

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Dean Ornish to Chris Jennings re: phone number (partial) (1 page)	08/27/1999	P6/b(6)
002. fax	Nicholas Gess to Chris Jennings re: phone number (partial) (1 page)	08/08/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20468

FOLDER TITLE:

Assisted Suicide [Folder 2]

2012-0463-S

rc721

RESTRICTION CODES

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

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

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

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

RR. Document will be reviewed upon request.

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

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



Office of Policy Development
United States Department of Justice

950 Pennsylvania Avenue, N.W.
Washington, D. C. 20530

TO: Devorah Adler FAX: (202) 456-5557
VOICE: (202) 456-5707

FROM: **Brian M. Hoffstadt** FAX: (202) 353-9164
Counsel VOICE: (202) 514-3116

PAGES: 6

RE: Physician-Assisted Suicide

MESSAGE: Devorah – Attached is a one-pager with recommended changes to your side-by-side chart. Others at DOJ are still looking at the chart, but I thought you could use my thoughts sooner rather than later. I've also attached the AG's June 5, 1998, letter (See the third page, third paragraph, which explains that the AG has not taken a position on the CSA's applicability anywhere other than Oregon). Hope this is helpful. – Brian

Changes To Side-By-Side Chart

Replace "Amendments Affecting Physician-Assisted Suicide" Section for the 1998 Act to read as follows (and change title from "Amendments to the CSA" (since the palliative care provisions also amend the CSA)):

Amends the CSA to create a new basis for denying an application or suspending or revoking registration to dispense controlled substances. The new bar would apply to persons who:

- (i) dispensed or distributed a controlled substances in the past five years to assist a suicide; and
- (ii) are shown, by clear and convincing evidence, to be seeking an application with the intent to use a controlled substance to assist a suicide.

Persons denied registration, or whose registrations were administratively suspended or revoked, would be permitted to show, as a defense, that they used (or intended to use) the controlled substance to alleviate pain, even if the risk of death might increase. These persons would have a right to appeal the merits of this defense to a Medical Advisory Board on Pain Relief, which would be empowered to review this issue independently and advise the Attorney General.

Replace "Provisions Protecting the Practice of Palliative Care" Section for 1998 Act with the following:

Implies (by exempting it from administrative sanction) that the distribution or dispensing of controlled substances to alleviate pain is permitted under the CSA, even if their use may increase the likelihood of death.

Replace the "Amendments Affecting Physician-Assisted Suicide" for the 1999 Act with the following:

Withdraws authorization under the CSA for dispensing controlled substances to assist suicides, and requires the Attorney General to ignore state laws authorizing physician-assisted suicide. This language would make physician-assisted suicide using controlled substances subject to administrative, civil and criminal sanctions.

(The Attorney General has stated that the CSA does not apply in states, such as Oregon, that authorize physician-assisted suicide after strict procedures have been followed. The Attorney General has not issued an opinion on whether the CSA would ban physician-assisted suicide in other states without authorizing legislation, or by physicians in Oregon who do not follow the state's detailed procedures.)

Thus, the effect of this bill is to use the CSA to ban physician-assisted suicide in all 50 states.

If you wish to add a description of both Act's applicability, both acts operate prospectively (so the statement that the 1998 Act operates retrospectively is inaccurate).



Office of the Attorney General
Washington, D.C. 20530

June 5, 1998

The Honorable Orrin G. Hatch
Chairman
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

This is in response to your request concerning the question whether the Department of Justice, through the Drug Enforcement Administration ("DEA"), may invoke the Controlled Substances Act ("CSA"), 21 U.S.C. §§ 801-971, to take adverse action against physicians who assist patients in ending their lives by prescribing controlled substances. The issue has arisen in the context of Oregon's "Death with Dignity Act," Oreg. Rev. Stat. §§ 127.800-127.995, which permits physicians to assist competent, terminally ill patients in ending their lives in compliance with certain detailed procedures. The Department has reviewed the issue thoroughly and has concluded that adverse action against a physician who has assisted in a suicide in full compliance with the Oregon Act would not be authorized by the CSA.

The Oregon Act was approved by Oregon voters on November 8, 1994, and went into effect on October 27, 1997. The Act provides for a detailed procedure by which a mentally competent, terminally ill patient may request to end his or her life "in a humane and dignified manner." 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 Honorable Orrin G. Hatch

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Prior to the Oregon Act's taking effect last year, you wrote to DEA Administrator Thomas Constantine seeking the DEA's view as to whether delivering, distributing, dispensing, prescribing, or administering a controlled substance with the intent of assisting in a suicide would violate the CSA notwithstanding a state law such as the Oregon Act. In response, Administrator Constantine explained that "physician-assisted suicide would be a new and different application of the CSA," and that the determination whether to pursue adverse action under the CSA would first require "a medico-legal investigation" involving "state and local law enforcement agencies and prosecutors." He also stated, however, that "the activities that you described in your letter to us would be, in our opinion, a violation of the CSA." Subsequently, many other Members of Congress have sent letters urging that I support the DEA's conclusions and enforce federal laws and regulations accordingly. I have received other correspondence supporting a contrary conclusion.

The Department has conducted a thorough and careful review of the issue of whether the CSA authorizes adverse action against a physician who prescribes a controlled substance to assist in a suicide in compliance with Oregon law.

The CSA is a complex regulatory scheme that controls the authorized distribution of scheduled drugs. Physicians, for example, are authorized to prescribe and distribute scheduled drugs only pursuant to their registration with the DEA, and the unauthorized distribution of drugs is generally subject to criminal and administrative action. The relevant provisions of the CSA provide criminal penalties for physicians who dispense controlled substances beyond "the course of professional practice," 21 U.S.C. § 802(21), see id. § 841(b), and provide for revocation of the DEA drug registrations of physicians who have engaged either in such criminal conduct or in other "conduct which may threaten the public health and safety," id. § 823(f). Because these terms are not further defined by the statute, we must look to the purpose of the CSA to understand their scope.

The CSA was intended to keep legally available controlled substances within lawful channels of distribution and use. See S. Rep. No. 91-613, at 3 (1969). It sought to prevent both the trafficking in these substances for unauthorized purposes and drug abuse. The particular drug abuse that Congress intended to prevent was that deriving from the drug's "stimulant, depressant, or hallucinogenic effect on the central nervous system," 21 U.S.C. § 811(f).

The Honorable Orrin G. Hatch

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There is no evidence that Congress, in the CSA, intended to displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice. Indeed, the CSA is essentially silent with regard to regulating the practice of medicine that involves legally available drugs (except for certain specific regulations dealing with the treatment of addicts, see 42 U.S.C. § 257a; 21 C.F.R. § 291.505).

Even more fundamentally, there is no evidence that Congress, in the CSA, intended to assign DEA the novel role of resolving the "earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide," Washington v. Glucksberg, 117 S. Ct. 2258, 2275 (1997), simply because that procedure involves the use of controlled substances. If Congress had assigned DEA this role under the CSA, it would ultimately be DEA's task to determine whether assistance in the commission of a suicide, in compliance with a state law specifically permitting and regulating such assistance, nevertheless falls outside the legitimate practice of medicine and is inconsistent with the public interest. These questions, however, are not susceptible of scientific or factual resolution, but rather are fundamental questions of morality and public policy. Such a mission falls well beyond the purpose of the CSA.

The state of Oregon has reached the considered judgment that physician-assisted suicide should be authorized under narrow conditions and in compliance with certain detailed procedures. Under these circumstances, we have concluded that the CSA does not authorize DEA to prosecute, or to revoke the DEA registration of, a physician who has assisted in a suicide in compliance with Oregon law. We emphasize that our conclusion is limited to these particular circumstances. Adverse action under the CSA may well be warranted in other circumstances: for example, where a physician assists in a suicide in a state that has not authorized the practice under any conditions, or where a physician fails to comply with state procedures in doing so. However, the federal government's pursuit of adverse actions against Oregon physicians who fully comply with that state's Death with Dignity Act would be beyond the purpose of the CSA.

Finally, notwithstanding our interpretation of the CSA as it applies to the Oregon Act, it is important to underscore that the President continues to maintain his longstanding position against assisted suicide and any Federal support for that procedure. This position was recently codified when he signed the Assisted Suicide Funding Restriction Act last year. While states

The Honorable Orrin G. Hatch
Page 4

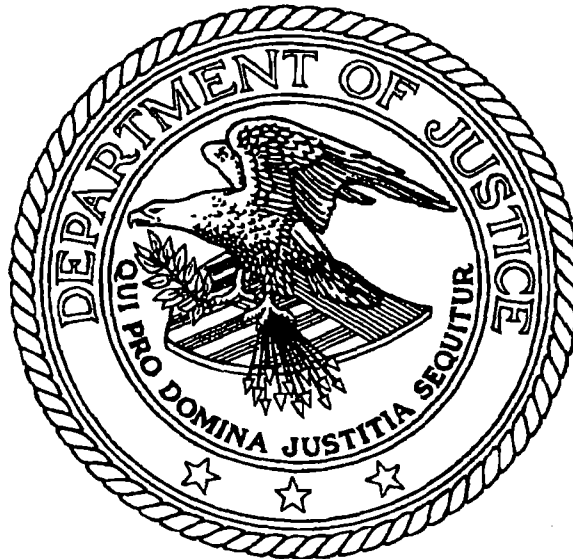
ordinarily have primary responsibility for regulating physicians, the President and the Administration nonetheless remain open to working with you and other interested members of Congress on this complex but extremely important issue.

Sincerely,

A handwritten signature in cursive script, appearing to read "Janet Reno".

Janet Reno

cc: The Honorable Patrick J. Leahy, Jr.
Ranking Minority Member



Office of Policy Development
United States Department of Justice
950 Pennsylvania Avenue, N.W.
Washington, D. C. 20530

TO: Chris Jennings FAX: 456-5557
VOICE: 456-5560

FROM: **Brian M. Hoffstadt** FAX: (202) 353-9164
Counsel VOICE: (202) 514-3116

PAGES: 2

RE: H.R. 2260

MESSAGE: Chris: Attached is a short list of the Justice Department's primary concerns with (and approach to) the physician-assisted suicide provisions of H.R. 2260, for inclusion in the memorandum you discussed with Eldie last week. - Brian

DOJ Position on Physician-Assisted Suicide Provisions of H.R. 2260

Here are the bare bones points DOJ wants made in any views letter on H.R. 2260 (the Pain Relief Promotion Act of 1999) concerning those provisions of the bill that are, according to the sponsors' staff, intended to and would, if implemented, certainly chill (if not effectively shut down) the use of controlled substances in physician-assisted suicide processes authorized by state law.

- H.R. 2260 is much more about inappropriate federalism than it is about physician-assisted suicide.
- H.R. 2260 expressly forbids the prescribing or administering of a controlled substance to assist a suicide and forbids the Attorney General from taking into account any state law authorizing physician-assisted suicide in determining whether a physician's registration is consistent with the public interest for purposes of the Controlled Substances Act.
- The Administration strongly opposes physician assisted suicide and would not support the practice as a matter of federal policy.
- Consistent with this view, the Administration strongly supports the ban on federal funding of physician assisted suicide.
- The prohibitions of H.R. 2260 do not, however, present a question of a federal policy choice but, in fact, operate to block state policy on an issue that the Administration (and the Supreme Court) have acknowledged is appropriately left wholly to the States to decide as each chooses. H.R. 2260 would affirmatively interfere with state policy making in a particular heavy handed way by imposing federal criminal felony liability carrying a mandatory 20-year prison sentence as well as civil and administrative sanctions.
- Accordingly, the Administration's objection to H.R. 2260 is based on federalism, and not on the merits of banning physician-assisted suicide.
- Aside from the federalism point, H.R. 2260 might well result in physician-assisted suicides that do not use sedative and pain-controlling substances because H.R. 2260's prohibitions would only reach controlled substances, which are used as sedatives and not as the actual agents of death.

Preventive Medicine Research Institute

Determined to be an
Administrative marking
VZ 2012-0463-S 7/13/2022

Personal & ~~Confidential~~

To: Mr. Chris Jennings
Company: The White House
Phone: 202/456-5560
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From: Dean Ornish, M.D.
Company: Preventive Medicine Research Institute
Phone: 415/332-2525 x222
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Date: 9/27/99 12:56 PM
**Pages including this
cover page:** 4

Comments:

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Preventive Medicine Research Institute

A non-profit public institute dedicated to research, education, and service

Dean Ornish, M.D.
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September 27, 1999

Mr. Chris Jennings
Deputy Assistant to the President for Health Policy
The White House
Old Executive Office Building, Room 216
Washington, DC 20502

Dear Chris,

Thank you so much for taking the time to talk with me earlier today. As we discussed, a notice is scheduled to be published in the Federal Register on Friday, and it goes on display tomorrow. HCFA has authorized the enclosed press release to be sent out and to hold a press conference to announce the demonstration project. Both would be separate from HCFA.

I thought this might be a good way to begin recruiting patients for the demonstration project. Also, I would like President Clinton and others like you who made this possible to receive credit for their vision and support. At a time when there is so much acrimony and division between various groups, I thought it might be useful for President Clinton and members of Congress to receive public acknowledgement for a truly bipartisan effort.

However, if for any reason you think this is unwise, then I will not send out a press release and I will not participate in a press conference. I value tremendously your judgement and experience. If you think it is a good idea, then I would appreciate very much if you would participate in the press conference. Please call me at [REDACTED] and let me know your thoughts when it is convenient for you.

[001]

As always, I remain very grateful for your advice and support. With best wishes and warm personal regards,

Sincerely,



Dean Ornish, M.D.
Clinical Professor of Medicine
School of Medicine
University of California, San Francisco

PRESS RELEASE

MEDICARE DEMONSTRATION PROJECT TO TEST LIFESTYLE CHANGE PROGRAM TO REVERSE HEART DISEASE

Program Provides New Hope for Heart Patients

The Health Care Financing Administration is implementing a demonstration project to determine if a comprehensive lifestyle program may be a safe and cost effective alternative to conventional medical treatments for selected Medicare patients.

The demonstration project will study up to 1,800 selected Medicare patients with severe coronary artery disease who have elected to follow Dr. Dean Ornish's Program for Reversing Heart Disease as an alternative to bypass surgery and angioplasty. This demonstration will be implemented at several medical facilities around the United States that have been trained by Dr. Ornish and his colleagues at the non-profit Preventive Medicine Research Institute in Sausalito, California.

The facilities currently offering the Ornish program and are eligible to participate in the Medicare demonstration include: Alegant Immanuel Medical Center/Alegant Heart Institute, Omaha, NB; Alegant Bergen Mercy Medical Center, Omaha, NB; Beth Israel Medical Center, New York, NY; Mercy Hospital Medical Center/Iowa Heart Center, Des Moines, IA; Broward General Medical Center, Fort Lauderdale, FL; Palmetto Richland Memorial Hospital, Columbia SC; Scripps Hospitals and Clinics, La Jolla, CA; Franciscan Health System of the Ohio Valley, Dayton, Ohio; Franciscan/Mercy Medical Center, Cincinnati, Ohio; Swedish American Health System, Rockford, IL; St. Francis Medical Center, Blue Island, Illinois; and Swedish Medical Center/First Hill, Seattle, WA. Also, Highmark Blue Cross/Blue Shield of Western Pennsylvania was the first insurer to both cover and to provide this program to its members, now at three different sites. Over 40 insurance companies are now reimbursing the cost of Dr. Ornish's program at these sites for selected patients.

In an earlier demonstration project conducted by Dr. Ornish and his colleagues, published last November in the *American Journal of Cardiology*, they found that 77% of patients who were eligible for bypass surgery or angioplasty were able to avoid it safely by making comprehensive lifestyle changes instead. As a result, Mutual of Omaha and other insurance companies calculated an immediate savings of almost \$30,000 per patient.

During the past 22 years, Dr. Ornish and his colleagues have conducted a series of clinical trials demonstrating-for the first time-that the progression of even severe coronary heart disease often can be reversed by making comprehensive changes in diet and lifestyle, without coronary bypass surgery, angioplasty, or a lifetime of cholesterol-lowering drugs. These lifestyle changes include a very low-fat, low-cholesterol diet, stress management techniques, moderate exercise, smoking cessation, and psychosocial support. Their latest findings were published last December in the *Journal of the American Medical Association*. They found even more reversal of heart disease after five years than after one year.

These research findings have particular significance for Americans in the Medicare population, since the older patients improved as much as the younger ones. No matter how old they were, on average, the more people changed their diet and lifestyle, the more they improved. This is a very hopeful message for Medicare patients, since the risks of bypass surgery and angioplasty increase with age, but the benefits of comprehensive lifestyle changes may occur at any age.

"We are trying to create a new model of medicine that is more caring and compassionate as well as more cost effective by addressing the causes of coronary heart disease rather than just literally or figuratively bypassing them," said Dr. Ornish.

Dean Ornish, M.D. is Founder and President of the non-profit Preventive Medicine Research Institute and Clinical Professor of Medicine at the UCSF School of Medicine.

HR 2260 IH

106th CONGRESS

1st Session

H. R. 2260

To amend the Controlled Substances Act to promote pain management and palliative care without permitting assisted suicide and euthanasia, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

June 17, 1999

Mr. HYDE (for himself, Mr. STUPAK, Mr. ADERHOLT, Mr. BAKER, Mr. BALLENGER, Mr. BARCIA, Mr. BARTON of Texas, Mr. BLUNT, Mr. BRYANT, Mr. BURR of North Carolina, Mr. BURTON of Indiana, Mr. CANADY of Florida, Mr. CHABOT, Mr. COBURN, Mr. COLLINS, Mr. CUNNINGHAM, Mr. DICKEY, Mr. DOOLITTLE, Mr. DOYLE, Mrs. EMERSON, Mr. EVERETT, Mr. FOSSELLA, Mr. GRAHAM, Mr. GOODE, Mr. GOODLATTE, Mr. HALL of Texas, Mr. HAYES, Mr. HERGER, Mr. HOEKSTRA, Mr. HUTCHINSON, Mr. ISTOOK, Mr. JOHN, Mr. KING, Mr. KNOLLENBERG, Mr. LAFALCE, Mr. LAHOOD, Mr. LARGENT, Mr. LEWIS of Kentucky, Mr. LUCAS of Kentucky, Mr. LUCAS of Oklahoma, Mr. MCINTYRE, Mr. MILLER of Florida, Mrs. MYRICK, Mr. NUSSLE, Mr. NETHERCUTT, Mr. PETERSON of Pennsylvania, Mr. PETERSON of Minnesota, Mr. PHELPS, Mr. PICKERING, Mr. PITTS, Mr. PORTMAN, Mr. RAHALL, Mr. ROGAN, Mr. ROGERS, Mr. SALMON, Mr. SCHAFFER, Mr. SENSENBRENNER, Mr. SHIMKUS, Mr. SHOWS, Mr. SKELTON, Mr. SMITH of Texas, Mr. SMITH of New Jersey, Mr. SPENCE, Mr. STEARNS, Mr. TANCREDO, Mr. TERRY, Mr. WALSH, Mr. WAMP, and Mr. WELDON of Florida) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Controlled Substances Act to promote pain management and palliative care without permitting assisted suicide and euthanasia, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the 'Pain Relief Promotion Act of 1999'.

TITLE I--USE OF CONTROLLED SUBSTANCES CONSISTENT WITH THE CONTROLLED SUBSTANCES ACT

SEC. 101. REINFORCING EXISTING STANDARD FOR LEGITIMATE USE OF CONTROLLED SUBSTANCES.

Section 303 of the Controlled Substances Act (21 U.S.C. 823) is amended by adding at the end the following:

`(i)(1) For purposes of this Act and any regulations to implement this Act, alleviating pain or discomfort in the usual course of professional practice is a legitimate medical purpose for the dispensing, distributing, or administering of a controlled substance that is consistent with public health and safety, even if the use of such a substance may increase the risk of death. Nothing in this section authorizes intentionally dispensing, distributing, or administering a controlled substance for the purpose of causing death or assisting another person in causing death.

`(2) Notwithstanding any other provision of this Act, in determining whether a registration is consistent with the public interest under this Act, the Attorney General shall give no force and effect to State law authorizing or permitting assisted suicide or euthanasia.

`(3) Paragraph (2) applies only to conduct occurring after the date of enactment of this subsection.'

SEC. 102. EDUCATION AND TRAINING PROGRAMS.

Section 502(a) of the Controlled Substances Act (21 U.S.C. 872(a)) is amended--

(1) by striking 'and' at the end of paragraph (5);

(2) by striking the period at the end of paragraph (6) and inserting '; and'; and

(3) by adding at the end the following:

`(7) educational and training programs for local, State, and Federal personnel, incorporating recommendations by the Secretary of Health and Human Services, on the necessary and legitimate use of controlled substances in pain management and palliative care, and means by which investigation and enforcement actions by law enforcement personnel may accommodate such use.'

TITLE II--PROMOTING PALLIATIVE CARE

SEC. 201. ACTIVITIES OF AGENCY FOR HEALTH CARE POLICY AND RESEARCH.

Part A of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended by adding at the end the following section:

`SEC. 906. PROGRAM FOR PALLIATIVE CARE RESEARCH AND QUALITY.

`(a) IN GENERAL- The Administrator shall carry out a program to accomplish the following:

`(1) Develop and advance scientific understanding of palliative care.

`(2) Collect and disseminate protocols and evidence-based practices regarding palliative care, with priority given to pain management for terminally ill patients, and make such information available to public and private health care programs and providers, health professions schools, and hospices, and to the general public.

`(b) DEFINITION- For purposes of this section, the term 'palliative care' means the active total care of patients whose prognosis is limited due to progressive, far-advanced disease. The purpose of such care is to alleviate pain and other distressing symptoms and to enhance the quality of life, not to hasten or postpone death.'

SEC. 202. ACTIVITIES OF HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(a) IN GENERAL- Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.), as amended by section 103 of Public Law 105-392 (112 Stat. 3541), is amended--

(1) by redesignating sections 754 through 757 as sections 755 through 758, respectively; and

(2) by inserting after section 753 the following section:

'SEC. 754. PROGRAM FOR EDUCATION AND TRAINING IN PALLIATIVE CARE.

'(a) IN GENERAL- The Secretary, in consultation with the Administrator for Health Care Policy and Research, may make awards of grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in palliative care.

'(b) PRIORITIES- In making awards under subsection (a), the Secretary shall give priority to awards for the implementation of programs under such subsection.

'(c) CERTAIN TOPICS- An award may be made under subsection (a) only if the applicant for the award agrees that the program carried out with the award will include information and education on--

'(1) means for alleviating pain and discomfort of patients, especially terminally ill patients, including the medically appropriate use of controlled substances;

'(2) applicable laws on controlled substances, including laws permitting health care professionals to dispense or administer controlled substances as needed to relieve pain even in cases where such efforts may unintentionally increase the risk of death; and

'(3) recent findings, developments, and improvements in the provision of palliative care.

'(d) PROGRAM SITES- Education and training under subsection (a) may be provided at or through health professions schools, residency training programs and other graduate programs in the health professions, entities that provide continuing medical education, hospices, and such other programs or sites as the Secretary determines to be appropriate.

'(e) EVALUATION OF PROGRAMS- The Secretary shall (directly or through grants or contracts) provide for the evaluation of programs implemented under subsection (a) in order to determine the effect of such programs on knowledge and practice regarding palliative care.

'(f) PEER REVIEW GROUPS- In carrying out section 799(f) with respect to this section, the Secretary shall ensure that the membership of each peer review group involved includes one or more individuals with expertise and experience in palliative care.

'(g) DEFINITION- For purposes of this section, the term 'palliative care' means the active total care of patients whose prognosis is limited due to progressive, far-advanced disease. The purpose of such care is to alleviate pain and other distressing symptoms and to enhance the quality of life, not to hasten or postpone death.'

(b) AUTHORIZATION OF APPROPRIATIONS; ALLOCATION-

(1) IN GENERAL- Section 758 of the Public Health Service Act (as redesignated by subsection (a)(1) of this section) is amended in subsection (b)(1)(C) by striking 'sections

753, 754, and 755' and inserting 'section 753, 754, 755, and 756'.

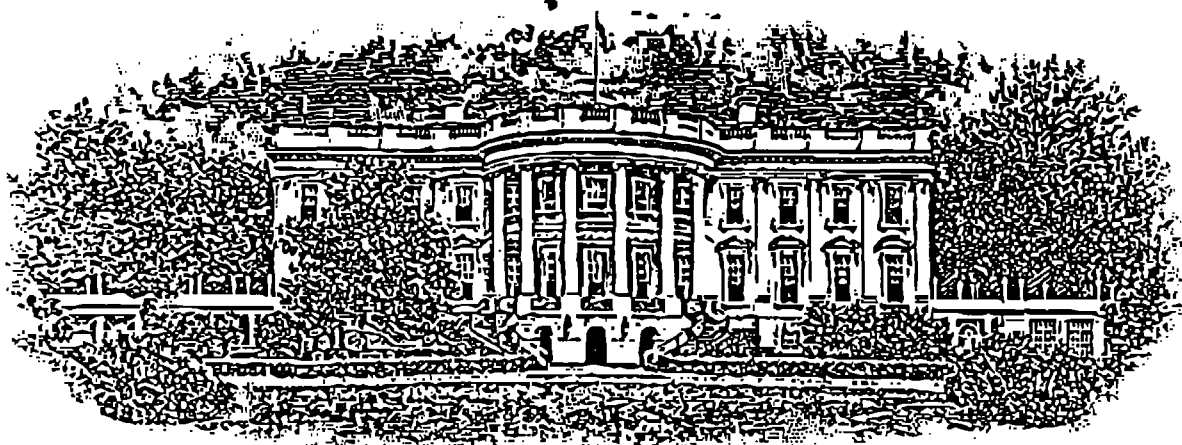
(2) AMOUNT- With respect to section 758 of the Public Health Service Act (as redesignated by subsection (a)(1) of this section), the dollar amount specified in subsection (b)(1)(C) of such section is deemed to be increased by \$5,000,000.

SEC. 203. EFFECTIVE DATE.

The amendments made by this title take effect October 1, 1999, or upon the date of the enactment of this Act, whichever occurs later.

END

The White House



COUNSEL'S OFFICE

Facsimile Transmission Cover Sheet

Telephone 202 456-6229

Fax 202 456-2146

DATE:

9/16/99

TO:

Devorah Adler

FACSIMILE NUMBER:

65557

TELEPHONE NUMBER:

FROM:

Sarah Wilson

TELEPHONE NUMBER:

62144

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

**FOR IMMEDIATE RELEASE
Friday, May 21, 1999**

**CONTACT: Bob Weiner
(202) 395-6618**

**WHITE HOUSE DRUG CZAR ISSUES STATEMENT
ON MARIJUANA FOR MEDICAL RESEARCH**

(Washington, D.C.) - General Barry R. McCaffrey, Director of the White House Office of National Drug Policy, issued the following statement today following the announcement by the Department of Health and Human Services of new procedures for the provision of marijuana for medical research.

"ONDCP endorses the Department of Health and Human Services' decision to facilitate further research into the potential medical uses of marijuana and its constituent cannabinoids. Such research will allow us to better understand what benefits might actually exist for the use of cannabinoid-based drugs, and what risks such use entails. It will also facilitate the development of an inhaler or alternate rapid-onset delivery system for THC or other cannabinoid drugs. Advisors to both the National Institutes of Health and the Institute of Medicine have concluded that such research is warranted. This decision underscores the federal government's commitment to ensuring that the discussion of the medical efficacy and safety of cannabinoids takes place within the context of medicine and science.

Continued strict regulation of cannabis is essential. Until we fully understand the ramifications of allowing cannabinoid-based medicines, such uses must only be part of clinical studies to expand the body of scientific understanding. In short, we need to be sure that as we examine cannabinoid-based drugs for possible medical benefit that we do not contribute to increased abuse of this psychoactive substance.

We look forward to working closely with the Department of Health and Human Services to promote bonafide clinical research and to ensure appropriate medical access to drugs and substances that are deemed safe and effective for medical use in treatment."



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

EMBARGOED UNTIL:
11:00 A.M. E.S.T. Wed., March 17, 1999

CONTACT: Bob Weiner/Steve Panton
(202) 395-6618

**WHITE HOUSE DRUG POLICY OFFICE ISSUES STATEMENT
ON INSTITUTE OF MEDICINE'S REPORT
ON MARIJUANA AND MEDICINE**

(Washington, D.C.) – The White House Office of National Drug Policy (ONDCP) issued the following statement today following the release of the Institute of Medicine's report, *Marijuana and Medicine: Assessing the Science Base*:

We are delighted that science is the basis of the discussion of this issue, as it must be. In January 1997, ONDCP asked the Institute of Medicine to conduct a review of the scientific evidence for assessing the potential health benefits and risks of marijuana and its constituent cannabinoids. ONDCP believed that an objective and independent evaluation of research regarding the use of marijuana for medicinal purposes was appropriate given the ongoing debate about cannabis and its health effects.

The report released today by the Institute of Medicine represents the most thorough analysis to date of the relevant scientific literature. It summarizes recent advances in molecular and behavioral neuroscience, in particular newly elaborated systems of transmitters, receptors, and antagonists -- all illuminating the physiological effects of cannabinoids. The Institute of Medicine has addressed all issues that ONDCP requested be examined, including: the science base and gaps in scientific knowledge regarding use of marijuana for medicinal purposes; scientific information about marijuana's mechanism of action; peer-reviewed literature on the uses of marijuana; and costs associated with various forms of the component chemical compounds in marijuana and other pharmacotherapies for special medical conditions. We thank the principal investigators, members of the advisory panel, biomedical and social scientists, patients, advocates, report reviewers, and all who supported the Institute of Medicine in developing this comprehensive report.

The report contains six specific recommendations that address:

1. Continued research into the physiological effects of cannabinoids.
2. Clinical trials of cannabinoid drugs for symptom management.
3. Evaluation of psychological effects of cannabinoids in clinical trials.
4. Studies of individual health risks in smoking marijuana.

5. Clinical trials of marijuana use under limited circumstances for medical purposes.
6. Short-term use of smoked marijuana under strict conditions for patients with debilitating symptoms.

These recommendations are supported by the following observations:

- Scientific data indicate the potential therapeutic value of cannabinoids for pain relief, control of nausea and vomiting, and appetite stimulation. This value would be enhanced by a rapid onset of drug effect.
- The psychological effects of cannabinoids are probably important determinants of their potential therapeutic value. They can influence symptoms indirectly, which could create false impressions of the drug effect or be beneficial as a form of adjunctive therapy.
- Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory diseases, but the data that could conclusively establish or refute this suspected link have not been collected.
- Because marijuana is a crude THC delivery system that also delivers harmful substances, smoked marijuana generally should not be recommended for medical use. Nonetheless, marijuana is widely used by certain patient groups, which raises both safety and efficacy issues.
- If there is any future for marijuana as medicine, it lies in its isolated components -- the cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug, but such trials could be a first step towards the development of rapid-onset, nonsmoked cannabinoid delivery systems.

The Office of National Drug Control Policy appreciates the contributions made by the Institute of Medicine to the debate on the medical efficacy and safety of cannabinoids. We will carefully study the recommendations and conclusions contained in this report. We will continue to rely on the professional judgement of the Secretary of Health and Human Services, the Director of the National Institutes of Health, and the Surgeon General on all issues related to the medical value of marijuana and its constituent cannabinoids. We note in the report's conclusion that "the future of cannabinoid drugs lies not in smoked marijuana, but in chemically-defined drugs that act on the cannabinoid systems that are a natural component of human physiology." We look forward to the considered responses from our nation's public health officials to the interim solutions recommended by the report.

The full text of the report is available from I.O.M. on line at <http://www.nap.edu> or call 1-800-624-6242.



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ONDCP Statement on Marijuana for Medical Purposes

August 4, 1997

The initiatives underway in a number of States have sent a confusing message to our children concerning marijuana that could not come at a worse time. In recent years we have seen drug use by our young people increase at an alarming rate. Among 8th graders, the use of illicit drugs — primarily marijuana — has tripled. This increase in marijuana use has been fueled by a measurable decrease in the proportion of young people who perceive marijuana to be a dangerous substance.

Advocates for legalized marijuana have mounted an intense and sophisticated public relations effort to persuade Americans to their point of view, citing anecdotal examples to support their thesis. As a result, many Americans are unclear about what the scientific research really says. For example, in the past month, researchers have shown that the main active ingredient in marijuana has precisely the same impact as heroin on a key brain site that influences addiction to many drugs. The same researchers also found that abrupt cessation of long-term marijuana use causes the same kind of cellular withdrawal reaction in lab rats as that produced by other major drugs of abuse. To clarify these issues surrounding marijuana research, we have commissioned a scientific review by the National Academy of Science's Institute of Medicine (IOM), a venerable scientific institution renowned for its integrity. The IOM assessment will produce a comprehensive summary of the scientific record on marijuana, which will serve as an objective foundation for public-policy discussion and future research. As an independent body of scientific and medical experts, the IOM is well suited to conduct this important study.

Besides efforts to protect the medical-scientific process, a number of other actions are underway by federal agencies to continue enforcement of Federal law, preserve drug-free workplace and safety programs, and protect children from increased marijuana availability and use.

The foremost objective of the Office of National Drug Control Policy is to create a National Drug Control Strategy based on science rather than ideology. We have worked closely with Director Harold Varmus of the National Institutes of Health (NIH), Director Alan Leshner of the National Institute on Drug Abuse, and other distinguished scientists and medical researchers. The Federal government endorses the therapeutic use of any substance but only if it meets strict scientific standards that ensure safe and efficacious use.

Research on the therapeutic use of marijuana should be treated with the same high standards for scientific research required of any other drug with a high potential for abuse. The existing FDA-NIH-DEA process ensures that decisions regarding Investigational New Drug applications are based on their

scientific merits. Any departure from this established process is a breach of the public trust that all Americans rely upon to safeguard the quality of our world class medical system.

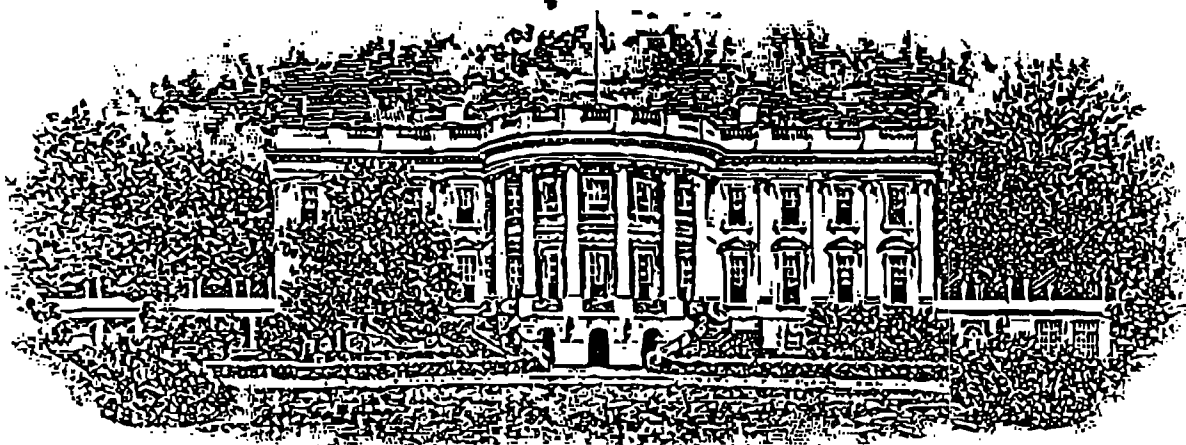
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With drug use by young people increasing, we must not send a mixed message to our youth about the dangers of marijuana. Our Nation's goal must be to reduce, not promote, the use of illicit drugs.

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The White House



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FROM:

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Assisted Suicide -- Priority of Senator Nickles and Congressman Hyde

The Republican Leadership has indicated that it may push for a version of the Nickles' assisted suicide legislation (S. 2151, the Lethal Drug Abuse Prevention Act), which would direct the Drug Enforcement Agency (DEA) to use the Controlled Substances Act (CSA) to apply penalties to physicians who used pain killer medications to assist in a suicide. This legislation was drafted to, in effect, preempt an Oregon state law that permits assisted suicide. Although (like the President), Senator Wyden opposes assisted suicide, he **STRONGLY** opposes any use of Federal law to preempt a law supported via referendum by the citizens of Oregon.

Because of the serious concerns medical groups like the AMA (who also oppose assisted suicide) have about the likely intimidating impact S. 2151 could have on physicians prescribing pain management medications for terminally ill patients, the AMA, the American Nurses Association, the American College of Physicians and numerous other national health care organizations strongly oppose the Nickles/Hatch/Hyde bill. They believe such legislation would exacerbate a long-documented problem of physicians under prescribing pain medications for the appropriate management of terminally ill patients. While we have repeatedly underscored the President's longstanding position against assisted suicide and our willingness to work on this legislation in the future (see attached letter to Judiciary Chairman Hatch), we have advised the Committee that their current bill is flawed and premature because it does not adequately address health care professionals' legitimate concerns in this area.

Senator Nickles' may be pushing for an alternative to his original bill or his most recent amendment, which attempted to codify a DEA letter on this issue that indicated DEA had the authority to this under current law -- a position which DoJ subsequently rejected. The latest rumor is that he has an alternative that DPC, White House Counsel, and DoJ has never seen. Altering our position on this issue would be vehemently attacked by Senator Wyden, the health care interest groups we have worked with for years, and the media elite who have consistently chastised the Nickles' approach.

Suggested Talking Points:

- As you know, the President strongly opposes assisted suicide. He reiterated this position when he signed the Assisted Suicide Funding Restriction Act just last year.
- However, as the Justice Department made clear in a letter to the Senate Judiciary Committee less than a month ago, we cannot support the Nickles/Hatch/Hyde bill -- or something that resembles it -- because we believe it has great potential to exacerbate the current problem of under prescribing pain medications designed to appropriately alleviate the suffering of the terminally ill.
- Our opposition to this bill is shared by many respected national health organizations, many of which also oppose assisted suicide, including the AMA, the Nurses Association, the American College of Physicians and numerous other national health care groups.
- As we have repeatedly said, we are willing to spend the time necessary to determine if appropriate legislation or other interventions can be designed. But this is the wrong policy, on the wrong vehicle, at the wrong time.



U.S. Department of Justice
Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

September 16, 1998

The Honorable Orrin G. Hatch
Chairman
Committee on the Judiciary
United States Senate
Washington, D.C. 20510-6275

Dear Mr. Chairman:

We are responding to your letter of September 9, 1998, to Mr. Joseph Onek, Principal Deputy Associate Attorney General, regarding S. 2151, the "Lethal Drug Abuse Prevention Act of 1998." We regret the delay in responding.

The President is committed to working with you, Senator Leahy, and Members on and off the Judiciary Committee to help develop approaches to curtail assisted suicide. As you know, this position is consistent with his longstanding opposition to assisted suicide and his support for the Assisted Suicide Funding Restriction Act last year. As such, he has requested that the Justice Department and the Department of Health and Human Services work collaboratively with you and other Members of Congress on this issue.

The President, however, is concerned that S. 2151 will have unintended adverse consequences, which cannot adequately be remedied in the limited time remaining in this Congress. The negative impact S. 2151 could have on the provision of pain relief medications for our nation's terminally ill is of particular concern to the Administration, as it is to virtually every major medical organization in the nation. These organizations share the President's abhorrence and opposition to assisted suicide, but, with very few exceptions, oppose the Lethal Drug Abuse Prevention Act.

There is broad consensus that the American medical system does a poor job of providing palliative care to terminally ill patients and, in particular, that it fails to provide effective pain management. As a result, many patients unnecessarily suffer excruciating pain and some patients -- in pain or fearing future pain -- seriously consider suicide (physician assisted or otherwise).

Health care experts in this field strongly believe that S. 2151 exacerbates this problem. The legislation authorizes the DEA to impose serious civil penalties against physicians who dispense controlled substances to assist a patient suicide. The legislation may also authorize the imposition of criminal penalties on such physicians. Virtually all potent pain medications are controlled substances. Thus, physicians who dispense these medications to ease the pain of terminally ill patients could well fear that they could be the subject of a DEA investigation whenever a patient's death can be linked to the use of a controlled substance.

The Lethal Drug Abuse Prevention Act is designed to address physicians' fears by prohibiting sanctions as long as physicians do not dispense the controlled substance with the intent of causing death. However, the issue of intent would not necessarily be resolved simply by asking physicians about their intent. To establish intent, the DEA might also need to investigate the details of the physician's prescribing practices and of the physician's relationships with the patient and the patient's family.

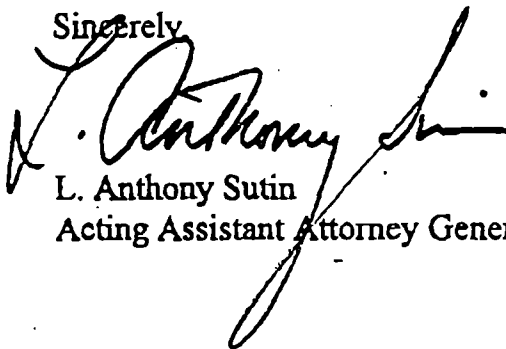
It is precisely the fear of a DEA investigation that creates the potential to inhibit physicians from providing adequate pain medication to terminally ill patients. In response, physicians may undermedicate patients, patients may suffer unnecessary pain and, as a result of increased incidence of great pain amongst the terminally ill, patient suicides -- physician assisted or not -- may increase. Such an outcome would be far more than ironic; it would be tragic. Understanding this, the American Medical Association, the American Nurses Association, the National Hospice Organization and many other respected national health organizations strongly oppose S. 2151.

We believe that the better way to avoid assisted suicides is to develop consensus guidelines on the appropriate use of controlled substances for terminally ill patients. Such guidelines would be designed to be sufficiently clear that a physician who followed them would be free from any fear of sanctions. The board charged with developing these guidelines would have representatives of doctors, nurses, consumers, theologians, ethicists, and law enforcement officials and would report back to the Congress and the Administration in a specified period of time. The board also could provide recommendations on the most appropriate entity to enforce these guidelines, as well as the authority and responsibility such an entity should have.

Clearly, any board charged with developing guidelines for this area should be carefully chosen. If we pursued this approach, we would want to determine a mutually acceptable appointment process. If you find this advisory board concept acceptable, which would be one way of coming closer to a consensus approach, we would be pleased to work with you to establish -- through legislation or, if legal and appropriate, by Executive Action -- any such entity.

The Administration believes that working together we can develop an appropriate way to address this important issue. We look forward to working with you in the future. The Office of Management and Budget has advised that there is no objection from the standpoint of the Administration's program to the presentation of this report. If we may be of additional assistance, we trust that you will not hesitate to call upon us.

Sincerely

A handwritten signature in black ink, appearing to read "L. Anthony Sutin", with a long, sweeping flourish extending from the end of the signature.

L. Anthony Sutin
Acting Assistant Attorney General

cc: The Honorable Patrick J. Leahy
Ranking Minority Member



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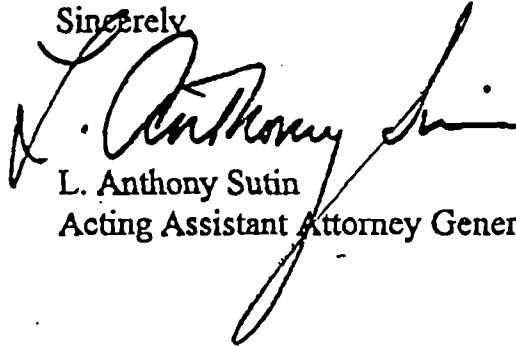
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cc: The Honorable Patrick J. Leahy
Ranking Minority Member

ASSISTED SUICIDE

• if letter → Admin has concerns & implicitly might be viewed to oppose it, that we ensure that POTUS recognizes that this means we oppose pain relief.

POTUS supportive of States rights → but this tends to conflict (perceptually) to position against assisted suicide.

Options

- ① Veto b/c supercedes state law work w/ more appropriate leg.
- ② sign / let become law support
- ③ Despite concerns about approach don't support ass. suicide, this is more important than States right (do not oppose) (DOJ)

Admin on record in terms of Fed policy → like to see a bill giving Ag discretion under CSA to deal w/ individual physician practice in this area.

not relevant

- ④ oppose

HHS → DES

Federalism prob & PBOB

Can't pass

① timing demands on letter
when
if

② DOJ outline from their
perspective different
positioning

end of the day tomorrow
on Hill

workability

feasibility

penalties being too harsh.

Call NGA

step removed from this
is a talking more of
a treatise on the issue than
this is what we believe.

Wyden bill just palliative
care

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. fax	Nicholas Gess to Chris Jennings re: phone number (partial) (1 page)	08/08/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20468

FOLDER TITLE:

Assisted Suicide [Folder 2]

2012-0463-S

rc721

RESTRICTION CODES

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

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

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

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

RR. Document will be reviewed upon request.

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

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

UNITED STATES DEPARTMENT OF JUSTICE

Office of Nicholas M. Gess
Associate Deputy Attorney General

950 Pennsylvania Avenue, N.W.
Room 4220
Washington, DC 20530
Telephone: (202) 514-0835



- three
issues
- time of release
(AFTER markup)
 - less emphasis
on CSA prob
 - Federalism
section too
strong.

TO: Chris Jennings

OFFICE NUMBER:

FAX NUMBER:

456 - 5557

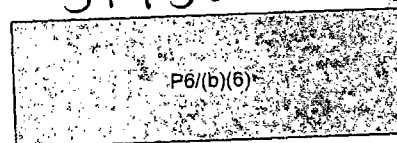
FROM:

Nicholas M. Gess

DATE/TIME:

September 8, 1999

Nick guess
5145000



(hm)

[002]

NUMBER OF PAGES INCLUDING THIS SHEET:

TELEPHONE NUMBER OF PERSON TO CONTACT UPON RECEIPT:

* * * FAX NUMBER: (202) 514-9368 PHONE NUMBER 202-514-0835 * * *

REMARKS: Chris - Copy of this went over to OMB for circulation, but I wanted you to have one directly. Physician-assisted suicide issue is back, with markup today / tomorrow. Proposed letter now pared down - Pls. Call when you have a moment so we can discuss White House desires on this. Thanks.



U.S. Department of Justice

Office of Legislative Affairs

right
after
markup

Office of the Assistant Attorney General

Washington, D.C. 20530

Honorable Henry Hyde
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

can't
send before
hearing too
complicated

DRAFT
9/7/1999

Dear Mr. Chairman:

This letter presents the views of the Department of Justice on H.R. 2260, the "Pain Relief Promotion Act of 1999."

H.R. 2260 makes two changes to federal drug law as it relates to the use of controlled substances by terminally ill patients. First, the bill clarifies that controlled substances may be used to alleviate pain in the course of providing palliative care to terminally ill patients. The bill also funds research and education on the appropriate use of controlled substances for this purpose. The Department strongly supports these provisions of H.R. 2260.

← insert language on POTUS stance against assisted suicide.

Second, H.R. 2260 provides that the use of controlled substances to assist a terminally ill person in committing suicide is not authorized by federal law. The Administration is opposed to physician-assisted suicide as a policy matter; but we are concerned about the federalism and other policy ramifications of making physician-assisted suicide a federal crime with harsh mandatory penalties at a time when, as the Supreme Court recently noted in Washington v. Glucksberg, 117 S. Ct. 2258, 2275 (1997), the States are still "engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide," and in the face of the choice of the citizens of at least one state to adopt a highly regulated and circumscribed procedure which could not be complied with without violating this bill.

Palliative Care

Section 101 of H.R. 2260 amends section 303 of the CSA, 21 U.S.C. § 823, to specify that the use of controlled substances to "alleviat[e] pain or discomfort in the usual course of professional practice" is a "legitimate medical purpose" under the Controlled Substances Act, 21 U.S.C. § 841, "even if the use of such a substance may increase the risk of death." Because a physician who acts with a "legitimate medical purpose" is acting

in compliance with the Act,¹ H.R. 2260 creates a "safe harbor" against administrative and criminal sanctions when controlled substances are used for palliative care. Sections 102, 201 and 202 amend the CSA and the Public Health Service Act (42 U.S.C. § 299) to authorize the Attorney General, the Administrator of the Agency for Health Care Policy and Research, and the Secretary of the Health and Human Services Department to conduct research on palliative care, to collect and distribute guidelines for the administration of palliative care, and to award grants, cooperative agreements, and contracts to health schools and other institutions to provide education and training on palliative care.

The Department fully supports these measures. H.R. 2260 would eliminate any ambiguity about the legality of using controlled substances to alleviate the pain and suffering of the terminally ill by reducing any perceived threat of administrative and criminal sanctions in this context. The Department accordingly supports those portions of H.R. 2260 addressing palliative care.

Physician Assisted Suicide

I thought we did not want to say this

Section 101 amends section 303 (21 U.S.C. 823) of the Controlled Substances Act (CSA) to add subsection (i), which provides that "[n]othing in this section authorizes intentionally dispensing, distributing, or administering a controlled substance for the purpose of causing death or assisting another person in causing death." We understand that the sponsors of this bill intend, by withdrawing authorization under the CSA, to make it a federal crime for a physician to dispense a controlled substance to aid a suicide. If the CSA were amended by H.R. 2260, a physician who prescribes the controlled substances most commonly used to aid a suicide would, because he necessarily intends death to result, face a 20-year mandatory minimum sentence in federal prison (as well as civil and administrative sanctions under the Act).² H.R. 2260 makes no exception for states like Oregon that authorize physician-assisted suicide, even though any physician complying with Oregon's procedures would effectively prepare the federal case against himself or herself because the Oregon law requires physicians to document their patients' intent to have

¹ See, e.g., 21 C.F.R. § 1306.04(a) (authorizing prescriptions only for "legitimate medical purposes").

² See 21 U.S.C. § 841(b)(1)(C) (setting 20 year mandatory minimum sentence when death results from the distribution of a Schedule II substance); 21 C.F.R. § 1308.12(a)-(c) (defining Schedule II substances). Schedule III drugs, which are sometimes used, do not carry any mandatory minimum sentence. See 21 U.S.C. § 841(b)(1)(D).

I thought
we did
not want
to say this

the physicians assist with their suicides.³

Although the Administration strongly opposes physician-assisted suicide and supports the ban on federal funding of such an activity, H.R. 2260's federally imposed penalties would effectively preclude states from adopting a policy authorizing physician-assisted suicide, even when the state authorization contains narrowly drafted conditions designed to protect the terminally ill (as Oregon's Death with Dignity Act does). The Supreme Court in Washington v. Glucksburg declined to cut short the policy debate now underway in state legislatures by precluding States from banning physician-assisted suicide, and we think it may be similarly inadvisable to curtail the debate by precluding States from regulating physician-assisted suicide, such as by requiring clear documentation of actions in order to protect the patient. As many Justices noted in Glucksburg, this is the type of issue best left to the States in the first instance.⁴ We accordingly oppose federal legislation, such as H.R. 2260, that would take away from states their ability to make policy judgments about this difficult moral and ethical issue.⁵

³ See, e.g., Or. Rev. Stat. § 127.855 (specifically requiring a physician in Oregon to "document[] or file[]" evidence of compliance with the Oregon Act's specific requirements concerning the patient's request to end his or her life in the patient's medical record, and "indicat[e] that all requirements under [the Oregon law] have been met"); id. §§ 127.800-127.897 (listing requirements).

⁴ Glucksburg, 117 S. Ct. 2258, 2274 (noting that debate over physician-assisted suicide is underway in the States, "as it should in a democratic society"); id. at 2303 (O'Connor, J., concurring) (endorsing majority's result, which left "the . . . challenging task of drafting appropriate procedures for safeguarding . . . liberty interests . . . to the 'laboratory' of the States"); id. at 2293 (Souter, J., concurring) (emphasizing that, in light of current state experimentation, "[t]he Court should stay its hand to allow reasonable legislative consideration [of this difficult issue]").

⁵ This approach to physician-assisted is consistent with the Department's approach to "medical marijuana." The legality of the latter turns on factual, not ethical, questions. That is, the scheduling of controlled substances is based on scientific testing to determine, among other things, whether they have any "currently accepted medical use for treatment in the United States," a "high potential for abuse," and "a lack of accepted safety for use . . . under medical supervision." 21 U.S.C. § 812(b)(1) and Schedule I(c)(10). As a result, the CSA appropriately creates a uniform national system of drug scheduling. In contrast, the only "evidence" supporting a

Moreover, we doubt whether H.R. 2260 would be entirely effective in preventing physician-assisted suicide, and it may have perverse consequences to the extent that it allows the practice. It is our understanding that in the most common "prescription" for death, controlled and non-controlled substances are used in combination; in such cases, the controlled substance is used as a sedative while the non-controlled substances is the actual cause of death. Because H.R. 2260 bans only the use of controlled substances, it is probable that at least some patients and physicians in states with authorized physician-assisted suicide procedures would forego the controlled substance sedative, resulting in more painful deaths for the patients.

Thank you for this opportunity to present our views. The Office of Management and Budget has advised us that from the standpoint of the Administration, there is no objection to the submission of this letter. Please do not hesitate to call upon us if we may be of further assistance.

Sincerely,

Jon P. Jennings
Acting Assistant Attorney General

cc: Honorable John Conyers, Jr.
Ranking Minority Member

federal prohibition on physician-assisted suicide under the Oregon Death with Dignity Act would be the ethical views of federal officials. Where an issue turns solely on ethics, not science, it is reasonable to allow individual states to reach their own conclusions, rather than impose a uniform national standard.

- DEA /
high standards
- high standards

Veto

Full policy = correct results
= Lab of democracy
AG discussion & del. of problem
in national relations



Aspects of work

Freedom

support

Flexibility

Workability
worker adaptability

Do not agree with his concerns

even though there is a role to be

Ron Wyden:

plc of political case

NGA:

Bob Moler