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TESTIMONY OF THOMAS J. MARZEN

ON H.R. 2260, THE "PAIN RELIEF PROMOTION ACT OF 1999"

Mr. Chairman, my name is Thomas J. Marzen, and I am General Counsel of the National Legal Center for the Medically Dependent and Disabled. The National Legal Center is a public interest law firm that supports the medical treatment rights of persons with disabilities and serious medical conditions. I testify in favor of H.R. 2260, the "Pain Relief Promotion Act of 1999" (the "Act"). In particular, I will address elements in the Act that would clarify existing law by specifically stating that the use of controlled substances to alleviate pain and discomfort is a legitimate medical practice under the federal Controlled Substances Act ("CSA"), while their use to commit euthanasia or to assist in suicide is not. I will also describe enforcement of the CSA in Oregon in the wake of the Pain Relief Promotion Act. Finally, I will address particular concerns that have previously been raised by Subcommittee Representative Frank.

Substantive Amendments to the Controlled Substances Act

In addition to provisions authorizing expenditure of federal funds to improve palliative care, the Pain Relief Promotion Act also contains clarifying amendments to the federal Controlled Substances Act which provide that: 1) there is no exception authorizing use of controlled substances for assisted suicide or euthanasia, and 2) that pain relief is a legitimate medical purpose under the CSA even if the use of controlled substances for this purpose increases the risk of death. The need for these clarifications was occasioned by the determination of the Attorney General that the Controlled Substances Act does not authorize enforcement actions for the use of controlled substances for assisted suicide or euthanasia insofar as these practices are permitted by state law. See June 5, 1998, Correspondence of Attorney General Janet Reno to Hon. Henry Hyde, Chairman, Committee on the Judiciary, U.S. House of Representatives, attached as Exhibit A.

Under this ruling, federal enforcement actions would continue to be appropriate when controlled substances are used in violation of state laws that proscribe assisted suicide. As the Attorney General stated, "Adverse action under the CSA may well be warranted in other circumstances: for example, where a physician assists in a suicide in a state that has not authorized the practice under any conditions, or

where a physician fails to comply with state procedures in doing so." *Id.* at 4.

Both at the time of the Attorney General's ruling and at present only one state, Oregon, has explicitly legalized the use of controlled substances for any killing purpose in any circumstances under any state law. "The Oregon Death with Dignity Act," Or. Rev. Stat. §§ 127.800 to 127.995, legalizes physician-assisted suicide by the prescription of lethal "medications" for terminally ill persons⁽¹⁾ when done in compliance with certain procedural requirements. Thus, as a practical matter, the exception to the CSA recognized by the Attorney General exempts from federal liability those assisted suicides performed in Oregon in accord with the formalities and restrictions of its law authorizing physician-assisted suicide. The use of a controlled substance for euthanasia or assisted suicide in any other state⁽²⁾ -- or in Oregon unless done in compliance with the Oregon law authorizing assisted suicide -- continues to subject the physician who prescribes or the pharmacist who dispenses such drugs to enforcement action by the federal Drug Enforcement Administration ("DEA").

The Pain Relief Promotion Act of 1999 closes a loophole created in federal law by the Attorney General's ruling through which a state might effectively overrule federal law banning the use of controlled substances for assisted suicide or euthanasia. Under the Attorney General's ruling, the federal Controlled Substances Act is enforceable against use of controlled substances for assisted suicide or euthanasia to the extent that state law proscribes these practices. However, the practical effect of the ruling is to effectively legalize the use of controlled substances for assisted suicide in one state -- Oregon -- to the extent that assisted suicide is performed in compliance with the restrictions and formalities of "The Oregon Death with Dignity Act."

The Attorney General's ruling renders federal law on assisted suicide and euthanasia a function of state policy in a manner inconsistent with the principles of federalism and existing federal policy on assisted suicide and euthanasia. The federal "Assisted Suicide Funding Restriction Act of 1997," ("ASFRA") 42 U.S.C. § 14401, for example, provides that no federal funds may be used, directly or indirectly,

(1) to provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing;

(2) to pay (directly, through payment of Federal financial participation or other matching payment, or otherwise) for such an item or service, including payment of expenses relating to such an item or service; or

(3) to pay (in whole or in part) for health benefit coverage that includes any coverage of such an item or service or any expenses relating to such an item or service.

Federal law thus forbids the use of any federal funds for assisted suicide regardless whether a state authorizes the practice -- yet,

under the Attorney General's ruling, permits the use of controlled substances for assisted suicide if a state authorizes the practice. The Pain Relief Promotion Act would correct this inconsistency in the application of federal policy and would result in a uniform policy on the use of controlled substances nationwide.

Oregon is not singled out by the Act for disparate treatment. To the contrary, the Act would assure that all states are treated equally by assuring that controlled substances should not be used for killing purposes under federal law regardless of state law on the matter. Thus, the Pain Relief Act amends the Controlled Substances Act by providing,

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

The Pain Relief Promotion Act would thus preclude the Attorney General from finding that the use of controlled substances falls within the "public interest" exception of the CSA (21 U.S.C. § 823) as grounds for carving out an exception to a general prohibition on the use of controlled substances for assisted suicide or euthanasia when states permit such practices.

At the same time, the Pain Relief Promotion Act specifically states that controlled substances may be used for the purpose of providing palliative care even if there is an indirect risk that the use of the substances may result in death:

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

This provision of the Pain Relief Act in effect states the "principle of the double effect" in the context of application of the CSA in order to sharply differentiate between encouraged use of controlled substances for palliative care and proscribed use of controlled substances for killing purposes. Following this common sense principle familiar to medical practitioners, use of controlled substances to relieve pain or discomfort is explicitly encouraged, although it is understood that their use may present an increased risk of death as a secondary and undesired consequence of their use. This aspect of the Act mirrors the same principle enshrined in ASFRA (42 U.S.C. § 14402):

(b) CONSTRUCTION AND TREATMENT OF CERTAIN SERVICES.--Nothing in subsection (a), or in any other provision of this Act (or in any amendment made by this Act), shall be construed to apply to or to affect any limitation relating to--

(4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

There is no provision in the current CSA that expressly protects prescribing or dispensing of controlled substances to control pain even if they carry the risk of death. At present, therefore, some physicians might arguably be chilled from prescribing controlled substances in doses sufficient to control pain for certain patients for fear that this might put their DEA registration at risk if large-dose prescriptions are seen as sufficient potentially to kill the patient. To the extent that there is fear that DEA's authority to revoke registrations prescribing controlled substances to assist suicide may chill appropriate prescriptions for pain relief, this fear can only be diminished by the passage of this Act. Because the law as interpreted by the Attorney General now allows revocation of DEA registrations for assisting suicide to the full extent that such conduct violates state law, it cannot be credibly argued that passage of the Act would increase reluctance to prescribe drugs for pain relief. On the contrary, it is only by passing the Pain Relief Promotion Act that an explicit provision ratifying provision of appropriate pain relief measures will be added to the Controlled Substances Act.

It also deserves emphasis that neither physicians nor pharmacists would have a legitimate basis for concern that their dispensing of controlled substances for appropriate pain relief without intent to assist suicide might cause their loss of DEA registration, even if a patient later misused those drugs to commit suicide. In order to revoke DEA registration under the proposed Act, the DEA must show that the registrant "*intentionally*" dispensed or distributed a controlled substance "*for the purpose of causing death or assisting another person in causing death.*" This creates a scienter requirement: to revoke a license, the DEA must show that the registrant had the knowing purpose of assisting suicide or committing euthanasia. Revocation of a registration is not authorized under the Act for negligence, but only for knowing and purposeful supplying of a federally controlled substance for a forbidden purpose.

Even if a physician intentionally prescribes federally controlled substances to assist suicide or commit euthanasia, it a separate question whether the pharmacist who fills the prescription is subject to revocation of DEA registration under the Act. To revoke the pharmacist's registration, the DEA must independently show that the pharmacist *intentionally* dispensed the substance *with a purpose of assisting in suicide or committing euthanasia.* The current DEA *Pharmacist's Manual* states that "the pharmacist who deliberately turns the other way when there is reason to believe that a purported prescription order had not been issued for a legitimate medical purpose may be prosecuted." U.S. Department of Justice, Drug Enforcement Administration, *Pharmacist's Manual* at 30 (Dec. 1995), citing *United States v. Kershman*, 555 F.2d 198 (8th Cir. 1977). The key word is "deliberately." Unless the pharmacist acts deliberately and intentionally to assist suicide or commit euthanasia, the

pharmacist's DEA registration may not be revoked.

Enforcement of the Act in Oregon

Special consideration to the manner in which the Pain Relief Promotion Act would operate in Oregon is appropriate because only Oregon has specifically legalized what the Act would forbid: Oregon explicitly permits the use of "medication" prescribed by physicians under certain conditions and certain patients for use in assisted suicide. Or. Rev. Stat. § 127.805.

The Act would cause the use of a controlled substance to assist in suicide to violate federal law -- the Controlled Substances Act -- regardless whether or not this violates any Oregon state prohibition.⁽³⁾ In the wake of the Act, use of a controlled substance for this purpose would offend federal law in Oregon just as it now does in the other states. In effect, therefore, the Act would create a uniform national standard under which it is never legitimate to use controlled substances to assist in suicide or commit euthanasia.

Although the Pain Relief Promotion Act will shield physicians, pharmacists, and other DEA registrants who provide appropriate pain relief and who prescribe or dispense controlled substances without the intent of assisting suicide or euthanasia, the Act will be readily enforceable so as to deter the prescribing or dispensing federally controlled substances to assist suicide in Oregon. This is so because the DEA has statutory authority to subpoena reports of assisted suicide that The Oregon Death with Dignity Act requires to be made to Oregon authorities in order for assisted suicide to be legal under Oregon law. This ability to subpoena records will, with minimal investment of DEA resources, rapidly and conclusively establish whether any violations of the Controlled Substances Act, as modified by the Pain Relief Promotion Act, have occurred. As soon as this becomes widely known in Oregon, it is likely to deter virtually all violations.

First, reports and records required by The Oregon Death with Dignity Act will readily reveal whether federally controlled substances have been intentionally dispensed to assist suicide. Under the Oregon law,

The following shall be documented or filed in the patient's medical record:

(1) All oral requests by a patient for medication to end his life in a humane and dignified manner;

(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner; . . .

(7) A note by the attending physician . . . indicating the steps taken to carry out the request, including a notation of the medication

prescribed. [Or. Rev. Stat. § 127.855.]

Under rules issued November 5, 1997, by the Oregon Department of Human Resources, Health Division:

At the time the attending physician writes a prescription for medication to end life of a qualified patient, the attending physician shall send two documents to the State Registrar . . . 1) a copy of the patient's written request for medication to end life, as specified in Section 6 of the Act, and 2) a signed and dated report, entitled "Request for Medication to End Life, Attending Physician's Report and Medical Records Documentation," . . . which either is a) fully and accurately completed or b) indicates that the attending physician agrees to make available the relevant portions of the patient's medical record for Division review to determine compliance with the Act . . . [Or. Admin. R. 333-009-0010(1)(a)(1997)].

Thus, in order to comply with The Oregon Death with Dignity Act and to escape criminal liability that would otherwise exist under Oregon law for assisting a suicide, a physician must note the medication used to assist a suicide in the patient's medical record, and the physician must file a form with the State Registrar reporting the provision of that medication. The physician must either list the specific medication in Part G of a two-page "Attending Physician's Compliance Form" or file a short form identifying the patient and physician together with a commitment "to make available to the Health Division the relevant portions of the patient's medical record to determine compliance with The Death with Dignity Act." See copies of form attached as Exhibit B.

Recent amendments to The Oregon Death with Dignity Act further clarify the process. Oregon Senate Bill 491⁽⁴⁾ amends Or. Rev. Stat. § 127.865 by adding a new subsection 1(b): "The [Oregon Health] division shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the division." Oregon Senate Bill 491 at p. 4, lines 9-10.⁽⁵⁾

Second, the DEA has federal statutory authority to subpoena the reports that must be provided to Oregon authorities, and, if necessary, the corresponding patient's medical record. Under 21 U.S.C. § 876 (1981),

In any investigation . . . with respect to controlled substances, the Attorney General may . . . require the production of any records (including books, papers, document, and other tangible things which constitute or contain evidence) which the Attorney General finds relevant or material to the investigation.

Monthly, or at other appropriate periodic intervals, the DEA could and should subpoena copies of the relevant reports filed with the Oregon authorities. These would provide identification of each patient and

physician, and they would identify the medication used. This information, once obtained in response to subpoena, would indicate unequivocally whether a federally controlled substance had been prescribed. If so, then this would be sufficient in itself -- without need for further investigation -- to provide adequate evidence for the suspension or revocation of the physician's registration to distribute controlled substances in accordance with 21 U.S.C. § 824(a) construed in light of the amendments of the Pain Relief Promotion Act.⁽⁶⁾

Use of this procedure would result in an efficient enforcement procedure against use of controlled substances in Oregon. Only physicians who comply with Oregon's record keeping and reporting requirements are immune from liability under Oregon law when they assist in suicide. However, when they comply with these requirements, they will be providing the evidence that the DEA can use to demonstrate their violation of the federal Controlled Substances Act.

Active Killing v. Withholding/Withdrawing Treatment

As amended by the Pain Relief Promotion Act, the Controlled Substances Act would prohibit the use of scheduled drugs for the purpose of assisting suicide or committing euthanasia: the use of active means to cause death. The Act does not affect the authority of the patient -- or, under circumstances described by state law, the patient's surrogate -- to order withholding or withdrawing of treatment necessary to sustain life.

The distinction between the use of active means that cause death and the foregoing of means that sustain life is well-acknowledged in state law and is already embodied in federal law. Thus, ASFRA denies the use of federal funds "to use for items and services (including assistance) the purpose of which is cause (or assist in causing) the suicide, euthanasia, or mercy killing of any individual. 42 U.S.C. § 14401(b). At the same time, ASFRA specifically states that "[n]othing in . . . [the Assisted Suicide Funding Restriction Act] . . . shall be construed to apply to or to affect any limitation relating to - (1) the withholding or withdrawing of medical treatment or medical care; (2) the withholding or withdrawing of nutrition or hydration . . ."

Nevertheless, the validity of the distinction between active means to cause death and forgoing treatment necessary to sustain life continues to be questioned. For example, at the April 1996 hearing before this Subcommittee, Representative Frank appeared to maintain that there is no difference in intention between a doctor who fails to provide life-saving medical treatment to a patient, knowing that this will result in the patient's death, and a doctor who gives the patient a lethal prescription or a lethal prescription. As Rep. Frank stated, "[A]s between the means of standing idly by when you have the ability easily to prevent something and helping it happen, that is not a significant difference . . . Doctors have acquiesced that you are as a doctor, under the law and by ethics, to allow someone to die even though you can prevent it because that individual wishes to die. [Here, Rep. Frank was referring to withholding or withdrawing life-saving medical treatment.] . . . I don't understand the moral distinction between acquiescing by giving someone the extra pills or simply saying, okay, we are going to let you die, when I could stop it." Transcript, Oversight Hearing: "Assisted Suicide in the United

States," Monday, April 29, 1996, House of Representatives, Subcommittee on the Constitution, Committee on the Judiciary at 162, 165.

Let us evaluate what this position entails. Since Rep. Frank maintains that there is no supportable distinction between rejecting life-saving treatment and taking lethal prescriptions to kill the patient, whenever the State permits rejection of treatment, it must also equally permit active killing. What follows from this?

First, one does not need have to any particular condition - for example, a terminal condition -- in order to refuse treatment of any kind. Under the law of informed consent, it almost always the case that a doctor cannot treat a competent patient if the patient refuses permission to be treated or to continue to be treated. This is true regardless of the nature of the treatment and regardless whether the patient would continue to live indefinitely if the treatment were provided. Thus, if there is no difference between actively killing and forgoing life-saving treatment, it follows that the government cannot prevent anyone from being provided a lethal prescription because, with rare exceptions, it cannot force anyone to accept life-saving treatment. For example, a mentally competent 18-year-old woman who, for whatever reason, refuses a blood transfusion or an antibiotic that would certainly save her life, but without which she would die, would also have an equal right to receive a prescription for a lethal overdose of drugs.

Second, if there is no distinction between the use of active means to cause death and forgoing life-saving treatment, then assisted suicide would be made available not only for competent adults, but also for mentally incapacitated adults and children. At least thirty-eight states and the District of Columbia impute the authority to order the withholding or withdrawing of life-sustaining medical treatment to surrogates to exercise on behalf of patients unable to make their own treatment decisions. See Thomas J. Marzen, Mary K. O'Dowd, Daniel M. Crone & Thomas J. Balch, 'Suicide: A Constitutional Right?' -- *Eleven Years Later*, 35 Duquesne L. Rev. 261, 279 n. 58 (1996) ("*Eleven Years Later*"), attached as Exhibit D. In state after state, it has been ruled, as has the Washington State Supreme Court, that "[a]n incompetent's right to refuse treatment should be equal to a competent's right to do so." *In re Guardianship of Grant*, 747 P.2d 445, 449 (Wash. 1987). If the right to forgo treatment necessary to sustain life is to be equated with a right to seek a lethal prescription, it follows that lethal drugs may be provided to mentally disabled adults and to children whenever surrogates may refuse life-saving treatment for them. Under the same circumstances in which a public guardian or family member might reject use of a respirator or chemotherapy for adults with Alzheimer disease or for children with disabilities, they would also have the authority to order lethal drugs be given to them.

The U.S. Supreme Court has explained the difference between use of active means to cause death and forgoing treatment:

First, when a patient refuses life-sustaining treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests

lethal medication . . . he is killed by that medication. . . . Furthermore, a physician who withdraws, or humors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes . . . [A] patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not . . . [P]atients who refuse life-sustaining treatment 'may not harbor a specific intent to die' and may instead 'fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs.' . . . [T]he law distinguishes actions taken 'because of' a given end from actions taken 'in spite of' their unintended but foreseen consequences. 'When General Eisenhower ordered American soldiers onto the beaches of Normandy, he knew that he was sending many American soldiers to certain death . . . His purpose, though was to . . . liberate Europe from the Nazis.'" [Quill v. Vacco, 117 S.Ct. 2293, 2299 (1997), quoting *Compassion in Dying v. Washington*, 79 F.3d 790, 856 (9th Cir. 1996) (Kleinfeld, J., dissenting)].

It is undoubtedly true that some patients or their surrogates may refuse life-sustaining treatment precisely in order to cause the death of the patient rather than to relieve the burden treatment imposes or to achieve some other end. From an ethical or moral perspective, such a decision may not be different from a decision to actively kill through the use of lethal agents. In both cases, the motive is homicidal rather than beneficent.

However, law and public policy are hardly in the position to distinguish between the subjective motives of the decision makers when the contemplated conduct -- foregoing life-sustaining treatment -- is the same when treatment is refused for entirely legitimate reasons and when it is refused for homicidal motives. The law cannot read minds. And any attempt to establish a system to distinguish among refusal of treatment cases by balancing risk of death versus prospect of benefit or through prior oversight by an authoritative decisionmaking body would involve tortuous, and ultimately subjective, bureaucratic entanglement in end-of-life decisionmaking processes. See *Eleven Years Later*, 35 *Duquesne L. Rev.* at 271-273. In contrast, homicidal intent is clearly always manifest when active means are used to cause death. Drawing a bright line between the use of active means to cause death and forgoing treatment is thus not only logically defensible and already widely accepted in law, but it is sensible practical public policy. Moreover, failure to acknowledge the distinction between use of active means and forgoing treatment would result in a regime that legitimized assisted suicide and euthanasia for virtually everyone since life-sustaining treatment can be refused by virtually everyone regardless of circumstance or condition.

Lack of Criminal Sanctions Against Suicide

It is sometimes argued that because there are at present no criminal penalties for those who commit or who attempt to commit suicide, it is irrational to make it crime to permit someone to assist others to commit suicide. After all, the argument goes, there are those who are

physically incapable of killing themselves without assistance and those who may not otherwise be able to obtain drugs to permit them to commit suicide in a "humane and dignified manner." Shouldn't they have the opportunity for suicide as those who are physically able to do so or who have some access to controlled substances without physician prescription?

Thus, Representative Frank at an earlier hearing asserted that the "difference between the State not doing something to punish somebody for doing an act and the State calling it a right, which gives it a sanction" is "a distinction without a difference. You leave me alone, and I do what I want, and that is okay. People legally should be allowed to kill themselves if you're driven to do that without any fear of adverse legal consequences either to themselves or their estates . . . [I]f I am . . . legally entitled to commit suicide without adverse legal consequences, and I become physically incapable of doing it, then it seems to me to say that in those limited circumstances I can get someone else to help me and share with them my immunity to legal action is not discriminatory." Transcript, Oversight Hearing: "Assisted Suicide in the United States," Monday, April 29, 1996, House of Representatives, Subcommittee on the Constitution, Committee on the Judiciary at 48-49.

This line of argument rests on a faulty premise: that people who are physically unable to do so in a desired manner now have a "right" or "freedom" to commit suicide.

Why is this premise faulty? Compare the situation of someone who avails herself of First Amendment rights by denouncing a politician in a public park. If an irate supporter of the politician tries to physically restrain the speaker and prevent her from continuing her denunciations, that person will be subject to criminal charges of assault and battery. On the other hand, suppose someone else tries physically to prevent that person from committing suicide. As the Minnesota Supreme Court held in a 1975 case, "[T]here can be no doubt that a bonafide attempt to prevent a suicide is not a crime in any jurisdiction, even where it involves the detention, against her will, of the person planning to kill herself." *State v. Hembd*, 305 Minn. 120, 126, 232 N.W.2d 872, 878 (1975). In fact, if public authorities detect someone in the act of attempting suicide, they will typically not only interfere, but also place the person in temporary custody of mental health authorities. Posing such a danger to oneself is grounds for involuntary commitment for mental health treatment by statute in every jurisdiction in the United States. See, e.g., Mass. Gen. Laws Ann. ch. 123, §§ 1, 18(a) (involuntary commitment to a mental health facility if there is "a substantial risk of physical harm to the person himself as manifested by evidence of threats or attempts at, suicide"); D.C. Code Ann. § 21-5459 (involuntary commitment for treatment for the mentally ill "likely to injure himself").

In short, it is not accurate to assert that there is a legal right or liberty to commit suicide. If this were so, then it would be no more constitutionally permissible for the State to interfere with suicide decisions than to interfere with free speech.

But if suicide is not today treated as a right, then why are there no

criminal penalties against it? In fact, under English common law there was criminal punishment of a sort for suicide: the suicide was buried "ignominiously" (at a crossroads, and sometimes with a stake through the heart) and the personal property of the suicide was forfeited to the State. See Thomas J. Marzen, Mary K. O'Dowd, Daniel Crone & Thomas J. Balch, *Suicide: A Constitutional Right?* 24 *Duquesne L. Rev.* 1, 56-100 (1985), for an extensive treatment of the history of the law of suicide. There were instances of ignominious burial and forfeiture in the American colonies. By the time of the American Revolution or shortly thereafter, however, these penalties had been abolished in virtually all the states. This was not because early America approved of suicide. In an influential 1796 treatise, Zephaniah Swift, later Chief Justice of the Connecticut Supreme Court, explained that they were discontinued because it was seen as "contemptible" to exercise "mean act of revenge upon lifeless clay, that is insensible of punishment" and cruel to inflict "a punishment, as the forfeiture of goods, which must fall solely on the innocent offspring of the offender." 2 Zephaniah Swift, *A System of Laws of the State of Connecticut* 304 (1795). Swift emphasized that suicide was nevertheless a "crime" that is "abhorrent to the feelings of mankind," but observed that "it is evident that were a person so destitute of affection for his family . . . as to wish to put an end to his existence, that he will not be deterred by a consideration of their future subsistence." *Id.* As the U.S. Supreme Court pointed out, abolition of the old common law of forfeiture of a suicide's personal property "did not represent an acceptance of suicide; rather . . . this change reflected the growing consensus that it was unfair to punish the suicide's family" by denying them their inheritance. *Washington v. Glucksberg*, 17 S. Ct. 2258, 2264 (1997). "Nonetheless, courts continued to condemn it as a grave public wrong." *Id.*

The colonies and later the states continued to punish assisting suicide and even attempted suicide. In the latter part of the Nineteenth and Twentieth Century, penalties for attempting suicide were generally repealed -- but not because suicide was seen as a liberty. Rather, the feeling grew that those who attempted suicide should be given treatment for mental or emotional disorders rather than punished by the criminal law. Typical was the 1902 statement of a Pennsylvania court about one who attempted suicide: "[I]t is the result of disease. He should be taken to a hospital and not sent to prison." *Commonwealth v. Wright*, 11 Pa. D. 144, 146 (1902). In 1980, the Supreme Court of Iowa wrote, "The only reason we view suicide [as] noncriminal is that we consider inappropriate punishing the suicide victim or attempted suicide victim, not that we are concerned about that person's life any less than others' lives. To say that aiding an abetting suicide is a defense to homicide would denigrate these views." *State v. Marti*, 290 N.W.2d 570, 581 (Iowa 1980). As the Florida Supreme Court stated in 1933, "No sophistry is tolerated . . . which seek[s] to justify self-destruction as commendable or even a matter of personal right." *Blackwood v. Jones*, 111 Fla. 528, 532-33, 149 So. 600, 601 (1933).

In sum, history a legal precedent does not support the notion that now or in the past suicide has been treated as an accepted liberty or freedom in the United States. That criminal penalties against suicide

have been abolished does not render suicide an affirmative right. It remains against public policy. If it did not, then the numerous laws against assisted suicide, that permit police and private parties to use necessary force prevent suicide, and that warrant involuntary commitment of those who attempt suicide could not survive under the Constitution.

Conclusion

I strongly encourage enactment of H.R. 2260, the "Pain Relief Promotion Act of 1999." This proposed law would create a needed uniform federal standard on the use of controlled substances for assisted suicide and euthanasia, create an explicit exception for doctors to use controlled substances for palliative care, and authorize needed federal funds for palliative care training.

1. 0. Neither the U.S. Constitution nor federal statutory law warrants carving out an exception to a general prohibition on assisted suicide based on the condition or status of a person -- such as whether the person has a terminal condition. *See Washington v. Glucksberg*, 17 S. Ct. 2258, 2265, quoting *Blackburn v. State*, 23 Ohio St. 146, 163 (1872) ("The life of those to whom life has become a burden - of those who are hopelessly diseased or fatally wounded -- nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in full tide of life's enjoyment, and anxious to continue to live"); *United States v. Rutherford*, 442 U.S. 544, 558 (1979) (no exception implied in the federal Food, Drug, and Cosmetics Act for terminally ill cancer patients to secure Laetrile).

2. 0. Euthanasia or "mercy killing" with or without the consent of the person killed is a homicide under the law of every state. Thirty-seven states have explicit statutory authority banning assisted suicide: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Iowa, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Mississippi, Montana, Nebraska, North Dakota, New Hampshire, New Jersey, New Mexico, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, and Wisconsin. At present, the District of Columbia and twelve states have no explicit statutory authority prohibiting assisted suicide: Alabama, Hawaii, Idaho, Massachusetts, Illinois, North Carolina, Nevada, Ohio, Utah, Vermont, Wyoming, and West Virginia. However, assisted suicide may not be safely done in any of these jurisdictions in view of the possibility that the courts in these jurisdictions might find that assisting in suicide is a form of homicide. *See, e.g., State v. Willis*, 255 N.C. 473, 121 S.E.2d 854 (1961)

3. 0. The Pain Relief Promotion Act does not repeal The Oregon Death with Dignity Act. Under the conditions prescribed by The Oregon Death with Dignity Act, assisted suicide would remain legal under Oregon law. If the use of a "medication" for this purpose does not also involve the use of a federally "controlled substance," then the use of such a "medication" would not violate the CSA as amended by the Pain Relief Promotion Act. However, since Oregon law requires that death through assisted suicide be accomplished through use of "medications" that will cause death in a "humane and dignified manner" (Or. Rev. Stat. § 127.805), and since only controlled substances would appear to satisfy these criteria, a federal ban on the use of controlled substances for assisted suicide would effectively ban assisted suicide in Oregon, as it is already banned elsewhere.

4. 0. Oregon Senate Bill 491 amends The Oregon Death with Dignity Act. It was passed by both the Oregon House and Senate; the Governor of Oregon has represented that he will sign it. It is attached as Exhibit C.

5. 0. The new amendments to The Oregon Death with Dignity Act also specifically provide for a circumstance in which the attending physician, rather than a pharmacist, dispenses the "medications" for assisted suicide. An attending physician may dispense lethal drugs, provided that "the attending physician is registered as dispensing physician with the Board of Medical Examiners, *has a current*

Drug Enforcement Administration certificate and complies with any applicable administrative rule . . ." Oregon Senate Bill 491 at p. 3, lines 13-16 (emphasis added).

6. 0. I respectfully urge the Subcommittee to include in its Committee Report accompanying H.R. 2260 an expression of clear Congressional expectation that the DEA will in fact on a periodic basis subpoena the relevant records from Oregon authorities or from authorities in any other state that would permit assisted suicide or euthanasia.

Hearing on H.R. 2260

"The Pain Relief Promotion Act of 1999"

June 24, 1999

SUBCOMMITTEE ON THE CONSTITUTION

Committee on the Judiciary

U.S. House of Representatives

Written Testimony of

ANN JACKSON, M.M.

Executive Director and Chief Executive Officer of the Oregon Hospice Association

Chairman Canady and Members of the Subcommittee,

My name is Ann Jackson. I am the executive director and chief executive officer of the Oregon Hospice Association (OHA). OHA is a 501(c)(3) public benefit organization dedicated to ensuring that all Oregonians have access to high quality hospice and comfort care. It has established expertise concerning all end-of-life options in Oregon.

OHA and Oregon's hospice providers are very concerned that the Pain Relief Promotion Act of 1999, like the Lethal Drug Abuse Prevention Act of 1998, will have a negative impact on pain and symptom management throughout the health care continuum in Oregon and throughout the country. OHA opposes the Pain Relief Promotion Act of 1999.

I am a member of the Task Force to Improve Care of Terminally-ill Oregonians, a consortium of 24 individuals who represent state health care professional organizations, state agencies involved with health care, and health systems in the Portland metropolitan area. The task force, which remains neutral on physician-assisted suicide, was convened in December, 1994. Its purpose is to promote excellent care of the dying and to address the ethical and clinical issues posed by the enactment of the Death With Dignity Act. The task force has published two documents: (1) The Final Months of Life: A Guide to Oregon Resources; and (2) The Oregon Death With Dignity Act: A Guidebook for Health Care Providers.

The Task Force to Improve Care of Terminally Ill Oregonians is concerned that the Pain Relief Promotion Act of 1999 will have a negative impact on pain and symptom management at end of life.¹

I am here today representing both OHA and the Task Force to Improve Care of Terminally Ill Oregonians. Neither group believes it possible that a law that will increase regulatory scrutiny and judge the "intent" of all health care providers can promote pain relief. Both groups are also concerned about the potential long term negative impact that may result from (3) restrictively defining palliative care, and (4) drawing too narrowly a line between appropriate and inappropriate uses of controlled substances.

I am also a member of the Physician Orders for Life Sustaining Treatment Task Force (POLST), whose goal is to ensure that Oregonians' end-of-life wishes are respected. The POLST form translates advance directives into doctors' orders.² I am active, too, in the Health Ethics Network of Oregon.

Finally, OHA is represented on Oregon's Legislative Task Force on Pain and Symptom Management. During the past two years I have both testified on behalf of OHA and represented OHA on the task force at regional meetings identifying barriers to pain management. Unrelieved pain—terminal pain, chronic pain, cancer pain, postsurgical pain—is epidemic throughout the country. Even in Oregon where the Board of Medical Examiners has urged physicians to address pain and other symptoms aggressively.

Even in Oregon, which is recognized as the national leader in end-of-life care.³

Regulatory Scrutiny Causes a Chilling Effect on Physician Prescribing Practices

At every meeting of the Task Force on Pain and Symptom Management, a parade of physicians testified that regulatory scrutiny was the cause of the unrelieved pain problem. Even the threat of an investigation has a chilling effect on prescribing practices, regardless of whether that threat comes from the DEA, the Board of Medical Examiners, or the local coroner, and regardless of whether that threat is real or perceived. This is not an unusual response for law-abiding citizens: when most Americans encounter a police car parked at the side of the highway, they slow down *below* the posted speed! This is not to suggest that no rules should apply to health care workers. It is, however, meant to say that the climate that already exists in end-of-life care encourages levels of caution which too frequently result in increased pain and suffering for sick and dying people. This proposed bill would only worsen those conditions.

Attempts to Measure Intent

Will Cause a Chilling Effect on Physician Prescribing Practices

While others are comforted that a medical advisory board is not included in the proposed 1999 legislation, we are still alarmed. We believe that this year's provision for the education and training of state, local and federal law enforcement personnel in the appropriate use of controlled substances is an even more hazardous substitute. It is unrealistic to think the Secretary of Health and Human Services will be more successful at effectively training law enforcement officials than medical schools or Boards of Medical Examiners have been at training physicians. If this bill is passed, the standard of care for any community will be determined by the investigative judgement or whim of its local law enforcement personnel. Rather than one unified standard across the states, there will be many, often conflicting standards, even within each state.

A Narrow Definition of Palliative Care

Will Cause a Chilling Effect on Physician Prescribing Practices

While we applaud efforts to establish that controlled substances should be used for pain control, even if the use of such substances may increase the likelihood of death, the bill's definition of palliative care negates that provision when it codifies into law ambiguous goals. Palliative care *seeks* to neither hasten nor postpone death. But it would be inhumane to not palliate inevitable pain and other symptoms of a patient who has asked to be removed from a ventilator, when her intent is to hasten her death. It would be inhumane to deny a patient interventions that may postpone his death just long enough to reach an important milestone, such as the wedding of a cherished daughter. Hastening or postponing the dying process, while not usual, does happen under good palliative care. While palliative care is an evolving specialty, it is so narrowly defined in this bill that the effect will be to put its practitioners into a too rigid box.

A Narrow Line Drawing the Distinction Between Appropriate and Inappropriate Uses

of Controlled Substances Will Cause a Chilling Effect on Physician Prescribing Practices

A goal of the Pain Relief Promotion Act is to make a clear distinction between an appropriate use of controlled substances to manage pain, even if death is hastened inadvertently, and an inappropriate use of controlled substances to assist in a suicide. It attempts to make black and white a very grey area, creating a tightrope, when a balance beam or even a bench would be both more acceptable and defensible. The use of controlled substances is always subject to question, when our society has invested so much time to curb their abuse. Questions will be raised by pharmacists, nurses, health aides, or family members, any of whom may be alarmed by what they perceive to be unusually large doses of narcotics or other drugs -- or a death following soon on the heels of a prescription. These questions will precipitate an investigation. These investigations will significantly undermine physicians' prescribing practices.

And it will be America's rural communities that suffer most. Rural physicians are often subject to more scrutiny. Urban physicians have more ready access to the latest information concerning pain management. Urban physicians have better access to pain specialists. Therefore urban physicians are more confident in their ability to defend their use of a controlled substance.

Regardless of its "intent", by trying to draw a clear line, the Pain Relief Promotion Act will prompt frequent questioning of the intent to manage pain versus the intent to cause death. It's very safe to say that every hospice in the country has had a request for help to die from at least one of its patients, not just Oregon hospices. Is that patient no longer entitled to have their symptoms relieved because they voiced that desire, because someone may question whether the intent of the physician was to grant their request or to relieve their symptoms?

Conclusion

When Sen. Nickles introduced the Pain Relief Promotion Act in the Senate, he indicated that a dynamic was created whereby some doctors underutilized controlled substances for pain. Hospices report that such instances were isolated and, most often, readily corrected. It was not until November, 1997, when the DEA issued its letter indicating that it would prosecute physicians who prescribed controlled substances under the Death With Dignity Act, that we saw a downward turn in what had been a steady increase in the use of controlled substances for pain and symptom management in Oregon. While we do not know that the letter from Mr. Constantine was the cause, the timing is suspicious. Copies of the Fall 1998 Oregon BME Newsletter documenting this trend have been made available to the subcommittee.⁴

OHA and the Task Force to Improve Care of Terminally Ill Oregonians have grave concerns about the Pain Relief Promotion Act of 1999. We are strongly convinced that this legislation, if passed, will have a profoundly negative impact on physician prescribing practices all across the United States. We are as strongly committed as we were last year that this law be challenged and defeated.

The Conquering Pain Act and the Advance Planning and Compassionate Care Act are more likely to accomplish much needed improvement in end-of-life care, than is the Pain Relief Promotion Act of 1999. Efforts to reduce unwarranted, unnecessary, and excessive regulatory scrutiny of the nations' hospices will accomplish improvement in end-of-life care. Efforts to reduce futile care will accomplish improvement in end-of-life care. The Pain Relief Promotion Act will not.

Thank you.

References

- 1 A statement and list of task force members. (Available to the subcommittee)
- 2 Focus: Oregon's POLST Program, State Initiatives in End-of-Life Care, Issue 3, April 1999. (Available to the subcommittee)
- 3 Focus: Oregon, State Initiatives in End-of-Life Care, Issue 1, June 1998. (Available to the subcommittee)
- 4 Tolle S, Haley K. Pain Management in the Dying, Successes and Concerns, Oregon BME Newsletter, Fall 1998. (Available to the subcommittee)

H.R. 2260 "The Pain Relief Promotion Act of 1999"

June 24, 1999 House Subcommittee on the Constitution

Testimony of David E. Joranson

Pain & Policy Studies Group

University of Wisconsin Comprehensive Cancer Center

<http://www.medsch.wisc.edu/painpolicy>

My name is David E. Joranson; I am a Senior Scientist and Director of the Pain & Policy Studies Group at the Comprehensive Cancer Center on the campus of the University of Wisconsin in Madison. I thank Chairman Hyde for inviting me to address the Committee on H.R. 2260, the "Pain Relief Promotion Act of 1999." In the interest of assisting the Committee, I wish to testify for information, and only in relation to the parts of the bill that amend the Controlled Substances Act (CSA). I have enclosed references at the end of my testimony, many of which are available on our website, listed above.

My knowledge of and experience with controlled substances law goes back some thirty years, to the vigorous debate and final adoption in 1970 of the CSA. Since then, I was administrative officer for the State of Wisconsin's Controlled Substances Board, during the administration of Governors Dreyfus, Earl, and Thompson. During this time, I worked with the subcommittees of Congressman Hughes and Congressman Waxman to adopt amendments to the CSA to strengthen DEA's program against diversion of controlled substances. In 1984 I co-founded the National Association of State Controlled Substances Authorities and the first State Cancer Pain Initiative, in Wisconsin. I have studied the Federal and State controlled substances laws, as well as the state professional practice statutes and regulations in great detail; I was privileged to serve for several years on the drafting committee of the National Conference of Commissioners on Uniform State Laws to revise the Uniform Controlled Substances Act for the States. I have worked with the National Conference of State Legislatures, many state regulatory agencies, and the Federation of State Medical Boards of the U.S. All of these efforts have been devoted to achieving a 'balanced' drug control policy which is envisioned by the United Nations Single Convention on Narcotic Drugs, 1961, i.e., a policy which prevents the abuse of drugs without interfering with their medical use, in particular for the relief of pain and suffering.

Mr. Chairman, it is essential for all of the parties who are interested in the subject of this hearing to be aware of what the CSA is intended to do, and what it is intended to avoid. The CSA is an anti-drug abuse, law enforcement statute, administered by the Attorney General (AG). On the other hand, the Congress in 1970 spelled out as fundamental principles that define the relation of the CSA to medical and scientific decisions, to the Federal Food, Drug and Cosmetic Act (FFDCA), and to State laws.

(1) Medical and scientific decisions. The Congress decided in 1970 that medical and

scientific decisions, such as those relating to the evaluation of drugs being placed in the schedules of the CSA, are the responsibility of the Secretary of the Department of Health and Human Services (DHHS), not the AG (See Section 811.(b) of the CSA). This fundamental principle, referred to as "balance," was established in the course of vigorous and extended debate over a Department of Justice bill that, as proposed, would have given the AG exclusive power to make decisions of a medical and scientific nature.⁽¹⁾ Congress appropriately rejected this approach. A variety of medical and scientific organizations were very much involved in helping to ensure that the CSA conveys a balanced policy; this policy has endured to this day.

(2) Relation of the CSA to the Federal Food, Drug and Cosmetic Act. The 1970 Congress determined a second fundamental principle, that the CSA is not to "be construed as in any way affecting...the provisions of the Federal Food, Drug and Cosmetic Act" (See Section 902). Mr. Chairman, it is extremely important that it is under authority of FFDCA, not the CSA, that drugs are approved as safe and effective for medical use, so that they can be marketed lawfully in interstate commerce. It is under the FFDCA, not the CSA, that drugs are scientifically evaluated and approved for various uses. Many opioids have been approved for treatment of pain, diarrhea, and cough. The fact that opioids are also controlled under the CSA does not affect their status as drugs that are legal to be prescribed by physicians. In addition, agency and court decisions have made it clear that although the Food and Drug Administration (FDA) approves drugs for marketing, it does not regulate medical practice, which is left to the States.⁽²⁾ It is true that there is a difference between legal and illegal drugs in the schedules of the CSA (i.e., the difference between schedule I and schedules II-V), but this difference is determined primarily by whether a drug is approved under the FFDCA as having an accepted medical use. Therefore, we should not expect to use the CSA to achieve recognition of the legal uses of drugs.

(3) Relation of the CSA to State laws. The third fundamental principle that was adopted by the Congress in 1970 is that the CSA is not intended to occupy areas of State laws which are within the authority of the States. This principle is stated in the CSA:

"No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together." (CSA, 1970, Section 903).

Without commenting on the matter of physician-assisted suicide itself, I think it is extraordinary to single out States with controversial policies on important societal issues, issues which are nevertheless within their authority, and then, because there is an (albeit tenuous) relation to the use of controlled substances, amend the CSA to contravene the policy of that State. This process would effectively overturn one of the fundamental principles of the relation between the federal government and the States.

Mr. Chairman, against the context of the foregoing fundamental principles which limit the scope of the CSA, I offer a few additional observations:

(1) Opioids are legal, under the FFDCA. H.R. 2260 states that opioids can be used in the treatment of pain. We already know that the use of opioids is legal for pain management under the appropriate federal statute, the FFDCA. If Congress starts using the CSA to state what is illegal, and also legal, we are ignoring one of the fundamental principles, and may set a precedent so that in the future you may be requested to consider legislation from various groups to clarify that controlled substances may also be used for diarrhea and cough, and for anxiety and Attention-Deficit Disorder (ADD).

(2) DEA has already clarified the use of opioids for pain. The DEA has made it perfectly clear in a 1974

regulation that nothing in the CSA precludes practitioners from providing opioids for intractable pain.⁽³⁾ DEA reemphasized this point again in its 1990 Physicians Manual, encouraging physicians to prescribe opioids when they are needed.⁽⁴⁾

"Controlled substances and, in particular, narcotic analgesics, may be used in the treatment of pain experienced by a patient with a terminal illness or chronic disorder. These drugs have a legitimate clinical use and the physician should not hesitate to prescribe, dispense or administer them when they are indicated for a legitimate medical purpose. It is the position of the Drug Enforcement Administration that these controlled substances should be prescribed, dispensed or administered when there is a legitimate medical need." (DEA, 1990, p. 21)

Further, DEA representatives are to be commended for their willingness to speak at pain conferences around the U.S.; the DEA, as well as major pain organizations, have also endorsed a new Model Guideline⁽⁵⁾

on the use of controlled substances for pain which we helped to draft; further, DEA has intimated that it is about to publish in the federal register a new statement that encourages the use of controlled substances for the treatment of pain.

(3) Defining appropriate medical uses in statute is a dangerous precedent. What about other uses of controlled substances - for diarrhea and cough, for ADD, for dyspnea and other symptom control? Will you have to consider legislation proposed by various medical groups to clarify other uses of controlled substances?

(4) What will the new DEA regulations say? H.R. 2260 at line 9 clearly contemplates that the AG/DEA may promulgate "regulations to implement this Act." Will the regulations (a) specify what is meant by the two conditions under which prescribing for pain management is legal (see lines 11-14), or (b) specify how the agency will decide what is meant by 'even if the use of such a substance may increase the risk of death' (see lines 14-15) as distinguished from 'intentional dispensing for the purpose of causing death?' (See lines 15-19). Apart from the inherent difficulty in determining a physician's intention, a recent review showed the notion that opioids hasten death to be more myth than fact.⁽⁶⁾

Given that H.R. 2260 allows for DEA regulations in connection with new language about pain, hastening death and assisted suicide, it seems likely that the Attorney General and the DEA would be faced with decisions involving medicine and science, in direct conflict with the first fundamental principle.

(5) The potential for a chilling effect. Mr. Chairman, I would like to close with the following point. I make the assumption that this Committee and the other witnesses fully accept that pain is not adequately managed in this country, and further, that this is due, in part, to the under-use of opioid analgesics, especially, but not only, for people at the end of life. There are many reasons for this situation. One of the reasons for inadequate pain management, and what prompted me to accept your invitation to be here today, is that while many physicians still do not have sufficient knowledge about pain management, they also fear being investigated if they prescribe 'too much.' The root causes of these fears are intertwined with how drug control policy has developed in this country. The solution to the problem depends upon achieving and communicating a balanced controlled substances policy that is also understood by regulators and practitioners. I fear that the amendments to the CSA proposed in H.R. 2260 seriously upset a balance the 1970 Congress established, and which many of us have been working to achieve. I could cite a litany of historical treatises and studies to convince you that this fear exists; instead, I will name some of the organizations that have recognized that physicians' fears of regulatory scrutiny affect their use of controlled substances for pain management:

The American Academy of Pain Medicine

The American Pain Society

The Federation of State Medical Boards of the U.S.
The Medical Board of California
The National Academy of Sciences, Institute of Medicine
The National Conference of Commissioners on Uniform State Laws
The National Conference of State Legislatures
The State Cancer Pain Initiatives

Finally, Section 102 would establish an education and training program for law enforcement officials. I think that such training could be very valuable. Indeed, we have conducted eleven workshops on pain management in a regulated environment for state medical board members with support from the Robert Wood Johnson Foundation and the Advocates for Childrens' Pain Relief. One of the risks however is that such a program might digress into discussion of drug abuse rather than pain management and palliative care, and possibly result in more second-guessing of medical judgements. While it is quite positive that Section 102 specifies that the AG should incorporate the recommendations of the Secretary of the DHHS, I would suggest that the Subcommittee go further to specify that the content of such education and training, in accordance with the fundamental principle, be *established* by the Secretary, in consultation with the AG.

Mr. Chairman, I thank you and the members of the Subcommittee for this opportunity to testify. In sum, it appears that H.R. 2260 challenges three fundamental principles that limit the scope of the CSA, thereby unbalancing drug control policy at a time when the opposite is needed. I would urge the Subcommittee to pursue other measures that could more directly address the root causes of inadequate pain management, for all stages of life, without disturbing the sensitive balance that is needed in controlled substances policy. I am happy to take questions or provide further information.

Note: Pursuant to the Committee's instructions to witnesses, I do not have and have not had for two years any involvement with federal grants, and I am not representing any other party at this hearing.

Selected Bibliography

Alpers A. Criminal act or palliative care? Prosecutions involving the care of the dying. *The Journal of Law, Medicine & Ethics*. 1998; 26:308-331.

Fohr SA. The double effect of pain medication: Separating myth from reality. *The Journal of Palliative Medicine*. 1998;1(4):315-328.

Joranson DE. Federal and state regulation of opioids. *Journal of Pain and Symptom Management*. 1990;5(Suppl):12-23.

Joranson DE. A new drug law for the states: An opportunity to affirm the role of opioids in cancer pain relief. *Journal of Pain and Symptom Management*, 1990;5(5):333-336.

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

Joranson DE, Gilson AM. Improving pain management through policy making and education for medical regulators. *The Journal of Law, Medicine & Ethics*. 1996;24(4):344-347.

Joranson DE, Gilson AM. Controlled substances and pain management: A new focus for state medical boards. *Federation Bulletin: The Journal of Medical Licensure and Discipline*. 1998;85(2):78-83.

Martino AM. In search of a new ethic for treating patients with chronic pain: What can medical boards do? *The Journal of Law, Medicine & Ethics*. 1998;26:332-349.

Musto DF. *The American Disease: Origins of Narcotic Control*, 3rd ed. New York, NY: Oxford University Press, 1999.

Von Roenn JH, Cleeland CS, Gonin R, Hatfield AK, Pandya KJ. Physician attitudes and practice in cancer pain management: A survey from the Eastern Cooperative Oncology Group. *Annals of Internal Medicine*. 1993;119:121-126.

Weissman DE. Doctors, opioids, and the law: The effect of controlled substances regulations on cancer pain management. *Seminars in Oncology*. 1993;20(2 Suppl 1):53-58.

1. Controlled Dangerous Substances, Narcotic and Drug Control Laws" Hearings before the U.S. House of Representatives Committee on Ways and Means. Washington, DC: U.S. Government Printing Office, 1970.

2. See for example Section 202 of the 1962 amendments to the FDCA, P.L.87-871, 76 Stat 780; and U.S. vs. Evers, 1981)

3. Code of Federal Regulations Part 21, Section 1306.07(c)

4. Drug Enforcement Administration. *Physician's Manual: An Informational Outline of the Controlled Substances Act of 1970*. U.S. Department of Justice: DEA; March, 1990.

5. Federation of State Medical Boards of the United States, Inc. *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain*. Euless, TX; May 1998.

6. Fohr SA. The double effect of pain medication: Separating myth from reality. *Journal of Palliative Medicine*. 1998;1(4):315-328.

Written Testimony

United States House Judiciary Committee

House Resolution 2260

Thursday, June 24, 1999

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Mr. Chairman, members of the Committee, ladies and gentlemen, it is a privilege to be here today and to offer you my thoughts on House Resolution 2260.

I am a full time hospice physician certified both in Internal Medicine and Hospice and Palliative Medicine. I use controlled substances with the frequency that an infectious disease practitioner uses antibiotics and I often use them in doses which exceed the recommended doses found in the Physician's Desk Reference and other standard medical references.⁽¹⁾ I am frequently involved in cases in which the side effects of these medications may indeed contribute to the death of the patient. Yet I know I must accept these side effects as undesired effects in the true goal of providing pain and symptom relief.

In short, the ethical Principle of Double Effect⁽²⁾ is with me daily. It guides my actions as a physician and it keeps me honest in my actions. It is a viable ethical principle and it is the foundation of one of the intentions of this legislation: not to interfere with legitimate pain and symptom control.

The Rule of Double Effect

As an example of the work I am called to do daily, let me describe a case of a young AIDS patient I cared for a few years ago. On a Monday morning the hospice for whom I worked received a phone call from his family that he was having difficulty breathing. His nurse and I

made a house call. When we entered the room we could hear his laborious and moist respirations across the room. His respiratory rate was 44 and he was unconscious. We immediately set to work. I gave him 40 mg of Lasix (furosemide)⁽³⁾ intravenously. There was no effect. I then gave him 10 mg of morphine⁽⁴⁾ intravenously. There was no effect after several minutes. I repeated the dose of 10 mg of morphine and waited several minutes. Again, there was no effect. I gave 5 mg of morphine. There was still no effect. I then gave 5 mg of Valium (diazepam) in an attempt to sedate him and ease the work of breathing. There was no effect. I repeated the Valium dose and there was still no effect. I gave 5 mg of morphine, waited, saw no effect and gave another 10 mg of morphine. After a few minutes, his respirations decreased to about 20. This was a reasonable goal. However, instead of stabilizing at 20, they continued to diminish and he stopped breathing several minutes later.

Did the fact that a respiratory rate of over 40 is terribly inefficient and allows toxins to build up in the body that can suppress respirations cause his death? Was he actively dying no matter what I did? Did the medications play a role in hastening the moment of death? Did I kill him? The answer is that the disease, his respiratory rate and the medications all may have combined to cause his death to occur a moment in time sooner than it would have occurred without my intervention. But I did not intend his death. I was using everything in my medical powers to ease the distress of his breathing. Had I deliberately wished his death, I would have given the Lasix, 40 mg of morphine and 10 mg of Valium as one immediate injection. Instead, I titrated the medicine against the clinical response I saw over the period of an hour. To apply the oft-quoted principle of Double Effect and apply it to this case would be useful in this example.

The Rule of Double Effect makes the following assertions:

The Nature of the Act. The act must be good, or at least morally neutral (independent of its consequences.)

The Agent's Intention. The agent intends only the good effect. The bad effect can be foreseen, tolerated, and permitted, but it must not be intended.⁽⁵⁾

The Distinction Between Means and Effects. The bad effect must not be a means to the good effect. If the good effect were the direct causal result of the bad effect, the agent would intend the bad effect in pursuit of the good effect.

Proportionality Between the Good Effect and the Bad Effect. The good effect must outweigh the bad effect. The bad effect is permissible only if a proportionate reason is present that compensates for permitting the foreseen bad effect.⁽⁶⁾

Using the above, let us analyze my patient utilizing each criterion from each perspective:

1. *The Nature of the Act.* The act (giving the patient the Lasix, morphine and Valium for the purpose of alleviating his respiratory distress) must be good, or at least morally neutral.

I would propose that his respiratory rate was too fast for any effective air exchange. This alone increased his risk of death not to mention how much discomfort it may have been causing him even though he appeared to be unconscious.⁽⁷⁾ Certainly, his family was present and to watch him gasp and labor for air was very difficult for them. Therefore, the act of giving him the medicine was good from the clinical perspective.

2. *The Agent's Intention.* The agent (the physician - I, in this case) intends only the good effect. (The alleviation of his labored breathing.) The bad effect (possibly depressing his respirations or even causing his breathing to stop as a result of side effects of the medications) can be foreseen, tolerated, and permitted, but it must not be intended.

I knew that there was a slight risk of lethal side effects to the medications. But I knew that I might have to risk them, tolerate them in part or in totality if I were to attempt to ease his breathing. I did not intend for him to die, but I did intend to make his breathing easier. Had I

intended the side effect of cessation of breathing, I would not have given incremental doses of medicine over time and observed his clinical response with each dose. I would have given a very large dose all at once to stop the breathing.⁽⁸⁾

3. *The Distinction Between Means and Effects.* The bad effect (the cessation of breathing) must not be a means to the good effect (ease in breathing.) If the good effect (ease in breathing) were the direct causal result of the bad effect, the agent would intend the bad effect in pursuit of the good effect.

Clearly, not breathing is not merely easier breathing. I intended only the effect of easing his breathing, not totally stopping his breathing. I, therefore, did not intend the bad effect in order to get the good effect.

4. *Proportionality Between the Good Effect and the Bad Effect.* The good effect (ease of breathing) must outweigh the bad effect (possible cessation of breathing as a side effect of medication.) The bad effect is permissible only if a proportionate reason is present that compensates for permitting the foreseen bad effect.

Unrelieved breathing at 44 times per minute without relief can become fatal in and of itself. It can be certainly uncomfortable for any conscious individual as it is literally a sense of suffocation. The risk of side effects of the medicine would be permissible to alleviate the certainty of the discomfort and danger of his uncontrolled respiratory rate of 44.

In short, the Principle of Double Effect guided me through the decision making process and the actions I performed in this case. H.R. 2260 recognizes what I did in this case as legitimate palliative care, does *not* view my actions as assisting a suicide or committing euthanasia, and therefore protects me from prosecution for committing those acts.

House Resolution 2260 and Hospice Practice

Nothing in this bill will change what I do daily in my work as a hospice physician. Nothing in this bill frightens me that I will become a "target" of the DEA in a misguided attempt to prevent abuses of these medications. My patients will continue to receive as much morphine and other controlled substances as is necessary to control their pain and symptoms. I do not fear the scrutiny of my peers in my daily work. In fact, I welcome such scrutiny. It is a tool to ensure that I am maintaining the highest competency in my work.

As in the case cited above, I know the ethical principles that provide the foundation for the work I do. I know that I am permitted, even *obligated*, to provide pain and symptom relief *even if doing so hastens the moment of death for the patient.* This, however, is a far cry from my acting to cause deliberately and willfully the patient's death by my actions.

I did not come to my understanding of the practice of hospice/palliative medicine and the ethical and legal underpinnings of it through my formal medical education curriculum in medical school and residency.⁽⁹⁾ I was in the practice of general internal medicine when I became painfully aware of my own deficiencies in these areas. I took the time and paid the monies over several years to attend formal classes in ethics and hospice and palliative medicine offered by the Kennedy Institute of Ethics (Georgetown University), the National Hospice Organization, and the American Academy of Hospice and Palliative Medicine.

Every practicing physician in the United States needs formal education in the ethical, legal, and medical principles of hospice and palliative care. This is critical for them to understand the intent of this bill and the intent of sophisticated palliative medicine. I shall return to this topic later as we look at this Bill's provision for monies earmarked for education and development of palliative care.

Others' Concerns Regarding House Resolution 2260

This bill, like predecessors last year, may be perceived by some in the medical community as a back door effort to thwart the development of assisted suicide and euthanasia for terminally ill patients. Many professionals may complain that it will discourage physicians from providing adequate pain relief for their patients. Some may believe it to be one more example of an intrusion by the Federal Government into the privacy of the physician-patient relationship. I think they are mistaken in these conclusions.

Certainly, the United States Supreme Court has ruled that there is no constitutional right to die. However, that Court has left open to individual states the right to create laws for or against assisted suicide. However, the Congress of the United States has every right to say that assisted suicide/euthanasia are not areas which the Congress will support. You have already passed legislation which prohibits the use of federal dollars to pay for assisted suicide/euthanasia. House Resolution 2260, as a mechanism for necessary reform of the Controlled Substances Act in regards to assisted suicide/euthanasia, is a meaningful action that the Federal Government will not participate in deliberate and direct killing of patients via the use of these federally controlled substances. I applaud this action. While assisted suicide has been debated extensively in this country, I continue to aver that it is dangerous public policy. It cannot and will not be contained to a very small group of "terminally ill" patients as proponents have us believe. The "safeguards" touted in all debates are paper tigers which have no real meaning in the real world of clinical practice.⁽¹⁰⁾ Additionally, I am of the firm belief that legalization of physician assisted suicide and euthanasia will radically change the nature of the medical profession itself.⁽¹¹⁾

As for any concerns that this bill might prevent physicians from adequately treating pain, I am afraid that the bill may be used as just one more excuse for poor pain management. However, the bill will *not* be the cause of poor pain management. We know that pain management *without* this bill is abysmal in the United States.^{(12), (13)} Unfortunately, because of many factors at work today in the practice of medicine, I believe undertreatment of pain is a path of lesser resistance in today's medical environment.⁽¹⁴⁾ We cannot simply remain paralyzed and fail to do the right thing simply because we are afraid our actions will be misconstrued by those who have not bothered to learn the truth of our actions. *HR 2260 is a principled and practical bill to protect and promote legitimate pain management.*

The language of this bill contains provisions to ensure that aggressive pain and symptom management, even at the risk of shortening a patient's life, is not the target of this legislation. This is very reassuring to me, particularly in light of my having to oppose Michigan State Senate Bill #200 which outlawed assisted suicide without adequate protections for appropriate palliative care.⁽¹⁵⁾ The incorporation of the Principle of Double Effect in HR2260 sends both an important symbolic *and* concrete message that the government of the United States recognizes the legitimate practice of pain and symptom management and the inherent dilemmas faced by professionals in providing excellent care to patients. However, this legislation does not proscribe me or any other knowledgeable health care practitioner from doing the right thing for the right reasons. If anything, this legislation stands as a clarion call to all health care professionals in this country to provide state-of-the-art pain and symptom management to our patients who need it, who deserve it, and who can benefit from it. This is government *leading* citizens in the development of public policy which provides a much needed service to the dying while protecting vulnerable persons from the real and dangerous effects of the acceptance and practice of assisted suicide/euthanasia as public policy.

Interpretation and Implementation of the Law

As a hospice physician I have no fears about this bill. I know the ethical principles that gird the practice of hospice and palliative care. I am thoroughly familiar with the uses of the controlled substances covered by this Act. I know the clinical application of the Principle of Double Effect. I am surrounded by dedicated hospice and palliative care colleagues who are ready to help me, to consult with me, to give me guidance in difficult cases. This law will make it illegal to use controlled substances covered by the federal Drug Enforcement Administration in the commission of assisted suicide or euthanasia. Even more importantly this law will proactively seek to provide much needed education at several levels to ensure that our citizens have access to appropriate palliative care.

The Justice Department must ensure that its agents know the difference between appropriate and inappropriate uses of controlled substances and do not engage in fruitless and counterproductive investigations where there are no abuses.

Education of the agents of the Executive branch of government is essential if this bill is to work as intended. A commitment made to provide for such education is critical and has been made within the context of this legislation. I applaud the efforts to include education of "local, State, and Federal personnel" in this regard. Education must occur also in the medical community. The medical community must understand the law established by this Act, its intent and be prepared to understand the differences between appropriate and inappropriate uses of controlled substances. Again, House Resolution 2260 makes provisions for education within the professional community in regards to pain and symptom management, the intent of this legislation, and promoting palliative care. This should alleviate any fears of the medical community that this law is but one more specter of "Big Brother" looking over their shoulders.

The Role of Licensing Agencies

For all the objections opponents may offer to this legislation, I believe they ignore relevant aspects of legitimate licensing concerns. All physicians are licensed by various agencies. All licenses carry certain requirements and restrictions. Violations of these provisions carry with them the possibility of forfeiture of the license.

Certainly, as a physician with a valid DEA license, I am aware that I could lose that license if I engage in deliberate diversion of controlled substances to anyone other than my patient. I know that I would face serious consequences if I willfully prescribed controlled substances to a known substance abuser who had no legitimate medical reason for receiving pain medications. These are "givens" with the license and I accept them when I accept the license. A license is granted by some one or some agency with the authority to grant it. In so doing, that authority attaches certain restrictions and conditions upon working under that license.

It does not seem unreasonable that the DEA would place a prohibition on the use of controlled substances in assisted suicides or euthanasia as a condition for maintaining a license. Such a prohibition sends a clear message in both symbolic and concrete terms that the United States Federal Government does not recognize the very dangerous practices of assisted suicide and euthanasia as legitimate medical practices. Perhaps detractors would rather have DEA

licensure, state medical licensure, hospital privileges, and any other number of regulatory conditions of medical practice removed so that physicians can simply do whatever they want, whenever they want.

Education of the Medical Community and Transforming End-of-Life Care in the United States: A Major Commitment

Just as the Executive branch of the government must be held accountable for the intent and provisions of the law, we must likewise ensure that the medical community understands the differences between legitimate palliative care and the intentional taking of human life. Some say that the lines between the two are just too nebulous and artificial to warrant clear distinction.⁽¹⁶⁾, ⁽¹⁷⁾ I vehemently disagree. Physicians can and must learn and understand thoroughly the Principle of Double Effect and how that principle is incorporated into the clinical practice of palliative medicine and the intent of this legislation.

Efforts are being mounted to educate American physicians in appropriate pain and symptom management and in hospice and palliative care. The American Medical Association has launched one such effort. Those of us who work in hospice and palliative medicine work with our representative professional associations and offer continuing education many times throughout the year on these topics. But attendance is woefully inadequate based upon the needs identified.

I am delighted that the House of Representatives, with this Resolution, recognizes the need to educate medical professionals in the principles and practice of palliative care. This bill contributes to current efforts at education by providing mechanisms and monies for these educational efforts. Again, you are proving to this country that it is time to get very serious about the need for improving how we care for our terminally ill and dying citizens. Professional education is expensive, to be sure. But if every physician, nurse and other health professional in this country truly understood the indications for palliative care, would we find that our citizens receive less aggressive, futile interventions and better symptom control? Would our citizens have a better quality of life, a more comfortable life and consume less expensive medical modalities when they enter the final stages of illness and face death squarely in the face? If our citizens truly understood what is available, and what is achievable, would they not welcome monies being spent to build a medical system of palliative care that would become the envy of the world? Would our seeming rush to embrace assisted suicide all but vanish if our citizens truly knew what a comprehensive hospice and palliative plan of care entailed and had it as available as any commonly utilized medical procedure in their communities? I urge the Congress to watch the fruits of this legislation closely and commit even more monies to these educational efforts in the future if the appropriate overseers can document that this is money being well spent in the development of palliative care.

There is much to do in the development of palliative care and I, for one, believe Congress is poised to become part of the solution to the problems facing us. For your future consideration, let us look at just two other issues which must be addressed as we change the face of end-of-life care in our nation.

We must ultimately address barriers which are present in private and governmental insurance programs that insist hospice is for those with only six months or less to live. Prognostication is *not* an exact science and patients with life-threatening, non-cancer diseases do not die neatly and conveniently within a six month or less time frame. The Medicare Hospice benefit has been of tremendous value to patients with cancer. But as our population ages and our citizens increasingly die of non-cancer diseases, the Medicare Hospice benefit often fails those who most need it because of regulatory barriers that impede patients accessing hospice services. This must be remedied as soon as possible as we re-evaluate the entire Medicare program and the services it will provide in the new century.

We must educate our nation and our nation's health care providers in medical ethics, current law, and the principles and practice of palliative care and the incredible holistic work of hospice programs. It is imperative that we develop a strong national response to oppose all efforts to legalize assisted suicide and euthanasia. I am deeply concerned that when assisted suicide and euthanasia become part of the normative culture, hospice and palliative care may well disappear from the landscape because they require far more resources of time, money, education and commitment than the deliberate hastening of death.⁽¹⁸⁾ Hospice is not nearly as developed in the Netherlands as it is in the United States. In the Netherlands, there is *de facto* assisted suicide and euthanasia. Why has hospice failed to develop over the years? Is it because a holistic, comprehensive hospice program requires far more energy, monies, and dedication than a policy of assisted suicide? What are the factors that may lead human beings to accept an easier path? Can we honestly say that our booming economic times of the last several years in the United States will last forever? What will a serious or severe economic downturn do to providing hospice and palliative care if assisted suicide and euthanasia have had time to settle comfortably into the national conscience?

I would urge you, Mr. Chairman, members of this committee and the entire Congress of the United States to work with the

hospice and palliative care communities to revolutionize the practice of hospice and palliative care in our nation. Let us commit to creating a comprehensive hospice and palliative care program for our citizens. Let us forge a new path with the Health Care Financing Administration and private insurance companies to ensure that all patients receive the finest in end-of-life care. Let us say to our citizens that no one must ever turn intentionally and deliberately to causing death because of pain, symptoms or the effects of a terminal illness.

Conclusion

I reiterate: *Nothing in this bill will change what I do daily in my work as a hospice physician.* This bill will in no way deter me from my commitment to my patients, their families, and to the professionals who consult me and utilize my services. I want to assure all health care professionals who hear or read my testimony that they have nothing to fear from this bill for doing the right thing for the right reasons. However, the right thing requires that we all arm ourselves with the appropriate knowledge, skill, attitudes, and commitment to provide the very best palliative care has to offer our patients. Additionally, this bill starts a noteworthy phase of proactive work by Congress in helping develop palliative care for our citizens. *This is a laudable development* and says to our nation that our elected representatives will stand shoulder to shoulder with all of us to become a caring community intent on providing care, comfort, and compassion without deliberately and intentionally killing citizens through assisted suicide and euthanasia.

Let this bill become not an end unto itself, but the beginning of a national commitment to caring for our citizens in the final stages of their lives. Let the legacy of this Congress be that it heard the cries of those in pain and those who are dying and answered their cries. Let the response be: Not one of you must perish at your own hands or at the hands of your physician simply because we failed to understand your physical and mental anguish.

Thank you for allowing me to be here today.

1.

⁰ *The Physician's Desk Reference* and other widely used references **do not** typically reflect the doses of controlled substances used in comprehensive hospice and palliative care settings. These references reflect only the standard doses utilized in drug trials mandated by the Food and Drug Administration to prove safety in selected patient populations. The doses of medications used in the hospice and palliative care setting can be found only in specialized literature based upon published reports of specific studies of unique patient populations.

2.

⁰ *Vide infra* for a complete look at the Principle of Double Effect.

3.

⁰ A diuretic which helps rid the body of salt and water by increasing excretion through the kidneys. This diuretic effect helps mobilize fluid out of the lungs and should theoretically improve the patient's breathing if fluid accumulation in the lungs is creating the breathing difficulty.

4.

⁰ Morphine is used in respiratory distress to ease the work of breathing.

5.

⁰ For an excellent look at the Principle of Double Effect and the role of intent, see Daniel Sulmasy, O.F.M., M.D.,

Ph. D., "The Use and Abuse of the Principle of Double Effect," *Clinical Pulmonary Medicine*, Vol. 3, No. 2, March, 1996.

6.

⁰ Beauchamp, Tom L. and Childress, James F. **Principles of Biomedical Ethics, 4th Edition**, Oxford University Press, New York, 1994.

7.

⁰ Interestingly, even though he was "unconscious," his family reported to me that when his two young nephews left the house earlier that morning with their father, they said to him from the door of the apartment, "Good bye, Uncle Joe." The family noted that upon hearing his name from the young boys he opened his eyes. In hospice work, we are convinced that patients are often able to experience the presence and hear the words of family and friends even though they (the patients) cannot effectively communicate their experience.

8.

⁰ Using the criteria of intent raised by Sulmasy in the article referenced above (Reference 5), had the patient *not* died, I would have felt relief and been happy. Additionally, by Sulmasy's criteria in analyzing my intent, I would then have calculated a dose of medication or combinations of medications based on my bedside work that morning which would have been designed to keep his breathing as comfortable as possible.

9.

⁰ Sadly, medical schools and residency programs throughout the United States still are not requiring clinical rotations in hospice and palliative medicine to any extent. There are, perhaps, a few exceptions, but we are still a long way from incorporating hospice and palliative care into the formal, required curriculum for our nation's physicians.

10.

⁰ While the purpose of this testimony is to consider House Resolution 2260, it is intimately tied to the entire concept of the legalization of physician assisted suicide. If the reader is interested in further learning my position on assisted suicide/euthanasia, please contact my office.

11.

⁰ Medical education in the late 20th century in the United States fails to incorporate rigorous philosophical training in the nature of the profession itself. Physicians are, lamentably, produced *en masse* to be highly proficient technicians who usually fail to understand the profound implications of the role they play in the society they serve. This role is dual: concrete and symbolic. In concrete fashion, physicians diagnose and treat the sick. Symbolically, they represent a body of professionals with specialized knowledge who have been granted the authority by the state to use their knowledge for the good of patients and the community. It is incumbent upon the profession to police itself and ensure that the work it performs is for both the individual good of the patient and the collective good of the community. I believe there are moments in history in which physicians are called upon to reject certain philosophical trends because of the danger those trends pose for patients and/or society. Physicians must resist any efforts by society or the state which might produce profound, long term negative effects upon that society or state. We have only to look back a few decades in this century to witness the devastating effects of the professional medical community's collusion with state policies of eugenics and euthanasia.

Proponents of assisted suicide and euthanasia in the United States are vociferous in their condemnation of comparisons to Nazi physicians. They assert that what happened in Germany could never happen here. However, I believe the comparisons are fair on a different level - a level much closer to what we see happening here and which ultimately provided the basis for the German horrors. It is perhaps prophetic to consider the following observation:

"At its heart (the role of physicians in the atrocities of the Nazi regime) is the transformation of the physician - of the medical enterprise itself - from healer to killer." - Lifton, Robert Jay. **The Nazi Doctors - Medical Killing and the Psychology of Genocide**, Basic Books, New York, 1986.

12.

⁰ *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients - The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, **Journal of the American Medical Association**, Vol. 274, No. 20, 1995, pp. 1591 - 1598.

Author's Note: One of the most disturbing discoveries of this oft-cited study of approximately 10,000 patients is that over 50% of patients who were conscious rated their pain as moderate to severe at least half the time before they died.

13.

⁰ Webb, Marilyn. **The Good Death - The New American Search to Reshape the End of Life**. Bantam Books, New York 1997.

Author's Note: In her important and well-documented book about death and dying in America, Webb devotes a substantial amount of time to the problem of pain and its treatment. It is worth quoting from her book to elaborate on the abominable state of pain management in the United States even without this legislation. Ms. Webb writes:

"In 1992...researchers conducted a nationwide survey of 322 members of state medical boards - the organizations that oversee physician licensing and medical practice in each state. The physicians on these boards have the power to censure other physicians - even take away their licenses to practice - for what they consider to be inappropriate treatment decisions. Researchers wanted to know whether these boards were a factor in the undertreatment of pain.

"Their findings revealed an astounding information gap:

"To treat prolonged moderate to severe cancer pain, most board members recommended medications that pain experts consider grossly inadequate...These board members also had imprecise knowledge of the law. When asked about the legality and medical acceptability of prescribing opioids for more than several months in four patient scenarios involving cancer and nonmalignant pain, with and without a history of narcotic drug abuse, their answers were not only wrong, but often shocking...only 12 percent realized that using narcotics is lawful and good medical practice for chronic, serious noncancer pain - for example, pain that comes with AIDS or other illnesses...

"Of ...897 doctors surveyed, 86 percent felt the majority of American patients in pain were undertreated; 49 percent of them also rated pain control for patients *in their own medical practice* as either *fair, poor, or very poor*." (Italics in the original.)

14.

⁰ I have often wondered how physicians might react if their license were subject to revocation if it could be proven they had **undertreated** their patient's pain. Would such a threat of censure provide the motivation to learn the principles and practice of modern pain management techniques and ensure appropriate consultations with pain management specialists in complex cases? Would such a threat of censure suddenly cause every licensed physician in the United States to demand that pain and symptom management courses be offered at once in their local communities?

15.

⁰ "Based upon the interpretation of the language, this bill (Michigan Senate Bill # 200) could target physicians who prescribe medications appropriately but whose patients deliberately use those medications as a means to commit suicide. While the goals of this bill are laudable - to protect the citizens of Michigan from unscrupulous

individuals who would take advantage of the vulnerabilities of the sick and dying - it could have unintentional consequences if it dissuades dedicated physicians and nurses in hospice and palliative care from using whatever means are available to alleviate physical suffering without intentionally killing the sufferer." Walter R. Hunter, M.D., Oral Testimony, Michigan House Judiciary Committee Hearing, Tuesday, January 20, 1998.

16.

⁰ Quill TE, Lo B, and Brock D W. "Palliative Options of Last Resort - A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia," **Journal of the American Medical Association**, 1997; 278: 2099 - 2104.

17.

⁰ Quill TE, Dresser R, Brock DW. "The Rule of Double Effect - A Critique of Its Role in End-of-Life Decision Making," **New England Journal of Medicine**, 1997; 337: 1768 - 1771.

18.

⁰ Caplan, AL. "Will Assisted Suicide Kill Hospice?" **The Hospice Journal**, Vol. 12., No. 2, 1997, pp. 17 - 24.

Testimony of Richard M. Doerflinger**on behalf of the****National Conference of Catholic Bishops****in support of****H.R. 2260, the Pain Relief Promotion Act of 1999****House Judiciary Subcommittee on the Constitution****June 24, 1999**

I am Richard M. Doerflinger, Associate Director for Policy Development at the Secretariat for Pro-Life Activities, National Conference of Catholic Bishops. I am also an Adjunct Fellow in Bioethics and Public Policy at the National Catholic Bioethics Center in Boston.

The Catholic bishops of the United States strongly support the Pain Relief Promotion Act of 1999 (H.R. 2260). We believe that swift enactment of this legislation is needed for two purposes: (1) to correct a seriously flawed 1998 ruling by U.S. Attorney General Janet Reno, which authorizes the use of federally regulated drugs to assist vulnerable patients' suicides wherever the practice is permitted by state law; and (2) to promote the legitimate use of these drugs to relieve pain and other distressing symptoms, especially for patients who are terminally ill.

In our view, these two goals are both important, and are closely related. Terminally ill patients deserve better pain control precisely because they have *the same innate worth and dignity* as all other human beings and are in special need of our love and support. When a society singles out these patients as candidates for physician-assisted suicide, it denies the value of their very lives, and thereby undermines respect for their dignity and their legitimate needs -- including their need for the best possible palliative care.

When we accept assisted suicide as a "good enough" solution for these patients, we preach a counsel of despair to *all* terminally ill patients. We tell them that we find it easier to kill *them* than to find ways to kill their pain. By rejecting the "quick fix" of assisted suicide, however, we reaffirm to ourselves and to the medical profession that these patients have lives worth living, and that they deserve real solutions for the pain, depression and isolation that they may experience.

In our view, then, the two titles of this bill -- one clarifying federal law on the use of controlled substances, the other providing federal support for training in palliative care -- serve the same goal of promoting genuine supportive care for some of our most vulnerable citizens. Because the bill's palliative care provisions in Title II will be discussed by experts in medicine and hospice care at this hearing, and receive further attention from the House Commerce Committee, I would like to focus on the urgent need to enact Title I, clarifying the Controlled Substances Act.

The Need to Clarify the Controlled Substances Act

On June 5, 1998, contradicting an earlier determination by her own Drug Enforcement Administration, U.S. Attorney General Janet Reno ruled that the state of Oregon, by rescinding its own penalties for assisting the suicides of certain patients, had effectively succeeded in unilaterally amending federal drug laws as well. According to the Attorney General, Oregon's law had established assisted suicide as a "legitimate medical practice" within Oregon's borders -- and the federal government lacked any basis for disagreeing with this judgment. Under this ruling, however, federal intervention by the Drug

Enforcement Administration (DEA) "may well be warranted" in other states -- and is warranted *even in Oregon*, when a physician "fails to comply with state procedures" regarding *how* and *when* to assist suicides. Federal law will protect the lives only of those still deemed by the state to deserve suicide prevention, instead of suicide assistance.

Thus Attorney General Reno's ruling requires the federal government to ratify Oregon's assisted suicide policy -- and to help implement it, by licensing physicians to prescribe and distribute federally regulated drugs for the required lethal overdoses. This is not only morally wrong -- it directly contradicts *everything* that Congress and federal agencies have ever said about terminally ill patients and assisted suicide:

- Current federal policy demands an *increased* penalty when the victim of a crime is seriously ill or otherwise "unusually vulnerable."⁽¹⁾ Yet in Oregon, it is now the U.S. Justice Department's policy that the serious illness of the victim transforms a crime into a "legitimate" medical procedure, so that it is no crime or offense at all. Oregon's discriminatory policy, which stigmatizes an entire class of patients and denies them the equal protection of the law, has effectively been ratified by federal administrative fiat.⁽²⁾

- As the U.S. Supreme Court noted in its 1997 rulings on assisted suicide, it is a longstanding policy under the federal drug laws "to protect the terminally ill, no less than other patients," from potentially lethal drugs.⁽³⁾ Yet in Oregon this policy is now turned on its head, so that federal prescribing licenses are used precisely for the *purpose* of facilitating lethal overdoses for the terminally ill.

- In 1997, Congress almost unanimously approved the Assisted Suicide Funding Restriction Act (42 U.S.C. §14401 et seq.) to ensure that federal funds, health facilities and health programs are not used for assisted suicide or euthanasia. Signing this bill into law, President Clinton said it "will allow the Federal Government to speak with a clear voice in opposing these practices"; he warned that "to endorse assisted suicide would set us on a disturbing and perhaps dangerous path." Yet an important federal statutory scheme, designed to ensure that potentially dangerous drugs are used only to promote patients' health, is now being used to condone and facilitate assisted suicide.

The Attorney General's ruling is especially indefensible as an interpretation of the Controlled Substances Act (CSA). Nothing in that Act indicates that an individual state, by dropping its own state penalties for a form of manslaughter, can convert such killing into a "legitimate medical purpose" for the use of federally controlled drugs within the meaning of the federal Act. Indeed, any "states' rights" argument on this issue is contradicted by the plain language and intent of the CSA. Provisions to ensure that narcotics and other dangerous drugs are used solely for a "legitimate medical purpose" (21 C.F.R. §1306.04), and are never used to endanger "public health and safety" (21 U.S.C. §823(b)(5)), have been included in this Act and its implementing regulations precisely to establish a uniform federal standard that would *not* rely on the vagaries of individual state laws.⁽⁴⁾

A clear and explicit purpose of such provisions was to prevent the use of federally regulated drugs for lethal overdoses, not only their use for addiction. Obviously, using drugs to cause people's deaths is an even greater threat to health and safety than using them to feed an addiction.

Current enforcement of the CSA reflects this understanding. In the past, physicians have had their DEA registrations revoked for giving dangerous drugs to patients who then used them to commit suicide (see, e.g., the case of Dr. Hugh Schade, reported at 60 *Fed. Reg.* 56354 [Nov. 8, 1995]). Some practitioners have lost their registrations in such cases even for *negligently* giving these drugs to patients who they should have known *might* use them for suicide.⁽⁵⁾

Such enforcement has often relied on the separate federal policy of protecting patients' health and safety, quite aside from whether a practitioner has violated state criminal laws or even state medical licensing standards. Especially since the CSA was clarified and strengthened in 1984, "state licensure is a necessary *but not sufficient* condition for DEA registration" (63 *Fed. Reg.* 8479 [Feb. 19, 1998]). By the same token, revoking a DEA registration does not imply that a physician will lose his or her state medical license or has violated state law.⁽⁶⁾

To reaffirm this longstanding and consistent federal policy that all citizens, including the terminally ill, deserve protection from the lethal misuse of potentially dangerous drugs, new legislation is needed and long overdue.

Choosing the Means: New Features of H.R. 2260

In 1998 legislation was introduced to correct the Attorney General's legal error. The Lethal Drug Abuse Prevention Act (H.R. 4006, S. 2151) was approved by House and Senate Judiciary Committees, but was opposed by many medical groups who claimed it would have an adverse effect on physicians' ability or willingness to prescribe controlled substances for pain relief. This year's Pain Relief Promotion Act addresses these concerns in the following ways:

1. In order to correct the anomaly the Attorney General has created in the way federal law is enforced in Oregon, last year's legislation established a new substantive policy against the use of controlled substances for assisted suicide throughout the 50 states. Critics feared that this explicit new authority might be taken as giving the DEA a new mandate to question and scrutinize physicians' medical decisions in order to detect assisted suicides.⁽⁷⁾ H.R. 2260 is based on a recognition that no new authority of this kind is needed. The Attorney General herself has acknowledged that the DEA *already* has authority to prevent the misuse of controlled substances for assisted suicide in every state *except* Oregon (and even has that authority in Oregon, when an assisted suicide does not comply with all the state's guidelines). The only new explicit statement on this issue in H.R. 2260 is that a state, by enacting a law permitting assisted suicide, does not succeed in changing the separate federal standard that already applies to all other states -- in other words, a law like Oregon's has no "force and effect" in determining whether a practitioner has violated separate *federal* standards for protecting patients' health and safety.

2. Last year's bill gave priority to stating a new policy against assisted suicide, then explained that this policy does not forbid the legitimate use of controlled substances to control pain. In H.R. 2260 the emphasis is reversed: It contains a forthright and explicit declaration on the legitimacy of using controlled substances to control pain, then adds that this and other policy statements in the relevant section of the CSA do not authorize the use of controlled substances for assisted suicide.

3. H.R. 2260 contains a new mandate that the DEA's continuing education programs for federal, state and local law enforcement personnel include education in how their enforcement procedures can better accommodate the legitimate medical use of controlled substances for pain relief. Combined with the Title II provisions supporting education and training in palliative care for health professionals, this provision underscores the federal policy that pain control is an important and legitimate purpose for the use of federally regulated drugs -- a policy that has never before been so explicitly stated in federal statutes.

The Pain Relief Promotion Act is carefully tailored to clarify federal law on assisted suicide only to the minimum degree needed to correct the Attorney General's ruling, so that the federal government will no longer actively *facilitate* assisted suicide in any state that has legalized the practice. It does not give new enforcement authority to the DEA, and does not change the law at all in the vast majority of states -- *except* to give new emphasis to the legitimate use of federally regulated drugs to control pain.

Killing Pain vs. Killing Patients

Because the relationship between optimal pain management and physician-assisted suicide is central to this legislative debate, the difference -- we would say, the contradiction -- between the two practices is worth further comment.

The medical profession has long recognized that efforts to control pain using powerful drugs may

sometimes have side-effects. Very rarely, controlling pain in dying patients may require the use of such large doses of drugs that the patient's breathing reflex may be suppressed and the dying process hastened. The physician's intent in these cases, however, is to use the minimum dosage needed to control the pain; any risk of hastening death is not intended, but is foreseen as the unavoidable side-effect of a legitimate medical action.⁽⁸⁾

This principle of double effect is not especially obscure. The difference between consequences which are intended, and those which are only foreseen, is part of everyday life.

As one federal appellate judge has observed, when General Eisenhower gave the order for D-Day he knew many American soldiers would die as a result -- but that does not mean he murdered them.⁽⁹⁾ Conversely, when King David ordered Uriah the Hittite to the front line of battle, then called back his other men so Uriah would be killed, he murdered him as surely as if he had wielded the weapon himself (2 Sm 11: 15-17).

The important factor here is the agent's intent -- what am I trying to achieve by this action? The goal of pain control is a patient who is relieved of pain. The goal of assisted suicide is a world that is relieved of one more patient. And this difference of purpose is reflected in the different ways drugs are used in the two practices. Pain control requires carefully titrating drugs to the point where pain is relieved with a minimum of side-effects; assisted suicide generally requires one sudden and massive dose of drugs, to make sure that the patient does *not* have time to build up any resistance to the drugs' lethal effects.

The euthanasia movement has tried to obscure this difference for its own narrow purposes. Jack Kevorkian claimed in his assisted suicide and murder trials that he was only trying to end "suffering," though the means he used had no analgesic properties. Assisted suicide supporters filed many briefs with the U.S. Supreme Court two years ago, claiming that pain control and assisted suicide were practically indistinguishable. They lost this debate. As the Supreme Court has said:

[A] physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them." *Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 368 (1996)* (testimony of Dr. Leon R. Kass). The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, "must, necessarily and indubitably, intend primarily that the patient be made dead." *Id.*, at 367. Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not....

Logic and contemporary practice support New York's judgment that the two acts are different, and New York may therefore, consistent with the Constitution, treat them differently.⁽¹⁰⁾

Since November 1994, when Oregon first approved its law allowing physician-assisted suicide, all other states discussing the issue have reaffirmed this distinction. No state has followed Oregon's lead; several have passed new laws against assisted suicide, including provisions to emphasize the distinction between assisted suicide and pain control.⁽¹¹⁾

What has happened to pain control in states enacting new bans, and in states that have rejected proposals to legalize assisted suicide? Time after time, actions to ban assisted suicide or to reaffirm existing bans have been followed by advances and *improvements* in pain control:

- When Rhode Island considered a new ban on assisted suicide in 1996, the state medical society objected that such a ban would have an adverse effect on physicians' willingness to use drugs like morphine for aggressive pain control.⁽¹²⁾ But in fact, the opposite happened. In the year following enactment of the ban, according to official figures from the DEA, Rhode Island more than *doubled* its per capita use of morphine for pain control, rising from 46th among the states to 19th in morphine use. A similar, though less startling, improvement was seen in Iowa after its ban was enacted the same year.
- The year after President Clinton signed the Assisted Suicide Funding Restriction Act, banning assisted suicide in all federal health facilities, advocates for palliative care reported that the Veterans Administration health care system had "made improving the quality of its end-of-life care a top priority" and implemented many positive changes in this field.⁽¹³⁾
- After a legalization measure was defeated by popular referendum in 1991, the Washington State Medical Association issued its first handbook ever for rank-and-file physicians on palliative care for dying patients. California's 1992 debate on a legalization measure, also defeated by popular vote, was the catalyst for a 1994 "Summit on Effective Pain Management" convened by the governor's office, which led to new policy changes to facilitate the prescribing of controlled substances for pain control (e.g., a new 1998 law ending the practice of triplicate prescription forms). Similarly, after Michigan enacted its ban on assisted suicide in 1998 it proceeded to enact several new laws to encourage physicians to practice effective pain control.

There is ample evidence for the observation, made by the American Medical Association and dozens of other medical groups in their 1997 Supreme Court brief in *Quill*, that **"the prohibition on physician-assisted suicide provides health care professionals with a tremendous incentive to improve and expand the availability of palliative care."**⁽¹⁴⁾

By the same token, as the National Hospice Organization noted in its brief in the same case, **"the acceptance of assisted suicide as a way to deal with terminal illness would undercut further efforts to increase the public's awareness of hospice as a life-affirming option."**⁽¹⁵⁾ As Supreme Court Justice Breyer noted during oral argument in these cases, we have certainly seen this in the Netherlands, where hospice care is woefully underdeveloped: that country, which permits assisted suicide, had only three palliative care centers, compared with 185 in England which prohibits assisted suicide.⁽¹⁶⁾

Some may claim that Oregon is an exception to this rule, that legalization has actually led to great improvements in hospice and palliative care. But those claims are misleading and exaggerated, for the following reasons:

- Oregon was a leader in palliative care long before legalization, and almost all the alleged improvements took place before the new law took effect in the fall of 1997. Many of these improvements were made by Catholic and other organizations seeking to ensure that patients would not be railroaded into assisted suicide once the objectionable law took effect.
- Many similar improvements have occurred in states which have passed new bans on the practice, or simply debated and then defeated legalization measures. It is the debate itself that often focuses lawmakers' and physicians' attention on the need to improve palliative care.
- Whatever brief incentive this debate may have created for improving care of the dying in Oregon now seems to be giving way to a more ominous trend. The state of Oregon has begun to provide public funding for assisted suicide, while cutting back on access to some pain control drugs and other treatments for terminally ill patients; the same trend has been observed among private health insurers in the state.⁽¹⁷⁾
- The DEA's figures on per capita use of morphine may be instructive in this regard. Oregon has always ranked among the top states in such use, coming in 3rd in 1992 (two years before its legalization proposal was first approved). It rose to 2nd place in 1996, when the measure was still enjoined and assisted suicide was still illegal. Briefly it rose to 1st place in the first quarter of 1998, a time when

Oregon physicians publicly said they were "chilled" in their ability to assist suicides due to the threat of adverse action from the DEA. But during the three months following Attorney General Reno's announcement that the DEA would *allow* use of federally regulated drugs for assisted suicides in Oregon, the state declined to 7th place -- falling behind West Virginia, Tennessee, Vermont, Nevada, New Hampshire and Missouri.⁽¹⁸⁾ Preliminary data for the first quarter of 1999 show Oregon in first place again, but with slightly lower per capita use of morphine than in the final months of 1998 when a federal bill to reassert DEA authority against assisted suicide in Oregon was pending; all the other states in the top seven prohibit assisted suicide, and two of these (Kansas and Louisiana) have enacted or strengthened their statutory bans in recent years. These data do not provide any clear support for the claim that legalizing assisted suicide encourages the use of drugs for pain control; they certainly disprove the claim that prohibiting assisted suicide discourages pain control.

Conclusion

H.R. 2260 supports and promotes palliative care as an integral part of good health care. It also helps *prevent* federal support for a practice that is ultimately the enemy of good palliative care -- the deliberate use of medications to pervert the goals of medicine and deliberately help cause patients' deaths. For both these reasons it deserves support and swift enactment.

1. United States Sentencing Commission, *Guidelines Manual*, p. 227, § 3A1.1.
2. The Oregon law has been found to violate constitutional guarantees of equal protection by the only federal court to review that law on the merits. See *Lee v. Oregon*, 891 F.Supp. 1429 (D. Or. 1995), *vacated on other grounds*, 107 F.3d 1382 (9th Cir. 1997), *cert. denied*, 118 S. Ct. 328 (1997). In its 1997 rulings on assisted suicide, the U.S. Supreme Court noted that it has yet to review the validity of this argument: "*Lee*, of course, is not before us... and we offer no opinion as to the validity of the *Lee* courts' reasoning. In *Vacco v. Quill*..., however, decided today, we hold that New York's assisted-suicide *ban* does *not* violate the Equal Protection Clause." *Washington v. Glucksberg*, 117 S. Ct. 2258, 2262 n. 7 (1997) (emphasis added). To this day no appellate court has ruled on the constitutionality of a law like Oregon's.
3. *Washington v. Glucksberg*, 117 S. Ct. 2258, 2272 (1997), quoting *United States v. Rutherford*, 442 U.S. 544, 558 (1979).
4. In particular, 1984 amendments to the CSA were designed "to make it easier for the [DEA] to suspend or revoke the authority of physicians ... who write or dispense prescriptions in a way that is threatening to the public health or safety," even in cases where they may not have been charged or convicted under state criminal statutes. Remarks of Rep. Gilman, 130 *Cong. Rec.* H9681 (daily ed. Sept. 18, 1984), quoted in *Trawick v. Drug Enforcement Administration*, 861 F.2d 72, 75 n.* (4th Cir. 1988).
5. Thus H.R. 2260's affirmation that the relevant section of the CSA does not authorize *intentionally* prescribing and dispensing federally regulated drugs for the *purpose* of causing death is restrained, and carefully focused on the legal anomaly created by the Attorney General's ruling.
6. "Registration of a physician under the Controlled Substances Act is a matter entirely separate from a physician's State license to practice medicine. Therefore, revocation of registration only precludes a physician from dispensing substances controlled under the Controlled Substances Act and does not preclude his dispensing other prescription drugs or his continued practice of medicine." S. Rep. No. 225, 98th Congress, 2d Sess., *reprinted in* 1984 U.S. Code Cong. & Admin. News 3182, 3449 n.40.
7. Indeed, the bill's creation of a new medical advisory board to review particular cases was taken by critics as evidence that massive new enforcement actions were contemplated -- though sponsors intended this board as an independent panel of experts to be convened only at the practitioner's request, to provide an additional *shield* against medically uninformed enforcement actions.

8. Such effects are far rarer than was once thought. "No more than 1 per cent of patients who receive narcotics for pain develop serious respiratory depression." M. Angell, "The Quality of Mercy," in 306 *New England Journal of Medicine* 99 (January 14, 1982). "There is close to universal ethical approval of the bold use of pain-control measures even if their use risks decreasing the period of survival. Yet palliative-care experience shows this situation to be extremely rare. The drugs for pain relief are very safe. Palliative-medicine specialists do not agree that good pain relief shortens life. Pain relief without sedation is a central and achievable goal of palliative care." J. Scott, "Fear and False Promises: The Challenge of Pain in the Terminally Ill," in I. Gentles (ed.), *Euthanasia and Assisted Suicide: The Current Debate* (Stoddart: Toronto 1995) at 100.

9. See *Compassion in Dying v. Washington*, 79 F.3d 790, 856 (9th Cir. 1996)(Kleinfeld, J., dissenting), rev'd, 117 S. Ct. 2258 (1997).

10. *Vacco v. Quill*, 117 S. Ct. 2293, 2298-99, 2302 (1997).

11. Since the end of 1994 new statutes against assisted suicide have been enacted in: Louisiana (1995); Rhode Island and Iowa (1996); Virginia, Michigan and South Carolina (1998); and Maryland (1999). In 1998, three states (Kansas, Oklahoma and South Dakota) added to their existing criminal prohibitions by providing civil penalties as well. The new Michigan law did not include an explicit disclaimer on the legitimacy of pain control, but such legislation was later enacted separately; Jack Kevorkian's flagrant but effective misuse of the "principle of double effect" in his trials made Michigan legislators hesitant to include such language in their ban.

12. "Assisted suicide to be R.I. felony," *American Medical News*, Aug. 12, 1996 at 31.

13. S. Beckwith, "VA Makes Better End-of-Life Care a Top Priority," *Last Acts Newsletter*, Summer 1998 at 6.

14. Brief for Amicus American Medical Association, et al., at 22, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858).

15. Brief for Amicus National Hospice Organization at 18, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858) and *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110).

16. Oral Arguments in *Vacco v. Quill*, reprinted in *12 Issues in Law & Medicine* 417, 437 (Spring 1997).

17. D. Gianelli, "Suicide opponents rip Oregon Medicaid's pain control policy," *American Medical News*, Sept. 28, 1998 at 7; S. Rojas-Burke, "Health Plan cuts threaten status of safety-net clinics," *The Oregonian*, Feb. 16, 1999; J. Hamby, "The Enemy Within," *The Oregonian*, Jan. 21, 1998.

18. These states all prohibit assisted suicide by statute (Missouri, New Hampshire, Tennessee) or by common law or interpretation of the state homicide law (Vermont, West Virginia), except Nevada, which has no clear law on the matter. In 1998 the DEA rankings on morphine use for the other three states without a clear ban were 40th (Wyoming), 48th (Utah), and 49th (Hawaii).

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Affirming an ethic that all human life is inherently valuable

PAIN RELIEF PROMOTION ACT OF 1999
TESTIMONY OF PHYSICIANS FOR COMPASSIONATE CARE
TO
SUBCOMMITTEE ON THE CONSTITUTION
COMMITTEE ON THE JUDICIARY
U.S. HOUSE OF REPRESENTATIVES

JUNE 24, 1999

SUMMARY STATEMENT

Physicians for Compassionate Care, an organization providing education about pain relief and palliative care, urges passage of the Pain Relief Promotion Act of 1999. The need for education on state-of-the-art pain management and palliative care is overwhelming. Individual medical organizations cannot do it alone. A nationwide and federally sponsored educational effort is required. This proposed legislation goes a long way toward helping doctors and nurses meet the needs of suffering patients.

The Pain Relief Promotion Act clarifies to law enforcement officers, as well as to physicians, nurses, and state medical boards, that provision of pain medicine is a legitimate medical practice, even if in rare instances there may be an added risk to a patient's life. That clarification will reassure doctors, nurses, and hospice workers that they need not fear while providing patients necessary care. Equally important, this legislation reconfirms that controlled substances may not be used intentionally to kill patients in any of the 50 states, as is currently the case in 49 states.

Assisted suicide and euthanasia inevitably interfere with pain management and palliative care. In Oregon, its rationed health plan for the poor denies payment for 171 needed services while it fully funds assisted suicide. Over 38% of Oregon Health Plan members report barriers to obtaining mental health services, yet assisted suicide costs the state as low as \$45, according to its own estimates. Oregon

insurance companies and health maintenance organizations (HMOs) generally limit two key elements of palliative care -- mental health and hospice care benefits. One Oregon HMO (Qual Med) caps in home palliative care (hospice) at \$1,000 while fully funding assisted suicide. Education of professionals and clarification that killing patients is not legitimate medical treatment will go a long way to assure improved care at the end of life.

Physicians for Compassionate Care urges passage of the Pain Relief Promotion Act of 1999 to protect patients and their doctors.

At each of Physicians for Compassionate Care's last two advanced pain and palliative care conferences national experts told our audiences that they could reassure their patients they do not need to die in unrelieved pain. Then, they proceeded to teach cancer doctors and nurses, hospice workers and psychiatrists, anesthesiologists and pain specialists state-of-the-art techniques available to make such a claim supportable.

Treatments for pain and other elements of suffering have improved dramatically over the past twenty years in the United States. Yet many, perhaps most, physicians and other health professionals remain unaware of the high success rate of recent advances in the use of pain-relieving drug regimens and procedures for control of severe pain in the seriously ill.

Conferences by voluntary organizations such as ours, however, cannot, by themselves, fill the gap between available treatments and knowledge of those treatments. Our Compassionate Care Conference will be joined by two additional conferences on palliative care of the seriously ill in the state of Oregon this fall. Yet the few hundred participants in these conferences pale by comparison to the over 8,000 physicians practicing in our small state alone, in addition to the thousands of nurses and hospice workers. Nationwide, the magnitude of the problem is staggering. Even broad ranging educational programs, such as those developed by the American Medical Association, are not enough. There is still woefully inadequate pain care training of most physicians. A national coordinated and funded effort is required to provide clinicians with the needed skills to alleviate the suffering of those ailing in our society. The Pain Relief Promotion Act goes a long way to provide the educational and research resources required to meet the physical, psychological, social, and spiritual needs of suffering individuals.

AGGRESSIVE PAIN MANAGEMENT IS LEGITIMATE

The Pain Relief Promotion Act wisely emphasizes that aggressive pain management is a legitimate medical use of controlled substances, even if, in rare circumstances, such treatment may increase the risk of death. This reassurance is entirely compatible with the long-standing ethics and practices of virtually all medical organizations, including the American Medical Association. In the vast majority of cases, it is fairly easy, given some degree of prudence, to ascertain that aggressive pain care will not kill the patient. It usually takes many fold the dose of an opioid to suppress respiration that it takes to alleviate pain or cause drowsiness, and there is medication available rapidly to reverse an inadvertent excessive dose of such medicines. Nevertheless, rarely and under extreme circumstances, pain medicines can pose some unwanted risk to life. This bill protects physicians, nurses, and patients in the event of such a circumstance.

Some proponents of assisted suicide have tried to portray this time-honored distinction between a rare, unintended death and intentional euthanasia or assisted suicide as arbitrary or disingenuous. Nothing could be further from the truth. Both doctors and patients historically have relied upon the clarity of the doctor's intention to comfort but never kill as a guiding principle. Religion and the law have adopted the same principle. In 1997, the United States Supreme Court reaffirmed that intent is a valid and verifiable legal concept. It declared in *Vacco v. Quill et al.* that "... in some cases, pain killing drugs may hasten a patient's death, but the physician's purpose and intent is, or may be only to ease his patient's pain. A doctor who assists a suicide, however, 'must necessarily and indubitably, intend primarily that the patient be made dead.'" The Supreme Court went on to emphasize that, "The law has long used actors' intent or purpose to distinguish between two acts that may have the same result." The distinction is clear enough. It is not possible to write a prescription for 90 barbiturates to be taken all at once, as has been the case in

nearly all Oregon assisted suicides, without intending to kill the patient. In such a case, the intent is clear. Fortunately, most doctors have no such intention and do not prescribe 90 barbiturates to be taken at once or 20 to 50 times the patient's most recent morphine dose to be injected quickly. The intention of the vast majority of doctors in prescribing pain medicine is clear enough, also. It is to alleviate suffering but never to kill. The Pain Relief Prevention Act makes this distinction clearly. It thereby protects doctors from inadvertent prosecution, even investigation, in all 50 states.

Apparent attempts by some to obscure this distinction make the need to educate law enforcement personnel, as well as health professionals, all the more pressing. The Pain Relief Promotion Act provides for the education of both law enforcement personnel and regulatory bodies.

Some public safety dangers inherent in leaving unclear the distinction between legitimate medical procedures and assisted suicide, as does the June 5, 1998 opinion of U.S. Attorney General Janet Reno, have been outlined in my previous testimony before this Subcommittee, July 14, 1998. Some additional public dangers, which have come to light in the past year, will be mentioned here.

ASSISTED SUICIDE CANNOT BE CONTROLLED

The United States Supreme Court, as discussed in its 1997 decision, *Washington et al. v. Glucksberg*, discovered that "...it turns out that what is couched as a limited right to 'physician assisted suicide' is likely, in effect, a much broader license, which could prove extremely difficult to police and contain." Once intentional killing using controlled substances is accepted, it becomes nearly impossible to prosecute virtually any killing in the medical setting. That is certainly the case in the Netherlands where non-voluntary killing in the medical setting is common and well documented (Hendin et al., 1997). And a similar inability is already apparent in Oregon.

When Patrick Matheny, received through the mail a huge quantity of barbiturates prescribed by his assisted-suicide doctor and undertook his assisted suicide with no doctor in attendance, just this year, he had difficulty swallowing the large number of bitter pills, because of his medical condition. He could not complete his attempt and tried again the next morning. After he could not complete the second attempt, his brother-in-law said he "helped" him die and complained that Oregon's suicide law discriminates against those who cannot swallow (Barnett, 1999a; Filips, 1999; Reinhard, 1999). The body was cremated before the day was out; consequently, no autopsy could ascertain the cause of death. Doctors and other citizens demanded that the prosecutor investigate the death, because illegal suffocation of the patient has been the most frequent method of "helping" patients whose attempts fail. The Coos County prosecutor, however, refused to pursue the case, apparently without ever questioning the only witness, and while making comments that individuals who are disabled by being unable to swallow should have the right to assisted suicide, as long as they are otherwise qualified (Barnett, 1999b). It is clear that the assistance the prosecutor had in mind could include either the plastic bag or lethal injection.

In response to further inquiry about this case from Oregon state Senator Bryant, Oregon's Deputy Attorney General issued an opinion (attached) indicating that lethal injection may need to be accepted once assisted suicide is accepted, because Oregon's assisted suicide law does not provide equal access to its provisions by disabled people who cannot swallow and may violate the Americans with Disabilities Act (American Medical Association, 1999). He issued this opinion much to the dismay of advocates for the disabled in Oregon.

An even more blatant failure to investigate and prosecute illegal killing in the medical setting was the Gallant case, in which a Corvallis doctor was found by the Oregon Board of Medical Examiners clearly to have ordered a lethal injection for an elderly woman who did not even request it (Barnett, 1999c). Nevertheless, the Eugene district attorney declined to prosecute him, because he did not think he could get a conviction in this state with its official sanctioning of assisted suicide. The public danger of this inability to "police and contain" assisted suicide, once it becomes an accepted use of controlled substances, is in marked contrast to Michigan. In that state, laws disallowing assisted suicide and euthanasia as legitimate uses of controlled substances were clarified and conviction of Jack Kevorkian became possible, thereby stopping a series of pseudo-medical killings of individuals, some of whom had no evidence of physical disorder whatsoever and many of whom were undoubtedly depressed.

ASSISTED SUICIDE INTERFERES WITH MEDICAL OVERSIGHT

Oregon's assisted suicide law makes it illegal for voluntary medical organizations, such as the American Medical Association and the American Nurses Association, even to criticize or censure their own voluntary members for breaking a code of ethics to which all members have voluntarily subscribed. That is, it is illegal for any medical organization or even individual health care provider in Oregon to censure, even to criticize a colleague for the unethical act of assisted suicide. This attempt forcefully to legitimize assisted suicide by depriving voluntary medical organizations of their essential self-monitoring function undermines the basis of enforcing medical ethics requirements and thereby endangers the public safety. Physicians for Compassionate Care considers this interference to be an abridgment of the free speech rights of our members.

The void created by removal of the freedom and responsibility of medical organizations to self-monitor in this life and death area of medicine endangers the public health and safety and requires clarification of the Controlled Substances Act, as well as improved education of health care professionals, regulatory bodies, and law enforcement personnel. The Pain Relief Promotion Act goes a long way to meet this need.

FAILURE OF REPORTING

The people of Oregon were told that government reports about assisted suicide were somehow going to function as a safeguard for assisted suicide. They have failed to provide protection.

There is no penalty for doctors who do not report, and it is undoubtedly true in Oregon, as it is in the Netherlands, that the majority of doctors who participate in assisted suicide or euthanasia do not submit reports. Since the state of Oregon has devalued human life by accepting assisted suicide for some citizens (Hamilton et al., 1998), many Oregon doctors have been impressed that the number of illegal and unreported killings in the medical setting are increasing dramatically here as they have in the Netherlands.

What reports there are, such as the Oregon Health Division report of the first 15 cases (Chin et al., 1999), seem to base their claims more on a lack of information than on clear data (Associated Press, 1999; Foley and Hendin, 1999; and Oregonian, 1999). For example, the report claims depression played no part in the first 15 cases when the medical literature (Hendin et al., 1998; Hamilton and Hamilton, 1999 -- attached) documents that the first publicly reported case was diagnosed as depressed. She was nevertheless given assisted suicide by her Compassion in Dying doctors in less than three weeks. Still, the report claims depression was not a factor. The report also claims economic factors did not influence patients contrary to an *Oregonian* (Barnett, 1999d) verification that economic factors did motivate at least one of those cases. Clearly, the report provides little useful information and its reassuring conclusions far overreach the data. Dr. Kathleen Foley, Professor at Sloan Kettering, and Dr. Herbert Hendin, Professor at New York Medical College, have contributed a scholarly and up-to-date discussion of this report in the *Hastings Center Report* (1999).

ECONOMIC PRESSURES TO COMMIT SUICIDE

The state of Oregon moved swiftly to fund assisted suicide for the poor on its health care plan, despite protests from groups representing the poor and disabled. Oregon's rationed health plan denies payment for 171 needed services (Rojas-Burke, 1999a) while it fully funds assisted suicide and gives it priority over the treatment of psychological adjustment disorders and some curative treatments for cancer. Yet assisted suicide can cost the state as little as \$45, according to its own estimates.

Over 38% of Oregon Health Plan members report barriers to obtaining mental health services (Rojas-Burke, 1999b), and within weeks of the assisted suicide law being implemented, Oregon state Senator Jeannette Hamby (1998) complained that the state placed barriers in the way of funding for state-of-the-art psychiatric medicines for the poor. Many private Oregon insurance companies have skirted federal laws forbidding discriminatory dollar limits on mental health benefits by translating those

dollar limits directly into number of visits; and Oregon, unlike many states, has failed to provide parity for mental health care (Rojas-Burke, 1999c,d). The treatment of depression is a central aspect of palliative care for the seriously ill. Yet limits on funding for mental health care and poor access to that care, along with the state of Oregon calling suicide a "dignified" death and paying for suicide, herds the seriously ill who become discouraged toward suicide. This result of economic policies may not be intended by well intentioned health policy planners, but the result is the same -- the poor and disabled are herded toward suicide, instead of toward good palliative care which includes treatment of depression, as well as pain.

Most hospice care in Oregon is either capitated or has a total limit. In addition to economic pressures created by these limits, there are other, more subtle barriers to good hospice care. For example, despite the fact that radiation therapy for primary brain tumors or metastases has a greater than 50% chance of decreasing pain and improving function, "Radiation therapy is considered an active antitumor treatment, and because hospices have a daily capitated rate, most patients must give up the hospice benefit to receive radiation therapy" (Foley, 1999, p. 1941). Such a barrier can place a patient in an agonizing dilemma, when assisted suicide becomes an allowed use of controlled substances.

A doctor from one Oregon HMO, Kaiser, mentioned in their recent conference titled, "When the Diagnosis is Terminal," that four of the few patients mentioned in the Oregon Health Division report were Kaiser patients. (The Health Division report contained no data on what kind of insurance patients had; so these four Kaiser patients were not previously known). These four early deaths must have saved the Kaiser HMO thousands of dollars; as a conference participant observed, "It is always cheaper to kill the patient." Even more blatantly, one Oregon HMO (Qual Med) caps in home palliative care at \$1,000 while fully funding assisted suicide. It was confirmed with an Oregon hospice director, Karen Bell, just a few weeks ago that this cap continues to be enforced despite repeated public complaints by Physicians for Compassionate Care. The vice-president and legal counsel for this same large, Oregon HMO even went so far as to write an opinion piece only a few weeks after implementation of the suicide law titled, "What Price Dying? The Debate over How to Die Now Can Shift to How Much Money We Think It's Worth" (Falk, 1998), implying throughout the article that care of the seriously ill, who may be near the end of life, might be an unnecessary extravagance which society can no longer afford.

While most managers of health care dollars probably do not intend to drive people toward suicide to save money, once assisted suicide is allowed as an accepted use of controlled substances, the result is that their decisions do just that. Restrictive economic decisions combined with allowing controlled substances to be used for patient suicides jeopardizes good palliative care, including pain care and treatment of depression, and thereby creates a public danger. The Pain Relief Prevention Act does much to alleviate this danger to the public health.

CONCLUSION

The need for improved education and research to promote pain and palliative care is overwhelming. As documented by the Oregon Pain and Symptom Management Task Force (1999), lack of education for physicians, nurses, law enforcement personnel and regulatory bodies, along with economic factors, create significant "barriers" (pp. 4-5) to provision of good pain care in the state of Oregon, like the vast majority of states. As the leader of an organization providing education about palliative care and pain relief, I can assure you that individual medical organizations cannot do it alone. Even large organizations, such as the American Medical Association with its fine educational project, needs assistance from medical schools, hospitals, hospices, specialty organizations and other medical education establishments. A nationwide and federally sponsored educational effort is required to enlighten practicing health professionals about the wonderful advances in pain and palliative care which lie unutilized. The Pain Relief Promotion Act of 1999 goes a long way toward helping doctors and nurses meet the physical, psychological, social, and spiritual needs of suffering patients.

This Act clarifies to physicians, nurses, and state medical boards, as well as to law enforcement personnel, that provision of pain medicine is a legitimate medical practice, even if in rare instances there may be an added risk to a patient's life. That clarification will reassure doctors, nurses, and hospice workers that they need not fear while providing patients necessary palliative care. Equally important,

this legislation clarifies that controlled substances may not be used intentionally to kill patients in any of the 50 states, as is already the case in 49 states. This clarification protects pain and other aspects of palliative care, including treatment of depression. It protects physicians and nurses. And it protects patients. Physicians for Compassionate Care urges you to support the Pain Relief Promotion Act of 1999.

Respectfully submitted,

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ATTACHMENTS

1. Schuman, D. (1999). Oregon State Justice Department Letter to Oregon State Senator Bryant, March 15, 1999.
2. Hamilton, N.G. (1999). "Therapeutic Response to Assisted Suicide Request." *Bulletin of the Menninger Clinic* 63:191-201.

REFERENCES

- American Medical Association (1999). "How Assisted Can Suicide Be? Oregon Controversy." *American Medical News*, April 12, 1999, p. 19.
- Associated Press (1999). "Group Criticizes Oregon's Assisted-Suicide Report." *Oregonian*, February 26, 1999.
- Barnett, E.H. (1999a). "Man with ALS Makes up his Mind to Die." *Oregonian*, March 11, 1999, p. D1.
- Barnett, E.H. (1999b) "Coos County Drops Assisted-Suicide Inquiry." *Oregonian*, March 17, 1999, p. D1.
- Barnett, E.H. (1999c). "Court of Appeals Affirms Decision against Physician: The Case Involves a Corvallis Internist Who Allowed a Nurse to Give a Dying and Comatose Patient a Lethal Drug Injection." *Oregonian*, April 3, 1999, p. B6.
- Barnett, E.H. (1999d). "Dealing with an Assisted Death in the Family: The Adult Children of a Woman Who Used Oregon's Suicide Law Talk about Conflicted Feelings." *Oregonian*, February 21, 1999, pp.G1&2.
- Chin, A.E., Hedberg, K., Higginson, G.K. et al. (1999). Legalized physician-assisted suicide in Oregon -- First Year's Experience. *New England Journal of Medicine* 340:577-583.
- Falk, T.C. (1998). "What Price Dying? The Debate over How to Die Now Can Shift to How Much Money We Think It's Worth." *Oregonian*, December 31, 1997.

Filips, J. (1999). "Difficult Suicide Magnifies Debate: Death: A Coos Bay Man Needs Help Ingesting Lethal Drugs, which Some See as a Step toward Euthanasia." *Eugene Register-Guard*, March 14, 1999, pp. 9-10D.

Foley, K. (1999). "A 44-Year-Old Woman with Severe Pain at the End of Life." *Journal of the American Medical Association* 281:1937-1945.

Foley, K. and Hendin, H. (1999). "The Oregon Report: Don't Ask, Don't Tell," *Hastings Center Report* 29:37-42.

Hamby, J. (1998). "The Enemy Within: State Bureaucratic Rules Threaten the Spirit of Oregon Health Plan's Founding Principles." *Oregonian*, January 21, 1998.

Hamilton, N.G. and Hamilton, C.A. (1999). "Therapeutic Response to Assisted Suicide Request," *Bulletin of the Menninger Clinic* 63:191-201.

Hamilton, N.G., Edwards, P.J., Boehnlein, J.K., and Hamilton, C.A. (1998). "The Doctor-Patient Relationship and Assisted Suicide: A Contribution from Dynamic Psychiatry." *American Journal of Forensic Psychiatry* 19:59-75.

Hendin H., Rutenfrans C., and Zylicz, Z. (1997). "Physician-Assisted Suicide and Euthanasia in the Netherlands: Lessons from the Dutch." *Journal of the American Medical Association* 277:1720-1722.

Hendin, H., White, M. and Foley, K. (1998). "Physician-Assisted Suicide: Reflections on Oregon's First Case." *Issues in Law & Medicine* 14:243-270.

Oregon Pain and Symptom Management Task Force (1999). "Report to the Seventieth Oregon Legislative Assembly and Governor John Kitzhaber," January, 1999.

Oregonian (Editor) (1999). "Don't Ask, Don't Tell: State Report on the First Year of Assisted Suicide May Be Most Notable for the Things It Doesn't Say." *Oregonian*, February 22, 1999, B6.

Reinhard, D. (1999). "Measure 16: Compassion in Killing: Despite the Promises of Advocates for Assisted Death and Measure 16, Oregon Skids down Slippery Slope with Latest 'Suicide' in Coos Bay." *Oregonian*, March 14, 1999.

Rojas-Burke, J. (1999a). "Oregon's Poor Slip from Safety Net of Health Coverage: Although More Money Went to the Oregon Health Plan, the Percentage of Uninsured Poverty-Level Residents Climbed Last Year to 23 Percent." *Oregonian*, March 29, 1999, pp. A1&9.

Rojas-Burke, J. (1999b). "Survey Gives Oregon Health Plan High Marks." *Oregonian* February 3, 1999, p. B15.

Rojas-Burke, J. (1999c). "Insurers Still Unfair with Mentally Ill, Study Says: Despite a Law Meant to Curb Coverage Bias, the Share of Plans Limiting Office Visits and Hospital Stays for Mind Disorders Jumps." *Oregonian*, April 30, 1999, pp. D1&5.

Rojas-Burke, J. (1999d). "Senate Bill Proposes Increase in Mental Health Benefits." *Oregonian*, June, 19, 1999, pp. D1&9.



AMERICAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS®

Pharmacists in health systems helping people make the best use of medications

Statement to the United States Senate Committee on the Judiciary

Re: S. 2151, the "Lethal Drug Abuse Prevention Act of 1998"

Submitted by the American Society of Health-System Pharmacists

July 31, 1998

The American Society of Health-System Pharmacists (ASHP) opposes the enactment of S. 2151, the "Lethal Drug Abuse Prevention Act of 1998," sponsored by Senator Don Nickles. ASHP is the 30,000-member national professional association that represents pharmacists who practice in hospitals, health maintenance organizations, long-term care facilities, home care, and other components of health care systems.

ASHP, like many organizations representing health care professionals, has struggled with the issue of physician-assisted suicide. At ASHP's annual meeting, held in June 1998, the House of Delegates took an important first step in addressing the controversial issue of physician-assisted suicide by adopting official ASHP policy recognizing a pharmacist's right to conscientiously object to morally, religiously, or ethically troubling therapies -- including physician-assisted suicide. In addition, ASHP has adopted policies to address appropriate pain management and care for dying patients. These ASHP policies are attached.

As advocates of humane and compassionate end-of-life care, ASHP's principal concern is for the comfort and safety of the patient. Although ASHP currently has no official policy that either condones or condemns the practice of physician-assisted suicide, we believe that passage of S. 2151 will have a negative impact on the ability of pharmacists to provide dying patients with necessary pain management therapies.

S. 2151 amends the federal Controlled Substances Act (CSA) to prohibit the intentional dispensing of controlled substances for the purpose of assisted suicide. ASHP recognizes that the language of S. 2151 seeks to protect the dispensing of drugs for the purposes of pain management, even if the drugs increase the risk of death, as long as they are not provided with the intent of causing or assisting a person's death. However, ASHP remains concerned that enactment of S. 2151 would leave physicians, pharmacists, and other health care professionals fearful that the dispensing of pain medications could result in Drug Enforcement Administration (DEA) sanctions -- even when death was unintended.

ASHP Statement Regarding S. 2151

July 31, 1998

Page 2

ASHP's greatest concern regarding S. 2151 is not that pharmacists will be held responsible for dispensing potentially lethal medications, but rather that the prescribing and dispensing of critically needed aggressive pain therapies intended for dying patients will be avoided altogether.

ASHP would also like for members of the Judiciary Committee to be aware of another significant concern with S. 2151 as currently drafted. Because it is the *pharmacy facility*, and not the *individual pharmacist*, that is registered by the DEA, the actions of an individual pharmacist that are perceived to be in violation of S. 2151 would jeopardize the provision of care in the entire *health system* (i.e., hospital, home health agency, ambulatory care center, etc.). If the DEA registration is suspended or revoked, a hospital, for example, could not administer controlled substances to patients. In effect, the hospital could not continue to operate. We ask that members of the Judiciary Committee consider the impact that this would have on the delivery of health services in many communities.

Finally, ASHP has strong concerns with the interference in the practice of pharmacy at the state level that would be created by S. 2151. ASHP believes that state boards of pharmacy are the appropriate regulatory bodies to ensure public health and safety. ASHP is especially concerned with the creation of a Medical Review Board on Pain Relief that is created by S. 2151. Such a national review board will be charged with determining whether the actions of a pharmacist or other health care professional under investigation constitute the "appropriate means to relieve pain." ASHP believes that this function does not focus on whether or not the *intent* of the pharmacist or physician's action was to cause or assist in causing the death of an individual, but rather focuses on what constitutes the legitimate practice of medicine. ASHP does not believe that it is sound public policy to establish a national board charged with second-guessing the clinical decisions of physicians and pharmacists.

ASHP is grateful for the opportunity to submit its views in writing on this controversial subject. Questions regarding ASHP's policy in this area should be directed to Ellen C. Evans, Government Affairs Associate, Government Affairs Division, 301-657-3000, ext 1326.



ASHP Policy Regarding Conscientious Objection to Morally, Religiously, or Ethically Troubling Therapies

ASHP recognizes a pharmacist's right to conscientious objection to morally, religiously, or ethically troubling therapies and supports the establishment of systems that protect the patient's right to obtain legally prescribed and medically indicated treatments while reasonably accommodating the pharmacist's right of conscientious objection.

ASHP Policies Regarding Pain Management, Care for Dying Patients

- **Pain management**

To advocate for fully informed patient and caregiver participation in pain management decisions as an integral aspect of pharmaceutical care: further.

To support any advancements in treatment that result in improved control of pain, especially relief of chronic intractable pain: further.

To work with other health care organizations in fostering improved pain management: further.

To increase ASHP's efforts in offering educational programs on contemporary pain management therapies and techniques.

- **Educating pharmacists to provide appropriate support for dying patients**

To provide education to pharmacists on caring for dying patients, including education on clinical, managerial, professional, and legal issues: further.

To urge the inclusion of such topics in the curricula of colleges of pharmacy.

- **Appropriate pharmacy support for dying patients**

To support the position that care of dying patients is part of the continuum of pharmaceutical care that pharmacists should provide to patients; further.

To support the position that pharmacists have a professional obligation to work in a collaborative and compassionate manner with patients, family members, caregivers, and other professionals to help fulfill the pharmaceutical care needs -- especially the quality-of-life needs -- of dying patients of all ages: further.

To support research on the needs of dying patients.

Adopted June 1998



Secretariat for Pro-Life Activities

3211 Fourth Street, N.E. Washington, DC 20017-1194 (202) 541-3070 FAX (202) 541-3054

October 4, 2000

Dear Senator:

As the 106th Congress nears its end, it must deal with much unfinished business. The most critically important of these is the long overdue task of passing the Pain Relief Promotion Act (H.R. 2260, S. 1272), to clarify the federal government's policy on pain management and assisted suicide.

This Act would restore the uniform application of federal drug laws, so the authority of the Drug Enforcement Administration (DEA) is no longer invoked in any state to promote suicides using lethal overdoses of federally controlled drugs. It would also promote use of these drugs for pain management, providing a clearer and more explicit "safe harbor" in the federal Controlled Substances Act even when the use of large doses of these drugs for pain control may increase the risk of death. Thus the medical-moral principle of "double effect" will be formally affirmed in federal drug laws – as it has been affirmed in many state laws on assisted suicide, and in all other federal programs through the Assisted Suicide Funding Restriction Act of 1997, with very positive effects on palliative care.

A great deal of misinformation has been disseminated to media, medical groups and Congress by those who want the federal government to continue facilitating assisted suicides in Oregon. Medical groups which oppose all laws against assisted suicide – American Pharmaceutical Association, state medical societies in Rhode Island and Vermont, etc. – have worked with Oregon Death with Dignity and other suicide advocacy groups to appeal to physicians' fears of federal scrutiny and legal liability. They have misrepresented the Pain Relief Promotion Act as a new grant of authority to the DEA, as an unwarranted intrusion into medical practice that will have a "chilling effect" on physicians' willingness to relieve pain. In response we offer the following observations:

1. The proposed Act does not create federal scrutiny over physicians but reins it in. Ample documentation is available on this point. Everything that opposing groups say would be introduced into federal policy by the proposed Act has already been in place for many years under the Controlled Substances Act.

2. The charge is not new, but is the standard argument made for years by medical and other groups opposing laws against assisted suicide. The same charges about a "chilling effect" on pain control were made by the Rhode Island Medical Society in 1996 to oppose a ban on assisted suicide in that state. When the law passed despite these objections, use of morphine for pain control in Rhode Island more than doubled; the state rose from 46th rank among states in use of morphine up to 18th in one year. Other states have seen similar results. The current ban on assisted suicide in all federal health facilities, which Congress adopted in 1997 (with language on "double effect" similar to that found in the proposed Act), has led to dramatic improvements in palliative care in Veterans Administration hospitals. Assisted suicide proponents had testified against that bill as well, insisting that it would have a "chilling effect" on end-of-life care.

3. This Act is strongly supported by the American Medical Association, National Hospice and Palliative Care Organization, American Pain Society, Hospice Association of America, American Academy of Pain Medicine, American Academy of Pain Management and other medical and hospice organizations. These groups are fiercely protective of health professionals' right and duty to offer effective pain management. *All* of them unhesitatingly opposed a previous bill to end federal support of assisted suicide in 1998, because they feared it may have had an adverse effect on pain management. They support the present Act because it was drafted to their specifications, to ensure that the Act's impact on pain control and hospice care will be completely positive.

4. Coordinating the campaign against the proposed Act is the American Pain Foundation, a small Baltimore-based group funded by major drug companies and billionaire assisted suicide proponent George Soros. When asked what change in the Act would address its concerns about a "chilling effect" on pain control, the APF demanded deletion of one sentence in the section providing a safe harbor for pain management: "*Nothing in this section authorizes intentionally dispensing, distributing, or administering a controlled substance for the purpose of causing death or assisting another person in causing death.*" APF's position, in effect, is that if the federal government provides legal protection for cases where use of pain control drugs may "increase the risk of death," it *must* protect cases where the drugs are deliberately used to kill patients. That is, federal policy is not allowed to distinguish pain control from assisted suicide, but should promote both. If this is not a pro-assisted-suicide position, I do not know what is.

Some have claimed that other bills on end-of-life care, such as Senator Wyden's "Conquering Pain Act," may achieve the benefits of this legislation without broaching the controversial issue of assisted suicide. This is untrue. Senator Wyden has refused to clarify his bill's definition of palliative care to *exclude* assisted suicide. His staff has confirmed that when his bill is implemented in a state like Oregon, whose Medicaid program defines "comfort care" to include assisted suicide, its programs will follow the state definition. By avoiding mention of assisted suicide, the Wyden bill would maintain and increase federal promotion of that practice.

Others say Congress has higher priorities in its last days, such as prescription drug coverage. With due respect for concerns about the cost of prescription drugs, a very serious issue in its own right, it is absolutely essential to decide whether these drugs will be used to heal and comfort or to kill.

The need for legislation improving pain management and other aspects of end-of-life care is enormous, and will not be exhausted by one bill. We will be happy to work with a broad array of medical and other groups in the 107th Congress to continue to address these issues. But first, the federal government must stop supplying the means for intentionally causing the deaths of vulnerable patients. Please do not adjourn without passing the Pain Relief Promotion Act.

Sincerely,



Gail Quinn
Executive Director

Justice Dept in medical marijuana case argues that federal govt has its own standard for legitimate medical

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE WILLIAM H. ALSUP, JUDGE

MARCUS CONANT, M.D., ET AL.,)

PLAINTIFFS,)

VS.)

NO. C 97-0139 WHA

BARRY R. MC CAFFREY,)
DIRECTOR, ET AL.,)

DEFENDANTS.)

SAN FRANCISCO, CALIFORNIA
THURSDAY, AUGUST 3, 2000

TRANSCRIPT OF PROCEEDINGS

APPEARANCES:

FOR PLAINTIFFS: AMERICAN CIVIL LIBERTIES UNION
FOUNDATION

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BY: GRAHAM BOYD
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BY: JONATHAN WEISSGLASS
ATTORNEY AT LAW

(APPEARANCES CONTINUED ON FOLLOWING PAGE)

REPORTED BY: JO ANN BRYCE, CSR, RPR, RMR, CRR
OFFICIAL REPORTER, USDC

COMPUTERIZED TRANSCRIPTION BY ECLIPSE

1 IN THE PUBLIC FORUM, NOT IN THE COURTS.

2 THE COURT: ALL RIGHT. BUT, ALL RIGHT, TAKE EXACTLY
3 THAT SITUATION, THAT THE -- TAKE THE HYPOTHETICAL WE WERE
4 THINKING ABOUT EARLIER. SOMEONE COMES INTO THE EXAMINATION
5 ROOM. THE DOCTOR CONCLUDES THAT THEY'RE VERY THIN. THEY NEED
6 TO EAT. THEY HAVE NO APPETITE. IT'S PAINFUL TO EAT. THE
7 DOCTOR THINKS AS A MATTER OF MEDICAL NECESSITY MARIJUANA IS THE
8 MOST EFFICACIOUS TREATMENT AND RECOMMENDS IT.

9 MR. LOBUE: YES.

10 THE COURT: ALL RIGHT. SO AT THAT POINT YOU THINK
11 THEY'VE DONE ENOUGH TO HAVE THEIR LICENSE REVOKED?

12 MR. LOBUE: THEIR LICENSE -- THEIR REGISTRATION TO
13 DISPENSE CONTROLLED SUBSTANCES, YES, FOR TWO REASONS. THROUGH
14 THAT RECOMMENDATION THEY HAVE EXPOSED THAT PATIENT TO A
15 SUBSTANCE WHICH HAS BEEN FOUND NOT TO MEET THE REQUIREMENTS FOR
16 USE IN THE MEDICAL PRACTICE, OKAY.

17 THE COURT: BUT --

18 MR. LOBUE: IT'S BEEN PROHIBITED BY FEDERAL LAW.

19 THE COURT: BUT THAT'S CALIFORNIA'S JUDGMENT CALL;
20 ISN'T IT?

21 MR. LOBUE: THAT IS NOT CALIFORNIA'S JUDGMENT TO
22 MAKE. THIS IS NOT SWITZERLAND. THIS IS NOT CANADA. THERE IS
23 A NATIONAL STANDARD HERE, AND THE NATIONAL STANDARD SAYS THAT
24 YOU CANNOT USE SCHEDULE I CONTROLLED SUBSTANCES, DOCTORS CANNOT
25 USE SCHEDULE I CONTROLLED SUBSTANCES IN THEIR MEDICAL PRACTICE

1 PERIOD, NOTWITHSTANDING WHATEVER THE STATE OF CALIFORNIA SAYS.
2 THAT'S THE FEDERAL REQUIREMENT. THAT'S WHAT APPLIES HERE.

3 SO THAT DOCTOR DOESN'T HAVE THE DISCRETION TO DECIDE
4 WHAT DRUG TO USE. HE CAN DECIDE WHAT DRUG TO USE ONLY AMONGST
5 LEGAL DRUGS, DRUGS THAT HAVE BEEN APPROVED BY THE FOOD AND DRUG
6 ADMINISTRATION. HE CANNOT SUGGEST, RECOMMEND, ADVISE HIS
7 PATIENT TO USE LSD TO TREAT A MEDICAL CONDITION. IT'S
8 PROHIBITED. IT'S SIMPLY NOT PERMITTED TO BE USED.

9 WHEN A PRACTITIONER COMES IN AND GETS HIS
10 REGISTRATION, HE'S PERMITTED TO PRESCRIBE ONLY SCHEDULE II
11 THROUGH SCHEDULE V DRUGS. HE CANNOT -- HE IS NOT AUTHORIZED --
12 NO ONE IN THE UNITED STATES IS AUTHORIZED TO PRESCRIBE SCHEDULE
13 I DRUGS. HE CANNOT USE IT IN HIS MEDICAL PRACTICE.

14 THE COURT: SO YOU'RE SAYING THAT THE FEDERAL
15 GOVERNMENT HAS THE POWER TO REGULATE THE PRACTICE OF MEDICINE.

16 MR. LOBUE: TO THAT EXTENT, IN THE UNITED STATES
17 VERSUS MOORE, THE SUPREME COURT SO HELD THAT WE CAN CONFINE THE
18 MEDICAL PRACTICE WITHIN ACCEPTED LIMITS. THOSE ACCEPTED LIMITS
19 IN THIS CIRCUMSTANCE HAVE BEEN SET BY CONGRESS.

20 THE COURT: U.S. V. MOORE, THE CITE ON THAT IS WHAT?

21 MR. LOBUE: IT'S A SUPREME COURT CASE, 423 U.S. 123,
22 DISCUSSED IN OUR REPLY BRIEF PAGES 9 AND 12. ←

23 THE COURT: THANK YOU.

24 MR. LOBUE: AND THE NINTH CIRCUIT HAS ALSO RULED
25 THAT THE UNITED STATES UNDER THE COMMERCE LAWS HAS AUTHORITY TO

1 PUBLIC HEALTH AND SAFETY. AND WHAT WE'RE SAYING IS, WHEN A
2 DOCTOR GOES OUT AS PART OF HIS MEDICAL PRACTICE AND RECOMMENDS
3 TO HIS PATIENT THAT HE USE HEROIN, HE'S CREATING A THREAT TO
4 PUBLIC HEALTH AND SAFETY.

5 THAT PATIENT MIGHT FOLLOW THAT RECOMMENDATION. AS A
6 MATTER OF FACT, MOST OF THE TIME PATIENTS DO. MOST OF THE TIME
7 WHEN A DOCTOR TELLS YOU THAT THE BEST THING FOR YOU IS TO TAKE
8 THIS DRUG, WE ACCEPT IT ON FAITH. HE KNOWS WHAT HE'S TALKING
9 ABOUT.

10 THE COURT: ALL RIGHT. WITH RESPECT TO FACTOR FIVE,
11 IF A DOCTOR DID WHAT WE SUGGESTED IN THE HYPOTHETICAL --

12 MR. LOBUE: RIGHT.

13 THE COURT: -- AND LET'S SAY THEY DID IT IN A STATE
14 WHERE THERE WAS A LAW LIKE THE COMPASSIONATE USE ACT, YOUR
15 POSITION, I TAKE IT, WOULD BE, WELL, THE CONDUCT WHICH AFFECTS
16 PUBLIC HEALTH AND SAFETY IS THE RECOMMENDATION TO USE
17 MARIJUANA --

18 MR. LOBUE: YES.

19 THE COURT: -- EVEN THOUGH IN THAT PARTICULAR STATE,
20 LET'S ASSUME THAT NOT ONLY DOES STATE LAW RECOGNIZE IT BUT
21 LET'S ASSUME THE MEDICAL AUTHORITIES IN THAT STATE WERE TO SAY
22 THIS IS DIFFERENT THAN HEROIN, THIS IS -- HAS ENOUGH OF A TRACK
23 RECORD TO BE RECOGNIZED.

24 MR. LOBUE: RIGHT. RIGHT. WE DON'T -- WE DON'T --
25 WE WOULD APPLY IT IN OKLAHOMA IF THEY HAD A LAW; WE WOULD APPLY

1 IT IN KANSAS IF THEY DIDN'T HAVE A LAW. THE EFFECT IS THE
2 SAME. THE PUBLIC HEALTH PROBLEM IS THE SAME. HE IS CREATING A
3 RISK TO THAT PATIENT, NUMBER ONE; BUT MORE THAN THAT, HE'S
4 EXACERBATING THE VERY PUBLIC HEALTH PROBLEM THAT LED CONGRESS
5 TO ENACT THE CONTROLLED SUBSTANCES ACT BECAUSE IF THE PATIENT
6 FOLLOWS THAT RECOMMENDATION, HE HAS TO OBTAIN THE DRUG
7 SOMEWHERE. WHERE IS HE GOING TO OBTAIN IT BUT DRUG
8 TRAFFICKERS?

9 THE COURT: IS THERE ANY CASE LAW THAT CONSTRUES
10 FACTOR FIVE? YOU CITED ME TO THREE CASES, THE MOORE CASE,
11 TISOR AND ROSENBERG. BUT ARE THEY ON FACTOR FIVE?

12 MR. LOBUE: NO, THEY'RE ON THE CONTROLLED SUBSTANCES
13 ACT. WHAT THE SUPREME COURT SAYS IN MOORE IS THAT THROUGHOUT
14 THE CONTROLLED SUBSTANCES ACT THERE ARE PROVISIONS WHICH
15 CONGRESS INTENDED TO CONFINE MEDICAL PRACTICE WITHIN ACCEPTED
16 LIMITS. IT CONTROLS WHAT PAPERWORK THEY HAVE TO KEEP, WHAT
17 THEY CAN PRESCRIBE, HOW THE PRESCRIPTIONS ARE TO BE ISSUED.

18 FOR EXAMPLE, IN MOORE THE QUESTION WAS, DID THE
19 DOCTOR EXCEED THE SCOPE OF WHAT IS PERMITTED FOR MEDICAL
20 DOCTORS, WHICH WAS CLEARLY A DECISION ABOUT WHETHER THAT DOCTOR
21 ACTED APPROPRIATELY IN PRESCRIBING THE DRUGS, WHETHER THAT WAS
22 A PERMISSIBLE MEDICAL PRACTICE; AND IN THAT CASE, NO, IT
23 WASN'T. IT WAS AN EXCESSIVE AMOUNT OF A CONTROLLED SUBSTANCE
24 THAT HE WAS GIVING THIS PATIENT THEREBY KNOWING FULL WELL IT
25 WAS GOING TO BE ABUSED. AND THE SUPREME COURT SAID THE LAW,

1 THE FEDERAL LAW, COVERS IT. THE STATES DON'T GET TO DECIDE
2 THAT. THAT'S A FEDERAL QUESTION.

3 THE COURT: WE'RE RUNNING LOW ON TIME, BUT I WANT TO
4 GO BACK TO MY ORIGINAL QUESTION WHICH I'M STILL NOT CERTAIN I
5 UNDERSTAND YOUR POSITION.

6 WITH RESPECT TO THE NINTH CIRCUIT AND THE MEDICAL
7 NECESSITY --

8 MR. LOBUE: RIGHT.

9 THE COURT: -- THE NINTH CIRCUIT HAS SAID THERE IS A
10 DEFENSE BASED ON MEDICAL NECESSITY. AND I AM STILL NOT CLEAR
11 WHAT YOUR POSITION IS ON WHETHER A PHYSICIAN CAN -- HOW DOES
12 THE PATIENT PROVE UP THE MEDICAL NECESSITY? YOU WOULD THINK
13 ORDINARILY THEY'D GO TO A DOCTOR AND SAY, "WRITE ME A LETTER
14 LIKE YOU WOULD SO THAT I DON'T HAVE TO GO TO SCHOOL TODAY OR
15 WORK TODAY, WRITE A LETTER THAT SAYS I'VE LOOKED AT THIS
16 PATIENT, IT'S A MEDICAL NECESSITY THAT THEY USE MARIJUANA."

17 MR. LOBUE: RIGHT.

18 THE COURT: NOW, HOW ELSE WILL THAT PATIENT EVER --

19 MR. LOBUE: OKAY.

20 THE COURT: -- BE CLEAR THAT THEY HAVE THE MEDICAL
21 NECESSITY DEFENSE?

22 MR. LOBUE: I DON'T THINK A LETTER WOULD DO
23 ANYTHING. THEY WOULD HAVE TO BRING THE PHYSICIAN INTO COURT,
24 ALL RIGHT. THE PHYSICIAN WOULD HAVE TO TESTIFY THAT IN THIS
25 PARTICULAR PATIENT'S CASE IT WAS A MEDICAL NECESSITY UNDER

A5

THE OREGONIAN ♦ THURSDAY, OCTOBER 12, 2000

Lieberman favors banning assisted suicide

Sen. Joseph Lieberman said Wednesday that he still supports a bill in Congress that would overturn Oregon's physician-assisted suicide law, and the vice presidential candidate implied that he would urge Al Gore to sign the bill if Gore becomes president.

"I would, in the privacy of our relationship, offer (Gore) my point of view," Lieberman said. "But, of course, his decision prevails and will be my decision once he makes it."

Lieberman is a co-sponsor of a bill, which soon may be added to a spending measure in the Senate, that would prohibit doctors from prescribing federally controlled drugs to end a person's life.

Sen. Ron Wyden, D-Ore., has tried to block the bill by arguing that it would hinder a doctor's ability to treat a dying patient's severe pain. Gore has said he shares some of the same concerns but hasn't de-

cidated whether he would support the bill.

In an interview Wednesday in Hillsboro, Lieberman said he simply disagrees with Wyden.

"He is one of my best friends in the Senate," Lieberman said of Wyden. "This has been, you know, awkward for us."

But Lieberman said sponsors "did make some alterations to make as crystal clear as one can make in a legislative proposal that there is no liability for a doctor" who aggressively treats a dying person's pain — as long as there is no intent to cause death.

In a visit last month to Oregon, George W. Bush, the Republican presidential candidate, said he is opposed to doctor-assisted suicide and would sign the bill, which is being pushed by Sen. Don Nickles, R-Okla.

— Jeff Mapes