U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

Assisted Suicide

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

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.

Second, H.R. 2260 states that the use of controlled substances to assist a terminally ill person in committing suicide is not authorized by federal law. The Department opposes physician-assisted suicide, but is concerned about the propriety of a federal law that would unquestionably make physician-assisted suicide a federal crime with harsh mandatory penalties. Imposing such penalties would also effectively block State policy making on this issue 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."

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

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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

H.R. 2260 would amend section 303 (21 U.S.C. 823) of the Controlled Substances Act (CSA) to provide 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." By withdrawing authorization under the CSA, H.R. 2260 would make it a federal crime for a physician to dispense a controlled substance to aid a suicide.[2] 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).[3]

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

[2] The criminal provisions of the CSA are triggered by the absence of proper authorization. See 21 U.S.C. §841(a) ("Except as authorized by this subchapter, it shall be unlawful . . .") (emphasis added).

[3] 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).

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The Administration strongly opposes the practice of physician-assisted suicide and would not support the practice as a matter of federal policy. H.R. 2260 side-steps the federal policy question, however, and operates instead by blocking state policy making on an issue that many, including the Supreme Court, think is appropriately left to the States to decide as each chooses.[4]

Moreover, H.R. 2260 would affirmatively interfere with state policy making in a particularly heavy handed way by using 20-year mandatory prison sentences (as well as civil and administrative sanctions) to effectively preclude states from adopting any policy that would authorize physician-assisted suicide, even if that authorization contains carefully drafted provisions designed to protect the terminally ill.

For these reasons, H.R. 2260 is particularly intrusive to state policy making and the Department accordingly opposes this portion of the bill.[5] The Department would, however, be willing to work with the Committee in formulating a legislative or regulatory solution that obviates the concerns identified in this letter.[6]

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[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. 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 through implied preemption of state medical standards.

[6] Any solution should also be careful not to make state-authorized assisted suicides more painful, as H.R. 2260 appears

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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,

Robert Raben
Assistant Attorney General

cc: Honorable John Conyers, Jr.
Ranking Minority Member

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to do. H.R. 2260's prohibitions would only reach controlled substances, which are most often used as sedatives and not as the actual agents of death. As a result, H.R. 2260 might well result in physician-assisted suicides that do not use sedatives and pain-controlling substances that are accordingly more painful.

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