



Secretariat for Pro-Life Activities

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TO: Senate aides addressing the Pain Relief Promotion Act

FROM: Richard M. Doerflinger *RD*
Secretariat for Pro-Life Activities
National Conference of Catholic Bishops

RE: New DEA figures disprove claims of those defending the Oregon assisted suicide law

The U.S. Drug Enforcement Administration has released its figures on per capita use of morphine for the first half of 2000. **The findings disprove central claims of those who defend the Oregon assisted suicide law and attack the Pain Relief Promotion Act.**

Assisted suicide proponents claim that Oregon's legalization of assisted suicide has brought it to first place among states in use of morphine for pain control. Similarly, they argue that laws like the Pain Relief Promotion Act, preventing use of such drugs for assisted suicide, will inevitably have a "chilling effect" on use of such drugs for pain management.

The DEA figures prove that these claims are false.

Oregon, the only state to legalize assisted suicide, has dropped to **sixth** place among the states in morphine use since legalization. It ranked higher in some years immediately preceding legalization. And states that have **passed** laws like the Pain Relief Promotion Act – laws that distinguish intentional aid in suicide from aggressive pain control that may unintentionally increase the risk of death – have greatly **increased** their use of morphine for pain control. Surveys of patients' families in Oregon also show increases in untreated pain among the terminally ill since legalization.

Assisted suicide proponents have tried to explain this away. They claim that Oregon doctors undertreat pain because of the threat of legal liability posed by the Pain Relief Promotion Act. But this is ludicrous. Their claim has been that the federal Act poses this "threat" to pain control all over the country. Yet states with laws like the Pain Relief Promotion Act are enjoying dramatic improvements in pain control – even as Oregon's ranking founders.

Many of these critics oppose **any and all** laws against assisted suicide for the terminally ill. They use the "chilling effect" claim as a surrogate for their real and more ominous agenda. The time has come to shed light on the real issue: Should the federal government promote and approve assisted suicide through its program regulating legitimate use of controlled substances?

For more rebuttals of false claims against the Pain Relief Promotion Act, see www.passprpa.org and www.nccbuscc.org/prolife/issues/euthanas/teststate.htm.

Oregon's Ranking Among States in Per Capita Morphine Use

The facts do not support a claim that legalization of physician-assisted suicide has made Oregon a leader in use of pain medication. Its ranking among states in per capita use of morphine was higher in 1992, two years *before* legalization, than in some years following legalization.

1992 - 3rd highest use in the nation

1993 - 10th

1994 - 11th (year of the campaign to pass assisted suicide measure)

1995 - 3rd (measure approved but enjoined by court)

1996 - 2nd

1997 - 6th (law takes actual effect in November 1997)

1998 - 6th

1999 - 2nd

2000 - 6th (for first half of year, most recent available figures)

These figures do not show what the morphine is used for -- that is, whether all of it is used in Oregon for pain control or some for deliberate assisted suicides. Despite this fact, in 1997 and 1998 Oregon was outpaced in per capita morphine use by **five states** that have *not* legalized assisted suicide. Three of these ban it by statute (New Hampshire, Missouri and Arizona). One state (Vermont) bans assisted suicide by common law, and one (Nevada) has no clear law on assisted suicide. For the first half of 2000, the only change is that Missouri was replaced in the top five by Tennessee, which has banned assisted suicide by statute since 1993.

For 1999 the ranking of the states with no clear law on assisted suicide was:

Nevada - 4th

Wyoming - 38th

Utah - 44th

Hawaii - 51st.

New Hampshire, ranked first among states in morphine use in 1999, has repeatedly debated and rejected legalization measures in recent years, most recently by Senate vote in February 2000.

In 1996, **Iowa** and **Rhode Island** passed new **bans** on assisted suicide. Both states experienced significant *increases* in morphine use after enactment. Rhode Island more than doubled its rate of morphine use in one year; such use remains about twice what it was the year before the ban was enacted. **Tennessee**, which ranked 16th among states in 1992, passed an assisted suicide ban in 1993 with language on the "principle of double effect" like that found in the federal Pain Relief Promotion Act; it rose to 2nd highest morphine use in the first half of 2000.

Source of morphine data: Drug Enforcement Administration



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Reality Check on the Pain Relief Promotion Act

Installment #1: A Constitutional Problem?

Among the false claims made against the Nickles/Lieberman Pain-Relief Promotion Act is the argument that this bill raises a constitutional problem.

In a September 12 "Dear Colleague" letter, opponent Senator Ron Wyden distorts the meaning of the U.S. Supreme Court's 1997 decisions upholding laws against physician-assisted suicide. He says that "the justices *unanimously* ruled the States, not the Federal Government, should determine how best to address the issue of physician-assisted suicide"(emphasis in original).

The Supreme Court justices said nothing of the kind. The facts are as follows:

* In its 1997 decisions, the Court held that constitutional guarantees of due process and equal protection are not violated by laws banning assisted suicide. The Court said nothing here about the relative roles of state and federal legislatures in preventing the misuse of drugs for this practice. Reviewing ways in which legislators have exercised their legitimate authority to act against assisted suicide, the Court cited federal laws (e.g., the Assisted Suicide Funding Restriction Act of 1997), as well as the national laws of other countries, alongside laws passed by most states in the U.S. When it reviewed the "legitimate State interests" which justify bans on assisted suicide, the Court was referring to "the State" in the sense of government in general.

* In support of his claim, Senator Wyden cites an amicus brief filed by 19 attorneys general in the assisted suicide cases. But that brief simply said that the decision whether to permit assisted suicide is "a matter appropriately left *for the people to decide through their duly elected representatives* or by initiative ballot." It said nothing about states unilaterally demanding federally controlled drugs for assisted suicide, and certainly did not deny that Congress, too, is a body of "duly elected representatives."

* To underscore government's valid and longstanding interest in protecting the lives of terminally ill patients, the Court approvingly cited its own 1979 decision upholding the *federal* Food and Drug Administration's authority "to protect the terminally ill, no less than other patients," from life-endangering drugs. *Washington v. Glucksberg*, 521 U.S. 702, 729 (1997), quoting *United States v. Rutherford*, 442 U.S. 544, 558 (1979). Plaintiffs in *Rutherford* had claimed that the government's usual concern for drug "safety" is not relevant to dying patients. In response the Court *unanimously* affirmed the federal government's authority to *protect all persons equally* under federal drug laws, specifically including the terminally ill.

* The Court in 1997 did *not* say that states (or nations) may selectively *permit* assisted suicide for certain classes of vulnerable patients, as Oregon has done. It said it would not rule on the Oregon law, because that law was not before the Court. "*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*, 521 U.S. at 709 n. 7. (The Ninth Circuit Court of Appeals declined to review the Oregon law on its merits, ruling instead that patients, doctors and health facilities opposing the law had no standing to challenge it.)

* **The only federal court ever to review the Oregon law on its merits found that it violates constitutional guarantees of equal protection under law.** The court found that this law excludes a class of vulnerable persons from the protection of the law against manslaughter, based on these persons' health condition, while retaining that protection for everyone else in the state. *Lee v. Oregon*, 891 F.Supp. 1429 (D. Or. 1995), *vacated on other grounds*, 107 F.3d 1382 (9th Cir. 1997), *cert. denied*, 522 U.S. 927 (1997). A federal policy that affirms and supports Oregon's discriminatory policy, preventing lethal misuse of federally controlled drugs for most persons while authorizing such misuse for certain patients, could have the same constitutional defect. **It is the current federal policy of providing drugs for assisted suicide in Oregon, not the Pain Relief Promotion Act offered to correct that policy, that is constitutionally suspect.**

* In its 1997 *Glucksberg* decision, the Supreme Court affirmed the important governmental interests that justify bans on assisted suicide: Government's "unqualified interest in the preservation of human life," which need not vary depending on a person's "quality of life"; protecting depressed and mentally ill persons from acting on their "suicidal impulses"; "protecting the integrity and ethics of the medical profession"; "protecting vulnerable groups – including the poor, the elderly, and disabled persons – from abuse, neglect, and mistakes."

* In the companion *Quill* decision, the Court affirmed **the validity of laws like the Pain Relief Promotion Act**, which oppose intentional assisted suicide while allowing aggressive pain management that may unintentionally hasten death:

[W]hen 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.".... 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. [Vacco v. Quill, 521 U.S. 793, 802, 808 (1997)]

* In 1997 the Supreme Court said that Americans are engaged in a debate on assisted suicide "throughout the Nation" and that its decision "permits this debate to continue." That debate (which the Court never said would be confined to state legislatures) will continue with or without the Pain Relief Promotion Act. But the federal government is now **taking the wrong side in that debate**, by approving assisted suicide as "legitimate" medicine in Oregon and authorizing doctors to dispense lethal drugs for this purpose. The Pain Relief Promotion Act will get the federal government out of this unethical, destructive and arguably unconstitutional business of facilitating assisted suicide for vulnerable terminally ill patients.

For more information on the Pain Relief Promotion Act and the urgent need for its enactment, see www.nccbuscc.org/prolife/issues/euthanas/index.htm and www.passprpa.org.



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Reality Check on the Pain Relief Promotion Act

Installment #2: A “Chilling Effect” on Pain Control?

Some have said that the proposed Pain Relief Promotion Act could actually have a “chilling effect” on pain control, by putting physicians on notice that they may be legally liable if they “intentionally” cause a patient’s death. Consider the following testimonials:

1. “If physicians are afraid of prosecution, they will be inhibited from providing adequate pain relief to those patients most in need.”
2. “It’s going to have a very, very chilling effect on physicians’ ability to deal with pain relief in terminally ill patients... because they’re not going to want to get in a situation where they are charged with hastening a death because they’ve been aggressive with pain management.”
3. “I have been an outspoken opponent of physician assisted suicide, but I am concerned about the effects this legislation might have on the care of the terminally ill... I fear that this legislation, if it passes, will simply contribute to the fear that physicians have and will lead to a further deterioration in the symptom relief that patients receive. This could paradoxically increase the demand for physician assisted suicide.”
4. “This is going to have a chilling effect.”
5. “When what can and cannot be discussed turns not on the certain and foreseeable outcome of treatment, but on what primary intention is in the mind of the physician, and therefore unknowable, the situation will be hopelessly confused. And in a situation of confusion, we know physicians usually err on the side of avoiding risk. I fear this would have a chilling effect...”

Responsible statements about the possible impact of this misguided federal bill, right?

WRONG.

NONE of these statements was about the Pain Relief Promotion Act. They were said years ago against other state and federal bills opposing assisted suicide. And every one of those laws has demonstrably **IMPROVED** pain management and palliative care.

The first three statements were made in 1996 against Rhode Island’s proposed criminal ban on assisted suicide; they were made, respectively, by the Rhode Island Medical Society’s president, the Society’s lobbyist, and the medical director of the state’s largest hospice. The fourth was made against Maryland’s virtually identical ban in 1999 by a doctor who belonged to the Maryland House of Delegates. And the fifth was made in 1997 by Barbara Coombs Lee of Compassion in Dying, testifying against the Assisted Suicide Funding Restriction Act of 1997.

All these laws were enacted despite these objections. (The federal bill passed the Senate 99-to-0.) And in the year following enactment: Rhode Island more than doubled its per capita use of morphine for pain control, leaping from 46th rank among states in morphine use up to 18th in one year; Maryland also increased its morphine use and made other improvements in palliative care; and hospitals covered by the federal ban, such as VA hospitals, made dramatic improvements in pain management and palliative care praised by medical and hospice groups nationwide.

The “chilling effect” argument has been used for years by assisted suicide proponents to try to kill legislation protecting the terminally ill from assisted suicide, because they know that their real arguments in support of assisted suicide will not win the debate. Those same proponents now oppose the Pain Relief Promotion Act, and have traded on physicians’ fear of the federal drug laws to give this old discredited argument more impact and broader appeal. Again, and again, and again, the “chilling effect” argument has been proved false. But that has no effect on its use, because its creators did not frame it to communicate a truth but to scare physicians and legislators away from protective legislation.

The real “chilling effect” on pain control comes from the cynical argument of assisted suicide advocates that killing pain and deliberately killing patients are essentially similar, that neither laws nor doctors can effectively distinguish them, that therefore we must allow **both** if we allow either.

The wide array of medical and hospice groups supporting the Pain Relief Promotion Act know this is false. They know that the real threat to optimum pain management comes from the attitude that terminally ill patients’ lives do not have the same dignity as others, that assisting their suicides is a “good enough” solution for their problems. If doctors can kill their patients when they are in pain, why bother learning good pain control?

Do not be fooled by opponents’ false and cynical claim about a “chilling effect.” Help provide terminally ill patients with better pain management AND respect for their inherent dignity. Support the Pain Relief Promotion Act.

References

Statement 1: Testimony to the Rhode Island Senate by Arthur A. Frazzano, M.D., President of the Rhode Island Medical Society, 1996

Statement 2: Rhode Island Medical Society lobbyist Steven DeToy, quoted by *American Medical News*, August 12, 1996, page 31.

Statement 3: Letter to Rhode Island State Senators by Edward W. Martin, M.D., Medical Director of Hospice Care of Rhode Island, May 30, 1996.

Statement 4: Maryland delegate Dan Morhaim (D-Baltimore County), quoted by Associated Press, March 29, 1999

Statement 5: Testimony to the House Commerce Subcommittee on Health and Environment by Barbara Coombs Lee, Executive Director of Compassion in Dying, March 6, 1997.

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Reality Check on the Pain Relief Promotion Act

Installment #3: American Pain Foundation's Misguided Attack

An attack on the Pain Relief Promotion Act, called "Common Sense Reasons to Oppose H.R. 2260," has been circulated by the American Pain Foundation, a Baltimore-based group funded by drug companies and assisted-suicide advocate George Soros. The APF's claims are reviewed below and contrasted with the facts about the bill.

APF: The bill's proposed "safe harbor" in the Controlled Substances Act for pain management is unnecessary, because such a policy already has "full force and effect of law" through "a 1974 DEA regulation" and "the DEA's 1990 Physician's Manual."

Fact: That 1974 regulation relates solely to "the administering or dispensing directly (but not prescribing) of narcotic drugs listed in any schedule to a narcotic drug dependent person for 'detoxification treatment' or 'maintenance treatment'" (21 CFR 1306.07). Subsection (c) of that regulation says that "this section [on detox treatment] is not intended to impose any limitations" on treating intractable pain. But this disclaimer does not affect the rest of the Controlled Substances Act. The ten-year-old Physician's Manual is even less relevant, as an informational booklet that has no force of law. While the Drug Enforcement Administration (DEA) has assured physicians that it does not intend to limit pain management, the DEA's current broad authority to revoke prescribing privileges in any case of risk to "public health and safety" is a concern of many physicians. The Pain Relief Promotion Act gives a clear legal answer for the first time to the question: What does the law do when a doctor says he is practicing legitimate pain management but someone else claims he is (even unintentionally) "overprescribing" and thus endangering "health and safety"? In such cases the Act gives maximum deference to the physician.

APF: The bill "expands DEA authority to evaluate the practice of medicine as it pertains to pain management."

Fact: The opposite is true. The DEA now has authority to question any pain management practice that it thinks may endanger "health and safety" (even unintentionally). The bill sets a new standard: "*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.*" Even if there are side-effects, these are to be accepted as inevitable features of aggressive pain management that are "consistent with public health and safety." Since the DEA only has authority to prevent "diversion" of controlled substances *away from* "legitimate medical purposes," this provision forbids the DEA to second-guess physicians' individualized pain management decisions.

APF: The bill “expands the DEA’s authority to question a physician’s decision in prescribing controlled substances, even when that prescribing is within state medical guidelines.”

Fact: This is not true. The provision quoted above establishes that pain control is a legitimate medical purpose for use of controlled substances; specific professional standards for pain control are established by state medical boards and professional societies. If a physician is practicing “in the usual course of professional practice” as defined by these authorities, his or her activities are classified as “legitimate medical purpose” for purposes of federal law as well. This bill *increases* federal deference to state professional standards on pain management.

APF: The bill “defines ‘legitimate medical purpose’ as it relates to pain management.”

Fact: No, the quoted provision *forbids* the federal government to establish any restrictive definition, by classifying pain management as “legitimate medical purpose” and thus outside the DEA’s investigative purview. The bill also states that its provisions cannot be used “to provide the Attorney General with the authority to issue national standards for pain management and palliative care clinical practice, research, or quality.”

APF: “The bill defines the scope of pain management and palliative care in the context of physician-assisted suicide.”

Fact: As noted above, the bill does not define this scope but rather prohibits the establishment of a restrictive legal definition. It does, of course, distinguish pain management from the very different practice of deliberately using a sudden lethal overdose of controlled substances for the purpose of intentionally causing death. So the bill’s provision establishing a clear and explicit “safe harbor” for pain management is followed by this sentence: “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.” Similar language is already found in the AMA’s ethics manual; in virtually all state laws on advance directives, which explain that documents for withdrawing medical treatment cannot be used to authorize assisted suicide or euthanasia; in recently enacted state laws against assisted suicide in Iowa, Rhode Island, Louisiana, Indiana, etc.; in the federal Patient Self-Determination Act; and in every other federal health program, through the Assisted Suicide Funding Restriction Act of 1997. The U.S. Supreme Court has upheld this legal distinction as a helpful and reasonable way to protect pain management without allowing the deliberate killing of patients. The APF presents no evidence why this well-established distinction is less appropriate here. If this disclaimer were *not* present, the bill’s “safe harbor” for pain management that may “increase the risk of death” would provide new federal protection for cases where the “risk” of death is 100% and is the intended goal of the physician’s action. This bill would then actively endorse physician-assisted suicide.

APF: The bill “creates an obligation for DEA to investigate and question the intent of physicians in prescribing controlled substances for pain management.”

Fact: Not at all. The only obligation this bill creates for the DEA is to train its personnel to “better accommodate” practitioners’ legitimate need for controlled substances for pain relief. Since current law allows the DEA to scrutinize any use of these drugs that may endanger “health and safety,” a standard forbidding only deliberate and intentional killing of patients greatly increases protection for doctors compared to current law; the bill provides additional protection by requiring that the DEA must have “clear and convincing evidence” of this intent (not the usual “preponderance” of evidence) to take action against a physician’s DEA prescribing license.

APF: “PRPA does not prohibit physician-assisted suicide,” but only the use of federally controlled drugs for the practice.

Fact: At last, a true statement. This bill governs only an area of clear federal jurisdiction, that of federally controlled drugs, and does not overturn state laws allowing assisted suicide -- it simply says that the federal government will not authorize or assist this practice. Since this is now conceded even by the group leading the campaign against this bill, opponents should stop making the false argument that this bill overturns Oregon’s law or tramples on “states’ rights.”

APF: “All of the health and medical groups opposed to PRPA oppose or are neutral on the issue of physician-assisted suicide.”

Fact: This is a ludicrous claim. The Hemlock Society, Oregon Death with Dignity, and Compassion in Dying actively oppose this bill and some of their leadership is on the American Pain Foundation’s E-mail network organizing the opposition. (They have urged their members not to mention their “right-to-die” credentials when contacting Senate offices, but to argue that the bill will “chill” pain control and violate states’ rights.) The state medical societies most strongly opposing the bill – Rhode Island, Vermont, Oregon – have dissented from the American Medical Association position against physician-assisted suicide for years. And some national medical groups in APF’s coalition, like the American Pharmaceutical Association, have formal policies opposing *any and all* laws restricting their members’ ability to assist suicides. The APF itself has said that its top priority is deletion of the sentence that keeps the bill’s “safe harbor” for pain management from authorizing assisted suicide and euthanasia. In effect, APF will stop opposing the bill only if it is amended to provide the same *protection* for intentional killing that it now provides for pain management. This does not sound like neutrality on assisted suicide.

For more information on the Pain Relief Promotion Act, see www.passprpa.org and www.nccbuscc.org/prolife/issues/euthanas/teststate.htm.



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Reality Check on the Pain Relief Promotion Act

Installment #4: Which Policy Risks a “Chilling Effect” on Pain Control?

Opponents of the Pain Relief Promotion Act claim that by preventing use of federally controlled drugs for assisted suicide, while encouraging their use for pain management, this Act could have a “chilling effect” on pain control.

This charge of a “chilling effect” runs contrary to all evidence. State and federal laws distinguishing assisted suicide from pain control have had universally positive effects on pain management [see Installment #2 in this series]. Moreover, it is the *failure* to draw a clear difference between the two that has a “chilling effect” on pain management and palliative care:

* A study in the October 3 *Annals of Internal Medicine* reports that support for assisted suicide among oncologists has halved in four years (from 46% to 23%). But the cancer experts least likely to have performed assisted suicide or euthanasia were also more reluctant to increase the morphine dose for patients with excruciating pain. They did not understand the ethical and legal difference between aggressive pain management and assisted suicide -- or they thought others would not understand it -- and so they were reluctant to practice effective pain relief. The authors comment: “This view may be encouraged by proponents of euthanasia who have argued that there is no difference between increasing narcotics for pain relief and euthanasia.”

* In April 1997, the New York State Task Force on Life and the Law urged people on all sides of the assisted suicide debate to keep these distinctions clear. Noting that “many physicians would sooner give up their allegiance to adequate pain control than their opposition to assisted suicide and euthanasia,” the Task Force noted that “characterizing the provision of pain relief as a form of euthanasia may well lead to an increase in needless suffering at the end of life.”

* Writing in the April 1998 *Minnesota Law Review*, Dr. Howard Brody likewise urged support for the “principle of double effect,” clearly distinguishing intentional killing from the unintended shortening of life that may occur during aggressive pain management. While Dr. Brody himself does not oppose assisted suicide, he is aware that many or most physicians do. He says pain management can be best served by clearly distinguishing it from assisted suicide. “Clinicians must believe, to some degree, in a form of the principle of double effect in order to provide optimal symptom relief at the end of life.. A serious assault on the logic of the principle of double effect could do major violence to the (already reluctant and ill-informed) commitment of most physicians to the goals of palliative care and hospice.”

* The same point has been made by national organizations committed to palliative care: Accepting assisted suicide as just another form of end-of-life care undermines genuine care for

dying patients. As the National Hospice Organization (now the National Hospice and Palliative Care Organization) said in its “friend of the court” brief in the Supreme Court’s 1997 assisted suicide cases, “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.”

* The converse is also true: clearly rejecting assisted suicide is a *benefit* to palliative care. As the American Medical Association said in its brief in the Supreme Court cases, “the prohibition on physician-assisted suicide provides health care professionals with a tremendous incentive to improve and expand the availability of palliative care.” Or as one hospice physician has said: “Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying” (quoted by Dr. Leon Kass in “Why Doctors Must Not Kill,” *Commonweal*, Sept. 1992, p. 9).

Experience has shown that these projections are correct: accepting assisted suicide alongside pain control undermines pain control.

* During oral arguments in the Supreme Court cases, Justice Stephen Breyer cited a British House of Lords report showing that acceptance of assisted suicide and euthanasia in the Netherlands has apparently led to the stagnation of hospice medicine: The Dutch operated only three hospices at the same time that Great Britain, which bans assisted suicide, had 185 of them.

* The same trend can be seen in Oregon. It ranked 3rd highest among the 50 states in per capita use of morphine for pain control in 1992, two years before Oregon voters voted to legalize assisted suicide; it ranked 6th in 1998, the first full year the new law was in effect. A major health insurance plan in the state has capped reimbursement for hospice care at \$1000 per patient, while providing unlimited support for assisted suicide. And Oregon families’ reports of moderate to severe pain among their dying hospitalized loved ones increased markedly (from 33% to 57%) in the last months of 1997, when the assisted suicide law took effect, and continued to be higher than previously throughout 1998 (*Western Journal of Medicine*, June 2000, pp. 374 ff.).

In short: Banning assisted suicide, or distinguishing it from aggressive pain management, does not have a “chilling effect” on pain control. Failing to do so has that effect.

Uninformed groups have asked why Congress can’t keep these issues separate: Banning assisted suicide in one law, and promoting pain management in another. But this would produce two bad laws. One would ban assisted suicide without making it clear that pain management is not banned – and that would have a chilling effect on pain management. The other would endorse efforts to kill pain, without making it clear whether that can include killing the patient – and that would be irresponsible, and ultimately have a chilling effect on pain control as well. **By making the distinction clear, the Pain Relief Promotion Act serves optimum pain management.**

Assisted Suicide Bill



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Do not be fooled by opponents’ false and cynical claim about a “chilling effect.” Help provide terminally ill patients with better pain management AND respect for their inherent dignity. Support the Pain Relief Promotion Act.

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Assisted suicide to be R.I. felony

PROVIDENCE, R.I. (AP) — Gov. Lincoln Almond has announced that he will sign bills making physician-assisted suicide a felony despite opposition from the medical community and the state's top health official.

"I certainly respect the issue of critically ill patients, and I would fully expect the medical profession to treat those patients aggressively, to treat them in accordance with medical standards," Almond said. "I think common sense will prevail."

The House and Senate have passed bills to punish doctors with up to 10 years in prison for assisting a suicide. The Senate must approve a minor amendment before the legislation can be sent to the governor.

Rhode Island would become the second state this year to pass a bill criminalizing the practice. Iowa earlier approved such a measure.

The state health director questioned whether the legislation is constitutional. Patricia Nolan, MD, had urged Almond to veto the bill, citing federal appeals court rulings in Washington and New York that assisted-suicide bans violate due process and equal protection laws.

"The interests of the state and its citizens will be well served if the constitutionality of this complex and emotional issue is settled before physicians face prosecution for violating these laws," Dr. Nolan wrote to the governor.

Other critics say criminalizing assisted suicide will cause doctors to withhold heavy doses of pain-relieving morphine, afraid their actions will be seen as illegally helping patients die.

"It's going to have a very, very chilling effect on physicians' ability to deal with pain relief in terminally ill patients ... because they're not going to want to get in a situation where they are charged with hastening a death because they've been aggressive with pain management," said Steven DeToy, lobbyist for the Rhode Island Medical Society.

Earlier this year, the medical society adopted a neutral position on the issue, opposing criminalizing assisted suicide and a "right-to-die" bill to legalize the practice.

Almond dismissed DeToy's claim. "I don't think you're going to find myself, or [Attorney General] Jeff Pine or anyone out there second-guessing the medical profession," the governor said.

Almond said he wanted to avoid a situation like the one in Michigan, where Jack Kevorkian, MD, has helped terminally ill patients end their lives.

At least one assisted-suicide supporter, Noel David Earley, plans to challenge the legislation if Almond approves it. Earley, a Lincoln resident dying of amyotrophic lateral sclerosis, is fighting for the legal right to kill himself.

AM NEWS AUGUST 12, 1996 PAGE 31

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Better by A

When are Americans at their best? When are we most likely to embrace the new ideas, and the leadership we need to advance our industries, our communities, and as a nation? America's associations know when we come together, when we share knowledge and information, and when we work together for innovation, excellence, and growth.

Making things better by association has been a guiding principle in American commerce since Revolutionary times. As a nation, we learned early on that we can achieve great things by joining with others. By association.

How is America making things better by association?

We're creating knowledge.

Pushing at the forefront of new technologies, from ethanol power to nanotechnology, from pollution in America's inner cities to better laboratory testing procedures around the world. Creating networks for sharing health care information. Doing the research to understand the role of women-owned businesses.

We're innovating.

Creating training programs that help workers shift from declining industries to growing ones. Helping communities create and sustain positive business models. Developing financing strategies to maintain affordable housing stock.

We're learning.

Helping workers gain and apply new technical skills that they need in a digital age. Certifying and re-certifying professionals—from accountants to nurses—as knowledge advances. Creating the public education programs that make everyone smarter about the health and lifestyle changes that can improve our lives.

We're defining standards for excellence.

Setting the bar high, for everything from standards for teachers to standards for elementary and secondary school to standards for nursing students. Taking on the tough ones: creating standards for ethical performance. Making sure that technology makes knowing what's right harder and harder.

And we're helping people and communities.

Sharing best practices across communities and professions, in education and customer service to building diversity in the workforce. Promoting community service. Creating forums, in communities and industry, for the generation of talented young leaders.



Associations Advance

American Medical Association

Physicians dedicated to the health of America

Rhode Island Medical Society

100 Finance Street, Providence, Rhode Island 02903-1164 (401) 331-3207 Fax (401) 751-8050

TO: Members, RI Senate

FM: Arthur A. Frazzano, MD
President

RE: 968-2558

*Past charges
about the
alleged "chilling
effect" of laws
against assisted
suicide*

As many of you know the Medical Society is neutral on the issue of whether or not physicians should assist a patient end his/her own life and we continue to STRONGLY OPPOSE any attempt to criminalize this activity for the following reasons:

*This bill would harm the very patients, your constituents, that the proponents say they want to protect. Those patients who have reached the end a terrible and painful disease process may no longer have access to the best pain medications available to make their final months, weeks or days more bearable.

If physicians are afraid of prosecution, they will be inhibited from providing adequate pain relief to those patients most in need. This irony between the supposed intent of this legislation and its practical impact could actually result in an increase in patients seeking assistance in ending their life because we have taken away the pain relief that makes the end of life more bearable.

*The argument that the bill would somehow protect physicians who are practicing aggressive pain relief is extremely flawed. This bill makes a presumption of criminality that could not be defended against until a physician is actually brought to trial. It is a frightening prospect for any physician to think that his/her best efforts to comfort a patient could get them arrested.

*Similar, if not identical, legislation has been ruled unconstitutional in 2 Federal Courts. It is clear that should this bill pass, it will immediately be contested and injunctive relief based on the federal cases is almost certain. It is also quite likely that the US Supreme Court will deal with the issue of assisted suicide in the near future, thus making this legislation moot.

*These types of decisions by patients should be left to the patient and their physician, not legislated.

The Medical Society is keenly aware of the difficult position you are facing on this issue. We urge you to put aside the emotional arguments of the bill's proponents and consider what you would want for your mother or other relative who may face the end of life in great pain. Would you want your physician to be afraid to help with the relief of that pain?

Hospice Care
of Rhode Island
A Lifespan Partner

Philip Hullbar Inpatient Center

50 Maude Street
Providence, RI 02908
Tel 401 261-5570
FAX 401 261 2613

May 30, 1996

Senator Paul Kelly
State House
Providence, RI 02908

Dear Senator Kelly:

I am writing to express my concern regarding the legislation which would criminalize physician assisted suicide. I have been an outspoken opponent of physician assisted suicide, but I am concerned about the effects this legislation might have on the care of the terminally ill. We do a very poor job relieving pain and other symptoms that dying patients suffer with. This is not because we await some new breakthrough in medical research or technology. The major barrier to symptom control is the reluctance of physicians to prescribe the medications necessary to relieve this suffering. Physicians often express concern that they will be scrutinized and sanctioned for prescribing medication in the doses and manner necessary to relieve the symptoms that dying patients experience. This is in spite of reassurances from medical associations and medical boards that this is not the case. I fear that this legislation, if it passes, will simply contribute to the fear that physicians have and will lead to a further deterioration in the symptom relief that patients receive. This could paradoxically increase the demand for physician assisted suicide. I think the best way to deal with this issue is to demand comprehensive palliative care and access to hospice services for all terminally ill patients. If patients could be assured that their pain and other symptoms would be aggressively treated and relieved, I believe support for physician assisted suicide would evaporate.

I thank you for your consideration in this matter.

Sincerely,

Edward W. Martin M.D.

Edward W. Martin, M.D.
Medical Director

EXCERPT FROM
STATEMENT OF
GOV. ALMOND OF
RHODE ISLAND

1994), *cert. denied* 115 S. Ct. 1795 (1995). If that line is not respected, voluntary and involuntary euthanasia are not far behind. Sadly, such is already the case in the Netherlands.

I believe that this Act prohibiting assisted suicide ultimately will be found to be constitutional by the courts.

II. *Does the Act Impair the Physician/Patient Relationship?*

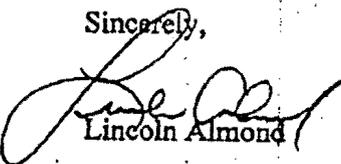
Several Rhode Island physicians and physician groups have opposed this bill based upon concern that physicians will be prosecuted for assisted suicide by prescribing pain medication which may result in, but is not intended to cause a patient's death. They also contend that the Act could adversely affect the quality of patient care. It is highly unlikely that either will come to pass.

First, it is significant that despite the fact that the nearly all states outlaw assisted suicide, there is no recorded instance to our knowledge of a prosecution based upon a physician's administration of pain relieving medication. The only case of a threatened prosecution that we know of was in 1990 in Minnesota. That case was never prosecuted and resulted in an amendment to Minnesota's anti-assisted suicide law to clarify that administration of pain relieving medication or procedures, even if they may hasten or increase the risk of death, do not violate the law unless they are knowingly administered to cause death. Importantly, the identical physician-protection provision is contained in this Act. Moreover, the provision is properly considered an exemption from the law and not an affirmative defense. Thus, in prosecuting any offense under the Act, the Attorney General must prove that a physician's action was knowingly intended to cause death. With these safeguards, I am satisfied that physicians practicing medically-responsibly pain control will face no increased liability.

As for whether the Act will negatively impact the quality of patient care, apparently the American Medical Association does not agree. In fact, to allow assisted suicide could change that relationship. Very recently, the AMA reaffirmed, by a nearly unanimous vote, its policy opposing physician-assisted suicide. Dr. Nancy W. Dickey, Chair of the AMA's Board of Trustees, summed up the AMA position: "To allow or force physicians to participate in actively ending the lives of patients would so dramatically and fundamentally change the entire patient/physician relationship that it would undermine the principles we, as a society, hold most dear. We must never lose sight of the caveat that physicians are healers, and where we cannot heal, our role is to comfort." *AMA News Release, June 25, 1996.*

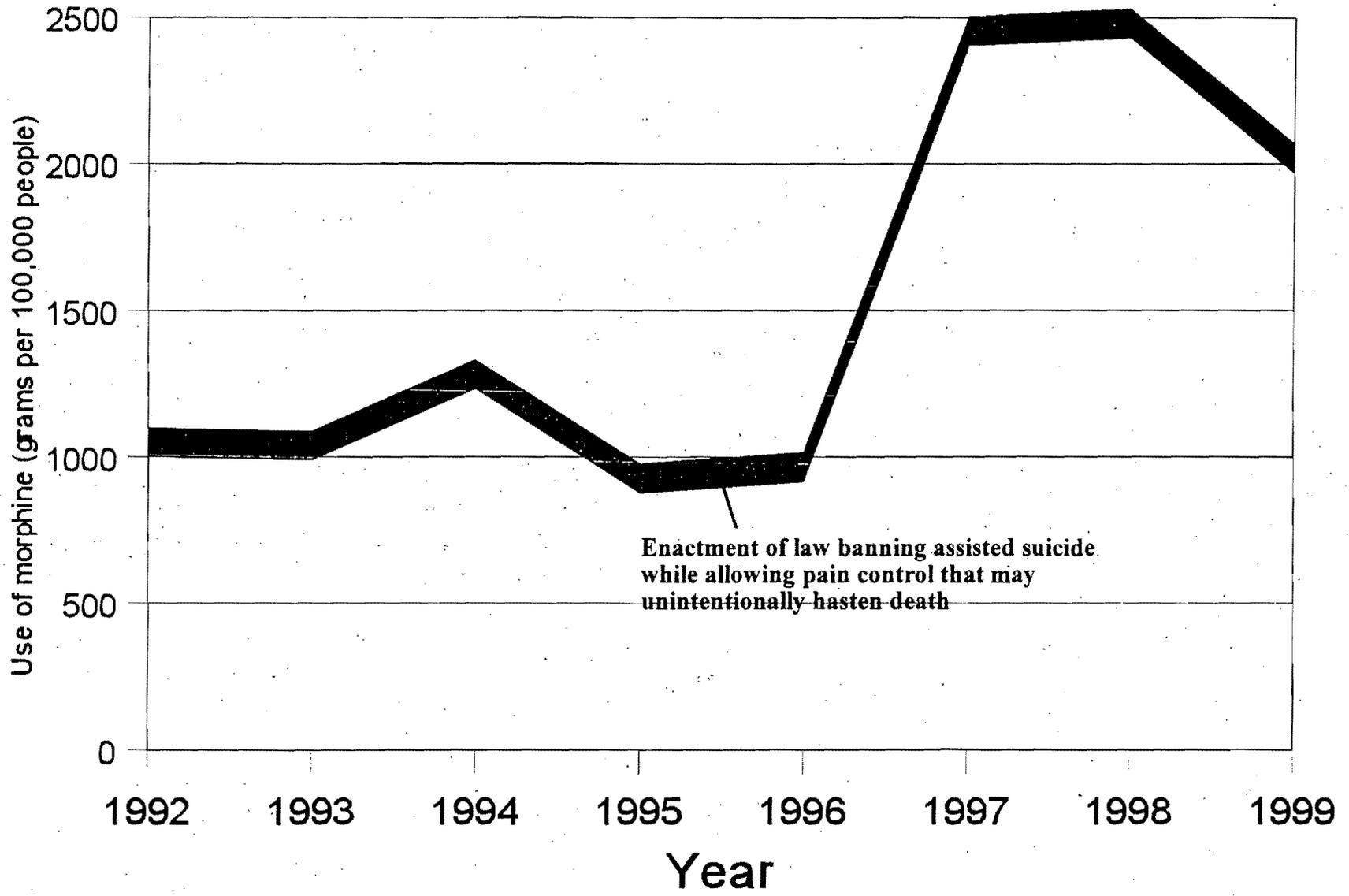
For the foregoing reasons, I sign this bill into law.

Sincerely,


Lincoln Almond

Use of Pain Control Drugs Rises When States Ban Assisted Suicide

RHODE ISLAND



(Source of morphine data: Drug Enforcement Administration)

Balti:oreSun:AP:Bills making it crime to ...t in suicide virtually assured of passage

Subject: BaltimoreSun:AP:Bills making it crime to assist in suicide virtually assured of passage
Date: Fri, 26 Mar 1999 18:56:29 -0500 (EST)
From: Sylvia Gerhard <sgerhard@world.std.com>
To: right_to_dic@efn.org

Url: <http://www.sunspot.net/cgi-bin/editorial/story.cgi?section=archive&storyid=1150070208262>

Assisted suicide law passes House

TOM STUCKEY Associated Press Writer
AP WIRE
March 29, 1999

ANNAPOLIS, Md. (AP) -- Bills making it a crime to help someone commit suicide in Maryland are virtually assured of passage now that the House of Delegates has joined the Senate in approving the legislation.

Each house has passed its own bill, and one or both must be approved by both houses before going to Gov. Parris Glendening, who has said he will sign it. With both houses now on record, there is little doubt that will happen.

The House bill was approved on a 78-54 roll call, seven votes more than the 71 required for passage.

Opponents argued in vain that it would make doctors reluctant to prescribe sufficient pain medicine for terminally ill patients out of fear they would be prosecuted.

"This is going to have a chilling effect," said Delegate Dan Morhaim, D-Baltimore County, the only physician in the House.

He said responsible health care professionals will be looking over their shoulders, worried they will be prosecuted because of "some ambitious state's attorney or some misguided but well-intentioned relative" of a patient who died after being given large doses of pain killers.

But the bill's supporters noted that the bill specifically says doctors can give as much medicine as is needed to control pain even if it hastens the death of the patient.

Delegate Donald Murphy, R-Baltimore County, said the bill will impose additional hardships on people who have to deal with loved ones who ask for help in ending their lives because they are suffering intractable pain.

"This is big government at its worst," he said. "Don't do this to your family. Don't do this to yourself."

"One day you'll wish you had never voted for this bill," he predicted.

The law passed and Maryland has improved its palliative care for dying patients since, according to Dr. F. Michael Gloth, President of Hospice Network of Maryland.

Balti.noreSun:AP:Bills making it crime to ...t in suicide virtually assured of passage

Delegate Joseph Vallario, D-Prince George's, said 46 other states already have placed restrictions on assisted suicide without any of the problems envisioned by opponents.

Delegate Joseph Getty, R-Carroll, said the bill is good for the medical profession.

"The bill says the doctor may administer advanced pain relief even if it hastens or increases the risk of death," he said.

Opponents also tried to stop the bill by arguing that Maryland does not have physicians such as Dr. Jack Kevorkian, who has openly helped terminally ill people kill themselves.

But Vallario said the law will be a signal to Kevorkian or someone like him to stay out of Maryland.

.....
This message is issued on the nonprofit Ergo! electronic mailing list.
To contribute, address your information to <right_to_die@efn.org>
It is a monitored list with over 600 international subscribers. To
subscribe (no fees) email to <listproc@efn.org> putting nothing in
the subject line and in the message text say only
"subscribe right_to_die yourfirstname yourlastname" To leave the
list, email to <listproc@efn.org> saying "unsubscribe right_to_die"
.....

**Excerpt: Testimony of Barbara Coombs Lee, Executive Director of Compassion in Dying
against the Assisted Suicide Funding Restriction Act of 1997**

Subcommittee on Health and Environment

House Commerce Committee

March 6, 1997

“My concern with the resolution under consideration is that the prohibition of federal funds for any service related to aid-in-dying would act as a gag rule on discussions with terminally ill patients that touch on any treatment having the possible effect of hastening death. When what can and cannot be discussed turns not on the certain and foreseeable outcome of treatment, but on what primary intention is in the mind of the physician, and therefore unknowable, the situation will be hopelessly confused. And in a situation of confusion, we know physicians usually err on the side of avoiding risk. **I fear this would have a chilling effect** on open dialogue between physicians and patients and greatly diminish the amount of information, options and control available to dying patients.” (Emphasis added)

(The federal bill passed anyway, and was followed by striking improvements in palliative care in VA hospitals, see next page.)

VA Makes Better End-of-Life Care a Top Priority

Far-reaching Plan Implemented System-Wide
By Sondra Beckwith

The nation's largest integrated health care system has made improving the quality of its end-of-life care a top priority.

The Department of Veterans Affairs is requiring its facilities to improve the quality of care for patients with advanced, incurable conditions, including cancer, heart failure, chronic lung disease and Alzheimer's disease.

"We are in a unique position to do this," explains Kenneth W. Kizer, MD, MPH, VA undersecretary for health. "We deal with a disproportionately older population that is burdened with excessive chronic illness. In addition, unlike other health care organizations, we are judged primarily on whether we do the right thing for our patients. And this is the right thing to do," he insists.

Bonnie Ryan, RN, chief, VA home and community-based care, and Judith Salerno, MD, MS, chief consultant, geriatrics and extended care, are developing a far-reaching plan that will be implemented system-wide.

"Our initiative was triggered by the Institute of Medicine report on end-of-life care released in 1997," Ryan noted. "It helped us see that the VA is one of the few national health care providers that can address all of the IOM recommendations."

"We don't have the constraints faced

by other health care organizations," says Salerno. "In addition, we have all the pieces in place to make the right changes - including affiliations with 1,000 universities nationwide where we can provide instruction on quality end-of-life care, and the capacity to research and measure our changes. Now we need to connect these pieces properly."

Constantly looking for leverage points that allow immediate action, the VA has already added a process requiring end-of-life care planning for all patients having advanced, incurable conditions.

"This performance measure resulted in documented end-of-life care planning increasing from 52% to 67% of patients at this stage. This is a 15% improvement in just three months," Ryan explains.

Other leverage points were identified in May, when the Department of Veterans Affairs held an internal end-of-life care leadership summit. "Our conference objective is to create a comprehensive, system-wide strategy for implementing change," Ryan notes. "We're developing it with leaders from all levels of our system."

"We have a wealth of expertise within the VA, and a lot of enthusiasm for this initiative. Our principal challenge now is to remove the barriers that keep our people from providing the best care possible

at the end of life," Kizer notes.

The VA's efforts to improve care of dying patients include:

- Identifying and disseminating "best practices" in care of the dying.
- Improving systems and processes, such as instituting a national performance standard for end-of-life care.
- Planning that focuses attention on improving care of the VA's terminally ill.
- Strengthening methods for measuring quality of life and other outcomes of care for dying patients and their families.
- Designing appropriate education for VA health professionals and affiliated trainees.
- Empowering patients and families through education about care at the end of life.
- Identifying priorities for research to strengthen the knowledge base.
- Collecting data on quality, access, cost and utilization to inform public policy.
- Collaborating with other groups with like goals.

Veterans Administration To Educate Medical Residents

The Veterans Administration has received a grant from the Robert Wood Johnson Foundation to establish a faculty development program and train resident physicians to provide better care for dying patients.

The Foundation awarded the VA \$982,595 for two years to establish a VA faculty fellows program for end-of-life and palliative care. Thirty faculty fellows will be selected from VA-affiliated internal medicine training programs throughout the country. The fellows' work aims to integrate palliative care into education and training in patient care.

These faculty will develop programs to

teach a holistic, interdisciplinary philosophy of care, emphasizing communication skills, empathy for patients, and planning that focuses on patients and their families. These principles will apply to care given in diverse settings, including hospitals, hospices, nursing homes and patient's own homes.

"The VA is very well positioned to become a leader in training future doctors in palliative care, because its patients are -- on the average -- 10 years older and more seriously and chronically ill than the population as a whole," said Foundation Senior Program Officer Rosemary Gibson, who will oversee the grant.

David P. Stevens, M.D., the VA's chief of academic affiliations, will direct the faculty development project. "We have an American medical culture that has traditionally emphasized aggressive, life-saving care -- even for patients with incurable diseases," Stevens said. "This grant is important because of its potential to make a broad impact on future physicians in their care for dying patients. In our current system, American medical students need not demonstrate knowledge of end-of-life care to become physicians, and their training does not often expose them to nursing homes or hospices," he said.



Secretariat for Pro-Life Activities

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Comments and Corrections on the Pain Relief Promotion Act

Opponents of the Pain Relief Promotion Act have misrepresented the legislation's scope. Below are some widely repeated claims, and appropriate factual corrections.

Claim: "The Republican-controlled House yesterday voted to ban physician-assisted suicide..." [*Washington Post*, 10/28}.

Correction: The bill affects only a special class of drugs that has been under federal jurisdiction for three decades. Prescribing such drugs requires a special federal "registration" or license from the DEA, which is separate from a state license to practice medicine. This bill simply prevents the federal government from condoning and aiding assisted suicides.

Claim: "The bill would give the Drug Enforcement Administration the power to determine whether a controlled substance has been prescribed for a legitimate medical purpose" [Ron Wyden, in *New York Times*, 10/23/99].

Correction: Congress gave the DEA that power in 1970 (see 21 CFR §1306.04, first published at 36 Fed. Reg. 7799 [1971]). In the last two decades, the DEA has applied the standard of "legitimate medical purpose" over 250 times to determine whether practitioners' federal registrations for using controlled substances should be retained or revoked.

Claim: The bill has a "draconian provision" under which "the prescribing doctor could spend 20 years in prison" [*New York Times* editorial, 10/30].

Correction: No such provision exists -- in fact, the bill has no penalty provision. It simply states that doctors who use controlled substances to assist suicides in Oregon are not exempted from the penalties that already apply to everyone else under existing law. A criminal penalty is possible in theory when any physician misuses controlled substances to cause a person's death; this applies today in 49 states, and even in Oregon when a physician assists a suicide outside the bounds of Oregon's guidelines. However, while physicians have had their DEA registrations revoked in recent years for being involved in suicides or other lethal overdoses using controlled substances [see list at www.house.gov/judiciary/attach1.htm], any follow-up criminal charges are at the discretion of the Justice Department and are virtually unheard of when physicians are involved. The House Judiciary Committee's report on H.R. 2260 cites past congressional statements on the intent of the Controlled Substances Act, to reaffirm that an administrative penalty (revoking special federal prescribing privileges) will generally be the only penalty contemplated -- Congress even expects that physicians will generally retain their state medical licenses after a federal registration is revoked.

Claim: Because the bill bans “intentional” use of narcotics to assist suicide, while allowing their use for pain control that may unintentionally hasten death, there will be “thousands of cases each year in which the intent of the physician could be questioned under this law” [Gov. John Kitzhaber of Oregon, *Washington Post*, 11/2].

Correction: No new “intent” standard is created by the bill. Intentional assistance in suicide is already a felony in most states and a violation of professional standards in all states, including Oregon -- and thus already provides a basis for revoking a DEA registration as well. The only cases of assisted suicide newly covered by the federal bill are those which have been newly permitted by Oregon -- and in all those cases, physicians are required by state law to report explicitly what their intent is. In no case, then, is any new questioning of doctors’ intent by the DEA called for. In 49 states, the only new standard created by this bill is its clearer and more explicit “safe harbor” for physicians practicing pain control -- a new protection, not a threat.

Background: Web Sites on Pain Relief Promotion Act

Pending federal legislation can be accessed on Congress’s online service “THOMAS”:
<http://thomas.loc.gov>. One can search for the text of a bill, or for a report on its status and sponsors; searches can be done by bill number, sponsor, key words, etc. This site also provides transcripts of floor debates as printed in the Congressional Record (House floor debate on HR 2260 was on October 27).

House Judiciary Committee report on HR 2260: **[ftp.loc.gov/pub/thomas/cp106/hr378p1.txt](ftp://loc.gov/pub/thomas/cp106/hr378p1.txt)**

House Commerce Committee report: **[ftp.loc.gov/pub/thomas/cp106/hr378p2.txt](ftp://loc.gov/pub/thomas/cp106/hr378p2.txt)**

Senate Judiciary Committee testimony on April 25, 2000:
www.senate.gov/~judiciary/wl4252000.htm

Recent issues of Life at Risk reporting on the legislation and its progress:
www.nccbuscc.org/prolife/publicat/liferisk/

Catholic Bishops’ testimony in support of the bill:
www.nccbuscc.org/prolife/issues/euthanas/painrelief.htm

Questions and answers on the bill, from the American Medical Association:
www.ama-assn.org/ama/basic/article/0,1059,199-483-1,00.html

A more technical analysis by AMA staff:
www.ama-assn.org/ad-com/roots/leg1099.pdf

CRS Report for Congress

Received through the CRS Web

Pain Relief Promotion Act of 2000: Legal Issues Associated with the Controlled Substances Act

Kenneth R. Thomas
Legislative Attorney
American Law Division

Summary

The proposed Pain Relief Promotion Act of 2000 provides that the Attorney General, in determining whether the registration of a doctor for the administration of controlled substances is in the public interest, shall give no force and effect to state law authorizing or permitting assisted suicide or euthanasia. This language would appear designed to abrogate the legal reasoning set forth by the Attorney General in a press release regarding the application of the Controlled Substances Act to acts of physician-assisted suicide. It does not, however, appear to require the Attorney General to revoke such registrations; nor does it appear to criminalize assisted suicide or euthanasia. This report will be updated if congressional action warrants.

The Pain Relief Promotion Act of 2000 (H.R. 2260),¹ amends the Controlled Substances Act to provide that the Attorney General, in evaluating a doctor's authority to administer controlled substances, shall give no force and effect to state law authorizing or permitting assisted suicide or euthanasia. The bill also provides that palliative care is a legitimate medical purpose, and provides that a finding that such care was outside of the usual course of professional practice must be established by clear and convincing evidence. Finally, the bill provides for research and education on the issue of pain relief.

The bill was:

- reported by the House Committee on the Judiciary (H. Rept. 106-378, part I) on October 13, 1999;
- reported by the House Committee on Commerce (H. Rept. 106-378, Part II) on October 18, 1999;
- passed by the House on October 27, 1999 by a vote of 271-156 (Roll No. 554); and
- reported by the Senate Committee on the Judiciary on April 27, 2000 (S. Rept. 106-299).

¹ 106th Cong. (reported to Senate with an amendment in the nature of a substitute).

Thirty-nine states forbid assisted suicide by statute,² and six states prohibit assisted suicide through application of common law.³ Four states appear to have neither a statute nor common law which prohibits assisted suicide.⁴ Although various proposals legalizing the practice have been considered,⁵ only the state of Oregon has a statute permitting physician-assisted suicide.⁶ Federal law currently does not forbid assisted suicide, although

² Alaska, Alaska Stat. §11.41.120(a)(2) (1978); Arizona, Ariz. Rev. Stat. Ann. §13-1103(a)(3) (1989); Arkansas, Ark. Code Ann. §5-10-104(a)(2) (1987); California, Cal. Penal Code §401 (1998); Colorado, Colo. Rev. Stat. §18-3-104(1)(B) (1990); Connecticut, Conn. Gen. Stat. §§53a, 56(a)(2) (1997); Delaware, Del. Code Ann., tit. 11, 645 (1995); Florida, Fla. Stat. Ann. §782.08 (1992); Georgia, Ga. Code Ann. §16-5-5(b) (1994); Hawaii, Haw. Rev. Stat. §707-702(1)(B) (1988); Illinois, Ill. Comp. Stat. Ann. 5/12-31(1992); Indiana, Ind. Stat. Ann. §35-42-1-2 (1998); Iowa, Iowa Code Ann. §707a.2, 707a.3 (1996); Kansas, Kan. Stat. Ann. §31-3406 (1992); Kentucky, Ky. Rev. Stat. Ann. §216:302 (1994); Louisiana, La. R.S. 14:32.12 (1999); Maine, Me. Rev. Stat. Ann. Tit. 17a, §204 (1983); Maryland, Md. Ann. Code Art. 27, §416 (1999); Michigan, Act of December 15, 1992, 1992 P.A. 270; Minnesota, Minn. Stat. Ann. §609.215 (1998); Mississippi, Miss. Code Ann. §97-3-49 (1994); Missouri, Mo. Ann. Stat. §565.023 (1983); Montana, Mont. Code Ann. §45-5-105 (1981); Nebraska, Neb. Rev. Stat. §28-307 (Supp. 1977); New Hampshire, N.H. Stat. Ann. §630:4 (1997); New Jersey, N.J. Stat. Ann. §2c:11-6 (1995); New Mexico, N.M. Stat. Ann. §30-2-4 (1978); New York, N.Y. Penal Law §120.30 (Mckinney 1997); North Dakota, N.D. Cent. Code §12.1-16-04 (1991); Oklahoma, Okla. Stat. Ann. Tit. 21, §818 (1983); Pennsylvania, 18 Pa. Cons. Stat. Ann. §2505 (1998); Rhode Island, R.I. Gen. Laws §11-60-1, 11-60-3 (1996); South Carolina, S.C. Code Ann. §16-3-1090 (1998); South Dakota, S.D. Codified Laws Ann. §22-16-37 (1998); Tennessee, Tenn. Health & Safety Code Ann. §672.020 (West 1992); Texas, Tex. Penal Code Ann §22.08 (1994); Virginia, Va. Code Ann., 8.01 622.1 (Michie 1999); Washington, Wash. Rev. Code Ann. §9a.36.060 (1998); Wisconsin, Wis. Stat. Ann. §154.11(6) (1998); *see also* Model Penal Code §210.5.

³ Alabama, Idaho, Massachusetts, Nevada, Vermont, and West Virginia.

⁴ North Carolina, Ohio, Utah and Wyoming.

⁵ During the nineties, voters in California and Washington defeated assisted suicide ballot proposals. In November 1998, voters in Michigan defeated a ballot measure to legalize doctor-assisted suicide. Also in 1998, proposed legislation legalizing doctor-assisted suicide was defeated in Maine. Although many such measures have been introduced into legislatures, they generally expire in committee, and seldom reach the floor of the full legislative body.

⁶ Or. Rev. Stat. 127.800-.995 (1995). The Oregon Death with Dignity Act was adopted as the result of a statewide referendum. The Oregon legislature responded by setting a new referendum proposing repeal of the Act, but the repeal was defeated. Meanwhile, the Act was challenged in a federal court, which struck it down as a violation of the Equal Protection Clause of the Fourteenth Amendment. *Lee v. Oregon*, 891 F. Supp. 1429, 1431 (D. Or. 1995). The United States Court of Appeals for the Ninth Circuit, however, reversed, holding that the plaintiffs were not sufficiently threatened by implementation of the law to obtain standing. *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997).

The core of the Oregon Death With Dignity Act provides that any competent Oregon resident who has been determined by two physicians to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life. A "terminal disease" is defined as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. The Act also sets forth specific requirements and procedures that must be satisfied before a patient can be prescribed a lethal dose of medication.

(continued...)

the "Assisted Suicide Funding Restriction Act of 1997"⁷ prohibits the use of federal funds to pay for assisted suicide.

In November of 1997, a Drug Enforcement Agency staff report concluded that prescribing a controlled substance with the intent of assisting a suicide would not be a legitimate medical purpose and therefore would violate the Controlled Substances Act. Consequently, the Drug Enforcement Administration issued a warning that under the Controlled Substances Act, doctors could lose their licenses to prescribe drugs if they helped someone commit suicide. On June 5, 1998, however, the Department of Justice (DOJ) issued a press release rejecting this conclusion.

The DOJ press release reads, in part, as follows:

Physicians . . . are authorized to prescribe and distribute scheduled drugs only pursuant to their registration with the DEA, and the unauthorized distribution of drugs is generally subject to criminal and administrative action. The relevant provisions of the CSA provide criminal penalties for physicians who dispense controlled substances beyond "the course of professional practice," and provide for revocation of the DEA drug registrations of physicians who have engaged either in such criminal conduct or in other "conduct which may threaten the public health and safety." Because these terms are not further defined by the statute, we must look to the purpose of the CSA to understand their scope.

The CSA was intended to keep legally available controlled substances within lawful channels of distribution and use. It sought to prevent both the trafficking in these substances for unauthorized purposes and drug abuse. . . . There is no evidence that Congress, in the CSA, intended to displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice. Indeed, the CSA is essentially silent with regard to regulating the practice of medicine that involves legally available drugs except for certain specific regulations dealing with the treatment of addicts.

The state of Oregon has reached the considered judgment that physician-assisted suicide should be authorized under narrow conditions and in compliance with certain detailed procedures. Under these circumstances, we have concluded that the CSA does not authorize DEA to prosecute, or to revoke the DEA registration of, a physician who has assisted in a suicide in compliance with Oregon law. . . .

⁶ (...continued)

The patient must be informed by an attending doctor of his or her diagnosis, prognosis, the potential risks associated with taking the medication, the probable result of taking the medication, and the feasible alternatives, including, but not limited to, comfort care, hospice care, and pain control. A second consulting physician must then confirm the terminal illness and determine that the patient is acting voluntarily. Further, if there is any indication that the patient may be suffering from a psychiatric or psychological disorder, or depression-causing impaired judgment, either physician must refer the patient for counseling. If there is a referral, no lethal medication may be prescribed until the person performing the counseling concludes that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.

⁷ Pub. L. 105-12 (1997).

The DOJ press release notes that physicians who dispense controlled substances beyond "the course of professional practice" may be subject to criminal penalties, and that those who engage in "conduct which may threaten the public health and safety" may have their authority to prescribe controlled substances revoked. Although the press release does not provide citations for these standards, the phrase "the course of professional practice" may be found in 21 C.F.R. §1306.04 (1999), which provides that:

A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. . . . An order purporting to be a prescription issued not in the usual course of professional treatment . . . is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person . . . issuing it shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

Some variation of the other phrase used in the DOJ press release, "conduct which may threaten public health and safety," is relevant to two different sections of the code: 21 U.S.C. §§823 and 824. Under §823, the Attorney General shall "register" or authorize a physician to prescribe or dispense controlled substances if it is consistent with the "public interest."⁸ In determining the public interest, a variety of factors may be considered, including whether such registration is "consistent with the public health and safety." Under 21 U.S.C. §824, a registration "may" be revoked for a number of reasons, including whether the physician has committed such acts as would render his registration inconsistent with the "public interest" as evaluated under the factors found in § 823.⁹

Both the House-passed H.R. 2260 and the version reported by the Senate Judiciary Committee would, among other things, amend 21 U.S.C. §823 by adding the following at the end:

(1) For purposes of this Act and any regulations to implement this Act, alleviating pain or discomfort in the usual course of professional practice is a legitimate medical purpose for the dispensing, distributing, or administering of a controlled substance that

⁸ Factors to be considered include: (1) maintenance of effective control against diversion of particular controlled substances into other than legitimate medical, scientific, and industrial channels; (2) compliance with applicable State and local law; (3) prior conviction record of applicant under Federal or State laws relating to the manufacture, distribution, or dispensing of such substances; (4) past experience in the distribution of controlled substances; and (5) such other factors as may be relevant to and consistent with the public health and safety.

⁹ Such factors include whether the physician has: (1) materially falsified any application filed pursuant to or required by this title or title II; (2) been convicted of a felony under this title or title III or any other law of the United States, or of any State, relating to any substance defined in this title as a controlled substance or a list I chemical; (3) had his State license or registration suspended, revoked, or denied by competent State authority and is no longer authorized by State law to engage in the manufacturing, distribution, or dispensing of controlled substances or list I chemicals or has had the suspension, revocation, or denial of his registration recommended by competent State authority; (4) committed such acts as would render his registration under 21 U.S.C. § 823 inconsistent with the public interest as determined under such section; or (5) been excluded (or directed to be excluded) from participation in a program pursuant to section 1128(a) of the Social Security Act, 42 U.S.C. §1320a-7(a).

is consistent with public health and safety, even if the use of such a substance may increase the risk of death. Nothing in this section authorizes intentionally dispensing, distributing, or administering a controlled substance for the purpose of causing death or assisting another person in causing death.

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

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

Paragraph (2) of this section appears to be the core of the language intended to discourage the practice of assisted suicide. Under this paragraph, the Attorney General, in evaluating registrations, "shall give no force and effect to State law authorizing or permitting assisted suicide or euthanasia." The intended effect of this language, however, is unclear, since the Attorney General does not have the legal authority to enforce Oregon laws. Rather, in her press release, Attorney General Reno indicated that the Oregon state law would be a standard by which she would interpret the phrases "course of professional practice" and "conduct which may threaten the public health and safety." Thus, it is not clear whether "giving force and effect" is an accurate description of how Oregon state law is utilized in the DOJ press release.

It is likely, however, that a court would construe the terms "give force and effect" to be consistent with the obvious congressional intent that such state laws should not be considered in interpreting the meaning of sections 21 U.S.C. 832 and 824.¹⁰ The language in question, however, still would not appear to require the Attorney General to deny registration to physicians who have engaged in assisted suicide, or to require that the Attorney General revoke the licenses of such physicians. Rather, it would require the Attorney General to reevaluate whether the "public interest" would be served by allowing the registration of doctors who are engaged in such activity, this time without consideration of existing state laws authorizing or permitting suicide or euthanasia.¹¹

Thus, the language in paragraph (2), does not appear to impose a legal standard for registration of doctors, but rather may be an attempt to abrogate the line of legal reasoning which underpins the DOJ press release.¹² As the term "public interest" is broad and ambiguous, paragraph (2) would appear to leave the Department of Justice with wide discretion to consider other factors to determine whether the revocation of a doctor's

¹⁰ House Rep. 106-378, 106th Cong., 1st Session (1999).

¹¹ This legislation does not address how the Attorney General should evaluate states that neither authorize nor forbid assisted suicide. Further, while the Attorney General must ("shall") register physicians to handle controlled substances if it is not inconsistent with public policy, she is not required to ("may") revoke such registration upon a finding that it is inconsistent with the public interest.

¹² It should be noted, however, that this language would not appear intended to affect physicians who choose to engage in assisted suicide or euthanasia using prescription drugs that are not listed as controlled substances.

license for engaging in assisted suicide was in the public interest. DOJ has indicated, however, that the Administration strongly opposes the practice of physician-assisted suicide.¹³ Thus, absent the concerns raised by DOJ regarding federal government establishment of medical practice policies for the states, the Administration might well conclude that the practice of assisted suicide is not in the public interest, and withholding or revoking the controlled substances registration of physicians engaging in such would be justified.

The other relevant paragraph in the proposed Act, paragraph (1), appears to be of negligible legal impact. The first sentence of paragraph (1) establishes that for purposes of the entire Act, the provision of palliative care is a legitimate medical practice consistent with the public interest. Although welcomed by a large part of the medical community as a clarification, it seems unlikely that the provision of palliative care by itself would be found by the Department of Justice to be either inconsistent with the public interest or an illegitimate medical practice, even absent the language of this bill. Thus, the effect of this language appears merely to reinforce existing practice.

The meaning of the second sentence of paragraph (1) would also appear to be noncontroversial, but questions have been raised as to its impact. At first glance, the language would appear to merely be a rule of construction, making clear that the language in the first sentence (discussed above) does not authorize assisted suicide or euthanasia. In an October 19, 1999 letter to the Honorable Henry J. Hyde, however, the Department of Justice maintains that the sentence "[n]othing in this section authorizes intentionally dispensing, distributing, or administering a controlled substance for the purpose of causing death or assisting another person in causing death," would make it a federal crime for a physician to dispense a controlled substance to aid a suicide, thus exposing him or her to a 20-year mandatory minimum sentence.

Such an interpretation would appear to be suspect. The second sentence of paragraph (1) indicates only that nothing in §823 authorizes assisted suicide or euthanasia, leaving unanswered the question of whether some other portion of the Act might do so. The fact that the first sentence of the paragraph authorizes palliative care under the Act might arguably be seen by a court as implying that the Act does not authorize assisted suicide or euthanasia. However, given the reasoning of the Department of Justice that compliance with state law is generally sufficient to establish "legitimate medical practice," it is unlikely that a court would find this alternate interpretation sufficiently clear to support a criminal prosecution.

¹³ Letter from Department of Justice to the Honorable Henry Hyde, Chairman, Committee on the Judiciary (October 19, 1999).

Pain Relief Promotion Act of 2000

House bill (H.R. 2260) introduced June 17, 1999 by Cong. Henry Hyde (R-IL) and Bart Stupak (D-MI). Approved by House on October 27 by a vote of 271 -156 (with 71 Democrats supporting).

Senate bill (S. 1272) introduced June 24, 1999 by Sen. Don Nickles (R-OK) and Sen. Joe Lieberman (D-CT); approved by Senate Judiciary Committee on April 27, 2000 by a vote of 10-8. Now has 41 sponsors (5 Democrats).

Supporting organizations:

Aging with Dignity
Agudath Israel of America
American Academy of Pain Management
American College of Osteopathic Family Physicians
American Medical Association
American Society of Anesthesiologists
Americans for Integrity in Palliative Care
Americans United for Life
Association of Pain Management Anesthesiologists
California Disability Alliance
Carondelet Health System
Catholic Charities USA
Catholic Daughters of the Americas
Catholic Health Association of the United States
Catholic Hospice (Florida)
Catholic Medical Association
Christian Medical Association
Coalition of Concerned Medical Professionals
Delaware Medical Society
Eagle Forum
Feminists for Life of America
Florida Hospices and Palliative Care, Inc.
Florida Medical Association
Focus on the Family Physicians Resource Council
Friends of Seasonal and Service Workers (Oregon)
Hope Hospice and Palliative Care (Florida)
Hospice Association of America
Louisiana State Medical Society
Lutheran Church - Missouri Synod
Medical Society of Delaware
Medical Society of New Jersey
Michigan State Medical Society
National Association of Pro-Life Nurses
National Catholic Office for Persons with Disabilities
National Conference of Catholic Bishops
National Council of Catholic Women
National Council on Independent Living

National Hospice and Palliative Care Organization (formerly National Hospice Organization)
 National Legal Center for the Medically Dependent and Disabled
 National Right to Life Committee
 Not Dead Yet
 Oklahoma State Medical Association
 OSF Healthcare System
 Pain Care Coalition (representing the American Academy of Pain Medicine, American Pain Society, and American Headache Society)
 Pennsylvania Medical Society
 Physicians for Compassionate Care
 Supportive Care of the Dying: A Coalition for Compassionate Care
 Union of Orthodox Jewish Congregations of America
 Vitas Healthcare
 Wisconsin Council on Developmental Disabilities

Individual endorsements (institutional affiliations for identification purposes only):

Dr. Ira Byock, Palliative Care Service (Missoula, MT)
 Dr. Carlos F. Gomez, Palliative Care Service, University of Virginia Medical Center
 Dr. Herbert Hendin, Medical Director of American Foundation for Suicide Prevention
 Dr. Walter Hunter, Associate National Medical Director, VistaCare Hospice
 Dr. C. Everett Koop, former U.S. surgeon general
 Dr. Ralph Miech, professor of pharmacology (emeritus), Brown University
 Dr. Robert Orr, Director of Clinical Ethics, Loma Linda University Medical Center
 Dr. Edmund Pellegrino, Professor of Medicine and Medical Ethics, Georgetown University
 Dr. Daniel P. Sulmasy, professor of medical ethics at St. Vincent's Medical Center (New York)
 John F. Tuohey, Ph.D., Chair, Applied Health Care Ethics, Providence Health System - Oregon
 Dr. Eric Cheflen, Director of Palliative Care, St. Elizabeth's Medical Center (Youngstown Ohio)
 Dr. F. Michael Gloth III, President, Hospice Network of Maryland
 Dr. Paul R. McHugh, Director of Psychiatry, Johns Hopkins University School of Medicine
 Rabbi J. David Bleich, Ph.D., Professor of Law, Benjamin Cardozo School of Law
 Dr. Francis L. Delmonico, Professor of Surgery, Harvard Medical School

The Pain Relief Promotion Act: *Long Overdue*

C. Christopher Hook, M.D.

Dr. Hook is a consultant in Hematology and Medical Oncology at the Mayo Clinic in Rochester, Minnesota. He is Chair of the Myeloproliferative Disorders Disease-Oriented Group at Mayo, the Mayo Clinical Ethics Council, the Mayo Reproductive Medicine Advisory Board, and the DNA Research Committee. He founded the Mayo Medical Center Ethics Consultation Service and is working now with colleagues to create a palliative care consultation service and a transplantation ethics committee. He is a Senior Fellow of the Center for Bioethics and Human Dignity and a member of the Christian Medical Association.

Note: Dr. Hook's comments are strictly his own and do not necessarily reflect the opinion(s) of the Mayo Foundation.

The Pain Relief Promotion Act (PRPA) is an invaluable piece of legislation for the promotion of patients' right to freedom from unnecessary pain. It also serves to add protection to their lives and dignity. While opponents have tried to label the legislation as nothing more than a means to restrict physician-assisted suicide (PAS), it is a liberating document, helping to ensure that physicians can aggressively treat pain without fear of possibly losing their licenses to practice medicine.

Presently, the Drug Enforcement Agency (DEA) may intervene in any physician-patient relationship if restricted substances, such as narcotics, are used in "large" quantities or might result in an earlier demise of the patient. The DEA may do so regardless of whether or not the quantities of medications were appropriately used to alleviate a patient's pain, and in which there was no primary goal of ending the patient's life. Physicians throughout the country have undergone the nightmare of "trials" before state authorities with the support of the DEA, sometimes losing their licenses for simply providing appropriate aggressive pain management.

Though medical ethics has long understood that negative consequences may occur from beneficent means, and are consequently to be accepted to pursue the good, the DEA is not bound by medical tradition or reasoning. Consequently, many physicians are afraid to prescribe necessary and appropriate doses of narcotic analgesics lest they be investigated, brought before some state board or pursued by the DEA. As a hematologist/oncologist I have had to struggle many times to get referring physicians to provide sufficient analgesics in order to give our shared patients some reasonable quality of life, and freedom from needless suffering.

Just last week I had another long discussion with a physician in another state about the medication requirements of one of my patients. This patient of five years suffers from a severe chronic pain syndrome resulting from a major motor vehicle accident and subsequent acute respiratory distress syndrome (ARDS). He spent many weeks on a ventilator in an intensive care unit and it is a miracle that he is alive today. But he, like many ARDS survivors, is left with a severe diffuse pain syndrome and requires fairly hefty doses of narcotic medications. His doses have been stable for the last two years. I have had him seen by pain specialists in our institution to explore other options of pain management, and they have repeatedly supported his current program. Most of last year I struggled to find him a physician at home who would continue to write renewal prescriptions for his medications. His primary physician abandoned him, refusing to write the prescriptions, for fear of investigation by state and/or federal officials. Other physicians have refused to take him as a patient claiming the same reason. Finally, we found a physician many miles from his home who would assume his care. Even then, I received a call

from the physician expressing concern that he might be investigated by his state's Board, or the DEA, if he provided the prescriptions for my patient. Finally, after I reassured him that 1) the patient's narcotic doses had been stable over several months (documented), 2) that pain management specialists had independently evaluated the patient and recommended the current course of therapy (documented), 3) that I would come to his defense if such an investigation were initiated, and 4) that our professional obligations required us to provide the necessary treatment to control the patient's suffering, he agreed to write the prescriptions. This is all the result of the status quo. Those who claim that the PRPA will cause a "chilling effect" on pain control in this country have the burden of proof to demonstrate that it would create a worse situation than currently exists, and they simply cannot do it.

Rather, the PRPA specifically declares "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." When individual states have changed their own internal standards to adopt similar positions and language, the use of narcotics for pain control and efforts in palliative care have increased dramatically. However, patients elsewhere should not have to suffer based upon whether they happen to be in one of the more enlightened states or not. It is the right of every American patient to receive appropriate, aggressive pain control. This statement is the first clear articulation in national legislation of what has been the ethical and appropriate standard of care for patients in pain. It is a statement and protection long overdue.

Further, the PRPA recognizes the need for education of members of the medical profession and regulators to improve and support appropriate palliative care. This process will bring together members of the different disciplines to ensure that patients may receive the care they need and that physicians may treat without fear and unnecessary encumbrances.

The PRPA declares that the use of controlled substances for the deliberate killing of patients is forbidden, a statement that is simply consistent with the nature and purpose of the FDA and the DEA. The FDA and DEA have been created by the Federal Government to ensure that pharmaceuticals are safe and effective and that powerful agents are not misused. Further, the use of any pharmaceutical to deliberately kill is incompatible with the ethical practice of medicine. This is a 2400 year old pillar of medical ethics and has served our patients well. To allow the use of controlled substances to explicitly kill is to make a mockery of the FDA, the DEA and the profession of medicine.

We should learn from history that whenever a society has allowed its physicians to kill, even for ostensibly beneficent purposes, serious abuses have occurred and physicians have become unworthy of trust. The experience of the German medical profession from the 1920's through the end of World War II is a glaring example, but many choose not to remember this. It was, however, physicians, empowered by the state to kill, who designed and implemented the means of the Holocaust.

For the past twenty years the Netherlands has continued to teach us this point. Though the requirements for euthanasia and physician-assisted suicide initially required that the patient initiate the request, nearly 1% of all deaths in Holland now occur with the deliberate killing of a patient without the patient's explicit request. Consequently, some patients now refuse to enter a hospital or a nursing home, or in some cases even to take medication, because they fear for their lives.

It is claimed that this will not happen in the "experiment" in Oregon, but it already is happening. The supposed safeguards to prevent abuse clearly do not work. The very first person killed under the Oregon plan demonstrates this. The woman had metastatic breast cancer, but was asymptomatic. She was discouraged because of this and wanted a lethal prescription. Her regular physician and oncologist believed she was clinically depressed and appropriately refused to give her the prescription. Data clearly has demonstrated that the majority of patients who are considering ending their lives are clinically depressed, and that with appropriate anti-depressant therapy, or even the passage of time, the patient's

desire for death will pass. Patient's who are clinically depressed lack the decision-making capacity for such critical, life-affecting decisions. The patient, however, then called Compassion in Dying and was referred to a physician who was guaranteed to write a prescription for a lethal overdose. Because the physicians who had a long standing relationship with the patient had declared that she was depressed, this individual felt obligated to dispute this claim and arranged a 20 minute phone conversation with a psychologist who declared that she was not depressed. This is in spite of the fact that in a recent survey 94% of Oregon psychiatrists stated that they were not confident (51% stating they were not at all confident) that they could spot a judgment-impairing psychiatric problem in just one visit. The lethal prescription was written and the patient committed suicide. So much for safeguards.

A more recent case illustrates that, though required by law, the patient need not make the request. The patient was an elderly woman suffering from dementia, and was declared incompetent by several physicians to request assisted-suicide. The patient's daughter went doctor shopping until she found someone who would write the prescription, despite the fact that the physician admitted, "the choices of the patient may be influenced by the family's wishes and the daughter was somewhat coercive".

Margaret Mead wrote in 1937,

Throughout the primitive world the doctor and the sorcerer ended to be the same person....He who had the power to cure would necessarily be able to kill. Depending on who was paying the bill, the doctor/witchdoctor could try to relieve pain or send the patient to another world. Then came a profound change in the consciousness of the medical profession - made both literal and symbolic in the Hippocratic Oath...One profession...was to be dedicated completely to life under all circumstances, regardless of rank, age or intellect - the life of the slave, the Emperor,...or the defective child. This is a priceless possession which we cannot afford to tarnish...but society is always attempting to make the physician into a killer - to kill the defective child at birth, to leave sleeping pills beside the bed of the cancer patient...It is the duty of society to protect the physician from such requests.

Indeed. The PRPA reflects this wisdom. Assisted suicide is not a legitimate form of medical practice and should not be permitted.

And speaking of "who is paying the bill", the Oregonian reported in October of 1998 that the Oregon Medical Assistance Program would now pay for physician-assisted suicide but no longer would pay for adequate palliative care. Pain medications were capped at low levels. The program had also suspended funding for antidepressants, but later reversed that position under significant protest. So much for a system that is supposed to be committed to the dignity of the patient. All this tells a poor patient is that we are happy to kill you, but that you are not even worth the cost of appropriate comfort care.

It is often stated that assisted-suicide is a necessary means to preserve patients' dignity. The Oregon program is even called the Death With Dignity Act. Once and for all we should put an end to this false rhetoric. If one looks in the dictionary, there are two common usages of the term dignity: one meaning intrinsic worth, and the other referring to imputed dignity - the subjective perception of worth or decorum. Intrinsic worth or dignity is something that all of us possess by the mere fact that we are human beings and each of inestimable worth. It is something that cannot be lost or eroded by the presence of disability or illness. If we imply that illness can diminish our dignity we diminish the worth of every human being, a rather dangerous course. If we believe rather that we should focus on imputed dignity in the question of assisted suicide then we encounter another problem. The patient is forced to come to another person to receive the means of death and states, "I think my life no longer has value, I have lost

my dignity". The physician in order to write the prescription must implicitly, if not explicitly, state, "I agree, your life no longer has meaning or value. Here take these...". At this point the physician has shredded any sense of imputed dignity the patient may have held onto. To agree to overtly kill another human being is the antithesis of respecting dignity by any definition.

This in essence leads to another commonly heard justification for assisted-suicide, that it promotes autonomy. As I have shown earlier, the majority of patients who request assisted suicide are depressed and lack decision-making capacity. Autonomy requires liberty and agency, the latter meaning decision-making capacity. Thus most requests for assisted-suicide are by definition not autonomous. Further, the Oregon program requires the permission and participation of others, so again it is not truly a promoter of autonomy. Any thoughts that the Oregon Death With Dignity Act promotes autonomy are illusory.

Thus criticisms that the PRPA will restrict the autonomy of Oregonians is false.

Is not the PRPA a usurpation of state's rights, a common complaint against the bill? The claim is that the Oregonians approved physician-assisted suicide and therefore the Federal Government has no jurisdiction in any realm that might interfere with that choice. To answer this question, I pose another question. Would we allow a state to authorize the sale of laetril, or other disproven, toxic drugs? What we have in this situation is the claim that one state can override the authority and power of the DEA, or ostensibly the FDA, or any other federal agency, which has regulatory authority throughout the United States. All physicians must have a DEA license to prescribe controlled substances, and yet somehow a state has now decided that the licensing agency for every other physician in the United States no longer has jurisdiction over its' physicians. This would not be accepted for any other similar Federal authority and should not be accepted here. The PRPA takes nothing from Oregon. It simply reminds that state what it means to be a member of a union of states under a central government. Oregon is trying to coerce the Federal Government to support physician-assisted suicide by exempting its physicians from the rules that apply to any other physician in the remaining 49 states, an act of injustice and impropriety. We either have national regulatory agencies with uniform authority throughout the 50 states or we revert to a system of inconsistent and arbitrary behavior regarding critical issues of safety and justice. The choice should be clear.

In summary, the PRPA is a valuable, long overdue piece of legislation promoting the freedom of patients to achieve relief from their pain, and of physicians to appropriately perform their duties. It recognizes the proper authority of federal agencies, specifically the DEA. It appropriately recognizes that the purpose of the medical profession and medication is to help, not to kill. In so doing it protects the safety of patients, the integrity of the medical profession and the dignity of us all.

Abuse Suicide File

PAIN CARE COALITION

A National Coalition for Responsible Pain Care

American Academy of Pain Medicine • American Headache Society • American Pain Society

STATEMENT

of the

PAIN CARE COALITION

JOEL R. SAPER, M.D., F.A.C.P., F.A.A.N., CHAIRMAN

in support of

H.R. 2260

THE PAIN RELIEF PROMOTION ACT OF 1999

September 7, 2000

The Pain Care Coalition is pleased to present this statement in support of H.R. 2260, the *Pain Relief Promotion Act of 1999*, as passed by the Senate Judiciary Committee. The Pain Care Coalition is a national coalition that advocates for responsible pain care policies at the federal level. The Coalition was formed in 1998 by concerned organizations representing the interests of pain care professionals and their patients. Constituent members of the Coalition represent a broad spectrum of physicians and other health care professionals involved in the diagnosis and treatment of patients suffering from acute and chronic pain. Members also include those professionals who conduct biomedical and related research into the causes of pain and the effectiveness of diagnostic and therapeutic approaches to freeing patients from pain or lessening the pain of those who must live with it.

While the Pain Care Coalition expressed reservations about the version of the legislation passed by the House last fall, the Senate Judiciary Committee's substitute to the House-passed bill includes several important changes that the Coalition strongly supports. Based upon these changes, the Coalition is pleased to support the measure.

The Coalition's reservations focused on concerns that the bill might have a "chilling effect" on the willingness of physicians to prescribe controlled substances for legitimate pain control purposes, particularly to patients at or near the end of life. Such concerns have been based in part on confusion over whether the bill actually grants new authority to the Drug Enforcement Administration to police physician prescribing practices, and in part on fears that enactment of the legislation might influence the DEA's use of its existing authority under the Controlled Substances Act.

Given these reservations about the House-passed bill, the Coalition, working with other interested organizations, advocated for certain modifications to ensure that appropriate -- and indeed sometimes aggressive -- pain care would not be compromised by the fear of overzealous DEA scrutiny. The Coalition's concerns were heard, and the bill was modified to include a number of beneficial changes. The Coalition is confident that the substitute measure will help physicians provide appropriate pain care to millions of Americans who endure unnecessary suffering.

First, by raising the standard of proof in certain DEA administrative proceedings to that of "clear and convincing" evidence, the substitute ensures that whatever new law is made by this bill, if any, could be used against physicians only in the most clear cut cases, and not simply because "20/20 hindsight" raises suspicion about a physician's intentions in prescribing controlled substances to terminally ill patients.

Second, and of equal or greater importance in the long run, are beneficial changes in the bill's new initiatives to further education and training in appropriate pain care, including the legitimate use of controlled substances. By broadening these new authorities to include pain care generally, and not just palliative care at the end of life, the substitute ensures that the use of controlled substances will be viewed in context with the other diagnostic and therapeutic options available in this rapidly maturing field of medicine. To equate pain care only with the needs of the dying, or to promote the use of controlled substances while ignoring other more appropriate modalities would have been a disservice to millions of Americans who suffer daily from pain

that is not related to terminal illness, and for which controlled substances are neither the most appropriate nor the most effective treatment.

Finally, the Coalition applauds the provision of the substitute bill which declares the next ten years to be the "Decade of Pain Control and Research." Despite its prevalence as a leading health problem, pain has often been a largely invisible condition. It lacks a significant constituency at the Federal level, and this has contributed to serious under-investment in research and treatment in the pain field. A congressionally declared "Decade" will bring a much needed focus on pain in both the public and private sectors. It can be an important first step in stimulating further progress in research, training, and clinical care.

For all of these reasons, the Coalition urges all Senators to support the *Pain Relief Promotion Act* when it comes to the Senate floor. While some well-intentioned critics may still fear the "chilling effect" of any legislation to be implemented, even in part, by the Drug Enforcement Administration, the Pain Care Coalition is persuaded that the substitute will not impede the legitimate use of controlled substances by the vast majority of pain care practitioners who will remain committed to providing appropriate pain and palliative care to terminal and other painful patients who, without such care, might be driven to consider the taking of their own lives.

***FOR FURTHER INFORMATION CONTACT:
ROBERT SANER OR AMY BACON AT (202) 466-6550***

Americans for Integrity in Palliative Care

"To care, always...to kill, never"

May 4, 2000

Dear Senator:

Opponents of H.R. 2260, the Pain Relief Promotion Act of 2000 (PRPA), insist that this legislation will have a "chilling effect" on doctors' willingness to prescribe controlled substances for the treatment of pain. All evidence, however, points to the contrary.

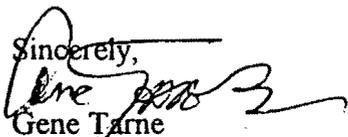
Enclosed is testimony offered by Eric Chevlen, M.D., before the Senate Judiciary Committee on April 25. Dr. Chevlen, a founding member of Americans for Integrity in Palliative Care (AIPC), serves as director for palliative care at St. Elizabeth's Hospital in Youngstown, Ohio, and as medical director of two hospices. He is also certified with the American Board of Medical Oncology, the American Board of Pain Medicine, and the American Board of Hospice and Palliative Medicine. In his testimony, Dr. Chevlen addresses the issue of the so-called "chilling effect."

As Dr. Chevlen points out, the argument of the "chilling effect" is "testable," and has been tested in the states. In those states which have passed laws similar to the Pain Relief Promotion Act — i.e., laws which reject assisted suicide while allowing for pain control that may unintentionally hasten death — the use of morphine for pain control has *increased*. This is exactly *contrary* to the predictions made by opponents of the PRPA. The data may not prove that the rise in morphine consumption and improvement in pain control is due exclusively to passage of such laws. But they certainly *disprove* the contention, so adamantly asserted by opponents of the PRPA, that passage of such laws worsens pain control by reducing the use of morphine.

Also enclosed are charts, offered into the record by Dr. Chevlen, that illustrate the increase in morphine use in states which have passed laws similar to the PRPA. The charts are based on the most recent data on per capita morphine use from the Drug Enforcement Administration.

Of related significance, when Congress passed the Assisted Suicide Funding Restriction Act in 1997, the same phenomenon was seen. This Act prohibited assisted suicide in all federal health programs and health facilities, while allowing pain control that may unintentionally shorten life. In the year following enactment, Veterans Administration hospitals made significant *improvements* in palliative care, as noted in the enclosed article from the *Last Acts* Newsletter.

As the enclosed data show, the fear of a "chilling effect" as reason to oppose the Pain Relief Promotion Act is without grounds. AIPC asks that you review this data, and give your support to H.R. 2260, the Pain Relief Promotion Act of 2000. Thank you.

Sincerely,

Gene Tarne

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Eric Cheflen, M.D.
Testimony Before the Senate Judiciary Committee
Concerning The Pain Relief Promotion Act
April 25, 2000

Mr. Chairman, members of the Senate Judiciary committee:

Thank you for inviting me to address you this morning to explain why the Pain Relief Promotion Act (PRPA) should be adopted as law.

Introduction

Allow me to introduce myself and explain my interest in this bill. My name is Eric Cheflen, M.D. I am a physician practicing in Youngstown, Ohio. I am the director of palliative care at St. Elizabeth hospital, and medical director of two hospices. I am certified by the American Board of Medical Oncology, the American Board of Pain Medicine, and the American Board of Hospice and Palliative Medicine. Every day in my practice I face the challenge of relieving the suffering of my patients. One of my best tools in this humane task is the class of drugs we physicians call opioids, and which this legislation refers to as narcotics. I unhesitatingly prescribe them to patients for whom they are the best analgesic, in doses that best balance side effects and benefit, no matter what the number of milligrams may be. Given the nature of my practice, it is not a surprise that I am one of the largest prescribers of opioids in Ohio. To borrow a phrase from the world of business, I am the "end-user" of this proposed legislation.

There is one other thing you ought to know about me. I am opposed to legalized euthanasia and physician assisted-suicide. The reason is this: In over twenty years of practicing medicine, more than a few of my patients have asked me to kill them. In every case—every case!—the request stemmed from depression, or anguish, or desperation, or fear of abandonment. In other words, my terminally ill patients sought euthanasia or assisted suicide for the same reasons that healthy people seek it. And, as in the case of healthy people, their suffering could be palliated, and their longing for death quelled, by proper use of medicine, lovingkindness, and what some have called the ministry of presence. The answer to anguish and desperation is not to coldly dispatch the anguished and desperate, but rather to enfold them within the bonds of a community that sees in them intrinsic, rather than merely utilitarian, value.

I am opposed to euthanasia. Nonetheless, Senators, if the PRPA were somehow to diminish the capability of physicians to relieve the suffering of the dying, if it were to increase the risk of harassment by overweening bureaucrats, or even if it were to chill the ardor of physicians to relieve suffering because they misunderstood the bill—if any of these were the case, then I would not be here speaking in support of the bill. Indeed, I would likely be here speaking against it.

Such, however, is not the case. The PRPA would not diminish the ability of doctors to relieve the suffering of the dying or others in pain. It is likely, frankly, that it would improve their ability to do so.

History of the Controversy

For some thirty years, the Controlled Substances Act (CSA) has regulated the therapeutic use of opioids and other substances. For thirty years, the federal law has recognized that, if misused, controlled substances present a significant potential harm to

the public. For thirty years the law has also recognized that, when used properly, they also offer a unique and wonderful relief of suffering.

To minimize the potential harm and to maximize the potential benefit of controlled substances, Congress mandated that they be prescribed only by practitioners who were licensed by the Drug Enforcement Agency. Congress also demanded—and who could argue with this?—that the prescribing of the controlled substances be done only for legitimate medical purposes.

"Legitimate medical purposes." That is a phrase you will hear often today, and whose interpretation—and misinterpretation—is the crux of the issue before us today.

Until quite recently, there was never any argument over the meaning of the term. Every doctor knew that he could not simply sell prescriptions for cash. Every doctor knew that he could not swap prescriptions for sexual favors. Every doctor knew that he could not use prescribed drugs to commit homicide, even if the victim consented or participated in that act.

There was never any question about all this. The meaning of the law was plain, and it was buttressed by numerous uncontroversial court decisions.

This clarity and integrity of the federal law came to an end, however, after the passage of Oregon's notorious physician-assisted suicide law. The question arose: if an Oregon practitioner is in compliance with the admittedly loose requirements of that state law, may he prescribe a controlled substance to kill his patient? The head of the DEA said no: a state law cannot change the fact recognized by federal law, that killing people is simply not a legitimate medical purpose. The Attorney General overruled him. She said, in effect, that in forty-nine states, killing patients was not a legitimate medical purpose, punishable under the Controlled Substances Act. In Oregon, however, it was to be considered a legitimate medical purpose—unless the practitioner failed to fill out the requisite state paperwork. Then, it would again be deemed not legitimate.

Usurping Congressional Authority

Although that decision certainly generated a lot of discussion, I am surprised at how little has been said concerning what a sweeping Executive branch usurpation of Congressional authority was thereby accomplished. The Attorney General's decision effectively eliminated the Controlled Substances Act. If the impact of the law is to be determined, as she says, by state standards, then there is in effect no longer any enforceable federal standard. Oregon has now empowered its physicians to prescribe lethal doses of controlled substances, and the Attorney General says that if the state permits it, so too does the federal government. In effect, she has created a federal license to kill, if only state law be permitting. There is nothing in her ruling that prevents other states from allowing physicians—or pharmacists or podiatrists for that matter—from prescribing a panoply of controlled substances according to any criteria that state may choose. According to the Attorney General's Alice-in-Wonderland ruling, the federal government must recognize the "legitimate medical purpose" of this, simply because such action would be compliant with that state's law.

This point has been argued, and will surely be argued again if the PRPA does not

become law. In 1996, two years before the Attorney General's decision in this case, California passed a law considerably liberalizing the use and distribution of marijuana. In that case, the Justice Department argued the opposite of its point in the Oregon matter, saying, "A state initiative cannot supplant the will of the people of the United States."¹ Later, however, in the Oregon matter, the Attorney General argued that Congress never intended the Controlled Substances Act to apply to such a duly passed state law. Rather, claimed the Attorney General, Congress intended the scope of the CSA to be somewhat limited, and authorized the DEA to prevent the "particular drug abuse" deriving from a drug's "stimulant, depressant, or hallucinogenic effect on the central nervous system."²

Set aside, for a moment, the fact that her theory of the law is completely unsupported by its legislative history, wording, and case law interpretation. Even if one grants the Attorney General's theory, that only drug abuse of this class is interdicted by the CSA, then use of controlled substances to cause death is surely forbidden by the CSA. After all, the very mechanism by which controlled substances in overdose cause death is by depressing the central nervous system, in particular the respiratory center.

Is there to be a uniform federal standard of "legitimate medical purpose" or is there not? If the Senate feels there should not be any standard meaning to a federal law, if it feels that the CSA should be eradicated by bureaucratic legerdemain, then it should not pass the Pain Relief Promotion Act. If, on the other hand, it feels as I do that the very purpose of federal law is to protect the common good by establishing clear and uniform application of the law, then it very much should pass the PRPA. This act has as its main purpose the restoration of a uniform national standard in the Controlled Substances Act, but in fact it would do more: it would prevent the effective elimination of the CSA by the Executive branch without the advice or consent of the Congress.

The PRPA Restores Proper Balance Between State and Federal Laws

Much mischief has been made of the fact that the PRPA puts into statute the law as it has been uniformly and unarguably enforced for many years. The act makes explicit that it is only purposeful killing of patients that is a violation of the CSA. Gentlemen, that is the law today. Even if the PRPA is not passed, the purposeful killing of a patient by use of a controlled substance will remain a violation of the CSA in forty-nine states. This act does not change the law for the doctors of those forty-nine states. It simply restores the effect of federal law to the one state that has abrogated its duty to extend state interest in the preservation of life to an apparently expendable segment of its population, namely those who are severely ill and despairing of life.

It is also important to note that the PRPA would not overturn the Oregon law allowing physician-assisted suicide. It would still be legal for a practitioner to prescribe a lethal potion there; only it must not contain a federally controlled substance. Sadly, there are a number of other drugs that can accomplish this wicked purpose, and there is no end to the inventiveness of people in whom are mixed the traits of cleverness and contempt for the innate value of every human being. While I believe that passage of the PRPA would diminish the number of victims of medical killing, I do not expect the practice to come to an end in Oregon. The states will retain the right to regulate medical practice

within their borders. Passage of the PRPA simply ends federal collusion in the nasty business of doctors killing their patients.

Objections to the PRPA, and Their Refutation

As noted above, there are reasons of both law and justice to pass the PRPA. Now let us review the four possible reasons for opposing it.

First logically, and not last in some opponents' motivation, it would be reasonable to oppose the PRPA if one feels that euthanasia is a public good to be promoted by federal policy. That would be contrary to the unanimous vote in the Senate in denying public funding for euthanasia and assisted-suicide, and contrary to the long history of government protection of vulnerable classes of citizens. But such opposition would be consistent with the effect of the Attorney General's ukase.

The second argument raised against the PRPA is that it diminishes a state's right to regulate the practice of medicine. Even before the inclusion of the amendments introduced by Senator Hatch, this argument held no water, for the bill does not overturn the Oregon act allowing physician-assisted suicide. After the inclusion of the amendments, which specifically declare that "nothing in this subsection shall be construed to alter the roles of the Federal and State governments in regulating the practice of medicine," such an argument is not even worthy of consideration. Unfortunately, physician-assisted suicide will remain legal in Oregon even if this bill is passed. The federal government, however, will no longer play the role of enabler. Actually, if this bill is not passed, the states will gain new and unconstitutional power to limit the right of Congress to control interstate commerce of drugs. Without passage of the PRPA, it is the states that have power of nullification over a federal law. This country has already experienced considerable unhappiness as a result of nullification theory, and the Congress would be ill-advised to resurrect it now.

The third argument against the PRPA is that its language will have a chilling effect on the willingness of doctors to prescribe adequate doses of opioids to relieve the pain of dying patients, that they will fear a meddlesome DEA bureaucracy eager to swoop down on them and throw them in jail for 20 years when poor Grandma dies of cancer after her final comforting dose of morphine. Since the language of the bill does not adversely affect the license to prescribe opioids in 49 states, this cannot be so. Quite the contrary, this bill puts into statute what has heretofore been only administrative guideline, namely, that it is legitimate medical purpose to use a controlled substance to relieve pain even if that use increases the risk of death. This doctrine of double effect will be the law whether the PRPA passes or not. Making it explicit by statute should increase, not decrease, physician comfort in prescribing opioids.

Opponents of the bill speak as if prosecutors distinguish between homicide and natural death by using a Ouija board, rattles, and feathers. Those of you who have served as prosecutors know how far from reality this is. The circumstances of a death, not the dose of the drug, are determinative. By comparison, in this town of Washington today, two men may die from having a knife stuck in their chests. One case will be an unintended and tragic outcome from a failure to save a patient during a coronary artery

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bypass operation. The other will be a mugging occurring in an alley near the hospital. Just as it is easy to see that the first death was unintentional and due to a procedure which unavoidably increased the risk of death, so it is easy to see that the second is purposeful and criminal. Deaths associated with opioid use are just as easy to distinguish.

Much mischief is made by the euthanasiasts of the alleged respiratory suppression effect of morphine. Like so much else they promulgate, this is a gross distortion. Experienced clinicians understand that there is an enormous difference between the effect of morphine during its first days of use as compared with its effect in the chronic setting. During the first few days of use, morphine may cause sedation; if used recklessly it may even cause respiratory suppression. But the respiratory system quickly acclimates to morphine therapy. With continued use, morphine—even in high doses—relieves pain, but does not make the patient stop breathing.³

Another source of confusion is the fact that several different pharmacologic classes of drugs are lumped together in the category of controlled substances. Most of our discussion has been about opioids. But opioids are virtually never used to intentionally induce death for the very reason cited above. The recently published data from Oregon shows that 100% of patients who died as a result of prescribed lethal drugs took an overdose of a barbiturate.^{4,5} Only one of the patients was even prescribed an opioid to accompany the barbiturate; in that case the barbiturate alone would clearly have been fatal. With the exception of the antiepileptic phenobarbital, barbiturates have very little legitimate medical use these days. There are much safer drugs available to treat anxiety and insomnia. Indeed, it is this very lack of safety that makes barbiturates attractive to the doctor intent on killing his patient. My point is that this bill should not lead to reduced use of opioids, because opioids are not the drugs used to kill people; barbiturates are.

The opponents of the PRPA may counter that the doctors will refrain from prescribing opioids for fear that DEA or state regulatory officials will misinterpret their use of opioids as intentionally causing death, when in fact the patient died either of natural causes or as an inadvertent effect of the drug. But the law already forbids use of controlled substances to intentionally cause death in forty-nine states. Failure to pass the PRPA will not eliminate this law. The increased comfort concerning overweening regulation that physicians crave will not come from defeating the PRPA, but from passing it. This bill, for the first time, calls for federal dollars to be spent in the training and education of both federal and local officials, so that they will be more knowledgeable about proper palliative care, and less likely to mistake good care for a violation of law. If the PRPA is not passed, then there is nothing to improve the situation as it now stands, nothing to reduce the regulatory fear that inhibits doctors from prescribing drugs properly.

Fourth and finally, we need to address the possible objection to this bill that it will be misinterpreted by doctors, and that their misunderstanding of the bill will lead them to refrain from treating pain adequately. In particular, opponents argue that this misunderstanding will lead to a lower rate of prescribing opioids such as morphine. That opponents of the bill make this argument is actually a stunning concession that the language of the bill itself cannot justify such fears. Let us set aside for a moment the

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other implication of this argument, that men and women who have spent years mastering the intricacies of anatomy, physiology, pharmacology, and therapeutics are somehow too knuckle-headed to understand the plain meaning of a simple law. This argument of a chilling effect via physician misunderstanding is testable. In fact it has already been tested. Several states have passed laws similar in impact to the PRPA. If the legislation were to have a chilling impact on a doctor's willingness to prescribe opioids, we should see a drop in, for example, morphine consumption in those states subsequent to the passage of the laws.

In fact, the opposite is observed. For example, in the spring of 1996, Louisiana passed a law banning assisted suicide, while allowing pain control that might unintentionally increase the risk of death. Per capita morphine consumption in that state rose 80% that year, and had nearly tripled by two years later. Similar results were seen when Iowa, Rhode Island, Virginia, and Kansas passed similar laws. In fact, of the top ten states in per capita morphine consumption in 1999, seven have specific statutes against assisted suicide.⁶ Now this rise in morphine consumption after passage of state laws resembling the PRPA does not prove that such laws improve pain control. But the data certainly disprove the contention that such passage will worsen pain control by reducing opioid prescribing.

Conclusion: Eliminate the Federal License to Kill

Gentlemen, when I first earned my federal license to prescribe controlled substances, I was proud that my country had recognized my competence to relieve the suffering of my fellow citizens, and had entrusted to me the privilege to prescribe these medications for their benefit. It is deeply offensive to contemplate how this license of which I was so proud, a license to palliate the misery of my patients and fellow creatures, has been degraded to be a federal license to kill them, state law permitting. Senators, remove this stain; erase this blot. Vote to improve pain treatment and to protect the vulnerable citizens of the country. Vote to allow honest physicians to relieve pain without the stigma of a federal license to kill. Please pass the Pain Relief Promotion Act.

¹ Justice Department attorney Mark Quinlivan, arguing before U.S. District Court Judge Charles Breyer, quoted by Reuters newservice, March 25, 1998.

² Attorney General Janet Reno, Letter to Congressman Henry Hyde, June 5, 1998.

³ P.D. Wall, "The Generation of Yet Another Myth on the Use of Narcotics [Editorial]," *Pain* 73, no. 2 (Nov 1997): 121-2.

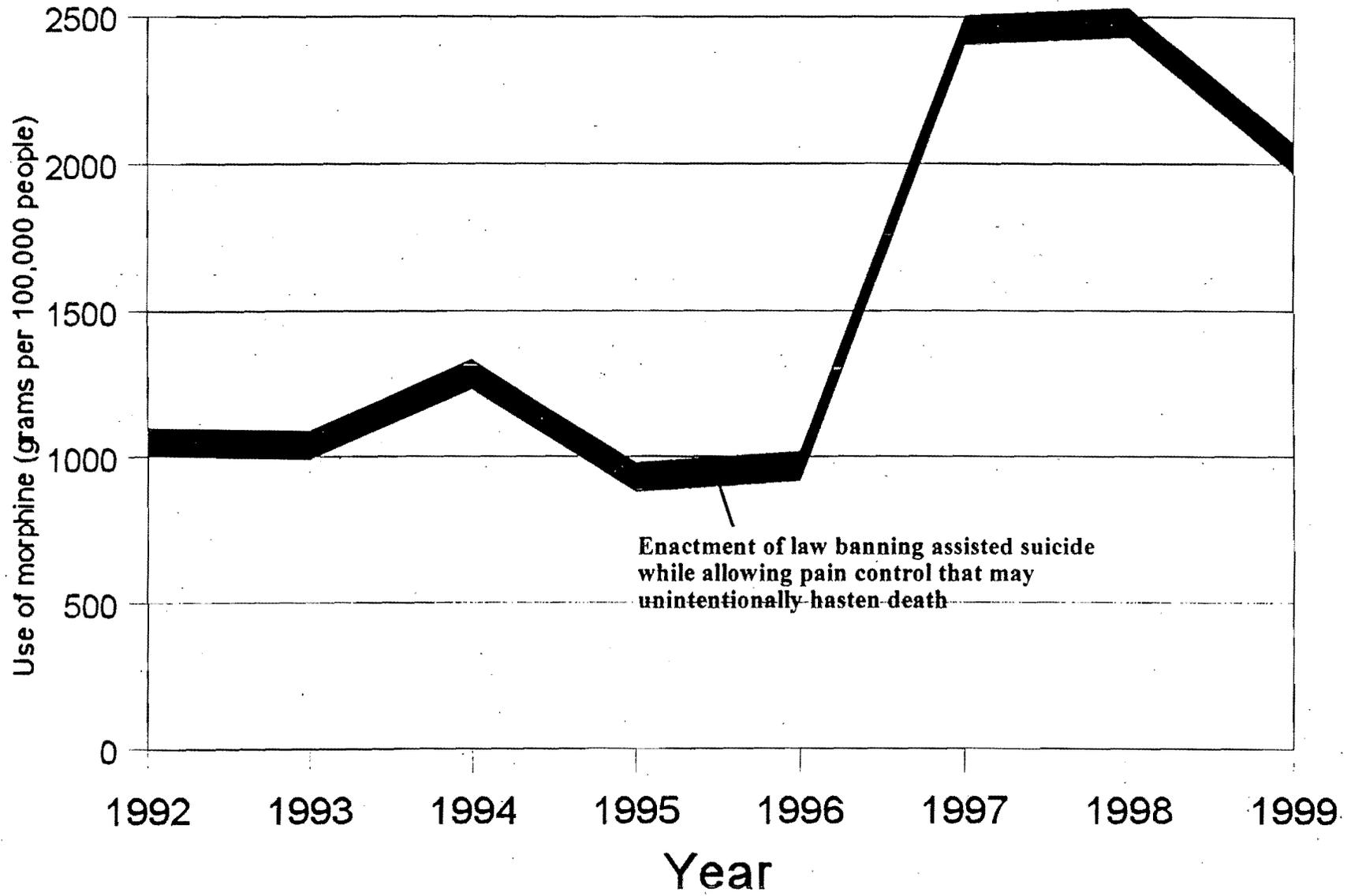
⁴ Arthur E. Chin, and others, "Legalized Physician-Assisted Suicide in Oregon--the First Year's Experience," *New England Journal of Medicine* 340 (1999): 577-83.

⁵ A.D. Sullivan, K. Hedberg, and D.W. Fleming, "Legalized Physician-Assisted Suicide in Oregon--the Second Year," *New England Journal of Medicine* 342, no. 8 (Feb 24 2000): 598-604.

⁶ Drug Enforcement Administration, U.S. Department of Justice, Statistics on Individual State Consumption of Morphine.

Use of Pain Control Drugs Rises When States Ban Assisted Suicide

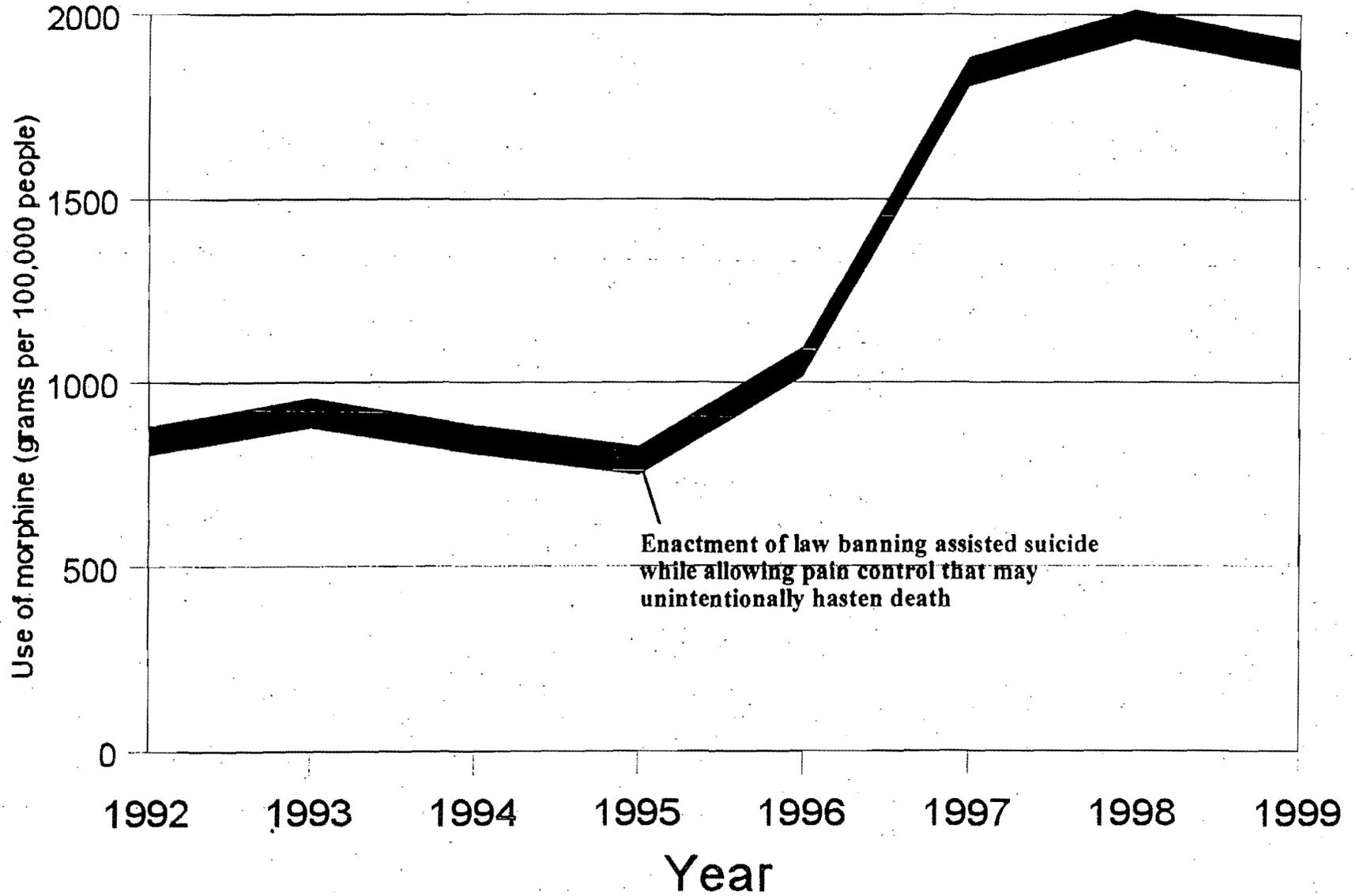
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(Source of morphine data: Drug Enforcement Administration)

Use of Pain Control Drugs Rises When States Ban Assisted Suicide

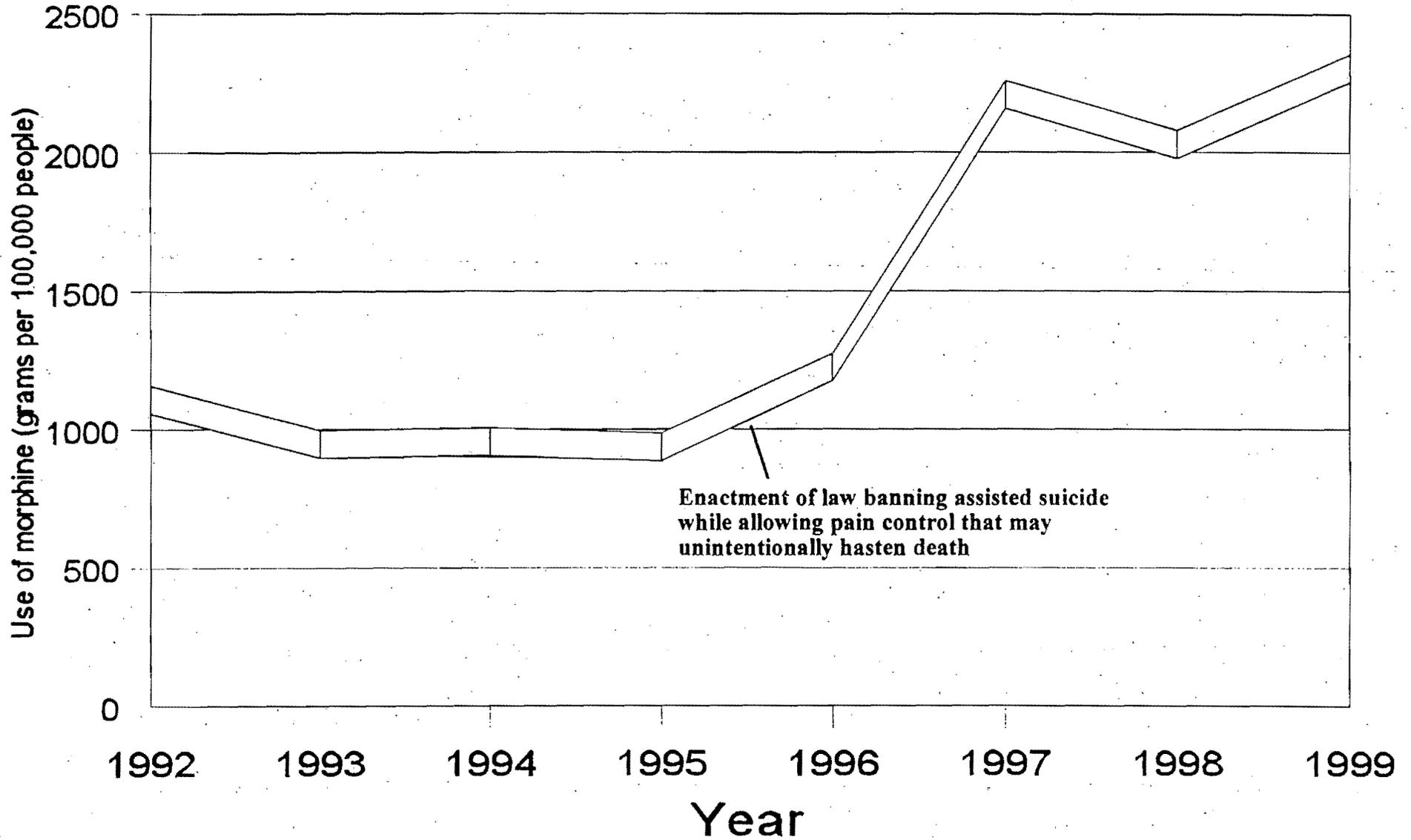
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(Source of morphine data: Drug Enforcement Administration)

Use of Pain Control Drugs Rises When States Ban Assisted Suicide

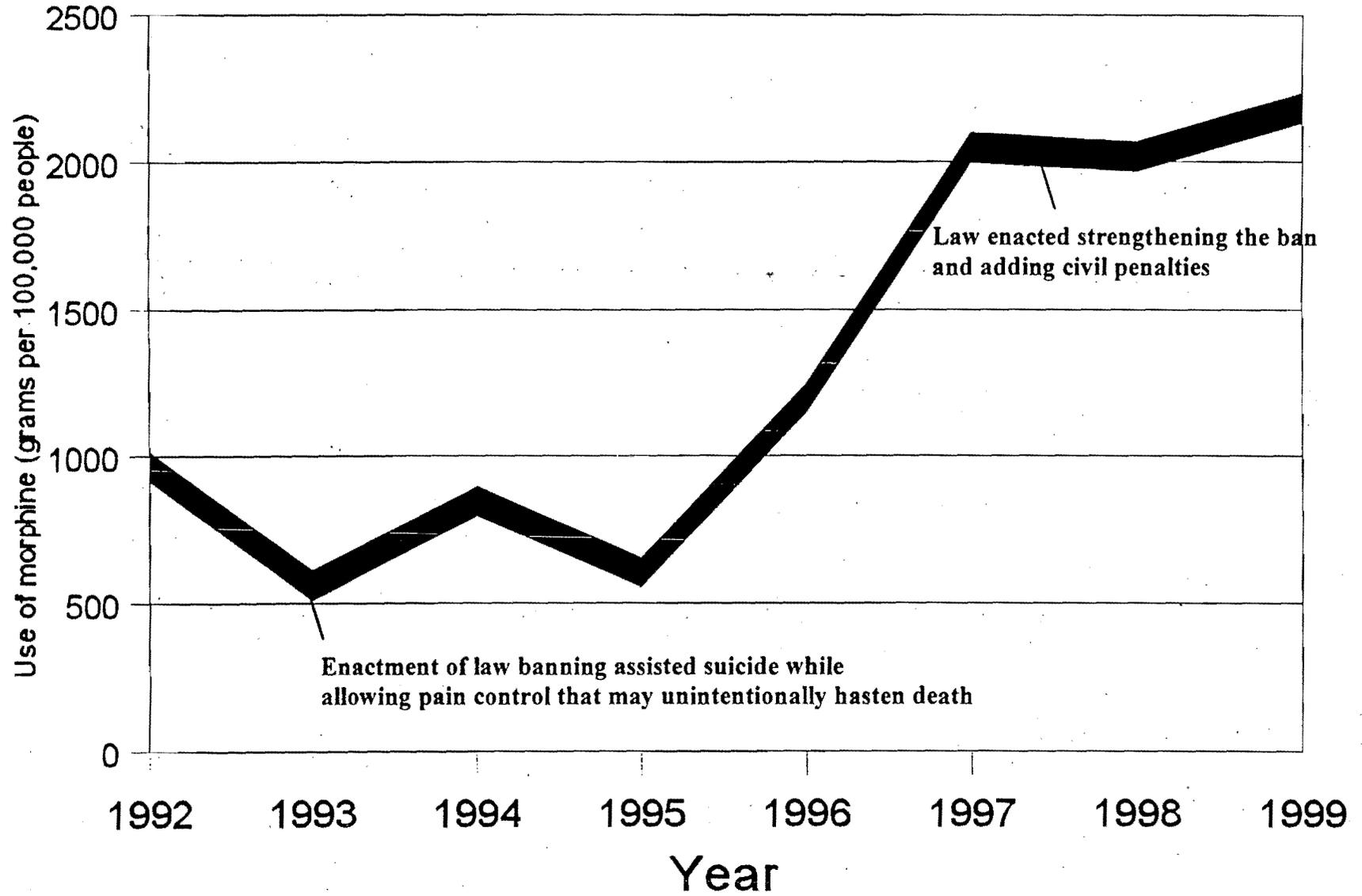
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(Source of morphine data: Drug Enforcement Administration)

Use of Pain Control Drugs Rises When States Ban Assisted Suicide

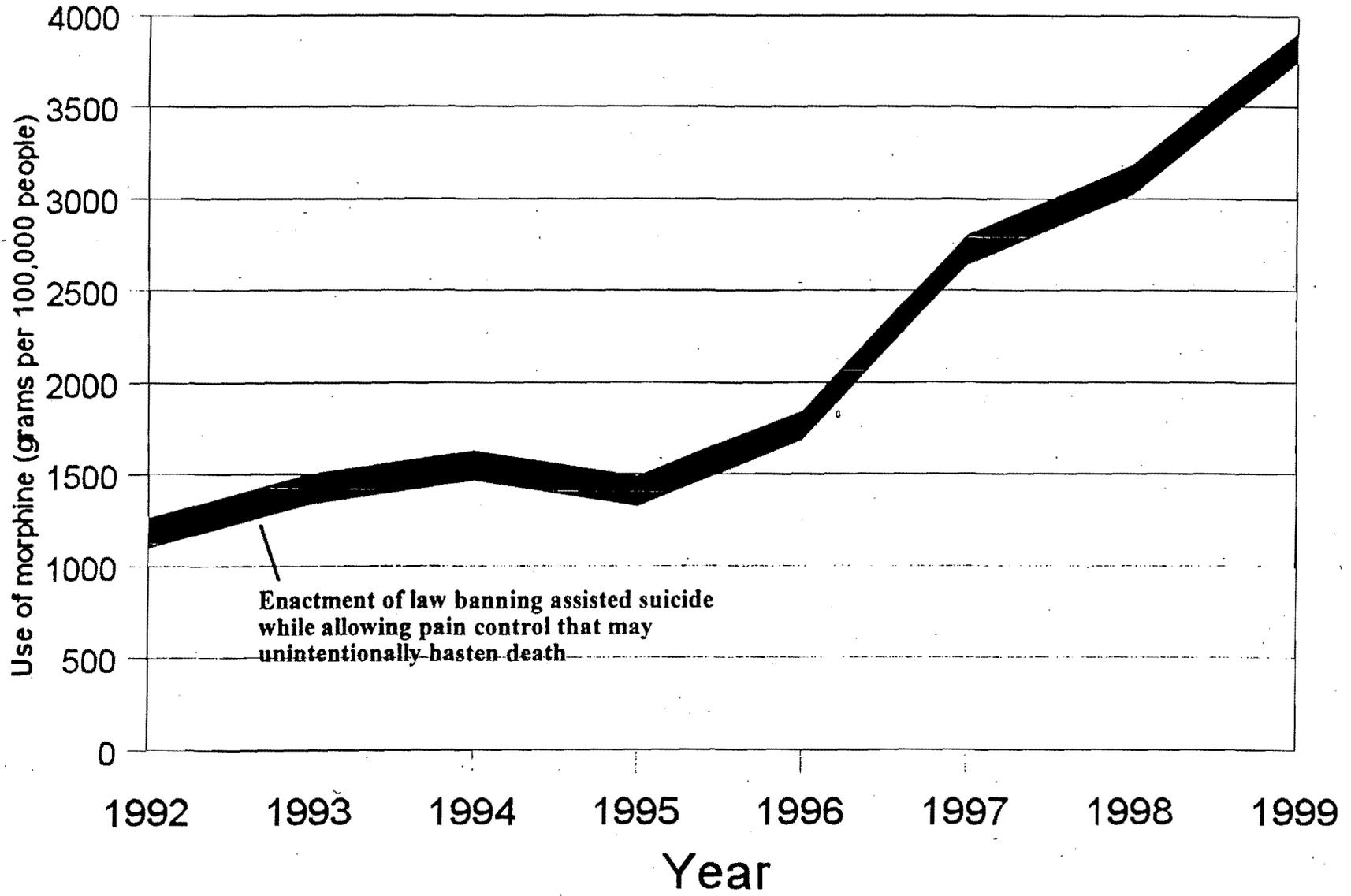
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(Source of morphine data: Drug Enforcement Administration)

Use of Pain Control Drugs Rises When States Ban Assisted Suicide

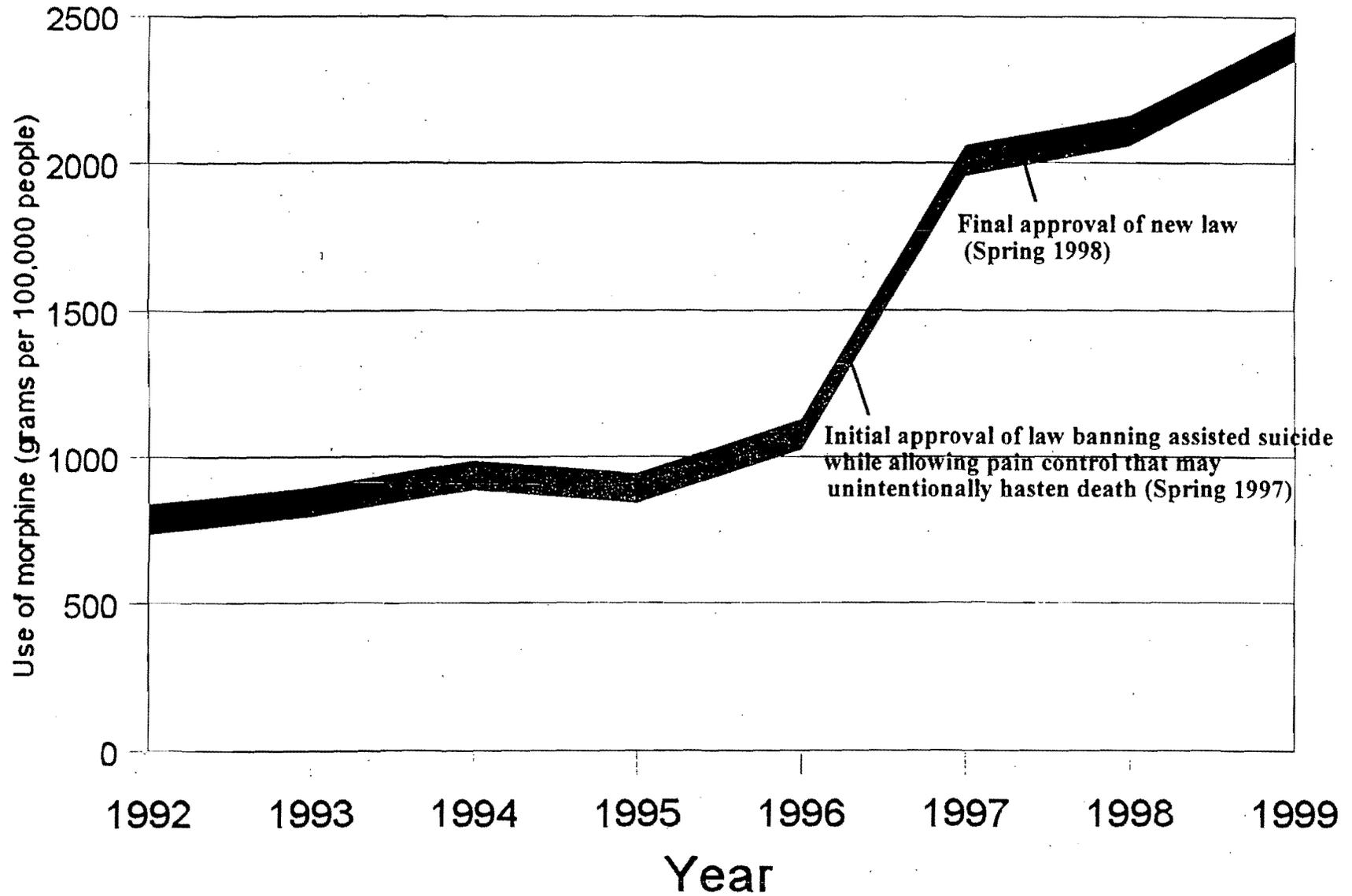
TENNESSEE



(Source of morphine data: Drug Enforcement Administration)

Use of Pain Control Drugs Rises When States Ban Assisted Suicide

VIRGINIA



(Source of morphine data: Drug Enforcement Administration)