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Comment

Questioning the Foundation of Attorney General Ashcroft's Attempt to Invalidate Oregon's Death with Dignity Act

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"The role of attorney general is to enforce the law as it is, not as I would have it."

-- United States Attorney General John Ashcroft,
at his confirmation hearing January 15, 2001. [FN1]

On November 6, 2001, United States Attorney General John Ashcroft issued a directive which reinterpreted the Controlled Substances Act as to invalidate Oregon's assisted suicide law, the Death with Dignity Act. This was the first time in history that the Controlled Substances Act was used to preempt state law. Although the Death With Dignity Act has been vigorously challenged since its passage by voter initiative in 1994, Ashcroft's challenge is the most dramatic and controversial to date. Ashcroft's directive threatens physicians who act in accordance with the provisions of the Oregon Act with revocation of their medical licenses and criminal prosecution. In choosing to invalidate the Oregon Act through the physicians who prescribe lethal ***506** medication, the Attorney General interfered with a power traditionally left to state governments: the power to regulate public health and medical licensing.

The encroachment of the federal government into an area traditionally regulated by state and local government provides the basis for the subject matter discussed in this Comment. The first section will examine the legal context in which this current challenge arose, with an emphasis on the Oregon law and the reactions of the federal judiciary, Congress, and the Attorney General to the controversy surrounding physician-assisted suicide in the United States. The second section of this Comment will discuss the history of the state exercise of power in the area of public health. This section will focus on the regulation of medical licensing and point out that although the federal government has increased its involvement in public health in the twentieth century, medical licensure has always been left to the states. This section will conclude with an explanation on how the Controlled Substances Act expanded the federal government's involvement in medication without intending to interfere with the ability of the state to license physicians.

The Ashcroft directive was made during a very significant stage in the history of the Supreme Court federalism jurisprudence. The Court's increasing use of federalism as a substantive tool through which to analyze, and often invalidate, the actions of the federal government places the directive on very shaky constitutional footing. The final section will examine three challenges to the directive that can be made

on behalf of the proponents of the Death with Dignity Act. The section will open with a brief discussion of the challenges made by the State of Oregon to the Attorney General's administrative interpretation of the Controlled Substances Act.

The subsequent arguments will assume that Oregon's challenge to the Attorney General's interpretation would fail. These sections will discuss the constitutionality of the effects of such an interpretation. First examined is the federal preemption of state law, and Gregory v. Ashcroft's warning that federal legislation should not be interpreted to preempt state law when preemption would interfere with state sovereignty. The second argument will assume that the federal interpretation of the Controlled Substances Act is not only permissible, but also fails to implicate any preemption problems. Instead, the relevant provisions of the ***507** Controlled Substances Act, as interpreted by Ashcroft, are attacked as an impermissible use of Congress' Commerce Clause power. The Death with Dignity Act will be analyzed using the framework provided by the Court's most recent decisions on the permissible use of the federal Commerce power, United States v. Lopez and United States v. Morrison. Both of these arguments, whether taken individually or cumulatively, indicate that Ashcroft has done exactly what he pledged not to do at his confirmation hearing: enforce the law as he sees it. Complicated issues arise when the public health law is used to enforce political, as opposed to scientific, decisions about what constitutes proper medical care. The usual examples are abortion and narcotics laws. [FN2] A more recent example is physician-assisted suicide.

I

Background

As a result of improvements in medical technology over the last century, Americans are living longer, and healthier, than ever before. Technology is also keeping many people alive much longer than they would like. The public debate over the right of terminally ill people to choose to end their lives with the help of a physician has intensified over the last twenty-five years, as the Baby Boom generation begins to address a multitude of end-of-life issues. [FN3]

***508** Proponents of physician-assisted suicide (PAS) maintain that PAS is a legal extension of the right to die that was established in In re Quinlan [FN4] and Cruzan v. Director, Missouri Department of Health, [FN5] and the privacy and autonomy of terminally ill persons choosing PAS should be respected. [FN6] Opponents of PAS argue that there is no logical legal connection between forgoing medical treatment and active assistance in hastening the death, and in any event, participation in PAS is immoral, unethical and unprofessional.

The movement to legalize PAS in Oregon solidified with the founding of the Oregon Hemlock Society in Eugene, Oregon in 1980. [FN7] In 1991, Oregon State Senator Frank Roberts introduced a bill to legalize assisted suicide, but the bill failed to pass out of committee. [FN8] In 1993, the Oregon legislature approved Senate Bill 286, which enabled terminally ill patients, or their family members, to receive as many painkilling drugs as needed to relieve illness related suffering. [FN9] The law stopped short of legalizing PAS, and Oregon Right-to-Die was subsequently founded to work toward the passage of a doctor-assisted suicide initiative. [FN10] That initiative was 1994's Ballot Measure 16, the Oregon Death with Dignity Act. Oregon voters approved Ballot Measure 16, 51%-49%, making the Act the

nation's first law permitting the use of PAS. [FN11] Physician assisted suicide became a legal medical option for terminally ill Oregonians.

***509** The Oregon Death with Dignity Act (Oregon Act), [FN12] allows terminally ill Oregon residents to obtain prescriptions for self- administered, lethal medications from their physicians and pharmacists. The Oregon Act permits PAS, but specifically prohibits euthanasia, where a physician or other person directly administers a medication to end the life of another.

A. The Oregon Statute

To request a prescription for lethal medication, the Oregon Act requires that the patient be an adult, a resident of Oregon, capable, [FN13] and diagnosed with a terminal illness that will lead to death within six months. [FN14] Patients that meet the requirements are eligible to request a prescription for lethal medication from a licensed Oregon physician. [FN15]

To receive a prescription for lethal medication, the following conditions must be satisfied:

- The patient must make two oral requests, separated by at least fifteen days. [FN16]
- The patient must provide a written request to his or her physician. [FN17]
- The prescribing physician and a consulting physician must confirm the terminal diagnosis and prognosis and determine whether that patient is capable. [FN18] If either physician believes that the patient's judgment is impaired by a psychiatric or psychological disorder, such as depression, the patient must be referred for counseling. [FN19]
- The prescribing physician must inform the patient of feasible alternatives to assisted suicide, including comfort care, hospice care and pain control. [FN20]
- The prescribing physician must request, but may not require, that the patient notify his or her next of kin of the prescription ***510** request. [FN21]

The Oregon Health Department (OHD) enforces compliance with the Oregon Act. [FN22] To comply with the law, physicians must report the writing of lethal prescriptions to the OHD. [FN23] Physicians who adhere to the requirements of the Oregon Act are protected from criminal prosecution and professional disciplinary action. [FN24] The Oregon Act also provides that ending one's life in accordance with the law does not constitute suicide; [FN25] the choice of legal PAS cannot affect the status of a patient's health or life insurance policies. [FN26] Physicians and health care systems are under no obligation to participate in the Act. [FN27]

The OHD is required to keep records of the number of Oregon residents taking advantage of the Oregon Act. [FN28] During 1998, the first year of the Oregon Act, twenty-four persons received legal prescriptions for lethal medication, and sixteen of those persons used the medication. [FN29] In 1999, thirty-three persons received lethal prescriptions, and twenty-seven used the medication. [FN30] In 2000, thirty-nine persons received lethal prescriptions, and twenty-seven used the medication. [FN31] The OHD reports that in 2001, the most recent year for which statistics are available, forty- four persons received a lethal prescription and twenty-one died from the use of the medication prescribed. [FN32]

***511** Oregon has continued to improve the Oregon Act. In 1999, the Oregon legislature passed Senate Bill 491, which amended the Oregon Act by clarifying certain provisions, including the rights of terminally ill Oregonians to contract with physicians outside of their health plans to explore the option of a hastened death. [FN33] The bill took effect June 30, 1999.

B. Delayed Implementation of the Oregon Act

In 1995, Federal District Judge Michael Hogan issued a preliminary injunction barring the application of the Oregon Act's provisions. [FN34] Initially, several plaintiffs' claims were dismissed for lack of standing. [FN35] After considering the claims of the remaining plaintiffs on the merits, Judge Hogan ruled that the Oregon Act was unconstitutional under the Equal Protection Clause of the Fourteenth Amendment. According to Judge Hogan, the Oregon Act failed to protect a vulnerable class of persons, the terminally ill. [FN36]

In 1997, the Ninth Circuit voted to vacate the district court's judgment. [FN37] The case was remanded with instructions to dismiss the plaintiffs' complaint for lack of standing and ripeness, and the district court was ordered to lift the injunction. [FN38] In its opinion, the Ninth Circuit did not address the constitutionality of the Oregon Act and, to date, no federal appellate court has reached the constitutional merits of the Oregon Act. The plaintiffs' petition for certiorari was denied, [FN39] and the injunction was lifted on October 27, 1997.

The Oregon Act faced another challenge in 1997, raised this time by the Oregon legislature. House Bill 2954, later Measure 51, once again referred the issue of whether to legalize PAS to Oregon voters. [FN40] On November 4, 1997, Oregon voters resoundingly defeated the repeal attempt by a margin of 60% to 40%. [FN41]

***512** C. Legal Challenges to PAS Outside of Oregon

While the legal battles over the constitutionality of the Oregon Act were raging in Oregon, two cases in Washington and New York were setting the stage for a Supreme Court determination of whether the right to assisted suicide would be recognized as fundamental under the United States Constitution. The issue in both cases was whether the states were required to allow PAS because PAS was a constitutionally protected right.

In Compassion in Dying v. Washington, the federal district court held that a criminal law banning assisted suicide was unconstitutional. [FN42] The law provided that "[a] person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." [FN43] The court held that competent, terminally ill adults have a constitutionally guaranteed right under the Fourteenth amendment to commit PAS. [FN44] The Ninth Circuit initially overturned the District Court's ruling and reinstated the anti-suicide law. [FN45] Several months later, an en banc panel reversed the original Ninth Circuit ruling. [FN46]

The Ninth Circuit's en banc panel thoroughly reviewed its own precedent on liberty and privacy and concluded that the right to assisted dying was constitutionally protected under the Due Process Clause of

the Fourteenth Amendment. [FN47] The opinion emphasized the value of freedom of choice in a democratic society:

> Those who believe strongly that death must come without physician assistance are free to follow that creed, be they doctors or patients. They are not free, however, to force their views, their religious convictions, or their philosophies on all the other members of a democratic society, and to compel ***513** those whose values differ with theirs to die painful, protracted, and agonizing deaths. [FN48]

The court recognized that although a state does have an important interest in safeguarding life, such an interest did not justify Washington's complete ban on PAS, especially for those persons facing terminal illness. [FN49] The court concluded that the Washington law was "unconstitutional as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians." [FN50]

In New York, the District Court for the Southern District of New York rejected a challenge to the constitutionality of a state criminal law that criminalized the assistance of a suicide. [FN51] The New York law imposed criminal liability on anyone who "intentionally . . . aids another person to commit suicide." [FN52] The Second Circuit, following the lead of the Ninth Circuit in Compassion in Dying, reversed the District Court ruling by recognizing a constitutional protection for assisted suicide. [FN53] The Second Circuit rejected the claim that there was a fundamental right to PAS under the Due Process Clause; instead the court evaluated the statute under the Equal Protection Clause of the Fourteenth Amendment. [FN54] The three-judge panel decided unanimously that the New York statute violated the Equal Protection Clause, as it was not rationally related to any legitimate state interest. [FN55] The court held that the law prohibiting PAS impermissibly discriminated between those who can end their lives by removing artificial life-support systems and those who cannot:

> [T]hose in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering the prescribed drugs. [FN56]

The Supreme Court granted certiorari in both cases during the fall of 1996, and in 1997 the Court reversed both circuit courts by ***514** upholding both the Washington and New York laws criminalizing physician-assisted suicide. [FN57] Chief Justice Rehnquist wrote the majority opinions in both cases, in which all the Justices agreed in the result.

First, Chief Justice Rehnquist considered whether the ability to commit suicide was a fundamental right. This issue was extensively examined in Washington v. Glucksberg. [FN58] After examining "history, legal traditions and practices," the court determined that the right to commit suicide was not deeply rooted in the nation's history and traditions, nor was the legal treatment of suicide indicative of treating suicide as a right under the law. [FN59] Thus, there was no basis for regarding assisted suicide as a fundamental right. The Court then applied the rational basis test to the New York and Washington statutes. In Glucksberg, it was determined that Washington's prohibition of assisted suicide did not violate any substantive due process right since "Washington's ban on assisted suicide is at least reasonably related to [the] promotion and protection" of the state's legitimate interest. [FN60] In Vacco,

the Court held that New York's distinction between allowing an individual to refuse life support and prohibiting PAS did not violate equal protection. [FN61]

In Glucksberg, Chief Justice Rehnquist indicated that the resolution of the PAS question would be best left to the democratic processes of individual states, rather than to the courts: "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society." [FN62] The Court did not curb the PAS debate; it simply de-federalized it by shifting the forum of the debate to the state level. [FN63]

The Court's decisions in Glucksberg and Vacco conveyed two ***515** clear messages. [FN64] First, in finding that PAS was not a constitutionally protected right under the Due Process Clause or the Equal Protection Clause, the Vacco and Glucksberg decisions established that states are not required to permit physician assisted suicide as a legal option. [FN65] Second, both the majority and concurring opinions in Vacco and Glucksberg explicitly indicated that the Court's holdings left open the question of whether the states can choose to permit PAS. [FN66]

The Court's instruction to leave PAS to the states was quickly challenged by the United States Congress. In 1997, President Clinton signed legislation that bars the use of federal money for doctor-assisted suicide. [FN67] No funds appropriated by Congress can be used for the purpose of paying for goods or services for use in an assisted suicide. [FN68] In 1999, Representative Henry Hyde and Senator Don Nickles introduced the Pain Relief Promotion Act (PRPA). [FN69] Passage of the PRPA would have reworded the Controlled Substances Act (CSA) to specify that prescribing controlled substances for assisted suicide is illegal. [FN70] The threat of a filibuster by Oregon Senator Ron Wyden prevented the PRPA from reaching the Senate floor for a full vote, and the 106th Congress adjourned without Senate action on the PRPA. [FN71]

PRPA has not been re-introduced in the 107th Congressional session. However, Senator Ron Wyden and Representative Darlene Hooley, both of Oregon, have introduced the Conquering Pain Act of 2001 in their respective chambers. [FN72] The Conquering Pain Act would require "coordination of Federal efforts . . . to improve access to high quality effective pain and symptom ***516** management in order to assure the needs of chronic pain patients and those who are terminally ill are met." [FN73] Passage of this legislation could indicate a dramatic change in the attitude of Congress toward PAS. However, any apparent change of Congressional attitude has not completely insulated the Oregon Act from the threat of invalidation by the federal government.

D. Reno, Ashcroft, and PAS

The Executive branch has also challenged the Oregon Act through its ability to interpret federal legislation and promulgate those interpretations as regulations. The Attorney General's treatment of the Oregon Act since its enactment reflects a power struggle between the federal government's right to regulate drugs and the state's right to regulate the standards of medical practice. [FN74]

In July 1997, Senator Orrin Hatch and Representative Hyde sent Thomas Constantine, the Clinton administration's Administrator of the Drug Enforcement Administration (DEA), a letter advocating an

interpretation of the Controlled Substances Act that would permit the DEA to revoke the registration of physicians and pharmacists who acted as authorized by the Oregon Act. [FN75] A second letter was sent in late October 1997; it expressed "'heightened . . . urgency' resulting from the Supreme Court's decision to deny certiorari in Lee v. State of Oregon." [FN76]

On November 5, 1997, the day after Oregon voters chose to retain the Oregon Act by defeating Ballot Measure 51, Constantine determined that physician aid in dying violated the CSA. [FN77] Constantine's letter was not intended to be an interpretive rule and was not published in the Federal Register. [FN78] However, Constantine acted without consulting his superior, Attorney General Janet Reno, who then directed that the issue be reviewed by the United States Department of Justice. [FN79] While Constantine's pronouncement ***517** was under review, Oregon Deputy Attorney General David Schuman wrote to the United States Department of Justice, asking it to reconsider the pronouncement. [FN80] This letter stated that in Oregon's view the pronouncement was inconsistent with the congressional intent of the CSA. [FN81]

On June 5, 1998, Reno reversed Constantine's DEA position and declared that the CSA did not prohibit doctors in Oregon from participating in assisted suicide. [FN82] According to Reno, the CSA had been designed only to prevent the trafficking and distribution of controlled substances for unauthorized purposes, not to supplant the states as regulators of medical care. [FN83] Finally, Reno announced that the federal government would not prosecute physicians who had assisted patients in dying while in full compliance with the Oregon Act. [FN84]

On February 1, 2001, the United States Senate confirmed President George W. Bush's appointee for Attorney General, John Ashcroft. [FN85] Ashcroft has long been a vocal opponent of PAS, and it was feared that his appointment would lead to a direct attack on the Oregon Act. [FN86] The following day, Oregon Attorney General Hardy Myers wrote to Ashcroft and requested an opportunity to be heard if Ashcroft chose to reexamine Reno's interpretation of the CSA as it affected the Oregon Act. [FN87] A response to Myers' request was not received until April 17, 2001. [FN88] The letter assured Myers that there was "nothing that would 'prompt a review of the Department's interpretation of the CSA as it relates to physician-assisted suicide"' and "'[s]hould such a review be commenced in the future, we would be happy to include your views in that review."' [FN89]

On June 27, 2001, Deputy Assistant Attorney General Sheldon Bradshaw and Special Counsel Robert J. Delahunty submitted a ***518** legal opinion to Ashcroft with a conclusion opposite that of Reno's June 1998 opinion. When the Attorney General adopted formal regulations implementing the CSA in 1971, [FN90] one of these regulations, now codified at 21 C.F.R. § 1306.04, provided that a physician violated the CSA if he issued a prescription other than for reasons constituting a "legitimate medical purpose." [FN91] Bradshaw and Delahunty's opinion concluded that the practices authorized by Oregon's Act did not constitute a "legitimate medical purpose," and that the Oregon Act therefore violated the CSA. [FN92] Although the memorandum stated that it was prepared at the request of Ashcroft, Myers was neither notified nor given an opportunity to present Oregon's view on the issue. [FN93]

On November 6, 2001, Ashcroft issued a directive that officially reinterpreted the CSA as effectively nullifying the Oregon Act. [FN94] The directive relied on the "legitimate medical purpose" regulation and was the first interpretive rule ever issued as to that regulation. [FN95] The directive made the use of a controlled substance to assist suicide per se illegitimate, because prescriptions issued and filled for the

purpose of assisting suicide were deemed not to constitute a "legitimate medical purpose." [FN96] The directive explicitly stated that it was intended to make no changes in DEA practice or procedures in any state other than Oregon. [FN97] In order to enforce the directive, the DEA was instructed to use its statutory authority [FN98] to obtain copies of the reports and records kept ***519** pursuant to the Oregon Act's reporting requirements. [FN99] The DEA would then use that information to determine whether physicians holding DEA registrations were prescribing scheduled substances in violation of the CSA. [FN100] This new interpretation of the CSA subjects any physician or pharmacist who acts under the Act to revocation of her prescribing license. [FN101] While the directive does not state so explicitly, the physician and pharmacist would likely be subject to criminal penalties under the CSA.

On November 8, 2001, the Attorney General of Oregon, Hardy Myers, as well as a physician, pharmacist, and four terminally ill patients, sought judicial relief from Ashcroft's directive. Oregon's position in the initial judicial proceedings was multifaceted. Initially, Oregon attacked the federal government's interpretation of the CSA. First, Oregon contended that Congress did not intend to delegate to the Attorney General any authority to override a state's determination as to the "legitimacy" of a medical practice. [FN102] Second, Oregon argued that even if Congress did, in fact, intend to delegate that authority to the Attorney General, that intent was not effectuated in the CSA. [FN103] Next, Oregon maintained that even if Congress did intend to delegate the authority to override a state's determination of the legitimacy of a medical practice to the Attorney General and effectively did so in the CSA, then the directive is invalid because ***520** the Attorney General failed to comply with the Administrative Procedure Act's rulemaking procedures in exercising his delegated authority. [FN104] Specifically, Oregon contended that Ashcroft issued the directive without accepting public comment. [FN105]

Oregon's final arguments went beyond the legality of the DEA's method of interpreting the CSA to attack the statute as it was interpreted by the DEA. If the regulation of medical practice is authorized by the CSA, Oregon's position was that Congress lacked the constitutional authority to override Oregon's determination that practices authorized by the Oregon Act serve a legitimate medical purpose. [FN106] In other words, Oregon believed that Congress went beyond its constitutional authority under the Commerce Clause. Oregon also argued that any attempt by Congress to invalidate the medical practices authorized by Oregon law impermissibly intrudes into areas reserved to the states in violation of the Tenth Amendment. [FN107] Finally, Oregon maintained that the directive violated the President's Executive Order on Federalism. [FN108]

The federal government responded by attacking Oregon's standing to challenge the directive. [FN109] The federal government further maintained that the directive is entitled to substantial deference and must be upheld unless it is "plainly erroneous." [FN110] The government also argued that a 1984 amendment to the CSA, the Supreme Court's recent decision in United States v. Oakland Cannabis Buyers Cooperative, [FN111] and other CSA cases confirmed that Ashcroft had authority under the CSA to issue his directive. [FN112] Finally, the government claimed that there was no basis in current Supreme Court jurisprudence for concluding that Congress ***521** exceeded its Commerce Clause powers if it, in fact, authorized the Attorney General to regulate medical practices. [FN113]

On November 8, 2001, United States District Judge Robert Jones issued a temporary restraining order which blocked implementation of Ashcroft's directive until November 20. [FN114] Judge Jones reasoned that there would be irreparable harm to Oregonians relying on the Act if the new federal

directive were to go into effect before the case was adjudicated on the merits. [FN115] On November 20, Judge Jones extended the temporary restraining order, [FN116] and on April 17, 2002, after almost five months of briefing and oral argument, permanently enjoined the application and enforcement of Ashcroft's order. [FN117] Jones concluded that:

> Congress did not intend the CSA to override a state's decisions concerning what constitutes legitimate medical practice, at least in the absence of an express federal law prohibiting that practice. Similarly, I conclude that Congress never intended, through the CSA or through any other current federal law, to grant blanket authority to the Attorney General or the DEA to define, as a matter of federal policy, what constitutes the legitimate practice of medicine. [FN118]

Jones did not address issues of administrative or constitutional law.

On May 24, Justice Department lawyers filed paperwork to appeal Judge Jones' order in the San Francisco-based Ninth Circuit Court of Appeals. [FN119] As of late May 2002, the Department had not elaborated upon the questions that will be presented on appeal; a written statement to reporters declared only that "there are important medical, ethical and legal distinctions between intentionally causing a patient's death and providing sufficient dosages ***522** of pain medications to eliminate or alleviate pain." [FN120]

II

History of State Regulation of Medical Licensing

The Supreme Court has long recognized that "direct control of medical practice in the states is beyond the power of the federal government." [FN121] A state's right to regulate medical practice is based upon a traditional interpretation of state's rights; "[a]s the power to regulate the health professions was not specifically entrusted to Congress, the Tenth Amendment reserves such power to the states." [FN122] In practice, the states have the plenary authority to pass regulations to protect the public health and safety of its citizens. [FN123]

Public health law is commonly defined as "the regulation of conditions that affect public health." [FN124] Matters of public health are not limited solely to the prevention and control of contagious or dangerous diseases. Public health includes such matters as sanitation, waste disposal, pollution of water supplies, licensing and regulation of health-related occupations, and injury prevention. [FN125] The law is the primary means through which behaviors detrimental to public health can be effectively discouraged, and, in some cases, prohibited. [FN126]

A. The History of State Control over Medical Licensing

Among the states' original sovereign powers during the colonial area was the protection of the public health. [FN127] The regulation of health care was a local function during the colonial period, and remained so during the first century of the nation's history. [FN128] The first boards of health were municipal, and the states began to seriously address health care after the Civil ***523** War. [FN129]

The state's ability to regulate public health is subject to few legal limitations. For example, despite the enormous amount of individual rights jurisprudence in the twentieth century, the Court has not substantially limited the police power as it relates to public health and disease control. [FN130] State exercises of police power in the field of public health are constitutionally limited to enforcement of public health laws to matters having real or substantial relation to the protection of public health. [FN131] The validity of the state police power in the area of public health continues to be reaffirmed by the Court. [FN132]

The licensing of medical practitioners is an ideal example of a state's use of the police power to achieve public health objectives. [FN133] Beginning in colonial times, the regulation of professions was viewed as a state activity in the United States. [FN134] Regulating the professional practice of medicine was the nexus of three traditional areas of state regulation under the police power: professional activity, activity that posed risks to public health or safety, and public health regulations as applied to epidemic disease and sanitation. [FN135] Despite the state's natural jurisdiction over medical licensing, there was very limited regulation of any profession during the colonial period. [FN136]

The shift to the common practice of medical licensing began in the post-Civil War period. States began to license physicians and institute regulations on the practice of medicine. [FN137] From 1850 to 1920, there was a shift toward formally regulating the medical profession. [FN138] Each state handled the licensure of physicians individually. Only later was there a gradual convergence toward compatible regulatory arrangements. [FN139]

In Dent v. West Virginia, the Court, for the first time, explicitly ***524** addressed whether the state had the power to license medical practitioners. [FN140] The Court held that states have the authority to require licensure to engage in medical practice, and to establish reasonable standards for medical practice. [FN141] Eleven years later, in Hawker v. New York, the Court rejected an ex post facto challenge on a New York law that made it a crime to practice medicine after being convicted of a felony, stating that "[n]o precise limits have been placed upon the police power of a state, and yet it is clear that legislation which simply defines the qualifications of one who attempts to practice medicine is a proper exercise of that power." [FN142] By the beginning of the twentieth century, the states' authority to pass legislation regulating the practice of medicine was firmly established. [FN143]

The power to determine the scope of a license to practice medicine and to establish conduct that may not be performed by licensed physicians is implicit in the states' power to require the license. [FN144] Minnesota ex. rel. Whipple v. Martinson was the Court's first ruling on the effect of state narcotic restrictions on physicians. [FN145] In holding that a state law making it illegal to dispense narcotics directly to an addict was constitutional, the Court stated:

> There can be no question of the authority of the state in the exercise of its police power to regulate the administration, sale, prescription, and use of dangerous and habit-forming drugs. . . . The right to exercise this power is so manifest in the interest of the public health and welfare, that it is unnecessary to enter upon a discussion of it beyond saying that it is too ***525** firmly established to be successfully called in question. [FN146]

Furthermore, in Whalen v. Roe, the Court rejected a challenge to a New York law that required the reporting of all Schedule II prescriptions to a central state agency. [FN147] The physicians argued that

the law invaded the patient's privacy and improperly interfered with the physicians' ability to practice medicine. The Court found that physician reporting was a valid public health function and, as such, the states had the authority to require the reporting. [FN148] Dent, Watson, Whipple, and Whalen are illustrative of the deference the Court continues to give to states with regard to medical licensing. The Court has only limited the power to practice medicine when it directly conflicts with the constitutional rights of the patient.

Glucksberg and Vacco, discussed above, are recent cases that have addressed the state's police power to regulate medical practice. [FN149] In holding that the state can criminalize PAS, the Court reaffirmed that it is ultimately the choice of the individual state to determine the propriety and legality of medical practices within its borders.

B. The Increasing Involvement of the Federal Government in Public Health

Despite the long history of state predominance in the field of public health and medical licensing, there is a recent parallel history of increasing federal involvement in the area of public health. The growth of information technology and the mobility of goods and services, combined with a significant federal financial role in health care, have loosened the grip of the state police power on the regulation of health care. [FN150] This parallel federal history of public health is important because any state challenge grounded in the history of state control over medicine will have to account for the increasing involvement of the federal government in health care issues.

Following the New Deal, the federal role in health care expanded after the Court broadly interpreted the Commerce Clause and Tax and Spending powers. The federal government ***526** was effectively given national police powers and Congress freely exercised its authority to regulate and funded that authority with numerous social programs. [FN151]

The federal government first established control over the dispensing of medication at the turn of the twentieth century. The Pure Food and Drug Act of 1906 made it illegal to ship misbranded or adulterated food or drugs in interstate commerce. [FN152] The Harrison Act prohibited the dispensation or distribution of narcotic drugs without a written order on a form provided by the Commissioner of Internal Revenue. [FN153] The Federal Food, Drug, and Cosmetic Act of 1938 required prescriptions for all habit-forming drugs, particularly narcotics and barbiturates. [FN154] The Drug Abuse Control Amendments of 1965 substantially expanded federal regulation of narcotic drugs. [FN155] The next major piece of drug control legislation was the CSA, enacted in 1970 as Title II of the Comprehensive Drug Abuse Prevention and Control Act.

1. The CSA in Operation

The CSA is a complex regulatory scheme that controls the authorized distribution of the drugs scheduled within its provisions. [FN156] The CSA contains five schedules, or categories, of controlled substances. [FN157] Based on the severity of the abuse potential of a particular drug, the extent to which it leads to physical or psychological dependence, and whether or not the drug has an accepted medical use, a drug is placed into one of five schedules. [FN158] For example, a Schedule I substance is one that has a high potential for abuse and no accepted medical use, while a Schedule V substance is one

with a relatively low potential for abuse and dependence and an accepted medical use for treatment. Drugs classified under Schedule I include heroin, cocaine, and marijuana. [FN159] These drugs have no currently accepted medical use. The controlled substances predominantly used in PAS in ***527** Oregon fall within Schedule III. [FN160]

The CSA specifies that the Attorney General is responsible for implementation of its provisions. [FN161] Those who wish to legally manufacture, distribute, import, export, dispense or administer controlled substances must obtain a registration from the Attorney General. [FN162] Those registered must adhere to certain record keeping and reporting requirements that monitor the flow of controlled substances. [FN163]

Pharmacists and physicians are required to register in order to prescribe or dispense controlled substances. [FN164] Physicians are only authorized to prescribe and distribute scheduled drugs pursuant to their registration with the DEA, and the unauthorized distribution of those drugs is generally subject to criminal and professional sanctions. [FN165] A professional is exempt from criminal prosecution as long as her drug dispension is within the scope of her professional practice. [FN166] The relevant provisions of the CSA provide criminal penalties for physicians who dispense controlled substances without a registration or in a manner that is beyond the "course of professional practice," and further provides for the revocation of DEA drug registrations of physicians who have engaged either in such criminal conduct or in other "conduct ***528** which may threaten the public health and safety," [FN167] including: (1) material falsification of an application, (2) conviction of a felony relating to controlled substances, or (3) suspension or revocation of the state license to practice medicine. [FN168] Proceedings to suspend or revoke registration are formal adjudications conducted under the Administrative Procedures Act. [FN169]

2. The History of the CSA

The implementation of the CSA was a response to a narcotics diversion problem that had grown so severe that, in the late 1960s, nearly half of all legally produced amphetamines and barbiturates were being diverted to illicit channels. [FN170] In order to address the problem of drug diversion, the CSA created a "closed system" of controlled substances distribution. [FN171]

The opening section of the CSA states explicitly that the statute's purpose is to control "traffic in controlled substances," [FN172] and the legislative history of the CSA contains many statements indicating that the principal purpose of the law was to deal in a comprehensive fashion with the growing menace of drug abuse in the United States through providing (1) authority for increased efforts in drug abuse prevention and rehabilitation of users, (2) more effective means for law enforcement aspects of drug abuse prevention and control, and (3) an overall balanced scheme of criminal penalties for offenses involving drugs. [FN173]

The legislative history of the CSA also indicates that Congress was concerned about the appropriateness of having federal officials determine the appropriate method of practicing medicine. [FN174] In response, Congress recognized that registration to prescribe controlled substances "would be as a matter of right where the individual or firm is engaged in activities involving these drugs which are authorized or permitted under State law." [FN175]

***529** The CSA has been amended numerous times since it was enacted in 1970. These amendments were all further attempts by Congress to address the problem of illegal trafficking in drugs and drug abuse. [FN176] In 1984, the CSA was amended as part of the Comprehensive Crime Control Act (CCCA). [FN177] The CCCA was designed to make major improvements to federal criminal laws. Sections 506-526 of the CCCA were designed to strengthen the government's ability to regulate controlled substances. [FN178] In particular, the amendments sought to address the diversion problem. [FN179]

Congress drafted the diversion control amendments in CCCA to address a variety of problems that had arisen since the initial passage of the CSA. [FN180] Congress felt that one weakness of the CSA as it was enacted was that it did not provide for a major shift in the source of illegal diversion from manufacturer and distributor to practitioner. [FN181] It was believed that the absence of adequate record-keeping hindered efforts to control diversion from practitioners, that there was insufficient authority to safeguard controlled substances held by persons whose registration had expired or who had gone out of business, and that the DEA had insufficient authority to control the import and export of ***530** scheduled substances. [FN182]

The amendments addressed the problem of maintaining the intended closed system at the practitioner level. One of these improvements was the "public interest" provisions. Section 823 (f) was amended to signify that the Attorney General would continue to routinely register most practitioner applicants, unless such registration was clearly against the interest of the public. "Public interest" was determined by an examination of the following factors:

> (1) The recommendation of the appropriate State licensing board or professional disciplinary authority.
>
> (2) The applicant's experience in dispensing, or conducting research with respect to controlled substances.
>
> (3) The applicant's conviction record under Federal and State laws relating to the manufacture, distribution, or dispensing of controlled substances.
>
> (4) Compliance with applicable State, Federal, or local laws relating to controlled substances.
>
> (5) Such other conduct which may threaten public health and safety. [FN183]

This made the conditions for practitioner registration similar to that of manufacturers and distributors. [FN184] However, these provisions were drafted so that the DEA should continue to give deference to the opinions of state licensing authorities, as evidenced by the fact that this is the first of the factors listed in the statute. [FN185] The remaining amendments to the CSA in the CCCA pertaining to the practitioner reinforced the general purpose of the amendments: the prevention of the diversion of controlled substances out of legitimate channels into the illegal market. [FN186]

The Drug Addiction Treatment Act of 2000 also added to the registration provision in section 823. [FN187] The Drug Addiction ***531** Treatment Act gave the Attorney General authority to adopt regulations for dispensing narcotics for treatment or detoxification purposes. The Act further provides that "[n]othing in such regulations or practice guidelines may authorize any Federal official or employee

to exercise supervision or control over the practice of medicine or the manner in which medical services are provided." [FN188]

In recent years, certain public health activities of State and local public health authorities have been influenced or overtaken by federal action. [FN189] Federal regulation of public health has removed complete control over certain health matters from local authorities and provided national standards for public health measures. [FN190] Federal regulation now reaches air and water quality, food safety, tobacco advertising, pesticide production and sales, consumer product safety, occupational health and safety, and medical care. Federal regulation has been especially prevalent in the field of narcotic drugs. Despite this, the state continues to control the regulation of those who practice medicine, and the federal government continues to give deference to the decisions of state medical licensing boards.

III

Legal Analysis of State of Oregon v. Ashcroft

A. Administrative Law

One of the primary arguments in defense of the Oregon Act is one of administrative law and the scope of an agency's authority to interpret the statute it executes. As applied to Ashcroft's directive and the Oregon Act, the focus of this argument is that Congress did not give the DEA authority to regulate the practice of medicine in the CSA. Rather, Congress only gave the DEA the ability to control the illegal trafficking of the scheduled substances and the diversion of controlled substances from legal to illegal channels. As the Oregon Act regulates the use of controlled substances in a channel that Oregon has deemed legal, Ashcroft's order was made outside of the scope of the DEA's power. A full discussion of administrative law is beyond the ***532** scope of this Comment, so the arguments presented by the State of Oregon to Judge Jones in the preliminary judicial proceedings are only briefly referenced here.

In the briefing to Judge Jones, the State of Oregon challenged, on three grounds, the administrative action taken by Ashcroft. First, based upon a reading of the CSA and its legislative history, Oregon argued that the directive exceeded the authority Congress delegated to the DEA. [FN191] Second, it was maintained that the directive was not entitled to the deference normally given to administrative interpretations of law. [FN192] Finally, Oregon attacked the procedure, or lack thereof, used by Ashcroft in promulgating the directive, in that Ashcroft's failure to follow the formal notice and comment provisions of the Administrative Procedures Act rendered the directive invalid. [FN193] The court would only need to address the constitutional issues of federalism, preemption, and the commerce clause if Oregon's administrative arguments failed.

B. Federalism

Federalism simply means the allocation of power between the federal and state governments. The Constitution delegates various enumerated powers to Congress and indicates through the Tenth Amendment that those powers not given to Congress are retained by the states. [FN194] At the same

time, the federal government can interfere in areas traditionally governed by the states, as long as it is acting within the scope of its enumerated powers.

1. Supreme Court Jurisprudence

Federalism decisions are among the most notorious instances of the Supreme Court overruling its own precedent. [FN195] Commerce ***533** Clause jurisprudence has typically been the focal point of federalism analysis, as most major federal regulations have been justified in terms of the federal commerce power. Between 1936 and 1995, the Court did not find a single federal law unconstitutional for exceeding the scope of Congress' commerce power. A considerable collection of statutes were promulgated under this expanded power: economic regulations, civil rights laws, environmental protection legislation, criminal laws, and the establishment of executive agencies. [FN196]

Gregory v. Ashcroft [FN197] and New York v. United States [FN198] laid a crucial foundation for the resurgence of federalism and that Court's overturning of a federal statute on Commerce Clause grounds that took place in United States v. Lopez. [FN199] The Gregory court indicated that the federal courts have a duty to be certain of congressional intent before declaring that federal law preempts state law and overrides the balance of state and federal power. [FN200] The New York court concluded that it was clear that the Tenth Amendment prohibited Congress from compelling states to enact or administer federal regulations. [FN201] As in Gregory, the Court in New York relied on the principle of federalism and declared that allowing Congress to commandeer state governments would undermine the state government's accountability and upset the balance between state and federal government. [FN202]

In Lopez, the Court declared unconstitutional the portion of the Gun-Free School Zones Act of 1990 making it a federal crime to have a gun within 1000 feet of a school. The Court rejected ***534** the government's claim that the regulation was justified because a gun near a school may result in violent crime that could then adversely affect the economy. [FN203] The Court believed the regulation's relationship to interstate commerce was too tangential and uncertain to uphold the law as a valid exercise of the commerce power. [FN204] Chief Justice Rehnquist concluded the majority opinion by stating that the validation of this statute by the court would remove all limits on Congress' ability to regulate. [FN205]

Justice Kennedy's concurring opinion, which was joined by Justice O'Connor, stressed federalism and the relationship between limiting congressional authority and protecting state rights. [FN206] Justice Kennedy believed assessing the validity of an extension of the commerce power involved an inquiry into "whether the exercise of national power seeks to intrude upon an area of traditional state concern." [FN207] The inquiry was necessary in order to prevent foreclosing "the States from experimenting and exercising their own judgment in an area to which States lay claim by right of history and expertise." [FN208]

In United States v. Morrison, [FN209] the Court had its first opportunity to apply the Lopez test to another federal statute. In Morrison, the Court invalidated provisions of the Violence Against Women Act (VAWA) that provided victims of gender-based violence with a civil remedy against their abusers in state court. [FN210] The Court explicitly warned against any interpretation of the enumerated powers of Congress that would create for Congress what the founders denied to it--a general police power superseding that of the State. [FN211]

2. The President's Executive Order on Federalism

Executive Order 13,132, issued August 4, 1999, addresses federal policies that have federalism implications. [FN212] These policies are defined in the Order as "regulations, legislative comments or proposed legislation, and other policy statements that have substantial ***535** direct effects on the States, on the relationship between national government and the States, or on the distribution of power and responsibilities among the various levels of government." [FN213]

Section 2 of the Order lists a number of fundamental federalism principles that agencies "shall be guided by" in formulating and implementing policies that have federalism implications. [FN214] Several of those principles are relevant to this discussion:

> The Framers recognized that the States possess unique authorities, qualities, and abilities to meet the needs of the people and should function as laboratories of democracy. [FN215]
>
> The nature of our constitutional system encourages a healthy diversity in the public policies adopted by the people of the several States according to their own conditions, needs, and desires. In the search for enlightened public policy, individual States and communities are free to experiment with a variety of approaches to public issues. One-size-fits-all approaches to public policy problems can inhibit the creation of effective solutions to those problems. [FN216]
>
> Acts of the national government--whether legislative, executive, or judicial in nature--that exceed the enumerated powers of that government under the Constitution violate the principle of federalism established by the Framers. [FN217]
>
> The national government should be deferential to the States when taking action that affects the policymaking discretion of the States and should act only with the greatest caution where State or local governments have identified uncertainties regarding the constitutional or statutory authority of the national government. [FN218]

Section 3 of the Order established a "federalism policymaking criteria" to which agencies "shall adhere" to the extent permitted by law. [FN219] One criteria states:

> National action limiting the policymaking discretion of the States shall be taken only where there is constitutional and statutory authority for the action and the national activity is appropriate in light of the presence of a problem of national significance. Where there are significant uncertainties as to whether national action is authorized or appropriate, agencies shall consult with appropriate State and local officials to determine***536** whether Federal objectives can be attained by other means. [FN220]

Finally, the Order contains procedural requirements, including prior consultation with States, which must be followed before an agency adopts policies that have federalism implications or takes actions that preempt state law. [FN221]

Scholars have referred to the rediscovered barrier between federal and state legislative authority as "new federalism." [FN222] The Rehnquist Court's "new federalism" jurisprudence has resulted in the adoption of a strong rule against "federal invasion of 'core state functions,' a presumption against

application of federal statutes to state and local political processes, and a disdain for federal action that 'commandeers' state governments into the service of federal regulatory purposes." [FN223] The contemporary Court's method of returning legitimacy to state sovereignty is often referred to as "new federalism." [FN224] The denial of the national police powers to Congress under the Commerce power in Lopez was a bold move by the Court in reaffirming the principle of federalism; the Lopez decision provided a constitutional basis for striking down innumerable federal laws and regulations. This jurisprudence, when combined with the implications of Executive Order 13132, signifies that Congress and agencies must now exercise more care when using enumerated or statutory power. These exercises are now subject to meticulous judicial scrutiny and possible invalidation.

The stability of federal regulations in the field of public health is especially intriguing. Simple reliance on the passage of federal law to accomplish national public health objectives is no longer enough. New federalism now means that a national health care agenda must comport with the federalist system of government and must not extend into the police powers of the state.

C. Preemption

The following section concerns the scope of the executive branch's power to interpret a federal law with the express intent ***537** of preempting state law. The recent case law in this area, and its overtones of federalism, indicate that the CSA should not be construed so as to conflict with Oregon's Death with Dignity Act.

As long as Congress is acting within the powers granted to it under the Constitution, it can legislate in areas traditionally regulated by the states. The Supremacy Clause of the United States Constitution provides that the Constitution, and the laws and treaties made pursuant to it, are the supreme law of the land. [FN225] If there is a conflict between federal and state law, the federal law controls, and the state law is invalidated because federal law is supreme.

An actual or potential conflict with federal law is sufficient to preempt state law only when "compliance with both federal and state regulations is a physical impossibility, or when state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." [FN226] Federal law can also preempt state law when (1) Congress expressly does so or (2) where "the scheme of federal regulation is sufficiently comprehensive to make reasonable the inference that Congress left no room for supplementary state regulation." [FN227]

1. Traditional Preemption Analysis

Prior to the Ashcroft directive there was no positive conflict between the practice of medicine in Oregon and the CSA. Compliance with the CSA and the Oregon Act was by no means a physical impossibility nor was it an obstacle to Congress' efforts to control illegal trafficking in drugs. There was also a lack of any comprehensive field of federal medical licensing regulations. Currently, although the CSA does not expressly preempt the Oregon Act through the enactment of a federal PAS statute, the actual effect of the Ashcroft interpretation of CSA is the preemption the Oregon Act by making it impossible for Oregon physicians to comply with both the CSA and the Oregon Act.

Furthermore, Ashcroft's directive is problematic from a preemption standpoint when the congressional intent expressed in the text of CSA is taken into account. As previously mentioned, ***538** the CSA expressly addresses the preemption of state laws. [FN228] There is an explicit intent not to preempt state law in subject matters otherwise within the jurisdiction of the state. The statute indicates that:

> No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which the provision operates . . . to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together." [FN229]

Creating a conflict between the CSA and the Oregon Act, when there was none in the past, implicates constitutional problems similar to those presented in Gregory v. Ashcroft. [FN230]

2. Gregory v. Ashcroft

In Gregory v. Ashcroft, the Court indicated that federalism would be considered in preemption cases. Gregory concerned a challenge by several state court judges to a provision of the Missouri constitution that set a mandatory retirement age. The judges contended that the provision violated the federal Age Discrimination in Employment Act (ADEA). [FN231] The Court did not use the Tenth Amendment to invalidate federal law. Instead, the Court used federalism as an analytical tool in determining that the ADEA should not apply to the Missouri state judiciary. [FN232] Justice O'Connor's majority opinion stressed the importance of autonomous state governments as a check on possible federal tyranny. [FN233]

The Court held that a federal law that imposed a substantial burden on state government, such as interfering with a state's determination of the proper qualifications for its state judiciary, would preempt the state law only if there was a clear statement from Congress that the federal law was meant to apply to the state. [FN234] The ADEA contained no reference indicating that it was intended to apply to state court judges. Furthermore, the ***539** Court stated that it would not attribute to Congress an unstated intent to intrude on traditional state authority in the exercise of Congress' Section V powers. [FN235] If Congress expressed no clear intention to disrupt the federal- state balance, the Court held that the powers of states to legislate in areas fundamentally related to their sovereignty without Congressional interference should be preserved. [FN236]

Preemption is only problematic, per Gregory, if it places a substantial burden on state government and creates federalism concerns. In Gregory, that substantial burden was Missouri's inability to dictate the qualifications for its own judiciary. In this case, Oregon is substantially burdened in a number of ways. First, there is the federal intrusion into an area of state police power, namely medical licensure. Second, Oregon is burdened with the predicament of its own law being used against its own physicians, pharmacists, and terminally ill residents. Oregon, via the voters who twice approved the legalization of PAS, is encumbered by the decision of un-elected federal officials to overturn the will of state voters. Despite the implication of these federalism concerns, there was not the requisite clear statement by Congress that the Attorney General was authorized to interfere with a state's determination of what medical practices are legitimate. Rather, as mentioned above, there was an explicit statement that the CSA was not intended to supercede a state's decision about the circumstances required to grant and revoke a medical license.

The directive's impact on the Oregon Act is a perfect example of the federal tyranny Justice O'Connor warned against in Gregory. Due to the continuing controversy over PAS in the United States, the Glucksberg Court felt it was best that the states decide whether or not to allow PAS within their borders. Although Oregon is the only state currently subject to the "tyranny" of the Ashcroft directive, the directive has effectively, and tyrannically, taken away the rest of the nation's ability to experiment with PAS.

D. Commerce Clause

Lopez [FN237] now provides the framework for Commerce Clause analysis. First, in order for Congress to regulate under the commerce ***540** power, an activity must regulate the channels of interstate commerce, the instrumentalities of interstate commerce or persons or things in interstate commerce, or activities having a substantial relation to interstate commerce. [FN238] The Court made it clear that for purposes of the third prong of the Lopez analysis, only economic activities could be looked at in the aggregate when determining whether an activity has a substantial effect on interstate commerce. [FN239] Lopez indicates that Congress can regulate noncommercial activity only if each individual occurrence of that activity substantially affects interstate commerce. [FN240] In other words, Congress must include a jurisdictional requirement or make factual findings sufficient to support a conclusion that a noncommercial activity affects interstate commerce.

There were no legislative findings in Lopez, but the court was given the opportunity to address that factor in Morrison. [FN241] In Morrison, the Court expanded and refined Lopez's third prong of permissible Congressional action under the commerce clause: regulation of activities having a substantial effect on interstate commerce. [FN242] Morrison concerned the constitutionality of provisions of the Violence Against Women Act that provided victims of gender-based violence with a civil remedy against their abusers in state court. [FN243] The Court held that the provisions in VAWA were not supported by the commerce power, as gender-based violence was not economic in nature. [FN244]

As gender-based violence was not economic in nature, the cumulative effect of gender-based violence could not be aggregated without violating precedent which allowed aggregation only when the regulated act is "economic in nature." [FN245] The "noneconomic, criminal nature of the conduct at issue" was dispositive despite extensive Congressional findings that gender-based violence has a significant economic effect on interstate commerce. [FN246] The Court believed the connection between gender-based violence and interstate commerce to be too tenuous to ***541** support Commerce Clause legislation. [FN247] According to the Court, the flaw with the attenuated analysis was that it could be "applied equally as well to family law and other areas of traditional state regulation since the aggregate effect of marriage, divorce, and childbearing is undoubtedly significant." [FN248] This, in the Court's view, was impermissible.

The Ashcroft directive has the most immediate impact on the physicians and pharmacists who prescribe and distribute controlled substances in accordance with the Oregon Act. The directive is, in effect, a regulation, not of the drugs, but of a physician's manner of practicing medicine. The Commerce Clause analysis of the directive has to then focus on the connections between the actions of

the physicians and interstate commerce. Regulation that is based solely on the intent of the doctor that prescribes, or the pharmacist that dispenses, a lethal prescription fits into none of the Lopez categories.

Ashcroft's interpretation of the CSA cannot be seriously defended as a regulation of the channels of interstate commerce. The directive does not concern the use of highways, navigable waters, or the air. The directive does not regulate the instrumentalities of interstate commerce. The clinics, homes, and doctors offices where the provisions of the Oregon Act apply bear no resemblance to rail yards, airports or interstate highways, or other activities previously found to be instrumentalities of interstate commerce. Furthermore, although terminally ill patients choosing to end their lives make use of controlled substances that have moved through interstate commerce, the CSA, as interpreted by the Attorney General, does not regulate "things" in interstate commerce. The directive only applies to the writing of prescriptions and purchase of medication within Oregon's borders.

The third prong of Lopez requires the examination of whether the directive regulates an activity having a substantial effect on interstate commerce. First, a determination must be made as to whether the directive regulates something that is economic in nature. If an activity is not economic, each individual incident of that activity must have a substantial effect on interstate commerce. As discussed above, medical licensing requirements were established to ensure the safety of the public, not to facilitate the ***542** manufacture or distribution of goods or the accumulation of profit. The delivery of medical advice and the purchase of prescription drugs may be commercial transactions, but that is not enough to make PAS an economic activity. If simple participation in a services or goods market rendered all subsequent activity involving the use of such goods sufficient to show a substantial effect on commerce, Lopez and Morrison would have been decided differently.

Even if it could be argued that regulating this practice of medicine is an economic activity and that the effect of each individual PAS should be aggregated in determining whether there is a substantial effect on interstate commerce, the directive would still fail Commerce Clause analysis. Less than 150 persons have utilized the Oregon Act, and only ninety-one of those persons have died as a result of the lethal prescription. Furthermore, the people who have died as a result of PAS were terminally ill. Bluntly stated, the economic productivity and activity of those persons was next to nothing. Whatever the impact of twenty or thirty voluntary decisions per year in one state may have on interstate commerce, it is clearly less than the impact that the Court conceded of gender-based violence in Morrison and should be considered inconsequential for Commerce Clause purposes. Without the Commerce Clause, Ashcroft's interpretation of the CSA has no constitutional validity.

Conclusion

> "I know the difference between enacting and enforcing the law . . . It means advancing the nation's interest, not advocating my personal interest."
>
> -- Ashcroft, at his confirmation hearing. [FN249]

The Ashcroft directive was a remarkable example of federal intrusion into the states' historical role of determining what constitutes a legitimate medical practice. In attempting to invalidate Oregon's Death with Dignity Act, the directive set the stage for the next chapter in the legal battle of whether a state has the right to legalize and implement physician-assisted suicide within its borders. Placing moral, ethical

and professional arguments aside, it appears that the directive was the result of questionable legal judgment on the part of the Attorney General.

***543** Ashcroft cited the Commerce Clause and the CSA to justify his decision. However, given the current state of Supreme Court jurisprudence on federalism, preemption and the Commerce Clause, the directive has no surefire constitutional foothold. The Court has indicated in numerous decisions that it will closely scrutinize any attempt by the federal government to disturb the distribution of power and responsibility between the state and federal government.

The Controlled Substance Act, as enacted and amended, lacks the requisite "clear statement" that the Supreme Court required in Gregory to find that Congress intended to alter the federal-state framework. Furthermore, the manner in which Oregonians choose to die is not a matter of interstate commerce. As a result of the decisions in Lopez and Morrison, the federal government can no longer use an attenuated connection to interstate commerce to justify federal intrusion into areas traditionally reserved to the states.

Finally, in Glucksberg, [FN250] the states were expressly given the authority to address the issue of physician-assisted suicide as individual states. The nation has a great interest in allowing states to continue to experiment with solutions to controversial legal issues. By disregarding the Supreme Court's, and Oregon's, belief that there was "no reason to think the democratic process w[ould] not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure," [FN251] Ashcroft has disregarded both the instructions of the Court and the principles of federalism that he has forcefully advocated in the past. As a result, it will once again be up to the courts to decide whether the federal government can dictate how, and when, its citizens choose to die.

***544** Appendix A: Full Text of Ballot Measure 51

Oregon Ballot Measure 51

Ballot Title: Repeals Law Allowing terminally Ill Adults to Obtain Lethal Prescription

Result of a "Yes" Vote: "Yes" vote repeals law allowing terminally ill adults to obtain physician's prescription for lethal drugs.

Result of a "No" Vote: "No" vote retains law allowing terminally ill adults to obtain physician's prescription for lethal drugs.

Summary: Repeals Measure 16, adopted by voters in 1994. That law:

- Allows terminally ill adult Oregon residents voluntary informed choice to obtain physician's prescription for lethal drugs when physicians predict patient's death within 6 months.
- Requires 15 day waiting period; 2 oral, 1 written request; second physician's opinion; counseling for patients with impaired judgment from depression.
- Give health care providers immunity from civil, criminal liability for good faith compliance.

- Permits person choice whether to notify next of kin.
- Allows health care providers to refuse to participate.

***545** Appendix B: Statement of Attorney General Reno on Oregon's Death with Dignity Act

The Department has conducted a thorough and careful review of the issue of whether the Controlled Substances 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." We have concluded that adverse action against a physician who has assisted in a suicide in full compliance with the Oregon Act would not be authorized by the CSA.

The Oregon Act was approved by Oregon voters on November 8, 1994, and went into effect on October 27, 1997. The Act provides for a detailed procedure by which a mentally competent, terminally ill patient may request to end his or her life "in a humane and dignified manner." The procedure requires, for example, that the patient's competence and the voluntariness of the request be documented in writing and confirmed by two witnesses, that the patient's illness and competence and the voluntariness of the request be confirmed by a second physician, and that the physician and patient observe certain waiting periods. Once a request has been properly documented and the requisite waiting periods have expired, the patient's attending physician may prescribe, but not administer, medication to enable the patient to take his or her own life. As a matter of state law, physicians acting in accordance with the Oregon Act are immune from liability as well as any adverse disciplinary action for having rendered such assistance.

The CSA is a complex regulatory scheme that controls the authorized distribution of scheduled drugs. Physicians, for example, are authorized to prescribe and distribute scheduled drugs only pursuant to their registration with the DEA, and the unauthorized distribution of drugs is generally subject to criminal and administrative action. The relevant provisions of the CSA provide criminal penalties for physicians who dispense controlled substances beyond "the course of professional practice," and provide for revocation of the DEA drug registrations of physicians who have engaged either in such criminal conduct or in other "conduct which may threaten the public health and safety." Because these terms are not further defined by the statute, we must look to the purpose of the CSA to understand their scope.

***546** 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 state of Oregon has reached the considered judgment that physician- assisted suicide should be authorized under narrow conditions and in compliance with certain detailed procedures. Under these circumstances, we have 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. We emphasize that our conclusion is limited to these particular circumstances. Adverse action under the CSA may well be warranted in other circumstances: for example, 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. However, the federal government's pursuit of adverse actions against Oregon physicians who fully comply with that state's Death with Dignity Act would be beyond the purpose of the CSA.

Finally, notwithstanding our interpretation of the CSA as it applies to the Oregon Act, it is important to underscore that the President continues to maintain his longstanding position against assisted suicide and any Federal support for that procedure. This position was recently codified when he signed the Assisted Suicide Funding Restriction Act last year. While states ordinarily have primary responsibility for regulating physicians, the President and the Administration nonetheless remain open to working with interested members of Congress on this complex but extremely important issue.

***547** Appendix C: Full Text of the Ashcroft Directive

MEMORANDUM

FOR: Asa Hutchinson, Administrator The Drug Enforcement Administration

FROM: John Ashcroft, Attorney General

SUBJECT: Dispensing of Controlled Substances to Assist Suicide

As you are aware, the Supreme Court reaffirmed last term that the application of federal law regulating controlled substances is uniform throughout the United States and may not be nullified by the legislative decisions of individual States. See United States v. Oakland Cannabis Buyers' Coop., 532 U.S. 483 (2001). In light of this decision, questions have been raised about the validity of an Attorney General letter dated June 5, 1998, which overruled an earlier Drug Enforcement Administration (DEA) determination that narcotics and other dangerous drugs controlled by federal law may not be dispensed consistently with the Controlled Substances Act, 21 U.S.C. §§ 801-971 (1994 & Supp. II 1996) (CSA), to assist suicide in the United States. Upon review of the Oakland Cannabis decision and other relevant authorities, I have concluded that the DEA's original reading of the CSA--that controlled substances may not be dispensed to assist suicide--was correct. I therefore advise you that the original DEA determination is reinstated and should be implemented as set forth in greater detail below.

The attached Office of Legal Counsel opinion, entitled "Whether Physician-Assisted Suicide Serves a 'Legitimate Medical Purpose' Under The Drug Enforcement Administration's Regulations Implementing the Controlled Substances Act" (June 27, 2001) ("OLC Opinion") (attached) sets forth the legal basis for my decision.

1.Determination on the Use of Federally Controlled Substances to Assist Suicide. For the reasons set forth in the OLC Opinion, I hereby determine that assisting suicide is not a "legitimate medical purpose" within the meaning of 21 C.F.R. § 1306.04 (2001), and that prescribing, dispensing, or administering federally controlled substances to assist suicide violates the ***548** CSA. Such conduct by a physician registered to dispense controlled substances may "render his registration . . . inconsistent with the public interest" and therefore subject to possible suspension or revocation under 21 U.S.C. § 824(a)(4). This conclusion applies regardless of whether state law authorizes or permits such conduct by practitioners or others and regardless of the condition of the person whose suicide is assisted.

I hereby direct the DEA, effective upon publication of this memorandum in the Federal Register, to enforce and apply this determination, notwithstanding anything to the contrary in the June 5, 1998, Attorney General's letter.

2.Use of Controlled Substances to Manage Pain Promoted. Pain management, rather than assisted suicide, has long been recognized as a legitimate medical purpose justifying physicians' dispensing of controlled substances. There are important medical, ethical, and legal distinctions between intentionally causing a patient's death and providing sufficient dosages of pain medication necessary to eliminate or alleviate pain.

3.No Change in Current DEA Policies and Enforcement Practices Outside Oregon. The reinstated determination makes no change in the current standards and practices of the DEA in any State other than Oregon. Former Attorney General Janet Reno's June 5, 1998, letter relating to this matter emphasized that action to revoke the DEA registration of a physician who uses federally controlled substances to assist a suicide "may well be warranted . . . where a physician assists in a suicide in a state that has not authorized the practice under any conditions." The reinstated determination does not portend any increase in investigative activity or other change from the manner in which the DEA presently enforces this policy outside of Oregon.

4.Enforcement in Oregon. Under 3 Oregon Revised Statutes (O.R.S.) § 127.855 (1999), an attending physician who writes a prescription for medication to end the life of a qualified patient must document the medication prescribed. Under 3 O.R.S. § 127.865(1)(b) (1999), the State of Oregon's Health Division must require any health care provider upon dispensing medication pursuant to the Death with Dignity Act to file a copy of the dispensing record with the Division. Those records should contain the information necessary to determine whether those holding DEA registrations who assist suicides in accordance with ***549** Oregon law are prescribing federally controlled substances for that purpose in violation of the CSA as construed by this Memorandum and the attached OLC Opinion.

The Department has the authority to take appropriate measures to obtain copies of any such reports or records sent to the Oregon State Registrar. See 21 U.S.C. § 876. When inspection of these documents discloses prohibited prescription of controlled substances to assist suicide following the effective date of this memorandum, then appropriate administrative action may be taken in accordance with 21 C.F.R. §§ 1316.41 to 1316.68 (2001).

Thus, it should be possible to identify the cases in which federally controlled substances are used to assist suicide in Oregon in compliance with Oregon law by obtaining reports from the Oregon State Registrar without having to review patient medical records or otherwise investigate doctors.

Accordingly, implementation of this directive in Oregon should not change the DEA's current practices with regard to enforcing the CSA so as materially to increase monitoring or investigation of physicians or other health care providers or to increase review of physicians' prescribing patterns of controlled substances used for pain relief.

5.Distribution. Please ensure that this Memorandum and the OLC opinion on which it is based are promptly distributed to appropriate DEA personnel, especially those with authority over the enforcement of the CSA in Oregon.

***550** Appendix D: Selected excerpts from the legislative history of the Controlled Substances Act

H.R. Rep. No. 91-1444 (1970), reprinted in 1970 U.S.C.C.A.N. 4566, 4569.	"The bill provides for control by the Justice Department of problems related to drug abuse through registration of manufacturers, wholesalers, retailers, and all others in the legitimate distribution chain, and makes transactions outside the legit distribution chain illegal."
H.R. Rep. No. 91-1444 (1970), reprinted in 1970 U.S.C.C.A.N. 4566, 4571.	"The bill is designed to meet problems that have arisen under existing narcotic and dangerous drug laws due to recent governmental reorganization, court rulings, and the changing posture of the drug problem facing this country. Since 1941, the Congress has enacted more that 50 pieces of legislation relating to control and diversion, from legitimate channels, of those drugs referred to as narcotics and dangerous drugs."
H.R. Rep. No. 91-1444 (1970), reprinted in 1970 U.S.C.C.A.N. 4566, 4571.	"The bill is designed to improve the administration and regulation of the manufacturing, distribution, and dispensing of controlled substances by providing for a "closed" system of drug distribution for legitimate handlers of such drugs. Such a closed system should significantly reduce the widespread diversion of these drugs out of legitimate channels into the illicit market, while at the same time providing the legitimate drug industry with a unified approach to narcotic and dangerous drug control."
H.R. Rep. No. 91-1444 (1970), reprinted in 1970 U.S.C.C.A.N. 4566, 4582-4588.	The Actions suggested by the Pettyman Commission focused on preventing drug abuse, mental health, investigation of illicit traffic and manufacturing and distribution regulations. "The Commission recommends that Federal regulations be amended to reflect the general principle that definition of legitimate medical use of narcotic drugs and the legitimate medical treatment of a narcotic addict are primarily to be determined by the medical profession." The Katzenbach commission recommended a sound and effective framework of regulatory and criminal laws with respect to dangerous drugs and focus on drug abuse.

***551** H.R. Rep. No. 91-1444 (1970), reprinted in 1970 U.S.C.C.A.N. 4566, 4594-95.	"This section states the principal reasons why it is necessary to make the controls of title II applicable to all controlled substances: many of the drugs included within this title have a presently accepted medical purpose, the illegal importation. . .and improper use of controlled substances have a substantial detrimental effect on the public's health and general welfare, controlled substances flow through commerce, and federal control over intrastate traffic in controlled substances is essential to control over instances of interstate traffic."
Conference Report 91-1603 (1970), reprinted in 1970 U.S.C.C.A.N. 4657, 4657.	The purpose of the CSA was "to amend the Public Health Service Act and other laws to provide increased research into, and prevention of, drug abuse and drug dependence; to provide for treatment and rehabilitation of drug abusers and drug dependent persons; and to strengthen existing law enforcement authority in the field of drug abuse . . . ."

[FNa1]. Third-year law student, University of Oregon, Articles Editor, Oregon Law Review, 2002-03. The author would like to thank Judge David Schuman for his wisdom, Corey Morris for his patience, and Steve and Nancy Kandra for their genes.

[FN1]. Ian Christopher McCaleb, CNN.com, Ashcroft: 'I know the difference between enactment and enforcement of the law': Senate panel opens three days of confirmation hearings (Jan. 16, 2001), at http://www.cnn.com/2001/ALLPOLITICS/stories/01/16/ashcroft.hearing/.

[FN2]. See Edward P. Richards, The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations, 8 Annals Health L. 201, 212 (1999).

[FN3]. By approximately two-to-one, most adults continue to favor the right to physician-assisted suicide. See Humphrey Taylor, The Harris Poll #2, 2-to-1 Majorities Continue to Support Rights to Both Euthanasia and Doctor-Assisted Suicide (Jan. 9, 2002), at http://www.harrisinteractive.com/harris_poll/index.asp?PID=278. By 65% to 29%, the majority of those polled believed that "the law should allow doctors to comply with the wishes of a dying patient in severe distress who asks to have his or her life ended." Id. Harris Interactive had asked this question numerous times since 1982, when a 53% to 34% majority supported it. Id. Support for PAS peaked, at 73% to 24%, in 1993. Id. A 63% to 32% majority disagreed with the 1997 Supreme Court ruling that individuals do not have a constitutional right to doctor-assisted suicide. Id. A 61% to 34% majority (when read a detailed description of the Oregon Act) favored the Oregon proposition that would allow doctor-assisted suicide for patients with six months to live, if all three of the following conditions were met: a) The patient requests it three times, b) There is a second physician's opinion and c) There is a fifteen-day waiting period for the patient to change his or her mind. Id. A 58% to 35% majority believed that the Attorney General is wrong to oppose this proposition. Id. See National Polling on

Physician Assisted Dying, at http://www.deathwithdignity.org/resources/polls.htm (last visited Feb. 5, 2002) for a summary of recent public opinion polling on the issue of assisted suicide.

[FN4]. 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976) (holding that a decision by daughter to permit a noncognitive, vegetative existence to terminate by natural forces is a valuable incident of her right to privacy which could be asserted on her behalf by her guardian).

[FN5]. 497 U.S. 261 (1990) (holding state can require clear and convincing evidence of a vegetative patient's wishes before implementing parents' request to terminate artificially delivered food and hydration).

[FN6]. 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, 1034-37 (1998).

[FN7]. Assisted Suicide Chronology, at http://www.oregonlive.com/special/assisted_suicide/index.ssf?/special/assisted_suicide/chronology.frame (last visited Feb. 1, 2002) [hereinafter Chronology]. See Brief Chronology of the Law, at http://www.dwd.org/law/chronology.asp (last visited June 19, 2002) for a more detailed chronology of the legislative and judicial challenges to PAS in Oregon and the United States.

[FN8]. Chronology, supra note 7.

[FN9]. Senate Bill 286 is codified at Or. Rev. Stat. § 677.474 (2001).

[FN10]. Chronology, supra note 7.

[FN11]. Challenges to DWD, Oregon Death with Dignity From Act to Law, at http://www.dwd.org/law/briefhistory.asp (last visited July 19, 2002).

[FN12]. Codified at Or. Rev. Stat. §§ 127.800-127.995 (2001).

[FN13]. "Capable" is defined by Or. Rev. Stat. § 127.800(3) as having the "ability to make and communicate health care decisions."

[FN14]. Or. Rev. Stat. §§ 127.805 and 127.800(12).

[FN15]. Or. Rev. Stat. § 127.805.

[FN16]. Or. Rev. Stat. § 127.840.

[FN17]. Id.

[FN18]. Or. Rev. Stat. §§ 127.815(1)(a) and 127.820.

[FN19]. Or. Rev. Stat. § 127.825.

[FN20]. Or. Rev. Stat. § 127.815(1)(c)(E).

[FN21]. Or. Rev. Stat. § 127.835.

[FN22]. Or. Admin. R. 333-009-0010 (2001).

[FN23]. Id. at 333-009-0010(1)(a).

[FN24]. Or. Rev. Stat. §§ 127.885(1) and (2).

[FN25]. Or. Rev. Stat. § 127.880.

[FN26]. Or. Rev. Stat. § 127.875.

[FN27]. Or. Rev. Stat. § 127.885(4).

[FN28]. Or. Rev. Stat. § 127.865.

[FN29]. Amy Sullivan, Ph.D., et al, Center for Disease Prevention and Epidemiology, Oregon Health Division, Oregon's Death With Dignity Act: The Second Year's Experience 9 (2000), available at http://www.ohd.hr.state.or.us/chs/pas/year2/ar-index.htm.

[FN30]. Id. at 3 (2000). One patient used a prescription issued in 1998. Id.

[FN31]. Center for Disease Prevention and Epidemiology, Oregon Health Division, Oregon's Death With Dignity Act: Three Years of Legalized Physician- Assisted Suicide 3 (2001), available at http://www.ohd.hr.state.or.us/chs/pas/year3/ar-index.htm.

[FN32]. Center for Disease Prevention and Epidemiology, Oregon Department of Human Services, Fourth Annual Report on Oregon's Death With Dignity Act 3 (2002), available at http://www.ohd.hr.state.or.us/chs/pas/ar-index.htm. Of the twenty-one PAS deaths in 2001, only nineteen were the result of prescriptions issued in 2001. The other two deaths were the result of prescriptions written and reported in 2000. Id.

[FN33]. Or. Rev. Stat. § 127.885(4).

[FN34]. Lee v. Oregon, 869 F. Supp. 1491 (D. Or. 1994).

[FN35]. Lee v. Oregon, 891 F. Supp. 1421 (D. Or. 1995).

[FN36]. Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995).

[FN37]. Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997).

[FN38]. Id. at 1386.

[FN39]. Lee v. Harcleroad, 522 U.S. 927 (1997).

[FN40]. The text of Ballot Measure 51 is reprinted in full at Appendix A.

[FN41]. Key Results, The Oregonian, Nov. 5, 1997, at A1. There is currently a move to place Oregon Initiative Petition 34 on the 2002 ballot. The initiative would amend the Oregon Constitution to prohibit PAS, pain control that may hasten death, abortion, and certain methods of contraception. Mabon v. Myers, 333 Or. 6, 7-8 (2001). Specifically, the proposed amendment would change Article 1, section 1 by adding the following text:

> (1) God Almighty gives Human Life. In the womb, He forms a Human Being. At the beginning of that process, it is God, not man, who establishes Human Personhood. Therefore, we the People of the state of Oregon, in humility and obedience to Nature's God, the Lord of Heaven and earth, shall keep safe from mortal harm all innocent Human Life, acknowledging and protecting the Human Person from the moment of fertilization until natural death, so help us God.

Mabon v. Myers, 332 Or. 633, 636 (2001).

[FN42]. 850 F. Supp. 1454 (W.D. Wash. 1994).

[FN43]. Id. at 1458.

[FN44]. Id. at 1460.

[FN45]. Compassion in Dying v. Washington, 49 F.3d 586 (9th Cir. 1995).

[FN46]. Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996).

[FN47]. Id. at 816.

[FN48]. Id. at 839.

[FN49]. Id. at 827.

[FN50]. Id. at 837.

[FN51]. Quill v. Koppell, 870 F. Supp. 78 (S.D.N.Y. 1994).

[FN52]. Id. at 81.

[FN53]. Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996).

[FN54]. Id. at 725.

[FN55]. Id. at 731.

[FN56]. Id. at 729.

[FN57]. Vacco v. Quill, 521 U.S. 793 (1997); Washington v. Glucksberg, 521 U.S. 702 (1997).

[FN58]. Glucksberg, 521 U.S. at 720-35.

[FN59]. Id. at 710.

[FN60]. Id. at 735.

[FN61]. Vacco, 521 U.S. at 797.

[FN62]. Glucksberg, 521 U.S. at 735.

[FN63]. Pratt, supra note 6, at 1080. See Death with Dignity Initiatives and Death with Dignity Bills, at http://www.dwd.org/law/statutes.asp (last visited July 24, 2002) for a description of how various states are deliberating the option of legalizing PAS within their borders.

[FN64]. Pratt, supra note 6, at 1074.

[FN65]. Id.

[FN66]. Id. Although the decision in both cases was unanimous, Justices O'Connor, Ginsburg, Breyer, Souter and Stevens wrote concurring opinions. The content of the concurrences was the same for both cases.

[FN67]. See Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, 111 Stat. 23 (1997) (codified in scattered sections of tits. 5, 10, 18, 22, 25, 29, 38, and 42 U.S.C.).

[FN68]. See 42 U.S.C.S. § 14402(a)(1)-(3) (Law. Co-op. 1999).

[FN69]. Pain Relief Promotion Act of 1999, H.R. 2260 and S. 1272, 106th Cong. (1999). Representative Nickles and Senator Hyde introduced similar legislation, the Lethal Drug Abuse Prevention Act of 1998, during the 105th Congressional session. H.R. 4006 and S. 2151, 105th Cong. (1998). The 1998 bill failed to reach the floor of the Senate or the House of Representatives.

[FN70]. Pain Relief Promotion Act of 1999, H.R. 2260 and S. 1272, 106th Cong. (1999).

[FN71]. Jim Barnett, Bush May Act on Assisted Suicide, The Oregonian, Feb. 2, 2001, at A7.

[FN72]. See Conquering Pain Act of 2001, H.R. 2156 and S.1024, 107th Cong. (2001).

[FN73]. Id. at § 2(10).

[FN74]. Pratt, supra note 6, at 1105-06.

[FN75]. Oregon v. Ashcroft, 192 F. Supp. 2d 1077, 1082 (D. Or. 2002), available at http://www.doj.state.or.us/OpinionandOrder.pdf.

[FN76]. Id.; Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997), cert denied sub. nom., Lee v. Harcleroad, 522 U.S. 927 (1997).

[FN77]. The Paper Trail, The Oregonian, Nov. 8, 1997, at A1.

[FN78]. Oregon's Concise Statement of Material Facts at 3, Oregon v. Ashcroft, 192 F. Supp. 2d 1077 (D. Or. 2002) (No. CV01-1647-JO), available at http://www.doj.state.or.us/ags09442.pdf [hereinafter Material Facts].

[FN79]. Pratt, supra note 6, at 1106.

[FN80]. Material Facts, supra note 78, at 3.

[FN81]. Id.

[FN82]. Reno's Statement, The Oregonian, June 6, 1998, at A11. The text of Attorney General Reno's letter in its entirety is located at Appendix B.

[FN83]. Id.

[FN84]. Id.

[FN85]. See Ashcroft Confirmed, Online News Hour at http://www.pbs.org/newshour/bb/politics/jan-june01/ashcroft_confirm_02-01.html (Feb. 1, 2001).

[FN86]. Judy Holland, GOP Targets Assisted Suicide, Seattle Post- Intelligencer, Mar. 19, 2001, at A1.

[FN87]. Material Facts, supra note 78, at 3-4.

[FN88]. Id. at 4.

[FN89]. Id.

[FN90]. See 36 Fed. Reg. 7799 (Apr. 24, 1971).

[FN91]. See DEA Purpose for Prescriptions Rule, 21 C.F.R. § 1306.04 (2001), which states "[a] prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."

[FN92]. Oregon's Supplemental Memorandum in Support of Motion for a Preliminary Injunction at 2, Oregon v. Ashcroft, 192 F. Supp. 2d 1077 (D. Or. 2002) (No. CV01-1647-JO), available at http://www.doj.state.or.us/trib3484.pdf [hereinafter Oregon Injunction Memorandum].

[FN93]. Material Facts, supra note 78, at 4. Myers was not even aware of the existence of Bradshaw and Delahunty's opinion until November 6, the day Ashcroft issued his directive. Id.

[FN94]. Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607 (Nov. 9, 2001) (codified at 21 C.F.R. Part 1306). The full text of the Ashcroft directive is located at Appendix C.

[FN95]. The only other interpretive rule issued as to any aspect of the CSA was issued one month before the Ashcroft directive. That rule interprets the definition of "marijuana" in the CSA to include paper, rope, and other industrial products made from hemp. See 66 Fed. Reg. 51530 (Oct. 9, 2001).

[FN96]. See 21 C.F.R. § 1306.04(a).

[FN97]. See Appendix C.

[FN98]. See 21 U.S.C. § 876(a) (1994).

> In any investigation relating to his functions... with respect to controlled substances... the Attorney General may subpoena witnesses, compel the attendance and testimony of witnesses, and require the production of any records (including books, papers, documents, and other tangible things which constitute or contain evidence) which the Attorney General finds relevant or material to the investigation.

Id.

[FN99]. See Or. Rev. Stat. § 127.865(1)(b) (2001) ("The department shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the department.").

[FN100]. See Appendix C.

[FN101]. See 21 U.S.C. § 824(a)(4) (1994).

> A registration pursuant to section 823 of this title to manufacture, distribute, or dispense a controlled substance or a list I chemical may be suspended or revoked by the Attorney General upon a finding that the registrant... has committed such acts as would render his registration under section 823 of this title inconsistent with the public interest as determined under such section.

Id. See also 21 C.F.R. §§ 1316.41 to 1316.68 (2001) (describing the procedure used to revoke a registrant's DEA registration).

[FN102]. Oregon Injunction Memorandum, supra note 92, at 3.

[FN103]. Id.

[FN104]. Id.

[FN105]. Ashbel S. Green, Ruling Adds Time to Weigh Suicide Law, The Oregonian, Nov. 21, 2001 at A8 [hereinafter Green, Ruling Adds Time].

[FN106]. Oregon Injunction Memorandum, supra note 92, at 3.

[FN107]. Id.

[FN108]. See Exec. Order No. 13,132, 64 Fed. Reg. 43,255 (Aug. 4, 1999). This argument was not presented during the briefings on Oregon's motion for a preliminary injunction. Rather, it was included in Oregon's Motion for Summary Judgment. Oregon's Memorandum in Support of Motion for a Summary Judgment at 2, Oregon v. Ashcroft, 192 F. Supp. 2d 1077 (D. Or. 2002) (No. CV01-1647-JO), available at http://www.doj.state.or.us/ags09436.pdf.

[FN109]. Oregon Injunction Memorandum, supra note 92, at 3.

[FN110]. Id.

[FN111]. 532 U.S. 483 (2001) (there is no medical necessity defense for a conviction of possession of Schedule I drugs).

[FN112]. Oregon Injunction Memorandum, supra note 92, at 3.

[FN113]. Id. at 3-4.

[FN114]. Ashbel S. Green, State Wins Time to Defend Suicide Law, The Oregonian, Nov. 9, 2001 at A1.

[FN115]. Id.

[FN116]. See Green, Ruling Adds Time, supra note 105, at A1.

[FN117]. Permanent Injunction, Oregon v. Ashcroft, 192 F. Supp. 2d 1077 (D. Or. 2002) (No. CV01-1647-JO), available at http://www.doj.state.or.us/PermanentInjunction.pdf.

[FN118]. Oregon v. Ashcroft, 192 F. Supp. 2d 1077, 1084 (D. Or. 2002), available at http://www.doj.state.or.us.opinionandorder.pdf/.

[FN119]. Gina Holland, Justice Department to Appeal Assisted Suicide Law, Associated Press (May 24, 2002), available at 2002 WL 21839847 and at http://www.dwd.org/fss/news/ap.05.24.02.asp. It is interesting to note the timing of Ashcroft's actions against the Oregon Act. The initial directive was issued on Election Day 2001, when the press was occupied with anthrax and the war on terror. The appeal was filed late Friday, prior to the long Memorial Day weekend.

[FN120]. Id.

[FN121]. Linder v. United States, 268 U.S. 5, 18 (1925).

[FN122]. Ross D. Silverman, Regulating Medical Practice in the Cyber Age: Issues and Challenges for State Medical Boards, 26 Am. J.L. & Med. 255, 256 (2000).

[FN123]. Id.

[FN124]. James G. Hodge, Jr., The Role of New Federalism and Public Health Law, 12 J.L. & Health 309, 316 (1998).

[FN125]. Id. at 324.

[FN126]. Id. at 317.

[FN127]. Id. at 310.

[FN128]. Kevin Outterson, Health Care, Technology and Federalism, 103 W. Va. L. Rev. 503, 515 (2001).

[FN129]. Id. at 506.

[FN130]. Richards, supra note 2, at 206.

[FN131]. Jacobsen v. Massachusetts, 197 U.S. 11 (1905).

[FN132]. See, e.g., Kansas v. Hendricks, 521 U.S. 346 (1997) (upholding involuntary commitment statutes that detained persons who are unable to control their behavior and thereby pose a danger to the public health and safety).

[FN133]. Silverman, supra note 122, at 256.

[FN134]. Richards, supra note 2, at 202.

[FN135]. Id.

[FN136]. Id. at 206.

[FN137]. Id. at 208.

[FN138]. Outterson, supra note 128, at 512.

[FN139]. Id.

[FN140]. 129 U.S. 114 (1889).

[FN141]. Id. at 122.

[FN142]. 170 U.S. 189, 192 (1898). See also Watson v. Maryland, 218 U.S. 173, 176 (1910), which described the foundation and rationale behind the states' regulatory power to regulate medicine:

> It is too well settled to require discussion at this day that the police power of the States extends to the regulation of certain trades and callings, particularly those which closely concern the public health. There is perhaps no profession more properly open to such regulation than that which embraces the practitioners of medicine. Dealing, as its followers do, with the lives and health of the people, and requiring for its successful practice general education and technical skill, as well as good character, it is obviously one of those vocations where the power of the State may be exerted to see that only properly qualified persons shall undertake its responsible and difficult duties.

[FN143]. Silverman, supra note 122, at 256 n.7.

[FN144]. Richards, supra note 2, at 219.

[FN145]. 256 U.S. 41 (1921).

[FN146]. Id. at 45.

[FN147]. 429 U.S. 589 (1977).

[FN148]. Id. at 598.

[FN149]. Richards, supra note 2, at 222-23.

[FN150]. Outterson, supra note 128, at 504.

[FN151]. Hodge, supra note 124, at 334.

[FN152]. Ch. 3915, 34 Stat. 768 (1906) (repealed 1938).

[FN153]. Ch. 1, 38 Stat. 785 (1914) (repealed 1970).

[FN154]. Ch. 675, § 503, 52 Stat. 1040, 1052 (1938).

[FN155]. Pub. L. 89-74, 79 Stat. 226 (1965) (codified in scattered sections of 21 U.S.C.).

[FN156]. Controlled Substances Act of 1970, Pub. L. 91-513, 84 Stat. 1242 (codified in 21 U.S.C. §§ 801-971 (1994 & Supp. II 1996)).

[FN157]. Id. § 812.

[FN158]. Id.

[FN159]. Id.

[FN160]. See Arthur Eugene Chin, M.D., et al., Center for Disease Prevention and Epidemiology, Oregon Health Division, Oregon's Death With Dignity Act: The First Year's Experience 13 (1998)

(listing secobarbital and phenobarbital as the controlled substances used in PAS); 21 U.S.C. § 812(c) (Schedule III(b) lists "any substance which contains any quantity of a derivative of a barbituric acid, or any salt of a derivative of barbituric acid.").

[FN161]. 21 U.S.C. § 811(a). Under the CSA, drugs are controlled through the exercise of the Attorney General's rulemaking authority. Id. The Attorney General has delegated his responsibilities to the Administrator of the DEA. 28 C.F.R. § 0.100(b) (2001).

[FN162]. 21 U.S.C. § 822(a)(2).

[FN163]. Id. §§ 821-863.

[FN164]. Id. § 822(a)(2).

[FN165]. See 21 U.S.C. § 824(a)(4); 21 C.F.R. §§ 1316.41 to 1316.68 for provisions relevant to administrative sanctions and §§ 841-843 for provisions concerning criminal sanctions.

[FN166]. See 21 U.S.C. § 844(a). The professional practice exception appears in the definition section of the CSA:

> The term "practitioner" means a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

Id. § 802(21).

[FN167]. Id. § 823(f).

[FN168]. Id. § 824(a).

[FN169]. Id. § 824(c).

[FN170]. H.R. Report No. 98-1030, at 261 (1984), reprinted in 1984 U.S.C.C.A.N. 3182, 3443.

[FN171]. Id.

[FN172]. 21 U.S.C. § 801(6).

[FN173]. H.R. Rep. No. 91-1444 (1970), reprinted in 1970 U.S.C.C.A.N. 4566, 4567. See also Appendix D.

[FN174]. Id. at 1970 U.S.C.C.A.N. 4581.

[FN175]. Id. at 1970 U.S.C.C.A.N. 4590.

[FN176]. See Narcotic Addict Treatment Act of 1974, Pub. L. No. 93-281, 88 Stat. 124 (1974); Narcotics Control Trade Act, Pub. L. No. 93-618, 88 Stat. 1978 (1975). Psychotropic Substances Act of 1978, Pub. L. No. 95-633, 92 Stat. 3768 (1978); Controlled Substances Penalties Amendments Act of 1984, Pub. L. No. 98-473, 98 Stat. 2068 (1984); Dangerous Drug Diversion Control Act of 1984, Pub. L. No. 98-473, 98 Stat. 2070 (1984); Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat. 3207 (1986); Anti-drug Abuse Amendments Act of 1988, Pub. L. No. 100-690, 102 Stat. 4312 (1988); Anabolic Steroids Control Act of 1990, Pub. L. No. 101-647, 104 Stat. 4851 (1990); Domestic Chemical Diversion Control Act of 1993, Pub. L. No. 103-200, 107 Stat. 2333 (1993); Drug Free Truck Stop Act of 1994, Pub. L. No. 103-322, 108 Stat. 2046 (1994); Comprehensive Methamphetamine Control Act of 1996, Pub. L. No. 104-237, 110 Stat. 3099 (1996); Drug-Induced Rape Prevention and Punishment Act of 1996, Pub. L. No. 104-305, 110 Sta. 3807 (1996); Western Hemisphere Drug Elimination Act, Pub. L. No. 105-277, 112 Stat. 2681-693 (1998); Controlled Substances Trafficking Prohibition Act, Pub. L. No. 105-357, 112 Stat. 3271 (1998); Drug Addiction Treatment Act of 2000, Pub. L. No. 106-310, Div. B, Title XXXV, 114 Stat. 7 (2000); Methamphetamine Anti-Proliferation Act of 2000, Pub. L. No. 106-310, Div. B, Title XXXVI, 114 Stat. 1222 (2000).

[FN177]. Comprehensive Crime Control Act of 1984, Pub. L. No. 98-473, 98 Stat. 1976 (codified as amended in scattered sections of 18, 21, 28, 29 and 42 U.S.C.).

[FN178]. H.R. Report No. 98-1030, supra note 170, at 260.

[FN179]. Id.

[FN180]. Id. at 262.

[FN181]. Id.

[FN182]. Id.

[FN183]. 21 U.S.C. §§ 823(f) and 824(f) (1994).

[FN184]. H.R. Report No. 98-1030, supra note 170, at 261-62.

[FN185]. Id. at 267.

[FN186]. Section 824 was amended to give the Attorney General authority to place under seal the controlled substances owned or possessed by a registrant whose registration had expired or who had gone out of business, section 827 was amended to require that practitioners report any change in their professional address, and section 843(a)(2) was amended to prohibit use of a fictitious, revoked, suspended, or expired registration number and the use of a registration number issued to another person.

[FN187]. Pub. L. No. 106-310, tit. XXXV, 114 Stat. 1222 (2000).

[FN188]. 21 U.S.C. § 823(g)(2)(H)(i)(II).

[FN189]. Hodge, supra note 124, at 336.

[FN190]. Id. at 338.

[FN191]. Oregon Injunction Memorandum, supra note 92, at 9-13.

[FN192]. Id. at 13-16.

[FN193]. Id. at 16-18.

[FN194]. These powers, collectively known as the police powers, give states broad jurisdiction to regulate matters affecting the health, safety, and general welfare of the public, including matters that affect public health. See, e.g., Hodge, supra note 124, at 315.

[FN195]. Frank B. Cross & Emerson H. Tiller, The Three Faces of Federalism: An Empirical Assessment of Supreme Court Federalism Jurisprudence, 73 S. Cal. L. Rev. 741, 744 n.10 (2000). See United States v. Darby, 312 U.S. 100 (1941) (overruling Hammer v. Dagenhart, 247 U.S. 251 (1918) and Carter v. Carter Coal Co., 298 U.S. 238 (1936)); National League of Cities v. Usery, 426 U.S. 833 (1976) (overruling Maryland v. Wirtz, 392 U.S. 183 (1968)); Garcia v. San Antonio Metropolitan Transit Authority, 496 U.S. 528 (1985) (overruling Darby, supra); United States v. Lopez, 514 U.S. 549 (1995) (first Supreme Court case in almost six decades to declare that federal law violated the Commerce Clause).

[FN196]. Erwin Chemerinsky, The Values of Federalism, 47 Fla. L. Rev. 499, 517-18 (1995).

[FN197]. 501 U.S. 452 (1991).

[FN198]. 505 U.S. 144 (1992).

[FN199]. 514 U.S. 549 (1995). See also Printz v. United States, 521 U.S. 898, 924 (1997) (holding that a law enacted by Congress under its Commerce Clause power may be invalid if it violated "the principle of state sovereignty reflected in... various constitutional provisions"); Alden v. Maine, 527 U.S. 706, 732 (1999) (stating that, in state sovereign immunity cases, "the question is not the primacy of federal law but the implementation of the law in a manner consistent with the constitutional sovereignty of the States").

[FN200]. Gregory, 501 U.S. at 460.

[FN201]. New York, 505 U.S. at 166.

[FN202]. Id. at 168-69.

[FN203]. Lopez, 514 U.S. at 561.

[FN204]. Id. at 565.

[FN205]. Id. at 567.

[FN206]. Id. at 574-75 (Kennedy, J., concurring).

[FN207]. Id. at 580.

[FN208]. Id. at 583.

[FN209]. 529 U.S. 598 (2000).

[FN210]. Id. at 619.

[FN211]. Id. at 618.

[FN212]. Exec. Order No. 13,132, 64 Fed. Reg. 43,255, 43,256 [§ 3].

[FN213]. Id. § 1(a).

[FN214]. Id. § 2.

[FN215]. Id. § 2(e).

[FN216]. Id. § 2(f).

[FN217]. Id. § 2(g).

[FN218]. Id. § 2(i).

[FN219]. Id. § 3.

[FN220]. Id. § 3(b).

[FN221]. See id. §§ 4, 5, and 6.

[FN222]. See, e.g., John C. Yoo, Sounds of Sovereignty: Defining Federalism in the 1990s, 32 Ind. L. Rev. 27 (1998); John C. Yoo, The Judicial Safeguards of Federalism, 70 S. Cal. L. Rev. 1311 (1997).

[FN223]. Hodge, supra note 124, at 352-53.

[FN224]. Id. at 354.

[FN225]. U.S. Const. art. VI, cl. 2.

[FN226]. Hillsborough County v. Automated Med. Labs, 471 U.S. 707, 713 (1985) (internal quotes and citations omitted).

[FN227]. Id. (internal quotes omitted).

[FN228]. 21 U.S.C. § 903 (1994).

[FN229]. Id. (emphasis added).

[FN230]. 501 U.S. 452 (1991).

[FN231]. Id. at 456.

[FN232]. Id. at 460.

[FN233]. Id. at 458.

[FN234]. Id. at 460.

[FN235]. Id. at 469.

[FN236]. Id. at 460.

[FN237]. U.S. v. Lopez, 514 U.S. 549 (1995).

[FN238]. Id. at 558-59.

[FN239]. Id. at 561.

[FN240]. Id.

[FN241]. U.S. v. Morrison, 529 U.S. 598 (2000).

[FN242]. Id. at 609.

[FN243]. Id. at 605-06.

[FN244]. Id. at 618.

[FN245]. Id. at 613.

[FN246]. Id. at 610.

[FN247]. Id. at 615.

[FN248]. Id. at 615-16.

[FN249]. McCaleb, supra note 1.

[FN250]. 521 U.S. 702 (1997).

[FN251]. Id. at 737 (O’Connor, J., concurring).