to determine the number and length of breaks that their employer, the Wage and Hour Division has taken the position that an employer offers a break of less than 20 minutes in duration, the time the employee spends on that break typically is compensable hours worked under the Fair Labor Standards Act.

Most of the Wage and Hour Opinion Letters that address this issue involve unauthorized breaks. However, on several occasions, the Wage and Hour Administrator has stated that short unauthorized breaks may also count as hours worked. Wage and Hour has taken the position that if an employee exceeds the time allotted for an authorized break, an employer may take a disciplinary action against the employee, or the employer may eliminate the option for rest periods/breaks.

I am committing the Wage and Hour Division and the Solicitor’s Office to carefully review our policy with respect to the compensability of unauthorized break time under the FLSA. Our review will specifically include analysis in which employers exceed the time allowed for a rest break. We will also consider what outcome is in the best interests of the employee if the employee exceeds the allotted time for a rest period/break, including the option of deduction of compensation for the time taken in excess of the allotted break time.

As part of our review, we will consider the statutory text, relevant legislative history and regulatory material, case law, previous Wage and Hour Opinion Letters, changing technology and any information that your office or a member of the public may provide. We will complete our review of this matter by February 1, 2000, and transmit our conclusions and supporting rationale in writing to the Chairman and Ranking Members of the relevant committees in the House and the Senate.

It is important that all officials of the Wage and Hour Division interpret and apply the law in a uniform manner, and so advise the public. I will instruct the Wage and Hour Division to take the resolution of any cases in which unauthorized break time are at issue is consistent with the outcome we reach in our overall review.

I very much appreciate your interest in these important questions.

Sincerely,

ALEXIN M. HERMAN.

COMPENSATING CERTAIN DEPARTMENT OF ENERGY WORKERS

Mr. THOMPSON. Madam President, yesterday, my colleague from New Mexico, Senator Bingaman, and I introduced legislation that is, frankly, long overdue.

For more than 2 years, I have been concerned that the Department of Energy was not taking seriously the complaints of a number of workers in Oak Ridge, KY. These workers, who it is we are talking about, are talking about workers who participated in the Manhattan Project, men and women who helped to ensure the superiority of America’s nuclear arsenal, and who directly contributed to our nation’s victory in the Cold War. We owe them a debt of gratitude. And if we put them in harm’s way without their knowledge, it’s time for us to make that right. This bill is a step in that direction. I look forward to its consideration by the Senate.

PAIN RELIEF PROMOTION ACT

Mr. NICKLES. Madam President, on June 23, 1999, Senator LIEBERMAN and I introduced S. 1272, the Pain Relief Promotion Act, which addresses two specific concerns. First, it provides federal support for training and research in palliative care. Second, it clarifies federal law on the legitimate use of controlled substances.

On October 27, 1999 the House passed its companion measure H.R. 2260 by the resounding bipartisan vote of 271 to 156. It is my hope that the Senate will soon have the opportunity to debate and vote on this important legislation.

In anticipation of that debate, and in light of inaccurate characterizations of the second aspect of our bipartisan legislation, I believe it is important for me to ensure that the record reflects precisely how this bill will—and will not—affect current federal law with regard to Drug Enforcement Administration (DEA) oversight of the use of federally controlled substances.

To understand the effect the Pain Relief Promotion Act will have on pain control, we must begin with what the law is now. The Controlled Substances Act, CSA, of 1970 charged the DEA with the responsibility of overseeing narcotics and dangerous drugs—including powerful prescription drugs which have a legitimate medical use but can also be misused to harm or kill. In asserting its authority over these drugs, Congress declared in the preamble of the Controlled Substances Act of 1970 that “Federal control of the intrastate incidents of the traffic in controlled substances is essential to the effective control of the interstate incidents of such traffic” (21 U.S.C. 801 (6)).

In 1984, Congress amended the CSA due in part to a specific concern regarding the misuse of prescription pain relief drugs in lethal overdoses. The Democratic-controlled House and a Republican Senate further strengthened the Act, empowering the DEA to revoke a physician’s federal prescribing
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 of July 31, 1984, Hearing Record No. 98-106, p. 365). Congress' view was that while the states are the first line of defense against misuse of prescription drugs, the Federal Government must have 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. Congress' 1970 and 1984 decisions have been upheld time and time again by federal courts.

It is clear that federal law is intended to prevent use of these drugs for lethal overdoses, and contains no exception for deliberate overdoses approved by a physician. Nowhere in the Controlled Substances Act has death or assisting death ever been considered a "legitimate medical purpose" for use of these drugs. In the past, physicians who were involved in the use of these drugs for suicide or other lethal overdoses have lost their federal authority to prescribe controlled substances on the grounds that they had endangered "health and safety."

In 1997, Congress passed the Assisted Suicide Funding Restriction Act of 1997 without a dissenting vote in the Senate and by an overwhelming margin of 398-16 in the House. President Clinton stated in signing the bill that "it will allow the Federal Government to speak with a clear voice in opposing these practices." He further warned that "to endorse assisted suicide would similarly set us on a disturbing and perhaps dangerous path." I would add only that authorizing a federal agency to endorse the use of controlled substances for assisted suicide would similarly "set us on a disturbing and perhaps dangerous path."

In November 1994, the State of Oregon adopted by referendum the so-called "Death with Dignity Act," allowing physicians to prescribe medication for the purpose of assisting patients' suicides. The week of the vote, Professor George Annas of Boston University pointed out the inconsistency between the Oregon referendum and the Controlled Substances Act in an article in the New England Journal of Medicine. He questioned whether such a state law was compatible with existing federal laws governing federally controlled drugs, "since the drafters of the federal statute certainly did not have this purpose [assisting suicides] in mind."

However, on June 5, 1998, overturning a previous determination by her own DEA Administrator, the Attorney General issued a letter carving out an exception for Oregon so it can use federally-controlled substances for assisted suicide. The Attorney General did not "intend to override a state determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice." The Pain Relief Promotion Act will respect the Attorney General's challenge, by clarifying that the intentional misuse of these drugs to cause patients' deaths is not authorized by Congress in any state, nor has it ever been.

On October 27, 1997, Oregon's "Death with Dignity Act" became effective. In the first year at least 15 patients have committed suicide with doctor's assistance under the new Oregon law. We really do not know the total number, because the information is not fully available in the hands of the doctors, and the Oregon Health Division admits it has no idea how many unreported cases there are. But regarding those 15 reported cases we know one thing: Every one of those patients' deaths was caused by a federally-controlled substance, prescribed with a federal DEA registration number, using federal authority. Today, without any decision to this effect by Congress or the President, the federal government is actively involved in assisting suicides in Oregon.

To hear some of the critics of this bill you might think that the Pain Relief Promotion Act creates a new authority on the part of the DEA to revoke doctors' registrations if they use controlled substances to assist suicide. On the contrary that authority has existed for 29 years and it exists now. Attorney General Janet Reno was very clear on this matter in her letter of July 16, 1997. Under the CSA may well be warranted . . . 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.

What does this mean for current law and practice? First, the DEA has full authority to revoke a DEA registration for assisting suicide in any of the 49 states where assisting suicide is not militarily legal. While critics of the Pain Relief Promotion Act have said that empowering the DEA to investigate physicians in such cases will have a "chilling effect" on the treatment of pain, the fact is that such authority already exists in 49 states.

What about the one State, Oregon, where the Attorney General said the DEA will not take adverse actions against physicians for assisting suicide in compliance with the Oregon law? Every one of the existing suicides remain illegal under state law. The state law authorizes assisting the suicide of those who are terminally ill, but not others. Under the Attorney General's determination, then, the DEA can continue to review cases of assisting suicide to make sure they do not "intend to override a state determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice." The Pain Relief Promotion Act will respect the Attorney General's challenge, by clarifying that the intentional misuse of these drugs to cause patients' deaths is not authorized by Congress in any state, nor has it ever been.

Thus, as interpreted by the Attorney General, a registration to prescribe federally-controlled substances can be revoked under the current Controlled Substances Act if these substances are used to assist suicide in any state in the Nation, with the exception of certain cases of assisted suicide that Oregon has legalized for the terminally ill. If DEA scrutiny of doctors' prescribing practices were going to "chill" the practice of pain control, that would already be occurring under current law.

How does the Pain Relief Promotion Act impact this situation? It establishes that, for the first time in federal law, the use of controlled substances for the relief of pain and discomfort is a "legitimate medical purpose," even if the large doses used in treating pain may unintentionally hasten death. Intentionally causing death or assisting in causing death remains forbidden. Thus this bill does not increase the DEA's regulatory authority at all. On the contrary, its only effect in 49 states (and even in Oregon, in cases involving those who are not terminally ill) is to provide new legal protection for physicians who prescribe controlled substances to control pain.

In Oregon, this bill eliminates the Attorney General's artificial exception designed to accommodate Oregon's suicid inances that are no longer penalized under Oregon law. The DEA can meet its responsibility here simply by looking at the reports required by Oregon law, in which doctors must identify the drugs used to assist suicide. Those records will make it clear whether federal controlled drugs were used; and since the physician is clearly reporting that his or her own intent was to help cause death, there will be no question of murky intentions or ambiguity. Thus this bill will not lead to any increase in the DEA trying to "second guess" or infer physicians' intentions, even in Oregon.****.****.-Name: Payroll No. -Folios: J1/S13-J1/S14 -Date: -Subformat: What of any unreported cases in which physicians assist the suicides of terminally ill patients? Those assisted suicides are already a crime under Oregon law, and thus already subject to adverse action by the DEA as well
under the Attorney General's interpretation. Only if a physician officially reports the case to the Oregon Health Division is the doctor subject to criminal penalties. So those cases are already covered by the same DEA authority that currently applies to assisted suicides in the other 49 states. Let me take this situation step by step.

First, removing the Oregon exception to the existing nationwide policy cannot increase any "chilling effect" on pain relief outside of Oregon, because the bill does not increase one iota the authority of the DEA to investigate the misuse of controlled substances to assist suicide outside of Oregon. In fact, in those states its only effect is to provide a more explicit "safe harbor" for the practice of pain control, which it is argued that if this bill is enacted, doctors will be more sensitive to physicians' need to prescribe large doses of these drugs for pain control.

If the answer is "yes," then there is no basis to be concerned about this bill—for this bill will not increase investigations into the dosages of drugs used for pain relief, and in fact instructs the DEA to be even more sensitive to physicians' need to prescribe large doses of these drugs for pain control.

The bill would not expand existing criminal penalties in the CSA for persons whose unauthorized use of a controlled substance leads to someone's death. . . . The bill would not expand the DEA's jurisdiction, and the Department already has the authority to subpoena them, if necessary; again, our legislation has no impact on this.

Thus, even in Oregon, this bill will not result in any increase in DEA oversight or investigations of doctors licenced on their prescribing patterns or the dosages they use for particular patients. This is clearly stated in the House Judiciary Committee report on this bill, H. Rep. 106-378 Pt. 1, pp. 12–13. It follows that no increase in DEA scrutiny of their practices, and therefore should not in any way be deterred from prescribing adequate pain relief.

This bill cannot have a "chilling effect" on pain control, but will have the opposite effect. For the first time, it will place in the Controlled Substances Act, as the American Society of Anesthesiology has long argued, "the recognition that there is an entirely legitimate medical purpose for dispensing 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." The American Medical Association says this bill "provides a new and important statutory protection for physicians prescribing controlled substances for pain, particularly for patients at the end of life." As they American Academy of Pain Management observes, this bill will protect the ability of "prescribers to relieve pain without fear of regulatory discipline."

Those who are concerned about the possibility of a negative impact on pain relief if we pass this bill need to answer this question: do they believe that now the Drug Enforcement Administration is having a chilling effect on pain relief because federally controlled substances cannot be used to assist suicide in 49 states and even, in many cases, in Oregon?

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the act. Thus, as an editorial in the (Port-
land) Oregonian noted, it is the Oregon law
that “restored a field of long-standing fede-
reral jurisdiction.” Thus passage of the act
would return national uniformity to the en-
forcement of drug laws.

It merely reaffirms existing federal law.
Because the act declares that assisted sui-
cide is not a “legitimate medical purpose”
under the Controlled Substances Act, critics
have wrongly accused supporters of granting
new authority to the Drug Enforcement
Agency to punish doctors. In fact, DEA has
had the power for nearly 30 years. Since 1980
it has brought more than 250 enforce-
ment actions for violating the federal legal
standard of “legitimate medical purpose.”

The medical community overwhelmingly
favors it. Proponents of the bill include the
American Medical Association, the National
Hospice Organization, the Hospice Associa-
tion of America, the American Academy of
Pain Management, the American Society of
Anesthesiologists and the American College
of Osteopathic Family Physicians. (True,
supporters note that the politically.

medical community has been led by the
Rhode Island Medical Association.)

It has broad bipartisan support. Seventy-

one House voted for the bill; its Senate sponsors include Joe Lieberman
(D., Conn.), Chris Dodd (D., Conn.) and Evan
Bayh (D., Ind.).

It would enhance pain control. If the act
becomes law, pain control will for the first
time be specifically identified in federal law
as a legitimate medical purpose, even if the
use of pain-controlling drugs has the
unintended side effect of causing death.
That is a much-needed legal reform, because
many doctors fail to treat pain aggressively
because they fear the government’s second-
guessing. Several states have recently passed
similar laws, leading to dramatic increases
in the use of morphine and other palliative
medications.

The Pain Relief Promotion Act looks like-
ly to pass the Senate. If President Clinton
truly feels our pain, he will sign it the mo-
ment it hits his desk.

[From the Oregonian, July 1, 1999]

KILL THE PAIN, NOT THE PATIENTS

CONGRESSIONAL SYSTEMS TO USE
CONTROLLED DRUGS FOR AGGRESSIVE PAIN
TREATMENT INSTEAD OF SUICIDE

It’s no secret to any reader of this space
that we oppose Oregon’s venture into physi-
cian-assisted suicide.

But last year, when the American Medical
Association and the National Hospice Orga-
nization came out against a bill in Congress
giving medical review boards the power to
deny or yank the federal drug-prescribing li-
gerence it intrudes on a state’s right
to allow physician-assisted suicide or eutha-
nasia.

To hear some recent converts to states’
right talk, you might think so. But you
could just as easily argue that Oregon’s as-
sisted suicide law intrudes on the federal do-
maint. The feds have long had jurisdiction
over controlled substances, even as states
kept the power to regulate the way physi-
cians prescribe them. At best, it’s a gray
area.

You’ll recall that the Department of Jus-
tice declined to assert a federal interest in
the Oregon law or the right it allows. It’s
shortly after Oregon voters approved as-
sisted suicide. It’s probably better—and high
time—that Congress asserts that interest ex-
plicitly.

This act would establish a uniform na-
tional standard preventing the use of feder-
ally controlled drugs for assisted suicide.
That, in itself, should advance the national
debate on this subject in a more seemly way
than, say, the recent efforts of Dr. Jack
Kevorkian.

Beyond that, it’s high time that Congress
made clear that improved pain relief is a key
objective of our nation’s health-care institu-
tions and our Controlled Substances Act.
The Pain Relief Promotion Act will do all
this. No wonder the American Medical Asso-
ciation and the National Hospice Organiza-
tion are now on board.

PRISON CARD PROGRAM

Mr. ASHCROFT. Madam President, I rise
today to talk about an important pro-
higly successful program operated
for more than 25 years by the Salvation
Army in conjunction with the Bureau of
Prisons. This program is called the Prison
Card Program. Under the pro-
gram, greeting cards are donated to the
Salvation Army that are then given to
inmates at correctional facilities
across the country. This program also
benefits the community as well. Inmates
who maintain strong ties with their fami-
lies and friends are less likely to return
to prison once their sentence is com-
pleted.

I want to commend the Salvation
Army, the Department of Justice, and
the Bureau of Prisons for supporting this
program. In particular, I want the
Department to know that this program
has the support of Congress. I have spo-
ken to Chairman GREGG, who has indi-
cated he is prepared to work with
me and other supporters of the pro-
gram in the coming months to ensure
that this important charitable program
is sustained well into the future.

THE CARIBBEAN BASIN INITIATIVE
AND THE IMPACT ON TRADE
WITH ISRAEL

Mr. JOHNSON. Mr. President. I
would like to alert my colleagues to an
issue raised by H.R. 434, the African
Growth and Opportunity Act and the
Caribbean Basin Initiative, regarding
trade with Israel under the U.S.-Israel
Free Trade Area Agreement. Notwith-
standing our free-trade agreement with
Israel, the CBI provisions of this legis-
lation would unfairly discriminate
against U.S. imports from Israel.

Under that legislation, most U.S.
textile products made with Israeli in-
puts, such as yarn, fabric or thread,
would not be eligible for duty free
status if the textile products contain
yarn, fabric or thread produced in
Israel. The trade bill creates a uni-

lateral change from the status quo in
our trade with Israel and a major bar-
er to U.S. companies using Israeli-or-
igin inputs.

I would like to submit for the
Record a letter from the Economic
Minister of the Israeli Embassy that
was sent to each of the Members of the
Senate Finance Committee urging Con-
gress to treat Israeli inputs on par with
U.S. inputs in this trade legislation. I
ask unanimous consent that letter be
printed in the Record.

There being no objection, the letter
was ordered to be printed in the
Record, as follows:

EMBASSY OF ISRAEL,

DEAR SENATOR: I am writing to you, as
well other members of the Committee on
Finance, to ask for your support during the