If this were the only reason for reconstruing the statute, Oregon would lack standing

76. *Lujan v. Defenders of Wildlife*, 504 U.S. 555 (1992).

77. *Id.*

78. *Id.* at 561.

79. *Id.* at 560.

80. *Id.*

81. *Id.*

82. *Id.* at 562.

83. *Ashcroft*, No. 01-CV-1647, 5.

84. *Id.* at 6.

85. *New York v. U.S.*, 505 U.S. 144 (1992).

86. *Id.* at 149.

87. *Ohio v. Dept. of Transp.*, 766 F.2d 228, 232-33 (1985).

88. *Massachusetts v. Mellon*, 262 U.S. 447-48 (U.S. 1923) (“[with respect to the citizens of a state and] their relations with the federal government . . . it is the United States, and not the state, which represents them as *parens patriae*”).

because it cannot inappropriately represent its citizens as *parens patriae* against the federal government. Underlying the Department of Justice's position is a desire to invalidate the Oregon Death with Dignity Act. The Attorney General's reversal brings directly into question Oregon's Death with Dignity Act. Oregon is protecting its interest in the matter to ensure that its law remains intact. While newly enacted federal laws often conflict with already existing state laws the distinguishing factor here is that the Department of Justice is making a complete switch from its previous position of allowing physician assisted suicide. Because the Department of Justice has done a 180 degree reversal, Oregon should be afforded an opportunity to present its case. Ensuring that the Act remains intact is not generalized, nor is it minute. Peoples' lives hang on the decision of the court. Oregon has a particularized injury to allege.

The causal connection between the complained of injury and challenged act need only be 'fairly traceable.' As noted above, the Attorney General's new position places the Act in a precarious situation. If a physician in Oregon, adhering to the Act, prescribes controlled substances to assist a patient's suicide, she could now face criminal penalties. The Act's new uncertainty represents a distinct causal connection. And, a favorable decision would restore certainty and ensure validity in the Act; hence, the injury alleged is redressable.

B. *The Controlled Substance Act*

The Controlled Substance Act (CSA) controls the manufacture and distribution of controlled substances.⁸⁹ Each substance is placed into a schedule based upon its "medical use, potential for abuse, and . . . dependence liability."⁹⁰ In order for a physician to handle controlled substances, she must be registered with the Drug Enforcement Agency (DEA).⁹¹ The DEA requires record keeping and places quotas on schedule I and II⁹² substances to curb unauthorized use.⁹³ Civil and criminal penalties are imposed on persons failing to strictly comply with the CSA.⁹⁴ A physician's DEA registration may

89. 21 U.S.C.A. § 801-971 (*see also* U.S. Drug Enforcement Administration <http://www.usdoj.gov/dea/agency/csa.htm>).

90. *Id.*

91. *Id.*

92. *See id.* (Schedule I and II are highly addictive and represent the greatest potential for abuse. Schedule II substance, however, possess some medical usage, while schedule I substances possess none.).

93. *Id.*

94. *Id.*

also be revoked if she participates in any criminal activities or jeopardizes public safety.⁹⁵

In discussing the scope of the CSA, Attorney General Reno said,

“The CSA was intended to keep legally available controlled substances within lawful channels of distribution and use. It sought to prevent both the trafficking in these substances for unauthorized purposes and drug abuse. The particular drug abuse that Congress intended to prevent was that deriving from the drug’s stimulant, depressant, or hallucinogenic effect on the central nervous system. There is no evidence that Congress, in the CSA, 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. Indeed, the CSA is essentially silent with regard to regulating the practice of medicine that involves legally available drugs except for certain specific regulations dealing with the treatment of addicts.”

The original ruling of the CSA, which Attorney General Ashcroft advocates, is a hard line rule restricting the use of controlled substances for the purposes of medical assistance. Doctors may administer controlled substances to reduce the suffering of an individual in extreme pain, but she may not go so far as to assist the patient in ending his life. Ashcroft’s position does nothing to address what will become of patients whom suffer with tremendous pain despite medical assistance. Drawing a well-defined distinction between life and death is admirable, yet it fails to take into consideration the choice of the patient.

It is true that the patient’s choice can not always be followed. In *U.S. v. Oakland Cannabis Buyer’s Co-op*, the Court held there was no medical necessity exception to the prohibitions set forth in the CSA.⁹⁶ In 1996, California voters initiated a movement hoping “[t]o ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes.”⁹⁷ The prohibitions set out in the CSA would no longer apply to patients or physicians who fell within the proposed medical necessity exception.⁹⁸ Under the CSA, schedule I controlled substances may legally be used in a government approved research project.⁹⁹ The Court declined to create a new exception, stating that “[w]hereas some other drugs can be dispensed and prescribed for medical use,¹⁰⁰ the same is not true for

95. *Id.*

96. 532 U.S. 483 (U.S. 2001).

97. *Id.* at 480 (*citing* Cal. Health & Safety Code Ann. § 11362.5 (West Supp.2001)).

98. *Id.*

99. *Id.* at 490.

100. *See* 21 U.S.C. § 829.

marijuana.”¹⁰¹ The CSA does not recognize an accepted medical use for marijuana.¹⁰²

Oakland Cannabis Buyer's Co-op is distinguishable from the case at hand. The Act does not permit physicians to prescribe schedule I controlled substances to patients. Rather it deals solely with schedule II controlled substances. Schedule II controlled substances possess legitimate medical purposes; for example, pain relief.¹⁰³ The State of Oregon legalized physician-assisted suicide by a majority vote. In so doing Oregon has elevated physician-assisted suicide to the level of a legitimate medical purpose. Barring a change in legislation, the CSA does not prohibit the use of schedule II controlled substances in physician-assisted suicide.

Furthermore, the Act is well designed and contains several safety mechanisms. An individual can not merely walk in off of the street and receive a physician's assistance in committing suicide. The patient must have an ongoing relationship with doctor, attend counseling sessions, seek a second opinion, be determined to be a competent adult, and is encouraged to discuss his decision with family and relatives. The Act does not encourage rash decision-making, but fosters patient participation during his medical treatment. Patients are given the right to make informed decisions regarding life and death every day, why shouldn't they be allowed to do the same here?

Attorney General Reno believed that the strict requirements of the Act combined with public support elevated the Act to a level, which could not be overlooked. Merely classifying physician assisted suicide as murder oversimplifies the issue. Continually administering pain medication to terminally ill patients is not necessarily humane. If a patient decides that pain medication does not help sustain a relatively normal way of life and decides to stop accepting the medication, he may eventually die in extreme pain. The patient is left between two alternatives, neither one of which may be appealing. With the Act, the patient may ask for physician assistance to end his life. The physician does not administer the medication, but merely prescribes it for the individual. The citizens of Oregon have looked at both sides of this issue and determined for themselves that the latter is the most humane approach. If nothing else, the will of the people should not be cursorily overlooked.

C. Federalism Issues

An Executive Order issued by President Clinton on August 4, 1999, was intended “to ensure that the principles of federalism established by the Framers guide the executive departments and agencies in the formulation and

101. *Oakland Cannabis Buyer's Co-op*, 532 U.S. at 491 (2001).

102. *See* 21 U.S.C. § 811.

103. *Id.*

implementation of policies.”¹⁰⁴ Explicit in the ideal of federalism is the notion that local government is best suited to deal with issues falling outside a national “scope or significance”¹⁰⁵ and States retain any power not prohibited by the Constitution nor enumerated to the federal government.¹⁰⁶ If the national government acts outside its enumerated powers a violation of federalism shall occur.¹⁰⁷ The Order continues by stating that “our constitutional system encourages a healthy diversity in the public policies adopted by the people of the several States”¹⁰⁸ with an aim to foster “effective solutions.”¹⁰⁹ Solutions should be achieved through “cooperative effort,”¹¹⁰ with deference to the State when it’s policymaking authority is affected and the “greatest caution” when constitutional issues surface.¹¹¹

Article II of the U.S. Constitution vests in the President executive Power.¹¹² Executive Power includes the right to issue Executive Orders. Executive Power is most effective when issued in conjunction with Congressional legislation and weakest when conflicting with Congress.¹¹³ No Congressional legislation specifically supports President Clinton’s Executive Order, but the Constitution expressly states “[t]he 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.”¹¹⁴ The Executive Order clearly reiterates the distinction between powers set out in the Constitution for the federal government and those for the States. The Executive Order also, indicates that as a matter of policy the federal government should encourage diversity amongst the States.

Considered alongside Justice O’Connor’s concurrence in *Washington v. Glucksberg*,¹¹⁵ the Executive Order implies that difficult public policies should be left up to the individual States. And, if the federal government should decide to intervene in an area of State diversity, it should do so cautiously and with an eye toward cooperation. Attorney General Ashcroft’s ruling does not foster an effective solution to the difficult issue of physician-assisted suicide. It disregards the decision Oregon’s citizens made when they twice passed the

104. Executive Order 13132, 64 Fed. Reg. 43,255 (August 4, 1999).

105. *Id.* at (2)(a).

106. *Id.* at (2)(b).

107. *Id.* at (2)(g).

108. *Id.* at (2)(f).

109. *Id.*

110. *Id.* at (2)(h).

111. *Id.* at (2)(I).

112. U.S. CONST. art. II.

113. *See Dames & Moore v. Regan*, 453 U.S. 654 (1981).

114. U.S. CONST. art. I.

115. *Washington*, 521 U.S. 702 (stating the proposition that certain public policies like physician-assisted suicide should be left to “the ‘laboratory’ of the States”).

ballot legalizing physician-assisted suicide. The ruling also oversteps its constitutional bounds.

In *Lopez v. United States*, the Court determined that Congress possessed the power to regulate three areas based upon the Commerce Clause.¹¹⁶ “First, Congress may regulate the use of the channels of interstate commerce.”¹¹⁷ “Second, Congress is empowered to regulate and protect the instrumentalities of interstate commerce, or persons or things in interstate commerce, even though the threat may come only from intrastate activities.”¹¹⁸ “Finally, Congress’ commerce authority includes the power to regulate those activities having a substantial relation to interstate commerce, . . . *i.e.*, those activities that substantially affect interstate commerce.”¹¹⁹ Attorney General Ashcroft’s ruling is an attempt to regulate an activity which has a substantial affect on interstate commerce. If the federal law has a demonstrable “substantial effect”¹²⁰ the ruling will be constitutional.

Both *Lopez* and *Morrison* illustrate what is meant by a substantial effect on interstate commerce. The *Lopez* Court declined to hold the Gun-Free School Zone Act of 1990 constitutional.¹²¹ A high school senior was convicted of violating the Gun-Free School Zone Act after he knowingly brought a handgun into his high school.¹²² The Court holds that “[the Gun-Free School Zone Act] neither regulates a commercial activity nor contains a requirement that the possession be connected in any way to interstate commerce.”¹²³ Substantial effect requires more than unfounded and far-reaching fear that future students will also bring handguns into school, destroying the classroom environment.¹²⁴ In a similar case, *U.S. v. Morrison*, the Court declined to uphold the civil remedy provision of a federal rape law.¹²⁵

Like the Gun-Free School Zone Act and the federal rape law, Attorney General Ashcroft’s ruling does not have demonstrable substantial effect on interstate commerce. The purpose of the Commerce Clause is to regulate and foster commerce between the several States. The ruling does not foster commerce and only purports to regulate commerce on its surface. Even assuming the ruling is valid, controlled substances will enter Oregon at roughly

116. 514 U.S. 549, 558 (1995).

117. *Id.* (citing *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964)).

118. *Id.* (citing *Shreveport Rate Cases*, 234 U.S. 342 (1914); *Southern R Co. v. United States*, 222 U.S. 20 (1911)).

119. *Id.* at 558-559 (citing *Jones & Laughlin Steel*, 301 U.S. 1, 21 (1937)).

120. *Id.* at 559.

121. *Id.* at 551.

122. *Id.*

123. *Id.*

124. *Id.* at 563-564.

125. *U.S. v. Morrison*, 529 U.S. 598, 601-02 (2000).

the equivalent rate as before, because very few individuals actually choose physician-assisted suicide. If the ruling is regulating anything, it is regulating the right to die, which is beyond the scope of the Commerce Clause. Attorney General Ashcroft's ruling violates the ideas set out within the Executive Order, Article II of the Constitution and the Commerce Clause.

V. CONCLUSION

In the present case, Oregon is challenging a ruling by Attorney General Ashcroft, which would permit DEA prosecution of physicians who prescribe controlled substances too assist patients in committing suicide. In order to reach the merits of its case, Oregon must show the court that it has standing to bring its lawsuit. Oregon achieves this by alleging infringement upon its sovereignty and regulatory interests. By bringing this suit, Oregon will succeed in finding out whether or not the Attorney General's ruling overrides Oregon law. If it does not, the Act remains intact and the Department of Justice is prevented from seeking criminal liability against physicians practicing under the Act.

Proceeding to the merits of the case, the CSA does not prohibit physicians from using controlled substances to assist patients in committing suicide. The CSA specifically authorizes the use of schedule II controlled substances to be administered to patients suffering from extreme pain and other legitimate medical purposes. When the citizens of Oregon passed the Act, they legitimized physician-assisted suicide. Hence, physicians are acting within the scope and guidelines of the CSA when they assist patient suicide.

Federalism necessitates that the Act be free from egregious federal oversight. The Constitution sets out enumerated federal powers, powers prohibited from the states, and places the remaining powers in the hands of the states or its people. Furthermore, the Executive Order by President Clinton encourages cooperation between the federal government and state governments when difficult policy concerns are at issue. Attorney General Ashcroft's ruling disregards the boundaries between what the federal government has the power to regulate and what should be left to the individual States. An analogy can best be drawn to the death penalty. States are divided on the issue of administering the death penalty. In fact, of the Western world, the United States is practically alone in its practice of the death penalty. Difficult moral concerns have caused States to act in accordance to the wishes of their individual citizens. President Clinton's Executive Order implies the same scenario applies to physician-assisted suicide. The federal government also, cannot claim that it is regulating commerce under the Commerce Clause, because what seems to be the real driving force behind the Attorney General's ruling is to invalidate the right to die.

In conclusion, the right to die is not a constitutional right, but that does not mean it is not a right. Attorney General Ashcroft cannot stop individuals from committing suicide, yet he is attempting to prohibit physician-assisted suicide. Is it more humane to prohibit physician-assisted suicide and prolong life by administering medication to reduce the amount of pain and suffering one undergoes, or is it more humane to allow physician-assisted suicide no matter what our moral position is? I for one could not bear to see a loved one suffer through incurable pain, yet I do not advocate physician-assisted suicide. I believe that there must be a better option. But, that is my choice and someone else may make a different decision, as did the voters of Oregon. The Act does not allow every patient to receive physician assistance in committing suicide. It requires that a relatively intense and scrutinizing process be carried out before any controlled substances are prescribed. The system has created safeguards to ensure that mentally capable adults are making the proper decision. Oregon has withstood countless morality attacks through the legal system and in the media during the past four years; it is time that Oregon be recognized for taking a leading and progressive viewpoint toward end of life care.

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