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Assisted Suicide File



AMERICAN PAIN FOUNDATIONSM

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PAW RELIEF PROMOTION ACT

11/16/00

Opponents of the Misnamed "Pain Relief Promotion Act"

(S. 1272/H.R. 2260 - Selected List as of 9/28/00)

Physician Groups and Medical Societies

American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Pharmaceutical Physicians
American Academy of Neurology
American Geriatrics Society
California Medical Association
Kansas Medical Society
Massachusetts Medical Society
Minnesota Medical Association
Oregon Medical Association
Rhode Island Medical Society
San Francisco Medical Society
Society of General Internal Medicine
Texas Medical Association
The Physicians of Kaiser Permanente
(Permanente Federation)
plus other state medical associations

Nursing Organizations

American Nurses Association
American Society of Pain Management Nurses
American Society of PeriAnesthesia Nurses
Association of Nurses in AIDS Care
Association of Pediatric Oncology Nurses
Hospice and Palliative Nurses Association
National Association of Orthopaedic Nurses
Oncology Nursing Society

Hospice Organizations

Arkansas State Hospice Organization
Hospice Federation of Massachusetts
Indiana State Hospice and Palliative Care Association
Kansas Association of Hospices
Maine Hospice Council
Michigan Hospice & Palliative Care Association
Missouri Hospice and Palliative Care Association
New Hampshire State Hospice Organization
New Jersey Hospice and Palliative Care Organization
New York State Hospice Association
Oregon Hospice Association

Pharmacists Associations

American Pharmaceutical Association
American Society of Health-System Pharmacists

Patient and Health Organizations

American Pain Foundation
American Society for Action on Pain
Bazelon Center for Mental Health Law
Center for Patient Advocacy
Chronic Pain Foundation
College on Problems of Drug Dependence
Continuum Health Partners (Beth Israel, St. Lukes-
Roosevelt, L.I. College, N.Y. Eye & Ear Hospitals)

Intercultural Cancer Council (58 orgs serving minorities)
Interstitial Cystitis Association
Johns Hopkins Medicine (JHU Hospital)
National Foundation for the Treatment of Pain
Society for Healthcare Consumer Advocacy
Triumph Over Pain Foundation

Pain Management Specialists

Among over 120 who oppose:

James N. Campbell, M.D. (Johns Hopkins)
Scott Fishman, M.D. (Univ. of California, Davis)
Kathleen Foley, M.D. (Memorial Sloan-Kettering)
Martin Grabojs, M.D. (Baylor College of Medicine)
Stratton Hill, M.D. (M.D. Anderson Cancer Center)

Bioethicists

Among 49 who wrote or testified opposing PRPA:

Margaret P. Battin, Ph.D. (Univ. of Utah)
Arthur Caplan, Ph.D. (Univ. of Pennsylvania)
Joseph Fins, M.D., F.A.C.P. (Cornell)
Kenneth Goodman, Ph.D. (Univ. of Miami)
Alan Meisel, J.D. (Univ. of Pittsburgh)

Law Professors and Lawyers

Among the numerous legal experts who have written:

Rebecca Dresser (Washington Univ.)
Charles Fried (Solicitor General under Pres. Reagan)
John Gilbert (Former atty., DEA Chief Counsel's Office)
Maxwell J. Mehlman (Case Western Reserve)
James Vorenberg (Former Dean, Harvard Law School)

Newspapers/Medical Journals

Arizona Daily Star
Asheville Citizen-Times
Buffalo News
Cincinnati Enquirer
Des Moines Register
Houston Chronicle
Los Angeles Times
New England Journal of Medicine
New York Times
Orange County Register
Palm Beach Post
Philadelphia Inquirer
Pittsburgh Post-Gazette
Providence Journal-Bulletin
Roanoke Times & World News
Sacramento Bee
San Jose Mercury News
Scranton Times
St. Louis Post-Dispatch
St. Petersburg Times
Tampa Tribune
Washington Post
Western Journal of Medicine



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MEMORANDUM

TO: Chris Jennings
Jeanne Lambrew

FROM: Jim Guest, Executive Director

DATE: September 30, 2000

SUBJECT: Opposition to Amendments That Threaten Effective Pain Care

On behalf of more than 50 organizations of patients, doctors, nurses, pharmacists, hospice workers and others, we urge that the White House strongly oppose – as you did with the bill’s predecessor in 1998 – any last-minute attempt in Congress to attach provisions of H.R. 2260, the wildly misnamed “Pain Relief Promotion Act” (PRPA), to the omnibus appropriations act or other bills.

PRPA attempts to overturn Oregon’s physician-assisted suicide law, approved twice by statewide referendum, by amending the federal Controlled Substances Act. None of our groups supports physician-assisted suicide. Rather, PRPA is a bad bill because according to most practitioners in the medical and palliative care fields it would chill effective use of morphine and similar medications to manage pain for patients in extreme suffering.

That’s why PRPA is opposed by the American Cancer Society, American Bar Association, American Nurses Association, American Academy of Family Physicians, American Geriatrics Society, American Pharmaceutical Association, state medical societies from California, Texas, Massachusetts and several other states, American Academy of Hospice and Palliative Medicine, American Pain Foundation, and others.

And that’s why major newspapers across the United States including the *New York Times*, *Washington Post*, *Los Angeles Times* and over two dozen others oppose the bill in recent editorials. The most active supporters of the bill are the National Right to Life Committee and the National Conference of Catholic Bishops.

Introduced by Congressman Hyde and Senator Nickles, PRPA would empower the Drug Enforcement Administration to investigate a doctor’s “intent” and “purpose” in prescribing large doses of morphine and similar medications to patients in pain, especially those near the end of life. If the DEA concluded that the doctor’s intent was

not to relieve pain but to hasten death, the doctor would face severe penalties including, according to the Department of Justice (which opposes the legislation), a mandatory minimum jail sentence of 20 years.

If the proposed amendments to the Controlled Substances Act pass, many doctors will be unwilling to treat pain aggressively for fear that their intentions will be misconstrued and they will undergo the expense, hassle, negative publicity and threat to their livelihood of a DEA investigation. Pain already is badly undertreated. Studies show that over 80% of cancer patients and 40% of AIDS patients receive lower doses of pain medication than recommended by national standards. Many of the 50 million Americans with chronic pain remain untreated or undertreated.

The amendments proposed by Congressman Hyde and Senator Nickles are highly controversial and dangerous. Senator Nickles has been unable to secure the votes to pass PRPA in the Senate, which is why we anticipate he will pursue the same end-game as two years ago of trying to add an amendment to an appropriations bill.

In the last four months our 50+ organizations have educated Senators to the dangers of the proposal through tens of thousands of phone calls, e-mails, letters and visits. Most Senators now "get it." Indeed, Senator Moynihan last week withdrew his name as a cosponsor of PRPA and it appears that four of the five other Democratic cosponsors are likely to oppose bringing the bill up this session and/or invoking cloture. (The apparent exception is Senator Lieberman, the lead Democratic cosponsor.) The latest version of PRPA barely made it out of the Senate Judiciary Committee by a close 10-8 vote with all but one Democrat, along with Senator Spector, voting against it.

I believe President Clinton has not stated a position on the bill. Vice President Gore has said publicly that he has "serious reservations" about the bill and that, "I am personally opposed to physician-assisted suicide. However, I don't want to see the criminalizing of doctors' ability to deal with severe pain."

Attached are a list of 52 groups opposed, excerpts from editorials, and a one-page backgrounder. More information appears on our campaign website at **StopPRPA.org**.

We ask that the White House steadfastly oppose efforts to add any version of this misguided and dangerous proposal to upcoming appropriations bills or other legislation. If you want more information, or if there is anything further we can do to help, please give me a call at 410-385-5260 or send me an e-mail at jguest@erols.com.

Thank you very much.

The Revised "Pain Relief Promotion Act" (H.R. 2260) Remains Bad Medicine for Patients

"If the bill becomes law, it will almost certainly discourage doctors from prescribing or administering adequate doses of drugs to relieve the symptoms of dying patients."

- New England Journal of Medicine Editorial (12/16/99)

Summary: Almost 40 major organizations of doctors, nurses, hospices, pharmacists, pain experts and patients, along with hundreds of nationally prominent experts in palliative care, law and bioethics, publicly oppose the misnamed "Pain Relief Promotion Act." Chief among their concerns:

- It would inhibit aggressive use of controlled substances to fight pain.
- It would expand the DEA's role from fighting illegal drug trafficking to regulating the practice of medicine – a responsibility presently handled by state authorities that should remain with the states and for which the DEA is unqualified and inappropriate anyway.
- It fails to promote real and meaningful solutions for improving pain relief.
- It would not even achieve the bill's underlying goal of reducing assisted suicide.

Empowering the DEA to investigate and punish the medical judgments of doctors, nurses and pharmacists will deter many of them from aggressively treating pain and cause patients to suffer needlessly.

The proposed Pain Relief Promotion Act would expand the DEA's role from fighting illegal drug trafficking to regulating the practice of medicine. It would give DEA agents explicit authority to question and investigate the *intent* of any physician or other healthcare worker who provides a controlled substance to a patient in pain who subsequently dies. "The result," writes a former attorney with the DEA's Office of General Counsel, "will necessarily be an increase in the DEA scrutiny of physicians treating patients for severe pain where death has occurred." If convicted under provisions of the Pain Relief Promotion Act, a healthcare professional would face a minimum mandatory 20-year sentence.

Numerous studies have shown that physicians in the U.S. are grossly undertreating pain and that fear of investigation is a leading cause of their reluctance to aggressively manage pain. If this bill passes, many doctors, pharmacists and other healthcare professionals will be more hesitant than they already are to dispense powerful pain-relieving drugs. They will fear losing their livelihood if their intentions are misinterpreted, and they will fear the time, cost and negative publicity of having to mount a defense to a DEA allegation in the first place.

DEA agents are unqualified to assume the new role of judging between legitimate medical use of controlled substances and intentionally causing death.

Palliative care experts note that the line between increasing the risk of death while treating pain (allowable under the bill) and intentionally causing death (a crime) can be hard to distinguish. The DEA acknowledged in a recent letter to Congress that it "lacks the resources or the expertise" to investigate patient deaths. The DEA testified in the last Congress that it would compensate by consulting medical textbooks for help – hardly a substitute for years of medical

education. In fact, even if DEA agents were given limited medical training, they would still be poorly equipped to second-guess doctors, nurses, and pharmacists with years of education and experience.

Pain relief therapy should be managed and monitored by healthcare professionals – physicians, nurses, and pharmacists – not by federal law enforcement officers whose job is to fight illegal trafficking in drugs. Oversight of the practice of medicine should remain with the expert medical authorities in each state without DEA duplication or interference.

Why increase the federal bureaucracy when state medical and pharmacy boards already fully regulate the unauthorized medical use of controlled substances?

All 50 states license physicians and pharmacists and have boards of medical experts to review and discipline practitioners who violate medical practice standards, including the medical misuse of controlled substances. Forty-nine states prohibit physician-assisted suicide. It makes no sense to add a redundant, unnecessary, and potentially contradictory layer of federal bureaucracy to the practice of medicine in those states in order to achieve the bill's underlying purpose – nullifying Oregon's law.

The "double effect" factor in prescribing pain medication is already protected.

The bill's proponents argue that one of its main values is that it protects physicians who prescribe a drug for pain relief that also has the potential "double effect" of increasing the risk of death. But this protection for "double effect" is already long-standing DEA policy and does not need to be codified into law – especially when it would be at the price of expanding the DEA's role into medical oversight and investigation of physicians' intent. What is needed is not a new law, but rather better implementation and communication of the DEA's existing policy.

By adding even more changes to the Controlled Substances Act than the original bill, the reported version creates additional confusion.

The legislation as reported adds language designed to be reassuring by saying that the bill should not be construed to alter the roles of the federal and state governments in regulating the practice of medicine. But at the same time the bill enhances the DEA's authority to regulate the dispensing and administering of controlled substances – a major medical practice. Another section limits certain federal actions but then undoes the limit by adding "except that the Attorney General may take such other actions as may be necessary to enforce this Act." These and other new ambiguities will leave the medical community guessing as to the actual extent of the new federal powers. Meanwhile, the provision that will have the most chilling effect on pain management – the clause explicitly authorizing the DEA to investigate a healthcare practitioner's "intent" – remains unchanged.

Former Harvard Law School Dean James Vorenberg and other experts summarized the changes as follows: "Senator's Hatch's substitute bill doubles the size of the original H.R. 2260 by adding to it some hastily put together jurisdictional and procedural provisions that exacerbate the bill's potential for frightening physicians into undertreating pain."

The privacy of the patient's family will likely be invaded during a DEA investigation, even if no wrongdoing has occurred.

To build a case that meets the bill's "clear and convincing evidence" standard, the DEA would likely have to interview grieving family members, nurses, doctors and health aides to determine what the patient and doctor said and what they intended. This may force the disclosure of communications classified as "privileged" under state law and the release of medical records protected under state medical privacy laws. A subsequent conclusion by the DEA that there is no evidence to justify prosecution will not undo the harm that the investigation caused the family and healthcare providers.

The bill will not stop assisted suicide, but rather will likely have the perverse effect of increasing suicides among desperately ill patients in pain.

Rabbi J. David Bleich, who testified before the Senate Judiciary Committee in support of the bill, acknowledged that the bill "will not have the effect of reducing the incidence of physician-assisted suicide." He added, "I doubt very much...that the passage of the bill will prevent as much as a single suicide." Medical experts have noted that a physician could circumvent this law by prescribing a non-controlled substance or an over-the-counter drug, or by using a chemical like carbon monoxide.

Rather than achieving its main goal of reducing physician-assisted, the bill will likely have the unintended effect of increasing suicides among desperately ill patients by deterring some physicians from dispensing large but necessary quantities of the strongest pain-relieving drugs available to the seriously ill.

The use of state morphine statistics to justify PRPA is a red herring.

Proponents of this legislation argue that it will not have a chilling effect on pain management because in some states that have passed similar laws against assisted suicide the use of morphine went up. But that argument is a fallacy. Proponents ignore the fact that some top-ranked states for per capita morphine use – including three of the top five states – have no comparable statutes to PRPA. They fail to recognize that the national average for morphine use increased during the periods they cite and that morphine use increased in most states during this period, not just in a few states with PRPA-type laws.

Indeed, some states that passed laws similar to PRPA experienced a decrease in morphine use or an increase less than the national average. Also, most morphine is prescribed for acute and chronic pain – not end-of-life care – so the morphine statistics don't really tell us about the chilling effect on the use of pain medication at the end of life.

Finally, state laws against intentionally using controlled substances for assisted suicide are implemented by state medical and regulatory authorities; that's entirely different from the chilling impact of having federal crime-fighters responsible for combating illegal drug traffic taking on this new function.

PRPA would not address the needs of terminally ill Americans or those suffering from chronic pain.

Fifty million Americans suffer from chronic pain, 2.4 million Americans die each year, and 25 million Americans each year experience acute pain from surgery or injury. Chronic pain alone costs an estimated \$100 billion annually in medical expenses, lost income, and lost workdays. This bill's narrow provisions for education, training and research and the minimal authorization of only \$5 million will have no real impact. It fails to address in a meaningful way the real needs to improve pain management and palliative care such as:

- Increasing basic and applied research and developing new protocols and practices
- Improving pain management education among all healthcare professions
- Reducing regulatory burdens on dispensers of controlled substances
- Increasing access to and reimbursement for pain medications
- Increasing public awareness about the need and availability of strong pain treatment.

Congress should develop a genuine, comprehensive, and well-funded bill that truly promotes improved pain management and palliative care and is worthy of the title "Pain Relief Promotion Act."

If Congress wants to prohibit physician-assisted suicide, it should enact a narrowly-tailored criminal statute to ban it.

The medical community is just now starting to make small gains in reversing the gross undertreatment of pain. It makes no sense to tamper with the Controlled Substances Act and risk undoing this delicate balance. Congress can pass a separate law addressing assisted suicide. It should not turn the "War on Drugs" into a "War on Patients."

Many clinicians in the trenches strongly oppose PRPA because of its chilling effect on pain management...and even organizations supporting PRPA are deeply divided.

Several major organizations that have expressed support for the Pain Relief Promotion Act have done so with deep divisions and differences of opinion among their memberships. Meanwhile, almost 40 major organizations of doctors, nurses, hospices, pharmacists, pain experts and patients, along with hundreds of nationally prominent experts in palliative care, law and bioethics, publicly oppose the bill.

Virtually every major nursing organization concerned about pain management and palliative care is opposed – including the American Nurses Association, Hospice and Palliative Nurses Association, Oncology Nursing Society, American Society of Pain Management Nurses, and others. Major physicians organizations against the bill include the American Academy of Family Physicians, American Geriatrics Society, American Academy of Hospice and Palliative Medicine, several state medical societies, and others. A long list of hospice and pharmacy groups, pain patient organizations, individual pain management specialists, bioethicists and legal scholars are also opposed.

The bottom line is that respected and experienced members of the medical community, as well as other professionals and patient advocates, have concluded that the so-called Pain Relief Promotion Act will be harmful to patients who suffer from pain. Congress should not pass this well-intended but harmful legislation.

American Cancer Society Position Statement on the Impact of the Pain Relief Promotion Act (PRPA) on Quality Care for People with Cancer

The American Cancer Society is the nationwide community based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives and diminishing suffering from cancer, through research, education, advocacy, and service. The American Cancer Society has set ambitious goals for significantly reducing the rates of cancer incidence and mortality along with dramatically improving the quality of life for all people with cancer. Meeting those goals requires a new partnership for the nation and will require a commitment from both the public and private sector.

Quality of Life and the Cancer Patient

For the first time in history, we have witnessed a downward trend in cancer mortality and in cancer incidence. Great strides in cancer treatment continue to increase not only the likelihood of surviving a cancer diagnosis, but the length of survival as well. Although too many lives continue to be lost to cancer, approximately 56% of those diagnosed with the disease this year can expect to live five or more years. Some years ago we celebrated the fact that cancer was redefined as a "chronic" disease rather than an acute or catastrophic one.

The obstacles that remain before us are formidable but not unattainable. As the millions of people living with cancer can attest, under the right conditions, adversity can result in new strength and growth. It is the goal of the American Cancer Society that those conditions are identified, fostered and made accessible to everyone affected by cancer. Without doubt, physical survival represents a great victory in the war against cancer. But it is a hollow victory indeed if one's happiness, meaning, inner strength, and joy pay the forfeit of the price.

While definitive measures for ascertaining quality of life are inherently subjective, some models have been developed that allow us to characterize aspects of quality of life which must be addressed to assure the well-being of those living with cancer. Broadly, quality of life is related to the impact of the illness or its treatment on a person's expected physical, psychological, and social well being. As part of addressing this critical goal, the Society supports and encourages national, state, and local efforts to prevent and ameliorate pain and suffering in people with cancer.

Advocacy for Pain and Symptom Management for People with Cancer

As an advocate for all people touched by cancer, the American Cancer Society will support public policies that address the control of physical pain and symptom management. Providing adequate pain and symptom management is a crucial component of improving and assuring quality of life. All cancer patients, regardless of stage of disease, should be assured access to comprehensive, palliative care including aggressive and thorough pain and symptom management. Furthermore, the Society supports initiatives that work to overcome barriers to

adequate pain and symptom management, such as health provider disincentives to managing their patients' pain.

Numerous treatment options are available for controlling cancer pain, yet many barriers exist for patients in getting the pain control they need. Clinical findings show that ninety percent of pain associated with cancer and cancer treatments can be relieved with existing medications and therapies when pain is identified, treated and monitored properly; yet, many patients experience severe pain and endure unnecessary suffering. Myths surrounding pharmaceuticals used to treat pain like opioids – a class of federally controlled substances – have contributed to the under treatment of pain. Such myths include fear of addiction, fear of building tolerance to pain medication and fear that pain medication will make the patient lose control. Public and provider education is greatly needed to correct these widely held, false beliefs.

In fact, despite safe, effective and available pain management therapeutics and regimens, pain continues to be a major public health problem. A 1993 study found fifty-six percent of cancer patients surveyed had moderate to severe pain¹ and a 1995 study found fifty percent of patients experience moderate to severe pain at least half the time in their last days of life.²

The Society recognizes and appreciates that more must be done to assure high quality pain and symptom management and end-of-life care for all people with cancer. Public policy is needed to proactively address pain and symptom management and end-of-life care, especially in light of the fact that severe pain prompts some patients with serious illness to contemplate ending their lives prematurely.³

Analysis of the Pain Relief Promotion Act (PRPA) Related to Pain Management Goals

The Society respects the right of patients to refuse therapy and the right to request that treatments be withheld or withdrawn, particularly if it dramatically interferes with quality of life. While the Society has clear and long-standing policy opposing assisted suicide and believes that pain should not be a reason to consider life terminating approaches to end suffering, we recognize advances must be made in our efforts to assure high quality pain management and end-of-life care for individuals with cancer.

The Pain Relief Promotion Act (HR2260 and S1272), sponsored by Representative Henry Hyde and Senator Don Nickles, would ban the use of federally-controlled substances for physician-assisted suicide (Title I). The bill also includes provisions relating to pain management, provider education and training in an attempt to clarify the important need for pain and symptom management. The American Cancer Society appreciates the commitment shown by the sponsors of the legislation to address these issues, but unfortunately is unable to support this legislation as written.

¹ VonRoenn JH, Cleeland CS, Gonin F, et al. Physician attitudes and practice in cancer pain management: a survey from the Eastern Cooperative Oncology Group. *Ann Intern Med.* 1993;119:121-126.

² The SUPPORT Principal Investigators. A controlled trial to improve the care for seriously ill hospitalized patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT). *JAMA.* 1995;274:1591-8.

³ Foley K. The relationship of pain and symptom management to patient requests for physician-assisted suicide. *Journal of Pain and Symptom Management.* 1991; 6:289-97.

Careful analysis of the House-passed measure and a substitute version of the Senate bill (sponsored by Senator Orrin Hatch and approved by the Senate Judiciary Committee), indicates the provisions related to the ban of federally controlled substances for physician-assisted suicide (Title II in the Hatch substitute) have serious potential to exacerbate the current problem of under-treatment of pain. While there are provisions to proactively address pain and symptom management, the Society maintains that any benefit from such provisions would not outweigh the potential threat posed by the changes to CSA. Furthermore, neither section of the bill comprehensively addresses the needs of providers, patients and families for ongoing support and education to counter the current problem of under-treatment of pain – a problem that often leads to requests for physician-assisted suicide.

In an effort to ban the use of federally-controlled substances for physician-assisted suicide, the Pain Relief Promotion Act amends the federal Controlled Substances Act (CSA), placing responsibility of determining legitimate medical practice with the Drug Enforcement Agency (DEA). Under the Act, all physicians and particularly physicians who care for those with terminal illnesses will be made especially vulnerable to having their pain and symptom management treatment decisions questioned by law enforcement officials not qualified to judge medical decision-making. This can result in unnecessary investigation, and further disincentives to aggressively treat pain.

Unfortunately, “intent” cannot be easily determined, particularly in the area of medicine where effective dosage levels for patients may deviate significantly from the norm. The question of deciding intent should remain in the hands of those properly trained to make such decisions – the medical community and state medical boards. The Pain Relief Promotion Act seeks to hold harmless any physician who treats a patient’s pain even if death occurs, and the measure attempts to create a “safe harbor” provision in an effort to shield physicians whose use of federally-controlled drugs unintentionally hasten or cause death. However, this provision does not change the fact that the DEA would now explicitly be charged with overseeing the medical use of controlled substances, resulting in a negative impact on cancer pain treatment.

The current CSA maintains a suitable balance between the interest of government to regulate and monitor the diversion and misuse of controlled substances with the needs of patients. Amending the CSA as in the PRPA would disturb this delicate balance. The original intent and historical interpretation of the CSA revolve around control of the trafficking, diversion and misuse of controlled substances, not determining legitimate medical practice.⁴ It is also important to note that by amending the CSA, PRPA does not prohibit all physician-assisted suicide, but only those events using federally controlled substances. Thus, the bill stops short of impacting that practice while having an unintended, but negative impact on palliative care.

Physician fear of regulatory scrutiny and criminal penalties, coupled with inadequate knowledge of pain assessment and management, pose looming barriers in assuring patients adequate treatment of pain caused by cancer or the treatment of cancer. Studies have shown that even the perceived threat of investigation leads to under-treatment of pain, as physicians are wary

⁴ Paul W. Saxton, M.D. 64 Fed Reg. 25,073-80 (May 10,1999).

of having their prescriptive practices involving controlled substances reviewed by regulators.⁵ The Pain Relief Promotion Act will send a clear message to the DEA and state and local law enforcement agencies that Congress now intends for the CSA to apply to the area of pain management – an area where the CSA has not historically played a role. Consequently, this Act would heighten physicians' perceived fear of investigation concerning the prescription of controlled substances for pain and symptom management likely leading to greater under treatment of pain.

The Society has longstanding policy voicing opposition to physician-assisted suicide and euthanasia as it violates one of the most basic tenets of physician practice – do no harm. In fact, a number of the Society's state or Division offices have actively and consistently opposed state-based measures that would permit assisted suicide in their respective states. Untreated or under treated pain, however, is often a determining factor in the patient's decision to take such life ending action. The Society asserts that pain need not be a reason to consider life-terminating approaches to end suffering, and will address this through front-end strategies that proactively promote quality pain care for all people living with cancer.

The American Cancer Society is encouraged by study findings that support our assertion that adequate pain and symptom management is a very meaningful strategy to significantly curtail patient requests for physician-assisted suicide⁶. Recent reports on the implementation of the Death with Dignity Act show an association between under treatment of pain and patients' requests for physician-assisted suicide. Cancer patients, as seen in Oregon and elsewhere, disproportionately seek out physician-assisted suicide; hence, we must be evermore vigilant in increasing access to pain and symptom management and ensuring that no further barriers be established limiting access to this necessary care. Living and dying with pain is a major public health concern⁷ and the Society strongly believes that the assurance of adequate pain and symptom management will not only improve quality of life for patients, but will prevent requests for physician-assisted suicide. Forty-six percent of patients requesting physician-assisted suicide in Oregon since November 1997 decided not to end their lives once they had been provided adequate pain and symptom management. This demonstrates the deterrent effect of proactively addressing pain and symptom management.

American Cancer Society Position Statement on PRPA

The American Cancer Society has engaged in a deliberative process to evaluate the impact of the Pain Relief Promotion Act on our Quality of Life goals for all people living with cancer. Its analysis included a review of existing Society policies on pain and symptom management and opposition to physician assisted suicide. We have concluded that as written, the Pain Relief Promotion Act would ban the use of federally controlled substances for physician-assisted suicide at the expense of controlling pain and advancing symptom

⁵ Joranson DE, Gilson AM. Controlled substances, medical practice and the law. In: Schwartz HI. *Psychiatric Practice Under Fire: The Influence of Government, the Media and Special Interests on Somatic Therapies*. Washington, DC: American Psychiatric Press, Inc., 1994:173-194.

⁶ "Physician Experiences with Oregon Death with Dignity Act Reported in Study". *New England Journal of Medicine*. MedscapeWire. February 24, 2000.

⁷ Gallup Institute. *Spiritual Beliefs and the Dying Process: A Report on the National Survey Conducted for the Nathan Cummings Foundation and Fetzer Institute*. Princeton, NJ: Gallup Institute; 1997.

management. These issues are both critically important, but are separate issues. While the Society strongly opposes all patient deaths stemming from assisted suicides, we must give heavier weight to the more than 1500 individuals who die of cancer every day in this country – more than half of whom die in pain unnecessarily. Moreover, the American Cancer Society believes that the best approach to help cancer patients and reduce and prevent assisted suicide is through the adoption of proactive policies and the provision of resources to prevent and ameliorate pain and suffering in people with cancer, especially for those at the end-of-life.

STATEMENT
of the
American Academy
of Family Physicians

Submitted for the Record

To The

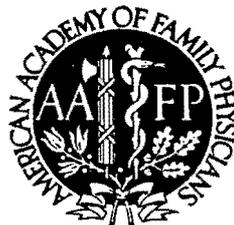
Senate Judiciary Committee

Concerning

"The Pain Relief Promotion Act of 1999"

April 25, 2000

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This statement is submitted to the Senate Judiciary Committee in opposition to H.R. 2260, the Pain Management Promotion Act, by the American Academy of Family Physicians. The Academy represents 89,400 practicing family physicians, family practice and medical students.

H.R. 2260 passed the House of Representatives on October 27, 1999 by a vote of 271-156. The intent of H.R. 2260, *The Pain Relief Promotion Act of 1999*, is to prevent federally controlled substances from being used in an assisted suicide. H.R. 2260 clarifies that the use of federally controlled narcotics to control pain is acceptable, and recognizes that the legitimate use of narcotics may increase the risk of death. The bill also clarifies that the use of controlled substances to assist in a suicide is illegal. The Academy opposed passage of H.R. 2260 by the House and remains opposed to passage in the Senate.

The Academy opposes physician assisted suicide as being fundamentally inconsistent with the physician's role as a healer. The Academy opposes H.R. 2260, **not** because it attempts to outlaw physician assisted suicide, but because in its attempt to do so, it may put at risk for criminal investigation physicians who are aggressively and appropriately prescribing narcotics to patients who are in great pain. Specifically, the measure calls for the Drug Enforcement Administration (DEA) to train its agents on how to determine whether the death of a patient was a result of physician assisted suicide, utilizing various sets of guidelines. Assessments by non-medical personnel of physicians' clinical management of patients is likely to result in the questioning of appropriate treatment regimens provided by well trained physicians acting in the best interest of their patients who are suffering severe pain. Such scrutiny of physicians, performed within the construct of DEA authority by DEA agents, may well create a chilling environment for the physician whose goal is appropriate medical treatment of a patient's pain.

Chairman Hatch (R-UT) has drafted a substitute measure in an attempt to address the concerns of the medical community. Although Chairman Hatch's substitute is an improvement over the House-passed version of H.R. 2260, the Chairman's mark retains objectionable provisions.

In particular, Sec. 102 of H.R. 2260 and Sec. 202 of the Chairman Hatch's mark would allow training of federal, state, and local law enforcement personnel on how to conduct investigations and enforcement actions involving controlled substances prescribed for pain management at the end of life. Such training would incorporate the recommendations of the Secretary of Health and Human Services. Training law enforcement officers who have no clinical education in medical decision making to review complicated end-of-life care decisions invites misunderstanding and misidentification of violations. Such training is also a way to redirect officers from their emphasis on drug traffickers to second-guessing physician decisions on pain management. For these reasons, the Academy opposes the Chairman's mark.

We would note, however, that the Chairman's mark does contain language that makes it preferable in some areas to the House-passed version of H.R. 2260. Specifically, the following sections are improvements over the House-passed bill:

Section 2. Findings (5) (page 2): This section finds that "adequate treatment of pain, especially for chronic diseases and conditions, irreversible diseases such as cancer, and end-of-life care, is a

serious public health program affecting hundreds of thousands of patients every year; physicians should not hesitate to dispense or distribute controlled substances when medically indicated for these conditions.” This language could be improved further by including the phrase, “in the quantities necessary.”

Title I Section 903(a) (page 3): This section emphasizes that the Agency for Healthcare Research and Quality may not develop national pain management standards, a change requested by this organization.

Title II(a) (page 9): This section makes clear that states retain the sole discretion with respect to the licensure of physicians and state prescribing privileges. There has been concern that this act creates a kind of national de facto licensure, to the extent that prescribing controlled substances is essential to practice.

Title II(a)(4)(B) (page 9) Prohibits the Attorney General from issuing national standards for pain management.

Title II(b)(2) (page 10) Represents perhaps the most important improvement in the draft. It increases the burden of proof greatly in any Department of Justice or Drug Enforcement Administration administrative, or civil, action against physicians accused of causing, or assisting in causing the death of a patient. The Attorney General has the burden, under this section of “proving, by clear and convincing evidence, that the practitioner’s intent.... was causing death or assisting another person in causing death.”

Despite the above noted improvements, however, the substitute proposal retains the objectionable elements of H.R. 2260, which are the basis for the Academy’s opposition to passage of the legislation.

Legislation such as H.R. 2260, or modifications to it like the Chairman's mark, may result in further government interference into clinical decision making, and may potentially subject physicians treating patients appropriately to scrutiny by DEA agents utilizing a set of government guidelines to assess medical practice. The American Academy of Family Physicians cannot support legislation that may create an environment in which physicians are fearful of treating their patients appropriately. Therefore, the Academy urges that the Judiciary Committee not support H.R. 2260 or the Chairman's mark.



The Honorable Orrin Hatch, Chairman,
and Members of the Judiciary Committee
U.S. Senate
131 Russell Senate Office Building
Washington, DC 20510

Dear Senator Hatch:

The American Society of Pain Management Nurses (ASPMN) is an organization of professional nurses dedicated to promoting and providing optimal care of patients with pain. On behalf of ASPMN, I would like to express our opposition to both H.R. 2260 and the Hatch Substitute. Our position statements justifying our opposition to assisted suicide and advocating appropriate end-of-life care are attached.

Nurses serve patients as direct care providers, advanced practitioners (with prescriptive authority in some states), managers, educators, and, most importantly, as patient advocates. Patients are significantly under-treated for pain. That is why the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and others are increasing attention and regulation in this area. H.R. 2260 will cause harm to patients who are suffering and need controlled substances by perpetuating fear and causing a chilling effect on physicians and nurse practitioners. The core of the bill places the Drug Enforcement Agency (DEA), rather than professional healthcare providers, in the role of making critical medical decisions. The legislation has not clearly defined intent or the means on which a non-medical professional would objectively base such a judgment.

Many patients can tolerate and indeed require extremely high doses of controlled substances to relieve their pain and other symptoms, while the same dose in another patient could be lethal. The line between increasing the risk of death while treating pain (an allowable medical practice) and intentionally causing death (a crime with severe penalties) is a very fine one. Nurses and physicians express significant concerns regarding non-trained medical professionals making this distinction and insecurity that the DEA will protect them if they aggressively manage pain with opioids.

ASPMN appreciates Senator Hatch's attempt to correct harmful legislation. However, the Hatch Substitute doesn't address the core issue of intent and interpreting legitimate medical and nursing practice. Nursing and medicine have traditionally been regulated by their respective state medical boards, not the government. In addition, while the Hatch Substitute states that the bill should not be construed to alter the roles of the federal and state governments in regulating the practice of medicine or nursing, it is unclear what those roles currently are. Another section limits certain federal actions but then undoes the limit by adding "except that the Attorney General may take such other actions as may be necessary to enforce this Act."

Rather than training law enforcement officers in pain medicine and palliative care, it is necessary to provide additional education for nurses, physicians, and patients. The amount "authorized" may never be appropriated by Congress and provides merely a fraction of the funding needed to ensure access and appropriate treatment for those that suffer from pain. Funding for research and evidence-based practices in pain management and palliative care are also needed. The proposed "Decade of Pain Control and Research" is an important way to raise awareness of the issues surrounding the under-treatment of pain; however, it requires significant financial support.

Assisted suicide appears to be at the center of the flawed legislation. ASPMN would encourage Congress to pass a separate law on assisted suicide without tampering with the Controlled Substances Act. This Act significantly threatens effective pain management and palliative care and in fact does just the opposite of what the bill would propose by "hindering" versus "promoting" pain relief. ASPMN encourages Congress to start a "War on Pain" not a "War on Patients that Suffer Pain" or a "War on Professionals Treating Pain."

Sincerely,

Nancy R Kowal /PA

Nancy R. Kowal, MSN, RN, C, ANP

President, ASPMN

THE AMERICAN GERIATRICS SOCIETY

THE EMPIRE STATE BUILDING, 350 FIFTH AVENUE, SUITE 801, NEW YORK, NY 10118 TEL: (212) 308-1414 FAX: (212) 832-8646

LINDA HIDDEMEN BARONDESS
Executive Vice President

July 28, 2000

Dear Senator:

The American Geriatrics Society (AGS), an organization of over 6,000 geriatricians and other health care professionals specially trained in managing the care of frail, chronically ill older patients, opposes the Pain Relief Promotion Act (H.R. 2260) as reported by the Senate Judiciary Committee.

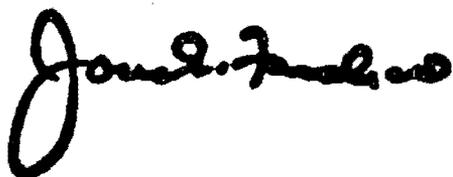
The AGS opposes H.R. 2260 as reported because we have concluded that the bill will have a chilling effect on aggressive and medically appropriate pain care for people with pain, especially those near the end of life. Though the Judiciary Committee added several minor amendments, it did not alter the underlying purpose or effect of the bill. The legislation continues to empower the Drug Enforcement Administration to investigate the purpose or intent of a prescription for some of the most effective pain-relieving drugs available to us: opioids and others regulated under the Controlled Substances Act.

The specter of a federal law enforcement agency investigating pain management practice, a role already served by the 50 state medical boards, will intimidate or worry many health care professionals into "erring on the side of caution" and prescribing less powerful medications that won't draw the DEA's attention. As a result, many of the most needy and vulnerable patients – the frail elderly whom we serve – will suffer needlessly.

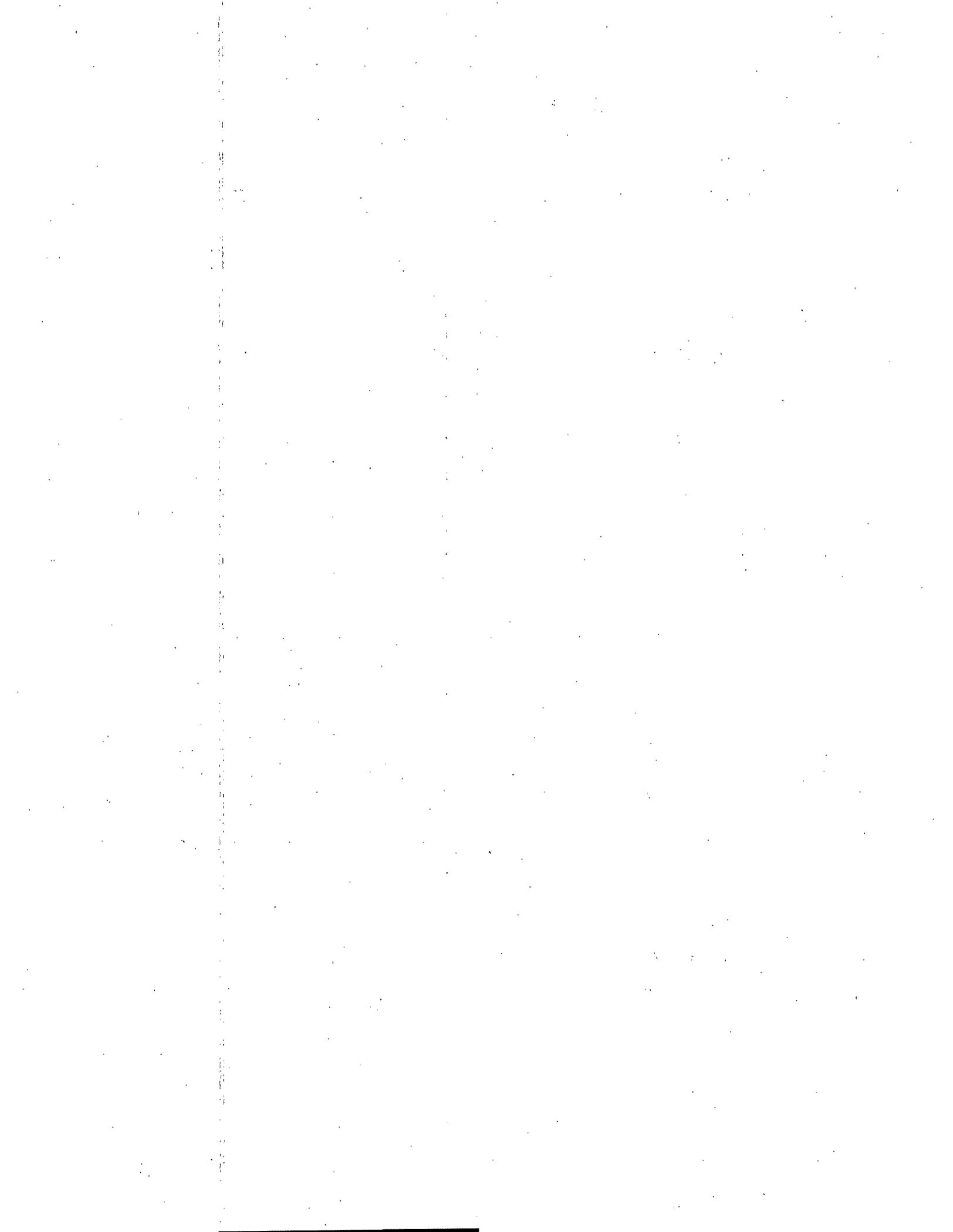
On a matter this complex and ambiguous – and with such devastating potential impact – it would be unfortunate to bring to the Senate floor a bill that will do more harm than good. Therefore AGS respectfully requests that you oppose the Pain Relief Promotion Act.

Thank you for your consideration of this letter. If you should have questions on this matter, please contact Susan Emmer at 301-320-3873 in the AGS Washington office.

Sincerely,



James Fanale, MD
President
American Geriatrics Society





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**STATEMENT ON THE "PAIN RELIEF PROMOTION ACT"
(H.R. 2260)
TO THE UNITED STATES SENATE JUDICIARY COMMITTEE**

SUBMITTED FOR THE HEARING RECORD

April 25, 2000

**James A. Guest
Executive Director
American Pain Foundation**

We commend the Judiciary Committee for holding hearings on the Pain Relief Promotion Act (H.R. 2260) and the Hatch Substitute Amendment, and we appreciate Chairman Hatch's attempt to take a bill that we feel will be harmful to effective pain management and make it less harmful. The changes in the Hatch Substitute are in most instances a step in the right direction. But in our opinion both versions of the Pain Relief Promotion Act are seriously flawed, and we oppose H.R. 2260, including the Hatch Substitute, because the legislation is likely to have a chilling impact on effective pain management and does not adequately promote pain relief.

The American Pain Foundation is an independent, nonprofit information, education and advocacy organization serving people with pain. Our mission is to improve the quality of life for people with pain by raising public awareness, providing practical information, promoting research, and advocating to remove barriers and increase access to effective pain management.

The Pain Relief Promotion Act and the Hatch Substitute are, in our view, well-intended but misguided legislation that threatens to hinder rather than help the treatment and care of people who suffer from serious pain, especially near the end of life. The threat of DEA investigators second-guessing their "intent" in medical decisions will most likely deter many physicians and other practitioners from aggressive treatment of pain and cause needless suffering by patients. Ironically, because of the deterrent effect on using opioids, the bill will almost surely increase rather than decrease the incidence of suicide, assisted and otherwise, by those who can no longer tolerate the agony of pain.

We are deeply concerned that if the bill passes physicians will be even more reluctant than they already are to use aggressive medication to treat patients suffering severe pain – even if they judge it to be medically appropriate – and that therefore many more Americans will

live and die in pain. We believe the Drug Enforcement Administration should continue to be a law enforcement agency fighting the illegal diversion of drugs. It should not be turned into a medical oversight body – a task for which it is inappropriate and unsuited. Yet this legislation has the potential for just that result.

Pain – A Major Public Health Crisis

The proposed legislation comes at a time when pain is already greatly undertreated because, in part, conscientious physicians and other healthcare professionals fear investigation and sanctions by regulatory bodies for aggressively managing their patients' pain.

Unrelieved pain – cancer pain, non-malignant chronic pain, and acute pain – is a major public health problem in the United States.

- Over 50 million Americans suffer from chronic pain, and each year nearly 25 million people have acute pain as a result of injury or surgery. Yet only 1 in 4 Americans receives proper treatment for their pain.
- Pain costs an estimated \$100 billion each year including medical expenses, lost income, and forced absence from work. Lost workdays resulting from pain add up to over 50 million a year.
- For most types of pain, there are safe, effective treatments available that can alleviate or relieve the pain. According to the federal Agency of Healthcare Research and Quality, for example, 90% of cancer pain can be relieved through relatively simple means. Yet fewer than half of cancer patients receive adequate treatment for their pain.
- In a large survey of oncologists, 86% of respondents felt that the majority of patients with pain were undermedicated. Another major national study found that in the their last days of life, more than half of hospitalized patients had unrelieved pain.
- Finally, unrelieved pain is devastating to individuals and families. When serious pain persists it permeates the patient's entire life, making it difficult to concentrate and perform even routine tasks. One of the most common reasons people cite for supporting Dr. Jack Kevorkian's controversial views on physician-assisted suicide is fear of intractable pain. Pain is a major reason patients ask their doctors to help them die.

There is an overwhelming need for Congress to effectively address the public health problem of unrelieved pain. But the Pain Relief Promotion Act, including the Hatch Substitute, does not. It is a bill aimed primarily at physician-assisted suicide, and it does so by using the vehicle of the Controlled Substances Act (CSA) and adding in some modest provisions relating to pain relief. The CSA amendments run the risk of a detrimental effect

on the aggressive and medically appropriate use of opioids for pain management while the provisions pertaining directly to pain relief are minimal and inadequate.

A Real Agenda for Pain Relief Promotion

We agree with the broader scope of coverage in the Hatch Substitute so that Title I covers not just “palliative care,” which is only one aspect of pain relief, but “pain management” as well. The problem is that the initiatives proposed in H.R. 2260 and the Hatch Substitute are insufficient to make any significant progress in promoting palliative care and pain management.

For example, the bill authorizes only \$5 million for education and training of physicians and other healthcare providers in pain medicine and palliative care – an amount equal to less than 10¢ a person for the over 50 million Americans who suffer from chronic pain – when this need has been consistently cited as badly needed and long overdue. The bill provides no additional funding for research.

Regarding protocols and evidence-based practices, the greater need is not distribution of protocols and practices, although that will be important later on, but support for the medical community to develop more protocols on pain management and palliative care in the first place. The proposed “Decade of Pain Control and Research” is a good idea, and we applaud Senator Hatch for proposing it. But there are no substantive programs attached to this one-sentence declaration of the “Decade of Pain Control and Research,” and it needs to be filled in.

We recommend that a true Pain Relief Promotion Act include a number of important initiatives such as the following:

- **Education and Training.** Require that all medical, osteopathic, chiropractic, nursing, physical and rehabilitative medicine, and other professional schools for direct care providers that receive federal funding provide comprehensive education and training in pain management.
- **Fifth Vital Sign.** Require that in all federal healthcare programs (in addition to the Veterans Administration, which has already started doing it) and in programs receiving federal monies, pain must be assessed in all patients as the “fifth vital sign” and be documented in a prominent place in the patient record.
- **Medicare and Medicaid Coverage.** Require that Medicare and Medicaid provide access to and pay for coverage of pain prevention and treatment services and medications used in the management of pain – including removing the Medicare restriction that denies coverage for self-administered pain medication.
- **Patient Self Determination Act.** Amend the Patient Self Determination Act to require that all patients admitted to federally funded health care facilities be informed of their right to adequate pain control.

- **Underserved Populations.** Require that in order for a healthcare organization or provider to receive federal funding or reimbursement of any kind, pain must be adequately assessed and managed in all underserved populations including but not limited to minorities, the young, the elderly and women.
- **Pain Relief Hotlines.** Establish two national toll-free “Pain Relief Hotlines” to answer questions and provide information about pain management – one for medical professionals and one for people with pain and their caregivers.
- **White House Commission.** Establish a White House Commission on Pain Control and Research to increase awareness, understanding and aggressive action to remove barriers and increase access to effective pain management.
- **Center or Advisory Panel at NIH.** Establish a Center for Pain Research at the Institutes of Health (NIH) – or, at a minimum, establish an External Advisory Board on Pain Medicine at NIH, analogous to the External Advisory Board on Cancer.
- **Policy Board at National Institute of Medicine.** Establish a National Pain Management and Palliative Care Policy Board at the National Academies of Science’s Institute of Medicine, analogous to the IOM’s National Cancer Policy Board.
- **Basic and Clinical Research and Outcomes-based Guidelines.** Increase federal funding for basic and clinical research on pain, and appropriate funds for outcome-based research and development of guidelines for treating different kinds of chronic and acute pain and delivery of pain management services.
- **Surgeon General Report.** Require the Surgeon General to prepare and submit a report concerning the state of pain management in the United States to the appropriate committees of Congress and the public.

Flaws in Amending the Controlled Substances Act as a Way to Ban Assisted Suicide and Euthanasia

If Congress wants to pass federal legislation prohibiting physician-assisted suicide, it should pass a separate criminal statute to ban it. We see a number of problems, however, with addressing physician-assisted suicide by tampering with the Controlled Substances Act.

- **Both the original Pain Relief Promotion and the Hatch Substitute will likely cause harm to patients who need pain care by threatening physicians and other healthcare professionals who provide it.** The legislation would give DEA agents the explicit authority – with the urgency of being written into federal statute – to question the intent of any physician or medical practitioner who provided a controlled substance to a patient

who died shortly thereafter. A physician could lose the right to practice medicine and be imprisoned for at least 20 years (the same punishment a drug dealer would receive). This would make doctors more hesitant than they already are to prescribe pain-relieving drugs and many more patients would suffer, especially at the end of life.

- **Pain relief therapy should be managed by healthcare professionals – physicians, nurses, and pharmacists – not by federal law enforcement officers.** The Pain Relief Promotion Act and the Hatch Substitute explicitly put the DEA in the middle of critical medical decision-making. They do so by flagging any deaths that follow the prescription of controlled substances. In those cases, the agency may then review the use of pain medications and decide whether a physician's intentions were to manage pain or hasten death. The very threat of regulatory intervention and oversight – and the fear of having their intentions misconstrued – could dissuade physicians from using aggressive efforts that are often needed to relieve pain effectively.
- **The Pain Relief Promotion Act and its enforcers will not be able to clearly distinguish between legitimate medical use of controlled substances and intentionally causing death.** Drawing the line is not easy for healthcare professionals with years of experience. It certainly will not be easy for law enforcement officers with no medical training. Many patients can tolerate and indeed require extremely high doses of controlled substances to relieve their pain and other symptoms, while the same dose in another patient could be lethal. The line between increasing the risk of death while treating pain (an allowable medical practice) and intentionally causing death (a crime with severe penalties) is a very fine one. Many physicians say they do not trust the DEA to make this distinction and do not feel secure that the DEA will protect them if they aggressively manage pain with opioids.
- **The "double effect" is already protected.** Since at least 1990, the DEA has accepted the "double effect" aspect of pain care – the recognition that aggressive pain relief may have the secondary effect of hastening a patient's death – although many in the medical community do not realize they are already protected at the federal level. It is not necessary to formalize this policy in statute, and doing so is certainly not worth the price of expanding the DEA's role into medical oversight and investigation of physicians' intent. What is needed is not a new law, but better implementation by the DEA of existing policy on "double effect" and better education of physicians and other providers in the use of opioids.
- **By adding even more changes to the Controlled Substances Act than the original bill, the Hatch Substitute may create additional ambiguity.** Raising the burden of proof on the DEA to "clear and convincing evidence" as provided in the Hatch Substitute is an attempt to reassure practitioners,

but making a physician's internal mental intent in prescribing medication subject to external second-guessing by any standard of proof will cause apprehension. Further, while the Hatch Substitute says the bill should not be construed to alter the roles of the federal and state governments in regulating the practice of medicine, it is unclear what those roles currently are so physicians are unlikely to feel reassured. Another section limits certain federal actions but then undoes the limit by adding "except that the Attorney General may take such other actions as may be necessary to enforce this Act." As more provisions are added to the Controlled Substances Act under the substitute amendment there is more new language requiring interpretation which means there is more potential ambiguity affecting all parties involved.

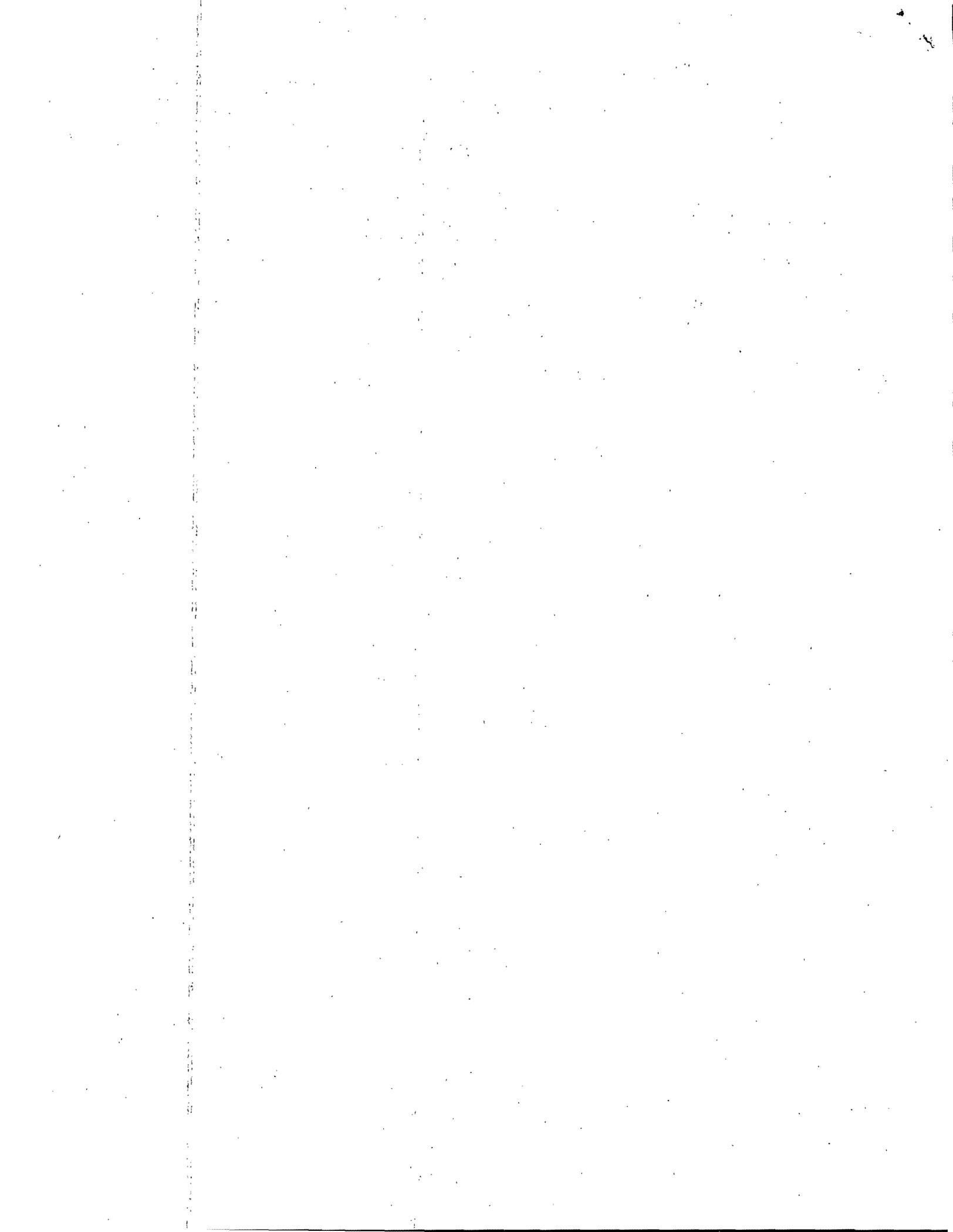
- **The funding provision in the Hatch Amendment suggests a new enforcement function for the DEA despite statements by the bill's supporters that no new authority or medical oversight is intended in the 49 states other than Oregon.** The provision refers to a new section (relating to a practitioner's "intent" and "purpose," and Oregon-type laws) as being "added by this Act" and earmarks funds for "carrying out" the section. This appears to indicate that a new function or standard would be applied to DEA activities under the Diversion Control Program – a function or standard needing funding – and that certainly would have a chilling effect on pain management. As with other provisions, it is unclear how the DEA in the future may interpret and implement the proposed section.
- **The Controlled Substances Act is an inappropriate and ineffective vehicle for addressing the issue of assisted suicide.** For one thing, prohibiting just healthcare providers registered under the CSA but not others from assisting in suicide – and prohibiting only those assisted suicides in which controlled substances are used – is a very narrow and ineffective way to ban the practice. This proposed law would not stop the Dr. Kevorkians of the world because they are not registered and do not use controlled substances. Moreover, by threatening good pain management the new law could have the unintended impact of driving even more people to seek suicide, assisted or otherwise, because they cannot get relief from their excruciating pain.

Separate Issues Calling for Separate Legislation

There are two big, highly complex issues involved in H.R. 2260: (1) physician-assisted suicide, and (2) the need for better pain management. Each issue raises important unanswered questions and deserves full and proper consideration in its own right. Assisted suicide goes far beyond the use of controlled substances. And relieving pain goes far beyond the DEA.

Assisted suicide should be dealt with in a separate law, not linked to the medical practice of pain management. We urge that you address each of these two issues separately – not linking them together – and that you act on each issue on its own merits. Potentially serious and far-reaching changes in the treatment of pain should not occur simply as the by-product of a bill on assisted suicide.

We urge the Members of the Judiciary Committee not to risk causing more pain for people who have already suffered enough by passing the Pain Relief Promotion Act when there are better ways to ban assisted suicide and better ways to promote pain relief. Don't turn patients with pain into political pawns by wrapping their medical care into the debate on physician-assisted suicide. Don't risk turning the "War on Drugs" into a "War on Patients." Don't pass the misnamed and misguided Pain Relief Promotion Act.





**American
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*The National Professional
Society of Pharmacists*

**Statement submitted for the record
By the American Pharmaceutical Association**

**United States Senate
Committee on the Judiciary
April 25, 2000
Hearing on HR 2260, The Pain Relief Promotion Act**

*"Pain is the single most common reason that patients visit physicians,
clinical facilities, and pharmacies."¹*

The American Pharmaceutical Association (APhA), the national professional society of pharmacists, represents pharmacist caregivers in hospitals, long term care facilities, community pharmacies and other practice settings. The Association is a leader in providing professional information and education for pharmacists and an advocate for improved health through the provision of comprehensive pharmaceutical care. APhA members have a direct and significant interest in pain management and end-of-life care.

Many pharmacists and other health care professionals are apprehensive about the Pain Relief Promotion Act (HR 2260/S 1272). We fear the Act will inappropriately increase Drug Enforcement Administration (DEA) scrutiny into practitioners' prescribing and dispensing of pain medications. As noted in the attached summary of relevant medical literature, current controlled substance regulations have a negative effect on pain management. We want to be able to alleviate patient suffering by dispensing the most appropriate and effective medication available—without fearing we will be suspected of providing medication used to assist a patient's suicide.

We realize the DEA does not have an easy job in this matter. Determining a prescription's genuine intent may not always be clear. While the DEA is charged with monitoring "intent" to "manufacture, distribute, or dispense" controlled substances as in Section 841 of the Controlled Substances Act, this is a substantively different inquiry than determining whether a controlled substance was prescribed or dispensed with the "intent" to manage pain or to hasten death. "Intent" to manufacture, distribute or dispense controlled substances by unauthorized individuals does not involve inquiry into medical practice—nor inquiry, as here, into the recent death of a patient. The ability of a DEA diversion control officer to discern the difference between a prescription intended to manage pain or other symptoms and a prescription to terminate life is not tested. It may sound straightforward for a DEA inspector to look for abnormally large amounts of medication going to one patient. As pain increases, however, so does tolerance to the medications. For significant pain, the dose required for managing pain in one patient may be lethal in another patient. Any revision to the Controlled Substances Act involving clarification of DEA oversight must be done carefully, after specific review of the potential consequences.

Further, the Pain Relief Promotion Act simply does not do enough to substantively relieve pain or improve pharmacists' ability to care for patients with pain. Across the country, pharmacists work collaboratively with physicians, nurses, hospice providers, patients and their families to use medications to control pain.

¹ Lipman AG. J Pharm Care Pain Sympt Control 1993;1:1-3.

Regrettably, the proposed regulatory change will only increase health care providers' fear of criminal penalties with its questionable and vague line of enforcement. Physicians, pharmacists and nurses will be cautious—and patients could suffer. If the ultimate goal of Congress is to help the terminally ill person in despair, this legislation does not advance that goal. It only complicates the delivery of compassionate end-of-life care.

It is important to note that the Association's concern with the legislation does not relate to the issue of physician-assisted suicide. APhA does not support physician-assisted suicide nor does it support the legalization of physician-assisted suicide. The formal policy adopted by the APhA House of Delegates in 1997 states: "Recognizing the diversity of opinions among its members and the public at large on the issue of physician-assisted suicide, the APhA shall support informed decision-making based upon the professional judgment of pharmacists, rather than endorsing a particular moral stance." The House of Delegates adopted further policy related to laws which sanction physician-assisted suicide, recommending that such laws should not specifically address the role of pharmacists in such situations: "APhA opposes laws and regulations that mandate or prohibit the participation of pharmacists in physician-assisted suicide."



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MARY E. FOLEY, MS, RN
PRESIDENT

DAVID W. HENNAGE, PhD, MBA
EXECUTIVE DIRECTOR

**Statement of the American Nurses Association
Submitted to the Senate Committee on the Judiciary
on H.R. 2260, the Pain Relief Promotion Act
April 25, 2000**

The American Nurses Association is pleased to have the opportunity to address H.R. 2260, the Pain Relief Promotion Act, which is under consideration by the Committee on the Judiciary. The American Nurses Association is the only full-service professional organization representing the nation's registered nurses through its 53 constituent associations.

ANA has been actively involved in efforts to prohibit assisted suicide and continues to hold a strong commitment to the principle that the role of medical and nursing professionals must be to heal and relieve those in pain but not to act to end a life or to make the means of death available to a person who seeks to end his or her own life.

However, ANA is concerned that provisions of H.R. 2260, even if amended by the proposed substitute to be offered by Senator Hatch, would have a chilling effect on pain management and result in needless suffering, a result that is totally at odds with the professional commitment of the nursing profession. Investigations by the Drug Enforcement Administration, using the ambiguous standard of the intentions of the health care professionals involved in the prescription of medication, would be intimidating and counterproductive. H.R. 2260, in making effective pain and symptom relief more difficult to obtain, is likely to increase, rather than decrease demands for assisted suicide. Furthermore, it would do nothing to address assisted suicide by means other than controlled substances.

Nurses have long been in the forefront as leaders and advocates for the delivery of dignified and humane end-of-life care and are obligated to provide relief of suffering and comfort to a dying person. Participation in assisted suicide is not acceptable under the ethical mandates of the profession, but neither should the legal system erect barriers to appropriate palliative care, which is also an ethical mandate for the profession.

ANA believes the Pain Relief Promotion Act would erect a tragic barrier to appropriate palliative care and is ethically bound to oppose it. ANA appreciates the Committee's consideration of these comments on this issue and urges members of the Committee to oppose this legislation.

Questions may be addressed to Stephanie Reed, Associate Director of ANA Government Affairs, 202-651-7088.

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AMERICAN PAIN FOUNDATION®

To: Chris Jennings CC: Neal Lane, Karen Tramontano, Melissa Goldstein
From: Jim Guest, Executive Director
Date: September 11, 2000
Re: Opposition to the Pain Relief Promotion Act Has Grown to the Point
Where Your Help Will Keep the Bill from Reaching President Clinton's Desk

Summary

Since you met with me and the delegation from the American Nurses Association, American Academy of Family Physicians and American Geriatrics Society in early June, our expanded coalition has put your advice into action and "turned up the noise" on the Hyde/Nickles Pain Relief Promotion Act. We have built enough opposition that a call from the White House to the Democratic leadership could keep the bill off the Senate floor or hold 41 or more Democrats together to defeat Nickles' attempt at cloture. This memo summarizes the work we have done since we met and why it would be worth an effort to keep the bill off the President's desk.

Progress Since We Met

- Increased number of organizations actively opposing the bill from 28 to 45⁵² (list attached).
- Most notable new opponent: the American Cancer Society. *and ASA*
- Visited 42 Senate offices (26 Democrats and 16 Republicans).
- Conducted two well-attended briefings for Senate staff.
- Held news conference and ~~have~~ audio news conference for out-of-town journalists scheduled.
- Placed op-eds in numerous papers and increased editorial opposition (see below). *30 to 1*
- Had Leahy ask all Democrats to oppose at last week's LD meeting. *Duscher, Rose or Carrey spoke at floor*
- Through heavy grassroots effort, greatly increased the number of letters, phone calls and emails *P.P.M. withdrew* going into Senate offices from our coalition members. *12,000*
- Launched website – www.stopprpa.org – and generated *12,000* additional letters *since inception* in *two weeks*.

Newspaper Editorials Against the Bill Have Grown

At least ~~15~~ major papers oppose, including the *New York Times, Washington Post, L.A. Times, Philadelphia Inquirer, Tampa Tribune, St. Louis Post-Dispatch, Cincinnati Enquirer, Pittsburgh Post-Gazette, Providence Journal, San Jose Mercury News* and the *Des Moines Register*. (See samples attached).

Gore Publicly Expressed "Serious Reservations" About PRPA, While Bush Supports

While in Oregon on Aug. 31 Gore publicly stated he had "serious reservations" about the bill. He added: "I am personally opposed to physician-assisted suicide. However, I don't want to see the criminalizing of doctors' ability to deal with severe pain." (*Oregonian* 8/31, p. A1). We recently met with Melissa Goldstein to reinforce our opposition. I believe she agrees with our position

substantively, but said it was up to the White House to convey the Administration's concerns. Gov. Bush is on record in full support of the Nickles bill.

DoJ and H&HS Continue to Oppose PRPA on the Merits

Last month we met with Jane Horvath at H&HS and John Tanner with DoJ's Office of Legislative Affairs. Both reiterated their opposition on the substance, but agreed the message has to come from the White House to the Democratic Leadership. (Tanner has spoken with some Democratic offices and offered to help where he can.)

Current Floor Situation

Recently, Nickles lifted his hold on a timber payments bill worth many millions to Oregon in exchange for Wyden lifting his hold on the Hyde/Nickles bill. Nickles is 100% determined to bring the bill to the floor for a vote this month, possibly as early as Sept. 18th. (We believe the timber bill has to be voted on by Sept. 15th due to a sunset provision.) Nickles personally appeared at a briefing for Senate staff on Sept. 7th with the AMA, Natl. Hospice Organization, DEA and others to drum up support. But the drafters of the bill – Conference of Catholic Bishops and National Right to Life Committee – appear to be the only groups having their grassroots really work the issue.

Senator Wyden will filibuster the bill and fight attempts at cloture. Senators Feinstein and Kennedy are also expected to be strong opponents on the floor. A couple of months ago Nickles boasted he had 80 votes. But we've made a dent, and in a Sept. 7th AP story he backed off his initial claim:

“Nickles told reporters he could have a tough time getting the 60 votes needed on the Senate floor to shut down a threatened filibuster by Sen. Ron Wyden, D-Ore. ‘That's not easily done,’ he said.”

Latest Vote Count

Our latest vote count bears this out. As a result of recent efforts, several members who were undecided have shifted to opposing the bill, and several who were leaning towards supporting it are now up for grabs. No new cosponsors were added since we met.

Republicans: We believe Nickles has only 41 solid Republican votes, with another 7 R's leaning his way. Four moderate, pro-choice R's will likely oppose, and three more are undecided but gettable.

Democrats: We believe only two Democrats are firmly with Nickles now – Biden and Lieberman – and Lieberman may not be present. Only three D's appear to lean Nickles' way (Breaux, Landrieu and Dodd) but we are working on them. 34 D's are either firm or likely “no” votes. Six D's appear undecided, but are gettable because all are pro-choice and/or strong on health issues and they are now hearing from important constituents against the bill: Bayh, Moynihan, Sarbanes, Mikulski, Byrd, and Dorgan.

Senators Perceive Vote as Undesirable Because Bill Is So Controversial

Most offices we met with – including several which support the bill – said they don't want it to come up because it is so controversial. They see it as being forced to choose between (1) hurting people who need pain relief, or (2) being accused of supporting physician-assisted suicide right before the election. Many Catholic Democrats appear particularly distressed.

Impact on President Clinton If Bill Passes

If the bill passes, the President will likewise be forced to choose between opposing physician-assisted suicide and chilling effective pain management. And pretty much only the pro-life community will want to attend the signing ceremony. Yet all but a few in the health/medical community, the President's allies on similarly tough issues like stem-cell, are actively fighting it.

All of the moderate to liberal editorial pages that have taken a position oppose the bill. We can assume that some will criticize President Clinton for giving in to the pro-lifers.

Having a floor vote will give pro-life activists ammunition to challenge select Democratic candidates who vote against the bill as "supporting the killing of defenseless elderly cancer patients," or some familiar rhetoric to that effect.

And while it is not our issue, the two most recent national polls show public support for physician-assisted suicide has grown to 75%. (CBS News, 1998; Roper, 1996).

Impact on Gore

If the bill passes and is signed into law, Gore as president would be confronted with two likely scenarios in 2001, both of which are unpleasant:

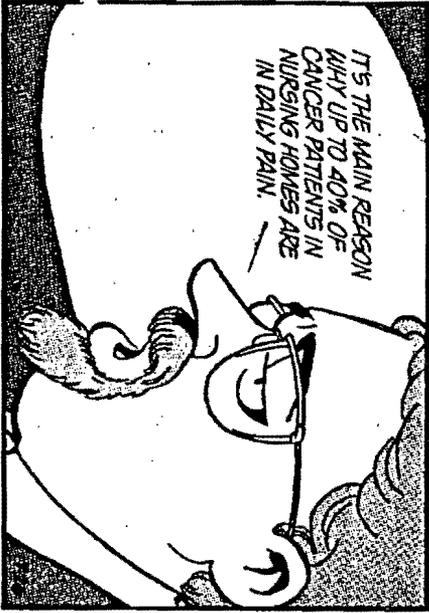
1. **A "Next Step" Bill:** The pro-life community's first step on this issue was the 1997 ban on federal funding of assisted suicide. If this bill passes, its proponents will continue to the next logical proposal for them that seeks to preserve frail adult human life by any and all means. That will likely be:
 - Either a bill that prohibits federally funded hospitals, nursing homes, and hospices from withdrawing nutrition and hydration from any patient under any circumstance,
 - Or, a bill that prohibits the use of non-controlled drugs and devices in assisted suicides.

We can't know for sure, but, if they win, it would make political and ideological sense for them to keep attacking other medical procedures they perceive as hastening death.

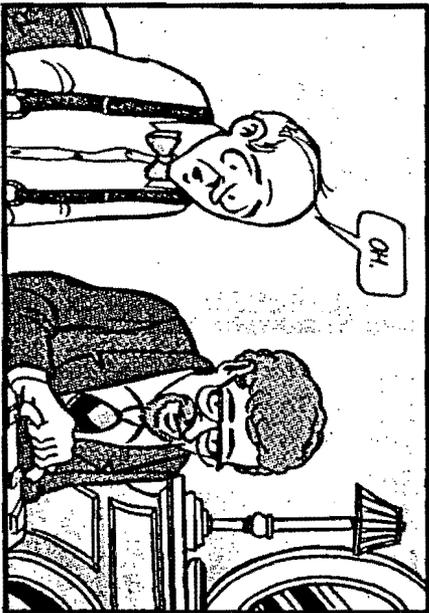
2. **A Lost Opportunity:** If the bill passes and is signed into law, most members of Congress, tired of the controversy, will think that at least the bill called the "Pain Relief Promotion Act" did something positive to promote pain management, even though it does just the opposite. There will be less support for a genuine initiative to address a major health care problem – the undertreatment of pain – that Republicans and Democrats alike agree has never been tackled at the national level.

Conclusion

The health impacts and political considerations of this bill argue strongly for the Administration to work with the Senate Democratic Leadership to keep the bill from the Senate floor or, alternatively, to help secure 41 votes against cloture. As representatives of the nearly 50 nurse, physician, pharmacist, patient and hospice organizations opposed to the dangerous Pain Relief Promotion Act, we ask for your help at this make-or-break moment. I will call you to follow up.



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By Garry Trudeau



Yes/Likely Yes on Cloture: 49 48 R's and
1 D (Lieberman)

No/Likely No on Cloture: 41 38 D's (including former cosponsor Moynihan, cosponsor Dodd,
who is yes on the underlying bill, and cosponsor Landrieu)
3 R's (Chafee, Jeffords and Warner)

Remaining Republicans:

Snowe (ME)	Undecided on bill
Specter (PA)	Leans no on bill (voted no in committee)
Stevens (AK)	Likely no on bill (and opposes adding to approps)

Remaining Democrats:

Bayh/IN	Undecided on bill (cosponsor); leans no on cloture
Biden/DE	Yes on bill; not sure on cloture
Breaux/LA	Undecided on bill (cosponsor)
Byrd/WV	Undecided on bill but opposes adding to approps.; possible no on cloture
Dorgan/ND	Undecided on bill; possible no on cloture
Mikulski/MD	Undecided on bill; possible no on cloture
Sarbanes/MD	Undecided on bill; possible no on cloture

11/15/00

The Associated Press.
October 30, 2000

Clinton Says He has 'Concerns' About Assisted Suicide Proposal

By JOHN HUGHES, Associated Press Writer

WASHINGTON - President Clinton said Monday he opposes assisted suicide but has concerns about a bill that would make Oregon's landmark law allowing physician-assisted suicide difficult - if not impossible - to use.

"My concern, frankly, right now is whether the bill as written would have a chilling effect on doctors writing medication for pain relief on terminally ill patients," Clinton said. "And I'm concerned, therefore, about the way it's worded."

The comments came in response to a reporter's question as Clinton discussed his efforts to reach a budget deal with Congress.

But Clinton made no commitment as to whether he would sign or veto the suicide legislation.

"And I know Sen. (Ron) Wyden's filibustering the bill and maybe we'll work that out too, before this is over," Clinton said. "I hope we can."

Wyden, D-Ore., has twice - on Friday and Sunday - prevented the Senate from considering a \$240 billion tax bill that includes language barring doctors from using federally controlled substances such as barbiturates to deliberately cause a patient's death.

All 43 people who died under Oregon's Death With Dignity Act since the law took effect in late 1997 used controlled substances to end their lives.

Sen. Don Nickles, R-Okla., the author of the suicide proposal, had the measure inserted in the tax bill with the hope of avoiding a Wyden roadblock. Wyden has said all year that he would filibuster any bill he believed would block Oregon's law allowing terminally ill patients to take their own lives.

Senate Majority Leader Trent Lott, R-Miss., has been working on a way to bring the tax bill up but said he has failed to reach an agreement with Wyden.

At a bill signing session at the White House on Monday, Wyden gave Clinton a memo outlining the senator's concerns about the assisted suicide bill. Clinton and Wyden also discussed the issue by telephone Monday after Clinton read the memo, Wyden said.

Wyden said he is not disappointed that Clinton has not taken a position on whether he would sign or veto the tax bill over the suicide issue because the president does not know what the final bill will look like.

"But what I was glad to hear," Wyden said, "was that the president of the United States is thinking about the voters of Oregon and the suffering the Nickles bill would cause in every community in the United States.

Clinton said in his comments to reporters, "Whatever your opinions about assisted suicide, and whether the people ought to have a right to vote on it in a given state, we certainly don't want to do anything that would in any way undermine the willingness of physicians to write pain relief medication for fear they'll later be prosecuted if the patient dies."

Clinton has threatened to veto the tax bill for reasons unrelated to assisted suicide.

The subject of assisted suicide also came up at the White House Press Secretary Jake Siewert's daily briefing on Monday.

"We've made it clear that we have some concerns about the Oregon law, but we think those ought to be discussed separately and that those ought to be discussed in some other context," Siewert said.

"It's important not to try to rush through a debate on an enormously complex issue in the heat of a last minute kind of a tax debate," he added.

The tax bill number is H.R. 2614.

On the Net:

Congress: <http://thomas.loc.gov>

Gore Expresses Reservations on Pain-relief Measure

By TARA BURGHART, Associated Press Writer

PORTLAND, Ore. - During a visit to the city Wednesday that centered on health care, Al Gore said he has reservations about a bill in Congress that would essentially block Oregon's physician-assisted suicide law. The Democratic presidential candidate said he personally opposes doctor-assisted suicide, but questions whether the Pain Relief Promotion Act would result in doctors withholding pain prescriptions for fear of federal prosecution. The bill is set for a vote in the Senate in a few weeks.

"I don't want to see the criminalization of doctors' ability to deal with severe pain in situations where the government doesn't really know how to order doctors to do their job," Gore said.

Republican presidential candidate George W. Bush has said he would sign the bill if elected president, and argues that it is the federal government's job to regulate controlled substances.

Meanwhile, Gore's health-care forum at Portland State University on Wednesday attracted a politician who has not always been in his cheering section - Gov. John Kitzhaber, who had endorsed Bill Bradley's bid for the Democrats' presidential nomination. But on Wednesday, Kitzhaber called on Oregonians to support Gore. The former emergency room doctor said Gore's plans for health care include getting more children covered by health insurance and boosting medical benefits and support for the low-income elderly.

"This is far and away a superior package than the one offered by the Bush campaign in terms of quality, its detail, its fiscal honesty and its impact on the health of the American people," Kitzhaber said. The vice president responded in kind, saying Kitzhaber has had the "guts and foresight to ask the really tough questions."

Ironically, Gore, when he was in the Senate, was an early opponent of the Oregon Health Plan, which was authored by Kitzhaber. The plan provides insurance to more low-income people by "rationing" medical services. Gore has since come around to supporting the plan, and his running mate, Joe Lieberman, specifically praised Kitzhaber for it.

Gore spoke to reporters about his thoughts on Oregon's physician-assisted suicide law after the forum.

Sen. Ron Wyden, D-Ore., has promised to filibuster the Pain Relief Promotion Act when it comes before the Senate because he said it would inhibit doctor's freedom to prescribe pain relief. Wyden said Wednesday he had talked to Gore three times during his visit to Oregon, trying to get him to state publicly his opposition to the bill, proposed by Sen. Don Nickles, R-Okla.

"I sure feel like we're making progress," Wyden said. "The vice president is very sympathetic to the arguments I'm making. "I made the case the Nickles bill is not just about a small state 3,000 miles away," Wyden said. "This is going to hurt patients in agony in every part of the United States because their medical providers are going to be very reluctant to treat pain aggressively."

The proposed bill would make Oregon's voter-approved law difficult - if not impossible - to use because it would revoke the prescription drug licenses of doctors who deliberately use controlled substances to aid a patient's death. The measure also would subject violators to a minimum of 20 years in prison, according to the Justice Department.

During a visit in May, Bush said he would sign the bill if he becomes president. "Controlled substances to control pain are fine, to take a life is not fine. I would sign that bill," Bush said.

Meanwhile, Green Party presidential candidate Ralph Nader said earlier this month that he thinks Oregon voters made a mistake by first approving the physician-assisted suicide law, then voting against repealing it. Nader said he believes it is open to abuse by doctors under financial pressure by health insurance organizations to hold down the costs of caring for the terminally ill.

Q: What do all of these papers have in common?

Arizona Daily Star

Asheville Citizen-Times (NC)

Augusta Chronicle (GA)

Buffalo News

Brunswick Times Record (ME)

Cincinnati Enquirer

Des Moines Register

East Valley Tribune (AZ)

Houston Chronicle

Lancaster Intelligencer Journal (PA)

Lewiston Morning Tribune (UT)

Los Angeles Times

New York Times

Orange County Register (CA)

Palm Beach Post

Philadelphia Inquirer

Pittsburgh Post Gazette

Providence Journal-Bulletin

Roanoke Times & World News (VA)

Sacramento Bee

San Jose Mercury News

Scranton Times

St. Louis Post-Dispatch

St. Petersburg Times

Tampa Tribune

Washington Post

A: They all oppose the Pain Relief Promotion Act.

Fact: Most of these editorials appeared after the Senate Judiciary Committee marked up the bill and reported it 10-8.

Fact: No newspaper has endorsed the bill since mark up.

Fact: Papers from around the U.S. all raise the same concerns about how this bill will interfere with good pain management.

“With DEA Agents looking over their shoulders, doctors are likely to become far more conservative in administering pain killing drugs.”

- Arizona Daily Star

“When a federal bill does the opposite of what its title says it does, rest assured the measure ought not pass – and probably would not if it had a more accurate name. The so-called Pain Relief Promotion Act is a case in point.”

- Houston Chronicle

“The bill isn’t designed to relieve suffering. In fact, it could set back much of the progress the country has made in treating chronic pain.”

- Palm Beach Post

“Americans are already suspicious about the role insurance-company pencil-pushers have assumed in influencing the care they receive. Now they are supposed to accept [DEA] bureaucrats doing the same?”

- Buffalo News

More →

More on what papers from around the country have said about the misnamed Pain Relief Promotion Act:

"The bill could have a chilling effect on palliative care. Fear of prosecution is already leading many doctors to undermedicate for pain."

- Los Angeles Times

"[P]hysicians and nurses are already reluctant to give large doses of medications that relieve pain to dying patients out of fear that they will be prosecuted. . . With the DEA looking over his or her shoulder, what doctor wouldn't be even more conservative in prescribing pain medication?"

- Asheville Citizen-Times

"The U.S. Senate is barreling toward a September vote on the so-called Pain Relief Promotion Act that, if passed, will do anything but encourage doctors to relieve the pain of terminally ill patients."

- Roanoke Times & World News

"Who is best qualified to decide how much pain medication to prescribe for severely ill people in the last days of their lives: doctors or cops?"

- San Jose Mercury News

"It could deny pain relief to those most desperately in need of it."

- Des Moines Register

"Just as alarming is the chilling effect this law would have on doctors treating patients who don't want to die, but just live their final days in the absence of agony. We share the objection raised by the medical professionals who actually stand at the bedsides of the dying – the American Nurses Association."

- St. Louis Post-Dispatch

"Do you really want your doctor worrying about answering a DEA agent's questions when he or she is making decisions about the kind of life you lead and death you may face? We don't."

- Lancaster Intelligencer Journal

Select Editorials Opposing the So-called "Pain Relief Promotion Act" (HR 2260/S 1272)

"A Bad Bill on Dying"

The Washington Post

February 16, 2000

The House last year used a seemingly hard-to-oppose cause, pain relief for the dying, to camouflage and pass a bill that essentially overturned Oregon's controversial law legalizing assisted suicide. Now the Senate may take up the ill-conceived, misleadingly named Pain Relief Promotion Act...

This year's bill purports to fix the problem by limiting penalties to drugs prescribed "with the intent" to cause death. (It also allocates money for palliative care.) But the fix doesn't work. Doctors who treat the dying say the line is inevitably fuzzy between a dose that hastens death and one that merely eases it; doctors (or nurses or pharmacists) afraid of criminal sanctions would be deterred not just from the former but from the latter as well.

"Caring for the Dying - Congressional Mischief"

The New England Journal of Medicine

December 16, 1999

If the bill becomes law, it will almost certainly discourage doctors from prescribing or administering adequate doses of drugs to relieve the symptoms of dying patients... The bill turns on discerning physicians' intentions in administering controlled substances and provides for harsh penalties if those intentions are found not to conform with a "legitimate medical purpose"...

The bill's effects would be felt more by terminally ill patients who do not wish physician-assisted suicide than by those who do, since there are so many more of them. Many terminally ill patients require extremely high doses of controlled substances for adequate relief of symptoms. Doctors, faced with the possibility of long prison sentences if their intentions are misread, may be reluctant to prescribe or administer such doses. Treatment of pain in the terminally ill is already notoriously inadequate, largely because our society's preoccupation with drug abuse seeps into the medical arena. Many doctors are concerned about the scrutiny they invite when they prescribe or administer controlled substances, and they are hypersensitive to "drug-seeking behavior" in patients. Patients, as well as doctors, often have exaggerated fears of addiction and the side effects

of narcotics. Congress would make this bad situation worse.

"Flawed Pain-Relief Bill"

The New York Times

August 14, 1999

In a misguided effort to legislate against physician-assisted suicide, a bill awaiting action in the House Judiciary Committee could discourage doctors from providing aggressive pain relief to patients with terminal illnesses...

The new bill tries to address that concern by declaring that alleviating pain through drugs is a legitimate medical purpose, "even if the use of such a substance may increase the risk of death." But doctors would still have reason to worry that they could be investigated and charged with intent to cause death even when no such intent existed...

The House should help desperate patients by dropping the ill-conceived restrictions on doctors, and focus instead on more federal support for palliative care.

"Do Not Suffer This 'Pain Relief' Bill"

Los Angeles Times

April 26, 2000

Sen. Orrin Hatch's Pain Relief Promotion Act is... hardly true to its name. Its broad provisions, far from improving palliative care, could in fact discourage doctors from effectively treating pain, and it should be defeated...

Hatch's bill would effectively require the federal Drug Enforcement Administration to determine whether physicians are appropriately prescribing pain medications. That is a task that, as the DEA admitted in a letter to Congress last month, it "lacks the resources or the expertise" to do.

There's also no evidence that doctors are over-medicating patients to hasten their deaths. On the contrary, the few studies that do exist indicate that under-medication of the terminally ill is more of a problem. For instance, a 1998 New York state task force on pain management polled 3,000 physicians and found 71% admitting that they had under-medicated patients for pain to avoid being punished by state medical boards.

**"A 'Double Effect:'
In Trying to Overturn an Assisted-suicide Law,
Congress Risks Intruding on Death-bed Care."
Philadelphia Inquirer
August 27, 2000**

As approved last year by the U.S. House of Representatives, a measure entitled the "Pain Relief Promotion Act" would cripple the controversial Oregon law by banning doctors' use of federally controlled drugs to bring about death intentionally... The trouble is that, in trying to supersede that controversial statute, Congress could blunder into the hospital rooms of the dying and make doctors even more skittish about using pain-relief drug regimen for fear of being called to account.

The bill would give law enforcement clearly enhanced powers to question doctors' intent when a heavily medicated patient succumbs. Some experts predict a chilling effect.... The best antidote to the assisted-suicide movement could be to reassure Americans they will receive the care needed to die with dignity. Too many lack such peace of mind.

**"A Real Pain:
Bill in Congress Raises Questions about
Doctor-patient Relations"
Intelligencer Journal, Lancaster, PA
July 31, 2000**

There's a bill working its way through Congress that could fundamentally change the relationship between a doctor and patient and, potentially, increase the possibility that any one of us could suffer a long, lingering, painful death.

The wildly misnamed Pain Relief Promotion Act ... would give Drug Enforcement Agency agents the authority to question the intent of any physician or medical practitioner who provided a controlled substance to a patient who dies soon thereafter... Giving DEA agents, who usually spend their days hunting down cocaine and heroin peddlers, the responsibility to probe the intent of a physician immediately criminalizes an already complex relationship. It will also likely chill the willingness of many doctors to aggressively manage the pain of their chronically and terminally ill patients.

The sad part of all this is that studies have repeatedly found that most Americans with severe, continual pain -- the kind that often presages death -- are undermedicated, rather than overdrugged. The pain relief bill appears to be attacking a problem that doesn't exist.

**"Pain-Relief Act Promises
More Pain Than Relief"
Roanoke Times & World News
August 1, 2000**

The U.S. Senate is barreling toward a September vote on the so-called Pain Relief Promotion Act that, if passed, will do anything but encourage doctors to relieve the pain of terminally ill patients.

Its effect is almost certain to be the opposite, a consequence that should send this legislation to an early grave. Don't count on it, though, unless Americans tell their senators they do not want federal drug agents second-guessing physicians who prescribe heavy doses of controlled drugs to relieve excruciating pain...

Physicians in the United States, already notorious for underprescribing pain medication, would be less likely than ever to offer adequate relief when to do so would increase a dying patient's immediate risk of death and expose a doctor to criminal investigation.

**"Compassionate Death? Or Painful?"
The San Jose Mercury News
April 6, 2000**

Who is best qualified to decide how much pain medication to prescribe for severely ill people in the last days of their lives: doctors or cops?...

As any doctor knows, the line between increasing the risk of death and intentionally causing death is fine indeed. Some patients can tolerate huge doses of medication that would kill others. Compassionate physicians routinely prescribe amounts that they know will hasten death when there is no alternative to agonizing pain.

Threatened with DEA investigations and prison, doctors are likely to under-medicate, and the severely ill and their families will suffer.

**"Legislating Pain and Death"
St. Louis Post Dispatch
October 31, 1999**

The most serious public issue standing in the way of our right to die peacefully is not the tortuous ethical question of physician-assisted suicide. It is under-treatment of pain by doctors fearful of criminal prosecution if powerful medications hasten the death of the terminally ill...

Just as alarming is the chilling effect this law would have on doctors treating patients who don't want to die, but just live their final days in the absence of agony... This is a meddlesome bill that would make bad law.



The New England Journal of Medicine

Established in 1812 as THE NEW ENGLAND JOURNAL OF MEDICINE AND SURGERY

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ORIGINAL ARTICLES

- Efavirenz plus Zidovudine and Lamivudine, Efavirenz plus Indinavir, and Indinavir plus Zidovudine and Lamivudine in the Treatment of HIV-1 Infection in Adults 1865
S. STASZEWSKI AND OTHERS
- Combination Therapy with Efavirenz, Nelfinavir, and Nucleoside Reverse-Transcriptase Inhibitors in Children Infected with Human Immunodeficiency Virus Type 1 1874
S.E. STARR AND OTHERS
- A Randomized Study of the Prevention of Sudden Death in Patients with Coronary Artery Disease 1882
A.E. BUXTON AND OTHERS

IMAGES IN CLINICAL MEDICINE

- Cutaneous Zygomycosis (Mucormycosis) 1891
C.F. CARPENTER AND A.K. SUBRAMANIAN

SPECIAL ARTICLES

- Risk Factors for Injury to Women from Domestic Violence 1892
D.N. KYRIACOU AND OTHERS
- Violent Injuries among Women in an Urban Area 1899
J.A. GRISSO AND OTHERS

REVIEW ARTICLE

- Primary Care: Infections in Patients with Diabetes Mellitus 1906
N. JOSHI, G.M. CAPUTO, M.R. WEITEKAMP, AND A.W. KARCHMER

CASE RECORDS OF THE

- MASSACHUSETTS GENERAL HOSPITAL
A 62-Year-Old Woman with an Infected Right Foot and Aneurysmal Dilatation of a Femoral Artery 1913
J.M. SLAIBY, C.-M. FAN, AND H.T. ARETZ

EDITORIALS

- Caring for the Dying — Congressional Mischief 1923
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- Violence against Women — A Challenge to the Supreme Court 1927
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- INFORMATION FOR AUTHORS 1930

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- Coronary Artery Disease in Men and Women 1931
- Integrated Screening for Down's Syndrome 1935
- Transplacental Transmission of Natural-Killer-Cell Lymphoma 1937
- Disseminated Intravascular Coagulation 1937
- Cardiac Contractility during Severe Ketoacidosis 1938
- BOOK REVIEWS 1939
- BOOKS RECEIVED 1942
- CORRECTIONS
- Integrated Screening for Down's Syndrome 1935
- Chest Pain with a Surprising Course 1944

HEALTH POLICY REPORT

- Executives with White Coats — The Work and World View of Managed-Care Medical Directors (First of Two Parts) 1945
T. BODENHEIMER AND L. CASALINO

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*Editorials*CARING FOR THE DYING —
CONGRESSIONAL MISCHIEF

FIVE years ago, the citizens of Oregon voted by a narrow margin to legalize physician-assisted suicide for certain terminally ill patients. There followed a variety of efforts to nullify the decision, which culminated in a second referendum in 1997. This time Oregonians voted overwhelmingly to affirm their original decision, and Oregon is now the only state in which physician-assisted suicide is practiced legally.¹ Surveys indicate that most Americans and their doctors believe it should be available in all states.²⁻⁴

Shortly before the second Oregon vote, the U.S. Supreme Court considered the issue of physician-assisted suicide. The cases before it concerned state laws in Washington and New York that prohibit the practice. Opponents of those laws argued that they violate an implied constitutional right to choose, within limits, the time and manner of one's death — a right that would be unduly restricted if doctors were prohibited from helping.⁵ The Court rejected that argument, unanimously finding no constitutional right to physician-assisted suicide.^{6,7} However, it explicitly left the states free to legalize the practice through legislation or referendums, as in Oregon. Justice Sandra Day O'Connor, for example, referred warmly in her separate opinion to the serious work being done on this issue in the "laboratory of the states."

The Oregon law has now been in effect for nearly two years. Called the Death with Dignity Act, it permits physicians to prescribe a lethal dose of a controlled substance (usually a barbiturate) under well-defined circumstances. Patients may take the drug if and when they choose, but physicians may not themselves administer it. Initially, Oregon doctors were intimidated when the Drug Enforcement Administration warned that doctors who took part in physician-assisted suicide were violating the Controlled Substances Act and might lose their licenses to prescribe such drugs.⁸ In June 1998, however, Attorney General Janet Reno put that fear to rest by stating that using controlled substances for physician-assisted suicide in accordance with Oregon law would not violate federal drug laws.

Last February, the Oregon Health Division reported on the first year's experience with the new law.⁹ It could find no evidence that the law had been abused. All told, 15 Oregonians (13 with metastatic cancer, 1 with chronic obstructive pulmonary disease, and 1 with heart failure) chose to end their lives under the law's terms. Early indications are that the second year's experience will be similar (Hedberg K:

personal communication). This is hardly the carnage opponents predicted. But the availability of physician-assisted suicide may well have been a solace for many other terminally ill patients who ultimately decided not to make use of it. Furthermore, the intense public debate over the issue led Oregon to redouble its attention to all aspects of care at the end of life. The state now is widely acknowledged to offer some of the best palliative care in the country, and of course, the better the palliative care, the less likely patients are to choose physician-assisted suicide.

Despite the apparent successes of the Oregon law, another effort has been launched to thwart it, this time in the U.S. Congress. If successful, that effort will have pernicious consequences, not just for terminally ill patients in Oregon who would like the option of physician-assisted suicide, but also for dying patients throughout the country who merely want their last days to be comfortable. Once again, the tool being used is the Controlled Substances Act. On October 27, the House of Representatives voted to amend the act to make it a federal crime, punishable by 20 years in prison, for doctors to prescribe drugs for terminally ill patients to end their lives.^{10,11} The Senate is now considering the same bill. Called the Pain Relief Promotion Act of 1999, the bill's purpose is "to amend the Controlled Substances Act to promote pain management and palliative care without permitting assisted suicide and euthanasia, and for other purposes."¹² It states that the attorney general "shall give no force and effect to State law authorizing or permitting assisted suicide or euthanasia," thus overriding Reno's earlier decision to defer to the voters of Oregon.

That may seem a small price to pay if the bill really promotes better pain relief, as its title promises. But the title is misleading. If the bill becomes law, it will almost certainly discourage doctors from prescribing or administering adequate doses of drugs to relieve the symptoms of dying patients. To be sure, the bill pays lip service to promoting adequate pain relief. It states that doctors may use controlled substances to alleviate pain or discomfort, "even if the use of such a substance may increase the risk of death" — a prerogative doctors have always had. But in the next sentence, it forbids "intentionally dispensing, distributing, or administering a controlled substance for the purpose of causing death or assisting another person in causing death." Thus, the bill turns on discerning physicians' intentions in administering controlled substances and provides for harsh penalties if those intentions are found not to conform with a "legitimate medical purpose."

The bill's effects would be felt more by terminally ill patients who do not wish physician-assisted suicide than by those who do, since there are so many more of them. Many terminally ill patients require extremely high doses of controlled substances for ade-

quate relief of symptoms. Doctors, faced with the possibility of long prison sentences if their intentions are misread, may be reluctant to prescribe or administer such doses. Treatment of pain in the terminally ill is already notoriously inadequate, largely because our society's preoccupation with drug abuse seeps into the medical arena. Many doctors are concerned about the scrutiny they invite when they prescribe or administer controlled substances, and they are hypersensitive to "drug-seeking behavior" in patients. Patients, as well as doctors, often have exaggerated fears of addiction and the side effects of narcotics. Congress would make this bad situation worse.

Furthermore, when the suffering of a dying patient is prolonged and intractable, a doctor who administers or prescribes large doses of a controlled substance may well have mixed intentions. Just as family members often feel a sense of relief along with their grief when such patients finally die, so doctors often wish both to ease suffering and to hasten death. The balance of those desires may vary from hour to hour, depending on the patient's condition. The congressional bill holds that it is permissible to hasten death only if that is not the intent. That view, which is based on a 13th-century theological argument called the doctrine of double effect, is too simplistic to capture the mixed feelings of doctors who are caring for grievously suffering patients. If all attempts at palliation fail, as they sometimes do, then the hope for an easier death may give way to the hope for a faster one. That is, the intent can shift.

Intent matters in criminal law. For example, whether a motorist who runs someone down is charged with homicide or manslaughter depends on whether it was done deliberately. The motorist knows what the intent was, even if it is difficult to prove in court, and whatever the intent, no one could approve of the act, least of all the victim. But the situation is different for compassionate doctors caring for the terminally ill. They simply want to relieve their patients' suffering, and that is what their patients want and expect of them, sometimes in whatever way possible. Not only is it difficult in such cases to parse the intent behind each element in the treatment, it is also doubtful that anyone should want to try. Mercy, especially in doctors, is not something to be rooted out. That is why the application of criminal law is inappropriate in this setting. It is absurd to imagine that doctors could be innocent in one hour, but deserving of 20 years in prison in the next, simply because the desired outcome of treatment changed. What is important is whether doctors are doing their utmost to ease suffering in accord with their patients' wishes.

Opposition to the bill comes not just from those who are concerned about adequate relief of symptoms for the terminally ill or from those who favor legalizing physician-assisted suicide. It also comes

from those who see the bill as a meddlesome encroachment on the practice of medicine. Many doctors believe that the authors of the bill, in defining legitimate medical use, are assuming the prerogatives of the medical profession. Not surprisingly, medical associations are divided on the issue. The American Medical Association, which opposes physician-assisted suicide, supports the bill. The Massachusetts Medical Society, which also opposes physician-assisted suicide, has attacked the bill as an unwarranted intrusion into medical practice that would have "a chilling effect on prescribing adequate medicine."¹¹

In addition, proponents of states' rights are dismayed by the attempt of the bill's supporters to thwart Oregon's law by misusing Congress's authority to regulate drugs. The Controlled Substances Act was enacted in 1970 to prevent and control drug abuse, not to define the medical uses of drugs.¹³ The aim was to interrupt the flow of illicit drugs to the streets. The congressional bill is now seizing on a stratagem far removed from the act's original purpose, simply to nullify Oregon's law. Ironically, the principal supporters of the bill are conservative Republicans, ostensibly committed to both individual liberty and states' rights. Yet they would restrict the liberty of dying patients and the rights of states to regulate the practice of medicine.

If the bill passes both houses of Congress and is signed into law by the President, Oregon will probably challenge the law in the courts. Even many Oregonians who opposed physician-assisted suicide in the state referendums, including the Oregon Medical Association, resent the attempt by Congress to overturn the outcome.¹⁴ The case might then reach the Supreme Court. If it does, one can hope that the justices will remember their commitment to the laboratory of the states. Otherwise, Congress will have done great harm — to dying patients, both those who want the option of physician-assisted suicide and those who simply want their suffering relieved, and to their physicians, who should be able to offer compassionate care without fear of reprisal.

MARCIA ANGELL, M.D.

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The New York Times

October 29, 1999

Leave the Personal to the States

By Charles Fried.

Charles Fried, a professor at Harvard Law School and a former Solicitor General, recently retired as a justice of the Supreme Judicial Court of Massachusetts.

Demonstrating again what Justice Sandra Day O'Connor has called its underdeveloped capacity for self-restraint, the House of Representatives voted overwhelmingly for a bill that would make it a crime for doctors to prescribe drugs to help terminally ill patients end their lives.

If the principles of federalism -- to which I'd bet many of those voting for this bill fervently swear allegiance -- mean anything, this issue is none of Congress's business. When the Supreme Court declined in 1997 to read into the due process clause a constitutional right to medical assistance in committing suicide, it emphasized that this is a matter for decision at the state level.

The passionate dissents in *Roe v. Wade* made a similar point about abortion: that it should be decided at the state level, like questions of marriage, divorce, child custody and the myriad decisions that make up the ordinary texture of our lives.

When, in 1995, the Supreme Court struck down the Gun-Free School Zones Act, which had been passed on the preposterous excuse that banning guns within 1,000 yards of a school somehow regulated interstate commerce, it made clear that Congress's power over the country is not unlimited. Congress may not legislate just because something seems like a good idea; there must be a connection to one of the topics the Constitution entrusted to the care of the national government. And the claim that those topics are so vague that in reality Congress may legislate about anything at all was emphatically rejected.

So what in the Constitution makes doctor-assisted suicide any of Congress's business? The House might offer two frequently cited sources of constitutional authority: that it has the power to regulate interstate commerce and that it can enact legislation enforcing the 14th Amendment's guarantee that "no state shall deprive any person of life . . . without due process of law."

Sorry, but this won't work.

Imagine a different Congress passing a "Right to Life Protection Act of 2003," prohibiting any state from imposing the death penalty. How could that be defended? As a regulation of interstate commerce because some of the material used in carrying out an execution might have crossed a state line? That is just the

Side effects of suicide bill criticized

Suffering must stop, family says; Bill's side effects tragic, critics say

By Bill Walsh

Washington bureau/The Times-Picayune

WASHINGTON — Gene Sperry was dying. There was no doubt of that. What his family wanted was for him to die in peace.

But when they asked officials at Rapides Parish Medical Center in Alexandria to administer morphine to the 74-year-old man, they said the hospital balked. According to Sperry's daughter, Paula, one top administrator told her he wouldn't help someone commit suicide: "This is a Jack Kevorkian technique. We can't have this."

Gene Sperry spent the last few hours of his life gasping for air and scratching his face in pain, the family said. Paula Sperry fears that if a bill pending in Congress is approved, other patients will suffer a similar fate.

Sperry spoke publicly about her father's death for the first time Wednesday in an effort to derail a proposed prohibition on physician-assisted suicide being pushed by Sen. Don Nickles, R-Okla. A fundamentalist Christian, Sperry said she opposes assisted suicide, but she said she believes Nickles' bill will have the unintended effect of scaring doctors and hospital administrators into withholding pain relief from dying patients for fear of being thrown in jail.

While the bill would let doctors administer pain relief, it also would subject them to criminal penalties if it is determined that they intended to help the patient commit suicide.

"My father was screaming in pain, and they wouldn't do anything," Sperry said. "With this bill it will continue to happen. It's



Photo by Mike Springer/The Times-Picayune

"My father was screaming in pain and they wouldn't do anything," Paula Sperry said Wednesday. "With this bill it will continue to happen. It's already happening in Alexandria. I don't want anyone to go through what we've gone through. It was terrifying."

already happening in Alexandria. I don't want anyone to go through what we've gone through. It was terrifying."

Fate uncertain

Nickles filed his bill in response to Oregon's first-in-the-nation law allowing physician-assisted suicide. The Nickles legislation calls for jail sentences and severe fines against doctors who prescribe narcotics to help patients end their lives. A version of the bill passed the House last year, although it appears to be losing momentum in the Senate as the congressional term winds down.

Sen. Mary Landrieu, D-La., was a co-sponsor, but she said Tuesday she wouldn't vote to end an expected filibuster against the

bill planned by Senate opponents. Sen. John Breaux, D-La., also a co-sponsor, said he hasn't decided what he will do. With less than two weeks left before adjournment, a filibuster likely would kill the bill for this session.

Nickles said the bill offers "safe harbor" to doctors who prescribe drugs only to relieve a patient's pain. Bolstering his case, the legislation has the backing of the American Medical Association.

A chilling effect

The bill's opponents, led by Sen. Ron Wyden, D-Ore., say it will have a chilling effect on physicians everywhere and end up taking its biggest toll on patients like Gene Sperry.

It was Wyden who arranged for Paula Sperry and Dr. Bruce Moses, the Sperry family physician who finally administered pain relief, to fly to Washington and tell their story Wednesday.

The elder Sperry, who suffered from chronic heart disease, was in failing health for years. But on Jan. 16, he took a turn for the worse and was rushed to the hospital.

Doctors told his family that blood was clotting in his left leg and that it had to be amputated before gangrene could spread to the rest of his body. The family consented to the operation.

Shortly afterward, Sperry was given morphine to help him cope with the effects of the surgery. But the following day, Paula Sperry said, the medication was terminated. She said she didn't know it happened and still doesn't know why.

Rapides Parish Medical Center officials declined to discuss the case, saying the hospital is prohibited from commenting because the matter is a "confidential peer review proceeding."

Sperry said that when she learned the morphine had been terminated, she asked the attending nurses and doctors to restore it. She said at one point she was told the drug would be restarted but then was told it would not. For more than a day, she said, there was confusion over what would happen. All the while, Sperry's condition worsened.

Paula Sperry said she finally confronted the hospital administrator, who said it was against hospital policy to administer morphine at that stage of an illness. She said the administrator suggested the drug would kill her father and that the

hospital wouldn't participate in a suicide.

For two days, Sperry went without morphine. As his family stood around his hospital bed, he pleaded with them for relief.

"He said, 'Can't you help me?' " Paula Sperry said.

Relief at last

On Jan. 19, after failing to persuade hospital staff to intervene, the relatives called Moses, the family doctor, who arrived at the hospital about 1 p.m.

Sperry's heart medication had already been shut off, and his lungs had started to fill with fluid. Moses said that when he arrived, Sperry was undergoing the twin horrors of pain from the amputation and the feeling that he was drowning.

"His (amputated) stump was waving around, his remaining leg was blue, his fingers were blue, his lips were blue," Moses said. "He was scratching at his face. He was gurgling for air. . . . A third-year medical student could tell that this man was dying."

Moses said he administered a shot of morphine. After a while, the pain seemed to dull somewhat, but it did not abate entirely, he said. At some point, after continued entreaties from the family and the threat of a lawsuit, the hospital authorized the use of a morphine pump to send regulated doses into the patient's system. Sperry died at 5 p.m.

Repercussions

Moses said Sperry didn't have to suffer as much as he did. He blamed the hospital's hesitation on a fear of adverse publicity if it was seen as assisting a patient to end his life.

"They are so worried about the adverse press about them euthanizing this man," Moses said. "The last hours of his life didn't have to be that bad."

Shortly after Sperry's death, Moses said, he found himself under attack.

The hospital terminated his medical privileges, and he lost his teaching job at Louisiana State University. Moses still has his license to practice medicine, but he said he has been forced to fill in at emergency rooms two and three hours from his home in Alexandria.

Moses said the hospital told him he was terminated for "nonjudicious use of morphine in a terminally ill patient."

The Times-Picayune

New Orleans, Louisiana

September 21, 2000

03/01/2000 17:11



U.S. Department of Justice

United States Attorney
District of MaineP.O. Box 9718
Portland, ME 04104-5018(207) 780-3257
TTY (207) 780-3060
Fax (207) 780-3304

February 18, 2000

MEDICAL REHAB ASSO INC
77 BATES STREET STE 102
LEWISTON ME 04240

Dear Physician:

I am seeking the assistance of the health care community in combating an increasingly serious problem in Maine. I am referring to the abuse and misuse of oxycodone, frequently prescribed for valid medical reasons and dispensed under the brand name of Oxycontin. There is significant abuse of a variety of drugs, but it appears that oxycodone, and in particular, Oxycontin, has become the pharmaceutical "drug of choice" on the streets.

Law enforcement agencies, as well as state and federal prosecutors, have become aware of serious problems across the state regarding the misuse of Oxycontin as well as other forms of oxycodone. When misused, these drugs, including Oxycontin, can give people a "heroin-like high." Some addicts use Oxycontin, in particular, when heroin is not available, by crushing the Oxycontin, thereby eliminating the time release trait of the drug. They then cook the Oxycontin, dissolve it, and inject it for their own use.

Health care practitioners in Maine should be aware of these problems. Some individuals who are misusing Oxycontin, as well as other drugs, engage in activities such as the following:

- They request more medication from the prescribers than what they actually need. They then sell the balance in order to pay for other drug activity.
- They seek out prescribers known locally as being lenient in their prescribing habits and specifically request Oxycontin. They also go "doctor shopping" and visit numerous hospital emergency rooms and clinics, thereby getting prescriptions from several different prescribers. Then, they fill the prescriptions at different pharmacies to avoid detection and oversight.
- They alter the quantities of medication on prescriptions written by the physician or steal prescription pads left unattended in physician offices.
- They "rinse" prescriptions and change innocently written prescriptions for non-controlled drugs into Oxycontin prescriptions.

(continued on back)

03/01/2000 17:11

- Page 2 -

- They often use a combination of public assistance programs, such as Medicaid, as well as insurance or cash payments for drugs, in order to obtain large quantities of the drugs.

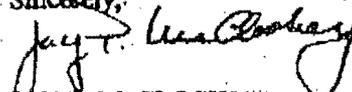
What can you do?

- Prescribers should be observant to any individuals exhibiting drug seeking behavior. Those who prescribe oxycodone for chronic pain relief should monitor their patients' response to the medication, including the effect of the drugs on Activities of Daily Living (ADL's).
- Write the quantity of drugs on your prescriptions in both numbers and letters to make it more difficult to alter the script.
- Pharmacists who are suspicious should ask for identification, in accordance with Board of Pharmacy regulations, and write down a driver's license number or other relevant information.
- Promptly report to the Maine Drug Enforcement Agency (MDEA) or your local law enforcement agencies any illegal activities regarding Oxycontin or other drugs of which you become aware. Prescribers and pharmacists should report to these agencies any prescriptions that are not legitimate. At this time, a number of state and federal agencies are coordinating multiple investigations related to the abuse of Oxycontin and other drugs. If you do not know the telephone number for the MDEA office near you, contact the Portland office at (207) 822-0380 and they can direct you to the appropriate office.
- If the individual that is engaging in questionable conduct is covered by the Medicaid program, you should report the matter to the Medicaid Surveillance and Utilization Review Unit, Maine Dept. of Human Services, 11 State House Station, Augusta, Maine 04333, telephone (207) 621-5220.

I believe that this is a significant problem that can be curtailed if we all work cooperatively in addressing the situation. If you have questions, feel free to contact Health Care Fraud Investigator Owen Colomb in our Portland office at telephone (207) 780-3257.

Thank you for your interest in this matter.

Sincerely,


 JAY P. McCLOSKEY
 United States Attorney

Yes/Likely Yes on Cloture: 49 48 R's and
1 D (Lieberman)

No/Likely No on Cloture: 41 38 D's (including former cosponsor Moynihan, cosponsor Dodd,
who is yes on the underlying bill, and cosponsor Landrieu)
3 R's (Chafee, Jeffords and Warner)

Remaining Republicans:

Snowe (ME)	Undecided on bill
Specter (PA)	Leans no on bill (voted no in committee)
Stevens (AK)	Likely no on bill (and opposes adding to approps)

Remaining Democrats:

Bayh/IN	Undecided on bill (cosponsor); leans no on cloture
Biden/DE	Yes on bill; not sure on cloture
Breaux/LA	Undecided on bill (cosponsor)
Byrd/WV	Undecided on bill but opposes adding to approps.; possible no on cloture
Dorgan/ND	Undecided on bill; possible no on cloture
Mikulski/MD	Undecided on bill; possible no on cloture
Sarbanes/MD	Undecided on bill; possible no on cloture

11/15/00

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.



AMA in Washington

Letters to Congress

Letter to Judiciary Committee Chairman Rep. Henry Hyde (R-IL) re: support for HR 2260, the "Pain Relief Promotion Act of 1999."

Also sent to Sen. Don Nickles (R-OK), supporting compatible Senate legislation, S. 1272.

June 28, 1999

The Honorable Henry J. Hyde
U.S. House of Representatives
2110 Rayburn House Office Bldg.
Washington, DC 20515

Dear Representative Hyde:

The American Medical Association (AMA), representing 300,000 physician and medical student members, is pleased to be able to support H.R. 2260, the "Pain Relief Promotion Act of 1999."

The AMA, as you know, is squarely opposed to physician-assisted suicide and believes it is antithetical to the role of physician as healer. We strongly advocated against the Oregon public initiative that has legalized physician-assisted suicide in the State. Nevertheless, we have found past federal attempts to control such activities to be an unacceptable intrusion of federal government into medical decision-making, with the potential to chill appropriately aggressive palliative care for patients, particularly at the end of life.

Physicians have been deeply concerned that such legislation must recognize that aggressive treatment of pain carries with it the potential for increased risk of death, the so-called "double effect." The threat of criminal investigation and prosecution for fully legitimate medical decisions is unacceptable to the AMA.

Thus, we are very pleased to note that your bill would recognize the "double effect" as a potential consequence of the legitimate and necessary use of controlled substances in pain management, and explicitly include this as a provision of the Controlled Substances Act. This is a vital element in creating a legal environment in which physicians may administer appropriate pain care for patients and we appreciate its inclusion.

Under the terms of the bill, in determining the "public interest," the Attorney General would give "no force or effect" to any state law authorizing or permitting assisted suicide, when evaluating DEA registrants. We do not view this as an expansion of DEA authority. We believe your bill takes the correct approach in addressing assisted suicide primarily as a question of the "public interest," rather than as a law enforcement evaluation of legitimate medical decision-making.

We have some concern regarding the language of Section 102 of the bill, regarding education and training programs for law enforcement personnel. We believe this language should be fine-tuned to make explicit that law enforcement investigative and enforcement activities would be required to recognize and abide by the language of Section 101 recognizing the legitimate use of controlled substances for pain management, even if such use may hasten death. We look forward to working with you and your staff to strengthen and clarify this provision and, further, to assure that development of these programs include input from physicians regularly engaged in a pain management practice.

We greatly appreciate the time and care you have demonstrated in crafting a bill that makes a strong statement against assisted suicide, while minimizing the potential for inappropriate federal intrusion into patient care decisions.

Respectfully,

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E. Ratcliffe Anderson, Jr., MD

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Published Jun 30 1999

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Testimony before the
Subcommittee on the Constitution
Committee on the Judiciary
U.S. House of Representatives

June 24, 1999

by

Samira K. Beckwith, CHE, LCSW

President and CEO

Hope Hospice and Palliative Care

9470 HealthPark Circle

Fort Myers, FL 33908

(941) 489-9140

My name is Samira K. Beckwith and I am President and CEO of Hope Hospice and Palliative Care in Fort Myers, Florida. I am here today representing my organization, and in my role as a loaned executive to the National Hospice Organization, and their Public Policy Committee. I appreciate the opportunity to testify in support of the Pain Relief Promotion Act of 1999.

Over the past 20 years, I have had both personal and professional opportunities to care for people during their final stage of life.

My interest in how people live and are cared for during this time began when I was in my 20's and being treated for Hodgkin's disease. It was my own personal experience and observation that there needed to be a better way to care for people with serious illnesses and for those at the end of life.

Death, like birth is a natural part of the life cycle. There are similarities and obvious differences. The end of life is usually not surrounded with the same sense of joy that encompasses the beginning of life, but both are more than just medical or physical events. Both require preparation, education, and support as well as special attention to the needs of the family. Birthing has become an intimate family time that is a celebration of life. As a nation, we must be sure that each person has the same loving care, support and specialized skills needed at the end of life as they do at the beginning.

Hospices developed in response to these needs as a program of care that provides the specialized skills and services that people need to meet the complex physical, psychosocial, spiritual, emotional and practical issues that confront a patient and family at the end of life. The goal of hospice care is to assist the patient in living each day as fully as possible, with their pain and symptoms managed, as well as to help the family cope with their grief and loss.

In 1982, Congress provided for the Medicare Hospice Benefit in the Tax Equity and Fiscal Responsibility Act. This was a bold and positive move to meet the needs of our nation's most vulnerable population, the terminally ill.

Last year, over 20% of the people who died in America were cared for by the nations' hospices. Over 540,000 people of all ages, with various end stage diseases had the positive benefit of hospice care.

Through hospice, the health care community never has to say to a person, "There is nothing more we can do for you." The choices at the end of life should not be between living in pain or suicide. With hospice, the focus of care shifts from cure to comfort and although we cannot extend a person's life, we can enhance the quality.

Even with all the progress we have made in end-of-life care, too many Americans still die alone or in pain, often enduring costly and ineffective treatments and being referred to hospice very late or not at all.

The crisis that exists for many people at the end of life has been documented by numerous groups including the Medicare Payment Advisory Commission. According to the commission, "the gap between the care now given to dying beneficiaries and ideal care is wider than in probably any other area of medicine. Closing this gap should be one of the highest priorities of the Medicare program. There has been too little thought (given) to how to care for chronically ill individuals and even less about how to provide care when people have reached a terminal point in their life."

There are many reasons for this ongoing crisis. Dealing with the final stage of life is difficult. Difficult for health care providers because their goal is to cure and far too often they have not received the necessary training in palliative care. It is also difficult for them to predict a prognosis with the certainty that is required by misplaced regulatory efforts.

Dying continues to be one of the most difficult topics to discuss. Most people fear the end of life and associate it with pain, suffering, a loss of control, and being a burden on their family. In fact, a recent survey conducted by the National Hospice Foundation found that

more than one out of every four American adults are not likely to discuss issues related to their parent's death with their parent even if the parent were terminally ill and had less than six months to live. Americans are more likely to talk to their children about such sensitive topics as drugs and sex. Additionally, fewer than 25% of Americans have thought about how they would like to be cared for at the end of life and put their thoughts in writing.

Since 1982, when the Medicare Hospice Benefit was enacted, there have been great advances in the methods and medications available to provide pain management and symptom control. However, this information has not been widely accepted outside of the hospice community.

"The Pain Relief Promotion Act of 1999" affirms the appropriate use of controlled substances to alleviate pain and symptoms. The bill also provides for education of health care professionals and research that will increase the competencies of those providing care. Another important aspect of this bill is that it recognizes that palliative care includes more than treatment of pain and symptoms, that it also includes the "enhancement of quality of life."

This increased awareness will help to break down the barriers that keep people from being able to access hospice care. It will also facilitate earlier referrals to hospice. Patients are too often referred at the brink of death. Currently, over half of our patients are admitted to hospice within 3 weeks of their death. Many of these patients have suffered needlessly and the most common question we hear from the families is "Why?" The son of a man who was cared for by our hospice for only 5 hours talked with me about the relief that he and his family experienced once their father was under hospice care. Even with such a short length of stay he was able to see the difference in his father's care.

An additional barrier to people receiving adequate pain management is that of cost. The reimbursement mechanism for hospice has not been reviewed since it was first enacted in 1982 and needs to be updated to account for the real costs associated with compassionate and modern approaches to care for the dying. A recent example in our hospice is a woman who needed 800 mg of an oral pain medication every 12 hours. The cost for this one medication was \$95 per day and our total reimbursement rate is only \$93 per day. This per diem reimbursement needs to cover all care and services including all

Physician's services, nursing care, counseling, spiritual support, medical appliances, drugs, home health aides, homemaker services, physical and occupational therapies, dietary advice and volunteer assistance.

A teacher was curled in a fetal position when the nurse and social worker went to his home to admit him to hospice service. He talked about his pain and asked for help to end his life. Within hours, his pain was controlled. He spent his final months visiting with friends and family. Good pain control is not difficult. What is difficult is to correct the misunderstandings that exist and make it available to those in need.

During a recent conversation, a woman talked with me about her mother who lives in our community. Her mother wanted a stash of pills to keep "just in case." She feared the agony she anticipated having to suffer in the final stage of her Parkinson's. After visiting

our Hospice House, she told her daughter that she would not need the "stash" after all. She felt safe knowing that she would have the care she needed when her time came.

We, in hospice, have hundreds of thousands of stories about making people's final days warm and memorable. Helping a couple to celebrate their anniversary; allowing a terminally ill wife and husband to live together until their deaths, which occurred within days of each other; a woman who wanted to see her granddaughter born before she died was able to see her in an ultrasound picture; a young mother who was able to write letters for her children to read as they grew up - these are just a few of those stories.

We can not make the end of life an easy time but we can make it less difficult for people as they take their final journey down the road of life. Hospices can easily and competently care for many more people in need of good end-of-life care.

Thank you.