



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

September 14, 1998
(House)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 4006 - Lethal Drug Abuse Prevention Act of 1998
(Reps. Hyde (R) IL and Oberstar (D) MN)

The President is opposed to assisted suicide and any Federal support for it. The Administration, however, opposes H.R. 4006 because it represents a flawed approach to the sensitive area of Federal regulation of medicine. In particular, the Administration is concerned that the bill's insertion of the Drug Enforcement Administration (DEA) into the role of overseer of the practice of medicine in the unique circumstances of suffering, terminally ill patients would inevitably divert agency attention away from its core drug enforcement mission. In addition, the medical, scientific, ethical, and related aspects of the practice of medicine at the end of life would involve the DEA in issues in which it has no particular expertise.

Furthermore, there is a growing consensus that the American medical system does not adequately provide palliative care to terminally ill patients and in particular that it fails to provide effective pain management. The Administration is concerned that this bill would chill effective pain management, and patients may unnecessarily suffer.

Although the President opposes H.R. 4006 as currently drafted, he remains committed to working with Congress, health care providers, consumers, medical ethicists, States, and others to attempt to develop an appropriate approach to this complex, but extremely important issue.

Pay-As-You-Go Scoring

H.R. 4006 could affect both direct spending and receipts: therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's preliminary scoring estimate of this bill is that it would have a net effect of less than \$500,000.

First Death Under an Assisted-Suicide Law

By TIMOTHY EGAN

SEATTLE, March 25 — While doctors, religious leaders and politicians continue to debate the ethics of allowing physicians to help terminally ill patients kill themselves, the issue took a sharp turn from the abstract today when the first known legal assisted suicide was announced in Oregon.

An advocacy group, Oregon Compassion in Dying, made public the details surrounding the death of a woman in her mid-80s who was said to be suffering from terminal breast cancer. The group did not release her name.

The woman died on Tuesday night, shortly after taking a lethal dose of barbiturates washed down by a glass of brandy, according to the group. Citing privacy provisions of the Oregon Death with Dignity Act, state officials would not confirm the case.

But the woman's family made public an audiotape, said to have been made on Sunday, two days before her death. In the tape, portions of which were played for reporters, the woman said of her coming suicide: "I'm looking forward to it. I will be relieved of all the stress I have."

Under the nation's only law to permit assisted-suicide, a terminally ill adult has the right to request a lethal dose of prescription drugs if the patient is of sound mind and judged by two doctors to have less than six

Moving a debate from the abstract to the actual.

months to live.

In the tape, the woman, who is from Portland, said she had been given less than two months to live. She died about half-an-hour after taking the prescription, said Barbara Combs Lee, who wrote the law.

Opponents of the measure, led by the Roman Catholic Church, condemned the death.

"I am deeply saddened at this news," said Archbishop John G. Vlazny of Portland. "The suicide of this elderly woman can only bring anguish to those who have resisted the public-policy initiatives that changed the law in Oregon."

The Catholic Church in Oregon led the fight against the initial ballot measure in 1994, when assisted suicide passed by a narrow margin in a statewide initiative. The law was held up by legal challenges for three years, and then it was reaffirmed by voters last fall by a wide margin.

But the prediction of critics — that Oregon would become a mecca for people who wanted to end their lives with medical assistance — has not

materialized. Until this week, Compassion in Dying had said it did not know of anyone who had used the law to end a life.

Other people may have killed themselves under the law, but have kept the details private. State officials said they will not release a report on how the law is working until they have recorded at least 10 deaths.

"This is simply the first one that we know about," said Judith Fleming, acting director of the Oregon chapter of Compassion in Dying.

Medical professionals have been troubled by the complexities in trying to make a law with no precedent work in their state. Last month, a state task force released a 91-page guidebook for doctors and patients. Physicians are not allowed to administer the fatal dose, only prescribe it.

But for all the details in the guidebook, the death of the Portland woman, according to her family and the advocacy group she consulted, was relatively simple. She had grown tired of fighting cancer, and had trouble breathing and walking, according to the audiotape. "I can't see myself living a few more months like this," she said on the tape.

Ms. Combs Lee said the woman died at home in Portland, in bed, surrounded by her family members. There were no complications in the death, Ms. Combs Lee said.

New York Times
3/26/98

PHOTOCOPY
PRESERVATION

Pain control won't end assisted suicide,

By Marilyn Webb

Four years ago, my 96-year-old father-in-law, Jack Sheedy, died what he and our family considered a good death. He'd lived a full life, discovered prostate cancer too late to treat it successfully, and opted for hospice care instead.

Jack actually died at Calvary Hospital in the Bronx — the sole advanced cancer center in the country to provide sophisticated comfort, or palliative, care only. His pain was well controlled. So was his shortness of breath. He got to say goodbye to each of his four children, 18 grandchildren, 17 great-grandchildren, and one great-great-grandson. And he spent his final days holding hands with his 94-year-old wife, Marie. Because his time at Calvary was so good, we all thought he took an extra three months to die.

Sadly, the story was very different last spring when Marie died. She had heart disease and two strokes — and doctors not as skilled at knowing when to call hospice for her, or as able to provide her good pain control. After fighting with her physicians, our family finally transferred Marie to Calvary, too. But by then, she was so ill she lived just four more days.

This dignified woman spent nearly a month at a local hospital, screaming night and day in pain. She didn't get to say any goodbyes. Because of the way her death was handled, Marie not only suffered but also left a family grieving with the feeling of having failed her. The difference between these two deaths was the management of pain and doctors' willingness to listen when family members said they knew what each parent wanted.

Just after Marie died, the U.S. Supreme Court made a historic decision that might have had an impact on her death. It ruled that assisted suicide is not a constitutional right but left legalization for each state to decide. Less noticed in that decision, though, justices also sent out a challenge to states and doctors to improve the care of the dying, most specifically in

the management of pain.

Oregon is the only state with an assisted suicide law. Last Tuesday, a woman in her mid-80s suffering from advanced breast cancer took her life with the help of a physician — one of only two known cases since the law was passed. She was reportedly fed up with the pain.

The medical profession long has argued that improved pain control would virtually eliminate requests for aid in dying in cases like these. Commissions on pain management and medical efforts to educate doctors and patients have emerged in state after state. National studies have found that undertreated pain is endemic in America and that some 50% of all terminally ill patients — and not just cancer patients — die in pain, although at least half of that pain could have been controlled.

In a soon-to-be-released report, a New York commission cites what long has been known in palliative care circles: Were doctors better trained in the care of the dying, were medical licensing boards better informed so that doctors would not fear having their licenses pulled for prescribing narcotics, were drug laws changed, and were patients' and families'

fears eased about addiction or overdosing, dying patients could be helped to live longer and more comfortable lives.

But what is not as freely admitted is this: Improving pain management and eliminating legal and medical barriers to using drugs for the terminally ill, though essential, will not eliminate the need for assisted suicide. Nor will it stop what is now a mushrooming grass-roots movement to legalize it.

Studies at world-class institutions, such as Memorial Sloan-Kettering in New York, show that not all pain can be controlled, even to a level of comfort most people could live with. Really intractable pain often cannot be controlled at all, short of complete, anesthesia-like sedation.

Terminal sedation is the medical profession's best hope for easing intense, long-term suffering. A patient is put into a coma-like state, artificial food and water are withheld, and the patient dies within roughly 10 days. The legal and moral defense for this is what's known as the double effect: The intent is to relieve suffering even if the effect is to hasten death.

Waiting for someone to die in a drug-induced, coma-like state is not something everyone would want. Nor is this the whole picture. The most telling study is one at Sloan-Kettering of 90 patients in severe pain who were cared for in their last four weeks of life by that hospital's pain team. This team included doctors skilled in the use of narcotics and psychiatrists to address depression.

Of those 90 patients, 18 (or 20%) could find some relief only if they lay perfectly still in bed. All 18 had thoughts of assisted suicide somewhere in the future. Four others out of the 90 had made real suicide plans, and four more specifically requested help in dying.

Two of the original 90 patients ended up committing suicide. At least two more, judging by the level of narcotics given, were helped with terminal sedation. And a fifth patient, convinced not to take steps to end his life after promises of help with terminal sedation, faced so terrible an end that his family reported he wished he had not taken his doctors up on their well-meaning promises. Even with the best pain-management team, about 5% of these patients in severe pain required — or took — more active steps to get help in dying.

Other studies show that pain is not the No. 1 reason for such requests. The top reasons given are hopelessness and fatigue with life as it is and with no

prospect for it to get any better. It's a feeling of utter debilitation, with death the only thing likely to come.

Medical science is now so sophisticated that doctors can prolong life nearly indefinitely. However, doctors also are put in the unenviable position of having to make regular decisions about when that ability should stop. Some 70% to 90% of all deaths in America today are what might be called "managed dying," whether a decision is made to withhold chemotherapy, antibiotics or an organ transplant, or to withdraw life support.

The sad fact is that pain

should be better controlled. Medical boards need to stop hampering doctors' prescribing, doctors need more training in the care of the dying, and state drug laws need to change to allow access to narcotic drugs for seriously ill patients.

But when all is said and done, to focus on pain alone is to lose the central issue. Not all pain can be controlled; and even if it could be, that still would not end what many see as a need to legalize assisted suicide.

Dying today is far more complex than it has ever been. Patients and families want more say about what is medically, morally and ethically right to do, but they also want far more say for themselves over how they face the very profundity of the end of life.

Marilyn Webb is the author of *The Good Death: The New American Search to Reshape the End of Life*.

Pain experts' six principles of good pain management

1. Don't limit drugs for fear of an overdose. Your body will adjust to what you need.
2. When drugs are used for pain control, there is little risk of addiction. And addiction is irrelevant to the dying.
3. Believe the patient. The amount of narcotics required is whatever it takes to best control pain.
4. Severe pain can occur a long time before someone dies. It needs to be treated during all this time.
5. A patient need not forgo a narcotic now in the hope that it will still be effective when the pain gets worse. It will be effective later, even if more is needed.
6. Pain relief is always the objective when someone is dying, even if high doses unintentionally contribute to death.

The Health and Human Services Department publishes guidelines for pain management. Call 1-800-358-9295.

Source: Based on research for *The Good Death*

One remedy: Lock up 'gun-happy' parents, relatives

In the wake of the Jonesboro killings comes the cry for tougher gun laws ("New territory for gun debate," News, Friday).

This, too, soon will pass. We will pass campaign-finance reform before we ever violate this country's love affair with all weapons.

But perhaps we can do a better job of controlling children's access to guns — particularly rifles.

In the case of children killing children, if adults locked up firearms, their kids couldn't get them.

As the driver in a getaway car is just as guilty as his or her friend who kills a guard in the bank, we should hold grown-ups responsible for their children's irrational behavior. And have the schools post signs that all threats are reported.

As for the 11-year-old child, he was tutored in using guns, conditioned to shoot at moving targets.

The anatomy of a murder by those two

youngsters would not be complete without the grandfather, manager of a wildlife area, who had an arsenal of guns all over his house, not locked up.

Want to put a damper on kids killing kids? Let their gun-happy relatives share equal blame.

Edward L. Resnick
Boynton Beach, Fla.

Sign of 'moral degeneration'

Jonesboro, Ark.; Pearl, Miss.; Paducah, Ky. — is this just the beginning?

Isn't children killing children another sign of the moral degeneration of our nation? Will it happen again? If so, where and when?

The value of life has dropped steadily for many years. Abortion, capital punishment and doctor-assisted suicide have been accepted.

Now our children have followed in our footsteps. They have taken matters into

their own hands. Their political heroes have no morals, as depicted in the newspapers, and their sports heroes are constantly being arrested for drunken driving, drugs and sexual assault. Most of them don't have any religious heroes. Some don't even have a mother and a father.

Why should we be shocked when something like this happens? My biggest concern is that one day soon we won't be shocked. It will become all too commonplace for anyone to be disturbed.

Ray Burkot
Bardstown, Ky.

NRA gun safety?

I want to commend the National Rifle Association for its program that teaches youngsters how to safely fire guns. It works. Neither of the two young shooters in Jonesboro, Ark., was injured.

Karen M. Borten
Miami Lakes, Fla.

Things in schools not better with Coke

Why did school officials in Georgia allow Coke to take over a high school ("This school is brought to you by: Cola? Sneakers?" Our View, Debate, Friday)?

I was shocked to read that a student was suspended for exercising his right to free expression for the sake of \$10,000.

Public schools should not be devoting an entire school day to a private corporation.

Educators need to teach our children to look past all the hype put out by advertisers and look at what they are getting for their money.

Gloria Hamilton, principal of the Greenbrier High School in Evans, Ga., has played right into the hands of The Coca-Cola Co. by forcing her entire school to wear clothing and to produce work based on Coke products.

I would not want my tax dollars going to help Coke get some cheap advertising.

I hope the principal realizes her mistake and apologizes to senior Mike Cameron for stomping on his constitutional rights and refuses the money if her school wins.

Coke needs to be told that it cannot buy our children.

Michael Kidder
Denver, Colo.

Case of poor judgment

The Georgia high school suspended a senior for wearing a specific shirt. But it wasn't because the shirt was too tight. And it wasn't because it had an unacceptable message on it, or was dirty, or was objectionable in any way.

It was because it didn't advertise the soft drink the school was promoting. This is a clear violation of this young man's civil rights.

Someone made a poor choice. The priorities seem to be misguided. Kids are in school to learn, and that shirt was not hindering his learning. The suspension, however, will.

This is all very offensive to me. What is the lesson supposed to be in this? To show who has the power? That doesn't make any sense.

If teachers or school officials need to reprimand a student, they should find a reason that has to do with disruptions in learning. This is preposterous. They should get back to basics.

Sue Simon
St. Pete Beach, Fla.

Students loans explained

In response to your recent editorial on the student loan interest-rate debate, you miss the point by attempting to compare student loans with car and home mortgage loans ("Banks acting like bullies," Our View, Debate, March 23).

Car loans average \$15,000 and are typically paid off in five years. Mortgage loans average around \$130,000.

Both types of loans experience delinquency rates 75% or lower than those experienced on student loans, which, incidentally, average \$8,800 in size as they enter repayment and are typically repaid over 10 years or longer.

The point? Student loans are labor-intensive loans made to borrowers with no income and no assets and who are highly mobile. The cost of collecting the loans, which are smaller, more likely to be subject to delinquency, and are in repayment for much longer periods of time, is dramatically higher per dollar lent than any other type of consumer loan.

Finally, about the borrower interest rate: It is not 8.23%, as claimed. It is actually less than 4% after government payment

Wisconsin speech dishonors Reggie White

The stereotypical, prejudicial and insensitive comments of Reggie White, the Green Bay Packers defensive end and ordained minister, on his views of race and gays made during his speech to the Wisconsin Legislature only served to make minorities more vulnerable to discrimination and ridicule from racists within and outside of this country ("White's talk sinks TV job bid," Sports, Friday).

Celebrity status is a privilege, not a right. High-profile individuals should recognize the heightened impact and consequences of their words, actions and deeds — particularly on the minds of impressionable children.

White simply chose to bring no honor to himself or his community by abusing his status to degrade and disrespect others. It is no small wonder that his careless words were received as offensive and caused Assembly Minority Leader Walter Kunicki to be at a loss for words.

Renee C. Gee
Florissant, Mo.

Thank you, Reggie

I haven't read or heard the entire speech made by Reggie White, but judging from the USA TODAY article, I must say "kudos" to Reggie for his personal interpretation of what he believes creates an image of God.

So what if he believes that homosexuality is a choice? So do many other Americans, including me. The days of homosexuals remaining "in the closet" out of fear of reprisal have been replaced with today's homosexuals flaunting their "choice" and demanding special treatment. In fact, it is now those who believe homosexuality is immoral and sinful who must keep their mouths closed or be branded homophobic.

The acceptance in our society of this behavior is just one more step down the ladder of moral decay. Also, to those who scream that Reggie is stereotyping different races, you're wrong. He's just pointing out certain strengths that different races seem to invariably possess. Reggie, thank you for speaking out on what you believe.

Matt Inman
Indianapolis, Ind.

What about free speech?

As I read the comments by Reggie White and the reactions to his speech, I



Victorious: In less controversial gesture, Green Bay's Reggie White, No. 92, leads prayer after 1997 Super Bowl victory.

couldn't help but shake my head and wonder how much further down we're going to go as a nation. Never before in the history of this country has its people been more hypersensitive and permissive than they are now.

These days, a person can't even comment on the obvious strengths and gifts of a particular race, sex or other group of people without someone taking offense. Must we qualify everything we say these days to make sure that no one is going to assume the worst and get their feelings hurt?

Finally, I know this isn't a popular opinion, but there is no scientific evidence that proves homosexuality is genetic like race is. It's just politically correct to espouse that belief. However, the last time I checked, it was still OK to have a differing opinion than even the majority of society in this country. That is, unless the destruction of moral backbone in this country has eroded that principle as well.

Bryan McLaughlin
Nashville, Tenn.

No common sense

After hearing Green Bay Packer Reggie White's speech to the Wisconsin Legislature, I'm convinced his brain cell is going to die a lonely death.

Mike Roeder
Madison, Wis.

of interest during in-school periods and the deductibility of interest from taxes is taken into consideration. Guaranteed loans are a good deal for both students and taxpayers.

Joe Belew, president
Consumer Bankers Association
Arlington, Va.

Give me 'real' country music

To Johnny Cash, bravo! It's about time someone fought the decline of country music into pop driven with a Southern accent ("Land of radio: Music that listeners don't want isn't played," Letters, Friday).

I used to be a faithful listener to country radio, but no more. Ever since the ascension of what I call the "beardless boy wonders" in country, the love of the music that made artists like Johnny Cash and Hank Williams Jr. so talented has disappeared, replaced by marketing to "Debbie," the target audience model that was mentioned in your newspaper in an article on country music marketing a few months ago.

The authentic musician has been re-

placed by the parody.

Most of today's artists are so interchangeable that you can't even tell them apart. There are a few exceptions, such as Travis Tritt, but most of today's "country" just leaves me cold.

Johnny, you may not get as much airplay as you used to, but you still have a lot of fans.

Darrin Ziliak
Evansville, Ind.

To comment . . .

We welcome your comments on editorials, columns, other topics in USA TODAY or on any subjects important to you. Only letters that include name, address and day and evening phone numbers, and that are verified by USA TODAY, can be considered for publication. Send e-mail to editor@usatoday.com. Fax 703-247-3108. Mail Letters to the Editor to 1000 Wilson Blvd., Arlington, Va. 22209. Letters and articles submitted to USA TODAY may be published or distributed in print, electronic or other forms.

"Assisted Suicide Funding Restriction Act of 1997"

- The Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12 (April 30, 1997), bans the use of federal funds to pay for or promote assisted suicide. The central restriction in the Act is phrased in the following terms: "[N]o funds appropriated by Congress for the purpose of paying (directly or indirectly) for the provision of health care services may be used" (1) to provide, (2) to pay for, or (3) to pay for health benefit coverage including, any "item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing." Sec. 3(a).
- The only provision of the Act that restricts the actual furnishing of services (as distinguished from funding) is applicable only to federal employees and to services provided in federal facilities. That provision states that "no such item or service may be furnished for the purpose of causing" death by assisted suicide, and applies to items and services furnished (1) "by or in a health care facility owned or operated by the Federal government," or (2) "by any physician or other individual employed by the Federal government to provide health care services within the scope of the physician's or individual's employment." Sec. 3(c).
- Nothing in the Act authorizes the federal government to take adverse action against a private physician for assisting in a suicide in a non-federal facility.

* WIDESPREAD PROMOTION ? — MONETARY RETURN FOR CLINIC.

* APPROVED USE VS. NOT APPROVED USE

* MISBRANDING THEORY (REJECTED IN 5TH CIRCUIT)

* ASSOCIATE PROHIBITED ACTS SECTION

↳ CRIME TO MISBRAND OR ENTER INTO
INTERSTATE COMMERCE FOR NON-APPROVED USE.

LETHAL INJECTIONS

ABORTION

MEDICAL
MARIJUANA

"Assisted Suicide Funding Restriction Act of 1997"

- The Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12 (April 30, 1997), bans the use of federal funds to pay for or promote assisted suicide.
- The Act does not have any effect on the Controlled Substances Act (CSA), and nothing in the Act is inconsistent with the conclusion that the CSA was not intended to authorize DEA to take adverse action against a physician who assists in a suicide in compliance with state law.
- Congress found in section 2(a)(3) of the Act: "Because of recent legal developments, it may become lawful in areas of the United States to furnish services in support of such activities [assisted suicide, euthanasia, and mercy killing]."
- In his signing statement, President Clinton stated: "The restrictions on the use of funds contained in [section 5(a)(3)], properly construed, will allow the Federal Government to speak with a clear voice in opposing these practices." 1997 U.S.C.C.A.N. 58 (April 30, 1997). He was addressing a portion of the Act ensuring that federal funds "not be used to subsidize legal assistance or other forms of advocacy in support of legal protection for assisted suicide, euthanasia, or mercy killing." Id. He proceeded to emphasize that the First Amendment required a narrow construction of this provision as covering only activities with the purpose of advocating assisted suicide, and not those providing "forums for the free exchange of ideas." Id.
- Nothing in President Clinton's signing statement is inconsistent with the conclusion that the CSA was not intended to authorize DEA to take adverse action against a physician who assists in a suicide in compliance with state law, or with the conclusion that such adverse action is unwarranted for reasons unrelated to opposition to assisted suicide (such as federalism concerns).

Oregon Initiative Procedure

- The Oregon Constitution provides that "[t]he people reserve to themselves the initiative power, which is to propose laws . . . and enact or reject them at an election independently of the Legislative Assembly." Or. Const. art. IV, § 1(2)(a). The Oregon Death With Dignity Act was enacted through the initiative process.
- The legislature apparently has the authority to repeal an act passed by initiative just as it can repeal an act passed by the legislature itself. Although neither the Constitution nor statutes specifically address repeal of initiatives, the Oregon Supreme Court has stated that "the Legislative Assembly, when convened, may amend or repeal a law passed by the people." State ex rel. Carson v. Kozier, 270 P. 513, 514 (Or. 1928).
- However, the Oregon legislature apparently has never repealed an initiative. Out of 99 voter-approved initiatives since 1904, the Secretary of State reports that none has been repealed by the legislature. Portland Oregonian, March 1, 1997, p. D1. "Many legislators consider it heresy to override the will of the people." Id.
- After efforts in the legislature to repeal Oregon's Death With Dignity Act failed last year, an initiative to repeal the Act was placed before voters. Voters rejected the repeal initiative on November 4, 1997.

DRAFT

FDA TALKING POINTS ON PHYSICIAN ASSISTED SUICIDE

- The FDCA prohibits causing the introduction or delivery for introduction into interstate commerce of any new drug for which the necessary FDA approval has not been obtained. While each time an FDA-approved drug is promoted for an unapproved purpose, it becomes an unapproved new drug for that purpose, we know that physicians do prescribe approved drugs "off-label."
- FDA generally relies on States to regulate physicians who prescribe approved drugs for off-label uses. FDA has only very rarely brought enforcement actions against physicians, and, in fact, there is legislative history to the effect that the FDCA is not intended--at least not directly--to regulate the practice of medicine.
- The suits brought by FDA have almost exclusively involved physicians who have promoted, sold, or distributed, with a sufficient interstate nexus, drugs or devices that are unapproved for any purpose--not physicians engaged in the ordinary practice of medicine who merely recommend or prescribe a particular approved drug for an unapproved use.
- FDA has only very rarely attempted to bring an enforcement action against a physician who was prescribing approved drugs off-label, and those few cases have involved physicians who were widely promoting the off-label use.
- Regulating physician conduct in assisted suicide in a State that permits the practice would be an inappropriate use of the Agency's authority. FDA's core function is the public health mission of regulating foods and medical products. The current debate about the morality of physician-assisted suicide is not an issue that can be resolved by science or according to ordinary public health principles.
- FDA's decision not to act against States' use of drugs for lethal injection--a similarly morally contentious issue--has been upheld by the Supreme Court.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Food and Drug Administration
Rockville MD 20857

JAN - 7 1998

The Honorable Tom Bliley
Chairman, Committee on Commerce
House of Representatives
Washington, D.C. 20515-6115

Dear Mr. Chairman:

This is in response to your letter of September 19, 1997 requesting the Food and Drug Administration's (FDA) views regarding use of a controlled substance in assisted suicide and supersedes our prior letter to you dated October 29, 1997. You asked for FDA views on whether delivering, distributing, dispensing, prescribing, filling a prescription, or administering a controlled substance with the deliberate intent of assisting in a suicide would violate the Federal Food, Drug, and Cosmetic (FDC) Act, applicable regulations, or other Federal law subject to FDA enforcement.

In order to market a new drug, a sponsor must demonstrate (generally through a new drug application) that the product is safe and effective for its intended uses. See, §§ 201(p), 505, FDC Act. The intended uses for which a drug has been determined to be safe and effective (approved uses) appear in the product's package insert (the approved labeling). Approved drugs may only be labeled and promoted for their approved uses.

Numerous prescription drugs approved by FDA potentially could be considered not safe and effective, or potentially could endanger human life, if these drugs are used for purposes other than the specific uses approved by FDA (off-label uses) or not used in the manner described in the approved labeling. While an argument could be made that off-label uses of prescription drugs for physician-assisted suicide would violate the FDC Act, physician off-label uses generally are regulated by individual state licensing boards and authorities. We believe that regulating drugs for physician-assisted suicide through FDC Act enforcement actions also would be inappropriate in the context of current state regulation and the national debate over this practice.

We hope this information is helpful. If we may be of any further assistance, please let us know.

Sincerely,

Diane E. Thompson
Diane E. Thompson
Associate Commissioner
for Legislative Affairs

Page 2 - The Honorable Tom Bliley

cc: The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

OCT 29 1997

Food and Drug Administration
Rockville MD 20857

The Honorable Thomas J. Bliley, Jr.
Chairman, Committee on Commerce
House of Representatives
Washington, D.C. 20515-6115

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Diane E. Thompson
Associate Commissioner
for Legislative Affairs

cc: The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce

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**U.S. House of Representatives
 Committee on Commerce**

Room 2125, Rayburn House Office Building
 Washington, DC 20515-6115

September 19, 1997

JAMES E. DERDERIAN, CHIEF OF STAFF

Michael A. Friedman, M.D.
 Lead Deputy Commissioner
 Food and Drug Administration
 5600 Fishers Lane
 Rockville, MD 20857

Dear Dr. Friedman:

As Chairman of the House Commerce Committee, I write seeking the Food and Drug Administration's view as to whether delivering, distributing, dispensing, prescribing, filling a prescription, or administering a controlled substance with the deliberate intent of assisting in a suicide would violate the Federal Food, Drug, and Cosmetic Act, applicable regulations, rulings, or other federal law subject to FDA enforcement, notwithstanding the enactment of a State law such as Oregon's Measure 16 rescinding State penalties against such prescriptions for patients with a life expectancy of less than six months.

Drugs used to assist in a suicide include such controlled substances as amobarbital, codeine, diazepam, flurazepam, glutethimide, chloral hydrate, hydromorphone, meprobamate, methyprylon, meperidine, methadone, morphine, phenobarbital, secobarbital, and pentobarbital. This list has been derived from Derek Humphrey's *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* (Hemlock Society 1991), at 117-120.

Interpretations of other agencies suggest that assisted suicide is not a legitimate medical practice within the meaning of federal law. The Health Care Financing Administration, for example, has written that physician-assisted suicide is not "reasonable and necessary" to the diagnosis and treatment of disease or injury and is therefore barred from reimbursement under Medicare. (See enclosed letter of May 1, 1996 from Debbie I. Chang, Director of HCFA's Office of Legislative and Inter-Governmental Affairs.) In addition, under existing regulations of the Drug Enforcement Administration, a lawful prescription for a controlled substance "must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 C.F.R. § 1306.04.

Michael A. Friedman, J.
September 19, 1997
Page 2 of 2

The American Medical Association, the American Nurses Association, the American Psychiatric Association, and at least 43 other national specialty and State medical societies have condemned assisted suicide, stating that it has "[l]ong [been] viewed as outside the realm of legitimate health care" and is "fundamentally incompatible with the physician's role as a healer...." [See Briefs Amici of the American Medical Association, *et al.*, at 4-5, in *Washington v. Glucksberg*, No. 96-110 (U.S.) and *Vacco v. Quill*, No. 95-1858 (U.S.), citing Code of Medical Ethics, § 2.211 (App. 11a).]

In my view, the prescription and use of drugs deliberately to assist a person to commit suicide cannot be consistent with FDA standards regarding "health," "legitimate medical use," and "safe and effective use" of drugs [*e.g.*, 21 U.S.C. §§301 (U), 353 (b)(1)(B), 355; 21 C.F.R. §§312.22(a), 312.2(b)(iii)] especially when the practice of assisted suicide is not reasonable and necessary to the diagnosis and treatment of disease and injury, legitimate health care, or compatible with the physician's role as healer. Past FDA action as upheld by the United States Supreme Court indicated that the agency's interest in ensuring that drugs are "safe and effective" and do not endanger human life is no less compelling in the case of patients with life-endangering illnesses. [*United States v. Rutherford*, 442 U.S. 544 (1979).]

As you know, this is an area of special interest to the Congress. On March 20, the Committee that I chair, by a 45-to-2 vote, approved legislation (H.R. 1003) to prohibit any use of federal funds, programs or facilities to perform or advocate assisted suicide. The bill was approved by the full House of Representatives on April 10 by a vote of 398-to-16, passed by the Senate on April 16 by a vote of 99-to-0, and signed by the President on April 30. Clearly, Congress would have serious concerns were any federal agency to construe the intentional prescribing of lethal drugs for suicide as a legitimate medical practice. Therefore, I would be grateful for your prompt response.

Sincerely,


Tom Bliley
Chairman



DEPARTMENT OF HEALTH & HUMAN

MAY 1 - 1998

Mr. John Neithercut
32 Leighton St.
Fitchburg, MA 10420

Dear Mr. Neithercut:

Rep. John Olver has referred your letter on recent Administration and Congressional proposals to restructure the Medicare program to my office for a response. In your letter you express opposition to Medicare paying for physician assisted suicide. You also asked Mr. Olver to vote in favor of changes to Medicare that would allow Medicare beneficiaries "to add their own money to be able to get unmanaged fee for service plans under MedicarePlus". We refer to such plans as "private fee for service plans".

In regard to your first issue, in general, the Medicare statute limits Medicare coverage to items and services that "are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Physician assisted suicide, even if allowed under state law, does not meet these statutory criteria. As such, the program is prohibited from making payment for it. Further, there is no provision in the President's balanced budget proposal to change Medicare so that it would cover physician-assisted suicide, either under the fee for service program or through a contracting managed care plan.

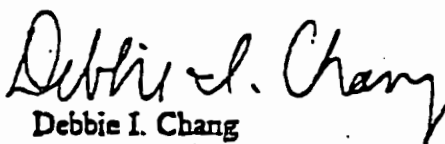
In regard to your second concern, the President has been clear that he does not support private fee for service plans as an option for Medicare beneficiaries because such an option could hurt many beneficiaries while helping none. The rationale for the President's position is as follows:

- o Currently, the law places limits on what doctors, hospitals and others can charge either the Medicare program or Medicare beneficiaries. For instance, if the Medicare approved charge for a physician visit is \$100, the beneficiary's share of the cost is limited to somewhere between \$20 and \$35 (depending on whether or not the doctor is a Medicare "participating physician"). Physicians are prohibited from billing for more than the "limiting charge" which is 115 percent of the Medicare payment amount.
- o Similarly, when a beneficiary goes to the hospital, whether the hospital charges \$5,000 or \$10,000 for the stay, the hospital can charge the beneficiary only certain established deductible and coinsurance amounts and it must accept Medicare's payment as payment in full.

- o However, under the Congressional plan, there are no provisions limiting what physicians and hospitals can charge enrollees of private fee for service plans. Therefore, beneficiaries enrolled in such plans would potentially face enormous additional charges. For instance, if a hospital charged \$10,000 and the private fee for service plan paid \$6,000, the beneficiary would be liable for the other \$4,000. Or if a surgeon charged \$5,000 for an operation and the private fee for service plan paid \$3,000, the beneficiary would be liable for the remaining \$2,000.
- o Given the ability to obtain extra revenue from beneficiaries in private fee-for-service plans, doctors and hospitals could decide they will only serve beneficiaries who choose their Medicare coverage through such plans. In other words, they would no longer serve beneficiaries who chose fee for service Medicare. This would mean that beneficiaries would face significantly higher costs for the same level of care that they receive today.

Thank you for sharing your concerns on the matters of physician assisted suicide and the availability of private fee-for-service plans in Medicare.

Sincerely yours,



Debbie I. Chang
Director

Office of Legislative and Inter-Governmental Affairs

**THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES**

**ISSUES TO BE ADDRESSED BY A PRESIDENTIAL ADVISORY TASK
FORCE ON END-OF-LIFE CARE**

- 1) What concrete actions can the federal government take to eliminate barriers to appropriate pain relief, provided that those actions are consistent with the President' opposition to assisted suicide?
- 2) What concrete actions can state governments take to eliminate barriers to appropriate pain relief, provided that those actions are consistent with the President's opposition ot assisted suicide?
- 3) What constructive steps can be taken by federal and state governments to encourage the medical education community to correct perceived deficiencies in education on end-of-life care?
- 4) What constructive steps can be taken by federal and state governments to make hospice and other forms of quality end-of-life care more readily available to those at the end of life?

THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

February 6, 1998

President William J. Clinton
The White House
Washington, DC 20500

Dear Mr. President:



On behalf of more than 1,200 Catholic-sponsored facilities and organizations nationwide that make up the membership of the Catholic Health Association of the United States (CHA), I write with regard to the critical issues surrounding the protection of life and the provision of pain relief for those nearing the end of life.

I am writing specifically to urge you to: 1) support the Drug Enforcement Agency's (DEA) recent legal interpretation of the Controlled Substances Act regarding physician-assisted suicide; 2) encourage you to issue enforcement guidelines to the DEA urging it to be sensitive to the legitimate concern that overly aggressive or misguided enforcement could have a chilling effect on pain relief for persons at the end of life; and 3) appoint a task force to make concrete recommendations on how to reduce legal and regulatory barriers to *appropriate* pain relief for dying persons.

First, CHA strongly supports DEA's declaration that "delivering, dispensing or prescribing a controlled substance with the intent of assisting a suicide would not be under any current definition a legitimate medical purpose." The religious beliefs and values upon which both CHA and its member hospitals and long-term care facilities are founded compel us to reject assisted suicide. More generally, this practice is radically inconsistent with proper regard for the dignity of human life and irreconcilably incompatible with the appropriate ends of medicine.

The DEA's legal interpretation is completely consistent with your support for the Assisted Suicide Funding Restriction Act passed last year. In that legislation, you supported the proposition that no federal funds, programs, or health facilities should be used to further assisted suicide. Thus, from the federal government's perspective, assisting in a suicide is not a legitimate medical practice. Consistency demands that you support the legal interpretation provided by the administrator of the DEA.

Second, your support for a consistent legal interpretation does not mean that you cannot take ameliorative steps with regard to enforcement. CHA is acutely aware that the DEA's correct, legal interpretation, if not carefully implemented, may *unintentionally* have a chilling effect on physicians who prescribe, dispense, and administer appropriate and effective amounts of

NATIONAL HEADQUARTERS
4455 Woodson Road
St. Louis MO 63134-3797
Phone 314-427-2500
Fax 314-427-0029

morphine and other opioids in treating pain as death approaches. Certainly, a physician would have reason for serious concern if the DEA routinely second-guesses his or her dosages to a dying person to determine if they violate the Controlled Substances Act. In a recent study, the Institute of Medicine (IOM) found that physicians have significant apprehension about legal sanctions related to addiction and anti-addiction regulations.

Therefore, when announcing your support for DEA's interpretation, CHA urges you to issue an enforcement directive to the agency concerning your expectations with regard to its agents' enforcement of the law. Specifically, the DEA must be aware of, and sensitive to, the impact that its investigation may have on the dispensing of needed pain relief medication to dying persons. The DEA should be aware that it is *not* a violation of the Controlled Substances Act to dispense controlled substances for the legitimate medical purpose of relieving pain, even if they may indirectly shorten the person's life. This essential distinction is codified in the Assisted Suicide Funding Restriction Act itself and was affirmed by the U.S. Supreme Court when it upheld laws prohibiting assisted suicide last June.

The DEA should initiate investigations or enforcement actions only when their agents have credible and substantive allegations that health care providers have established a pattern or practice of prescribing or dispensing controlled substances to persons for the purpose of helping them to take their lives. It is not, nor should it be, a DEA priority to expend significant resources second-guessing the opinions of health care providers about the controlled substances needed to adequately and appropriately relieve the pain of dying persons.

Third, CHA asks that you form a federal/state advisory task force to make concrete recommendations to you and to the 50 governors on how to reduce legislative and regulatory barriers to pain relief. A 1997 Institute of Medicine Study, *Approaching Death: Improving Care at the End of Life*, states the concern succinctly:

Outdated and scientifically flawed drug-prescribing laws, regulations, and interpretations by state medical boards continue to frustrate and intimidate physicians who wish to relieve their patient's pain. Addiction to opioids appropriately prescribed to relieve pain and other symptoms is virtually non-existent, whereas underuse of these medications is a well-documented problem (pp 5&6).

Specifically, the IOM identifies, among others, triplicate prescription laws, limits on the number of medication dosages that may be prescribed at one time, medical board policies, and state anti-addiction laws as barriers to effective pain relief.

CHA recognizes the critical need to address illegal drug use and diversion. Yet, as the IOM points out, there is little evidence that the prescription of opioids in the care of dying persons contributes in any meaningful way to illegal drug use and drug diversion problems. It is both counterintuitive and counterproductive if drug control laws tragically result in the increasing reluctance of physicians and other health professionals to treat dying persons by seeking to alleviate their pain. Dying persons should not be held hostage by regulations that, while rightly motivated, can cause great suffering and distress for them and their families.

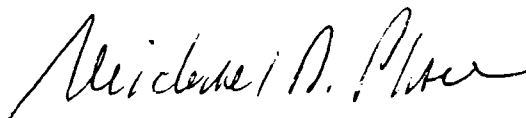
CHA and its member facilities and organizations are committed to provide dying persons and their families both competent and compassionate care. Toward that end several Catholic health systems and CHA have joined together in a collaborative effort, *Supportive Care of the Dying: A Coalition for Compassionate Care*. One specific goal of this project is to ensure that adequate and effective pain management is available to every person living with life-threatening illness so that they may live well even while dying.

Mr. President, concrete recommendations for reform by a federal/state task force on these issues will allow you to suggest legitimate steps to improve pain relief for dying persons. In this way, you can continue your consistent support for the principle that assisting in a suicide is not a legitimate medical purpose and, at the same time, suggest appropriate and necessary public policy mechanisms to improve pain relief for dying persons.

In conclusion, CHA urges you to remain consistent on the federal government's treatment of assisted suicide while exploring all available and legitimate methods for improving pain relief for those in the last stages of life.

With personal best wishes, I am

Sincerely,

A handwritten signature in cursive script, appearing to read "Michael D. Place".

Rev. Michael D. Place, STD
President

cc: Attorney General Janet Reno

LEGISLATIVE HISTORY OF FEDERAL DRUG LAW SUPPORTS AUTHORITY TO ACT AGAINST PHYSICIAN-ASSISTED SUICIDE

The Controlled Substances Act of 1970 was amended in 1984 to strengthen the Drug Enforcement Administration's ability to prevent diversion of federally regulated prescription drugs for illicit purposes. The amendments were approved by the U.S. Senate 91-to-1 on February 2, 1984 as part of a Comprehensive Crime Control Act (S. 1762). Almost identical language was approved by the House 392-to-1 as a free-standing "Dangerous Drug Diversion Control Act of 1984" (H.R. 5656) on September 18, 1984. The House and Senate versions were reconciled and ultimately approved as part of H.J. Res. 648, a continuing resolution which became law on October 12, 1984 (P.L. 98-473).

This legislative background helps answer some questions raised about the federal government's authority to apply this federal law against physicians who prescribe controlled substances to assist suicides:

Was the federal law directed primarily against street drugs like heroin and cocaine?

No, the 1984 amendments were directed specifically against the misuse or "diversion" of federally regulated prescription drugs which have a legitimate medical use. The prime House sponsor said these had become a more serious problem in some ways than street drugs but had "failed to get the societal or the enforcement attention that it deserves" (Rep. Hughes, Cong. Record, 9/18/84, H9679).

Was the law directed against physicians?

Yes, though not exclusively. "The bill gives to DEA greater latitude to suspend or revoke the registration of a practitioner who dispenses drugs in a manner that threatens the public health and safety" (Id.). As the chairman of the House Commerce Subcommittee on Health and the Environment said at the subcommittee hearing on this bill: "Today's pusher is not always a back alley salesman. He or she may well be a highly educated health professional" (Rep. Waxman, Hearing of July 31, 1984, Hearing Record No. 98-168, p. 365). There were also provisions directed at manufacturers and pharmacists.

Was the law directed against addiction, or against the use of drugs to cause death?

The chief concern cited was their potential to cause physical harm and death. Sponsors cited a government study indicating that "prescription drugs are responsible for close to 70 percent of the *deaths* and injuries due to drug abuse" (Rep. Hughes, Cong. Record, 9/18/84, H9679). The chairman of the Health subcommittee in the House agreed: "Drugs legally manufactured for use in medicine are responsible for a substantial majority of *drug-related deaths* and injuries" (Rep. Waxman, Hearing Record No. 98-168, op. cit., p. 365). One sponsor used the example of an

opiate widely used as a pain-killer, saying: "Because these pills have an even greater potential for *physical injury and danger*, they involve more than half of the hospital entries for illegal use and *overdose* of drugs" (Rep. Sawyer, Cong. Record, 9/18/84, H9680).

Was the law designed to defer to states' judgments on the proper medical use of drugs?

On the contrary: It was designed to give the DEA more independent authority to revoke a physician's registration in cases where a state *refused* to intervene. The 1984 amendments authorized the DEA to revoke a physician's registration if it deems that registration to be "inconsistent with the public interest" (in cases where, for example, revoking registration will serve "public health and safety"). As Rep. Charles Rangel said in support of the amendments: "Under current law, the DEA must register physicians, pharmacies, or other practitioners if they are authorized to dispense drugs by the law of the State in which they practice.... The public interest standard added by H.R. 5656 will provide greater flexibility to deny or revoke registrations in the most egregious cases" (Cong. Record, 9/18/84, H9682). (When a law is enacted to prevent prescription drugs from being used for lethal overdoses, there is nothing more egregious than a physician who *intentionally* dispenses drugs for such overdoses.) Prime Senate sponsor Strom Thurmond spoke similarly, saying that this provision "expands the standards for practitioner registration beyond the current exclusive reliance upon authorization by the practitioner's own jurisdiction" (Cong. Record, 2/2/84, S758). Sponsors said giving such flexibility to the federal government was necessary because states often did not respond adequately to these abuses: "State policing of these activities, as well as peer review within the profession, have not been adequate control measures. State laws regarding the dispensing of controlled substances are also inadequate" (Rep. Fish, Cong. Record, 9/18/84, H9680). At a hearing before the House Commerce Subcommittee on Health and the Environment, the DEA called the expanded federal authority to revoke practitioner registration "one of the most important sections of the bill," not only because states were often ill-equipped to enforce their own drug laws but also because "many controlled drug violations involving prescription drugs *are not felonies under state law* and therefore cannot be used in a DEA revocation action" under then-existing law (Testimony of Gene R. Haislip, Deputy Assistant Administrator, Drug Enforcement Administration, Hearing Record No. 98-168, p. 404). Congress's view was that while the states are the first line of defense against misuse of prescription drugs, the federal government must enforce its own objective standard as to what constitutes such misuse -- and it must have the authority to enforce that standard when a state cannot or will not do so.

In light of this history, it cannot be maintained that the Controlled Substances Act as it exists today was directed only against professional drug traffickers rather than physicians, or only against addiction rather than lethal drug overdoses, or only against physicians who violate state laws. Independent federal authority to enforce federal drug standards was intended to apply to "Schedule II" prescription drugs like barbiturates or morphine as much as to "Schedule I" drugs like marijuana or cocaine -- most especially when such drugs are being used to cause death.

Legal Issues

The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.

Cruzan v. Director, Missouri Department of Health, 497 US 261, 278 (1990)

A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions.

Justice Sandra Day O'Connor, concurring opinion in *Cruzan*, 497 US at 28

The roles of judges, legislators, and administrative officials in influencing care at the end of life vary from the dramatic to the commonplace. On the dramatic end of the continuum are the court cases about the legality of physician-assisted suicide, which were argued before the U.S. Supreme Court as this report was being drafted. In contrast, the right of people to refuse unwanted life-sustaining and other treatments—once the subject of highly charged court cases—is now commonly accepted and enforced (if not always perfectly).

Documenting the impact of statutes, regulations, case law, and administrative actions on clinicians, patients, families, and others can be difficult. In addition, the applicability of various statutes and judicial precedents to specific patient circumstances is quite often a matter of dispute and speculation rather than straightforward matching of law to facts. Nonetheless, in the committee's view, the legal issues discussed here raise concerns either about their possible effects on compassionate and effective care for those approaching death or about the unrealistic expectations they may create or both.

This chapter considers laws relating to prescription of opioids, informed consent and advance directives, and assisted suicide. Among those with clinical, administrative, or similar involvement in end-of-life care, much of the debate about issues such as prescription regulation or informed consent is practical. For example, how can prescription laws be modified so that they do not discourage effective pain management but still respond to legitimate concerns about misuse of controlled substances? For some issues, most notably assisted suicide and euthanasia, ethical concerns may dominate legal discussions, but practical issues also arise as described later in this chapter. The focus here is primarily on how laws may affect the quality of care for dying patients.

Although the impact of malpractice litigation on medical practice is a complex and disputed question, it is discussed only briefly because the committee did not view the prospect of malpractice litigation as likely to have a significant impact on end-of-life care specifically. The committee, however, recognized concerns that physicians may engage in defensive medicine (e.g., ordering extra tests, prescribing unnecessary medications, performing hopeless CPR) because they fear being sued for a bad outcome that plaintiffs might attempt to attribute to lack of a test or procedure. Similarly, decisions might sometimes be influenced by the fear of being sued for not following a family's wishes, even if those wishes were contrary to the doctor's clinical judgment and the patient's own wishes. The committee did not find evidence that physicians were concerned about liability for failure to intervene to relieve pain or other symptoms.

In any case, many of the steps proposed in this report would tackle problems of undertreatment, overtreatment, or mistreatment of dying patients in ways that should reduce the potential for litigation and physician uncertainties and fears about being sued. At the practitioner level, these steps include changing clinicians' attitudes, knowledge, and practices so that they communicate more effectively with patients and families, engage patients and families in a process of goal setting and decisionmaking that increases trust and minimizes misunderstanding, and properly assess and treat pain and other symptoms. At the system level, they include strategies for measuring, monitoring, and improving care that seek to identify and respond to the preferences, experiences, and feelings of patients and families. If, however, these strategies fail to correct the deficits identified in Chapter 3 and if patients come to understand that the standards of care (e.g., practice guidelines) call for efforts to relieve symptoms, then litigation stemming from inattention to symptom management might become more likely—but not necessarily productive. The primary injured plaintiff would, in the case of a dying patient, likely have died, and although a family could claim injury and testify about the decedent's suffering, damages would be hard to establish. In addition, the status of practice guidelines in the courts

is still evolving. Overall, the committee was doubtful that malpractice litigation could be relied upon as an instrument to improve care at the end of life.

PREScription LAWS AND BARRIERS TO PAIN RELIEF

All patients who suffer pain—not just the dying—deserve relief through treatments that are known to be effective for most pain. Indeed, early treatment of pain as a part of a continuum of good care for those who are seriously ill may be the best approach to minimizing pain at the end of life. Other parts of this report document deficiencies in pain management and gaps in scientific knowledge. This section examines how effective pain management may be compromised by prescription drug laws that are intended to minimize drug addiction and diversion of drugs from legal to illegal sources. (Relief of dyspnea may also be affected by these laws, although this has not been the subject of much attention.) Because these laws both arise from and interact with the misperceptions and attitudes of physicians, medical boards, lawmakers, patients, and the public, reform needs to go beyond revisions in written policies to affect knowledge and values.

Anti-Diversion Policies

The Problem of Diversion and Regulatory Responses

Diversion occurs when persons with legal access to controlled substances distribute them or use them for illegal purposes or when people fraudulently obtain drugs from legal sources (Cooper et al., 1992; Cooper et al., 1993).¹ Pain relief medication, for example, might be prescribed to phony patients and then sold on the streets. Alternatively, people might forge prescriptions or misrepresent their symptoms to secure prescriptions. Newspaper articles and television news reports periodically expose the problems of diverted opioids and clinician addiction. No reliable studies document the extent of opioid diversion specifically or compare it to other illegal sources (e.g., illegal imports and domestic production). A 1990 household survey estimated that 4 percent of the population over the age of 12 had used prescription analgesics, stimulants, tranquilizers, or sedatives at least once for nonmedical reasons in the preceding year, and almost 1.5 percent were currently using them (NIDA, 1991). A California estimate puts the

¹Theft and other forms of illegal access are also problems but are less susceptible to control through anti-diversion regulations.

dollar value of diverted controlled substances during the mid-1980s at somewhere between \$500 million and \$1 billion (Marcus, 1996).

Legal and regulatory policies intended to prevent diversion include triplicate prescriptions and limits on the number of medication dosages that may be prescribed at any one time. These policies are burdensome and appear to deter legitimate prescribing of opioids (see, e.g., Cooper et al., 1992; IOM, 1995a, 1996d; Joranson, 1995a). Triplicate prescription programs require the prescribing physician to complete detailed, multiple-copy prescription forms. The forms themselves are often difficult to obtain and, if incorrectly filled out, must be completed again by the physician. The triplicate forms also become available to the state medical board, which may choose to pursue disciplinary measures on the basis of such information. Electronic forms and monitoring systems would ease the burden on physicians as well as allow easier monitoring but such systems have not been widely adopted or rigorously evaluated nor have appropriate norms to guide such oversight been developed and tested.

Some states have laws limiting the dosages a physician may prescribe to one patient at any given time. These laws force patients who suffer pain that requires frequent medication to request and renew prescriptions repeatedly. This not only inconveniences both patients and physicians but may subject patients to possible interruptions in pain management if something disrupts the timely requests and responses. Such problems are a special concern for patients who are not in a medical facility but are at home or in a care facility without an on-site physician.

The committee recognizes the problems created by illegal drug use and drug diversion and the need for law enforcement responses. It, however, knows of no evidence, anecdote, or other reason to believe that the prescription of opioids in the care of dying patients contributes in any meaningful way to drug diversion problems.

Effects on Care at the End of Life

The effect of anti-diversion policies on their intended targets is unclear. They do, however, appear to affect the rate of prescriptions and perhaps increase the use of less effective or even harmful medications (Cooper et al., 1993; Joranson and Gilson, 1994a, b; IOM, 1995a, 1996d). One study reported that when Texas introduced a multiple-copy prescription program, prescriptions for opioids to control pain were halved (Sigler et al., 1984). It is not known whether this dramatic drop resulted from declines in inappropriate prescribing and diversion or whether physicians and pharmacists became reluctant to prescribe appropriate medications. Nonetheless, the magnitude of the change makes it reasonable to expect that the regulation had some impact on patient care (Von Roenn et al., 1993; Wastila and

Bishop, 1996). Surveys of physicians—discussed further below—suggest that anti-diversion and anti-addiction policies combined with social antipathy toward real or imagined addiction discourages effective, appropriate, and legal pain prevention and management.

Options for Improvement

How can laws be constructed and interpreted in ways that minimize drug diversion without obstructing effective medical management of pain? Options include (1) replacing triplicate forms with electronic reporting of prescriptions and (2) allowing standing prescriptions for outpatients (to be monitored by home health care professionals or pharmacists). In addition to reducing regulatory barriers to effective pain prescribing practices, states could require that pain experts or palliative care specialists be represented on state medical boards to help inform board policies and interpretations. Information collected from triplicate or electronic prescriptions might also be analyzed to identify questionable prescribing practices, which could be used to guide education of physicians and pharmacists about effective and appropriate use of opioids. Another IOM committee has already recommended additional research on the effects of controlled substance regulations on patient care and scientific research (IOM, 1996d).

Anti-Addiction Policies

The creation of new addictions is a separate issue from the diversion of drugs to the black market. A collection of social forces joins with legal restrictions to create a general antipathy toward drug use that flows into the area of medical practice and undermines effective pain management. Even the terminology muddies the waters when chronic use of opioids, which produces physical dependence, is sometimes equated with addiction. For example, California law defines addicts as “habitual users,” which might include patients with chronic pain who regularly and appropriately take opioids necessary to manage their pain (Marcus, 1996).

States have addressed the perceived problem of medically induced drug addiction through varied combinations of laws, regulations, and medical board disciplinary policies. Because the committee concluded that policies often reflect inadequate understanding of the mechanisms of pain and addiction, these mechanisms will be described before the policies are considered.

Mechanisms of Pain and Addiction

Efforts to devise reasonable anti-addiction policies are complicated by

ignorance and confusion about the biological and psychological mechanisms of pain management and addiction (Bruera et al., 1987; WHO, 1990; Nestler et al., 1993; Von Roenn et al., 1993; Portenoy et al., 1994; Buchan and Tolle, 1995; Joranson, 1995a; Portenoy, 1996). Research indicates that addiction in patients appropriately receiving opioids for pain is very small, ranging from roughly 1 in 1,000 to less than 1 in 10,000 (Porter and Jick, 1980; Angell, 1982; Jaffe, 1985; Rinaldi et al., 1988; Portenoy and Payne, 1992; Portenoy, 1996).

The committee concluded that drug tolerance and physical dependence should be more uniformly and clearly distinguished from addiction. *Tolerance* occurs when a constant dose of a drug produces declining effects or when a higher dose is needed to maintain an effect. *Physical dependence* on opioids is characterized by a withdrawal effect following discontinuation of a drug. Such dependence is a common effect in chronic pain management, but it is not restricted to opioids. Other agents such as beta-blockers, caffeine, and corticosteroids also produce physical dependence. Further, clinical evidence suggests that patients receiving opioids can be easily withdrawn from them in favor of an alternative, effective pain control mechanism if that is clinically indicated. Typical practice is to reduce the dose by fractions, stopping administration of opioids altogether after a week or so (Doyle et al., 1993). This practice may not be relevant, however, for dying patients.

Neither physical dependence nor tolerance should be equated with addiction or substance abuse. Portenoy and Kanner (1996) proposed that "addiction is a psychological and behavioral syndrome characterized by (1) the loss of control over drug use, (2) compulsive drug use, and (3) continued use despite harm" (p. 257). This is consistent with a definition proposed by the American Medical Association: "the compulsive use of a substance resulting in physical, psychological, or social harm to the user and continued use despite that harm" (Rinaldi et al., 1988, p. 556). The federal Controlled Substances Act defines an addict as someone who habitually uses an opioid in ways that endanger public health or safety (AHCPR, 1994a).

Unfortunately, the general term *substance dependence* is often used as a synonym for addiction, perhaps because the latter is more stigmatizing. For example, the American Psychiatric Association sets out criteria for dependence rather than addiction in its *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., 1995). Despite a disclaimer that the scheme focuses on "maladaptive" substance use, the discussion of substance dependence may nonetheless mislead (p. 181). A later disclaimer about distinguishing legitimate medical purposes from opioid dependence is not specific, given that, as described below, many seem to be confused about what is legitimate. The committee is particularly concerned about misinterpreta-

tion of criteria related to tolerance, withdrawal, and overuse. Tolerance and withdrawal are, in general, clinically acceptable (although not necessarily invariable or desirable) consequences of effective use of opioids to manage pain, and "overuse" as defined above may be difficult to distinguish from increasing use due to uncontrolled pain, which may result from increasing pathology, tolerance, or other sources (Weissman and Haddox, 1989). Similarly, some behaviors suggestive of addiction may be confused with those resulting from inadequately managed pain or anxiety about the reliability of pain management.

Regulatory Responses

Responses to the problem of addiction take several forms including some of those already identified in the discussion of drug diversion. Federal and state laws and regulations attempt to control the prescribing behavior of physicians, nurses, and pharmacists by criminalizing certain activities. In addition to legislatures and courts, state medical boards set policies that, although not having the official force of law, may be just as powerful in their effect. These policies dictate the standards by which physicians may be professionally disciplined. Laws and medical board policies are also intertwined, in that legislatures may place legal limitations on the extent of a medical board's powers.

Medical Board Policies. State medical boards may establish guidelines on pain-prescribing practices that constitute official statements of board policy. Such guidelines describe acceptable medical practice and notify health care practitioners of professional boundaries. Violating them may lead to disciplinary action. The sometimes restrictive perspective of state boards could interfere with the treatment of pain. In 1987, for instance, the Washington State Medical Disciplinary Board stated that it did "not recognize repeated prescribing of controlled drugs as appropriate therapy for chronic pain" (cited in Joranson, 1995a, pp. 2-3).

Several state medical boards have issued guidelines that deal with the use of opioids to treat intractable pain.² In California, the nursing and pharmacy boards have also created guidelines addressing the same issue (Joranson, 1995b). These guidelines are intended not only to instruct phy-

²State medical boards that have issued guidelines regarding the use of controlled substances to treat pain (along with the year in which the guidelines were first issued) include: Utah (1987), Minnesota (1988), Massachusetts (1989), Arizona (1990), Georgia (1991), Oregon (1991), Alaska (1993), Texas (1993), Wyoming (1993), Alabama (1994), California (1994), Idaho (1995), Colorado (1996), Florida (1996), Maryland (1996), Montana (1996), North Carolina (1996), and Washington (1996) (Joranson, 1997).

sicians and other caregivers on the proper use of opioids in pain management but also to reduce physicians' fear of attracting board discipline for such use. Another way for state medical boards to improve pain control might be for the boards to educate the physicians within their states about how to comply with laws, regulations, and board-set standards. Information collected from triplicate prescription forms could be used in this educational effort.

Some state boards, however, continue to require that physicians avoid the potential for addiction and that they justify the continued prescribing of opioids (Joranson, 1995b). A survey of state medical board members conducted in 1991 showed that most would discourage the use of opioids to relieve chronic, noncancer pain; a third of them said they would investigate such a prescription as a potential violation of the law (Joranson et al., 1992). There is still, it seems, an inappropriate sense of distrust on the part of the medical boards, which this committee believes has developed, in part, on the basis of misperceptions discussed above about the nature and consequences of dependence and addiction.

Laws and Regulations. In 1974, the federal government, through the Federal Intractable Pain Regulation, clarified the federal law that prohibits physicians from prescribing opioids to detoxify or maintain an opioid addiction (Code of Federal Regulations, Title 21 Part 1300). The regulation states that the prohibitive regulations are "not intended to impose any limitation on a physician . . . to administer or dispense narcotic drugs to persons with intractable pain in which no relief or cure is possible or none has been found after reasonable effort" (21 Code of Federal Regulations, Title 21 Sec. 1306.7[c]). The policies of the Drug Enforcement Administration are similarly explicit.

Even when antiaddiction laws exempt those with intractable pain, the protections generally do not extend to those already addicted (Joranson, 1995a). When these people become patients suffering intractable pain, physicians are not free to prescribe opioids to relieve their suffering. This problem becomes especially acute in the AIDS wards of many urban hospitals.

At the state level, a number of prescribing laws include provisions that could interfere with effective medical use of opioids. For example, in New Jersey, regulations call on physicians "periodically to either cease the medication or taper down the dosage . . . to reduce the addiction propensity for the patient" (Joranson, 1995a).

In 1988, the Commonwealth of Virginia passed the first state law addressing the need to treat pain in terminally ill cancer patients (Joranson, 1995a). The legislation—despite its positive provisions—also illustrated the misperceptions surrounding the treatment of pain. It allowed physicians to

prescribe heroin to their terminally ill patients even though heroin is not legally available under federal law and has no significant advantages over other available opioids (Joranson, 1995a).

Texas was the first state to pass an Intractable Pain Treatment Act, in 1989. California followed suit in 1990 and Florida in 1994 (Joranson, 1995a).³

Some state pain treatment laws, (e.g., Colorado and Washington) recognize the benefits of pain control and allow physicians to prescribe controlled substances but do not address concerns about inappropriate discipline by medical boards. The Texas and California acts do address this problem by prohibiting medical board discipline of physicians who follow the provisions within the laws. Both acts also define intractable pain (following the model of the Federal Intractable Pain Regulation⁴), authorize physicians to prescribe controlled substances to treat intractable pain, and prohibit health care facilities within the states from limiting such prescriptions. California's act requires an evaluation of the patient by a specialist.

Effects on Care at the End of Life

Surveys suggest that physician apprehension about addiction and anti-addiction regulations is widespread (Cleeland et al., 1986; Portenoy, 1990; Weissman, Joranson et al., 1991; Hill, 1993; Von Roenn et al., 1993). Such apprehension is not limited to physicians within the United States. In a survey of all the governments in the world conducted by the International Narcotics Control Board (within the United Nations International Drug Control Program), 47 percent of responding governments cited health care provider reluctance due to concerns about legal sanctions as an impediment to medical use of opioids (Joranson and Colleau, 1996).

The frequency of punitive action against physicians for apparently legitimate prescribing practices is unknown, but the committee heard many

³States with intractable pain treatment policies (along with the year in which the policy was instituted) include Virginia (1988), Texas (1989), California (1990), Colorado (1992), Washington (1993), Florida (1994), Missouri (1995), Nevada (1995), Oregon (1995), and Wisconsin (1996) (Joranson, 1997).

⁴Both statutes define intractable pain as "a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and surgeon and one or more physicians and surgeons specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain" (Code of Federal Regulations [1988] Title 21 Sec. 1306.07[c]).

anecdotes about threatening statements by medical disciplinary boards and about physicians who find the scrutiny and requirements sufficiently burdensome that they choose not to prescribe medications needed to manage pain effectively. In addition, the earlier discussion of regulations to limit drug diversion indicate that these policies may discourage the appropriate medical use of opioids and may discourage research to develop better medications.

Options for Improvement

More states could pass carefully drawn pain treatment laws. The American Medical Association (AMA) recently adopted a resolution to create a model state law, based on the Texas and California acts (AMA, 1996a). By protecting physicians from disciplinary actions, the AMA hopes to "provide patients with the security and knowledge that intractable pain resulting from terminal illness need not persist in a chronic, unrelieved manner" (AMA, 1996a, p. 4).

Although such laws constitute an important step to promote effective pain management for patients, they may not go far enough or may imply clinical clarity that does not exist. By making positive statements about the benefit of opioid use in the control of pain, legislators hope to reduce the fear of arbitrary medical board discipline. Yet they do not, in all cases, mark a clear area of medical practice in which physicians feel free to manage their patients' pain. The more specific laws, for example those that set out detailed prescription practices, may actually afford physicians less leeway in the practice of medicine. Additionally, by carving out an area of pain treatment that is immune from medical board discipline, there may be an implication that other forms of pain treatment should be subject to disciplinary review.

Even the strongest intractable pain law is still limited by the term *intractable*. Many cases are ambiguous, and physicians may believe that they must delay opioid treatment until pain is far enough along to be called intractable. An additional problem arises when state laws define addiction without regard to pain management. As noted earlier, California defines addicts as "habitual users," which might include patients taking opioids for chronic pain. Such confusing definitions once again expose physicians to the threat of medical board discipline.

Finally, the legal affirmations in these laws of the importance of pain control do not, in themselves, correct practice patterns or improve physician training. Laws could, however, encourage patients to expect diligence in pain relief, including use of generally effective medications. Medical boards could consider disciplining physicians who fail to apply proven methods of pain control.

Overall, the committee is encouraged by recent actions to revise drug prescribing. It urges continued review of restrictive state laws, revision of provisions that deter effective pain relief, and evaluation of the effect of regulatory changes on state medical board policies, physician attitudes and practices, patients, and illegal or harmful drug use.

INFORMED CONSENT AND ADVANCE CARE PLANNING

A series of legal decisions over the past three decades has affirmed the right of people to refuse unwanted medical treatments (President's Commission, 1982; Faden et al., 1986; Appelbaum et al., 1987). As stated in an important 1960 California Supreme Court case, "Anglo-American law starts with the premise of thoroughgoing self-determination," which includes the right of individuals to refuse medical treatments (*Natanson v. Kline*, 1960). This legal reasoning reinforced a shift in emphasis in medical ethics from a dominant paternalism (i.e., action in the best interest of patients as judged by physicians) toward autonomy (i.e., patients' right to choose the course they prefer) (Childress, 1982).

One means for recognizing patient autonomy in decisionmaking is informed consent, which means that patients voluntarily accept (or refuse) a medical intervention after disclosure of its expected benefits and risks and discussion of the alternatives. For dying patients who are unconscious or in such distress that they cannot reasonably communicate their wishes when a treatment decision needs to be made, the legal concept of informed consent may have limited application.

In response, the concept of *advance care planning* was devised to allow people (whether or not they are "active patients") to specify how they want to be treated should serious illness or injury leave them without the capacity to make decisions or communicate (see, e.g., President's Commission, 1982; AARP, 1986; Emanuel and Emanuel, 1989; Annas, 1991; Burt, 1994). Documents used in advance care planning, called advance directives, take several forms, including surrogate decisionmaking arrangements and what are popularly called "living wills." For purposes of this report, advance directives refer particularly to statements intended to be legally binding.⁵

As discussed in Chapter 3, advance care planning is a broader, less legally focused concept than that of advance directives. It encompasses not

⁵Guardianship involves the court appointment of a decisionmaker in cases where the patient is, for some reason, incompetent to make decisions for him or herself. A guardian is usually appointed for reasons other than health care, such as financial management. State guardianship laws vary on the power of a guardian to consent to or refuse medical treatments. The committee here limits its discussion to decisionmakers appointed by patients themselves.

only preparation of legal documents but also discussions with family members and physicians about what the future may hold for people with serious illnesses, how patients and families want their beliefs and preferences to guide decisions (including decisions should sudden and unexpected critical medical problems arise), and what steps could alleviate concerns related to finances, family matters, spiritual questions, and other issues that trouble seriously ill or dying patients and their families. Impediments to advance planning and the implementation of written directives may be less a matter of law than of ordinary inertia or unwillingness to consider unpleasant matters. The rest of this section discusses resuscitation orders, living wills, designation of surrogates, and the Patient Self-Determination Act of 1991.

Do Not Resuscitate Orders

Do not resuscitate orders or DNRs are orders placed by a physician with a patient's or surrogate's consent into the patient's treatment chart. As discussed in Chapter 2, it is not unusual for severely ill patients, who may be dying from any of a variety of diseases, to suffer cardiac or respiratory arrests. The normal action when this occurs is called a "code."⁶ DNRs, or "no-codes," inform hospital staff or other caregivers that, in the event of such an episode, no attempts at revival should be made. Even when attempted, success rates of cardiopulmonary resuscitation are often low, especially for elderly patients (Murphy et al., 1989). For that reason, DNRs are sometimes called DNARs or "Do Not Attempt to Resuscitate" orders.

Because DNRs are physicians' orders, they come out of the clinical rather than the legal tradition. They thus have more in common with orders for medication or lab tests than they do with such legal documents as living wills or durable powers of attorney. Additionally, many hospitals had DNR options in place before they were required to do so by law. DNRs might, however, have some legal significance, if courts take them into account when determining whether a patient's preferences have been followed. Also, because the decision by the physician to place the DNR in the chart should be made in consultation with the patient and should reflect a patient's decision to forego certain forms of life-prolonging treatment, DNRs share with living wills and durable powers of attorney a role in the process of advance care planning.

⁶Caregivers attempt, through the insertion of breathing tubes and a pump, or by electric shock to the heart, to revive the patient. These attempts may stabilize the patient or may result in actual damage, leaving the patient alive but in a worse condition than before the code.

Living Wills

As of 1990, 40 states and the District of Columbia allowed adults to create what is popularly called a "living will" (Strauss et al., 1990). These statutes vary in their particulars, but they generally envision that individuals may make legally binding arrangements to the effect that they shall not be sustained by medical treatment that artificially prolongs the dying process if they are in a terminal condition and can no longer make decisions.

The statutes include several safeguards against abuse. Most include a requirement that the two witnesses to the signing of the document be neither related to the patient nor involved in his or her treatment or financial support. Also, the determinations that the patient fits the statutory definition of terminal and is unable to make decisions sometimes must be made by at least two physicians. A mentally competent individual is always entitled to revoke his or her advance directive. The statutes vary on whether nutrition and hydration are considered "artificially life-sustaining" treatments. Some statutes explicitly exempt nutrition and hydration from the care a patient may choose to refuse, others give the signer the option to explicitly include them, while a third group is silent on the matter (Strauss et al., 1990).

Skeptics of living wills argue that these documents, which may be standard forms approved by the legislature of some states, provide little practical guidance in real life clinical situations, which often involve many more factors or contingencies than anticipated by standard forms (see, e.g., Brett, 1991; Lynn, 1991). Indeed, by leading patients to believe that the signing of a living will means that their preferences for an end-of-life treatment plan have been made clear, these documents could even discourage active and ongoing discussions among patients, their families, and health care professionals. In contrast, a document designating a surrogate decisionmaker could encourage such communication.

Designation of Surrogate Decisionmakers

Adults

Another legal option for advance care planning involves the designation of a surrogate to act on one's behalf in the event one becomes incompetent to make decisions about medical care. State statutes (or, in some cases, sections within the living will statutes) vary in the amount of authority a person can assign to a surrogate. For example, in California, the patient's agent, who is assigned durable power of attorney⁷ for health care.

⁷"Durable" power of attorney differs from general power of attorney in that it does not expire when the designator loses the competence to make decisions. This is integral to health

may make all health care decisions that the patient could make for himself or herself, had he or she the capacity (California Civil Code Sec. 2500). The attorney-in-fact's duty is to follow the wishes of the power's grantor, but specific instructions need not be included in the document. In contrast, Nevada and Rhode Island that require statutory forms be used (Nevada Chapter 449 Secs. 2-8; Rhode Island Sec. 23-4.10-1). Grantors of the power of attorney choose options on the form, instructing their agents when to consent to or refuse life-sustaining treatments.

In one sense, although the statutes that provide for standard forms and checked options seem more specific, they may still lead to ambiguities of definition and decision. For example, when an agent is instructed to refuse treatment when that treatment's burdens outweigh the expected benefits, it remains up to the agent (with the help of the health caregivers and others involved) to make the determination. In fact, under the broader powers available under California's statute, the grantor and the agent may be more likely to sit down together and discuss the grantor's wishes, rather than have the grantor check a box and leave it at that.

Other states place even more limits on the powers of the agent. In New York, power of attorney may not be used to delegate medical decision-making authority, only to communicate the wishes of the grantor (Strauss et al., 1990). This inflexible provision restricts people's ability to plan ahead and may prevent humane care at the end of life.⁸

Children

Decisions regarding dying children involve special considerations (Lantos and Miles, 1989; Strain, 1994; AAP, 1995; Fleischman, 1996). Although specific state laws vary, those below a certain age are legally unable to agree to or refuse medical treatment, and so others must make decisions for them. Even so, the best interests of these patients often oblige caregivers to discuss the situation with the children in ways appropriate for their developmental level and physical condition. This discussion may go beyond the sharing of information to ask children what they want for themselves (see discussion in Chapter 3). Problems arise when those with the power to consent to treatment for children disagree with each other or with clinicians. For health care providers, parental decisionmaking may also be complicated by spousal disagreement or evidence of child abuse.

care decisionmaking, as it is exactly at the time of a patient's incompetence that the designated attorney-in-fact's role begins.

⁸The Conference of Commissioners on Uniform State Laws has recently proposed a Uniform Act on surrogate decisionmaking.

Parents' decisionmaking discretion is not absolute, and pediatricians view themselves as having a professional obligation to look after the best interest of their patients (AAP, 1995). In some cases, their conclusions may conflict with those of the patients' families. Some of the most difficult cases arise from parents' demands for what clinicians regard as "futile" or "inhuman" care. The possibilities for resolving conflict include sensitive conversations between the child's physician and the parents; involvement by social workers, ethicists, pastoral counsellors, or others trained in working with grief-stricken families; mediation by a hospital ethics committee; or recourse to the legal system. The latter is widely viewed as a last resort because of the burden it places on families, the stress it creates for clinicians, and the potential for negative publicity for families and institutions.

The Patient Self-Determination Act

The Patient Self-Determination Act (PSDA) was enacted by Congress in 1990 and went into effect in December 1991 (White and Fletcher, 1991; GAO, 1995b). The PSDA requires health care institutions that receive Medicare or Medicaid funds to provide written information to adult patients about state laws regarding advance directives. It also requires those institutions, among other things, to note any advance directive in a patient's file, not to discriminate between patients on the basis of whether they have an advance directive, and to educate staff and community about the availability of advance directives.

The purpose of the PSDA was to encourage greater awareness and use of advance directives so that situations of ambiguity, as illustrated by the Nancy Cruzan case, might be avoided. In that 1990 case, the United States Supreme Court recognized a competent patient's right to refuse life-sustaining treatment, but left it to the lower courts to determine whether testimony of Nancy Cruzan's previously expressed oral wishes was persuasive. In *Cruzan v. Director, Missouri Health Department*, Justice Sandra Day O'Connor suggested in a concurring opinion that written advance directives could dispel such ambiguity. That year, Congress passed the PSDA.

The law, however, appears to have had modest effects (Teno, Lynn et al., 1994; Morrison et al., 1994; Emanuel, 1995a; see also Chapter 3). There are no national studies on the rates of persons completing advance directives, but studies of discrete populations (e.g., nursing home residents or hospital patients) conducted both before and after passage of the PSDA show rates between 5 percent and 29 percent (GAO, 1995b; Yates and Glick, 1995). The SUPPORT investigators found a small increase of seriously ill patients having an advance directive since the PSDA went into effect (from one in five to one in four), but this increase did not translate

into higher rates of documented resuscitation discussions or DNR orders for patients who seemed to want them (Teno, Lynn, Wenger et al., 1997).

Although it requires health care organizations to provide information, the PSDA does not specify the content of that information. Often, patients are informed of their rights regarding advance directives during admission to a hospital or long-term care facility. The information is provided on a piece of paper, one of many that crosses the table during this usually stressful time. Other problems with implementation of the PSDA exist. One study found problems in the accessibility of previously completed advance directives during subsequent hospitalizations (Morrison et al., 1995). Another study found that, of the patient charts that indicated the existence of an advance directive, only 57.5 percent actually contained a copy of the directive (Yates and Glick, 1995). The study also revealed that a mere 32 percent of medical institutions covered by the law had done any community education on advance directives. The lack of involvement of physicians, especially primary doctors, also contributes to the tendency of patients to overlook the information offered.

The committee, while recognizing the value of advance directives, questions the urgency of intensive efforts to universalize their use. In this area of decisionmaking at the end of life, the law's favorite product—the legally binding document—may sometimes stand in the way of, rather than ease, the process, especially if these documents are naively viewed as ultimate solutions to the difficulties of decisionmaking. Rather, the documents known as advance directives should be seen as a set of tools useful in the ongoing process of advance care planning. Methods must be developed for encouraging continuing conversation among patients, their families, and the health professionals involved in their care. Less legalistic ways to approach planning and decisionmaking at the end of life were discussed in Chapter 3.

PHYSICIAN-ASSISTED SUICIDE

"Physician-assisted suicide" refers to a practice by which physicians provide, but do not directly administer, the means for a patient voluntarily to hasten his or her own death. This typically is done by prescribing lethal doses of medication that the patient then ingests. "Euthanasia," in contrast, is a practice by which the means of hastening death are administered directly by the physician, for example, when a doctor injects a patient with a lethal medication.

Controversies about assisted suicide have received recent widespread attention as a result of two lawsuits challenging the constitutionality of New York and Washington laws that prohibit physician-assisted suicide. The U.S. Supreme Court heard arguments on the cases (*Vacco v. Quill*, No.

95-1858 and *State of Washington v. Glucksberg*, No. 96-110) in early 1997.⁹ The litigation followed popular referenda in California and Washington in 1990 and 1991 in which proposals to legalize physician-assisted suicide were defeated. In 1992, however, Oregon voters approved a similar proposal. Oregon thus became the first jurisdiction in the United States to provide formal legal recognition of the practice of physician-assisted suicide, although court challenges delayed implementation of the law and legislative reconsideration was being discussed as this report was completed.

The committee agreed that it would not take a position on the legality or morality of assisted suicide, but it did examine some of the issues that might arise if the Supreme Court ultimately ruled either that a terminally ill person who is mentally competent and voluntarily chooses suicide has a constitutional right to self-administer lethal drugs received with the assistance of a physician or that it was constitutionally permissible for individual states, such as Oregon to permit the practice. Many of these issues were explored in friend-of-the-court briefs filed with the Court.¹⁰

Although proposals to legalize physician-assisted suicide typically include various safeguards or restrictions to protect patients and physicians, these provisions involve a number of ambiguities that might make them impossible or impractical to implement. For example, as noted earlier in this report, the status of being "terminally ill" has not been satisfactorily defined conceptually or in application because no boundary prognosis correlates precisely with an important clinical change and none can reliably be supported by data (Lynn et al., 1996). Subjective definitions of illness can be criticized as being so variable as to seem capricious. Already, several hospices have been challenged over terminal illness identifications, prognoses of survival, and small percentages of patients who survive for more than six months (see Chapter 6). In the case of care that is widely viewed as beneficial, the acceptance of some prognostic errors for a large population of patients is reasonable. It is harder to be so sanguine about such errors when the issue is assistance in suicide.

⁹On June 30, 1997 (after the initial release of this report), the Supreme Court ruled that there is no general constitutional right to physician assistance in suicide. Some of the justices, however, wrote statements that suggested that a narrowly defined right might be upheld in specific circumstances.

¹⁰See, for example, the briefs filed by the American Geriatrics Society, the American Medical Association, the American Nurses Association, the American Psychiatric Association et al., the Project on Death in America, and Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon and Judith Jarvis Thomson. The latter was reprinted in *The New York Review of Books*, March 27, 1997, pp. 41-47. Several briefs are available at www.soros.org/death/brieftxt.html.

The criterion of voluntariness also presents problems in determining patient status and articulating boundaries (e.g., what constitutes undue influence by another party). Further, the question can be raised whether serious socioeconomic disadvantage nullifies voluntariness. If a desirable treatment would bankrupt a patient's family and, therefore, a patient chooses suicide, should a physician be authorized to assist? The dilemma between complicity with societal inequalities (by allowing assisted suicides) and magnification of them (by refusing assistance in suicides) is not readily resolvable.

Similarly, requiring that patients be mentally competent raises questions about what standards will be used, what threshold will be set, how fluctuating capacities will be handled, and what will be done about directions in advance. If competence requires very good mental functioning, then few persons known to be near death may qualify. If, however, one cannot direct suicide in advance of becoming incompetent, then people may consider preemptive suicide far in advance of death.

Proposals typically require that self-administrated prescription drugs be authorized by a physician. If many physicians consider themselves ethically or otherwise precluded from doing so, pressure for more involvement of nonphysicians is likely to arise and, perhaps, to require new safeguards.

In sum, the proposed restrictions and intended safeguards in initiatives to legalize physician-assisted suicide are problematic: difficult to define, uncertain in implementation, or vulnerable to unanticipated and unwanted consequences for those they propose to protect. Resolving uncertainties would likely be a difficult process for clinicians, and the courts almost certainly would be involved in further challenges to the implementation of assisted-suicide laws.

Other questions can be posed concerning autonomy—an individual's right to exercise free choice regarding his or her life. This is the core principle that is advanced in favor of physician-assisted suicide. The committee agrees that this principle is a centrally important value. It also believes that the current serious deficiencies in the provision of care to dying people—deficiencies highlighted throughout this report—themselves compromise the autonomy principle by depriving individuals of many choices that should, and realistically can, be made available to them. As discussed in Chapter 5, substantial numbers of dying people today suffer from avoidable pain and other symptoms, and many of the arguments for physician-assisted suicide reflect fear of pain. Offering these patients just two options—either physician assistance for hastened death or continued life with untreated pain—is a highly constricted choice that undermines the principle of autonomy. Truly autonomous choice would allow for adequate relief of pain and other distressing symptoms, adequate psychological support from properly trained health care professionals, and adequate financial and per-

sonal service support for home care in preference to impersonal hospital or nursing home settings.

If, one way or another, Oregon proceeds, the committee believes that its implementation of legal physician-assisted suicide should be carefully and intensively monitored. One key objective would be to learn whether legal safeguards are truly effective. A second objective would be to determine whether general deficiencies in the care of dying people influence individual choices for physician-assisted suicide and whether legalization stimulates correction of deficiencies. If the Oregon law is implemented, advantage should be taken of the opportunity to develop a more adequate factual basis for evaluating the competing claims for and against legal recognition of physician-assisted suicide.

Individual committee members had varied views about the morality, legality, and administrability of assisted suicide. The group fully agreed, however, that the current deficiencies in the provision of care for dying people are so extensive that they may provide inappropriate incentives for people to choose hastened death if that option is made available to them without accompanying remedial measures to improve their care. The nation should not need the prod of assisted suicide to drive it to act in behalf of the dying, although this committee, realistically, believes that media coverage of the assisted suicide cases has put the issues before the public and the professions in a very attention-getting fashion.

CONCLUSION

Reliable, excellent care at the end of life is an objective that should be supported, not impeded, by public policy. Unfortunately, some laws, regulations, and policies of public/private regulatory bodies may obstruct good care, either by their specific provisions or by the fear and misunderstanding they create. Drug-prescribing laws stand out in this regard and, in the view of the committee, warrant revisions to minimize discouragement of effective pain management. Other laws and regulations reflect an overly optimistic view of the effectiveness of laws and legal documents in clarifying how people wish to be treated when dying. Legal documents have a role to play but should not deflect attention from the more significant and complex process of advance care planning as considered in Chapter 3.

Deficiencies in care of the dying were recognized well before recent assisted suicide referenda, legislative activities, and court challenges. Nonetheless, much of the recent attention to deficiencies in end-of-life care arose only when the issue of assisted suicide came before the Supreme Court. Even if assisted suicide becomes legal, both society and the professions should feel confident that no one who chooses suicide does so because care systems are deficient in meeting their needs.



RON WYDEN
U.S. Senator
Oregon



printed on recycled paper A small circular logo with a recycling symbol inside.

Tim Kelley
Project Coordinator

717 Hart Senate Office Building
Washington, D.C. 20510
(202) 224-5244
Tim_Kelley@wyden.senate.gov

COMMITTEE

CHAIRMAN

JUDICIARY

INTERNATIONAL RELATIONS

Congress of the United States
House of Representatives
 Washington, DC 20516-1300

July 29, 1997

File
 Drugs
 Assisted
 Suicide

Thomas A. Constantine
 Administrator
 Drug Enforcement Administration
 Washington, D.C. 20537

Dear Mr. Constantine:

As chairmen of the House and Senate Judiciary Committees, we write seeking the Drug Enforcement Administration's view as to whether delivering, distributing, dispensing, prescribing, filling a prescription, or administering a controlled substance with the deliberate intent of assisting in a suicide would violate the Controlled Substance Act, applicable regulations, rulings, or other federal law subject to DEA enforcement, notwithstanding the enactment of a state law such as Oregon's Measure 16 which rescinds state penalties against such prescriptions for patients with a life expectancy of less than six months.

Drugs used to assist in a suicide include such controlled substances as amobarbital, codeine, diazepam, flurazepam, glutethimide, chloral hydrate, hydromorphone, meprobamate, methyprylon, meprobamate, methadone, morphine, phenobarbital, secobarbital, and pentobarbital. Derek Humphry, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying* (Hemlock Society 1991), at 117-120. Under existing regulations, a prescription for a controlled substance "must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 C.F.R. Sec. 1306.04. Case law indicates "that the physician must have some therapeutic purpose to prescribe lawfully." George J. Annas, "Death By Prescription: The Oregon Initiative," *New Eng. J. of Med.* 1240, 1242 (Nov. 3, 1994).

The Health Care Financing Administration has stated that physician-assisted suicide is not "reasonable and necessary" to the diagnosis and treatment of disease or injury and is therefore barred from reimbursement under Medicare. See enclosed letter of May 1, 1996 from Debbie L. Chang, Director of HCFA's Office of Legislative and Inter-Governmental Affairs. The American Medical Association, the American Nurses Association, the American Psychiatric Association, and at least 43 other national specialty and state medical societies have condemned assisted suicide, stating that it has "[l]ong [been] viewed as outside the realm of legitimate health

THIS STATEMENT IS NOT A RECOMMENDATION OF THE U.S. DEPARTMENT OF JUSTICE

P. 8

11. 7. 1997 14:28

503 284 5150 - ELI SUTAMAN ATTY AT LAW: Page 8

Received: 11/7/97 2:22PM

FROM

MAY 1 - 1986

Mr. [REDACTED]

06/01/87 97-11-87 16:48 DDP
FBI OM:AS FAX 182 541 3313

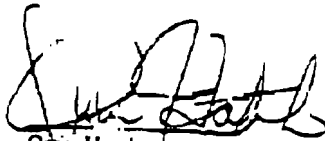
USCC-GOVN'T LIAISON

P. 3 2002

care" and is "fundamentally incompatible with the physician's role as healer...." See Briefs of Amici of the American Medical Association, et al., at 4-5, in *Washington v. Glucksberg*, No. 96-110 (U.S.) and *Vacco v. Quill*, No. 95-1858 (U.S.), citing Code of Medical Ethics, sec. 2.211 (App. 11a).

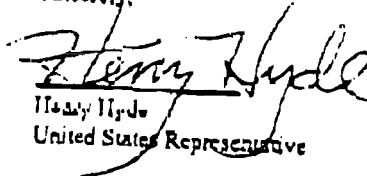
In our view, assisting in a suicide by prescribing or filling a prescription for a controlled substance cannot be a "legitimate medical purpose" under DEA regulations, especially when the practice is not reasonable and necessary to the diagnosis and treatment of disease and injury, legitimate health care, or compatible with the physician's role as healer.

As you know, this is an area of special interest to the Congress. On March 20, the House Commerce Committee, by a 45-2 vote, approved legislation (H.R. 1003) to prohibit any use of federal funds, programs or facilities to perform or advocate assisted suicide. The bill was approved by the full House of Representatives on April 10 by a vote of 398-to-16, by the Senate on April 16 by a vote of 99-to-0, and signed by the President on April 30. Clearly Congress would have a serious concern were any federal agency to sanction the intentional prescribing of lethal drugs for suicide as a legitimate medical practice. Therefore, we would be grateful for your prompt response.



Orrin Hatch
United States Senator

Sincerely,



Henry Hyde
United States Representative

603 294 8158 - 111 BILBMAN ATTY AT LAW; Page 8
11.7.1997 14121

Received: 11 / 7/97 2:23PM
FROM

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ONE HUNDRED FIFTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON THE JUDICIARY

2138 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515-8218

THOMAS A. MCNEELY, JR.
 CHIEF OF STAFF - CHIEF OF COUNSEL

JOHN CLINE
 STAFF DIRECTOR - DEPUTY GENERAL COUNSEL

(202) 225-3951

http://www.house.gov/judiciary

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October 31, 1997

Mr. Thomas A. Constantine
 Administrator
 Drug Enforcement Administration
 Washington, D.C. 20537

Dear Mr. Constantine:

- FEDERAL MEASURE TO PROHIBIT
 MAIL ORDER PRESCRIPTIONS TO
 PROMOTE ASSISTED SUICIDE ?

As you know, on July 29, 1997 we wrote you, in our capacity as chairmen of the House and Senate Judiciary Committees, seeking the Drug Enforcement Administration's view as to whether delivering, distributing, dispensing, prescribing, filling a prescription, or administering a controlled substance with the deliberate intent of assisting a suicide would violate the Controlled Substance Act, applicable regulations, rulings, or other federal law subject to DEA enforcement, notwithstanding the enactment of a state law such as Oregon's Measure 16 which rescinds state penalties against such prescriptions for patients with a life expectancy of less than six months.

Recent action by the U.S. Supreme Court has heightened the urgency of our request. On October 8, the Court denied certiorari to a case that had kept the Oregon statute from going into effect. *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997), cert. denied, 66 U.S.L.W. 3282. As soon as the court's denial is officially transmitted to the district court level, the injunction will be lifted, and consequently it will very shortly be legal under Oregon law to prescribe lethal medications for the purpose of assisting suicide.

Even the immediate effects of such a development would reach beyond the state of Oregon. While Measure 16 will allow lethal prescriptions only for Oregon "residents," this term is undefined in state law and could include people who cross state lines solely to obtain lethal drugs in Oregon. See C. Smith, "Safeguards for Physician-assisted Suicide: The Oregon Death with Dignity Act," in S. McLean (ed.), *Death, Dying and the Law* (1996), 69-93 at 78. Since the prescribed drugs would generally be provided to individuals for self-administration in a physician's absence, they would easily be carried to other states, for use by those individuals or others who may want to kill themselves or others. The Oregon State Pharmacists Association has expressed concern that lethal drugs prescribed in Oregon could even legally be sent to other states through mail-order pharmacies for use in suicides. See D. Gianelli, "Oregon pharmacists

Mr. Thomas A. Constantine
Drug Enforcement Administration

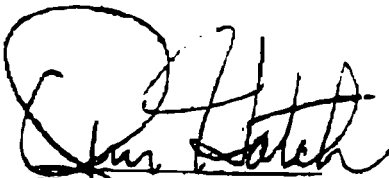
October 31, 1997
Page 2

wary of assisted-suicide measure," *American Medical News*, Oct. 24-31, 1994, at 12. The threat posed to public health by this situation seems clear.

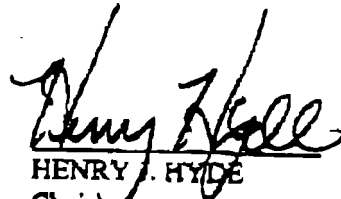
We are appending a brief memorandum of law to demonstrate that the DEA ought to interpret existing law and regulations as preventing the prescription of controlled substances for the purpose of causing the death of patients.

Because lives now hang in the balance, we look forward to your prompt and positive reply.

Sincerely,



ORRIN HATCH
Chairman
Committee on the Judiciary
United States Senate



HENRY J. HYDE
Chairman
Committee on the Judiciary
U.S. House of Representatives

U.S. Department of Justice

Drug Enforcement Administration

Office of the Administrator

Washington, D.C. 20537

NOV 05 1997

Honorable Henry J. Hyde
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Hyde:

Thank you for your letter of July 29, 1997. In that letter, you requested the Drug Enforcement Administration's (DEA) view as to "whether delivering, distributing, dispensing, prescribing, filling a prescription, or administering a controlled substance with the deliberate intent of assisting in a suicide would violate the Controlled Substances Act (CSA), applicable regulations, rulings, or other federal law subject to DEA enforcement, notwithstanding the enactment of a state law such as Oregon's Measure 16 which rescinds state penalties against such prescriptions for patients with a life expectancy of less than six months."

I apologize for the delay in responding to you. As you know, the CSA authorizes DEA to revoke the registration of physicians who dispense controlled substances without a legitimate medical purpose. Historically, DEA's experience with the phrase "without a legitimate medical purpose" has focused on cases involving physicians who have provided controlled substances to drug addicts and abusers. The application of this phrase to cases involving physician-assisted suicide presented DEA with a new issue to review.

Since receiving your inquiry, my staff has carefully reviewed a number of cases, briefs, law review articles and state laws relating to physician-assisted suicide, including the documents referenced in your letter. In addition, my staff has conducted a thorough review of prior administrative cases in which physicians have dispensed controlled substances for other than a "legitimate medical purpose." Based on that review, we are persuaded that delivering, dispensing or prescribing a

FROM

11. 2.1997 1417

Honorable Henry J. Hyde

Page Two

controlled substance with the intent of assisting a suicide would not be under any current definition a "legitimate medical purpose." As a result, the activities that you described in your letter to us would be, in our opinion, a violation of the CSA.

Because physician-assisted suicide would be a new and different application of the CSA, a number of issues remain unresolved. For example, suspicious or unnatural deaths require a medico-legal investigation. The first priority in such an investigation would be a comprehensive forensic inquiry by a state or local law enforcement agency, which is traditionally supported by the efforts of a medical examiner, forensic pathologist, and/or coroner. At the conclusion of this stage of the inquiry, the evidence often is submitted to a grand jury or similar process for a determination of potential criminal liability of the person who assisted in the death.

This initial determination as to the cause of death is not DEA's responsibility. Rather, DEA would have to rely on the evidence supplied to us by state and local law enforcement agencies and prosecutors. If the information or evidence presented to DEA indicates that a physician has delivered, distributed, dispensed, prescribed or administered a controlled substance with the deliberate intent of assisting in a suicide, then DEA could initiate revocation proceedings on the grounds that the physician has acted "without a legitimate medical purpose."

In addition to moving to revoke a physician's registration for dispensing controlled substances "without a legitimate medical purpose," please also be aware that the CSA provides a number of other grounds upon which DEA might revoke the registration of a physician who assisted in a suicide. For example, DEA will revoke the registration of any physician whose state license to practice medicine has been revoked for assisting suicide. Similarly, DEA has authority to revoke the registration of any physician whose acts in assisting a suicide result in a conviction under state controlled substances laws.

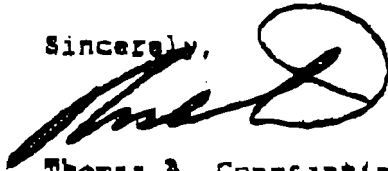
DEA must examine the facts on a case-by-case basis to determine whether a physician's actions conflict with the CSA. If the facts indicate that a physician has acted as set forth in your letter, however, then DEA would have a statutory basis to initiate revocation proceedings.

Honorable Henry J. Hyde

Page Three

I trust that this response addresses your inquiry. If you have any further questions, please feel free to contact me.

Sincerely,



Thomas A. Constantine
Administrator



JOHN A. KITZHABER, M.D.
GOVERNOR

November 18, 1997

The Honorable William J. Clinton
President of the United States
1600 Pennsylvania Avenue
Washington DC 20500

Dear Mr. President:

I am writing to bring to your attention a matter of importance to the citizens of Oregon. Oregonians have now twice considered the issue of physician-assisted suicide at the polls. In 1994 our voters approved the procedure by a narrow margin. Subsequently, the legislature, in an attempt to repeal the measure, re-referred the issue to voters in a statewide election held November 4, 1997. This repeal was rejected by 60 percent of the vote with only 40 percent voting in favor of repeal. We are now at a point where voters of the state have confirmed by an overwhelming margin their original decision. In addition, the U. S. Supreme Court has refused to hear legal challenges to the statute. It is time for us to implement the will of the Oregon voters.

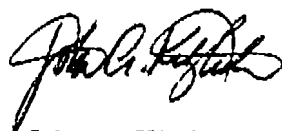
Following the most recent vote, the Drug Enforcement Agency (DEA) issued a letter stating that physicians and pharmacists who follow Oregon law may be subject to federal penalties. I believe that this action was premature, ill-considered and inconsistent with accepted notions of federalism. Your administration has, correctly, asked the U.S. Department of Justice (USDOJ) to review this determination. I appreciate the open and inclusive nature of the discussions between the USDOJ and members of my administration, the Oregon Department of Justice, and our congressional delegation. To further facilitate this review, I am sending a delegation from my administration to Washington, D.C. later this week to meet with officials from the USDOJ. I have also instructed the delegation to call on your domestic policy office in order to update your staff on the Oregon perspective on this issue.

The Honorable William J. Clinton
November 18, 1997
Page 2

I believe that a thorough review of the facts in this matter will demonstrate that Oregon has the authority to proceed in implementing our Death with Dignity Act. Should your administration desire to review this matter further, I respectfully request that you include representatives of my administration, the Oregon Department of Justice and our congressional delegation in any such discussions.

Thank you for your consideration in this important matter.

Sincerely,



John A. Kitzhaber, M.D.

JAK/MG/d

Citation	Search Result	Rank 74 of 88	Database
10/24/94 DJNS 06:24:00			WIRESPLUS
10/24/94 Dow Jones News Serv. 06:24:00			

Dow Jones News Service-Wall Street Journal Stories
Copyright (c) 1994, Dow Jones & Co., Inc.

Monday, October 24, 1994

Oregon Takes On Another Taboo -2-

"I just know how painful it is to watch someone as they become more and more physically diminished as their pain becomes greater," she says. "And when it becomes very clear that you have a terminal patient with no quality of life left, it's very hard not to have a sense of the patient's need to make a choice for himself."

All that leaves the Roman Catholic church in the state as the principal opponent trying to block passage of the ballot initiative, although several other denominations have voiced opposition as well. The Catholic church opposes suicide under any circumstances. The church is principally financing a \$1 million-plus campaign.

If voters approve the Oregon measure, it isn't likely to produce an instant cascade of acceptance in other states. More likely, Oregon would become a national test tube for doctor-assisted suicide, much as the Netherlands is closely watched now because it tolerates euthanasia.

Ethicists who follow the right-to-die issue predict that if the Oregon measure passes, it will become increasingly difficult to hold the line limiting suicide pills to a strictly defined group. "Once you start saying you can do this, how do you draw a line at that group of patients? What's significant about six months?" says Alexander Capron, an ethicist at the University of Southern California who has written against right-to-die initiatives. "Then you face the person too weak to lift the cup to his lips or too housebound to go to the pharmacy."

No one expects the national debate generated by Dr. Kevorkian's 20 assisted deaths to end in Oregon. "It's a debate that no matter what Oregon does will continue," says Pat McCormick, campaign director for the coalition opposing Measure 16.

The People Will Speak

A sampling of ballot initiative proposals to be decided by voters in various states on Nov. 8:

STATE	PROPOSAL
-------	----------

10/24/94 DJNS 06:24:00

Alaska	Declaration of rights for victims of crime; federal term limits
Arkansas	Authorize a casino and create a state gambling commission
Arizona	Inhibit government action that lowers value of private property; tobacco tax for health care; restrict the right to sue for injuries
California	"Three strikes and out" provision to increase sentences for repeat felons; deny education and health services for illegal aliens; gas tax for public transportation; single-payer health system
Colorado	Tobacco tax for health and education revenue; state and federal term limits
Florida	Formula to limit growth of state revenue collections
Georgia	Mandatory sentences for violent crimes
Idaho	Restrict gay rights and education about gay lifestyles; federal and state term limits
Maine	Federal and state term limits
Massachusetts	Federal and state term limits; prohibit rent control
Missouri	Require government reimbursement for revenue lost to acquisition of lands for parks; constitutional amendment on riverboat gambling
Montana	Voter approval of all tax increases
Nevada	Impose federal, state and local term limits
Oregon	Right to die; restrict gay rights; mandatory sentences for violent crimes; require state prison inmates to work full time
Rhode Island	Allow gambling in certain cities
Utah	Impose federal and state term limits and require a runoff when no candidate receives

10/24/94 DJNS 06:24:00

a majority in an election

Source: The Hotline

(END) DOW JONES NEWS 10-24-94

6 24 AM

---- INDEX REFERENCES ----

NEWS SUBJECT: Health; Law & Legal Issues; Politics; Religion (HLT LAW PLT
RLG)

MARKET SECTOR: Consumer Non-Cyclical (NCY)

INDUSTRY: Health Care Providers (HEA)

GOVERNMENT: State Government (STE)

REGION: North America; United States (NME US)

Word Count: 527
10/24/94 DJNS 06:24:00
END OF DOCUMENT

Citation

11/10/94 DJNS 06:11:00

Search Result

11/10/94 Dow Jones News Serv. 06:11:00

Rank 64 of 88

Database

WIRESPLUS

Dow Jones News Service-Wall Street Journal Stories

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Thursday, November 10, 1994

Voters Pass Ground-Breaking Suicide Law In Oregon

By Barbara Rosewicz

Staff Reporter of The Wall Street Journal

Election Day '94 marked a turning point in the right-to-die movement, with Oregon voters narrowly accepting the nation's first law legalizing physician-assisted suicide.

Among scores of ballot initiatives across the country, the suicide measure in Oregon, where uncounted absentee ballots were delaying the official announcement of an outcome, and a California measure denying health and education benefits to illegal aliens, which passed by a comfortable margin, broke new social ground. Voters continued to vent their frustration at Congress by enacting federal term limits in six more states. They also took steps to toughen crime and campaign-finance laws.

But voters also spoke volumes in what they rejected. Californians lopsidedly turned down a proposal heavily bankrolled by the tobacco industry that would have nullified tough local anti-smoking ordinances in favor of milder statewide rules. The industry, led by Philip Morris Cos., spent more than \$20 million on the losing measure. In a conservative mood on social issues, California voters also showed little interest in creating a government-run, taxpayer-financed health insurance system similar to Canada's.

Voters in Oregon and Idaho defeated anti-homosexual measures that, like a 1992 Colorado proposition that spurred a boycott of the Rocky Mountain state, sought to deny civil-rights protections to homosexuals. Gay forces, however, lost a fight in Alachua County, Fla., which voted to strip protections for homosexuals from an antidiscrimination ordinance.

Despite the Florida results, Tim McFeeley of the Human Rights Campaign Fund, a gay political organization, called the outcome encouraging, especially considering conservatives' big wins in other contests.

The Oregon suicide measure is expected to gain international attention, provided its passage is confirmed by the counting of 265,000 absentee ballots over the next couple of days. The measure was leading 52% to 48%, with 99% of precincts reporting -- a margin of close to

11/10/94 DJNS 06:11:00

40,000 votes -- and neither supporters nor opponents expected the outcome to change. While other states are moving to ban assisted suicides like those involving Jack Kevorkian of Michigan, Oregon's measure goes in the opposite direction and would make it the first place in the world to legalize doctor-assisted suicides. The Netherlands now tolerates euthanasia, though it is still technically illegal.

The measure would allow doctors to prescribe suicide pills to a terminally ill patient with less than six months to live, who gets a second medical opinion, makes three requests and doesn't appear to be suffering from a mental disorder. Polls show the American public is deeply split over the issue. While supporters argue that people deserve more control over their deaths, assisted suicide is opposed by the Roman Catholic Church and other religious groups, the American Medical Association and some ethicists who argue it could lead to wider uses of euthanasia.

Derek Humphry, founder of the Hemlock Society, which favors assisted suicides, said he doesn't expect a surge of suicides once the law goes into effect in 30 days -- provided opponents don't find a way to block it. He estimated "probably a handful in the whole state, if that," will be interested in using the law anytime soon. But he said its passage increases chances that other states and legislators will try to adopt similar measures.

(END) DOW JONES NEWS 11-10-94

6 11 AM

---- INDEX REFERENCES ----

NEWS SUBJECT: Environmental News; Health-Care Policy; Health; Law & Legal Issues; Law Enforcement; Special News Events; Politics; Trade Groups (ENV HCP HLT LAW LEN NWS PLT TRG)

MARKET SECTOR: Financial; Consumer Non-Cyclical (FIN NCY)

INDUSTRY: Health Care Providers; Life Insurance; Insurance; Tobacco (HEA INL INS TOB)

GOVERNMENT: Local Government; State Government (LOC STE)

REGION: Alaska; Alabama; Arizona; California; Colorado; Florida; Georgia; Idaho; Massachusetts; Maryland; Maine; North Dakota; Nebraska; North America; Nevada; Ohio; Oregon; Pacific Rim; South Dakota; United States; Central U.S.; Eastern U.S.; Southern U.S.; Western U.S.; Utah; Wisconsin; Wyoming (AK AL AZ CA CO FL GA ID MA MD ME ND NE NME NV OH ORG PRM SD US USC USE USS USW UT WI WY)

Citation

12/1/94 JWIRE 05:27:00

Search Result

12/1/94 Japan Econ. Newswire 05:27:00

Rank 62 of 88

Database

WIRESPLUS

Japan Economic Newswire
Copyright Kyodo News International Inc. 1994

Thursday, December 1, 1994

Opponents of doctor-assisted suicide to seek injunction

LOS ANGELES, Dec. 1 --

Opponents of a bill that legalizes euthanasia in the U.S. state of Oregon said Thursday they will seek a court injunction against the law due to go into effect next Thursday.

The plaintiffs, including doctors, AIDS patients and health workers, argue the bill is unconstitutional since there are not enough safeguards to protect the patient.

They said they will take legal action to stop the bill at the Eugene Federal District Court on Friday. James Bopp, chief counsel for "Right to Life" -- the largest U.S. antiabortion group that supports the anti-euthanasia movement -- told Kyodo News Service the plaintiffs will ask the court to make its decision before the bill goes into effect on Dec. 8.

Passed narrowly by a state ballot on Nov. 8, Measure 16, as the bill is known, allows an informed and capable terminally ill adult with less than six months to live to request a prescription for medication to end his or her life, and decriminalizes the doctor's role in prescribing a lethal dose of medication.

The measure requires two oral and one written request, and the written request requires two witnesses verifying the patient is acting on his or her own accord.

At least 15 days must pass from the time of the initial oral request and 48 hours must pass from the time of the written request before the doctor may write up the prescription.

The bill drew international attention since it is the first to explicitly legalize euthanasia.

The Netherlands was the first country to regulate mercy killing by passing a law in December last year.

The Dutch law though stopped short of legalizing euthanasia but guaranteed doctors immunity from prosecution as long as they perform

12/1/94 JWIRE 05:27:00

mercy killings in compliance with strict guidelines and report all cases to the authorities.

Lawyer Bopp, who is from Indiana, said the Oregon law invites abuse. For example, he suggested, doctors could be tempted to talk a terminally ill patient who cannot pay his medical bills into committing doctor-assisted suicide.

He also said the bill violates the constitutional principle of equality as well as disabled laws since it lacks sufficient safeguards to protect patients from misapplications.

The measure had sparked strong opposition from a coalition of religious groups, led by the Roman Catholic Church, which raised most of the 1 million dollars collected to defeat the measure, and medical groups such as the national board of the American Medical Association.

A report by the Ecumenical Ministries of Oregon called the measure "unwise and dangerous public policy" and said it crosses a moral and ethical boundary between "allowing death to occur" and "causing death to occur."

---- INDEX REFERENCES ----

REGION: Far East; Japan; Pacific Rim (FE JA PRM)

Word Count: 445

12/1/94 JWIRE 05:27:00

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Citation
8/3/95 DJNS 16:44:00

Search Result

Rank 57 of 88

Database
WIRESPLUS

8/3/95 Dow Jones News Serv. 16:44:00

Dow Jones News Service
Copyright (c) 1995, Dow Jones & Company, Inc.

Thursday, August 3, 1995

Oregon's Assisted Suicide Law Ruled Unconstitutional

PORTLAND, Ore. -AP- A law that would have allowed doctors to prescribe lethal doses of medication for dying patients, was ruled unconstitutional by a federal judge.

The measure was approved by voters in November 1994 but was blocked Dec. 7, the day before it was to have become law.

U.S. District Judge Michael Hogan ruled the law violates the equal protection clause of the Constitution's 14th Amendment.

Hogan had been mulling the case since hearing arguments in it three months ago.

Opponents, including the Oregon Catholic Conference and National Right to Life, challenged the act's constitutionality.

(END) DOW JONES NEWS 08-03-95

4:44 PM

----- INDEX REFERENCES -----

NEWS SUBJECT: General News; Law & Legal Issues (GEN LAW)

GOVERNMENT: Justice Department (JUS)

REGION: North America; Oregon; Pacific Rim; United States; Western U.S. (NME ORG PRM US USW)

Word Count: 103
8/3/95 DJNS 16:44:00
END OF DOCUMENT

Citation
8/8/95 BWIRE 16:00:00
8/8/95 Bus. Wire 16:00:00

Search Result

Rank 55 of 88

Database
WIRESPLUS

Business Wire
Copyright (c) 1995, Business Wire

Tuesday, August 8, 1995

Oregon's Physician-Assisted Suicide Act Forces Doctors To Confront New Clinical
And Ethical Issues, According To A UCSF Analysis

(ADVANCE) SAN FRANCISCO--(BUSINESS WIRE)--Aug. 8, 1995-- Oregon's Death With Dignity Act, which legalizes physician-assisted suicide for qualified terminally ill patients, forces physicians to confront new clinical and ethical issues, according to a UC San Francisco analysis.

While a federal judge last week declared the initiative unconstitutional, sponsors of the measure have promised an immediate appeal. Oregon voters passed the initiative in November 1994.

"Physicians can expect patients with conditions such as advanced cancer and AIDS to request assisted suicide," says Bernard Lo, MD, UCSF professor of medicine and co-author of the UCSF analysis published in the August 9 issue of the Journal of the American Medical Association. Lo is director of the UCSF Program in Medical Ethics.

"Physicians will need to consider how legalization of physician assisted suicide would actually occur in clinical practice," he says.

The issue is no longer whether assisted suicide should ever be legalized, according to the UCSF analysis, but rather how this initiative will be implemented and whether other states will follow Oregon's example.

"This law illustrates how hard it is to specify conditions under which to legalize physician-assisted suicide," Lo says. "Because many crucial terms are not defined in the act, physicians will have wide authority to interpret them and broad discretion to apply the act."

For example, each physician will have to determine individually how to interpret "terminal illness" and "patient competence," and how to carry out referrals to consultants. "All of these issues are difficult in practice, although they are required by the law," Lo says.

The choice of whether to implement the act is left to each individual physician. Lo says that physicians, whether they support or oppose the issue, should always respond to suicide requests by trying to determine why the patient is making the request, what the nature of the suffering is and how that suffering may be better relieved.

8/8/95 BWIRE 16:00:00

Physicians who are willing to provide assistance may raise the issue to terminally ill patients rather than waiting for patients to broach the subject. However, Lo warns that physicians should be careful not to encourage or favor suicide, particularly because many terminally ill patients are influenced by their doctors.

Physicians need to also decide if they will provide assistance with suicide to patients they do not know well. Many terminally ill patients do not have long-standing relationships with physicians.

"It would be unwise for physicians to write lethal prescriptions based on brief encounters without providing further care," Lo says. "It may give the impression of an 'assisted suicide mill,' which only facilitates suicide without promoting better terminal care."

Physicians who are morally opposed to assisted suicide must determine what they are willing to do for patients who request assistance and should be candid in explaining what they oppose and what alternatives they recommend, according to the UCSF analysis.

The analysis suggests three possible approaches for physicians opposed to assisted suicide. First, they may try to dissuade patients from considering suicide. Second, the physician may decide to withdraw from the case and transfer the care to another clinician. However, Lo warns some physicians may feel that such referrals would make them complicit in an immoral act.

Third, the physician may choose to continue seeing the patient if someone else prescribes the medication.

"No matter which of these three options a physician adopts," Lo says, "all physicians who refuse to provide the requested prescription should affirm their commitment to relieving symptoms, providing emotional support, and respecting the patient's wishes to forgo life-sustaining interventions."

Pharmacists are also not required to participate in an act over their moral or religious objections. Those who object to assisted suicide may take several steps. They might refuse to stock drugs used in lethal prescriptions, or they might ask the patient whether he or she planned to use the drugs to commit suicide. If the patient answered yes, the pharmacist could refuse to fill the order or to answer questions about the drug.

More troubling, Lo says, is that pharmacists could also consider giving only a sublethal dose of medications, which could deceive the patient and could harm those who ingested enough medication to cause serious damage but not enough to bring about death.

"It is also counterproductive, because it probably would not prevent the patient from accumulating a lethal dose," Lo says.

8/8/95 BWIRE 16:00:00

The Oregon act does not address the inevitable tragedies that will result from failed suicide attempts. Emergency department physicians need to consider whether to resuscitate and treat terminally ill patients who undergo a failed suicide attempt.

"In their deliberations and actions," Lo says, "physicians should view their goal as improving care for terminally ill patients, not fostering their own personal views regarding assisted suicide."

Ann Alpers, JD, UCSF assistant professor of medicine, co-authored the analysis.

The UCSF analysis was supported in part by grants from the Robert Wood Johnson Foundation and the National Institute of Mental Health.

(End of advance for release 3 p.m. CST, Tuesday, Aug. 8)

CONTACT: UC San Francisco
ET AUG 08, 1995

Rebecca Higbee, 415/476-2557 14:49

----- INDEX REFERENCES -----

NEWS SUBJECT: Health; Law & Legal Issues (HLT LAW)

MARKET SECTOR: Consumer Non-Cyclical (NCY)

INDUSTRY: Health Care Providers (HEA)

REGION: North America; Oregon; Pacific Rim; United States; Western
U.S. (NME ORG PRM US USW)

Word Count: 824
8/8/95 BWIRE 16:00:00
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Citation
3/6/96 DJNS 14:20:00

Search Result

Rank 53 of 88

Database
WIRESPLUS

3/6/96 Dow Jones News Serv. 14:20:00

Dow Jones News Service
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Wednesday, March 6, 1996

Fedl Appeals Court Strikes Dn Ban On Doctor-Aided Suicide

SAN FRANCISCO (AP)--Declaring that the Constitution protects the "right to die" a federal appeals court struck down Washington state's ban on doctor-assisted suicide.

In an 8-3 decision, the 9th U.S. Circuit Court of Appeals said the law violates the rights of terminally ill, mentally competent adults who want to hasten their deaths with drugs prescribed by doctors.

"A competent, terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incompetent," said the opinion by Judge Stephen Reinhardt.

While the preservation of life is a legitimate function of the state, Reinhardt said, "when patients are no longer able to pursue liberty or happiness and do not wish to pursue life, the state's interest in forcing them to remain alive is less compelling."

He also said the court disagreed with a ruling by a federal judge in Oregon overturning the first such law in the nation. That law, passed by Oregon voters in November 1994, established a terminally ill patient's right to physician assistance in dying.

The Oregon law was not before the court in today's case, but is likely to be upheld if today's ruling stands.

(END) DOW JONES NEWS 03-06-96

2:20 PM

---- INDEX REFERENCES ----

NEWS SUBJECT: General News; Hot Stories; Law & Legal Issues (GEN HOT LAW)
GOVERNMENT: State Government (STE)
REGION: North America; Pacific Rim; United States; Western U.S.;
Washington (NME PRM US USW WA)

Citation	Search Result	Rank 44 of 88	Database
2/28/97 DJNS 01:01:00			WIRESPLUS
2/28/97 Dow Jones News Serv. 01:01:00			

Dow Jones News Service-Wall Street Journal Stories
Copyright (c) 1997, Dow Jones & Company, Inc.

Friday, February 28, 1997

From The Wall Street Journal: What's News, World-Wide

From The Wall Street Journal

DEATHS OF AIDS PATIENTS FELL for the first time in early '96, the CDC said.

The federal agency said 12% fewer people with AIDS died from the disease in the first half of 1996 than in the year-earlier period, the first marked decline since the disease emerged 15 years ago. New drugs only became available late in the 1996 first half, so experts say other factors, such as growing availability of AIDS-related health care and continuing prevention campaigns, may have played big roles.

HHS Secretary Shalala called the findings "great news," but the report may raise more questions than it answers about progress in the AIDS fight.

Clinton made angry phone calls to Democratic senators this week, complaining of demands inside the party for an independent counsel to investigate campaign fund raising. Meanwhile, Democrats said approval of a budget for Senate hearings on the issue depends on the GOP permitting a vote on a reform measure.

An ex-paratrooper was convicted in the 1995 murders of a black couple near Fort Bragg, N.C. Prosecutors said the killings, which prompted an Army racism inquiry, were done as an initiation rite to earn a Nazi skinhead tattoo. The jury will now decide whether to impose the death penalty. A co-defendant is to be tried next month.

Arafat condemned Israel's plan to build 6,500 homes in East Jerusalem, but his Fatah party reined in protesters marching to the site. Israeli media said Netanyahu was offering a quicker West Bank pullout to avert violence. Meanwhile, militant Palestinian groups, including Hamas, agreed to support Arafat in final-status talks with Israel.

2/28/97 DJNS 01:01:00

A Senate chairman said he won't begin hearings on Lake's bid to be CIA director until the White House releases the nominee's full FBI file. Sen. Shelby's announcement came after two Republicans on his Intelligence panel said they plan, barring surprises, to vote for Lake. The backing of Sens. Lugar and Chafee could be decisive.

Kim Young Sam began what is expected to be a broad shake-up of South Korea's government over the Hanbo Steel bribes-for-loans scandal. Government ministers and ruling-party officials offered to quit this week after the president made a televised apology. Today he fired several top aides, and a cabinet reshuffle is expected soon.

The Clintons' legal defense fund said it took in only \$62,000 in the second half of 1996, and had to return twice that amount in the period because of questions about the origins of the funds. Dwindling donations to the fund, set up to defray the Whitewater legal expenses of the Clintons, left more than \$2.25 million in unpaid bills at the end of 1996.

North Korea's acting defense chief died less than a week after his boss did. The two men were 69 and 78, respectively, and Pyongyang listed the causes as a heart attack and "an incurable disease." The deaths are expected to give Kim Jong Il a chance to bolster his military power base.

X A U.S. appeals court dismissed a challenge to Oregon's law allowing doctor-assisted suicide. The court said the suit failed to show the law, approved in 1994 but tied up in court since, posed an immediate threat of harm. Plaintiffs could seek a rehearing or petition the Supreme Court.

The Justice Department will investigate whether the FBI covered up allegations that a crime-lab agent testified falsely in proceedings that led to Congress's 1989 ouster of Alcee Hastings as federal judge. The bureau has said a memo challenging the testimony was withheld from the proceedings.

(END) DOW JONES NEWS 02-28-97

1 01 AM

Citation	Search Result	Rank 39 of 88	Database
4/17/97 DJNS 03:54:00			WIRESPLUS
4/17/97 Dow Jones News Serv. 03:54:00			

Dow Jones News Service
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Thursday, April 17, 1997

Clinton To Sign Bill Barring Fed Funding Of Assisted Suicide

WASHINGTON (AP)--President Clinton will sign into law a bill that forbids any future use of federal money to support physician-assisted suicide, the White House says.

The bill cleared the Senate Wednesday, 99-0, after passing the House last week by a 398-16 vote.

The narrowly focused measure bars the use of federal funds for assisted suicides, a practice already illegal under state statutes throughout the country. The measure does not address the broader issue of the constitutional "right to die" or the rights of doctors to help people end their lives.

But lawmakers who initiated the legislation said it was important to show their concern about any trends toward making assisted suicide acceptable or legal.

The limited opposition in the House was offered by Democrats who said the bill was unnecessary because assisted suicide is already illegal and the emphasis should be on improving mental health services as a way to prevent suicides.

The bill also contains language authorizing the health and human services secretary to fund research into pain prevention and suicide prevention and requires a study of how health care professionals are trained in end-of-life care.

Supporters said Congress must act now, before the Supreme Court rules on two cases challenging state laws banning assisted suicide. They are additionally worried about a 1994 referendum in Oregon, now being studied in federal court, that approved assisted suicide, and statements from an Oregon health official that Medicaid would cover costs if assisted suicide is legalized.

The legislation does not affect the legal practice of withdrawing treatment from the terminally ill or limit the use of federal funds for pain relief, even when that relief may increase the risk of death.

(END) DOW JONES NEWS 04-17-97

3:54 AM

Citation
5/15/97 BWIRE 11:17:00
5/15/97 Bus. Wire 11:17:00

Search Result

Rank 38 of 88

Database
WIRESPLUS

Business Wire
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Thursday, May 15, 1997

U.S. Supreme Court to decide right-to-die laws; Faye J. Girsh, Hemlock Society,
available for questions

DENVER--(BUSINESS WIRE)--May 15, 1997--As you may know, the U.S. Supreme Court will decide in June or July of this year the constitutionality of state laws forbidding assistance in dying by a physician who agrees to help a terminally ill, mentally competent patient requesting help.

The following information on The Hemlock Society USA and its executive director, Faye Girsh, Ed.D., is for your reference should you need expert comment on this or any of the following issues:

- end-of-life options
- the case for physician aid in dying
- pending legislation and litigation on a state-by-state basis
- physician-assisted suicide, the right to die, and euthanasia

Donna Moreno, APR, can be contacted regarding these topics or in arranging interviews with Dr. Girsh at 303/777-9603.

Dr. Faye Girsh is the executive director of the Hemlock Society USA, a national right to die organization founded in 1980 with more than 25,000 members in 80 chapters. Hemlock is a member of the 34 nation World Federation of Right to Die Societies whose goal is to legalize physician aid in dying for terminally ill, mentally competent patients who request it.

Before coming to Denver, Dr. Girsh was a clinical and forensic psychologist in San Diego testifying and evaluating litigants in civil and criminal cases. It was in this role that she became involved in the right to die movement in 1983 evaluating a young quadriplegic woman who wished to die through refusal of food and hydration -- a right that was ultimately affirmed by the U.S. Supreme Court.

Through a continuing interest in the question of patient self-determination in the dying process, Dr. Girsh founded the Hemlock Society of San Diego in 1987 where she continued as president and newsletter editor until 1996. She was president of the San Diego Psych-Law Society and Psychologists in Addictive Behavior; her public issues radio program won an award from the California Bar

5/15/97 BWIRE 11:17:00

Association and she was a board member of KPBS, the public broadcasting stations in San Diego as well as of several ACLU affiliates, Americans for Death with Dignity and the Euthanasia Research and Guidance Organization.

Dr. Girsh received her doctorate from Harvard University and was on the faculties of Morehouse College and the University of Chicago. Her research was cited by the U.S. and California Supreme Courts; she has published extensively in psychology and legal journals. Dedicated to choice and dignity at the end of life, she has spoken internationally and has appeared on TV and radio in three countries.

Fact Sheet

The Hemlock Society USA A not-for-profit 501 (C) 3 organization

- Mission: To maximize the options for a dignified death, including voluntary physician aid in dying for mentally competent, terminally ill adults who request it, in the context of legal safeguards
- Founded 1980 by Derek Humphry
- 25,000 members across the U.S.A.
- 80 chapters and community groups
- Web Site receiving 70,000 hits a month
- Quarterly publication with current information on physician aid in dying around the world
- Patient Advocacy program for Hemlock members
- Speakers provided to professional meetings, civic forums
- Nine national conferences on physician aid in dying
- Member of the World Federation of Right to Die Societies
- Backed three state-wide initiatives in Washington, California and Oregon to legalize physician aid in dying
- Introduced legislation into more than 15 states
- Supported litigation to challenge state laws prohibiting

5/15/97 BWIRE 11:17:00

physicians from assisting terminally ill patients
PRO-USA (Patients' Rights Organization - USA)
A not-for-profit 501 (C) 4 organization

-- Mission: To provide direct assistance to states for
lobbyists, political action and legislative change.

CONTACT: The Hemlock Society USA, Denver Faye Girsh, Ed.D.,
303/639-1202 or 800/247-7421 Fax: 303/639-1224 Web
site: <http://www.hemlock.org/hemlock> e-mail: hemlock
@privatei.com 11:02 EDT MAY 15, 1997

Word Count: 620
5/15/97 BWIRE 11:17:00
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Citation	Search Result	Rank 35 of 88	Database
6/26/97 DJNS 23:39:00			WIRESPLUS
6/26/97 Dow Jones News Serv. 23:39:00			

Dow Jones News Service-Wall Street Journal Stories
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Thursday, June 26, 1997

Justices Deny -2-: Majority Distinguishes Physician Intent

But the court yesterday distinguished between "letting a patient die and making that patient die." Chief Justice Rehnquist also drew a line between giving a patient a painkilling drug and helping a patient commit suicide. In one case, he said, the intent is to relieve pain; in the other, the intent is to cause death.

Such differences in intent matter, the chief justice argued. "When Gen. Eisenhower ordered American soldiers onto the beaches of Normandy, he knew that he was sending many American soldiers to certain death," the chief justice noted, quoting from a lower-court ruling in the case. "His purpose, though, was to . . . liberate Europe from the Nazis."

The high court didn't directly address the question of whether states have the right to allow physician-assisted suicide. In 1994, Oregon voters approved such an initiative, though it hasn't been implemented yet because of a legal challenge.

(END) DOW JONES NEWS 06-26-97

11 39 PM

---- INDEX REFERENCES ----

NEWS SUBJECT:	Health-Care Policy; Health; Public-Policy and Regulatory Issues (HCP HLT PBP)
MARKET SECTOR:	Consumer Non-Cyclical (NCY TPX)
INDUSTRY:	Health Care Providers (HEA)
PRODUCT:	Health Care (DHC)
GOVERNMENT:	Supreme Court (SUP)
REGION:	North America; New York; Pacific Rim; United States; Eastern U.S.; Western U.S.; Washington (NME NY PRM US USE USW WA)

Word Count: 157
6/26/97 DJNS 23:39:00

Citation
10/15/97 LATIMES 08:19:00
10/15/97 L.A. Times 08:19:00

Search Result

Rank 30 of 88

Database
WIRESPLUS

Los Angeles Times
Copyright (c) 1997

Wednesday, October 15, 1997

High Court OKs Assisted Suicide Law in Oregon
Judiciary: U.S. Supreme Court rejects final efforts to block state's
'Death With Dignity Act' approved by voters. But another initiative
seeks to repeal statute.

Publication Date: Wednesday October 15, 1997

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Los Angeles Times (Home Edition)

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By DAVID G. SAVAGE

TIMES STAFF WRITER

WASHINGTON -- Oregon became the first state Tuesday where doctor-assisted suicide for dying persons is legal, as the Supreme Court rejected the final appeals of those who have until now blocked the state's voter initiative from taking effect.

"It is clear . . . the Supreme Court is standing behind its own decision to support full and robust debate in the 50 states," said Portland attorney Eli Stutsman, a leading advocate of the 1994 law.

In June, the court ruled that the Constitution does not give individuals a "right to die" with medical help. However, the court did not reject the notion of doctor-assisted suicide itself. Instead, it said that this difficult issue should be resolved by the states and their voters, not by federal judges.

Under Oregon's "Death With Dignity Act," a competent, terminally ill person may ask a doctor to prescribe a lethal medication. In every other state, a physician who gives a patient medicine for the purpose of ending his or her life faces possible criminal prosecution.

But soon after Oregon voters approved the measure, 51% to 49%, lawyers for the National Right to Life Committee challenged it as unconstitutional.

"State-sanctioned suicide" deprives the terminally ill of the equal protection of the laws, the Right to Life lawyers argued, because these patients--but not others--are not shielded from subtle pressures to end their lives.

Based on that claim, a federal judge in Eugene ruled the measure unconstitutional. Last year, however, the U.S. 9th Circuit Court of Appeals overturned that judge's decision and said that the challengers had no standing to bring the lawsuit.

The right-to-life group appealed to the Supreme Court, but the justices dismissed their appeal without comment on Tuesday (Lee vs. Harclerod, 96-1824).

"This is consistent with our position all along, that [the 1994 law] is constitutional because it gives you a choice. It doesn't require you do

10/15/97 LATIMES 08:19:00

anything," said Peter Cogswell, a spokesman for the Oregon attorney general.

But the battle over assisted suicide is far from over in Oregon.

Leaders of the Right to Life group condemned the high court for failing to protect "our most vulnerable citizens" but agreed that the matter must be settled at the ballot box.

"We must not expect the courts to protect us from this dangerous legislation," said James Bopp Jr., chief counsel for the committee and the attorney in the Oregon case. "It is now up to the voters to repeal this fatally flawed legislation."

Unlike many of California's ballot measures, the 1994 Oregon initiative did not change the state's Constitution. It merely added a new law. And laws can be revised or repealed by the state Legislature.

Earlier this year, the state's Republican-led Legislature signaled that it wanted to repeal the 1994 law. But Oregon Democratic Gov. John Kitzhaber, a supporter of the measure, refused. He said that he would go along with revisions that improve the law but not a repeal of it.

Stymied, the Republicans instead passed a bill putting on the ballot a Measure 51 that asks whether the 1994 initiative on assisted suicide should be repealed.

Ballots are being mailed out this week, state officials said. They must be returned by mail before Nov. 4.

A phone survey of 505 voters taken last month found that the respondents, by a 2-1 margin, oppose the repeal. Many of those surveyed said that they were irked by the Legislature's decision to seek a second vote on the same question.

However, opponents, led by the Oregon Catholic Conference and the Oregon Assn. of Hospitals and Health Systems, said that the flaws of the 1994 law are just now being exposed. They are supporting a major advertising campaign urging a "yes" vote for the repeal.

The ads themselves have become a focus of controversy. Last week, three major television stations in the Portland area refused to broadcast commercials that show a young person dying a painful, prolonged death as a result of lethal medication.

"He'll choke on his own vomit, in painful convulsions, and linger for days," the narrator says.

Proponents of the law attacked the ad as false and inflammatory. They said that a lethal dose of barbiturates puts a person into a deep sleep and causes death in several hours.

The assisted-suicide law has deeply split doctors and other health care professionals. Major statewide organizations, including the Oregon Medical Assn., have spoken in favor of the repeal. They said that the authority to end life should not be sanctioned as legal. Allowing lethal medications poses a real threat of abuse, they declared.

But other doctors, including Gov. Kitzhaber, have been leaders of the move to preserve the option of assisted suicide in controlled situations.

"As a physician, I can tell you there's a clear difference between prolonging someone's life and prolonging . . . death," he said in a recent statement. "One of the downsides of modern medicine is that often it prolongs death, which I'm not sure is humane and I'm not sure is ethical."

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Citation
11/5/97 LATIMES 07:36:00
11/5/97 L.A. Times 07:36:00

Search Result

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Database
WIRESPLUS

Los Angeles Times
Copyright (c) 1997

Wednesday, November 5, 1997

Voters in Oregon Soundly Endorse Assisted Suicide

Publication Date: Wednesday November 5, 1997

Page A-1

Los Angeles Times (Home Edition)

Copyright 1997 / The Times Mirror Company

By KIM MURPHY

TIMES STAFF WRITER

PORTLAND, Ore. -- Oregon voters cleared the way Tuesday for a landmark statute on doctor-assisted suicide, resoundingly rejecting a repeal attempt and permitting doctors for the first time to prescribe a fatal dose of barbiturates to terminally ill patients.

But in Washington state, voters appeared to be rejecting a far-reaching handgun licensing measure that would have required all handgun owners to pass a gun safety course and obtain a license. The National Rifle Assn. launched an all-out assault on the measure, which also would have required trigger-locking safety devices on handguns.

Houston voters, meanwhile rejected a bid to end the city's affirmative action program, with 54% voting to maintain preferences on city contracts to female- and minority-owned firms. With about 97% of the ballots counted, 46% were voting in favor of the affirmative action ban modeled on California's Proposition 209.

The three measures were the most widely watched among more than 40 state ballot initiatives that highlighted election campaigns in an otherwise lackluster season; Washington voters also were decisively rejecting a measure to authorize medical use of marijuana and other drugs, including heroin and LSD.

In Portland, backers of physician-assisted suicide cheered wildly as early returns showed 60% of the voters rejecting an attempt to repeal the controversial statute, originally adopted in 1994 but blocked from taking effect by a court challenge.

A federal appeals court ruling Monday lifting the injunction appeared to remove the last hurdle to implementation of the law, which would allow doctors to prescribe a fatal dose of barbiturates to patients found by two doctors to have less than six months to live.

"Basically, the measure is in effect now," said Eli Stutsman, manager of the campaign to block the repeal effort and uphold the law. "We know that two of three Oregonians want this option. I would assume that whatever percentage of those Oregonians are dying will get some immediate comfort from this."

Barbara Oskamp, a 66-year-old retiree from West Linn, Ore., who is suffering from an inoperable brain tumor, joined backers of the measure at a

11/5/97 LATIMES 07:36:00

victory celebration Tuesday night.

"I feel like I could leap up in the air and hit the ceiling," Oskamp said. "I know it's only a small percentage of patients that reach a point where the pain is so bad that it can't be relieved. I hope I'm not one of them, but knowing that I have an option, I have a choice to do something to end the pain sooner, just gives me a wonderful feeling of relief."

Leaders of the campaign to repeal the statute, the only one of its kind in the world, complained that it will place pressure on sick patients without financial resources to take a quick way out. They say doctors cannot reliably predict when a person has only six months to live, and warn that its focus on oral dosages will lead to many patients taking hours to die, perhaps uncomfortably.

The Catholic Church and the National Right to Life Committee led the massive campaign to repeal the statute and raised more than \$3.5 million, far more than the assisted-suicide backers.

"What bothers me the most is that the people of Oregon were misled to believe that this was a vote on personal autonomy. In reality, this may affect every American family," said Carrie Gordon, spokeswoman for the Colorado-based Focus on the Family, which supported the move to repeal the measure.

"It makes this legal for the first time in the world, and that changes the climate of health care," Gordon said. "It dismantles 2,500 years of medical tradition, and I just have to ask myself, 'Were we wrong for 2,500 years?' It cheapens medical care at a time when we have the best pain management and the best treatment in the history of the world."

The Netherlands is the only other place in the world where doctor-assisted suicide is practiced openly and legally, and even there, euthanasia is not legal, but doctors are permitted to assist dying patients under certain recognized guidelines. An Australian statute permitting assisted suicide was overturned, and the courts in Colombia have indicated they will not prosecute in most such cases.

But only Oregon has placed such a statute on the books, and proponents and opponents alike predicted it would lead to the adoption of similar measures in other states.

However, it appears likely that opponents will renew their court challenge, which failed earlier on procedural grounds, largely because the statute had not yet taken effect. Removal of the court injunction and failure of the appeal could give potential plaintiffs the standing they need to challenge the measure in court, said James Bopp Jr., attorney for the National Right to Life Committee who filed the earlier challenge.

"We will certainly consider all available legal options," Bopp said.

The repeal effort drew the highest voter turnout in Oregon since 1963, officials said.

Handgun Measure

In Washington state, voters were rejecting an initiative to require statewide licensing and trigger-lock safety devices on handguns, with 69% in early returns voting against the measure.

Although a growing number of states are beginning to look at the issue of handgun licensing--13 have some procedure in place--the Washington measure would have taken the unprecedented step of requiring licensing and safety

11/5/97 LATIMES 07:36:00

training for more than 600,000 citizens who already own handguns.

The measure was supported by Microsoft Corp. Chairman Bill Gates and his family, but its small group of backers ran up against a massive attack by the NRA, which poured \$2.1 million into defeating the measure.

"Initiative 676 means no safety, no self-defense and no right of privacy for Washingtonians," NRA lobbyist Tanya K. Metaksa said during a tour of the state in October. Actor and NRA officer Charlton Heston also made an appearance in Washington against the measure, but analysts said it was the widespread opposition of law enforcement--with the exception of several big-city police chiefs--that was likely to prove more persuasive in defeating the initiative.

Law enforcement officials complained it would be difficult to monitor handguns already in the home, and even more difficult to confiscate guns from unlicensed owners. Proponents said a gun safety course and trigger locks on all handguns would make ownership safer and prevent deaths of children injured by unlocked guns in the home.

"We see licensing as being the significant area on the national level of where the debate on gun control is moving, and Washington state is really leading the charge with a local group taking on the NRA," said Luis Tolley of the Los Angeles-based Handgun Control, which supported the Washington initiative.

He said handgun licensing might find easier passage in California because proponents there have the backing of state police chiefs and two prospective gubernatorial candidates. Most California proposals do not include a retroactive licensing requirement for existing handgun owners.

Affirmative Action

In Houston, voters elected to maintain the city's affirmative action policy after a strong campaign in favor of retaining the practice by outgoing Mayor Bob Lanier, one of the city's most popular politicians.

Houston's voluntary affirmative action program, adopted in 1985 and strengthened under Lanier in 1995, helps female- and minority-owned businesses win city contracts. Last year, about 20% of \$1 billion in city business went to minorities, compared to just 5% before the plan was enacted.

The 72-year-old Lanier, a white millionaire businessman, warned that returning to the days "when guys like me got all the business" will hurt the economy of an increasingly diverse city striving to become an international hub.

Times researcher Lianne Hart in Houston contributed to this story.

* WHITMAN WINS NEW JERSEY: GOP moderate squeaks by unheralded Democrat to recapture governorship. A18

* LOCAL ELECTIONS: Results on B1, B3

(END)

07:36 EST November 5, 1997

---- INDEX REFERENCES ----

NEWS SUBJECT: Newspapers' Section Fronts; Health-Care Policy & Issues;
Health; Los Angeles Times; Front Page Stories; Public-
Policy & Regulatory Issues (FRT HCP HLT LATM PAG PBP)

Administration studies suicide sanctions

■ The Justice Department and its drug agency are reviewing Oregon's law to determine whether to take action against doctors who help patients kill themselves

By STEVE SUO and ERIN HOOVER
of The Oregonian staff

The Clinton administration, reacting to the nation's first physician-assisted suicide law, is considering whether to sanction Oregon doctors who help terminally ill patients kill themselves.

Such a move could have a chilling effect on doctors and might render inoperable Oregon's law, reaffirmed Tuesday by voters. It has precedent in the administration's attempt last year to stop doctors from prescribing medicinal marijuana under a voter-approved initiative in California.

Oregon's doctor-assisted suicide law is being reviewed by the U.S. Justice Department and the U.S. Drug Enforcement Administration.

"This is on the front burner here, and that's basically all I can say," said Catherine Shaw, chief of congressional and public affairs for the DEA, an arm of the Justice Department.

■ **THE COURTS:** Two federal appeals judges say the assisted suicide law is in effect. A14

A spokesman confirmed the department is carefully studying the assisted suicide issue, but he emphasized the agency hasn't finalized its policy.

"It's premature to draw any conclusions as to the ultimate outcome of the department's review," spokesman Gregory King said.

The White House press office did not return phone calls. But President Clinton repeatedly has voiced opposition to doctor-assisted suicide.

Although states license doctors, they must be registered by the DEA to prescribe controlled substances, including the barbiturates that probably would be used under Oregon's law.

Federal law gives Attorney General Janet Reno the power to revoke a doctor's registration for prescribing a controlled substance for anything other than a "legitimate medical" purpose.

Shaw said DEA officials would consider, on a case-by-case basis, whether assisted suicide constitutes a legitimate purpose. But she also noted that,

Please turn to
SUICIDE, Page A14

Clinton on assisted suicide



■ **POSITION:** "While I have deep sympathy for those who suffer greatly from incurable illness, I believe that to endorse assisted suicide would set us on a disturbing and perhaps dangerous path."
President Clinton, April 30

■ **RECORD:** Last year, Attorney General Janet Reno threatened to revoke the registration of California doctors who prescribed medicinal marijuana under a voter-passed law. A similar action could block doctor-assisted suicide in Oregon.

■ Continued from Page One

■ **Federal law speaks against assisted suicide and chroniclers using federal Medicare and Medicaid money to pay for the procedure.**

■ **The American Medical Association does not consider assisted suicide a legitimate medical use of barbiturates, and the DEA normally defers to the AMA to judge what is medically legitimate.**

"The doctors' association campaigned against assisted suicide in Tuesday's mail election and has decried the practice 'incompatible with the physician's role as healer.' Nevertheless, voters overwhelmingly rejected a repeal of the assisted-suicide law."

Dr. Thomas Reardon, president of the American Medical Association, said he would welcome a DEA move to pull doctors' drug-prescribing privileges for taking part in an assisted suicide.

"Indeed, we hope that it would have such a (chilling) impact on any physician contemplating physician-assisted suicide," Reardon said.

But the Oregon Medical Association disagrees. Spokesman James Kronenberg said, "He said his group would protect a doctor's legal right to participate even though the group had pushed to repeal the law."

"We may have opposed it, but it's the law," Kronenberg said. "Physicians should not be penalized for doing something that is legal."

Oregon voters approved the Death With Dignity Act in 1994 as Measure 16, but it was blocked by a judge's order until Oct. 27. The law allows mentally competent, terminally ill adults to ask doctors for a lethal prescription.

It remains unclear how much authority the federal government has to intervene.

After California voters approved a

Hot Clip

11-7-97

“

If they take away my DEA license, I can't prescribe the Seconal — or any other drugs I use. It would be a great impact

Dr. Nancy Crumpacker,

Tualatin oncologist
and a member of Physicians For Death With Dignity

”

1996 initiative allowing medicinal use of marijuana, the administration considered its response for eight weeks, then began an assault on the new law.

Reno and Donna Shalala, the Health and Human Services secretary, threatened to suspend the registration of doctors who recommended marijuana to patients and to criminally prosecute doctors who gave the drug to minors.

Fighting back

But a group of doctors fought back with a lawsuit claiming their right to recommend marijuana was constitutionally protected free speech. In April, they won an injunction blocking federal officials from threatening or punishing doctors.

"Initially, when the government announced its policy, it had a very definite chilling effect on doctors," said Graham Boyd, a lawyer representing the doctors.

Oregon's law prevents the state Board of Medical Examiners from punishing a doctor for participating — or not participating — in assisted suicide, said Kathleen Haley, the board's executive director.

She was not sure how the DEA could interfere with that legal protection.

"Under the law, a lethal prescrip-

tion is legal as long as the physician is in conformance with the statute," Haley said.

On Thursday, the Oregon Board of Pharmacy adopted a rule requiring doctors to specify in writing on the prescription that the medication is being requested for assisted suicide. The rule is meant to alert pharmacists who don't want to take part in a suicide, but it also would give the DEA evidence of a doctor's participation.

Decision draws praise

On April 30, Clinton signed a bill that bans the use of federal money for assisted suicide, euthanasia and mercy killing. In June, he lauded a U.S. Supreme Court decision that upheld laws banning doctor-assisted suicide in New York and Washington.

Trish Conrad, who ran the unsuccessful campaign to repeal Measure 16, applauded the administration's review of the law.

"It's just one more sign that this law was not the answer to the problems that we were promised," Conrad said.

Measure 16 supporters said they are confident state law could not be overruled by the DEA.

"It's my tentative understanding that the DEA has a prohibition," said Eli Stutsman, an attorney for Oregon Right to Die. "But whether the use of drugs is appropriate or not is determined by the state and state guidelines. When we changed the law, what was not a legitimate medical purpose now is."

But some doctors say the DEA could shut down their ability to assist in suicide.

"If they take away my DEA license, I can't prescribe the Seconal — or any other drugs I use," said Dr. Nancy Crumpacker, a Tualatin oncologist and a member of Physicians For Death With Dignity. "It would be a great impact."

Seconal, used as a sedative for many patients, including to help ease terminally ill patients' suffering, is one of the barbiturates that could be used for assisted suicide.

Sen. Ron Wyden, D-Ore., who opposes assisted suicide, vowed to prevent the administration from interfering with the law.

"My personal position notwithstanding, the people of Oregon have spoken," Wyden said in a prepared statement. "I'm going to ask this administration what part of 'No' they don't understand."

Oregonian, 11/8/97 Page One

DEA deems suicide law illegal

Oregon doctors could lose their right to prescribe some drugs if they assist in a suicide

The paper trail

While Oregonians debated whether to retain doctor-assisted suicide, two influential members of Congress asked the U.S. Drug Enforcement Administration whether the practice is illegal. Here are excerpts from letters on the issue:

July 25, 1997

To: Thomas A. Constantine
Administrator Drug Enforcement
Administration

The members of the House and Senate Judiciary Committees, we write seeking clarification of the Drug Enforcement Administration's view as to whether delivering, distributing, dispensing, filling a prescription, or administering a controlled substance with the deliberate intent of assisting in a suicide would violate the Controlled Substances Act.

In our view, assisting in a suicide by prescribing or filling a prescription for a controlled substance cannot be a "legitimate medical purpose" under DEA regulations.

From Sen. Orrin Hatch,
R-Utah, and Rep. Henry J. Hyde,
R-Ill.

Orrin Hatch



Oct. 31, 1997

To: Thomas A. Constantine
Administrator Drug Enforcement
Administration

Recent action by the U.S. Supreme Court has heightened the urgency of our request. ... It will very shortly be legal under Oregon law to prescribe lethal medications for the purpose of assisting suicide. ... Because lives hang in the balance, we look forward to your prompt and positive reply.

From Sen. Orrin Hatch,
R-Utah,
and Rep. Henry Hyde,
R-Ill.



Henry Hyde

Nov. 5, 1997

To: Hon. Henry J. Hyde
U.S. House of Representatives
Washington, D.C.

As you are aware, the Controlled Substances Act (CSA) authorizes the DEA to revoke the registration of physicians who dispense controlled substances "without a legitimate medical purpose." ... the activities that you describe in your letter to us would be, in our opinion, a violation of the CSA.

DEA must examine the facts on a case-by-case basis. ... If the facts indicate that a physician has acted as (described) ... then DEA would have a statutory basis to initiate revocation proceedings.

From Thomas
A. Constantine,
DEA administrator



Thomas A. Constantine

Nov. 7, 1997

To: Hon. Janet Reno
Attorney General of the United States
Washington, D.C.

While I have serious personal reservations about the practice of assisted suicide, I believe it would be a grave mistake for the Federal government to seek to try to override the twice-expressed will of my state's people.

If there is need for reforms or fine-tunings in this law, that process should take place in Salem, not Washington, D.C.

From: Sen. Ron Wyden,
D-Ore.



Ron Wyden

By STEVE SUO and ERIN HOOVER
of The Oregonian staff

The U.S. Drug Enforcement Administration has determined that prescribing lethal medication to assist in a suicide violates federal narcotics law — meaning Oregon doctors could lose their right to prescribe some drugs if they aid in a suicide.

Thomas A. Constantine, DEA administrator, wrote the chairmen of the U.S. House and Senate judiciary committees in a letter dated Wednesday that "delivering, dispensing or prescribing a controlled substance with the intent of assisting a suicide" is not a "legitimate medical purpose" allowed by law.

The letter responded to an inquiry from Sen. Orrin Hatch, R-Utah, and Rep. Henry J. Hyde, R-Ill. They told Constantine earlier this year that Congress "would have a serious concern" if the agency allowed

doctors to prescribe drugs for suicides.

It remained unclear Friday how far the Clinton administration would go in backing up Constantine's interpretation of the law. The Oregonian obtained a copy of his letter only a day after the DEA acknowledged to the newspaper that the state's physician-assisted suicide law was under review.

Administration officials and assisted suicide supporters played down the possibility of sanctions against doctors.

"The Justice Department is continuing to review this, and no conclusions have been reached," spokesman Gregory Kling said. The Drug Enforcement Administration is an arm of the Justice Department.

But an administrator for the DEA's Portland subdivision, which received Constantine's letter Friday, said his office would start proceedings against doctors who clearly prescribed drugs to aid in suicide.

"Assuming that the medical examiner or whatever ruled this death to be suicide, and assuming someone ... dropped it in our lap, I don't think we would have any choice but to proceed," said Arnold Lochner, group supervisor of the Portland DEA's diversion program. "But are we going to go scouring the medical records? Probably not."

News about the agency's involvement exploded into political clashes from Oregon to Capitol Hill. Rep. Darlene Hooley and Sen. Ron Wyden, both Oregon Democrats, sent letters to Attorney General Janet Reno saying there is no need for the administration to intervene.

And in a tense confrontation on a Capitol elevator, Rep. Peter DeFazio, D-Ore., wanted Hyde for trying

Please turn to
SUICIDE, Page A6

Inside

■ **THE RECORD:** Oregon's congressional delegation is divided on the issue of doctor-assisted suicide and what to do about it. A6

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to bring federal law to bear on an issue Oregon voters had settled Tuesday, when they overwhelmingly defeated a measure to repeal assisted suicide.

"He won't do anything — Henry believes in states' rights," DeFazio said.

"When they're right," Hyde fired back.

"Have you ever seen someone die in horrible, horrible pain?" DeFazio said.

Yes, Hyde said, his wife.

DeFazio said he had seen his father die painfully and that no one should have to go through such an experience. When he started to describe how horrible it is when someone has trouble breathing, Hyde yelled, "Don't tell me how it is."

Sen. Gordon Smith, R-Ore., was the only member of the Oregon delegation who applauded the DEA's finding.

"I'm not a supporter of assisted suicide," Smith said. "I respect the vote of the people, but I also understand that this is a law that has consequences far beyond the border of Oregon, and it may contravene federal law."

The law, approved by voters as Measure 5 in 1994, allows mentally competent, terminally ill patients to request a lethal prescription.

DEA controls prescriptions

In a July 15 letter to the DEA, Hyde and Hatch argued that the federal Controlled Substances Act prohibits doctors from prescribing drugs except for a legitimate medical purpose.

Although physicians are licensed to practice medicine by states, the agency registers doctors to prescribe controlled substances, including barbiturates and most other drugs that could be used in physician-assisted suicide.

The ability to prescribe controlled substances is so crucial to many doctors that having their DEA registration revoked could put them out of business. They would be unable to prescribe such common painkillers such as Tylenol with codeine, for example.

The National Conference of Catholic Bishops has pushed the view that Oregon's law conflicts with federal drug regulations. The conference raised the issue in testifying against assisted suicide before Hyde's committee in 1996 and before another committee in March.

On June 26, the U.S. Supreme Court ruled there is no constitutional right to suicide and left it to the states to debate the issue. Shortly afterward, the organization asked

law could be in conflict with federal drug law.

Hyde contacted Hatch, said Richard Doerflinger of the bishops' conference.

"We've been trying to get them interested in it for some time," Doerflinger said. "I think the prospect that the Oregon law might be allowed to kick back into effect made it more of a timely issue."

Doerflinger said the issue was a legitimate one for the federal government to be taking up.

"I found it interesting that no one was noticing that Oregon citizens are also citizens of the United States," he said. "There are lots of implications for other states, and federal policy that has to be addressed somehow."

The American Medical Association is on record as opposing assisted suicide. But a spokesman said Friday the professional association hadn't asked congressional leaders to intervene in Oregon and has not taken a position on DEA involvement.

Suicide supporters skeptical

Supporters of Oregon's law vowed to sue the DEA if the agency moves against doctors. But they remained skeptical the administration would do so.

In California this year, the agency threatened to act against doctors who recommended medicinal marijuana to patients under a voter-approved initiative. A group of doctors sued, and in April they won a temporary court injunction blocking the DEA from threatening or

Suicide: Smith only delegation member to support move

2 of 3

Tim Sturtzman, a lawyer for Oregon Right to Die, said he is confident Oregon doctors can write lethal prescriptions without violating federal drug law. The fact that Oregon voters approved the assisted suicide makes it a legitimate medical purpose under the Controlled Substances Act, he said.

"I'm not aware of any hard information from the DEA that they would sanction doctors who follow the Death With Dignity Law," said Dr. Rick Bayer, a Portland physician and a supporter of doctor-assisted suicide. However, "We're certainly in favor of clarification," he said.

Bill Wyatt, chief of staff to Gov. John Kitzhaber, said the governor has no indication that the White House has taken a position.

He said Kitzhaber, a doctor, thinks it's up to Oregon voters to determine what appropriate medical practice is, and they have done so.

"Short of specific legal prohibitions, we expect Oregon doctors should be able to operate under Oregon law without federal intervention, and we believe that will happen," Wyatt said.

White House noncommittal

Administration officials were noncommittal. White House spokesman Mike McCurry reiterated President Clinton's opposition to doctor-assisted suicide but said he "would want to check" with Clinton about his stance on Oregon's law.

If the federal government decides

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WHERE THE OREGON DELEGATION STANDS

The state's congressional delegation is split on the issue of doctor-assisted suicide — and whether the federal government should act against Oregon doctors who help terminally ill patients kill themselves.



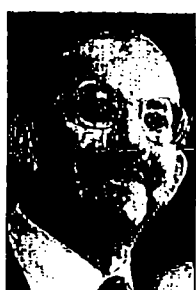
SEN. GORDON SMITH (R)

Position: Opposes doctor-assisted suicide
On federal intervention: "If the president decides to enforce laws that would penalize doctors who prescribe controlled lethal substances, I would support him in this action."



SEN. RON WYDEN (D)

Position: Opposes doctor-assisted suicide
On federal intervention: "Oregon's assisted-suicide statute has been upheld by the courts. The federal government should respect Oregon's process, not second-guess Oregonians."



REP. PETER DeFAZIO (D)

Position: Favors doctor-assisted suicide
On federal intervention: "The DEA is attempting to make criminals of physicians helping Oregonians deal with very personal, difficult decisions in the final days of their lives. I believe they're way out of line, and they ought to just butt out."



REP. DARLENE HOOLEY (D)

Position: Opposes doctor-assisted suicide
On federal intervention: "For very personal reasons, I am opposed to assisted suicide. But Oregon voters twice voted to enact this law. ... I respect the will of Oregon voters, and I would urge the Justice Department to do so as well."



REP. ELIZABETH FURSE (D)

Position: Favors doctor-assisted suicide
On federal intervention: "They're saying, 'OK, it's legal in Oregon, but we are going to go after you, physician.' I think that's just horrible. I have no idea why the administration would want to do such a thing and send such a chill to physicians."



REP. EARL BLUMENAUER (D)

Position: Unavailable
On federal intervention: "These are sensitive matters that have been before the Oregon people, and if there are things that need to be worked out, they should be worked out by Oregonians through their legislative and initiative processes."



REP. BOB SMITH (R)

Position: Opposes doctor-assisted suicide
On federal intervention: Did not return phone calls seeking comment

— Nena Baker and David Hogan of The Oregonian Staff

The Oregonian

in a legal thicket.

"This is very much a states' rights issue, balanced against the power that the national government has operated under for a long time — regulating interstate transportation," said Richard Shugrue, a professor at Creighton University School of Law in Omaha, Neb.

Shugrue said the debate might go like this: Washington would say there's a national interest in controlling pharmaceuticals. States would say they have a right to allow prescribing lethal drugs under their police powers.

"It's a classic battle of a state's right to control its destiny and the

federal government's right to have uniform code of conduct," Shugrue said.

Nena Baker, Jim Barnett, Jeff Mapes and Gail Kinsey Hill of The Oregonian staff contributed to this report.

Oregon politicians tell feds to back off suicide law

Kitzhaber is among leaders opposing action by the DEA against the state's doctors.

BY ERIN KELLY
Statesman Journal

WASHINGTON — A majority of Oregon's congressional delegation told Jus-

stice Department officials Friday to mind their own business and quit trying to thwart the assisted-suicide law approved by state voters this week.

"I just don't think the federal government should step into a state and tell the people what to do," said Democratic Rep. Darlene Hooley, who represents the

Salem area. "The people of Oregon have the right to make up their own minds."

Sen. Ron Wyden and Reps. Earl Blumenauer of Portland and Elisabeth Furse of Hillsboro — all Democrats — agreed. Reps. Bob Smith, R-Medford, and Peter DeFazio, D-Springfield, could not be reached for comment.

However, Republican Sen. Gordon Smith said he would support Justice Department officials if they decide to penalize Oregon doctors who prescribe narcotics to terminally ill patients who want to commit suicide.

"Instead of encouraging a path to death, we should try to strengthen the quality of

hospice and end-of-life care," Smith said. "I want to offer support — not suicide — as the acceptable, responsible and viable action."

The Oregon lawmakers were reacting to news reports that the Drug Enforcement Administration — a branch of the Justice Department — is consider-

ing the possibility of punishing Oregon doctors who assist suicide.

Specifically, the DEA could strip doctors of their power to write prescriptions for narcotics that patients could take to commit suicide. Although doctors are licensed by the state, they must be registered with the DEA to prescribe drugs.

Gov. John Kitzhaber said he also would oppose any federal attempt to penalize doctors who aid terminally ill patients in committing suicide, a top aide said Friday.

Bill Wyatt, Kitzhaber's chief of staff, said the governor thinks it's up to Oregon voters "to determine what

SEE SUICIDE / 2A

Suicide: Congressmen initiated review

CONTINUED FROM 1A

appropriate medical practice is, and they have done so."

"Short of specific legal prohibitions, we expect Oregon doctors should be able to operate under Oregon law without federal intervention, and we believe that will happen," Wyatt said.

Justice Department officials said Friday that they are merely conducting a routine review of Oregon's suicide law to see if it conflicts with any federal laws. No decisions have been made about how — or if — the federal government should respond, they said.

"It is much too soon to be discussing any policy issues that might arise during the course of this routine review," said Gregory King, a spokesman for the Justice Department.

Clinton administration officials said members of Congress — not the president or Attorney General Janet Reno — initiated the DEA review of the Oregon law.

Specifically, the request came from Sen. Orrin Hatch, R-Utah, chairman of the Senate Judiciary Committee, and Rep. Henry Hyde, R-Ill., chairman of the House Judiciary Committee, administration sources said.

Senate aides confirmed that the two conservative lawmakers, who oppose assisted suicide, had written to the DEA about the Or-

egon law.

Federal agencies reviewing Oregon's law have not contacted the Oregon Health Division or the state Attorney General's office, state officials said.

"Our understanding is that the law is in effect," said Dr. Katrina Hedberg, deputy state epidemiologist.

She acknowledged that a move by the Justice Department to yank a doctor's registration for prescribing a controlled substance could drive people "underground" and make them hesitate to file the appropriate medical records with the state.

The assisted-suicide law requires doctors to submit information to the health division when a patient requests a lethal dose of medication.

At this point, the Justice Department review of the Oregon statute consists of a few attorneys reading the law, sources said.

However, the news that the Justice Department is considering the possibility of punishing doctors will frighten some physicians out of assisting suicides, Furse said.

"This sends a very chilling message to the medical profession," she said. "Quite frankly, I think it's an outrage that the administration would even consider this."

Barbara Connolly Lee, one of

the chief petitioners of the assisted-suicide law, termed the review by the U.S. Drug Enforcement Administration "a lot of loose talk."

"I don't think doctors are at risk," she said, noting that the Death With Dignity Act provides immunity for physicians who choose either to follow the provisions of the law or not to participate in the practice.

"The DEA does not have the authority to determine what is appropriate medical practice in the state of Oregon. This is not an appropriate concern — to try and cheat dying Oregonians out of a peaceful death."

Although Hooley and Wyden oppose assisted suicide, they said the will of Oregon voters should prevail. Voters have twice approved the suicide law.

Hooley and Wyden each sent letters to Reno on Friday urging her not to interfere.

"The people have spoken," Wyden said. "The federal government should respect Oregon's process, not second-guess Oregonians."

Blumenauer said he feels an obligation to uphold the voters' wishes.

"The congressman said he thinks the federal government should chill," said Bob Crane, Blumenauer's top aide.

The Associated Press contributed to this report.

Oregon's choice

11/8

*Good or bad, state's assisted suicide law
deserves respect from federal government*

It stands to reason that the federal government wants to take a look at Oregon's assisted suicide law. The government regulates prescription drugs, and the essence of the law upheld by voters last week is allowing doctors to prescribe life-ending drugs at the request of a terminally ill patient.

But the government's proper authority over safe and properly used drugs has limits. Officials would be stepping over those limits if they substituted their judgment — or the administration's — for Oregon's on the proper policy for treating patients in the last stage of life.

We continue to oppose the physician-assisted-suicide law as a dangerous step beyond historically accepted medical practice. But we also accept Oregon's right to take that step, subject, of course, to constitutional protections and federal law (which already prohibits spending federal money on assisted suicide).

A federal decision to punish Oregon doctors for doing something permitted by Oregon law would usurp that right.

The potential state-federal conflict arises because the state licenses doctors, but the federal government requires them to register to prescribe controlled substances. If Attorney General Janet Reno decides that a life-ending prescription is not a "legiti-

mate medical purpose," she could revoke the registration and put a doctor out of business.

Advocating that position, apparently, is the American Medical Association, which opposes doctor-assisted suicide and does not consider it a legitimate use of barbiturates, the drugs that presumably would be used. But

despite the influence of the AMA, this is by no means a settled issue among doctors. Considering the difference within the medical community, Reno needs to beware of letting a voluntary association, even a big one, speak for all doctors.

— Bill Wyatt,
chief of staff,
to Gov. John Kitzhaber

Instead, the reasonable course for Reno is to give credence to Oregon's own standard of legitimate medical purpose and leave doctors alone who are abiding by that standard.

Meanwhile, if Reno or other officials have specific concerns about the application of Oregon's law, they can express them to Oregon. Specifically, they can give their advice to the legislative subcommittee that is being formed to look at implementation of the law and consider possible changes.

Or, she can express her views to Oregon voters. But she should recognize, as we do, that voters have spoken pretty decisively on the subject and don't want to be second-guessed by Washington, D.C.

“Short of specific legal prohibitions, we expect Oregon doctors should be able to operate under Oregon law without federal intervention, and we believe that will happen.”

Nation turns to Oregon

*Second passing of assisted-suicide ballot
puts state at front of debate over how we die*

This time the words seem almost understated. "Groundbreaking" and "landmark" barely describe how much the topography has now changed, how deeply the American landscape of dying is being re-contoured.

In Oregon, the people have taken death in their own hands. For the second time in three years, they have voted in favor of legalizing doctor-assisted suicide for terminally ill patients.

Just three years ago, a controversial referendum passed by a slim margin of 2 percent. But this year, a heavily financed attempt to repeal that law was defeated by a huge margin of 20 percent.

The voters meant what they said. And what they said — again — means that once the postelection confusion clears, Oregon is slated to become the proving ground for doctor-assisted suicide.

For the first time, doctors will legally provide a proscribed group of dying patients with lethal drugs. A theoretical debate between ethicists, doctors, lawyers and citizens will become a reality.

Last June when the Supreme Court ruled that there was no constitutional right to die, Justice Rehnquist wrote that "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."

Oregon has been a virtual debating society on compassion and dying, on high tech and hospice, on pain and palliative care. It will continue as this state becomes the laboratory for every reporter on a story, or advocate out to prove a point.

But what is remarkable about this evolving argument is not the hostility among its leading combatants. That we have come to expect. It's the gradual tilling of public common ground.

"People of good will now understand that America has made a hash of dying," says ethicist Art Caplan from the University of Pennsylvania. "It's terrifying to think we might have to endure a technological death. What Oregon did was cry out and say, 'something has to be done.'"

Virtually no one defends the status quo anymore. Even in this campaign, political opponents chose to argue against the efficacy of the law as much as its morality.

The most controversial attack warned that the drugs would not work. This time the scare was that instead of "death with dignity" a patient would "choke on his own vomit."

At the same time, those who favor legalizing doctor aid-in-dying no longer describe it as the alternative but rather the last resort.

Barbara Coombs Lee, the nurse, lawyer and driving force behind this campaign, says that the "wide benefit of the law is from the knowledge that it is there. ... If they find themselves in their worst nightmare, there is a way out."

Indeed, her side points with pride to the hospice movement that has burgeoned in the wake of attention to dying. On the morning after victory, Lee added, "We have much common ground that we share with our opponents. We and they can work together to improve the end of life care. ... We only differ about what we have to offer patients for whom palliative care fails."

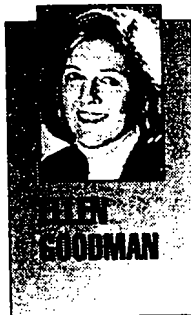
Oregon's law may well be the country's first draft, not the last word, on assisted suicide. Others may refine this law — and the guidelines that allow only oral drugs — and may not be cautious enough about screening for depression. There is, moreover, much common ground left uncharted.

An assisted-suicide law that affects only the competent ill does not begin to address the deepest of our terrors — to be left so debilitated or so disabled that we can't ask to be released. Nor does this doctor's permission slip relieve the other set of terrors, about a too-cheap solution in an era of managed care and ill-managed chronic care.

As Art Caplan says, "Passing laws is very dramatic. But putting them into practice is where the action is." Will we develop new ceremonies for this new way of dying, he asks? New businesses? Will we have a new set of expectations for a pastor, a new set of emotions for a daughter?

The people of Oregon have now become the first to vote mercifully and overwhelmingly to provide the terminally ill with what many call "a parachute." Step by careful step, the rest of us have begun to follow the Oregon Trail.

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Hot Clip 11-10-97 Oregonian

Utah Sen. Hatch vows to fight Oregon's law

■ His committee oversees the Justice Department, and he will push to prosecute any doctor who aids in a suicide

By JIM BARNETT
of The Oregonian staff

WASHINGTON — Despite the public objections of Sen. Ron Wyden, D-Ore., the chairman of the Senate Judiciary Committee vowed Sunday to continue a legal campaign against Oregon's assisted-suicide law.

"I'm going to encourage the Justice Department to prosecute any doctor that prescribes drugs to kill people, that are illegitimately prescribed under our federal laws," Sen. Orrin Hatch, R-Utah, told The Oregonian.

Since voters in Tuesday's election reaffirmed Oregon's 1994 physician-assisted suicide law, it has come under heavy scrutiny and attack in Washington.

A day after the election, the Drug Enforcement Administration wrote a letter to Hatch and House Judiciary Chairman Henry Hyde, R-Ill., concluding that federal law would prohibit doctors from prescribing drugs for suicide.

The letter came in response to an inquiry Hatch and Hyde made earlier this year. The chairmen said Congress would "have a serious concern" if the agency allowed doctors to make suicide prescriptions.

In an interview Sunday evening, Hatch said his objections to Oregon's assisted-suicide law were personal as well as legal. Federal interven-

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HATCH, Page A8

Hatch: Wyden objects to federal intervention

■ Continued from Page One
tion is appropriate and necessary, Hatch said.

"I not only think it's a good idea, I think it's essential if that's the kind of law it's going to be, that you can let doctors kill people," Hatch said. "I just don't think we should go down that slippery slope. I feel really deeply about it."

Although Hatch has no direct authority over DEA actions, his committee oversees the agency and the entire Justice Department. Support from Hatch and Hyde would be critical if DEA officials threaten to punish offending doctors by stripping them of their right to prescribe drugs.

Meanwhile, Wyden took to the Senate floor Sunday afternoon to object to any federal action against the assisted suicide law, saying it would amount to inappropriate meddling in state affairs.

"It seems to me the Clinton administration and the Drug Enforcement Administration have plenty to do right now other than to meddle in the internal affairs of the state of Oregon," Wyden said.

Wyden said he had deep personal reservations about assisted suicide and had voted against the practice on several occasions. But the federal government should respect the will of Oregon voters, he said.

"When the people have spoken and in this case, the people of my state have spoken twice — it's time for the federal government to back off," Wyden said.

Although he did not reveal his next possible step, Hatch said he would continue to fight the Oregon law — even over the objections of Wyden and other members of the state's congressional delegation.

"I don't see where a senator's objection is valid if it's against the law, if it's contrary to the law," Hatch said. "It's one thing to have an emotional or sociological viewpoint. It's another thing to have a viewpoint that is contrary to the law itself."

Hatch said he had not discussed the matter with his friend and ally, Sen. Gordon Smith, R-Ore. Hatch said that he would "not necessarily" ask for Smith's assistance.

Smith said in an interview Friday that he opposed physician-assisted suicide and would support the Clinton administration's efforts to render the law inoperable.

"In the end, Oregon state law will have to be consistent with federal law if it is to be operable," Smith said.

Hatch said he would prefer not to intervene in Oregon's affairs, but federal law would trump any state measure that is contrary.

"We're talking about food and drug law," Hatch said. "That's a federal, preemptive law. Normally, I don't like to interfere with the states. When you're talking about killing people in violation of food and drug laws — and federal laws — then I think that's where you draw the line."



with
the Oregonian

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TOWN SQUARE



Sen. Gordon Smith (R)

On federal intervention:

"The Clinton Administration has taken only a preliminary step toward reviewing Oregon's physician assisted suicide law. If the President decides to enforce laws that would penalize doctors who prescribe controlled lethal substances, I would support him in this action.

"I have always opposed physician assisted suicide. Instead of encouraging a path to death, we should try to strengthen the quality of hospice and end-of-life care. I want to offer support-- not suicide-- as the acceptable, responsible and viable option."

[Email Sen. Smith](#)



Federal law has its own integrity

"The question is not whether the Clinton Administration should intervene in Oregon.

The question is whether one state, Oregon, can unilaterally amend federal and international law. The answer is no."

Should the Administration intervene in the suicide issue? Or is this needless meddling in Oregon's affairs? Speak your mind on the issues important to you in our [Townsquare](#) forum.

November 14,
1997

DEA suicide policy surprises Reno

The AG says she wasn't notified the agency declared it could sanction doctors who follow Oregon's law

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Sen. Ron Wyden (D)

On federal intervention:

"My question today is, 'What part of no does the Federal

Government fail to understand?' We saw just a few hours after the Oregon vote some of the most powerful Members of the U.S.

Congress and the Clinton administration looking to overturn the popular will of the people of Oregon. Within hours of the Oregon vote, a letter emerged from the Drug Enforcement

Agency to the Members of Congress who control the budget for the Drug Enforcement Agency.

In effect, the Drug Enforcement Agency indicates they want to declare war on physicians in Oregon and those they serve by threatening to revoke the drug dispensing privileges of any physician who abides by the law that Oregon has now passed on two separate occasions. In effect, the Drug Enforcement Agency is interested in thwarting the will of Oregonians...

"But the voters of my State have spoken. It would be wrong for those at the Federal level to meddle with that decision. It would be wrong to override the judgment of

Oregon voters. And it
is my view, Mr.
President, that neither
this Congress, nor the
Clinton administration,
nor the Drug
Enforcement Agency,
should trample on the
judgment of Oregon
voters on an issue that
the courts have already
decided is a matter that
should be decided in
my home State of
Oregon."

Excerpt from a Senate
floor speech given by
Wyden on November
10, 1997

Email Sen. Wyden

Questions? Comments? Suggestions? We welcome your feedback.

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Reno: Justice reviewing advice on Oregon's assisted-suicide law<
Eds: Version moved late for Thursday PMs<

WASHINGTON (AP) Attorney General Janet Reno says her chief drug-law enforcer should have waited for a full Justice Department review of Oregon's assisted-suicide law before warning doctors about prescribing lethal medication.

Reno said Thursday she did not get advance word of a letter by the head of the Drug Enforcement Administration saying that Oregon doctors could lose their licenses to prescribe federally controlled drugs if they dispensed such medications to help assist suicides.

Asked if DEA chief Thomas Constantine had sent the letter prematurely to Congress, Reno said: "I think it's important on a legal issue such as this the whole department review it, and we are in the process of doing so."

That review would be completed "as soon as possible," Reno said at her weekly session with news reporters.

Reno said she had not talked about the letter with Constantine, who had replied to Sen. Orrin Hatch, R-Utah, and Rep. Henry Hyde, R-Ill., chairmen of the Senate and House judiciary committees, about how the DEA would respond to the Oregon law.

Aides to Reno did not know about the letter for several days after it was sent to Hatch, officials said.

Oregon voters reaffirmed the assisted suicide law at the polls last week.

The law, first approved three years ago but held up by court challenges, allows Oregon physicians to prescribe drugs to assist suicides.

Meanwhile, the four Democrats in Oregon's U.S. House delegation asked President Clinton Thursday to intervene to prevent the Justice Department from interfering with the Oregon law.

"We urge you to consider the constitutional implications of allowing the federal government to infringe on the will of Oregon voters and instruct the Justice Department to withdraw from their involvement in shaping Oregon's medical law," the letter signed by Reps. Peter DeFazio, Elizabeth Furse, Darlene Hooley and Earl Blumenaur.

The letter says, incorrectly, that the Oregon law has been declared constitutional by federal courts. In fact, the 9th U.S. Circuit Court of Appeals ruled only that those who had filed suit challenging the law had no standing to do so. The U.S. Supreme Court declined to review the appeals court decision. Neither court ruled on the merits of the law.

Sen. Ron Wyden, D-Ore., plans to discuss the issue with Reno next week.

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11/15/97 ASSOCPPS

11/15/97 Associated Press Pol. Serv. (Pg. Unavail. Online)

1997 WL 2562918

(Publication page references are not available for this document.)

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Saturday, November 15, 1997

Legal experts favor state over DEA in suicide battle
Associated Press

PORTLAND, Ore. (AP) _ Legal experts from around the country favor the state of Oregon over the federal government in the dispute over the state's doctor-assisted suicide law, The Sunday Oregonian reported.

Professors around the country who have expertise in law and medicine agree that the Drug Enforcement Administration overstepped its authority when the agency said Oregon doctors would lose their licenses if they prescribed lethal medication for terminally ill patients who want to die.

"The stronger argument is the states' rights argument," said Richard Shugrue, a professor at Creighton University School of Law in Omaha, Neb. "You've subjected (doctor-assisted suicide) to a popular vote. You've debated it till the cows come home. You've seen interest groups pour millions into campaigns. And you've voted a second time and upheld it."

Oregon voters on Nov. 4 defeated an attempt to repeal the state's assisted suicide law, which originally passed in 1994 as the Death with Dignity Act. Because of court challenges, legal questions and political interest on Capitol Hill, the law never has been put to practical use.

Oregon ran afoul of the DEA when Sen. Orrin Hatch, R-Utah, and Rep. Henry Hyde, R-Ill., received a letter from DEA administrator Thomas A. Constantine dated the day after Oregonians rejected the repeal measure.

Constantine told the two influential lawmakers that he had reviewed the situation and concluded that physicians who aid the terminally ill, although they might satisfy Oregon law, would violate the federal Controlled Substances Act. The penalty would be revocation of their licenses to prescribe certain drugs.

Last Thursday U.S. Attorney General Janet Reno entered the fray,

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(Publication page references are not available for this document.)

but only to say that Constantine acted without her knowledge and that the U.S. Justice Department was conducting its own review of the matter. The DEA is a branch of Reno's Justice Department.

Reno didn't say whether she would go along with Constantine's analysis or rein him in.

Gov. John Kitzhaber and several members of Oregon's congressional delegation have called for the federal government to let the law take effect. But the complicated interplay of power offers Oregonians a look at the methodical way a ground-breaking, socially controversial state law moves forward.

"It takes time, and it will be frustrating," said Arthur LaFrance, a professor at Northwestern School of Law at Lewis & Clark College. But the legal and political wranglings "are the hallmarks of a healthy democracy," he said.

DEA regulations say, "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." The key words in the debate: "legitimate medical purpose."

Based on a "thorough review," Constantine said, "we are persuaded that delivering, dispensing or prescribing a controlled substance with the intent of assisting a suicide would not be under any current definition a 'legitimate medical purpose.' "

"I see where they're trying to come from," said Edward Larson, a University of Georgia law professor specializing in health care issues and the courts. "But it's a long reach.

"They can argue that physician-assisted suicide is not a medical use, but that's a pretty slender read."

The federal government usually stays out of a physician's way once a drug has been approved for use, even though the medication might be used for something other than its intended purpose, Larson said. A recent example is the use of the drug methotrexate for abortions; for years, it has been used to treat cancer.

The intent of the DEA regulation is to prevent illicit drugs from getting into the hands of drug dealers or junkies, not to prohibit doctors from prescribing medication that, under state law, has been deemed legal, experts agree.

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Critics of the Oregon law say the federal government does have the authority to prevent the law from going into effect.

"We live in a federal system," said Richard Coleson, a lawyer for National Right to Life, which filed a suit against the law in 1994 and blocked implementation for three years. "There are clear federal laws that cover this."

---- INDEX REFERENCES ----

KEY WORDS: EDUCATION; CRIME; MEDICAL; POLITICAL

STORY ORIGIN: OREGON

Word Count: 693

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Sunday

11-16-97

Oregon on firmer ground than DEA on assisted death

■ Legal experts expect that states' rights would trump attempts by the agency to prosecute physicians

By GAIL KINSEY HILL

of The Oregonian staff

In an ongoing clash between the U.S. Drug Enforcement Administration and Oregon voters over physician-assisted suicide, legal experts are siding with the state.

The battle is of classic proportions, a struggle between the U.S. Constitution's 10th Amendment and the state's police powers. But a judicious look at the duel puts the deadlier weapon in the state's hands.

"The stronger argument is the states' rights argument," said Richard Shugrue, a professor at Creighton University School of Law in Omaha, Neb. "You've subjected (doctor-assisted suicide) to a popular vote. You've debated it till the cows come home. You've seen interest groups pour millions into campaigns. And you've voted a second time and upheld it."

Professors from throughout the nation with expertise in law and medicine agree that Thomas A. Constantine, the DEA administrator, overstepped his authority when he said he could take action against doctors who prescribe

“You’ve subjected (physician-assisted suicide) to a popular vote. You’ve debated it till the cows come home. You’ve seen interest groups pour millions into campaigns. And you’ve voted a second time and upheld it.”

Richard Shugrue,
a professor at
Creighton University
School of Law

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lethal drugs under Oregon's assisted-suicide law.

The apparent breach came in a letter to Sen. Orrin Hatch, R-Utah, and Rep. Henry Hyde, R-Ill., dated the day after Oregonians soundly rejected a measure to repeal the Death With Dignity Act, which they had approved in 1994. Constantine told the two influential congressmen that he had reviewed the situation and concluded that physicians who aid the terminally ill, although they might satisfy Oregon law, would violate the federal Controlled Substances Act. The penalty to physicians: revocation of their licenses to prescribe certain drugs.

Three days ago, U.S. Attorney General Janet Reno entered the fray, but only to say that Constantine acted without her knowledge and that the U.S. Justice Department was conducting its own review of the matter. The DEA is a branch of Reno's Justice Department.

Reno declined to hint at whether she would go along with Constantine's analysis or rein him in.

Although academicians seem to agree the DEA appears to be displaying more bluster than substance, they caution that the debate is far from over and that the judgment could go either way. Lawyers continue to argue vigorously about where the authority lies. And political players, from Hatch and Hyde to Reno, continue to jockey for the most appropriate position.

The morass of legal and political questions makes quick clarification unlikely. And it makes voters, who twice have declared their support for assisted suicide, angry about the federal heavy-handedness. Nevertheless, the complicated interplay of power offers Oregonians a look at the workings of federal authority and the incremental way a groundbreaking, socially controversial state law moves forward.

"It takes time, and it will be frustrating," said Arthur LaFrance, a professor at Northwestern School of Law of Lewis & Clark College. But the legal and political wranglings "are the hallmarks of a healthy democracy," he said.

LaFrance said momentum is on the side of the Oregon law.

The thing to note is the context," he said. "It has moved from the ballot box to the offices of those who deliver health care. . . . What it all means is that assisted death has arrived."

But first a look at the law and the 10th Amendment: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

No specific federal directive addresses doctor-assisted suicide, but the commerce clause, under which the government regulates a range of activities, includes the trafficking of narcotics.

That is where the DEA and the Controlled Substances Act come in, and where the clash with Oregon law occurs.

DEA regulations say, "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." The key words in the debate: "legitimate medical purpose."

Based on a "thorough review," Constantine said, "we are persuaded that delivering, dispensing or prescribing a controlled substance with the intent of assisting a suicide would not be under any current definition a 'legitimate medical purpose.'"

"I see where they're trying to come from," said Edward Larson, a University of Georgia law professor specializing in health care issues and the courts. "But it's a long reach."

"They can argue that physician-assisted suicide is not a medical use, but that's a pretty slender reed."

An established tradition in the court allows the federal government to override state law only when a clear declaration of the pre-emption exists.

There are exceptions, Larson points out, such as segregation policies in the South, which the federal government ruled intolerable. But, he said, "there's a presumption against pre-emption."

The federal government usually stays out of a physician's way once a drug has been approved for use, even though the medication might be used for something other than its intended purpose, Larson said. A recent example is the use of the drug methotrexate for abortions; for years, it has been used to treat cancer.

The intent of the DEA regulation is to prevent illicit drugs from getting into the hands of drug dealers

from threatening or punishing physicians.

But significant differences exist between the Oregon and California situations.

In California, the Clinton administration's intentions were more firmly established, coming after eight weeks of review. Reno and Donna Shalala, Health and Human Services secretary, were among

or junkies, not to prohibit doctors from prescribing medication that, under state law, has been deemed legal, experts agree.

"It's not a conventional medical use, but it's a medical use," Larson said.

The power-struggle debate often rages in California, where the DEA recently tried to stop doctors from prescribing medicinal marijuana under a 1996 voter-approved initiative. Doctors sued and in April won an injunction blocking federal officials

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Suicide: Politics can push debate either way

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those who formally objected to the California law. In Oregon, the federal threat is less formal or consolidated.

In addition, marijuana never has been a legal, government-approved drug. Barbiturates, the medication most likely to be used under the Oregon law, are.

All of this suggests a stronger case for DEA action in California, but the assault on the law remains on shaky ground.

The important similarity between the two situations is that "each state voted on a position that the federal government was hostile to," said Graham Boyd, a lawyer for the California doctors.

"In both, the DEA is attempting to use law enforcement powers to effectively reverse that position," Boyd said.

In Oregon, critics of assisted suicide say the federal government does have the authority to prevent the law from going into effect.

"We live in a federal system," said Richard Coleson, a lawyer for National Right to Life, which filed a suit against the law in 1994 and blocked implementation for three years. "There are clear federal laws that cover this."

On the other hand, Portland lawyer Eli D. Stutsman contends the state made the practice legal when the law was enacted.

"If a doctor meets all the conditions of the act, it's legitimate," he said. "There's no question it's legal."

Stutsman, who represents Oregon Right to Die, said he's prepared to go to court to protect physicians from DEA sanctions, but he's waiting for clarification from Washington, D.C. He said he is confident the Justice Department will direct the DEA to back off.

Beyond the legal controversies lie the politics, which easily could affect the outcome.

Hatch and Hyde head the Senate and House Judiciary committees, respectively. Their responsibilities include the crafting of DEA budgets. When they jointly wrote letters to Constantine in July and in October expressing their concerns about assisted suicide, they were certain to

get the administrator's attention.

Hatch says he is opposed to assisted suicide but insists federal law stands behind his beliefs. Federal intervention is essential, he said. "If that's the kind of law it's going to be, that you can let doctors kill people."

Hyde, too, says his reasons for pursuing the issue are both personal and legal. "I like the law to protect human life," Hyde said. "I think that's the fundamental reason for government and for law."

At this point, however, neither Hatch nor Hyde plans to take up the matter in his committee if DEA enforcement fizzles.

The conclusion of legal experts: "It's political smoke," LaFrance said.

William Banks, a professor at Syracuse College of Law in Syracuse, N.Y., agreed that "the state is probably on pretty strong footing" in its resistance to federal sanctions. If federal leaders want to prevent the practice, he said, they should amend DEA regulations to outlaw lethal prescriptions for the purpose of assisted suicide. Stronger yet, Congress could pass such a law.

Banks said it's ironic that Hyde and Hatch are pushing for stronger federal action.

"They're classic states' rights people," Banks said. "They ought to be chastised roundly."

While the legal and political battles rage, Oregon voters — who passed the law 51 percent to 49 percent in 1994, then rejected the repeal measure 60 percent to 40 percent Nov. 4 — watch in dismay.

Brian Lovell, 36, who suffers from colon cancer, believes terminally ill adults should be able to hasten their deaths if the pain becomes too great. The federal government shouldn't interfere with what Oregonians have decided, he said.

"It's frustrating," said Lovell, a Hillsboro resident and former postal carrier. "Voters should be respected."

Might he ever request a lethal prescription?

"I doubt it," he said. "I've got a 2½-year-old daughter I want to see grow up as far as I can."

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Legal experts favor state over DEA in suicide feud

■ **Rights:** Experts say the agency exceeded its authority by threatening to take away licenses.

By The Associated Press

PORTLAND — Legal experts from around the country favor the state of Oregon over the federal government in the dispute over the state's doctor-assisted suicide law. The Oregonian reported.

Professors around the country who have expertise in law and medicine agree that the Drug Enforcement Administration overstepped its authority when the agency said Oregon doctors would lose their licenses if they prescribed lethal medication for terminally ill patients who want to die.

"The stronger argument is the states' rights argument," said Richard Shiner, a professor at the Creighton University School of Law in Omaha, Neb. "You've subjected (doctor-assisted suicide) to a popular vote. You've debated it till the cows come home. You've seen interest groups pour millions into campaigns. And you've voted a second time and upheld it."

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Wyden will make strong case for voters

By PETER WONG
of the Mail Tribune

Despite his personal opposition to it, U.S. Sen. Ron Wyden says he doubts the Justice Department has strong legal grounds to derail Oregon's assisted-suicide law that voters reaffirmed two weeks ago.

Wyden will discuss the issue this week with Attorney General Janet Reno. He also said his office will be the host for a meeting this week of the department's legal review team and representatives of Oregon Gov. John Kitzhaber and Oregon Attorney General Hardy Myers.

"I will be pressing the case for the federal government to back off," Wyden said Friday night in Medford. "I don't see how they can find an argument that has them doing anything other than meddling, if they try to set aside the majority will of Oregon."

Wyden made his comments in a brief interview after he spoke to the 47th annual Roosevelt-Kennedy Dinner of Jackson County Democrats. It was his first public appearance in Oregon since Congress adjourned for the year Thursday night.

• Reno apparently was surprised when the

Drug Enforcement Administration, a subordinate agency in her department, declared it could discipline Oregon doctors who prescribe lethal medication under the 1994 law. Her department is reviewing the first-in-the-nation law, which voters upheld Nov. 4.

A similar review was conducted after voters in California and Arizona approved legalizing the medical use of marijuana last year. Though the Justice Department said later that doctors would face sanctions if they prescribed marijuana, a federal judge has granted a preliminary injunction to bar sanctions. A lawsuit is pending.

The Supreme Court has upheld bans on assisted suicide in other states but declined last month, largely on technical grounds, to

hear an appeal of Oregon's law. Its opinion in the earlier cases left the way open for states to enact their own laws.

At Friday's dinner, which about 120 people attended at the Reston Hotel, Wyden restated his position that Oregon's popular will should be honored despite his personal opposition to physician-assisted suicide.



Wyden

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Wyden

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"It goes back to my days as the director of the Gray Panthers," he said in reference to the senior advocacy group he led between 1974 and his election to the U.S. House in 1980. "I think nowhere near enough has been done in the field of pain management and promotion of hospice services.

• "But I have said the people of Oregon have spoken — twice. So my personal views notwithstanding, it's time to respect the popular will of the people of Oregon. At a time of such great skepticism and cynicism about government, we have to ensure that people understand that their vote counts and is meaningful."

Wyden is the first Democrat to win a Senate seat from Oregon since Wayne Morse won his fourth and final term more than three decades ago. Wyden, a volunteer driver in Morse's final campaign in 1974, is up for a full six-year term next year. In January 1996 he won the seat that Republican Bob Packwood left vacant by his resignation.

In his talk, Wyden said the increasing cost of health care and increasing numbers of people without coverage nationally may once again draw national attention to how Oregon has moved to solve those problems.

His reference was to the Oregon Health Plan, which sets priorities

for treatments based on their medical effectiveness and emphasizes prevention of illnesses and injuries. Kitzhaber is its chief author; Wyden helped secure federal approval for its start in 1994.

"It's becoming clearer and clearer that we cannot solve this health riddle until we get everybody under the tent of decent health care," Wyden said. "We have a good model and we have a governor who can help us lead that fight. We have the opportunity in this state to lead the way toward health care reform."

Call communities reporter Peter Wong at the Mail Tribune's Ashland bureau at 482-4646.

Suicide law attracts D.C. ire

"They believe in local control until the locals do something they don't like," political scientist Bill Lunch of OSU says.

BY ERIN KELLY
Statesman Journal

WASHINGTON — Now that Oregon voters overwhelmingly have reaffirmed their support for assisted suicide, why are key members of Congress and the Clinton administration threatening to punish doctors who participate?

After all, isn't this the Congress that shouts "local control" as the answer to the nation's ills?

"They believe in local control until the locals do something they don't like," said Bill Lunch, a political scientist at Oregon State University.

GOP Sen. Orrin Hatch of Utah, chairman of the Senate Judiciary Committee, and Henry Hyde of Illinois, his House counterpart, asked the Drug Enforcement Administration to look into the possibility of punishing Oregon doctors who prescribe lethal doses of narcotics for terminally ill patients who request them under state law.

Hatch and Hyde advocate states' rights — but the two conservatives also are fiercely opposed to assisted suicide.

"In the end, ideology rules,"

Lunch said.

But most analysts think Oregon ultimately will win the classic struggle between states' rights and federal power. The reason: fear.

"Most Congress members will avoid this issue like the plague," Lunch said. "If you're a politician who wants to get re-elected, you don't want to touch this with a 10-foot pole because, whatever you do, you're going to make people mad."

And President Clinton will not want to alienate Oregon's predominantly Democratic congressional delegation, Democratic Gov. John Kitzhaber or the voters who helped elect him to two terms in the White House.

"I think they're figuring out that they could do damage to their own people in Oregon," Lunch said.

Also, by upholding bans on assisted suicide in Washington and New York, the Supreme Court already has come down on the side of states' rights, said James Moore, a political scientist at the University of Portland.

"The Supreme Court clearly said assisted suicide is not a national issue," Moore said.

Oregon's suicide law is embroiled in the latest example in a never-ending conflict between states' rights and federal power on issues ranging from civil rights to abortion.

Suicide laws seem unlikely elsewhere

■ States are expected to tackle better end-of-life care, particularly aggressive pain relief, instead of following Oregon's lead

By ERIN HOOVER
of The Oregonian staff

Oregon probably will stand alone in the arena of legalized physician-assisted suicide, at least in the near future.

Some states are considering legislation or initiatives to ban or allow assisted suicide. But observers and activists predict the real movement in the next few years will be in legislating better palliative, or end-of-life, care — in particular, clearing barriers to the aggressive use of pain medication to ease suffering.

"What Oregon's vote is going to do is get states to try to deal more with palliative care," said Marla Rothhouse, a policy specialist with the Health Policy Tracking Service at the National Conference of State Legislatures in Washington, D.C.

"Oregon has always been so much on the forefront of end-of-life care that I think it will take a while for other states to catch up."

This year, nine states, including Oregon, have considered legislation banning assisted suicide, and 11 states have introduced bills authorizing the practice, Rothhouse said. But none of those bills has passed.

Oregon lawmakers asked voters to decide whether to repeal the state's law allowing assisted suicide, which was approved in 1994 but had been held up in the courts. The repeal measure failed Nov. 4.

Prospects appear slim for legalization of doctor-assisted suicide anywhere outside Oregon.

A Michigan citizens' initiative, worded much

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Suicide:

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like Oregon's law, needs 247,000 signatures to get on the 1998 ballot. But Merlan's Friends, the group behind the initiative, has collected only 85,000 signatures since July, and time is running out.

In Maine, activists are confident an assisted-suicide bill will proceed from a legislative committee. But getting full legislative approval is far less certain. Fred Richardson, a former state lawmaker and a backer of the bill, said most legislators support assisted suicide, but not all are ready to vote for it.

Meanwhile, the Roman Catholic Church and state affiliates of the National Right to Life Committee are deeply involved in fighting bills that would allow assisted suicide and backing legislation that condemns the practice.

But some bills that forbid assisted suicide also hint at the possibility of consensus. Legislation in South Dakota and a smattering of other states specifies that doctors are not committing assisted suicide by giving medication to relieve the pain of dying patients, even if the medication hastens death.

Doctor-assisted suicide supporters are zeroing in on this acceptance of aggressive pain control. They have observed from the debate in Oregon that legalizing assisted suicide requires narrowing the pool of eligible people to prevent misuse of the law. Focusing on pain control could serve a broader group of terminally ill patients, some activists say.

They are using the U.S. Supreme Court's June ruling on doctor-assisted suicide as a road map to common ground.

Justice Sandra Day O'Connor wrote: "There is no dispute that dying patients ... can obtain palliative care, even when doing so would hasten their deaths."

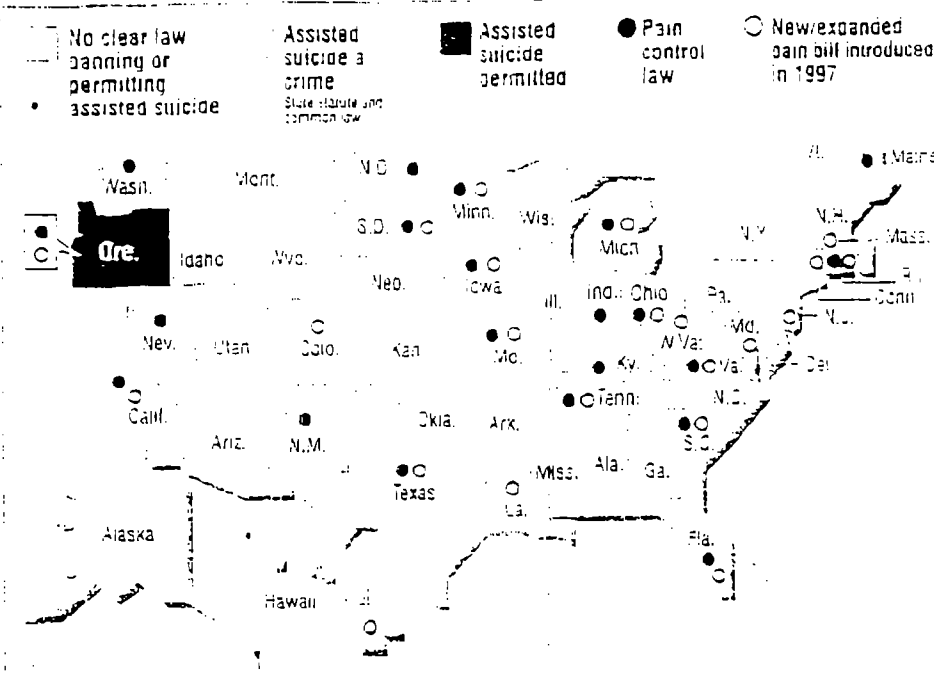
Doctors call this practice the "double effect." The agony of some patients in the final days of a terminal illness can be so intense that only extremely high doses of painkillers or sedatives will relieve it. In some cases, medication causes the patient to slip into unconsciousness; breathing slows, and the patient dies.

Oregon doctors estimate that doses that potentially could hasten death are given to 5 percent to 10 percent of terminally ill patients in hospitals or hospice care.

Assisted-suicide supporters, such

2/35

Oregon is the only state with laws that both permit aid in dying and allow terminally ill patients enough pain medication to relieve suffering. While some states are considering bills banning or allowing physician-assisted suicide, the debate for many is shifting to the area of pain control or palliative care. Laws entitling patients to adequate pain medication and/or protecting doctors from sanctions for prescribing it are on the books in 21 states. This year, 22 states introduced new or additional bills either to study or strengthen access to pain medication.



Source: National Conference of State Legislatures

DAVID AGUIAR/The Oregonian

as the Hemlock Society and the Compassion in Dying Federation, are on the opposite pole from the anti-assisted-suicide stands of the American Medical Association and the Roman Catholic Church. But all of the groups accept the "double effect."

As far back as the April 22, 1992, issue of the *Journal of the American Medical Association*, the association's Council on Ethical and Judicial Affairs said: "Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death."

Morton Leonard Yanow of Seattle, a board member of the American Civil Liberties Union, said this broad acceptance of aggressive pain management is an opportunity for consensus.

"We all believe in the good death: I want to go to sleep and not wake up and not have to suffer. So palliation, even if it means unconsciousness that would hasten death, is the middle ground that all extremes seem to believe is valid," Yanow said.

Medicine and the law

But the new debate will be about

whether and how this method of relieving suffering should move from the realm of medical practice — a world in which patients have limited influence — to the more publicly accessible arena of state law.

Oregon has a progressive pain law that entitles dying patients to "medication . . . to relieve pain and suffering." But some states, including Arizona, Washington, Florida and potentially California, are planning to propose bills next year that would put the patient even more in charge.

In Arizona, state Rep. Sue Lynch, a Republican, is sponsoring a bill championed by the Hemlock Society and the ACLU's Yanow.

An initial bill proposed allowing patients to state their preferences for such accepted options as withdrawing life support. Further, patients could tell their doctors of their willingness for sedatives or pain medication in dosages high enough to relieve suffering, even if the drugs also could quicken death.

But in a compromise with the Arizona Medical Association, the language was toned down to avoid stating the drugs' potential for hastening death, said John Westbrook, a Tucson resident and presi-

dent of Hemlock USA.

"We're not cutting out the intent; we're just trying to state it gently," said Westbrook, who said his group sees the need to build consensus.

"This is a different approach. We didn't get anywhere with the (lethal) prescription approach."

The state medical association has agreed to discuss the legislation before the Legislature's session begins in January, Westbrook said.

A similar run at consensus is happening in Florida.

After a failed attempt to gain acceptance for assisted suicide under state privacy laws, the Hemlock Society of Florida joined forces with the Florida Commission on Aging With Dignity, which opposes assisted suicide. The two groups are drafting a bill similar to Arizona's.

"I do think this is the way the states are going to move in the next couple of years," said Mary Bennett Hudson, president of the Hemlock Society of Florida.

The Commission on Aging With Dignity, a group supported by Sen. Rob Graham, D-Fla., Archbishop John C. Favalora of Miami and Florida Gov. Lawton Chiles, is holding a series of public forums. Chiles and

3/35

others will urge participants to talk with their families about end-of-life care.

"We don't want to polarize this issue (of care for the dying) like other issues have become," said Jackie Roberts, program coordinator of the Commission on Aging With Dignity. "Let's think about what we can work on together."

Not smooth sailing

Although better palliative care is enjoying wide support, activists such as those in the Hemlock Society have more hurdles to clear.

The National Right to Life Committee, for example, supports legislation that promotes good palliative care. But the committee's Arizona affiliate has called Lynch's bill a blank check for doctor-assisted suicide.

The National Conference of Catholic Bishops shares that concern.

"If you say, 'I want pain control because it will cause my death,' then that is assisted suicide. If you're focusing on whatever medicine is necessary to relieve the pain, then that is standard medicine," said Richard Doerflinger, associate director of the Catholic Conference's Secretariat for Pro-Life Activities. "The idea that sedation is some kind of covert euthanasia is not legally correct or medically correct."

Doerflinger said laws that spell out how dying patients can attain aggressive pain medication are not necessary. The Supreme Court has verified that all patients have the right to this kind of treatment, and many living-will laws also address the issue.

Doerflinger said putting medical practice into law can have unintended effects. Laws that permit pain medication for dying patients who are not addicted drug users, for example, can restrict appropriate care for people who contracted AIDS by sharing hypodermic needles.

"If you just let doctors practice medicine, it's usually more flexible than anything you can put into statute," Doerflinger said.

But people such as Yanow plan to press forward.

"My personal feeling is that there is need for a paradigm shift to continue the debate the Supreme Court referred to" on palliative care, he said. "I want to get to the point where we all agree that people want to die without suffering."

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PM-OR--Assisted Suicide, Bjt.555k
Clock running on assisted suicide law
By BRAD CAIN Associated Press Writer

SALEM, Ore. (AP) At least in theory, terminally ill people could kill themselves with a doctor's prescription later this week under Oregon's physician-assisted suicide law.

In practical terms, though, it likely will be quite some time before anyone uses the law.

The law, which was upheld by Oregon voters Nov. 4, has a 15-day waiting period from the time patients request a lethal prescription to when they could receive the drugs.

What brings the law into possible play this week is the fact the Oregon attorney general's office announced on the same day as the election that earlier legal impediments were gone and that the law was in effect.

That means, conceivably, a qualified patient could have asked his physician for suicide drugs the next day, and could receive them after 15 days have elapsed, which would be Friday.

However, sponsors of the law and the state's largest medical organization said Monday that, to their knowledge, no terminally ill patient has yet put in a request for life-ending

drugs.

"I don't know of a single patient or physician who is contemplating taking advantage of the Oregon death with dignity act," said Eli Stutsman, a Portland lawyer who represents Oregon Right to Die.

"It may be true to say the law has a 15-day waiting period, but we know from experience that terminally ill patients' plans are made over a matter of months, not weeks," Stutsman said.

Legal questions and threats of possible federal sanctions against doctors who dispense suicide drugs also were cited as reasons why the law likely won't be put into use anytime soon.

Thomas Constantine, head of the U.S. Drug Enforcement Administration, recently warned doctors that helping someone commit suicide will put their licenses to write prescriptions at risk.

But Constantine's boss, Attorney General Janet Reno, said last week that the DEA chief jumped the gun and that her office is conducting a review to decide whether to punish doctors who assist in patients' suicides.

Sen. Ron Wyden, D-Ore., is awaiting word on a review of the matter at the Justice Department, his spokesman David Seldin

said Monday.

Nyden plans to talk with Reno and meet with members of the department's review team this week, Seldin said.

State officials from Oregon will be a part of the meeting with the Justice Department lawyers reviewing the case. That meeting may take place on Thursday but has not yet been finalized, Seldin said.

James Kronenberg, spokesman for the Oregon Medical Association, said he thinks most doctors would be reluctant to participate in assisted suicides until the OER matter is resolved.

"It isn't a very good environment to proceed, regardless of what the voters have said," Kronenberg said. "There is too much legal static out there right now."

He noted that National Right to Life lawyer James Bopp has said he is ready to file a new lawsuit to try to further sidetrack the law.

Bopp, a Terre Haute, Ind., lawyer, filed the first lawsuit that kept the suicide law on hold for three years until the U.S. Supreme Court last month refused to consider the case.

Bopp contends an earlier injunction blocking the law is still in effect, and plans to make that argument before U.S. District

Judge Michael Hogan in a Nov. 25 hearing in Eugene.

Bopp didn't return several phone calls to his office Monday.

PLEASE ENTER A REQUEST.

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Pharmacy panel affirms suicide disclosure

■ Upholding a rule that doctors must identify prescriptions for assisted-suicide drugs heats up a dispute between pharmacists and physicians

By PATRICK O'NEILL
of The Oregonian staff

The state Board of Pharmacy dug in its heels Tuesday by letting stand a ruling that doctors must specify when prescriptions are for terminally ill patients who want to commit suicide.

The decision intensifies a disagreement between pharmacists and doctors about Oregon's newly reaffirmed physician assisted suicide law.

At the heart of the conflict is the pharmacists' right to refuse to take part

in a suicide and doctors' right to protect patient confidentiality and their own privacy.

Oregon's law allows doctors and other health care workers to choose not to participate in a suicide if it violates their ethics.

Pharmacists, who would fill prescriptions for life-ending medication under the law, say they also should have the chance to refuse to participate.

But the law doesn't spell out how pharmacists would know whether they were filling a prescription for a dose of

drugs to be used in a suicide.

Early this month, the pharmacy board approved an emergency rule requiring doctors to specify in writing the purpose of a prescription written to help a patient commit suicide.

Doctors resent the rule as a breach of patient confidentiality. Two weeks ago, the Oregon Medical Association's governing body announced opposition to the pharmacists' rule and threatened court action.

On Tuesday, during a telephone conference meeting of the Oregon Board of

Pharmacy, members decided to keep the rule intact.

Helen Noonan-Harnsberger, a pharmacy board member, said the rule protects pharmacists.

As for patient confidentiality, board members concluded that by their nature, prescriptions reveal much about patients' medical conditions. A prescription for AZT, an AIDS treatment drug, plainly indicates a patient is infected with the AIDS virus, for instance.

Jim Kronenberg, Oregon Medical As-

sociation spokesman, said Tuesday that his organization "is very sympathetic with their (the pharmacists') problem" but hadn't ruled out court action.

Representatives of the association and the pharmacy board are scheduled to meet Friday to try to resolve the issue.

If talks aren't successful, "some kind of injunction would be a strategy we would have in mind," Kronenberg said.

Please turn to
SUICIDES, Page E10

Suicide: Wyden makes pitch to Reno

■ Continued from Page E1

Doctors are worried that their participation in an assisted suicide might become public. That could make them the target of protests by assisted suicide opponents, much in the same way that doctors who perform abortions are targeted by anti-abortion groups.

Early this month, the federal Drug Enforcement Agency provided another reason for physicians' uneasiness. Thomas A. Constantine, DEA administrator, wrote a letter to two congressmen, warning that doctors who prescribe medicine under the assisted suicide law would violate the federal Controlled Substances Act.

Although Constantine's boss, Attorney General Janet Reno, has not

decided whether the DEA might intervene in assisted suicide, doctors fear the prescriptions could present a paper trail for DEA discipline.

Sen. Ron Wyden, D-Ore., talked with Reno on Tuesday to make a case against federal intervention in Oregon's assisted suicide law.

"She mostly listened," Wyden said. "She seemed anxious to get our arguments laid out. And I stressed that the people of Oregon wanted an answer quickly."

Since Constantine's letter was disclosed, Wyden and other Democratic members of Oregon's congressional delegation have complained that the DEA policy would strip states of their rights to regulate doctors' conduct.

Reaction to the letters has prompted Reno to order a review of the pol-

icy by the Department of Justice, which oversees the DEA. The review panel is scheduled to meet Thursday with Oregon officials, including representatives of Wyden, Gov. John Kitzhaber and state Attorney General Hardy Myers.

11 AP 11-20-97 18:08 EST 73 Lines. Copyright 1997. All rights reserved.
AM-OR--Assisted Suicide, 1st Ed-Writetru,536<
Wyden optimistic Oregon will prevail in assisted-suicide case<
Eds: INSERTS new grafs 4, 13, 14, 15 to UPDATE with Wyden chief
of staff meeting at White House.<
By SCOTT SONNER Associated Press Writer

WASHINGTON (AP) Oregon's legal team scored some constitutional points with Justice Department lawyers Thursday, increasing the chances the state will be allowed to implement its assisted suicide law unimpeded by federal threats, Sen. Ron Wyden said.

"I think we're going to win at this point," Wyden told reporters after the meeting in his office. "My judgment that our case is strong was strengthened today."

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Wyden's chief of staff, Josh Kardon, and other members of the Oregon team received additional encouraging signals during a meeting at the White House later Thursday with Clinton's domestic policy advisers.

PRESS RETURN TO CONTINUE OR ENTER A REQUEST.

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Among those who took part in Thursday's meeting was Bill Wyatt, Kitzhaber's chief of staff, who said the Justice Department lawyers were an "open and willing audience, but pretty noncommittal."

But Wyden said the participants had a "discussion that weighs in Oregon's favor" in regard to the federal government's possible use of the U.S. Constitution's "commerce clause" to block the law.

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PRESS RETURN TO CONTINUE OR ENTER A REQUEST.

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Kardon said he got a similar message later in the day from Clinton administration officials at the White House.

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Although Clinton personally opposes assisted suicide, Kitzhaber said he hoped the president would make sure that the issue is decided strictly on the merits of the law.

11 AP
11-20-97
2 of 2

Clinton leans toward Oregon's side in suicide fight

Representatives from Oregon discuss the issue with federal officials.

BY ERIN KELLY
Statesman Journal

WASHINGTON — President Clinton's opposition to assisted suicide does not mean he will support efforts by the Drug Enforcement

Administration to thwart Oregon's assisted-suicide law, White House aides told Oregon officials Thursday.

"They made a point of saying that the president's views toward assisted suicide do not preclude him from overruling the DEA in favor of the right of state voters to make their own decisions," said Josh Kardon, Wyden's chief of staff.

Kardon said it was the most encouraging sign in a

day full of meetings between Oregon representatives and federal officials.

Wyden and state officials pressed White House aides and Justice Department lawyers to back off from threats by the DEA to punish Oregon doctors who assist suicides.

"We impressed upon them the urgency we feel in Oregon to resolve this issue," said Bill Wyatt, chief of staff to Gov. John

Kitzhaber.

Justice Department officials gave no indication of which way they are leaning as they review whether Oregon's law conflicts with federal law, Wyatt said. They also would not say when they expect to complete their review.

Until the issue is resolved, Oregon physicians will be reluctant to write prescriptions for lethal doses of narcotics for lying

patients who request them, state officials said.

They may be afraid to write prescriptions for pain killers for terminally-ill patients because pain killers may hasten death, said Mark Gibson, the governor's health policy adviser.

The possibility of federal intervention came from Thomas Constantine, the administrator of the Drug Enforcement Agency, which

is overseen by the Justice Department.

Constantine, in a recent letter to assisted suicide opponents Sen. Orrin Hatch, R-Utah, and Rep. Henry Hyde, R-Ill., said Oregon's law appears to be in conflict with the federal Controlled Substances Act.

The act makes it illegal for doctors to prescribe narcotics "without a legitimate medical purpose."

Statesman
Journal
11-21-97
A1

Oregon thinks assisted-suicide case strong

■ A deputy attorney general argues the DEA can't interfere with medical prescriptions and practices that are in accordance with Oregon law

By DAVE HOGAN
of The Oregonian staff

11/21

WASHINGTON — Oregon officials, after meeting with federal representatives Thursday, said they were confident that federal drug regulators won't be allowed to interfere with the state's law on physician-assisted suicide.

The trio from the offices of Gov. John Kitzhaber and state Attorney General Hardy Myers received no commitment on how soon the U.S. Department of Justice will complete its legal review of the matter.

But they said they think the review will conclude that the U.S. Drug Enforcement Administration cannot penalize physicians who lawfully prescribe lethal medications under Oregon's assisted suicide law.

"We feel we have a strong case here," said Bill Wyatt, Kitzhaber's chief of staff. Oregon Deputy Attorney General David

Schuman told Justice officials in a morning meeting that the DEA lacks legal authority to take action against doctors who prescribe lethal medication under the Oregon law.

In a letter earlier this month, DEA Administrator Thomas A. Constantine said that such prescriptions would trigger the agency's authority under the Controlled Substances Act to revoke its registration of physicians who dispense controlled substances "without a legitimate medical purpose."

But neither that law nor the DEA was designed to define or regulate legitimate

medical practices, Schuman said.

"The Controlled Substances Act deals with illicit traffic in drugs and drug abuse," Schuman said. "It does not deal with regulation of the medical profession."

"We told them that once you realize that, it seems clear to us that the DEA was exceeding its authority and is regulating a medical practice that had been approved by the voters of the state and was not condemned by the state Board of Medical Examiners."

Please turn to
MEETING, Page D17

Meeting: State says federal rule cited by DEA doesn't apply

■ Continued from Page D1

In addition, the DEA policy raises serious constitutional issues, Schuman said.

"We tried to explain that ... if the federal government insists on interpreting the Controlled Substances Act in such a way as to make it regulate medical practice in the state, we have serious constitutional problems with that with respect to state sovereignty and intrusion by the federal government," Schuman said.

Mark Gibson, Kitzhaber's health policy adviser, attended the meeting and said the need for a quick decision on the DEA policy is urgent because it affects Oregon physicians and terminally ill patients.

The meeting was held in the office of Sen. Ron Wyden, D-Ore., who said the Justice officials gave no clues as to what direction they might be leaning in considering the assisted suicide issue.

"They didn't tip their hand in any way," Wyden said. "There was no discussion of 'We think you're right' or 'We think you're wrong.'"

Kardon, Wyden's chief of staff, met Thursday afternoon with the staff from the domestic policy and legislative affairs offices of the White House to discuss the DEA policy on assisted suicide.

Kardon said the White House representatives emphasized that President Clinton's personal opposition to assisted suicide will not control the review of the issue.

"It's opposition to assisted suicide does not necessarily mean that he will support the DEA administrator," Kardon said. "They made a point of saying it is equally possible that he will oppose the DEA administrator, but that he has reached no decision at this point and is awaiting the legal review by the Justice Department."

Wyatt said that if the federal government decides DEA can take action against doctors in connection with the assisted suicide law, Oregon officials might go to court to respond. "Those are options that are out there and have been examined to some extent."

Wyatt said, "It's premature, though, to go down that road, but it's certainly a possibility."

Neither meeting Thursday produced a timeline for completing the legal review. Although U.S. Attorney General Janet Reno told Wyden that an internal review would be completed within one and a half to two weeks, a decision in the matter is not imminent, Kardon said. "It may take longer than we hope," he said.

At her morning press briefing Thursday, Reno declined to estimate how soon the process would be completed.

"I don't know," she said. "I want it done as soon as possible, consistent with a thorough, complete review of the issue."

Register Guard 11/21/97 P. 3A

Wyden optimistic on ultimate fate of assisted suicide

■ **Dispute:** Federal officials appear receptive to Oregon's case.

By SCOTT SONNER
The Associated Press

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Hot Clip

Leanne Shimabukuro

(v) 456-5574

(f) 456-7028

Assisted-suicide law puts judge back in spotlight

■ U.S. District Judge Michael R. Hogan will revisit the controversial issue in a hearing Tuesday in Eugene.

By ASHBEL S. GREEN *of The Oregonian staff* 11/24

This week, the focus on physician-assisted suicide shifts from Washington, D.C., to Eugene.

While U.S. Justice Department lawyers muli over Oregon's assisted-suicide law, a federal judge in Eugene will hold a status conference Tuesday on a dismissed lawsuit that prevented the law from taking effect for nearly three years.

The hearing could involve routine paper-shuffling. Or it could mark the start of another drawn-out court battle.

Nobody knows which, except possibly U.S. District Judge Michael R. Hogan, and he's not talking. But his vehement 1995 ruling against Oregon's assisted-suicide law, even though a higher court reversed him, has created an air of apprehension about Tuesday's hearing.

"We're all trying to figure it out," said Charles F. Hinkle, an attorney for Right to Die. "Judge Hogan is sort of a wild card."

In 1994, Oregon voters approved Measure 16, the Death With Dignity Act. But opponents challenged the law in court, and Hogan in 1995 declared it unconstitutional.

A 9th U.S. Circuit Court of Appeals panel overturned Hogan earlier this year. And in October, the U.S. Supreme Court declined to take the case.

Earlier this month, voters overwhelmingly reaffirmed their support for assisted suicide, defeating Measure 51, which would have repealed 1994's Measure 16.

The hearing is for the 9th Circuit decision, which held that the plaintiffs had no standing to challenge the law. The plaintiffs, a woman with muscular dystrophy and two doctors, did not have standing to sue because they were not personally harmed by Oregon's assisted-suicide law, the panel ruled.

Please turn to HOGAN, Page A6

Hogan: Opponents might find new plaintiffs and file a new suit

■ Continued from Page One

According to Measure 16 supporters, that gives Hogan virtually no leeway to do anything other than formally dismiss the case.

"Our assumption is that the case will be dismissed because that is what the 9th Circuit Court of Appeals ordered," said Stephen K. Bushong, an assistant Oregon attorney general.

But opponents of assisted suicide are trying to use the hearing to resuscitate their case. And they have said that if they fail, they might recruit new plaintiffs to challenge the law.

That could be as early as Tuesday.

Another argument

James Bopp Jr., a lawyer for National Right to Life who brought the original suit, has asked Hogan to consider another argument on the

This case is over. There is nothing to do but follow the mandate and dismiss the complaint, not amend it.

Thomas M. Christ,
from a court brief

standing issue. In court papers filed Nov. 1, the same day Oregonians voted 60 percent to 40 percent against repealing Measure 16, Bopp argued that terminally ill people suffer a stigmatic injury because legalized assisted suicide makes their lives worth less by virtue of allowing them to kill themselves.

And in a Nov. 19 brief, Bopp said Hogan also should consider a recent letter from Thomas A. Constantine,

head of the U.S. Drug Enforcement Agency, giving his opinion that his agency could revoke the registration of doctors who dispense lethal medication under the assisted-suicide law.

U.S. Attorney General Janet Reno, who oversees the DEA, has since said the agency spoke too soon, and her lawyers are reviewing the matter.

Bopp's associate, Richard Coleson,

said he will ask Hogan to set a schedule for filing briefs on their motion to reconsider standing.

In the meantime, Coleson will seek to keep in place an injunction Hogan issued in 1995, blocking the assisted suicide law.

Coleson insists that the injunction blocking Measure 16 is in effect, although Oregon Justice Department lawyers say the 9th Circuit Court of Appeals lifted it on Oct. 27.

Two of the three judges on the 9th Circuit panel said in interviews that they lifted the injunction.

Bushong and other lawyers defending the law say Hogan should deny Bopp's motion because the 9th Circuit has ruled that the plaintiffs have no standing. As a result, Hogan has no authority to second-guess their judgment.

"This case is over. There is nothing to do but follow the mandate and

dismiss the complaint, not amend it," Thomas M. Christ wrote in a court brief. Christ is a lawyer arguing in support of the law on behalf of a terminally ill AIDS patient, his doctor and the American Civil Liberties Union.

Taking nothing for granted

Although Bopp and Coleson refuse to divulge their strategy beyond asking Hogan to reconsider the standing issue, one opposing lawyer expects them to find new plaintiffs and file a new suit.

"I guess if I were (Bopp and Coleson), that's the strategy I would be pursuing," said Hinkle, the Right to Die attorney. "I don't see how this case could be resurrected."

Short of a new lawsuit, the hearing should be routine, Hinkle said. Yet he isn't taking anything for granted.

"Judge Hogan may be looking for

a way to lick his wounds and say, 'Yeah, but ...' " he said. "He may be grasping at straws because he is clearly opposed to assisted suicide."

Normally, Hinkle said, Hogan is a thoughtful, moderately conservative judge who is careful about judicial restraint. But in this instance, he ignored those principles.

Arthur LaPrance, a professor at Northwestern School of Law at Lewis & Clark College, said he expects no bombast in the hearing.

"I would anticipate that (Hogan) would not restate preliminary belief since that requires a probability of ultimate success on the merits," LaPrance said. "Right now, and success is unlikely in view of the 9th Circuit opinion."

Ashbel S. Green of The Oregonian staff can be reached at 503-221-6292 or by e-mail at ashysgre@news.oregonian.com

13/24

Elena / Jose

Important, interesting info.

I suggest we work with these guys whatever we do. Their counsel, Peter Leibold, is a good friend of mine. Quinn

THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

February 6, 1998

President William J. Clinton
The White House
Washington, DC 20500

Dear Mr. President:

On behalf of more than 1,200 Catholic-sponsored facilities and organizations nationwide that make up the membership of the Catholic Health Association of the United States (CHA), I write with regard to the critical issues surrounding the protection of life and the provision of pain relief for those nearing the end of life.

I am writing specifically to urge you to: 1) support the Drug Enforcement Agency's (DEA) recent legal interpretation of the Controlled Substances Act regarding physician-assisted suicide; 2) encourage you to issue enforcement guidelines to the DEA urging it to be sensitive to the legitimate concern that overly aggressive or misguided enforcement could have a chilling effect on pain relief for persons at the end of life; and 3) appoint a task force to make concrete recommendations on how to reduce legal and regulatory barriers to *appropriate* pain relief for dying persons.

First, CHA strongly supports DEA's declaration that "delivering, dispensing or prescribing a controlled substance with the intent of assisting a suicide would not be under any current definition a legitimate medical purpose." The religious beliefs and values upon which both CHA and its member hospitals and long-term care facilities are founded compel us to reject assisted suicide. More generally, this practice is radically inconsistent with proper regard for the dignity of human life and irreconcilably incompatible with the appropriate ends of medicine.

The DEA's legal interpretation is completely consistent with your support for the Assisted Suicide Funding Restriction Act passed last year. In that legislation, you supported the proposition that no federal funds, programs, or health facilities should be used to further assisted suicide. Thus, from the federal government's perspective, assisting in a suicide is not a legitimate medical practice. Consistency demands that you support the legal interpretation provided by the administrator of the DEA.

Second, your support for a consistent legal interpretation does not mean that you cannot take ameliorative steps with regard to enforcement. CHA is acutely aware that the DEA's correct, legal interpretation, if not carefully implemented, may *unintentionally* have a chilling effect on physicians who prescribe, dispense, and administer appropriate and effective amounts of

CHA

NATIONAL HEADQUARTERS
4455 Woodson Road
St. Louis MO 63134-3797
Phone 314-427-2500
Fax 314-427-0029

morphine and other opioids in treating pain as death approaches. Certainly, a physician would have reason for serious concern if the DEA routinely second-guesses his or her dosages to a dying person to determine if they violate the Controlled Substances Act. In a recent study, the Institute of Medicine (IOM) found that physicians have significant apprehension about legal sanctions related to addiction and anti-addiction regulations.

Therefore, when announcing your support for DEA's interpretation, CHA urges you to issue an enforcement directive to the agency concerning your expectations with regard to its agents' enforcement of the law. Specifically, the DEA must be aware of, and sensitive to, the impact that its investigation may have on the dispensing of needed pain relief medication to dying persons. The DEA should be aware that it is *not* a violation of the Controlled Substances Act to dispense controlled substances for the legitimate medical purpose of relieving pain, even if they may indirectly shorten the person's life. This essential distinction is codified in the Assisted Suicide Funding Restriction Act itself and was affirmed by the U.S. Supreme Court when it upheld laws prohibiting assisted suicide last June.

The DEA should initiate investigations or enforcement actions only when their agents have credible and substantive allegations that health care providers have established a pattern or practice of prescribing or dispensing controlled substances to persons for the purpose of helping them to take their lives. It is not, nor should it be, a DEA priority to expend significant resources second-guessing the opinions of health care providers about the controlled substances needed to adequately and appropriately relieve the pain of dying persons.

Third, CHA asks that you form a federal/state advisory task force to make concrete recommendations to you and to the 50 governors on how to reduce legislative and regulatory barriers to pain relief. A 1997 Institute of Medicine Study, *Approaching Death: Improving Care at the End of Life*, states the concern succinctly:

Outdated and scientifically flawed drug-prescribing laws, regulations, and interpretations by state medical boards continue to frustrate and intimidate physicians who wish to relieve their patient's pain. Addiction to opioids appropriately prescribed to relieve pain and other symptoms is virtually non-existent, whereas underuse of these medications is a well-documented problem (pp 5&6).

Specifically, the IOM identifies, among others, triplicate prescription laws, limits on the number of medication dosages that may be prescribed at one time, medical board policies, and state anti-addiction laws as barriers to effective pain relief.

CHA recognizes the critical need to address illegal drug use and diversion. Yet, as the IOM points out, there is little evidence that the prescription of opioids in the care of dying persons contributes in any meaningful way to illegal drug use and drug diversion problems. It is both counterintuitive and counterproductive if drug control laws tragically result in the increasing reluctance of physicians and other health professionals to treat dying persons by seeking to alleviate their pain. Dying persons should not be held hostage by regulations that, while rightly motivated, can cause great suffering and distress for them and their families.

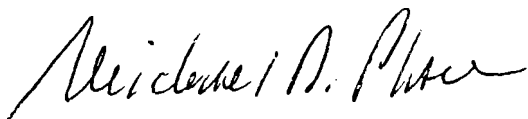
CHA and its member facilities and organizations are committed to provide dying persons and their families both competent and compassionate care. Toward that end several Catholic health systems and CHA have joined together in a collaborative effort, *Supportive Care of the Dying: A Coalition for Compassionate Care*. One specific goal of this project is to ensure that adequate and effective pain management is available to every person living with life-threatening illness so that they may live well even while dying.

Mr. President, concrete recommendations for reform by a federal/state task force on these issues will allow you to suggest legitimate steps to improve pain relief for dying persons. In this way, you can continue your consistent support for the principle that assisting in a suicide is not a legitimate medical purpose and, at the same time, suggest appropriate and necessary public policy mechanisms to improve pain relief for dying persons.

In conclusion, CHA urges you to remain consistent on the federal government's treatment of assisted suicide while exploring all available and legitimate methods for improving pain relief for those in the last stages of life.

With personal best wishes, I am

Sincerely,

A handwritten signature in cursive script, reading "Michael D. Place".

Rev. Michael D. Place, STD
President

cc: Attorney General Janet Reno



Bruce/Tor -

Assisted Suicide

Karen Popp called this U. S. Department of Justice week to say that DOJ is ready to opine that Oregon doctors who assist Office of Legal Counsel suicides are not violating the Controlled Substances Act. (This is contrary to an initial DEA ruling.) We need to decide

Office of the
Assistant Attorney General

whether to accompany ^{Washington, D.C. 20530} this ruling with a request ^{new} for legislative making assisted suicide a federal crime. I think January 16, 1998 This is a fairly terrible idea, but I know Breyer likes it.

MEMORANDUM TO THE ATTORNEY GENERAL Do we need to run some
THROUGH: THE DEPUTY ATTORNEY GENERAL kind of policy process?

THROUGH: THE ASSOCIATE ATTORNEY GENERAL

Elena

FROM: Dawn E. Johnsen *[Signature]*
Acting Assistant Attorney General, Office of Legal Counsel

John C. Keeney *[Signature]*
Acting Assistant Attorney General, Criminal Division

Frank W. Hunger *[Signature]* *[Signature]* *[Signature]*
Assistant Attorney General, Civil Division

SUBJECT: Physician-Assisted Suicide

In October 1997, Oregon's "Death with Dignity Act" (Oregon Act), codified as Oregon Revised Statutes ("O.R.S.") §§ 127.800-127.995, which had been approved by referendum in 1994, went into effect. The Oregon Act removes all state law disabilities and penalties that otherwise might be imposed on physicians for prescribing medication to enable their competent, terminally ill patients to end their lives, as long as physicians comply with the detailed terms of the act. In response to a joint letter from Senator Orrin G. Hatch and Representative Henry J. Hyde to the Drug Enforcement Administration ("DEA"), Administrator Thomas A. Constantine wrote on November 5, 1997, that "delivering, dispensing or prescribing a controlled substance with the intent of assisting a suicide would not be under any current definition a 'legitimate medical purpose,'" and that such actions would therefore constitute "a violation of the [Controlled Substances Act, 21 U.S.C. §§ 801-971 (1994) ("CSA" or "Act")]" and could lead to the "initiat[ion] of revocation proceedings [to withdraw the physician's DEA controlled substances registration]." *Id.* at 2. A joint letter of December 15, 1997, addressed to you and signed by 64 members of Congress, urges the Department to support the DEA's position, while others have urged the Department to reject that view. According to Senator Hatch and Representative Hyde, the American Medical Association ("AMA") and 45 other professional associations have stated that assisted suicide is outside legitimate health care. In a meeting with Department employees, the AMA and the Oregon Medical Association affirmed that view, but

took the position that the federal government should not take adverse action against a physician who engages in such practice.

In connection with these events, you have asked us to review DEA Administrator Constantine's position and also address the relation between responses to the Oregon Act under the CSA and the federal government's response to the Arizona and California initiatives regarding the purported medical use of marijuana. This memorandum provides a brief overview of the possibility of a response under the CSA and our ultimate recommendation. We have also attached a more extensive background memorandum prepared by several attorneys in our components. Neither this memorandum nor the background memorandum considers potential actions under statutes other than the CSA. The letters from Senator Hatch and Representative Hyde requested only DEA's views on the CSA and other federal laws subject to DEA enforcement, and DEA Administrator Constantine's response discussed only actions under the CSA. We understand that members of Congress have written to the Department of Health and Human Services ("HHS") about possible adverse action against physicians under the Federal Food, Drug, and Cosmetic Act ("FDCA"), 21 U.S.C. §§ 301-395 (1994), which includes criminal penalties, and that HHS has replied that it does not intend to proceed under the FDCA against physicians for assisting their patients in committing suicide in compliance with Oregon law.

The Oregon 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." O.R.S. § 127.805. 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, see id. § 127.810(1), that the patient's illness and competence and the voluntariness of the request be confirmed by a second physician, see id. § 127.820, and that the physician and patient observe certain waiting periods, see id. §§ 127.840, 127.850. 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 Office of Legal Counsel, the Criminal Division, and the Civil Division, all agree that the federal government does not have authority under the CSA to take adverse action against a physician for assisting a suicide in compliance with the Oregon Act, and would be happy to assist in preparing responses to congressional or other inquiries regarding this matter. Because they reach this conclusion for somewhat different reasons, the two views are briefly summarized below.

I. Views of the Office of Legal Counsel and the Criminal Division

In refraining from striking down state laws banning the practice permitted by Oregon, the Supreme Court recently noted: "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." Washington v. Glucksberg, 117 S. Ct. 2258, 2275 (1997). Although the Court rejected a challenge that such a ban is unconstitutional whenever applied to mentally competent, terminally ill patients, it left open the possibility of a successful, particularized challenge brought by an individual patient. Id. at 2275 n.24. A decision by the Department to pursue adverse action against physicians for assisting in suicide would not necessarily end the national debate (because it could ultimately be overturned by federal legislation), but, as we discuss below, such a decision would have an impact on this debate beyond anything Congress would have intended in crafting the CSA.

The relevant provisions of the Controlled Substances Act allow for criminal prosecutions against physicians who are acting beyond "the course of professional practice," 21 U.S.C. § 802(21), and it provides for the revocation of physicians' licenses for such criminal conduct or for "conduct which may threaten the public health and safety," id. § 823(f)(5). The statute itself provides virtually no guidance on the scope of these terms. Apart from expressly authorizing the Secretary of HHS, in consultation with the Attorney General, to determine "the appropriate methods of professional practice in the medical treatment of . . . narcotic addicts," 42 U.S.C. § 257a (1994), the CSA is silent with respect to determining the proper scope of the professional practice of medicine.

In the context of a criminal enforcement action, especially given the rule of lenity, the statute must be read as authorizing the prosecution of physicians only when they are not reasonably and in good faith acting as physicians.' To the extent that federal law does not specifically address this question, the inquiry must be factual. The Department has not been authorized to decide what, as a normative matter, it believes ought to be part of the course of professional practice. In light of the considered judgment of the state as primary regulator of the profession to authorize this conduct as part of the practice of medicine, and recent reports revealing that a significant minority of physicians throughout the United States have, in fact, engaged in this conduct, we are unable to conclude that assisting the suicide of a competent, terminally ill patient is beyond the course of professional practice within the meaning of the CSA. We therefore believe that the CSA does not authorize the prosecution of physicians for assisting in suicide in compliance with Oregon law.

A license revocation proceeding for "conduct which may threaten the public health or safety," although somewhat less implausible, should ultimately be rejected as well. As we have just stated, a physician who assists a mentally competent, terminally ill patient in committing suicide in compliance with state law, cannot be said to be acting beyond the current practice of medicine within the meaning of the CSA. In light of the purposes of the CSA, Oregon's clear judgment that the benefits of physician-assisted suicide outweigh the risks, and the existing practice of a significant minority of physicians, we do not see the basis on which the Department could conclude that such assistance threatens the public health and safety within the meaning of the CSA. The CSA, which is concerned primarily with the abuse of drugs deriving from their "stimulant, depressant, or hallucinogenic effect on the central nervous system," 21 U.S.C. § 811(f), and which was drafted to give some deference in license revocation proceedings to state

licensing authorities, was not generally intended as a means to weigh in on debates about good or bad practices of medicine.

A determination that the Department lacks the authority to proceed against physicians who assist in suicide would not necessarily undermine efforts to prevent the use of marijuana for purported medical purposes in states, such as California, that have eliminated state law prohibitions on such use of the drug. Congress initially placed marijuana in Schedule I, and the Attorney General (as delegated to the DEA Administrator) is justified in refraining from rescheduling it to Schedules II-V as long as the drug has a "high potential for abuse," and there is "no currently accepted medical use in treatment in the United States" and "a lack of accepted safety for use of the drug . . . under medical supervision." 21 U.S.C. § 812(b)(1). Once having scheduled marijuana as a substance that may not be prescribed, the Attorney General (through the DEA Administrator) may reasonably find that prescribing the drug even for purported medical use threatens the public health and safety. The CSA does not give the Attorney General or the DEA Administrator any comparable authority to determine for the nation whether a particular use of a Schedule II-V drug is part of "the course of professional practice."

Finally, a decision by the Department to apply the "public health and safety" factor in a manner that would intrude into state affairs as deeply as it would here, risks offering courts an opportunity to limit the Department's administrative discretion. The Fourth Circuit has twice held that administrative interpretations that fundamentally shift the federal/state balance must be "clearly" authorized by statute. See United States v. Wilson, ___ F.3d ___, 1997 WL 785530 (4th Cir. Dec. 23, 1997); Virginia Dep't of Educ. v. Riley, 106 F.3d 559 (4th Cir. 1997) (en banc). The Administration has taken issue with the holding of these cases. A Department interpretation that the CSA authorizes revoking the licenses of Oregon physicians or assisting in their patients' suicides in accordance with state law may prompt a court to entrench, or even further expand, this principle limiting executive branch authority.

II. Views of the Civil Division

Civil Division agrees with the conclusion that the federal government does not have authority to take adverse action against a physician for assisting a suicide in compliance with the Oregon Act, but for reasons different than those expressed by the Office of Legal Counsel and the Criminal Division or the background memorandum. Civil Division believes that the meaning of the CSA's term "in the course of professional practice" is ambiguous. Because of this ambiguity, it is necessary to look to the legislative history to discern Congressional intent. That legislative history shows that Congress was concerned with drug abuse, and concerned with doctors as a source of drug diversion to illegal markets. Therefore, Civil Division believes that the CSA should not be read to allow for criminal or civil action where a doctor prescribes medicine within a bona fide physician-patient relationship, pursuant to a physical examination or similar inquiry, where there is no implication for drug diversion. (Civil Division does not agree with the argument that any improper use of a drug constitutes diversion and/or conduct

outside the course of professional conduct.) Civil Division does believe that if a doctor violates state law within a *bona fide* physician-patient relationship, the CSA authorizes federal action regardless of the implications for diversion.

Because the Civil Division believes that the CSA does not authorize the federal government to take adverse action against a physician for prescribing medicine within a *bona fide* relationship, and because prescribing under the Oregon Act would, by definition, occur within that relationship, the Civil Division believes that the federal government has no authority under the CSA to take adverse action against a physician for assisting in suicide in compliance with Oregon law.

Finally, Civil Division agrees that the conclusion that the federal government does not have authority to take adverse action against a physician for assisting a suicide in compliance with the Oregon Act is not inconsistent with the government's position in the "medical marijuana" cases. The CSA does allow the federal government to intrude into a *bona fide* relationship when a Schedule I substance is at issue. In contrast to the practice of medicine generally, Congress specifically gave the federal government the authority to determine whether drugs have a "currently acceptable medical use in treatment in the United States."