

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member:

Subseries:

OA/ID Number: 19394

FolderID:

Folder Title:

Correspondence - SLT - Incoming - 7/97 [Folder 2]

Stack:

S

Row:

66

Section:

6

Shelf:

6

Position:

2

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. talking points	re: Needle exchange Q & A [Personally Identifiable Information] [partial] (1 page)	07/21/1997	b(6)

COLLECTION:

Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19394

FOLDER TITLE:

Correspondence - SLT - Incoming - 7/97 [Folder 2]

2018-0764-F

jm2046

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

^{Family}
CORR - SUT
DHHS - Medicaid
Maryland
7/97

TOTAL HEALTH CARE FOR OUR COMMUNITY



**HOWARD
BROWN**
HEALTH
CENTER

945 WEST GEORGE STREET, CHICAGO, ILLINOIS 60657 • VOICE: 773.871.5777 • FAX: 773.871.6929 & 773.871.5843

Thursday, September 11, 1997

Sandra Thurman
White House National AIDS Policy
Sent Via Fax: 202.632.1096

Dear Ms. Thurman:

On October 4, 1997, Howard Brown Health Center is opening its new 20,000-square-foot health facility. Founded in 1974, Howard Brown is the leading private provider of HIV/AIDS services in the Midwest and the region's largest gay and lesbian health center. The Center provides comprehensive health services to more than 5,000 men and women a year.

The new Center is located in Chicago's Uptown neighborhood, which has the highest AIDS incidence rate of any neighborhood in the Midwest. With more than double the space of our current facility, this new Center will allow us to greatly improve the quality of life for this medically under-served community.

As you visit Chicago in November, I want to personally invite you see first hand this tremendous new health center. It is the result of the resounding support and commitment of Chicagoans to provide quality health care for people with HIV/AIDS and the gay and lesbian community.

I will call your office in mid-October to check your availability. Thank you.

Sincerely,



Eileen Durkin
Executive Director



10/3

**National Council for International Health**

1701 K Street, NW - Suite 600
Washington, DC 20006-1503 USA
Tel: 202-833-5900 - Fax: 202-833-0075
E-mail: <ncihids@ncihids.org>

*insight C. Asch. DHS. 9/24***FAX TRANSMITTAL**To: SarahFax: 202-632-1096At: White House Office on AIDS

Tel: _____

From: Helen Cornman *Y 210*Date: 9/24/97Dept: NCIH AIDS ProgramPages: 2**MEMORANDUM**

Sarah,

Here is a copy of the proposed agenda and additional information for the October 3rd meeting. Please note this is not a finalized copy. If Ms. Thurman is able to attend, we invite her to make a few opening remarks about the importance of domestic groups becoming involved in Global AIDS. (This only needs to be a few minutes-nothing involved).

If you have any questions, please feel free to contact our office. As always thank you for your support! I look forward to hearing from you soon.

NCIH National Council for International Health

1701 K Street NW, Suite 600, Washington, DC 20006-1503 ♦ Tel. 202-833-5900, Fax 202-833-0075, Internet <ncih@ncih.org> <www.ncih.org>

Agenda

Words of Welcome and Introduction - NCIH Global AIDS Program

- I. UNAIDS Presentation by Peter Piot
- II. Example of WHO Collaborating Centers
- III. Breakout Sessions

Two groups (*concurrent)

1. Domestic ASOs - Peter Piot

Patsy Fleming, facilitator

Objective - Brainstorm on role UNAIDS can play in the United States with ASOs, what are ASOs expectations of UNAIDS, how can ASOs get better familiarized with UNAIDS activities.

2. International PVOs - Sally Cowal

Victor Barnes, facilitator

Objective - Brainstorm on role of UNAIDS in working closer to PVO community, how can PVOs benefit from UNAIDS collaboration, what can UNAIDS benefit from PVO support in the field and at the base.

Report Back to Large Group and Discussion of Reports

Conclusion / Follow Up Activities

Lunch

Addressing the US NGO/PVO* response to the global AIDS pandemic in collaboration with UNAIDS

October 3, 1997

Statement of Purpose

Historically, many global programs, including United Nations Programs, leave the United States out of their targeted geographical regions, as if the US were not part of the same globe. This reasoning has it that the US, as a donor country in the context of global economic development, is not in need of services provided by global health and development organizations. This reasoning would also imply that US-based non-government organizations working in HIV/AIDS have nothing to profit from global exchange.

In the context of the AIDS pandemic, these ideas have been challenged on a daily basis. Much of what has been achieved in the US in helping to reduce the stigma and fatality rates due to AIDS are the results of worldwide cooperation on a variety of AIDS prevention, research, and care-focused projects. And, the rest of the world, particularly the developing countries of Africa, Asia, the Caribbean, Eastern Europe, and Latin America, are watching closely how the US responds to the AIDS epidemic not only within our own borders, but in our outreach efforts to them.

The rest of the world is also watching on television and listening on radio programs in their corners of the world about how AIDS fatalities are on the decline in the US, and how hope is coming alive for many persons living with HIV/AIDS in the United States. While the devastation of the AIDS epidemic ravages through Africa and Asia, this news that is spawning hope in the US is once again providing frustration and despair for those places in the world where economic constraints mean death for 23 million HIV-infected men, women, and children. The epidemic that started the first true global partnership at addressing a single disease, and that brought together partners from around the globe, is becoming an issue of the haves vs. the have nots. How will we, US non-governmental organizations working in HIV/AIDS programming and policy, respond to this ever widening global gap?

The Joint United Nations Programme on AIDS (UNAIDS) and the United States Agency for International Development (USAID) are the two main mechanisms by which the US Congress channels its outreach efforts in response to the global AIDS epidemic. While USAID's mission of providing AIDS prevention services to select countries around the world works on a fairly fixed agenda, there are efforts at coordinating the NGO response among the international NGO (or "PVO") community. UNAIDS' role as a coordinating mechanism for the United Nations system's response to AIDS has components that may be able to offer opportunities for enhancing the involvement and interaction of US organizations in its global coordination of prevention, care, research, and treatment for HIV/AIDS.

* *PVO, Private and Voluntary Organization, is a legal term to define a non-governmental organization that meets legal requirements to receive funding from and implement overseas activities on behalf of the United States Agency for International Development (USAID).*

**Addressing the US NGO/PVO* response to the global AIDS pandemic
in collaboration with UNAIDS**

October 3, 1997

Organized and facilitated by the Global AIDS Program of the National Council for International Health. To be held, Friday, October 3, 1997, from 9:30 a.m. to 1:00 p.m., at the American Red Cross building, 430 17th St. NW, Washington, DC.

Invitees

from United Nations

Dr. Peter Piot, Executive Director, UNAIDS
Ambassador Sally Cowal, Director, External Relations, UNAIDS
Mr. Calle Almedal, NGO Liaison Officer, UNAIDS (as of November 1997)
Rafael Mazin, Regional Advisor on AIDS, PAHO
Jairo Pedraza, UNAIDS Program Control Board, North American NGO Representative

from US Government

Sandra Thurman, Director, White House Office of National AIDS Policy
Holly Dempsey, USAID HIV/AIDS Division
Cliff Cortez, USAID HIV/AIDS Division
Victor Barnes, Director of International Programs, CDC
Marcia Martin, Special Assistant to the Secretary, Dept. of Health and Human Services
Eric Goosby, Director, Office of HIV/AIDS Policy, Dept. of Health and Human Services

from US AIDS Organizations working domestically

Cornelius Baker, Executive Director, National Association of People Living with HIV/AIDS
Jane Silver, American Foundation for AIDS Research
David Harvey, Chair, National Organizations Responding to AIDS,
Exec. Dir. AIDS Policy Center for Children, Youth, and Families
Daniel Zingale, Executive Director, AIDS Action Council
Ken South, Executive Director, AIDS National Interfaith Network
Alice Blair, American Red Cross
Mohammed Ahkter, President, American Public Health Association
Jacqueline Coleman, Asso. Director for Technical Assistance, National Minority AIDS Council
Adele Mora dePuma, External Relations Director, Mother's Voices

* 2 PVO, Private and Voluntary Organization, is a legal term to define a non-governmental organization that meets legal requirements to receive funding from and implement overseas activities on behalf of the United States Agency for International Development (USAID).

Paul Boneburg, Executive Director, Global AIDS Action Network

from US Organizations working internationally in HIV/AIDS

Rebecca Gilad, Academy for Educational Development

Carol Kauffman, American Red Cross

Katherine McKaig, CARE

Sam Avrett, International AIDS Vaccine Initiative

Gail Goodrich, FHI/AIDSCAP

Lori Heise, Co-Director, Health and Development Policy Project

Geeta Rao Gupta, President, International Center for Research on Women

Andrew Fisher, International Programs Director, Population Council

Alex Brown, Vice President, Population Services International (PSI)

Nancy Pendarvis Harris, John Snow Inc./Family Planning Services

from NCIH

Frank Lostumbo, President

Patricia Fleming, consultant to NCIH Global AIDS Program

Helen Cornman, Program Officer, Global AIDS Program

Ron MacInnis, Program Officer, Global AIDS Program



**National Episcopal
AIDS Coalition**

NEAC Board of Directors

Jesse Milan, Jr., Esq.
President

Philadelphia, Pennsylvania

Harriet G. Langfeldt,
Vice President

The Dalles, Oregon

The Very Reverend
Thomas B. McCusker, III
Treasurer

Springfield, Virginia

The Reverend
Gordon L. Chastain
Secretary

Indianapolis, Indiana

The Reverend
Richard F. Brewer, M.H.A.
Brooklyn, New York

The Reverend
Drucilla P. Ferguson, M.Ed.
Dallas, Texas

The Reverend
C. William Frampton, III
Williamstown, New Jersey

John I. de Lashmet
High Point, North Carolina

Gilberto A. Hinds, RN, M.P.H.
Reno Park, New York

Peter R. Lee, M.P.H.
Columbia, South Carolina

William J. Martin, Ph.D.
Tucker, Georgia

Walter J. Moreau, M.P.A.
Austin, Texas

Elizabeth C.
Payne, M.A., M.Ed.
Houston, Texas

Frank Romanowicz
Birmingham, Alabama

Hart T. Roussel, M.A.
Washington, D.C.

The Reverend
Carlos Sandoval, M.D.
Miami, Florida

Sue Scott
Pasadena, California

John P. Steward, M.D.
Palo Alto, California

Sandra L. Thurman
Atlanta, Georgia

The Reverend Ted Karpf
Executive Director

Memorandum

To: NEAC Board of Directors

From: Ted Karpf, Executive Director

Date: September 17, 1997

In just a few weeks we will be meeting in Washington, DC. I trust each of you has ordered your tickets for travel at the lowest rate possible. Hotel reservations have already been made for each of you at the Hotel Lombardy at 2019 Pennsylvania Avenue NW---telephone number is 800.424.5486 or 202.828.2600. The Hotel is four blocks from the White House and St. John's Church Lafayette Square and two blocks each direction from the Farragut West or the Foggy Bottom Metro stops on the Orange and Blue Lines. Each of you has a single unless you have requested a double.

The Proposed Agenda for the Weekend is as follows:

Friday - October 10 - The White House

Breakfast on your own -- business attire

10:00 am - meet in Hotel Lobby and walk together to the White House

10:30 am - 2:30 pm: Board Member Updates

12:30 pm - 1:15 pm: Lunch on your own

2:00 pm - 3:15 pm: Ted's final report to the Board

3:30 pm - 5:00: National Church Report- Church Center Staff (invited)

5:30 pm - 7:30 pm: Dinner together

8:00 pm - 9:00 pm: Evening Tour of the White House with Sandra Thurman

Saturday - October 11 St John's Parish - Lafayette Square

Breakfast on your own -- relaxed attire

9:30 am - 5:30 pm: Board Meeting all day

++Lunch will be brought in for this meeting++

Themes for the Day:

How We got Here

Where We are

Where We are Going

1. Discuss Board and Esther relationship.
2. Decide about RFP for management of a NEAC Office
3. Parameters of Planning for meeting the expectations of the next Triennium
4. Covenant for Communicating for the Next Six Months

Dinner on your own

Sunday - October 12 Hotel Lombardy meeting room

Breakfast on your own -- travel attire

8:00 am - Worship at St. John's, St. Paul's K Street or St. Mary's (all walking distance)

9:30 am - 11:30 am: Shape of the Board for Next Year

Who's on/ Who's off/ Who's leaving?

Assemble Nominating Committee

Design a Process

11:30 am - 1 pm: Preliminary Design and Location for the January Annual Meeting

Decide on a Retreat Process for bringing the Board together and setting agenda for the triennium

Adjourn

Events in the Life of NEAC since mid-August.

I. NEAC Office closed in Washington, DC and moved to temporary quarters at the business offices of LTG Associates in Takoma Park, Maryland. This was accomplished on August 26, at *no cost to NEAC* and *no rent* (\$3,200) for the remainder of the year. The phone is on Call-forwarding from 628-6628 or you may use the 301.270.0893 telephone number.

II. The Executive Committee has contracted with Esther Walter, formerly of the AIDS Commission and the NEAC Board (89-93) to staff the Board only for the next five months at \$20 per hour up to 10 hours per week. Esther's telephone number in Des Moines, Iowa is 515.279.2936. Call her if you need anything.

III. The Executive Committee has extended the Executive Director's salary and benefits to January 31, 1998, in order to complete the annual audit of the NEAC accounts before the end of January. He will, however, only be doing NEAC work on a 10-15 hour per week basis from November 1-January 31. All requests will be fulfilled and books, banking, and reports will be kept by him until December 31.

IV. The Executive Committee decided to "cash-in" the planned giving Life Insurance Policy on Warren W. Buckingham III for a value of \$5,000 rather than to continue to pay \$2000 per year for premiums on the \$160,000 policy. Due to enhance and dramatically improved health since giving NEAC the policy, it is increasingly clear that Mr. Buckingham may well live for a number of years.

The Committee also decided to reimburse the Conference Fund with the \$5000 insurance remittal. This lowers the amount which must be reimbursed by the end of the year to \$3131.08.

V. The Bookkeeper for NEAC, Carolyn Feinglass, has advised that that the Designated Accounts account be closed by the end of the year. Maintaining cash balances in the designated accounts can be achieved through prudent bookkeeping and do not necessarily need a separate bank account in order to be maintained. In fact, the paper work involved in moving checks back and forth is redundant and expensive.

VI. Board members are urged to complete their pledges for the year during the third quarter. This is the period in which NEAC often experiences a cash flow crisis. Things are no different this year. Please pay your pledges.

VII. Two awards for outstanding ministry and support -- The Tull Washburn Awards (one for clergy and one for lay) will be presented at the Board meeting on Friday, October 10.

VIII. NEAC will be seeking funds from CDC in a through the Council of National Religious AIDS Networks and AIDS National Interfaith Network for salary support of a staff person at the Balm in Gilead Ministries in New York. Since a number of prominent black Episcopalians are supporting Balm in Gilead, it might be novel to support outreach in black Episcopal Churches through a well-established Black Church ministry. The proposal to CDC will be assembled this fall.

VIII. We have received a grant from AIDS National Interfaith Network under a cooperative agreement from CDC for \$4,500 for TAP in Province Seven (VII). The training, under the direction of Elizabeth Payne, will be held in Austin on November 21-23. This is the weekend before Thanksgiving. Please send people to this event if at all possible. This is the last TAP training for this triennium which is supported by General Convention resolution.

IX. See you soon. Thanks for all that you do and are doing for the future of NEAC and success of our ministry.

Always
ted +



California Institute
of Technology

Post-it Fax Note	7671	Date	9/19	# of pages	2
To	Sarah		From	Max Bengtson	
Co/Dept.	AIDS office		Co.	Caltech	
Phone #			Phone #		
Fax #			Fax #		

NEWS RELEASE

For Immediate Release

September 9, 1997

Cure for AIDS to be the focus of October 8 Caltech Biology Forum

PASADENA—Progress toward a cure for AIDS will be discussed by the country's leading AIDS researchers and spokespersons at the 1997 Caltech Biology Forum. The event will be held October 8 in the Beckman Auditorium on the California Institute of Technology campus in Pasadena, California.

To date, the confirmed panelists are David Ho, who was named the 1996 *Time* Man of the Year for his promising AIDS treatment protocol; Nobel Prize-winning biologist David Baltimore, who is chair of the AIDS Vaccine Research Council; and Mel Simon, who is chair of the Caltech Division of Biology.

The moderator will be Sandra Thurman, who as director of the Office of National AIDS Policy is President Clinton's point-person on AIDS.

Additional panelists will be announced at a later date.

The fourth annual forum has been devoted to AIDS because many experts in the field believe that AIDS research is at a critical stage. Recent scientific developments including new and more powerful drugs such as the AIDS "cocktail," and the establishment of a national commission to create an AIDS vaccine, have signaled a new age in AIDS research.

The event begins at 7:30 p.m. and is free to the general public, although tickets are required. Tickets may be obtained by calling (626) 395-4652. Media representatives may make arrangements by contacting Caltech Media Relations at the contact numbers below. More information may be obtained at the special Web site located at <http://www.caltech.edu/~media/AIDS97>. The Web site will be activated on September 10.

Susan McHugh
(626) 395-3227
mchugh@caltech.edu

Max Benavidez
(626) 395-3226
benavidez@caltech.edu

Robert Tindol
(626) 395-3631
tindol@caltech.edu

Visit the Caltech Media Relations Web site at: <http://www.caltech.edu/~media/home.html>

1997 CALTECH BIOLOGY FORUM

The Quest for a Cure: **AIDS Research at the Millennium**

October 8, 1997, 7:30 p.m., Beckman Auditorium

AIDS research has reached a critical stage. Recent scientific developments, including new and more powerful drugs such as the AIDS "cocktail," and the establishment of a national commission to create an AIDS vaccine have signaled a new age in AIDS research. In 1996, for the first time in the history of the epidemic in America, fewer people with AIDS died than had died in the previous year; however, the number of new diagnoses did not decrease. The fourth annual Caltech Biology Forum will focus on the latest developments and challenges in AIDS research, and an eminent panel will present views of the future of scientific investigations on the disease.

The Public is invited to attend.

Seating is limited.

Reserve your ticket by calling

626/395-4652

Attendance is free.



A project of the
Division of Biology and the
Office of Institute Relations at the

Who:

DAVID BALTIMORE,
PH.D.
*President-Elect, California
Institute of Technology
Chair, National Institutes of
Health AIDS Vaccine Research
Committee
Nobel Laureate*

DAVID HO, M.D.
*Scientific Director, Aaron Diamond
AIDS Research Center,
Rockefeller University
Professor and physician, Rockefeller
University
1996 Time Magazine Man of the
Year*

MEL SIMON, PH.D.
*Chair, Division of Biology
Anne P. and Benjamin F. Biaggini
Professor of Biological Sciences
California Institute of
Technology*

Moderator

SANDRA L. THURMAN
*Director, Office of National AIDS
Policy
Member, Presidential Advisory
Council on HIV/AIDS*

Co-Sponsors:

Glaxo Wellcome
Agouron Pharmaceuticals, Inc.
Huntington Memorial Hospital

ONAP Letter Tracking

Letter ID	Writer First Name	Writer Last Name	Received Date
10178	Paul	Patterson	9/29/97
Addressed To			
Thurman, Sandra			
Sender's Organization			
Cal-Tech			
Sender's Street1			
Sender's Street2			
Sender's City	Sender's State	Sender's Zip	
Pasadena	CA	91125	
Subject			
Forum			
☐ Response Needed?	Response Type	Response Date	Responder ID
Responder Name	Action Promised	Action Complet	Action Date
Notes			

CALIFORNIA INSTITUTE OF TECHNOLOGY

DIVISION OF BIOLOGY 216-76

PAUL H. PATTERSON
PROFESSOR
EXECUTIVE OFFICER

September 29, 1997

Sandra Thurman
Office of National AIDS Policy
White House
Washington D.C.
Fax: (202) 632-1096

Dear Sandra,

Attached is the schedule of events for the Caltech AIDS Forum.
Looking forward to meeting you then.

Sincerely,



<David.Ho@adarc.org>
From: Paul Patterson <php@caltech.edu>
Subject: Caltech AIDS Forum
Cc: Max Benavidez <max_benavidez@starbase1.caltech.edu>, Steven Koonin
<koonin@cco.caltech.edu>

Bcc:

X-Attachments:

As the time approaches quickly for our Forum, I thought it would be a good idea if we had the speakers clarify and exchange their plans for their talks. This could avoid unnecessary overlaps, and provide opportunities for citing each others' points as we move through the program. I think the optimal program would be as follows:

S. Koonin (CIT Provost) (5')

S. Thurman (10')

D. Ho (20')

M. Simon (20')

D. Baltimore (20')

B. Freiberg (15')

Q & A from the audience, mediated by S. Thurman, with questions submitted in writing and vetted by myself and Max Benavidez. (~15')

My present conception of the topics to be covered are as follows, but I look forward to getting your feedback and a more detailed picture of what will be covered.

- 1) Steve will welcome the audience to the event and make a few remarks about the Public Forum series and then introduce Sandy Thurman.
- 2) Sandy will provide a brief overview of the function of her office and where she sees national AIDS policy going in the near future. She will then introduce David Ho.
- 3) David will first give us the big picture of the disease - pathology, epidemiology, etc., and then discuss his and others' findings on cutting edge treatments, with some predictions for the future.
- 4) Sandy returns to the podium and introduces Mel Simon.
- 5) Mel's presentation will begin with a summary of a "view from academia" - how crystallographic knowledge of protein structure can be used to study protein-protein and virus-cell interactions. He will then give us a "view from industry" - how his and other companies are using this approach to design drugs, with specifics on the design and testing of the latest protease inhibitors. He will finish with a look to the future, discussing the problems of resistance and mutation, and ideas for novel approaches to this.
- 6) Sandy introduces David Baltimore.
- 7) David will discuss the vaccine commission and summarize the promise and difficulties of vaccine production and use with HIV.
- 8) Sandy introduces Brenda Freiberg.
- 6) Brenda will provide the "human" side of the disease, discussing her family's own experience, and will also give us an outlook on volunteer and activist organizations(?).

Clearly, much of the above (apart from Mel's presentation) is mere guesswork on my part. I think it would be good if the Davids, in particular, could provide the other speakers with a more accurate and detailed picture of what they plan to present.

Two other very important points:

First, do any of you plan to use anything other than standard 2x2 slides? If so, we need to know what AV equipment should be set up.

Second, please remember that this program is intended to reach the general, lay public. At the risk of offending our distinguished panel, I must emphasize that we have had the experience in past Forums that speakers can assume too much scientific knowledge in this audience. A Scientific American-level talk is too advanced! Tables of data and complicated graphs are incomprehensible to most of these folks. Thus, cartoons, pictures and summary slides are optimal. Humor is also warmly received.

Finally, we all really appreciate the time and effort you are taking to do this. It looks to be a truly informative and exciting evening. Please plan on meeting with me and Max Benavidez on Wednesday, the 8th, at approximately 4:30pm in Caltech's Athenaeum to go over the program and discuss any questions you may have. See you then.

- Paul

**FAX TRANSMISSION SHEET**

TO: Daniel Montoya
for Sandra Thurman
FAX#: 202.632.1096

FROM: Jesse Loving ^{Research Editor}
OF PAGES: 2 ph (212) 242-2163 x 213
(including this one) fax (use cover sheet) (212) 675-8505

DATE: 9/11/97

notes

See 2nd pg.
I just need confirmation
that this is an accurate
portrayal of your position.
Thanks.

P.S. - my deadline is tomorrow morning.
Thanks.

Ms. Thurman,

I'm Research Editor here at POZ, the national AIDS magazine. We're running an article that relates to AIDS and women. I just need confirmation that the following description reflects your views.

Sandra Thurman, the White House AIDS policy coordinator is concerned that women are often overlooked by medical professionals because they don't fit the original, previous model of whom got AIDS. She thinks this is not a responsible way to look at AIDS vis a vis women. *stereotype*
appropriate -

and the symptoms.

Office of HIV/AIDS Policy

Office of Public Health & Science
Office of the Secretary
200 Independence Avenue, S.W., Room 736-E
Washington, D.C. 20201



Deliver To: Sandy

Fax: () -

Phone: () -

From: Deborah von Zinkernagel
Senior Policy Analyst
Phone: (202) 690-5560
Fax: (202) 690-7560
E-mail: DvonZinkernagel@osophs.dhhs.gov

Date: 1/4

This fax contains 1 page(s) + cover

If transmission problems occur, please call: Shellie Abramson @ (202) 690-5560

Comments: Medical Marijuana



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY

Washington, D.C. 20503

February 5, 1997

The Honorable Benjamin J. Cayetano
Governor of the State of Hawaii
State Capitol, 415 S. Beretania St.
Honolulu, HI 96813

Dear Governor Cayetano:

As you are aware, voters in California and Arizona have approved ballot initiatives that, among other things, provide for the legal use of marijuana for medicinal purposes. We understand that your Legislature convened on January 15, 1997, with the increased possibility that a similar initiative will be introduced. We want to share with you some of the reasons why such approval would be damaging to the good citizens of Hawaii.

There is no question that marijuana is a dangerous drug. Research shows that marijuana is harmful to one's brain, heart, lungs, and immune system. It limits learning, memory, perception, judgement, and complex motor skills like those needed to drive a vehicle. Marijuana smoke contains over 400 chemical compounds, many of which are carcinogenic. Marijuana has been implicated in a high percentage of non alcohol related highway crashes, as well as accidents in the workplace. Drug-related visits to hospital emergency departments involving marijuana have more than tripled since 1990.

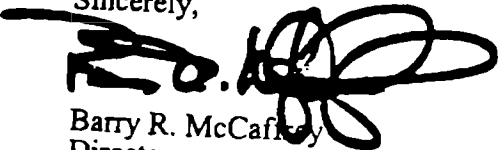
While there is abundant evidence that marijuana is harmful, there is no scientifically sound evidence that smoked marijuana is medically equivalent to currently available therapies, such as the medication Marinol, which contains THC, the active ingredient in marijuana. The Food and Drug Administration has reviewed the scientific data and found this medication to be safe and effective. Further, Marinol is free of contaminants found in smoked marijuana, thereby reducing damaging effects upon the lungs, heart, and immune system. Smoke is not a medicine, ever.

Arguments that you will hear for approval of such legislation are not based on science. This is not an appropriate way to determine the value of a proposed medical therapy. The fact is, according to science, smoking marijuana is more likely to cause new health problems rather than solve existing ones. With its false and fraudulent messages that "marijuana is medicine," any proposition that supports passage of such laws will serve only to undermine the critical drug prevention efforts that have been occurring across the country and in your beautiful State of Hawaii.

The President approved a coordinated Administration strategy to minimize the tragedy of drug abuse in America. We need to continue with the partnership of the States to: 1) provide effective enforcement efforts within the framework created by the Federal Controlled Substance Act and the Food, Drug, and Cosmetic Act; 2) ensure the integrity of the medical-scientific process by which substances are approved as safe and effective medicines; 3) preserve drug-free workplace and safety programs; and 4) protect children from increased marijuana availability and use. Enclosed are documents outlining the Administration's position.

We urge you to continue to protect the health of the citizens of Hawaii and reject initiatives to permit designating a substance a medicine without subjecting it to established scientific review. We must ensure that citizens have the protection of medical experts in deciding what medicines are safe and effective.

Sincerely,


Barry R. McCaffrey
Director
Office of National Drug Control Policy


Donna E. Shalala
Secretary
Department of Health and Human Services



**EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503**

**FOR RELEASE:
JANUARY 7, 1997**

**Contact: Bob Weiner/Don Maple
(202) 395-6618; fax 395-6730**

**MCCAFFREY ANNOUNCES WHITE HOUSE DRUG POLICY OFFICE
DECISION TO FUND REVIEW OF SCIENTIFIC EVIDENCE ON
THERAPEUTIC EFFECTIVENESS OF MARIJUANA**

(Washington, DC) — Barry R. McCaffrey, National Drug Policy Director, today announced that the Office of National Drug Control Policy (ONDCP) in December, 1996 committed \$995,639 to fund a comprehensive review by the Institute of Medicine (IOM) of the National Academy of Sciences of the state of knowledge of the health effects and potential medical use of smoked marijuana. The review is pending approval by the Institute of Medicine and the National Academy of Sciences, scheduled for January 8. This evaluation is intended to provide a comprehensive assessment of the state of scientific knowledge and to identify gaps in the knowledge base about marijuana.

The Institute of Medicine will be asked in its review to include existing clinical, medical, and scientific evidence on the following topics:

- Neurological mechanism of action of marijuana.
- Effects of marijuana on health and behavior.
- Marijuana's possible "gateway" characteristics.
- Efficacy of therapeutic use of marijuana for specific medical conditions (e.g. glaucoma; multiple sclerosis; wasting diseases such as AIDS and cancer; nausea; and pain compared with alternative pharmacotherapies).
- Effects of marijuana use compared with approved alternative pharmacotherapies.

The IOM has been asked to appoint an expert committee, representing a broad spectrum of viewpoints and expertise. The panel would include neuroscientists; behavioral scientists; physicians who treat patients with AIDS, cancer, pain, etc.; and specialists in public health policy, law, and health economics. The IOM expects to complete its study within 18 months.

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

February 20, 1997

Contact: NIH Press Office
(301) 496-5787

INVESTIGATING POSSIBLE MEDICAL USES OF MARIJUANA

Background: *The National Institutes of Health held a workshop on February 19-20, 1997 to discuss research in the field of possible therapeutic uses for smoked marijuana. Non-federal experts in fields such as cancer treatment, infectious diseases, neurology, and ophthalmology reviewed research published to date and heard presentations. The studies discussed were gathered through a search of the peer-reviewed literature, including both NIH-supported research as well as case reports and studies conducted independently of NIH.*

The invited experts assessed what is known about marijuana's possible therapeutic potential, and discussed the major scientific questions that remain unanswered; the indications that might hold promise for future research; and factors to be taken into account in undertaking clinical research on this subject.

The workshop concluded that there are too few scientific studies to determine marijuana's therapeutic utility, but that research is justified into marijuana's use for certain conditions or diseases: the nausea of patients who are undergoing chemotherapy for cancer; loss of appetite and weight (cachexia) related to AIDS; and glaucoma. The experts also called for peer-reviewed research to provide clear answers about marijuana's effects in the most promising applications. They also stressed that clinical trials to determine any therapeutic affects of marijuana would have to be well-designed and carefully conducted to produce reliable results.

The written summary of the panel's conclusions will be provided to the NIH director later this year, and the advice should help in considering what action NIH should take. As in other research areas, NIH will review grant applications on the medical utility of marijuana and is prepared to fund those applications that meet the accepted standards of scientific design and that, on the basis of peer review, are competitive with other applications that qualify for funding

In addition to the NIH workshop, the Institute of Medicine, part of the National Academy of Sciences, is carrying out a separate review of the state of knowledge of health effects and possible medical uses of marijuana. The IOM project is funded by the Office of National Drug Control Policy.

- 2 -

Past Research

The NIH workshop reviewed independently sponsored studies as well as research that has been federally supported. In the past, NIH's research on the therapeutic aspects of marijuana has focused primarily on a synthetic form of the major active ingredient in marijuana, delta-9-tetrahydrocannabinol (THC). Currently, NIH has only one application for support of research involving smoked marijuana for therapeutic purposes.

In the late 1970s, two NCI pilot studies were performed with smoked marijuana as well as oral THC. These small studies suggested that the utility of smoked and oral THC varied in part by the type of cancer chemotherapy being administered. As information developed regarding the potential benefit of THC as an anti-emetic for patients undergoing chemotherapy, the National Cancer Institute (NCI) supported the development of the drug dronabinol--synthetic THC--as an oral antinausea drug for such patients. In 1985, the Food and Drug Administration (FDA) approved dronabinol (Marinol), for treatment of nausea and vomiting associated with cancer chemotherapy in patients who have not responded to conventional antinausea (antiemetic) therapy. FDA also approved dronabinol in 1992 for use in loss of appetite and weight loss related to AIDS.

To determine whether dronabinol might be of benefit for treating wasting or cachexia from cancer, NCI has a clinical trial under way comparing dronabinol with another drug, a synthetic hormone known as megestrol acetate, or Megace, for cancer cachexia.

Other NIH institutes have conducted or supported some research--beginning over 20 years ago and into the present--aimed at evaluating the potential of synthetic THC in the management of conditions that include pain, muscle spasms, and HIV-associated cachexia. In particular, the National Eye Institute supported a study, in the late 70's and early 80's, in which smoked marijuana was used. One purpose of the study was to determine whether or not smoked marijuana reduced intraocular pressure in glaucoma patients. Although the study found that smoked marijuana did decrease intraocular pressure, this decrease was accompanied by an increased heart rate and a decrease in blood pressure as well as other potentially harmful side effects. As a result, the investigator did not recommend the use of smoked marijuana in the general glaucoma population.

- 3 -

Existing Therapies

In assessing possibilities for future research, the experts attending the February meeting weighed the potential of smoked marijuana as a medicine as compared with existing approved therapies for conditions where smoked marijuana has been suggested.

In glaucoma and nausea associated with cancer chemotherapy, for example, safe and effective treatments other than marijuana now exist for these conditions. Glaucoma (elevated intraocular pressure) can usually be effectively controlled with several existing medical and surgical treatments. These include a variety of prescription eyedrops and pills used for glaucoma treatment that either enhance the drainage of fluid from the eye or decrease its production. Treatment with an argon laser has proved beneficial in NEI-sponsored clinical trials and is usually used in conjunction with drops or pills. Finally, several procedures that employ incisional surgery may be performed to improve drainage flow. Although these procedures have a fairly high success rate, they are generally reserved until medical therapy is no longer effective.

According to the National Cancer Institute, other antiemetic drugs or combinations of antiemetic drugs have been shown to be more useful than marijuana or synthetic THC as "first-line therapy" for nausea and vomiting caused by anticancer drugs. Examples include drugs called serotonin antagonists, including ondansetron (Zofran) and granisetron (Kytril), used alone or combined with dexamethasone (a steroid hormone); metoclopramide (Reglan) with diphenhydramine and dexamethasone; high doses of methylprednisolone (a steroid hormone) combined with droperidol (Inapsine); and prochlorperazine (Compazine). Research with other agents and combinations is under way to determine their usefulness in controlling chemotherapy-induced nausea and vomiting.

A number of medications have been shown to be effective for pain control and for HIV-associated wasting, which are among the most frequently cited conditions for which marijuana has been proposed as potentially helpful. These medications include opiates and anti-inflammatory drugs for pain, while for HIV wasting, megestrol acetate, dronabinol and somatropin are FDA-approved. Researchers in government and the private sector are continuing to develop improved methods of treatment for each of these conditions.

- 4 -

Research Challenges

Research involving smoked marijuana poses several challenges. For example, studies on smoked marijuana would have to take into account the difficulty in objectively measuring a positive therapeutic effect, given the fact that a blind study, in which neither the doctor or patient knows which drug is being used, is not possible. In addition, the psychoactive effects of marijuana limit its use in people who experience depression instead of euphoria from the drug and in those who find the intoxicating sensation disorienting and unpleasant.

NIH has focused its marijuana-related research on purified THC because the orally-administered drug eliminates some of the known difficulties of using smoked marijuana as a drug-delivery system. These difficulties include the respiratory effects of smoking, exposure to a large mix of chemicals present in the marijuana plant (including about 60 cannabinoids) and to potential contamination with organisms that may be hazardous to someone whose immune system is impaired, and the variability of the dose that patients absorb when they smoke. Like smoked marijuana, THC has psychoactive as well as therapeutic effects.

In addition, those considering research with smoked marijuana must consider known negative health effects. The immediate effects of marijuana include rapid heart beat, some loss of coordination, and impaired short-term memory. In addition, the drug adversely affects critical skills, including those necessary to drive a car safely, such as judgment of distance and reaction time. With respect to long-term use, marijuana contains some of the same cancer-causing compounds as tobacco, sometimes in higher concentrations. Marijuana smokers have an increased frequency of respiratory problems. In addition, marijuana can be addictive, a problem for patients who have medical conditions that would involve marijuana use over many years.

###



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

December 30, 1996

STATEMENT RELEASED BY BARRY R. McCAFFREY
DIRECTOR OF THE OFFICE OF NATIONAL DRUG CONTROL POLICY

THE ADMINISTRATION'S RESPONSE TO THE PASSAGE OF CALIFORNIA
PROPOSITION 215 AND ARIZONA PROPOSITION 200.

1. **General:** The recent passage of propositions which make dangerous drugs more available in California and Arizona poses a threat to the National Drug Control Strategy goal of reducing drug abuse in the United States. At the direction of the President, the Office of National Drug Control Policy developed a coordinated administration strategy with the other agencies of the Federal Government to minimize the tragedy of drug abuse in America.

2. **Objectives:** An interagency working group chaired by ONDCP included the Departments of Justice, Treasury, Defense, Health and Human Services, Transportation, and Education, the Postal Service, and the Nuclear Regulatory Commission. This group met four times in November and December. It developed the following strategic objectives for our coordinated Federal response:

a. Maintain effective enforcement efforts within the framework created by the Federal Controlled Substances Act and the Food, Drug, and Cosmetic Act.

b. Ensure the integrity of the medical-scientific process by which substances are approved as safe and effective medicines.

c. Preserve Federal drug-free workplace and safety programs.

d. Protect children from increased marijuana availability and use.

3. **Courses of Action:** In developing this strategy, the inter-agency group gave due consideration to two key principles: federal authority *vis a vis* that of the states, and the requirement to ensure American citizens are provided safe and effective medicine. ONDCP and Federal drug control agencies have formed a partnership to undertake the following coordinated courses of action:

December 30, 1996

B. OBJECTIVE 2 - ENSURE THE INTEGRITY OF THE MEDICAL-SCIENTIFIC PROCESS BY WHICH SUBSTANCES ARE APPROVED AS SAFE AND EFFECTIVE MEDICINES IN ORDER TO PROTECT PUBLIC HEALTH

The Controlled Substances Act embodies the conclusion of the Congress, affirmed by DEA and HHS, that marijuana, as a Schedule I drug, has "high potential for abuse" and "no currently accepted medical use in treatment in the United States." To protect the public health, all evaluations of the medical usefulness of any controlled substance should be conducted through the Congressionally established research and approval process managed by the National Institutes of Health and the Food and Drug Administration. Currently there are a few patients who receive marijuana through FDA approved investigations.

HHS to ensure the continued protection of the public health will: (a) examine all medical and scientific evidence relevant to the perceived medical usefulness of marijuana; (b) identify gaps in knowledge and research regarding the health effects of marijuana; (c) determine whether further research or scientific evaluation could answer these questions; and (d) determine how that research could be designed and conducted to yield scientifically useful results.

HHS will undertake discussions with medical organizations throughout the nation: (a) to address the "compassionate use" message; and (b) to educate medical and public health professionals by underscoring the dangers of smoked marijuana and explaining the views of NIH that a variety of approved medications are clinically proven to be safe and effective in treating the illnesses for which marijuana is purported to provide relief, such as pain, nausea, wasting syndrome, multiple sclerosis, and glaucoma.

C. OBJECTIVE 3 - PRESERVE FEDERAL DRUG-FREE WORKPLACE AND SAFETY PROGRAMS

Transportation Workers: Department of Transportation has issued a formal advisory to the transportation industry that safety-sensitive transportation workers who test positive under the Federally-required drug testing program may not under any circumstance use state law as a legitimate medical explanation for the presence of prohibited drugs. DOT is encouraging private employers to follow its example.

Federal Contractors and Grantees: Under the Drug-Free Workplace Act, the recipients of Federal grants or contracts must have policies that prohibit the use of illegal drugs. Each Federal agency will issue a notice to its grantees and contractors to remind them: (a) of their responsibilities; (b) that any use of marijuana or other Schedule I



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

FOR IMMEDIATE RELEASE
Tuesday, July 22, 1997

CONTACT: Bob Weiner
(202) 395-6618

PRESIDENT'S DRUG POLICY ADVISOR WRITES D.C. LEADERS;
REITERATES ADMINISTRATION'S OPPOSITION TO DRUG-LEGALIZING

SAYS WASHINGTON D.C. MARIJUANA BALLOT INITIATIVE UNDERMINES
NATIONAL EFFORT TO PREVENT DRUG USE AMONG AMERICA'S 68
MILLION CHILDREN

(Washington, DC) – General Barry McCaffrey, President Clinton's chief drug policy advisor and spokesperson, today underscored the Administration's continued opposition to efforts to legalize marijuana through referenda and ballot initiatives. He singled out Initiative #57, the "Legalization of Marijuana for Medical Treatment Initiative of 1997," which is now being considered by residents of the District of Columbia as the latest effort to undermine sensible drug control policies designed to keep marijuana, cocaine, heroin, methamphetamines, and other dangerous substances away from the nation's children.

Director McCaffrey wrote letters to Eleanor Holmes Norton (U.S. Representative), Andrew Brimmer (Financial Control Board Chairman), Lieutenant General Julius Becton (Board of Education Chief Executive Officer), Marion Barry (Mayor) and Linda Cropp (Acting Chair of D.C. City Council).

McCaffrey stated in this letter: "A critical element in our national drug control policy is the federal drug approval process. This established process for approving medications is based on the rigorous application of science, not ideology. Thus, in America, every potential medication must meet rigorous scientific criteria before it can be sold to the public or prescribed by doctors. This process protects Americans from dangerous drugs, unproven substances and ineffective treatments. It has helped provide America with medical care that is the envy of the rest of the world. This process must be preserved. Exempting any potential medication from this scientific scrutiny undermines the proven system and does a grave disservice to the public, as it will have neither a tested, rational basis on which to conclude the benefits of a drug outweigh its risks nor the assurance that the product is accompanied by sufficient information to permit its accurate prescription."

"At present, leaf marijuana has not met the necessary scientific standards for approval as a safe and effective medication. It is listed in the federal Controlled

CONT. →

Substances Act as a Schedule I drug. Thus, in the view of the nation's scientific and medical community, marijuana has a high potential for abuse and no generally accepted therapeutic value. Based upon the scientific evidence to date and the advice of such organizations as the American Medical Association, the American Cancer Society, the National Multiple Sclerosis Association, the American Academy of Ophthalmology, the National Eye Institute and the National Institute on Drug Abuse, there is no rational basis to change that designation through ballot initiatives in conflict with federal law."

"The weight of scientific evidence to date demonstrates marijuana is not a benign drug. It is a contributing cause of injury and death to users and non-users alike. Research shows that smoked marijuana damages the brain, heart, lungs and immune system. It impairs learning, and interferes with memory, perception, and judgment. Marijuana smoke contains over 400 compounds, including some known to cause cancer. Marijuana has been implicated in a high percentage of non-alcohol related highway crashes, as well as accidents in the workplace. Drug-related visits to hospital emergency rooms involving marijuana have tripled since 1990. Last month, the National Institute of Drug Abuse released two studies confirming that marijuana's addictive mechanism acts on the brain in a manner similar to that of cocaine and heroin."

"Some 140,000 individuals seek treatment each year for marijuana dependency, many of them young people. Marijuana is also a gateway drug. Surveys show that young people who smoke marijuana are 85 times more likely later to use cocaine than those who don't. The director of the Haight-Ashbury Free Clinic in San Francisco recently remarked, in opposing a "medical marijuana" clinic in his neighborhood, that he treats over one hundred marijuana-dependent kids a month and that greater access to marijuana would only exacerbate that problem. Responsible adults must recognize the confusing message our children receive when we call smoked marijuana a medicine, thus "good for you," without subjecting it to the same tests we subject all other medicines. Smoke is not a medicine."

"Nevertheless, in response to the claims that smoked marijuana may have some medical benefits, the federal government is undertaking additional steps to analyze carefully the state of all scientific knowledge available about the risks and alleged benefits of marijuana for medical uses. In January, the Office of National Drug Control Policy committed nearly \$1 million to fund a comprehensive review by the Institute of Medicine of the National Academy of Sciences of the existing clinical, medical, and scientific knowledge of the health effects and potential medical use of smoked marijuana. Last February, the National Institutes of Health conducted a two-day workshop at which non-government experts in fields such as cancer treatment, infectious diseases, neurology and ophthalmology reviewed existing research about marijuana, assessed what is known

-3-

about its possible therapeutic potential, and discussed the factors to be taken into account in undertaking clinical research of marijuana. If and when there is adequate scientific evidence to support a reclassification of marijuana under the Controlled Substances Act, rule making proceedings could be used to change marijuana's current classification as a Schedule I controlled substance."

"With drug use by young people increasing, we must not send a mixed message to our youth about the dangers of marijuana. Equally important, we must safeguard the nation's scientific/medical process by which medications are approved for use. I call on all District of Columbia officials to act to preserve this important protection of our nation's health and welfare."

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. talking points	re: Needle exchange Q & A [Personally Identifiable Information] [partial] (1 page)	07/21/1997	b(6)

COLLECTION:

Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19394

FOLDER TITLE:

Correspondence - SLT - Incoming - 7/97 [Folder 2]

2018-0764-F
jm2046

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

NEEDLE EXCHANGE Q & A
JUNE 19, 1997

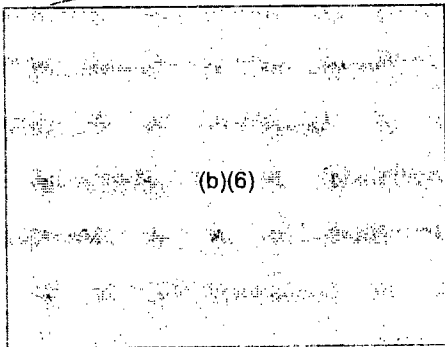
690-2560

Q: Do you believe local communities ought to be able to spend Federal money for needle exchange programs to help prevent spread of AIDS?

A: Under current law, the Administration cannot authorize the use of Federal funds for needle exchange programs unless there is conclusive evidence that these programs reduce the spread of AIDS and do not encourage drug use. Although there is strong evidence indicating that needle exchange programs help reduce the spread of AIDS, we have not concluded our review on whether these programs increase the use of drugs. However, local communities remain free to use non-Federal funds to support such programs if they choose to do so.

Regina — 888 207-5170

Sandy - I hear you've been tasked with doing talking points on needle exchange for tomorrow. This is our latest q + a on the question. Thanks.



[001]

Elena

Michael ~~Re~~ Crisci —
 Rahm Emmanuel —
 John Podesta —
 Sarah Lashem —
 John Podesta —
 Sylvia Mathews —
 June Gail Turner —

New York Times

NEW YORK, THURSDAY, JANUARY 9, 1997

\$1 beyond the greater New York metrop

Government to Spend \$1 Million Studying Marijuana as Medicine

WASHINGTON, Jan. 8 (AP) — One week after denouncing the approval of laws in Arizona and California that permit the medical use of marijuana, the White House said on Tuesday that the Government would spend up to \$1 million gathering scientific evidence on the effectiveness of marijuana as a medical treatment.

Gen. Barry R. McCaffrey, the retired Army officer who heads the White House Office of National Drug Control Policy, said his office committed the money last month for a comprehensive review by the Institute of Medicine at the National Academy of Sciences.

Bob Weiner, a spokesman for the drug policy office, said: "A lot of people have said we're not interested in the facts on this — and I think this shows that we are."

The Clinton Administration was criticized last week by individuals active in the fight against AIDS when Federal officials threatened to sanction doctors in Arizona and California who took advantage of those states' newly relaxed restrictions on the medical use of some illegal

drugs, including marijuana.

Those same critics questioned on Tuesday the credibility of any study sponsored by the White House.

"Putting McCaffrey in charge of this research is like putting Nixon in charge of the Watergate files," said Steve Michael, a spokesman for Act Up, an AIDS advocacy and protest group.

Mr. Weiner responded that the Institute of Medicine was above politics.

"It's a totally objective, scientific study," he said. "We're not going to get into the emotional arguments."

The institute was to report within 18 months on its compilation of clinical, medical and scientific evidence on the health effects of marijuana and its efficacy as a medical treatment.

Several experts have said there is no proven medical use for smoked marijuana. But some research has suggested that the drug is useful in relieving internal eye pressure in glaucoma, for controlling nausea in cancer patients on chemotherapy, and for combating wasting, a severe weight loss associated with AIDS.

ONDCP Director Gen. Barry McCaffrey urged that physicians be the final authority on medical issues in a broadcast on National Public Radio's Talk of the Nation, today (2/15/98). He buttressed his opposition to legalizing marijuana for medicinal use by the public by saying of the proposal, "It was opposed by every legitimate medical organization in the state of Washington....I'm leaning on [medical doctors] Alan Leshner (Director of NIDA) and Harold Varmus, our NIH Director Nobel laureate...(and) the American Medical Association."

McCaffrey called for "the centrality of medical decision making" to improve the quality of pain management in the U.S. and punctuated his position in opposition to marijuana as medicine by declaring, "We are servants of the National Institutes of Health and the American Medical Association in this area."

McCaffrey said " [the answers to] such questions ought to be medical, not political."

Proposal to Establish a California Marijuana Research Center (CMRC)

Phase I

Introduction

The passage by California voters of Proposition 215 envisions that medical marijuana should be made available to patients, and should be allowed to be recommended by physicians, under certain circumstances. The California initiative has drawn concerned reactions from some Federal and State officials. While there are many facets to the controversy, a key missing link is that there remains a significant information gap concerning the indications, efficacy, and safety of medical marijuana. The purpose of this proposal is to establish a California Marijuana Research Center (CMRC) whose primary objective will be to develop new knowledge on efficacy, safety, and indications for use of medical marijuana.

When fully developed, it is envisioned that the CMRC will serve as the centerpiece of a statewide research and treatment initiative. Headquartered at the University of California, San Diego (UCSD), the CMRC would actively involve investigators and clinicians, as well as patient participants from various regions of the State.

The current request is for support for Phase I of the CMRC. In this phase we propose to set up the basic infrastructure for the CMRC. Such an infrastructure of key personnel, information systems, patient outreach functions, and the development of a patient registry are all prerequisites to conducting comprehensive medical research on marijuana.

Objectives

The objectives of the Phase I proposal are: (1) to establish a critical mass of key personnel – clinician/scientists and support personnel to develop a program of research on potential uses of medical marijuana; (2) to develop procedures for outreach to patients with various medical conditions that may be suitable participants in research on medical marijuana; (3) to establish a

patient registry so that, should approval and funding come available to conduct medical marijuana research, this can be started and completed in a timely fashion; (4) to create an information management system that has two components (a) databases suitable for recording information about possible study participants, investigators, and clinicians; (b) creating a database suitable for depositing and analyzing research data that accrue as part of clinical trials, once these are initiated; (5) to develop protocols suitable for research on medicinal marijuana addressing several diseases for which some evidence exists that marijuana may be useful. These include wasting in AIDS, painful peripheral neuropathy (in AIDS and other conditions), control of nausea and vomiting due to anticancer treatment, glaucoma, and seizure disorders; (6) to establish a specimen laboratory capable of housing plasma, urine, and other tissue specimens necessary to study the concentration of cannabinoids in various tissues, as well as housing specimens for related studies on possible toxic effects of medical marijuana; (7) to establish a laboratory capable of analyzing marijuana for purity and THC content and to have the capacity to detect contaminants, e.g. pesticides.

The ultimate objectives of the CMRC, once it became fully funded and its research was approved (Phase II), will be: (1) to conduct focused controlled trials of medicinal marijuana in disease states of interest; specifically, to organize clinical trials that compare inhalational marijuana to oral THC products, as well as to other state-of-the-art treatments; (2) to study the short and long term adverse effects of medicinal marijuana on mental processes, the immune system, the respiratory system, and other physiological systems; (3) to conduct state-of-the-art behavioral prevention research aimed at teaching older children and adolescents specific skills to help them resist experimenting with or becoming regular users of marijuana.

Two Year Budget for Phase I

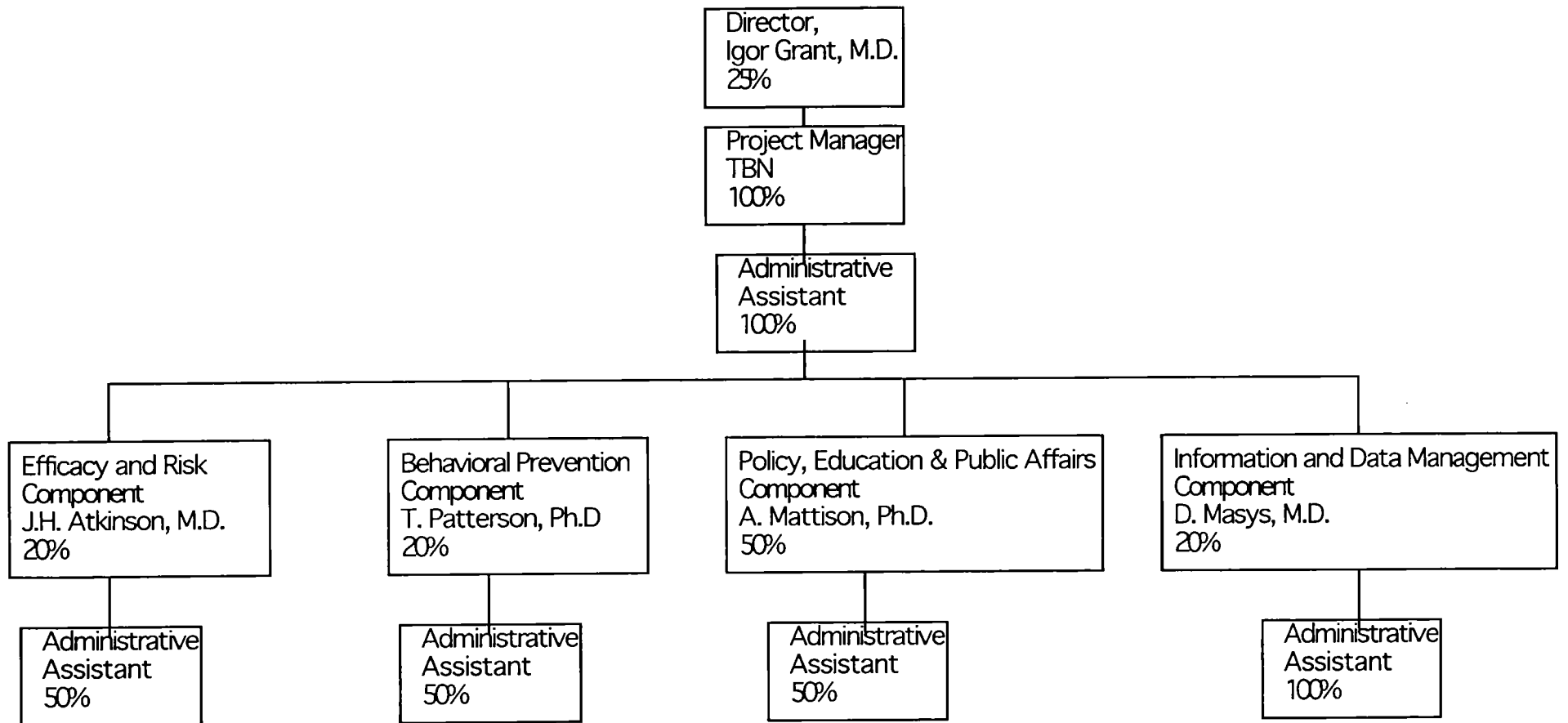
[See attached]

DETAILED BUDGET FOR INITIAL BUDGET PERIOD					FROM 7/1/97	THROUGH 6/30/98	
PERSONNEL		TYPE APPT. (months)	% EFFORT ON PROJ.	INST. BASE SALARY	SALARY REQUESTED	FRINGE BENEFITS	TOTALS
NAME	ROLE ON PROJECT						
Igor Grant, M.D.	Director	12	25	125,000	31,251	5,560	36,811
J.H. Atkinson, M.D.	Co-Director & Head, Efficacy & Risk	12	20	121,056	24,803	4,414	29,217
David Deitch, M.D.	Co-Director & Head, Behavioral Prevention	12	20	77,800	16,143	2,873	19,016
Dan Masys, M.D.	Co-Director & Head, Informatics & Data Management	12	20	120,000	24,751	4,404	29,155
Andrew Mattison, Ph.D.	Co-Director & Head, Policy, Education & Public Affairs	12	50	60,528	31,172	7,417	38,589
TBA	Project Manager, Asst. Researcher	12	100	36,000	36,540	6,502	43,042
TBA - Asst. Data Manager	Admin. Assistant	12	100	21,960	22,619	5,382	28,001
TBA - Asst., Coordinator CMRC	Admin. Assistant	12	100	21,960	22,619	5,382	28,001
TBA - Asst, Effic/Risk Compon	Admin. Assistant	12	50	21,960	11,309	2,691	14,000
TBA - Asst, Behav/Prev Compon	Admin. Assistant	12	50	21,960	11,309	2,691	14,000
TBA - Asst, Policy/Educ Compon	Admin. Assistant	12	50	21,960	11,309	2,691	14,000
SUBTOTALS →					243,825	50,007	293,832
EQUIPMENT							
FAX Machine - \$2,000							
Computer equipment - \$14,000							16,000
TRAVEL							
One trip for each Director to meet with Co-investigators statewide @ \$1,000 ea. x 5 = \$5,000							5,000
OTHER EXPENSES							
Leased space - (1,000 sq.ft. x \$2.10 = \$2,100) x 12 = \$25,200							
Office supplies = \$200/mo. x 12 = \$2,400							
Telephone - 6 lines @ \$50/mo. = \$3,600							
Photocopying = \$200/mo. x 12 = \$2,400							33,600
SUBTOTAL OF DIRECT COSTS FOR INITIAL BUDGET PERIOD							348,432
INDIRECT COSTS FOR INITIAL BUDGET PERIOD (15%)							52,265
TOTAL COSTS FOR INITIAL BUDGET PERIOD							400,697

**BUDGET FOR ENTIRE PROPOSED PROJECT PERIOD
DIRECT COSTS ONLY**

BUDGET CATEGORY TOTALS		INITIAL BUDGET PERIOD (from page 4)	ADDITIONAL YEARS OF SUPPORT REQUESTED			
			2nd	3rd	4th	5th
PERSONNEL:						
<i>Salary & fringe benefits</i>						
<i>Applicant organization only</i>		293,832	293,832			
CONSULTANT COSTS		0	0			
EQUIPMENT		16,000	0			
SUPPLIES		0	0			
TRAVEL		5,000	5,200			
PATIENT CARE COSTS	INPATIENT	0	0			
	OUTPATIENT	0	0			
ALTERATIONS AND RENOVATIONS		0	0			
OTHER EXPENSES		8,400	8,736			
<i>Lease</i>		25,200	26,208			
SUBTOTAL DIRECT COSTS		348,432	333,976			
CONSORTIUM CONTRACT COSTS	DIRECT	0	0			
	INDIRECT	0	0			
TOTAL DIRECT COSTS		348,432	333,976			
INDIRECT COSTS		52,265	50,096			
TOTAL COSTS		400,697	384,072			
TOTAL COSTS FOR ENTIRE PROPOSED PERIOD OF SUPPORT						\$784,769

CMRC Personnel





HIV Neurobehavioral Research Center

2760 5th Ave, Suite 200
San Diego, CA 92103
(619) 543-5000

April 24, 1997

Dear Ms. Thurman:

Over the past few months, Igor Grant, M.D. and I have worked with state Senator John Vasconcellos in developing the research proposal portion of his enactment legislation for the implementation of Proposition 215, The Medical Marijuana Proposition. Two weeks ago, Dr Grant gave testimony on the merits of the development of a California Medical Research Center before the Senate's Health Committee. Currently, we are looking in the private sector for funding of Phase I of the Proposed Research Center.

The enclosed documents give an overview of the process we are following as well as some of the problems that may be encountered in achieving our goal.

Sincerely,

A handwritten signature in cursive script, reading "Andrew M. Mattison".

Andrew M. Mattison, Ph.D.

UNIVERSITY OF CALIFORNIA, SAN DIEGO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

IGOR GRANT, M.D.

PROFESSOR AND VICE CHAIRMAN
DEPARTMENT OF PSYCHIATRY 0680
CLINICAL SCIENCES BUILDING
SCHOOL OF MEDICINE

9500 GILMAN DRIVE
LA JOLLA, CALIFORNIA 92093-0680
VOICE: (619) 534-3632
FAX: (619) 534-7723
E-MAIL: igrant@ucsd.edu

January 22, 1997

The Honorable John Vasconcellos
State Capitol, Room 4061
Sacramento, CA 95814
FAX: (916) 324-0283

Dear Senator Vasconcellos:

Thank you for taking the time yesterday to discuss the idea of a California Marijuana Research Center (CMRC) with Dr. Drew Mattison and myself. We were gratified to hear that you had been thinking much along these lines.

We appreciate also the materials that you have arranged be faxed to us. Once again, these materials emphasize that we are very much on the same wavelength.

Per your suggestion I am sending my CV as well as a summary of the CMRC concept. We have decided to send you the concept statement as we developed it, without modifying it, based on the documents you sent. We thought that in this way you can see exactly the ideas we had in mind. As we discussed, we think that the funding for such a Center would be in the order of two million dollars annually. Additionally, we would strongly recommend that if the State chose to make such an investment, it should do so for a minimum of five years because some of the therapeutic and preventive studies require time to be initiated and for follow-up to be complete. Too short a time frame may actually not represent the best use of funds.

Finally, should the legislature decide to establish such a Center, we hope that a mechanism can be developed to streamline its implementation so that much valuable time is not lost in bureaucratic processes.

Thank you very much for your interest, and please let us know how we can be of help.

Sincerely,

A handwritten signature in dark ink, appearing to read "Igor Grant", is written over a horizontal line.

Professor of Psychiatry and Director,
HIV Neurobehavioral Research Center

IG/mbh

cc: Andrew Mattison, Ph.D.

Proposal for a California Marijuana Research Center (CMRC)

Introduction

Recently the people of California passed Proposition 215 indicating their desire that medicinal marijuana be available for therapeutic use under certain circumstances. The passage of this initiative has created a confrontation with the Attorney General's Office in California and Federal officials who have expressed that insufficient data exist to support the benefits of medicinal marijuana to counterveil the known adverse effects on health and behavior.

The development of rational health and social policy requires that valid and reliable information be available on the possible benefits as well as adverse effects of marijuana. Unfortunately, despite years of debate, there continue to be significant gaps in our understanding of both the therapeutic potential and longer term health consequences of marijuana. The following proposal outlines an approach to the problem through the establishment of a California Marijuana Research Center. It is envisioned that through a multidisciplinary approach, additional critical information can be developed in order to guide the State in its policy development.

Objectives

The CMRC is envisioned as having three primary research and development components.

(1) Clinical Trials Component

To enhance understanding of the efficacy and adverse effects of marijuana as a pharmacological agent, it is proposed that the CMRC will conduct focused controlled clinical trials on the usefulness of marijuana in conditions such as chronic pain (including AIDS neuropathy), utility of marijuana in treatment of nausea related to chronic disease or antineoplastic chemotherapy, its utility as an anticonvulsant, usefulness in chronic inanition, in treatment of glaucoma, and other possible conditions. In particular, such trials should focus on comparisons between routes of delivery (e.g., inhalational vs. oral) and develop further information on pharmacokinetics.

(2) Adverse Effects Component

This component of the CMRC would concern itself with (a) safety of medicinal marijuana in patients with various medical disorders, (b) long-term adverse consequences in long-term users be they medically sanctioned or "recreational".

(3) Prevention and Intervention Component

Irrespective of whether medicinal marijuana is determined to be useful under certain circumstances, because it is a psychoactive drug society has a stake in preventing individuals, particularly children and adolescents, from experimenting with marijuana or becoming regular users. It is proposed that the CMRC develop new and more targeted approaches, whose efficacy can be established, and thereby provide a scientific basis for efforts at prevention. Additionally, it is envisioned that the CMRC will take the lead in developing new treatment techniques directed at those who have become regular marijuana users.

Implementation

The three-pronged approach described above requires the establishment of a Multidisciplinary Research Center in which biomedical and behavioral scientists as well as policy makers interact. A comprehensive Center approach is proposed precisely because the past 30 years of research on marijuana have been uncoordinated and fragmented. If a Center is established, it should be funded for a minimum of five years so that adequate progress can be made on clinical trials and behavioral interventions. The Center should be established at a University and under the leadership of persons with demonstrated ability to direct research and produce results from a multidisciplinary team endeavor.



IGOR GRANT, M.D.

PROFESSOR AND VICE CHAIRMAN
DEPARTMENT OF PSYCHIATRY 0680
CLINICAL SCIENCES BUILDING
SCHOOL OF MEDICINE

9500 GILMAN DRIVE
LA JOLLA, CALIFORNIA 92093-0680
VOICE: (619) 534-3652
FAX: (619) 534-7723
E-MAIL: igrant@ucsd.edu

April 21, 1997

To: Op-ed Editor

From: Igor Grant, M.D.
Professor and Director
HIV Neurobehavioral Research Center

Medical Marijuana: Can We See Beyond the Smoke?

When California voters passed the Medical Marijuana Initiative on November 5, 1996, they signaled that seriously ill Californians have a right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician. The passage of this initiative, along with a similar measure by Arizonans, has rekindled the dialectics of marijuana.

My concern is that the pyrotechnics of the marijuana debate, so engaging in some of their aspects, not leave behind two unintended victims - patients who are suffering, and the truth itself. In that spirit, I want to focus on what we know and what we have yet to learn about the medicinal value of marijuana, and to demonstrate that the provision in SB535 which proposes the establishment of a research program to fill in the gaps in our knowledge on medicinal marijuana is critical and timely.

Proposition 215 lists cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, and migraine as among the conditions for which marijuana might perhaps be used. What are the data?

Cancer. There are no credible data that marijuana products have anti-cancer properties. There are, however, some data that marijuana may be useful in the treatment of nausea and vomiting associated with cancer and its treatment. Several studies have shown that tetrahydrocannabinol (THC) is better than placebo (sugar pill), but may not be as powerful as some newer medications in emesis control. What we do not know is whether inhaled marijuana is better than dronabinol (THC capsule) nor whether marijuana might produce benefit over and above currently accepted therapies, perhaps in combination. Treatment trials aimed at comparing inhaled marijuana with newer anti-nausea agents such as ondansetron would be helpful in resolving some of these issues.

Anorexia. There is plenty of anecdotal evidence that people smoking marijuana in social settings tend to eat more and there are some studies with cancer patients that suggest appetite is increased by THC. Neither for the wasting associated with cancer nor for AIDS do we know if marijuana would actually produce weight gain and, in particular, increase lean body mass (rather than produce weight gain through adding body fluid or fat). Comparative studies between marijuana and more accepted treatments for wasting, such as growth hormone and testosterone would be very useful.

AIDS. There is no credible evidence that marijuana in any way influences the course of AIDS. However, it is possible that the wasting associated with AIDS could be ameliorated by marijuana, as noted above.

Chronic Pain. Both animal and human studies indicate that marijuana has some analgesic properties, though it is clearly not as powerful as opiate drugs. What we do not know is whether “adjunctive” marijuana (that is, adding it to more standard treatments, such as morphine) could actually reduce the amount of narcotic required, and improve quality of life.

Fragmentary data suggest that marijuana might have a special place in treating “neuropathic” pain - the sort of painful hypersensitivity that AIDS patients and others experience when their nerves are damaged. Well controlled studies with patients suffering from painful peripheral neuropathy would be very timely.

Spasticity. We now know that marijuana acts in part by binding to cannabinoid receptors (docking sites for molecules on the surfaces of various cells). There are at least two types of cannabinoid receptors throughout the body; interestingly, the ones in the brain are especially plentiful in regions that control movement and muscle tension. Therefore, there is theoretical reason to believe that marijuana may have anti-spasm effect. Unfortunately, the research in this area is even scantier than in some of the others. A few animal and human studies point to the likelihood that marijuana might be useful for spasm and increased muscle tone associated with conditions such as multiple sclerosis. Again, here is a promising avenue for clinical research on marijuana.

Glaucoma. Glaucoma involves abnormal accumulation fluid in the front chamber of the eye between the cornea and the lens; unchecked, this condition can lead to blindness.

There is now substantial evidence that marijuana lowers ocular pressure, but the effect is short acting (not more than a few hours). Because very good anti-glaucoma agents already exist, there may be less promise that marijuana, given its mental side effects, will be useful. Nevertheless, there may be individual patients for whom it might be indicated; in addition, studies of the way in which THC works to lower ocular pressure could lead to development of newer compounds which are more effective and have fewer side effects.

Arthritis. To my knowledge, there is no evidence that marijuana products have anti-inflammatory actions; also, since they are not very strong analgesics (with the possible exception of neuropathic pain) it is doubtful that this avenue of treatment research will be promising.

Migraine. There is little systematic evidence that marijuana prevents or curtails attacks of migraine, and no firm grounds for pursuing research into medicinal marijuana in this area.

Epilepsy. While not a condition mentioned in the initiative, epilepsy may be another disorder for which marijuana products could show benefits. Many animal studies have shown that cannabinoids are anticonvulsants. Cannabinoids may have beneficial effect, particularly on grand mal and partial complex seizures. However, cannabinoids may not be as potent as some of the currently available anticonvulsants, and the mental and perceptual changes produced by marijuana may preclude their use as anticonvulsants on a continuing basis.

What can California do? As policymakers ponder how to implement Proposition 215, and to reconcile its requirements with those of federal law, we in California have an opportunity to go beyond opinion and fancy to generate new knowledge both to benefit patients who suffer, and to inform a truly rational social policy. In this context, SB 535, which proposes the establishment of a medical marijuana research program to evaluate the clinical potential of marijuana in some of the conditions and diseases listed above, and to study the adverse effects and toxicities of marijuana, in medical patients, is an important step in the right direction. As I understand it, such a research program would coordinate much needed, state-of-the-art, highly focused clinical trials of both inhalational and oral marijuana preparations, and compare the efficacy and safety of these to established or newly developed treatments. By involving patients and medical scientists from all parts of the state, such research promises to yield definitive and generalizable information on appropriate uses of marijuana as medicine. I urge the Legislature and the Governor to look seriously at SB 535, and to support it. In this way, California can lead us from opinion to fact, from passion to understanding. Those in California whose suffering may be ameliorated surely deserve no less.

A handwritten signature in black ink, appearing to read "Jeff Knauer". The signature is fluid and cursive, with the first name "Jeff" and last name "Knauer" clearly distinguishable.

NEW ENGLAND JOURNAL OF MEDICINE

January 30, 1997 -- Volume 336, Number 5

Editorial

Federal Foolishness and Marijuana

The advanced stages of many illnesses and their treatments are often accompanied by intractable nausea, vomiting, or pain. Thousands of patients with cancer, AIDS, and other diseases report they have obtained striking relief from these devastating symptoms by smoking marijuana. (1) The alleviation of distress can be so striking that some patients and their families have been willing to risk a jail term to obtain or grow the marijuana.

Despite the desperation of these patients, within weeks after voters in Arizona and California approved propositions allowing physicians in their states to prescribe marijuana for medical indications, federal officials, including the President, the secretary of Health and Human Services, and the attorney general sprang into action. At a news conference, Secretary Donna E. Shalala gave an organ recital of the parts of the body that she asserted could be harmed by marijuana and warned of the evils of its spreading use. Attorney General Janet Reno announced that physicians in any state who prescribed the drug could lose the privilege of writing prescriptions, be excluded from Medicare and Medicaid reimbursement, and even be prosecuted for a federal crime. General Barry R. McCaffrey, director of the Office of National Drug Control Policy, reiterated his agency's position that marijuana is a dangerous drug and implied that voters in Arizona and California had been duped into voting for these propositions. He indicated that it is always possible to study the effects of any drug, including marijuana, but that the use of marijuana by seriously ill patients would require, at the least, scientifically valid research.

I believe that a federal policy that prohibits physicians from alleviating suffering by prescribing marijuana for seriously ill patients is misguided, heavy-handed, and inhumane. Marijuana may have long-term adverse effects and its use may presage serious addictions, but neither long-term side effects nor addiction is a relevant issue in such patients. It is also hypocritical to forbid physicians to prescribe marijuana while permitting them to use morphine and meperidine to relieve extreme dyspnea and pain. With both these drugs the difference between the dose that relieves symptoms and the dose that hastens death is very narrow; by contrast, there is no risk of death from smoking marijuana. To demand evidence of therapeutic efficacy is equally hypocritical. The noxious sensations that patients experience are extremely difficult to quantify in controlled experiments. What really counts for a therapy with this kind of safety margin is whether a seriously ill patient feels relief as a result of the intervention, not whether a controlled trial "proves" its efficacy.

Paradoxically, dronabinol, a drug that contains one of the active ingredients in marijuana (tetrahydrocannabinol), has been available by prescription for more than a decade. But it is difficult to titrate the therapeutic dose of this drug, and it is not widely prescribed. By contrast, smoking marijuana produces a rapid increase in the blood level of the active ingredients and is thus more likely to be therapeutic. Needless to say, new drugs such as those that inhibit the

nausea associated with chemotherapy may well be more beneficial than smoking marijuana, but their comparative efficacy has never been studied.

Whatever their reasons, federal officials are out of step with the public. Dozens of states have passed laws that ease restrictions on the prescribing of marijuana by physicians, and polls consistently show that the public favors the use of marijuana for such purposes. (1) Federal authorities should rescind their prohibition of the medicinal use of marijuana for seriously ill patients and allow physicians to decide which patients to treat. The government should change marijuana's status from that of a Schedule 1 drug (considered to be potentially addictive and with no current medical use) to that of a Schedule 2 drug (potentially addictive but with some accepted medical use) and regulate it accordingly. To ensure its proper distribution and use, the government could declare itself the only agency sanctioned to provide the marijuana. I believe that such a change in policy would have no adverse effects. The argument that it would be a signal to the young that "marijuana is OK" is, I believe, specious.

This proposal is not new. In 1986, after years of legal wrangling, the Drug Enforcement Administration (DEA) held extensive hearings on the transfer of marijuana to Schedule 2. In 1988, the DEA's own administrative-law judge concluded, "It would be unreasonable, arbitrary, and capricious for DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record." (1) Nonetheless, the DEA overruled the judge's order to transfer marijuana to Schedule 2, and in 1992 it issued a final rejection of all requests for reclassification. (2)

Some physicians will have the courage to challenge the continued proscription of marijuana for the sick. Eventually, their actions will force the courts to adjudicate between the rights of those at death's door and the absolute power of bureaucrats whose decisions are based more on reflexive ideology and political correctness than on compassion.

Jerome P. Kassirer, M.D.

► [Text](#)

► [References](#)

Please send me the [complete article](#).

[NEJM Home](#) | [Table of Contents](#) | [Previous Article](#) | [Next Article](#)

Copyright © 1997 by the Massachusetts Medical Society