

In the words of Mr. Adams, the Unionists need to "get real" and enter into the power-sharing executive as called for under the agreement. And Britain's new Secretary for Northern Ireland, Peter Mandelson, has warned politicians, and I quote "the people of Northern Ireland will not forgive them if they put barriers in the way of permanent peace."

Mr. Speaker, if the Good Friday Agreement should fail, it may prove disastrous for the peace process because there is no alternative.

It is a dangerous game the Unionists are playing with real lives at stake. It is my hope, and that of so many Irish Americans, that this game of brinkmanship by the Unionists will end before it is too late for the Good Friday Agreement.

REPUBLICANS WANT 100 PERCENT OF SOCIAL SECURITY LOCKED UP

(Mr. CUNNINGHAM asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. CUNNINGHAM. Mr. Speaker, many of my friends on the other side of the aisle claim Republicans are spending Social Security money. They support the President's plan, where the President said he wanted 100 percent in Social Security, then 3 weeks later he came back and said, well, 60 percent in Social Security, 15 percent in Medicare.

What he does is take \$466 billion out of Social Security and puts it up here for new spending. He will not identify cuts. New spending. Then he took \$19 billion and put it up here for new spending.

We are saying no, put the 100 percent in Social Security, lock it up, let it accrue interest. We will not only save Social Security and Medicare forever, but that accrued interest also pays down the national debt, in which we pay nearly a billion dollars a day.

I would ask of believability, fiscal conservative or liberal Democrat, being fiscally conservative is an oxymoron.

REPUBLICANS WANT TO PROTECT AND PRESERVE 100 PERCENT OF SOCIAL SECURITY

(Mr. KINGSTON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KINGSTON. Mr. Speaker, there are two prevailing issues or schools of thought on what to do about Social Security surpluses. The Republican Party wants to protect and preserve 100 percent of it. But do not take my word for it as a Republican, let me quote to my colleagues what John Podesta, the White House Chief of Staff says. "The Republicans' key goal is to not spend the Social Security surplus." Again, words spoken by the White House Chief of Staff John Podesta, Clinton's right-hand man.

Now, the Democrats, on the other hand, led by the President, last January, wanted to spend 38 percent of it. The President stood right behind where I am now and said, "Let us preserve 62 percent of Social Security but spend the rest on other programs."

Now, as of late he has come around to say, well, maybe we should not do that. But this is what the Democrat leader, the gentleman from Missouri (Mr. GEPHARDT), said this Sunday. And I will just put these words here, and again it is a direct quote. That, "since we have the surplus, we have to get ready for baby boomers, and we should spend as little of it as possible."

Now, join us, please. I ask the Democrats, protect 100 percent of Social Security, not just most of it. The way to do it is if we cut one penny out of every dollar in the budget, we can protect and preserve Social Security. A penny saved is a retirement earned and secured for our seniors.

PROVIDING FOR CONSIDERATION OF H.R. 2260, PAIN RELIEF PROMOTION ACT OF 1999

Mr. LINDER. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 339 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 339

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 2260) to amend the Controlled Substances Act to promote pain management and palliative care without permitting assisted suicide and euthanasia, and for other purposes. The first reading of the bill shall be dispensed with. Points of order against consideration of the bill for failure to comply with clause 4(a) of rule XIII are waived. General debate shall be confined to the bill and shall not exceed one hour equally divided among and controlled by the chairmen and ranking minority members of the Committee on Commerce and the Committee on the Judiciary. After general debate the bill shall be considered for amendment under the five-minute rule. It shall be in order to consider as an original bill for the purpose of amendment under the five-minute rule an amendment in the nature of a substitute consisting of the bill modified by the amendments recommended by the Committee on Commerce now printed in the bill. That amendment in the nature of a substitute shall be considered as read. No amendment to that amendment in the nature of a substitute shall be in order except those printed in the report of the Committee on Rules accompanying this resolution. Each amendment may be offered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, and shall not be subject to amendment. The Chairman of the Committee of the Whole may: (1) postpone until a time during further consideration in the Committee of the Whole a request for a recorded vote on any amendment; and (2) reduce to five min-

utes the minimum time for electronic voting on any postponed question that follows another electronic vote without intervening business, provided, that the minimum time for electronic voting on the first in any series of questions shall be 15 minutes. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. Any Member may demand a separate vote in the House on any amendment adopted in the Committee of the Whole to the bill or to the amendment in the nature of a substitute made in order as original text. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

The SPEAKER pro tempore (Mr. PETRI). The gentleman from Georgia (Mr. LINDER) is recognized for 1 hour.

Mr. LINDER. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the gentleman from Massachusetts (Mr. MOAKLEY), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, this is a structured rule providing for consideration of H.R. 2260, the Pain Relief Promotion Act of 1999. H. Res. 339 provides 1 hour of general debate equally divided and controlled by the chairmen and ranking minority members of the Committee on Commerce and the Committee on the Judiciary.

The rule waives clause 4(a) of Rule XIII, which requires a 3-day layover against consideration of the bill.

H. Res. 339 makes in order as an original bill for the purpose of amendment the Committee on the Judiciary amendment in the nature of a substitute, as modified by the amendments recommended by the Committee on Commerce and printed in the bill.

The rule provides for consideration of only the amendments printed in the Committee on Rules report accompanying the resolution. The rule further provides these amendments will be considered only in the order specified in the report, may be offered only by a member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent and shall not be subject to amendment.

Specifically, the rule makes in order an amendment offered by the gentleman from Virginia (Mr. SCOTT) and the gentleman from Oregon (Mr. DEFazio) to be debated for 10 minutes and a substitute amendment offered by the gentlewoman from Oregon (Ms. HOOLEY) and the gentlewoman from Connecticut (Mrs. JOHNSON) to be debated for 40 minutes.

The rule also allows the Chairman to postpone recorded votes and reduce to 5 minutes the voting time on any postponed question, provided the voting time on the first in any series of questions is not less than 15 minutes. This provision will simply facilitate consideration of amendments.

House Resolution 339 also provides for one motion to recommit with or without instructions.

Mr. Speaker, for the purpose of background, the Administrator of the Drug Enforcement Agency decided in late 1997 that delivering, dispensing, prescribing or administering a controlled substance with the deliberate intent of assisting in a suicide violates the Controlled Substance Act or applicable regulations. The regulations stated that a controlled substance must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. However, Attorney General Reno unfortunately decided in 1998 that such usage is now part of the ordinary practice of medicine in Oregon, and therefore exempt from the Controlled Substances Act of 1970.

Clearly, physician-assisted suicide is a danger to society. I share the views of the gentleman from Illinois (Mr. HYDE), the chairman of the Committee on the Judiciary, that assisting in a suicide by giving a prescription for a controlled substance cannot be a "legitimate medical purpose," especially when the practice is not reasonable and necessary to the diagnosis and treatment of disease and injury, legitimate health care, or compatible with the physician's role as healer.

With this bill, we do want to reaffirm that the Controlled Substances Act does not authorize intentionally using federally regulated drugs to cause the death of a patient. However, this is an important bill because it ensures that we encourage aggressive pain relief for patients, while also reinforcing the current law that administering, dispensing, or distributing a controlled substance for the purpose of assisting in a suicide is not authorized by the Federal Controlled Substances Act.

This legislation will promote the responsible use of these drugs for pain control rather than leaving the patients with the impression that suicide is the only option to escape from the pain of a terminal illness. It is unacceptable that we would permit terminally ill patients to think that suicide is the only option because pain relief options are not available to them. Today, we help make improved pain relief an objective in health care institutions across the country by authorizing the Agency for Health Care Policy and Research to develop and advance a scientific understanding of palliative care; authorizing a program for education and training in palliative care in the Health Resources and Services Administration of the Department of Health and Human Services; and authorizing additional funding for the palliative care award program beginning in fiscal year 2000.

I do want to note that a previous bill in 1998 caused concerns that it might inhibit doctors from prescribing adequate pain relief. H.R. 2260 has been drafted to resolve those concerns. I am very pleased that the interested parties

have worked together over the past year and have crafted legislation that will not only encourage doctors to prescribe effective pain management but also encourage alternatives to euthanasia.

□ 1045

Today, the National Hospice Association states that "this legislation is a step toward better awareness of effective pain management techniques and should ultimately change behavior to better serve the needs of terminally ill patients and their families."

The organization Aging With Dignity states that, "improving end of life care is the best way to keep legalized euthanasia and assisted suicide away from mainstream America. Doctors can treat their patients and lessen their pain, and this needs to happen now. This law will help them do that."

These groups join the American Medical Association, the Coalition of Concerned Medical Professionals, Physicians for Compassionate Care, the American Academy of Pain Management, and the American Society of Anesthesiologists in supporting H.R. 2260.

I want to commend the gentleman from Illinois (Mr. HYDE), the chairman of the Committee on the Judiciary, and the gentleman from Michigan (Mr. STUPAK), the cosponsor, for their efforts in sponsoring this excellent piece of bipartisan legislation.

Mr. Speaker, H.R. 2260 was favorably reported out of both the Committee on the Judiciary and the Committee on Commerce, as was the rule by the Committee on Rules. I urge my colleagues to support the rule so that we may proceed with general debate and consideration of the merits of this important bill.

Mr. Speaker, I reserve the balance of my time.

Mr. MOAKLEY. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I thank the gentleman from Georgia (Mr. LINDER) for yielding me the time.

Mr. Speaker, this is a restrictive rule which will allow for the consideration of H.R. 2260, the Pain Relief Promotion Act of 1999. As the gentleman from Georgia described, the rule provides 1 hour of general debate equally divided and controlled by the chairman and ranking member of the Committee on Commerce and the chairman and ranking member of the Committee on the Judiciary.

Mr. Speaker, this rule permits consideration of only two amendments selected by the Committee on Rules. No other amendments are made in order. We on the Democratic side made an effort to allow amendments by all Members who submitted them in advance to the Committee on Rules, but were voted down on a party line.

This bill prohibits doctors from using drugs for suicide and euthanasia. It would have the effect of overturning the Oregon State law permitting physician-assisted suicide.

On the other hand, Mr. Speaker, the bill specifically permits doctors to provide pain reducing drugs, even if the use of those drugs increases the risk of death. This provision is very necessary to ensure that terminal patients can be given the treatment that they need so their suffering may be reduced.

This bill also creates a program to study pain management and to make the information widely available. This program is a very meaningful way to improve the way health professionals treat patients suffering from pain.

Mr. Speaker, I have known from personal experience the importance of these pain reducing drugs. Though this bill is controversial, it has very important features that deserve to be discussed by this entire body.

Mr. Speaker, I reserve the balance of my time.

Mr. LINDER. Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from south Texas (Mr. PAUL).

(Mr. PAUL asked and was given permission to revise and extend his remarks.)

Mr. PAUL. Mr. Speaker, I thank the gentleman from Georgia for yielding me this time.

Mr. Speaker, I rise in support of the rule, but I would like to make a couple of comments about why I do not think we should support this bill.

I am strongly pro-life. I think one of the most disastrous rulings of this century was Roe versus Wade. I do believe in the slippery slope theory. I believe that if people are careless and casual about life at the beginning of life, we will be careless and casual about life at the end. Abortion leads to euthanasia. I believe that.

I disagree with the Oregon law. If I were in Oregon, I would vote against that law. But I believe the approach here is a legislative slippery slope. What we are doing is applying this same principle of Roe versus Wade by nationalizing law and, therefore, doing the wrong thing.

This bill should be opposed. I think it will backfire. If we can come here in the Congress and decide that the Oregon law is bad, what says we cannot go to Texas and get rid of the Texas law that protects life and prohibits euthanasia. That is the main problem with this bill.

Also, I believe it will indeed dampen the ability of doctors to treat dying patients. I know this bill has made an effort to prevent that, compared to last year, but it does not. The Attorney General and a DEA agent will decide who has given too much medication. If a patient is dying and they get too much medicine, and they die, the doctor could be in big trouble. They could have criminal charges filed against them. They could lose their license or go to jail.

Just recently, I had a member of my family pass away with a serious illness and required a lot of medication. But nurses were reluctant to give the medicine prescribed by the doctor for fear of

lawsuit and fear of charges that something illegal was being done. With a law like this, it is going to make this problem much, much worse.

Another thing is this sets up a new agency. For those conservative colleagues of mine who do not like the nationalization of medical care, what my colleagues are looking at here is a new agency of government setting up protocols, educating doctors and hospitals, and saying this is the way palliative care must be administered. My colleagues will have to answer with reports to the Federal Government.

As bad as the Oregon law is, this is not the way we should deal with the problem. This bill applies the same principle as Roe versus Wade.

I maintain that this bill is deeply flawed. I believe that nobody can be more pro-life than I am, nobody who could condemn the trends of what is happening in this country in the movement toward euthanasia and the chances that one day euthanasia will be determined by the national government because of economic conditions. But this bill does not deal with life and makes a difficult situation much worse.

Mr. Speaker, the Pain Relief Promotion Act of 1999 (H.R. 2260) is designed for one purpose. It is to repeal the state of Oregon's law dealing with assisted suicide and euthanasia.

Being strongly pro-life, I'm convinced that the Roe vs. Wade Supreme Court decision of 1973 is one of the worst, if not the worst, Supreme Court ruling of the 20th century. It has been this institutionalizing into our legal system the lack of respect for life and liberty that has and will continue to play havoc with liberty and life until it is changed. It has been said by many since the early 1970s that any legalization of abortion would put us on a slippery slope to euthanasia. I agree with this assessment.

However, I believe that if we are not careful in our attempt to clarify this situation we also could participate in a slippery slope unbeknownst to us and just as dangerous. Roe vs. Wade essentially has nationalized an issue that should have been handled strictly by the states. Its repeal of a Texas State law set the stage for the wholesale of millions of innocent unborn. And yet, we once again are embarking on more nationalization of law that will in time backfire. Although the intention of H.R. 2260 is to repeal the Oregon law and make a statement against euthanasia it may well just do the opposite. If the nationalization of law dealing with abortion was designed to repeal state laws that protected life there is nothing to say that once we further establish this principle that the federal government, either the Congress or the Federal Courts, will be used to repeal the very laws that exist in 49 other states than Oregon that prohibit euthanasia. As bad as it is to tolerate an unsound state law, it's even worse to introduce the notion that our federal congresses and our federal courts have the wisdom to tell all the states how to achieve the goals of protecting life and liberty.

H.R. 2260 makes an effort to delineate the prescribing of narcotics for alleviating pain from that of intentionally killing the patient. There is no way medically, legally, or morally

to tell the difference. This law will serve to curtail the generous use of narcotics in a legitimate manner in caring for the dying. Claiming that this law will not hinder the legitimate use of drugs for medical purposes but not for an intentional death is wishful thinking. In fear that a doctor will be charged for intentionally killing a patient, even though the patient may have died coincidentally with an injection, this bill will provide a great barrier to the adequate treatment of our sick and dying who are suffering and are in intense pain.

The loss of a narcotic's license, as this bill would dictate as punishment, is essentially denying a medical license to all doctors practicing medicine. Criminal penalties can be invoked as well. I would like to call attention to my colleagues that this bill is a lot more than changing the Controlled Substance Act. It is involved with educational and training programs to dictate to all physicians providing palliative care and how it should be managed. An entirely new program is set up with an administrator that "shall" carry out a program to accomplish the developing and the advancing of scientific understanding of palliative care and to disseminate protocols and evidence-based practices regarding palliative care.

All physicians should be concerned about a federal government agency setting up protocols for medical care recognizing that many patients need a variation in providing care and a single protocol cannot be construed as being "correct".

This program is designed to instruct public and private health care programs throughout the nation as well as medical schools, hospices and the general public. Once these standards are set and if any variation occurs and a subsequent death coincidentally occurs that physician will be under the gun from the DEA. Charges will be made and the doctor will have to defend himself and may end up losing his license. It will with certainty dampen the enthusiasm of the physician caring for the critically ill.

Under this bill a new program of grants, cooperative agreements and contracts to help professional schools and other medical agencies will be used to educate and train health care professionals in palliative care. It is not explicit but one can expect that if the rules are not followed and an institution is receiving federal money they will be denied these funds unless they follow the universal protocols set up by the federal government. The bill states clearly that any special award under this new program can only be given if the applicant agrees that the program carried out with the award will follow the government guidelines. These new programs will be through the health professional schools, i.e. the medical schools' residency training programs and other graduate programs in the health professions. It will be a carrot and stick approach and in time the medical profession will become very frustrated with the mandates and the threat that funds will be withheld.

The Secretary of Health and Human Services in charge of these programs are required to evaluate all the programs which means more reports to be filled out by the institutions for bureaucrats in Washington to study. The results of these reports will be to determine the effect such programs have on knowledge and practice regarding palliative care. Twenty four million dollars is authorized for this new program.

This program and this bill essentially nationalizes all terminal care and opens up Pandora's box in regards to patient choices as well as doctor judgment. This bill, no matter how well intended, is dangerously flawed and will do great harm to the practice of medicine and for the care of the dying. This bill should be rejected.

Mr. MOAKLEY. Mr. Speaker, I yield 5 minutes to the gentleman from New Jersey (Mr. ROTHMAN).

(Mr. ROTHMAN asked and was given permission to revise and extend his remarks.)

Mr. ROTHMAN. Mr. Speaker, I rise in support of the rule, but I join the gentleman from Texas (Mr. PAUL) in opposing the bill. Make no mistake about it, the bill in question deals with pain, excruciating, horrible pain, the kind of pain that afflicts literally tens of millions of Americans, chronic pain, terminally-ill pain.

What is the difference? Well, what is the story here in America with regards to providing pain medication to those tens of millions of Americans who so desperately need the pain medication? Well, there is a consensus in the United States, Democrats, Republicans, liberals, conservatives, everyone agrees. There is an undertreatment of pain in the United States of America.

Why? Primarily we are told because doctors feel intimidated if they give too much pain medication to those patients in terrible pain who are asking for it, they do not want to die, they just want pain relief, because the doctors are afraid of a civil medical malpractice lawsuit.

So what does the underlying bill do? It provides for a criminal penalty against doctors, 20 years in jail maximum. It provides license revocation, if a DEA drug enforcement agent can go through the pain prescription of every doctor prescribing pain prescription in America, and this drug enforcement agent feels the pain medication might have been intentionally overdose.

Now, if one thinks there is a chilling effect on doctors providing pain medication now, wait till H.R. 2260 if this bill gets passed. Hopefully my colleagues on both sides of the aisle who agree with me, and there are many of us, will support the substitute.

What does the substitute say? It says we are against physician-assisted suicide. We are against physician-assisted suicide. It says we want more research into pain medication. We want more understanding amongst doctors about the right way to prescribe pain medication.

But what it does not have, what the underlying bill has, is it does not provide this criminal penalty against doctors and license revocation. It keeps our eye on the ball.

We are talking about providing pain relief for those millions of American children, men and women in agony, dying horrible deaths. So why would my colleagues, some of them, be wanting to introduce this bill in the first place? It is clear, and they say so quite

candidly. They do not like the Oregon physician-assisted suicide law. Many of us do not.

I voted against physician-assisted suicide here in the Congress, as did the majority of my colleagues. We do not like the Oregon physician-assisted suicide law, but do not have a law. Go to the Supreme Court. Get it thrown out if it is unconstitutional. But do not have a law that will affect all 50 States, tens of millions of Americans who are suffering who need pain medication. Do not affect all those Americans because one does not like the law that the people of Oregon twice chose in referendum. If my colleagues do not like it, ask the Supreme Court to declare it unconstitutional, but do not cause so much suffering.

Some of my colleagues will say, well, there is a law like the one we want to introduce today in Congress passed in a couple of States, and pain medication went up, and they had no problem. Well, those State laws did not involve the Drug Enforcement Agency having the right to review every single prescription for pain medication that every doctor in America is going to prescribe. It goes against common sense.

If one is a doctor and now the DEA can come in to review one's records of every pain prescription one prescribes, it would go to intimidate. The Drug Enforcement Agency should be going after the drug cartels in South America. They should not be looking at every single pain prescription that every single doctor in America prescribed.

We need pain relief. We need doctors and local medical societies, the majority of whom support the substitute and are against the bill. The majority of the nurses associations in America are for the substitute and against the bill, while the doctor organizations are split.

What you have here is obvious. Doctors are conflicted. They are afraid. They are uncertain. The nurses who are the last line of defense, who treat these terminally-ill patients writhing in pain, they are almost unanimous against the bill and in favor of the substitute.

So if my colleagues want to deal with pain in America and they do not want to inhibit doctors from providing the pain medications that tens of millions of Americans are going to be affected with, vote against the bill, vote for the substitute which says we are against physician-assisted suicide.

We want more doctors to prescribe pain medication, not to kill the patient, but to provide the relief that they are begging for in their last days and months on Earth. But do not put them in jail. Do not threaten to put them in jail. Let the States' local medical societies who each have their own traditions and customs and have worked on the details of these bills for so long, let them deal with it appropriately. I ask my colleagues to support the substitute.

Mr. LINDER. Mr. Speaker, I am pleased to yield 4 minutes to the gentleman from Oklahoma (Mr. COBURN.)

Mr. COBURN. Mr. Speaker, this is the bill. What the gentleman from New Jersey (Mr. ROTHMAN) just said is false. There is no penalty in here. Every doctor in this country today, every controlled substance is available for review by the DEA. There is no change in that. The gentleman knows that. There is no penalty, new penalty in this bill for anybody. What this bill is about is saying that Federal law, as far as narcotics control, cannot be preempted by a State in the use of those narcotics. That is what it is about.

The gentleman has not ever given pain medicine to somebody who is dying. I have. I have intentionally medicated somebody to help them with their pain. Unfortunately, as a consequence of that, some have died. There is nothing that keeps us from doing that today except our fear of rhetoric that is untrue.

That is untrue, absolutely blatantly false that there is criminal penalties in this bill for any doctor who does the right thing. This is about not allowing the State to stick their nose out at a Federal law that we all know is important, and that is controlling dangerous substances.

Now, the gentleman's desire is an honorable desire that, in fact, we should help doctors alleviate pain; and we can do that. There is no question that I have seen in my 18 years of practice of medicine that we, in fact, do not do as good a job as we should at that issue. But to take and create that as a reason to allow any State to use narcotics to kill a patient is wrong. That is what is going to happen.

We have great testimony. We have the great experience of the Dutch. We had 2,100 people in 1995 in Holland who were euthanized against their will. They did not want to die. But a doctor decided they should not live anymore.

The slippery slope that the gentleman from Texas (Mr. PAUL) talked about and his understanding of this bill I believe is wrong. There is a slippery slope. But it is not the slope of allowing the Federal Government to continue to enforce the laws of this land and to have a Federal standard on narcotics. That is not the slippery slope.

The slippery slope is to create an environment where any State, regardless of their own desires, can ignore Federal law today; every doctor who writes a prescription for a controlled substance can be reviewed; every prescription can be looked at by the DEA.

There is no new authority for the DEA in this. What this bill says, and it is only this few pages, is that the law applies to every State equally, and that just because Oregon decides that they want to take someone's life, that they should not be able to say that Federal law does not apply.

The fact is all life has value. As we have determined in this country, we have said the unborn does not have

value. Now Oregon says the dying do not have value, and that in the future, those that are not dying have no value.

□ 1100

There were just 1,100 babies that were born last year and the year before in the whole land that the doctor decided should not live. So what did they do? They gave them paregoric, they paralyzed the respiration, and they died.

Do we want doctors deciding who lives and who dies? No, we do not want that. This is a slope, a real slope where we are going to become God. We do not have that power. The Declaration of Independence says that we should have the right to pursue life, liberty, and the pursuit of happiness. Nothing in it says we have the right to pursue death, nothing.

Mr. MOAKLEY. Mr. Speaker, I yield 1 minute to the gentleman from New Jersey (Mr. ROTHMAN).

Mr. ROTHMAN. Mr. Speaker, I would like to respond to my colleague.

The gentleman was very clever. Even though he is a physician, he spoke like a Philadelphia lawyer, and he said this bill does not provide criminal penalties if they do nothing wrong. But if they did in the opinion of the Drug Enforcement Agency, then the doctor can go to prison.

Mr. LINDER. Mr. Speaker, will the gentleman yield?

Mr. ROTHMAN. I yield to the gentleman from Georgia.

Mr. LINDER. Mr. Speaker, what he said, as I heard it, is that it does not provide any additional penalties that are not already there.

Mr. ROTHMAN. Mr. Speaker, reclaiming my time, he said that. And then he said, to clarify it, there will be no jail time if they do not do anything wrong, or words to that effect. Because if they do do something wrong in the opinion of the Drug Enforcement Agency, which is now being called upon in this bill to look into this, they can go to jail and they will lose their license.

Again, the question is, if we are concerned about pain medication, let us pass a bill about pain medication. That is the substitute, which is also against physician-assisted suicide. And if my colleagues did not like the Oregon referendum of physician-assisted suicide, as I do not, then go to the Supreme Court and declare it unconstitutional.

Do not let the tens of millions of American children, men, and women suffer because they do not like the Oregon law. Change the law, get it declared unconstitutional, and leave these patients and doctors alone.

Mr. LINDER. Mr. Speaker, for a point of clarification, I yield myself 30 seconds to make this point.

What the gentleman from Oklahoma (Mr. COBURN) said was that this bill does not provide any new or additional penalties that are already not extant. This is nothing changed. Those penalties can occur today. He made the point very clear, I thought, that the whole point of this bill is to not allow

States on their own to exempt themselves from Federal laws with respect to controlled substances.

Mr. MOAKLEY. Mr. Speaker, I yield 3 minutes to the gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, the gentleman who preceded me in the well may well be a good physician, but he is not an attorney.

The Department of Justice says, "By denying authorization under the Controlled Substances Act, H.R. 2260 would make it a Federal crime for a physician to dispense a controlled substance to aid a suicide. However, a physician who prescribes the controlled substances most commonly used to aid a suicide would, because he or she necessarily intends death to result, or may have intended death to result, or should have known that death should have resulted, would face a 20-year mandatory minimum sentence in Federal prison."

That is what we are talking about here, the Drug Enforcement Administration second-guessing the intention after the fact of every physician in America.

Let us use a real-life example. This is a pain medication. If this were a barbiturate for end-of-life care and it was prescribed by my physician aggressively that I was to take one every 2 hours to relieve my excruciating pain, say from bone cancer, that would be legal.

Now, if this prescription, a pain relief prescription, was prescribed by my doctor for aggressive pain relief management, one to be taken every 2 hours, and I took this entire vial all at once and died, the question would be what was my physician's intent in giving me this prescription? Was it that I would really take one every 2 hours, or did my physician know or should my physician have known that I might choose to take all of them at once?

What this means ultimately, the absurdity of this, is any physician who does not want to risk being investigated by the Drug Enforcement Administration, and nobody wants that, is going to have to say they can have one pill every 2 hours, send their wife or kids down to the 24-hour pharmacy to pick them up for them, because he gives them more than one and they take them all at once and they die, the Drug Enforcement Administration is going to question his intent.

That is the cover of law that is being ripped away by this well-sounding, theoretically well-meaning legislation.

In their zeal to overturn the Oregon law, which is not euthanasia, which does not allow a doctor to give an injection, which does not allow a doctor to administer a prescription, which allows individuals who are terminally ill who have a diagnosis they will die within 6 months, after consulting with two physicians, after consulting with a psychiatrist to go to their physician

and ask for a prescription which they can only self-administer.

This is not euthanasia, and it has been very, very infrequently used in our State. In fact, probably fewer people have shot themselves or otherwise killed themselves under fear of the pain they were going to undergo because of the Oregon law.

But these people on this side of the aisle who are for States' rights every day of the week when a State says something they agree with are suddenly today standing up and saying, well, we are for States' rights as long as we agree with the State.

Preempt the will of the Oregon people. It is not the State of Oregon, it is the people of the State of Oregon twice by initiative and referendum who have passed this law.

Mr. LINDER. Mr. Speaker, for a quiet and dignified response, I yield 2 minutes to the gentleman from Oklahoma (Mr. COBURN).

Mr. COBURN. Mr. Speaker, what the gentleman fails to state is that the DEA already has that power.

Yes, there is no more important thing than intent. Every doctor, when they graduate from medical school, their goal is to preserve life, not take it. There are lots of times in my life that have been low, I would have loved to have been out of here. But I am glad somebody did not help me leave. Because there is always another day.

For those of my colleagues who have not treated dying patients with metastatic bone cancers, first of all, we do not use barbiturates. We use narcotics. Barbiturates are not used for pain relief. They are used to accentuate pain relief. But narcotics are used for pain relief.

There is no new law. The DEA, if I misuse a drug today, a controlled substance, can in fact harm me, take away my license to dispense drugs, and incarcerate me. And rightly so.

We do not in this country, under our Constitution or our Declaration of Independence, have the right to die. That is not one of the guaranteed freedoms in this country. We do not have the right to die. As a matter of fact, it is against the law to commit suicide in many States.

So what we are really saying is the motivation of the people from Oregon is a good motivation. People are in pain. How do we fix that? Well, the professionals have already said we need to do a better job of training doctors and we need to make sure doctors do not feel afraid to go up with the intention of alleviating pain and worry about the unintended consequence it might suppress somebody's respiration and they die.

This bill truly addresses that because it does not give the free will for a physician to say, we are going to take their life. Most people who want their life taken have a clinical depression, a clinical depression. They have another illness besides the illness that is in front of everybody, and it is that, that we need to recognize.

Mr. MOAKLEY. Mr. Speaker, I am happy to yield 3½ minutes to the gentlewoman from Oregon (Ms. HOOLEY).

Ms. HOOLEY of Oregon. Mr. Speaker, I rise in opposition to the underlying bill and in support of the Johnson-Rothman-Hooley substitute amendment to H.R. 2260.

All of us come to this issue of pain and end of life from very different perspectives. Some would like to effectively overturn Oregon's law that allows physicians to assist terminally-ill patients with less than 6 months to live in ending their lives. Since we passed that law, and we passed it twice, 15 terminally-ill patients have used such assistance.

Undoubtedly, the proponents of H.R. 2260 are motivated by a heartfelt desire to eliminate a physician-assisted suicide. The Johnson substitute seeks that same outcome, but the difference is it addresses the problem as a medical problem and not a law enforcement problem.

In the 6 months that it took the gentlewoman from Connecticut (Mrs. JOHNSON) and I to draft the Conquering Pain Act, H.R. 2188, from which this Johnson substitute is derived, not one expert concerning improving end-of-life care said we need to take away authority from the State. Not one expert recommended amending the Controlled Substances Act, in which the Pain Relief Promotion Act would. Not one expert said this was the best way to improve pain management.

Interestingly, the American Medical Association and the National Hospice Organization were an integral part in our working group and ultimately endorsed the Conquering Pain Act, on which the Johnson substitute is based, never once raising the issue of the Controlled Substances Act.

In fact, at a hearing in October at the Senate Committee on Health, Education, Labor, and Pensions, where experts were asked where should we begin to improve management, every expert witness said we should begin with education and research. Not one expert said the best way to improve management pain management for patients is to amend the Controlled Substances Act.

Dr. Richard Payne, Chief of Pain & Palliative Care Services at Memorial Sloan Kettering Cancer Center, and a co-chair of the Agency for Health Care Policy and Research panel on cancer pain guidelines summed it up well. "While H.R. 2260 is well-intentioned, it is counterproductive. It would have a chilling effect on aggressive pain management."

Dr. Payne and many physicians and other health care practitioners, those who specifically specialize in pain management, not the generalist, are urging the support of the substitute based on H.R. 2188, "the bill that would constructively promote end-of-life and palliative care," and urge a no vote on H.R. 2260 as reported by committee.

I know others may disagree. But it is clearly not worth the risk that people

will suffer, and people will suffer in more pain by passing H.R. 2260.

Under the Johnson substitute amendment, Congress expresses its clear opposition to assisted suicide, makes every effort to reduce it. What is more important is the Johnson substitute seeks to address the reason a suffering individual at the end of their life might seek that dreadful option, fear and exhaustion of being in pain.

I urge a yes vote on the Johnson substitute and a no vote on H.R. 2260.

Mr. LINDER. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut (Mrs. JOHNSON), the author of the Johnson substitute.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I thank the gentleman for yielding me the time, and I rise in support of the rule and appreciate the Committee on Rules allowing me to offer my substitute.

To just comment on the earlier debate, Mr. Chairman, the Hyde bill does not impose new penalties, but the Hyde bill does identify a new role for DEA agents, who are nonmedical people. That role involves judging the intent of a physician and thereby exposing physicians to criminal penalties, not for trafficking or other illegal activities involving drugs but for exercising their professional judgment in the delivery of patient care.

□ 1115

But I rise at this point in the debate to call the attention of my colleagues to a Dear Colleague that I sent out recently about the testimony of David Jorensen. He is the director of the pain and policy studies group at the Comprehensive Cancer Center at the University of Wisconsin, cofounder of the National Association of State Controlled Substances Authorities and the State cancer pain initiative. He served many years on the drafting committee of the national conference of commissioners on uniform State laws to revive the Uniform Controlled Substances Act for the United States. In other words, he is extremely experienced in this issue of managing controlled substances and in pain management. I urge my colleagues to review the rather dry Dear Colleague that I sent out, because it lays out the clear history of this matter. Under current law, medical issues are deferred to enforcement by medical agencies, whether it is HHS at the national level or State medical agencies or medical review boards that have been put in place to oversee medical practice and standards of care at the State level. In other words, current law clearly allows the use of controlled substances for pain management and regulates such medical uses through HHS and State health agencies, including medical review boards and licensure laws and clearly does not allow DEA or agencies who have no knowledge in this area to be part of the enforcement mechanism.

Mr. MOAKLEY. Mr. Speaker, I yield 5½ minutes to the gentleman from North Carolina (Mr. WATT).

Mr. WATT of North Carolina. Mr. Speaker, I rise in opposition to the rule and in opposition to the bill in its current form and want to make several points. First of all, this is the whip notice for today. It says we are getting out of session this afternoon between 3 and 4 o'clock. Two amendments, very important amendments, were offered to the Committee on Rules which the Committee on Rules chose not to make in order, we presume because we do not have time to debate the issues that were to be debated related to this bill. One of those amendments is an amendment that would have been offered by myself in conjunction with the gentleman from Oregon (Mr. WU) and several other Members of this House which in effect walks a line between the bill as it is currently structured and the substitute as it is proposed. There are some of us who really do not have any problem with parts of this bill as it is drawn. We ought to be encouraging palliative care and pain relief, but we ought to be doing it in such a way that it is explicitly clear that we are not preempting States' laws. That is what our amendment would have done. But apparently the Committee on Rules decided that that kind of balanced approach to this debate was not something that this House ought to entertain. We ought to either have it all on the one hand or have a complete substitute on the other hand. That should not have happened and it certainly should not have happened on a day that the House is recessing at 3 or 4 o'clock in the afternoon.

The second amendment that was offered is one that is of equal importance, because a number of us through the years have had severe problems with the disparity in sentencing between crack cocaine and powder cocaine. Under this bill, a physician can prescribe cocaine for the purposes of alleviating pain. It is a schedule 2 drug under the Controlled Substances Act. But if that physician prescribes crack, a form of cocaine, and if the opponents of this bill are correct that that would subject the physician to a criminal penalty if he prescribed powder cocaine for the relief of pain, it would subject him to one-tenth of the penalty that it would subject the physician to if he prescribed crack cocaine, a derivative of the same product, we should at least equalize the penalties if we are going to penalize physicians even if there were some rationale for doing it out in the community which we do not believe there is and which has resulted in disparate imprisonment between poor people and rich people, poor people being typically people who take crack cocaine and rich people being people who take powder cocaine, the only distinction rationally that you could even argue. There is no reason that we ought to penalize a physician disproportionately under this bill.

Now, there is something wrong with my colleagues saying one day that we believe in States' rights and the next

day saying we are going to preempt Oregon's State law. That is what my amendment would have done. It would have protected Oregon's law in one simple phrase, the simple phrase being "except in compliance with applicable State or Federal laws." This whole law could have applied. If the objective is to increase the use of palliative care and encourage pain relief, then we should not be here debating about whether to overrule a State's law.

Unlike the physician who came to the floor who may be very skilled in his knowledge of medicine, I want to direct his attention to amendment 10 to the Constitution. It says that the powers not delegated to the United States by the Constitution nor prohibited to the States are reserved to the States respectively or to the people. The people have the right to pass a statute in Oregon and have that statute honored and we should honor it here on this floor of the House.

Mr. LINDER. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. CANADY), the author of the bill.

Mr. CANADY of Florida. Mr. Speaker, I appreciate the gentleman yielding time. Actually the gentleman from Illinois (Mr. HYDE) is the author of this legislation.

I want to address this misconception that we keep hearing here, that somehow this bill will expand the investigative or enforcement authority of the DEA. That is simply not true. That is not what this bill will do. If we look at what the Attorney General said, and I do not agree with the Attorney General on the way she has approached the application of the law in Oregon, but she said, "Adverse action under the Controlled Substances Act may well be warranted where a physician assists in a suicide in a State that has not authorized the practice under any conditions or where a physician fails to comply with State procedures in doing so." She herself has acknowledged that. Everyone who has looked at the law understands that physicians who violate a State law in providing a controlled substance for assisted suicide face penalties from the DEA. There is no question about that. That is the state of the law now. We are not creating any additional regulatory scheme. That scheme is already in place. It is very important that people understand that.

Mr. MOAKLEY. Mr. Speaker, I yield 5 minutes to the gentleman from Michigan (Mr. STUPAK).

Mr. STUPAK. Mr. Speaker, I rise to support the rule. I am proud to have introduced this legislation with the gentleman from Illinois (Mr. HYDE) of the Committee on the Judiciary. This legislation is cosponsored by 150 bipartisan Members of this House.

This legislation amends the Controlled Substances Act to clarify that doctors and other licensed health care professionals who dispense, distribute and administer pain control drugs for legitimate medical purposes of alleviating a patient's pain or discomfort

are permitted to do so even if the use of these drugs may increase the risk of death.

This bill also reinforces current Federal policy that the administration, dispensation or distribution of a controlled substance for the purpose of assisting in a suicide is not authorized by the Controlled Substances Act. We make clear that the Attorney General in implementing the Controlled Substances Act shall not recognize any State law permitting assisted suicide or euthanasia.

This legislation reflects the hard work of many, many people and many organizations. We have brought the hospice organizations on board to support this legislation. In addition to the National Hospice Organization, this bill is supported by the American Medical Association, Hospice Association of America, American Academy of Pain Management, American Society of Anesthesiologists, American College of Osteopathic Family Physicians and C. Everett Koop.

Some organizations and Members as we have heard today are concerned that this bill would chill the doctor's ability to prescribe pain medication. Nothing could be further from the truth. Currently, doctors run afoul of the Controlled Substances Act if their actions cause or contribute to the fatal or near fatal overdose of drugs. In essence, the current standard for enforcement by the DEA is whether or not the use of controlled substances by a doctor served a legitimate medical reason. That is the standard. The bill makes clear that the Controlled Substances Act allows doctors to administer drugs for the purpose of relieving pain. This has always been the Federal policy and it remains the Federal policy under this legislation.

If the critics would examine the first sentence of section 101 of the bill, they will see that the bill provides for a safe harbor for aggressive treatment of pain, even if the treatment increased the risk of death. The second sentence of the same provision limits the safe harbor, because without it people could always claim they were assisting suicide in the treatment of pain.

I urge my colleagues to listen to the criticism and compare it to the actual language of the bill and I am confident that my colleagues are inaccurate who criticize this bill.

H.R. 2260 does a lot more than provide a safe harbor for the treatment of pain. Last year in the Committee on Commerce, we debated the Assisted Suicide Funding Restriction Act. Many Members expressed concern that the lack of palliative care in this country was responsible for the helplessness that many chronically ill patients feel that lends to assisted suicide. The bill addresses those concerns as we amend the Public Health Services Act to authorize the development and advancement of scientific understanding of palliative care. The agency is directed to collect and disseminate protocols and

evidence-based practices for palliative care with priority for terminally ill patients. The bill also amends the Public Health Services Act by authorizing a program for education and training in palliative care.

This bill ends assisted suicide and relieves pain. This legislation makes sense. It makes clear and again reinforces the current Federal policy that under the Controlled Substances Act, the distribution of a controlled substance for the purpose of assisting in suicide is illegal. The legislation gives physicians the ability to treat patients, to provide palliative care and increase our understanding of palliative care. The bill reinforces the written policy of the Federal Government and the administration, and I quote from that policy, that it "strongly opposes the practice of physician-assisted suicide and would not support the practice as a matter of Federal policy." What we are doing here is reinforcing Federal policy that has always been on the books.

Vote for the Pain Relief Promotion Act of 1999. Stand up for palliative care for terminally ill patients and their families and stand up against assisted suicide. Vote "yes."

Mr. LINDER. Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from Arkansas (Mr. HUTCHINSON).

Mr. HUTCHINSON. I thank the gentleman for yielding me this time.

Mr. Speaker, I rise in support of the Pain Relief Promotion Act. This bill is good legislation because it is simple, it is straightforward and it addresses the concerns of every family member who has ever held the hand of a loved one who is in pain and near death.

The gentleman from North Carolina (Mr. WATT) for whom I have high regard raised the concern about States' rights and are we violating this. First of all, it is very appropriate and necessary that Congress legislate on this issue in order to retain a uniform national standard over controlled substances. This is very important.

□ 1130

I want to harken back to the gentleman from Connecticut who raised an issue and said this is a new role for the DEA. This is not a new role for the DEA. The DEA does not have the final judgment over this.

I was United States Attorney. I actually had to prosecute a doctor for dispensing controlled substances without a legitimate medical purpose. It appeared to me that that was the case, that they were just putting out controlled substances without any good medical reason for it. Well, we went to a jury on that case, and the medical community came in, and they gave testimony and said it was for a legitimate medical purpose. They reviewed that and said it was appropriate, and then the jury made a decision on that.

That is how the system presently works, but the problem is because of

the issue of physician-assisted suicide and because of the chilling impact and the concern of physicians they are not dispensing pain relief medication because they are concerned that they could be second guessed that it is not for legitimate medical purpose.

So what this does is it tightens it, it makes it clear, it tells the DEA that we cannot look into it if it is to relieve pain. We want to make it clear and provide the guidance for physicians. We want to remove that chilling impact so that they can appropriately administer pain medication without concern that they are going to be second guessed by someone that it is not for legitimate medical purpose.

But we also clarify that if they have the intent to cause the death of someone, then they cross the line. They cross the line, and that will not be accepted medical purpose. It will not be accepted in our society, and so we are drawing a clear line of distinction there that gives the physician the guidance that they need, it takes the discretion away from a DEA agent, and it follows the same path that we have handled in our cases under the Controlled Substances Act for decades and decades.

And so this should be helpful to the physicians, but it should be very helpful to our society and to the patients who need the pain medication, who want a higher quality of life as death approaches or they have a terminal illness; but it makes it clear that in our society that doctors honor the Hippocratic Oath that they will protect and enhance the quality of life. I ask support.

Mr. LINDER. Mr. Speaker, I yield 2 minutes to the gentleman from Kansas (Mr. MORAN).

Mr. MORAN of Kansas. Mr. Speaker, I thank the gentleman for yielding this time to me.

Mr. Speaker, I speak today in support of H.R. 2260, the Pain Relief Promotion Act, and in support of this rule. This legislation will establish that the practice of assisted suicide and euthanasia are neither legal nor condoned medical procedures in this country. In addition, this legislation is a significant step forward in our efforts to effectively encourage pain management for terminally-ill Americans.

For those who have concerns with this measure, I would encourage them to read the bill language. The legislation is explicit that it does not affect health professionals providing care and treatment even in the case of accidental death. In fact, H.R. 2260 encourages, encourages physicians to provide the full range of treatment to alleviate pain and suffering for their patients.

Physicians in the hospice community have endorsed this bill, and the evidence is clear that banning assisted suicide does not deter pain relief. I would encourage any remaining skeptics to look at the experiences in my home State of Kansas and other States

where similar measures have been implemented. The concern by the opponents of this legislation is that it would deter the use of pain medications such as morphine.

While I was a member of the State Senate, Kansas first enacted legislation to ban assisted suicide in 1993 and then again strengthened those protections in 1998. The evidence in our State of Kansas is clear. The use of morphine to alleviate pain has not declined and in fact has risen significantly. In 1993 Kansas health professionals administered roughly 561 grams of morphine per 100,000 individuals. Six years after the ban on assisted suicide, morphine prescriptions rose to 4,573 grams, a significant increase, not a decrease.

Mr. Speaker, rather than encouraging euthanasia, we need to aggressively pursue effective pain management. Today, we have the technology and medication to successfully control pain. This legislation establishes education and training initiatives to ensure that health professionals recognize the array of pain management tools that are available to them. I encourage my colleagues to support this rule and to ultimately support the passage of this act.

Mr. LINDER. Mr. Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. LATHAM).

Mr. LATHAM. Mr. Speaker, I thank the gentleman for yielding this time to me, and I just rise in support of the rule and, as a cosponsor of the bill, obviously for passage of this.

I really believe that we are on a very slippery slope when we look at the sanctity of life and the quality of life, and it is a very personal issue with me. I have an 87-year-old father who has advanced Alzheimer's; and as my colleagues know, we could question what the quality is or what the value of that life is, but to my mother who has been married, they have been married for 61 years, and that is her life every day, is to go to the home, visit my father, and there is extraordinary quality there.

And my parents have worked very, very hard all of their lives, and they are fortunate that they have enough money saved up that they are able to pay for their care. I am very concerned that on this slippery slope, if we have the opportunity for a third person to make decisions, life and death decisions for folks, who is going to live and who is going to die in the case of my father as an example. My father is able to pay for his care. If we have a third person, a bureaucrat who is making a decision for a ward of the county or of the State, what is their decision? I think we have to look very, very closely at the direction we are heading in this country. This bill allows my father, if he were to go into pain, have real problems, to get that kind of treatment. But it is wrong, it is very wrong, for someone else to make that decision to take his life and for other motivations that may be outside of his own well-being, obviously.

So again, on a very personal level I rise in support of this rule and in support of the underlying bill.

Mr. MOAKLEY. Mr. Speaker, I yield 30 seconds to the gentleman from Oregon (Mr. WU).

Mr. WU. Mr. Speaker, I rise in opposition to the rule and to address an issue placed on this floor by the gentleman from Oklahoma concerning whether there is a constitutional right involved in this debate or not. I commend to the gentleman the Bill of Rights amendment number four, the right of the people to be secure in their persons shall not be violated, and amendment 10, the powers not delegated to the United States, et cetera, are reserved to the States or to the people.

I submit to my colleague that 208 years ago the founders of this republic foresaw this day when the rights of the few would be trampled by the political fears of the many, and that is why these amendments are in this Constitution.

Mr. LINDER. Mr. Speaker, I yield 2 minutes to the gentleman from Oklahoma (Mr. COBURN).

Mr. COBURN. As my colleagues know, I thank the gentleman for his words. I actually take that a completely different way. One does have the right to be secure, which means nobody has the right to take their life, nobody; and I would put forth to this body that if our Founding Fathers thought we killed 3 to 5 million unborn babies a year in this country, they would be sickened of heart at how we have not held on to the very principles of life, liberty and the pursuit of the qualities that go along with life and liberty.

There is not a stronger States' rights person here than me, but with the tenth amendment gives no right to take someone's life. We do have a Constitution of the United States; and if it was my own State, Oklahoma, had passed the Oregon law, I would be here fighting them because not only are they wrong constitutionally, they are wrong morally; and our founders founded this country on the basis of moral beliefs and the beliefs of a higher being that endowed us with inalienable rights, but one of those rights was not the right to take someone's life.

Mr. MOAKLEY. Mr. Speaker, I yield 5 minutes to the gentleman from Massachusetts (Mr. FRANK).

Mr. FRANK of Massachusetts. Mr. Speaker, to begin, I will respectfully dissent from the notion that this should be settled by the moral views of the Founding Fathers. They were very wise people in deciding how government should be structured, but people who spent a lot of time protecting the institution of slavery are not my moral instructors in all things.

What we have is a decision that we have to make, not people who lived 200 years ago, and the question is: does an individual who has been found competent, not a third party, because the

Oregon law that is here under assault from the majority, the Oregon law that would be effectively repealed by this action of the United States Congress, the Oregon law twice passed by a referendum by the people of Oregon that would be undone, makes it clear that there is not a third party involved. The person themselves must have made the decision that they want assistance in committing suicide and they must be found competent to do so.

Now we can argue about the role of the DEA and this and that, but that is not what got any of us here. We are talking about two fundamental philosophical questions. One is the right of a State to make decisions. We have traditionally said that where there is no need for a national uniform policy we will leave it to the States, and Members have said, "Oh, no, we have to have a uniform drug policy."

Well, we have to have uniform policy sometime for manufacturing. It is true if we are talking about manufacturing a substance in one State to be sold in every State it has to be uniform, but why the need for uniformity here? Is it the fear that someone will be in Idaho and mistakenly think she is in Oregon? Is it that someone will be in Oregon and forget and think they are in Washington? We are talking here about a specific discrete physical act, the act of someone being assisted in ending a life which he or she has decided, being of sound mind, that this life is no longer supportable.

There is no confusion. Everyone will know where the person is. There is no need for uniformity except, as the previous speaker said, if we decide to impose nationally the moral judgment of the Federal Government on this issue, and clearly the people of Oregon knew what they were doing; they were put to this twice.

They have twice decided that a sound individual, an individual of sound mind who finds life insupportable, who finds pain overwhelming, who finds paralysis in which they could do nothing but lay in bed intolerable, that that individual has the right to ask for assistance in committing suicide. And remember what I assume we are talking about, people who clearly would have the right, and I assume no one is interposing a Federal objection to suicide if the individual is capable of doing it. So the question is whether individuals who are not physically capable themselves and would otherwise have the right to commit suicide can ask someone, being of sound mind, to do that.

Now clearly there is no reason why the Federal Government has to intervene. There is no need for uniformity here. The existence of a right of assisted suicide in Oregon has no effect in Massachusetts or Oklahoma or Washington State unless someone wanted an individual to be transported there. But clearly the need for uniformity simply reflects a desire of people here to impose their moral views on the people of Oregon who have been found to be morally deficient in this particular regard.

Now that is a perfectly rational argument, but it is not one we can make and still be a States' rights proponent.

Let me also say, by the way, that the arguments about including palliative care, et cetera, those really cannot be made here because the gentleman from North Carolina pointed out he had a perfectly sensible amendment that would have preserved every aspect of this bill except its impulse to overturn the Oregon law. His amendment would have allowed every single other factor of the bill and say and because of that the Committee on Rules unfortunately would not allow it.

So the only thing that is at issue between us is this decision to overturn the Oregon law, and now we get to the philosophical issue: Does an individual have the control of his or her own life; does an individual have the right to say it is my life and I am in charge of it, and that includes the right to decide that it should be ended?

And we have people who believe philosophically, some out of a religious belief, some out of some other set of philosophical belief, that that is not true, one's life does not belong to them. We, the government, the national government of the United States, we, the Congress, can say to them: no, they may not do that.

□ 1145

We do not care how much pain one is in. We do not care how much one is tormented. We do not care how much, and I believe in many cases the psychological pain of being confined, rigid, being only a mind and nothing else, being totally dependent on others for everything else, and perhaps combining that with some pain, that is irrelevant. We will decide. We will decide under what conditions one will live. We will compel one to live against one's will.

That is what we are saying here, we, the United States Government, will compel one to live against one's will even though the people of one's State decided otherwise, because we have a moral framework which excludes one's right to end one's life.

I do want to have one other point here. We say, well, this is not interfering with States' rights, because these are federally controlled substances, so the Federal Government has the right to control them. The fact that we regulate something in one regard does not mean the Federal Government owns it. What is at stake here is a decision by the Federal Government to impose the moral views of a majority of this House on the people of the State of Oregon.

Mr. LINDER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, nearly 50 years ago, Doctors Watson and Crick were given the Nobel Prize in medicine for discovering the stuff of life. They defined deoxyribonucleic acid, DNA. Twenty years ago, Dr. Crick suggested seriously in Great Britain that people reaching the age of 80 ought to be

eliminated because they were very expensive and not productive. That is the casual attitude about life and death that we ought not let States undertake.

This bill does two substantive things. It adds protections for doctors who use medications to treat pain, and it applies a 1970 law on controlled substances equally across 50 States. All States must abide by that law, irrespective of Oregon's decision to exempt itself from it.

If Texas chose to exempt itself from a national law in deadbeat parents, would we sit by and say, well, that is fine; they had a vote, it is not our business? If New York voted to allow no welfare reform and allow people to stay on welfare forever, would we sit back and say that is fine, it is not of our business, they voted?

Federal laws should be abided by equally by 50 States, and we have a 1970 Controlled Substances Act that Oregon has chosen to exempt itself from. This law would change that. Must we treat life with more dignity than we are in Oregon? Should we allow people to take their lives or to ask others to take their lives? We think so.

Two decades ago, a Methodist pastor was in Connecticut Hospital in serious pain from cancer and wrote a letter to Bill Buckley, the editorialist. He said, "I have spent a great bit of time thinking about suicide and praying about it. But then I concluded that I have no right to take away what God has given me on this Earth. I do, however, have the right to pray for early release from this diseased ravaged carcass."

We have no right to take away what God has put on this Earth or asking our friends who are doctors to take it away. But this bill is not about that. This bill is about saying that 50 States must abide equally by national laws, in this instance the 1970 Controlled Substances Act.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. COBURN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 2260, and to insert extraneous material on the bill.

The SPEAKER pro tempore (Mr. PETRI). Is there objection to the request of the gentleman from Oklahoma?

There was no objection.

PAIN RELIEF PROMOTION ACT OF 1999

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Pursuant to House Resolution 339 and rule XVIII,

the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 2260.

□ 1149

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 2260) to amend the Controlled Substance Act to promote pain management and palliative care without permitting assisted suicide and euthanasia, and for other purposes, with Mr. PETRI in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. Pursuant to the rule, the bill is considered as having been read the first time.

Under the rule, the gentleman from Oklahoma (Mr. COBURN), the gentleman from Michigan (Mr. STUPAK), the gentleman from Florida (Mr. CANADY), and the gentleman from Michigan (Mr. CONYERS) each will control 15 minutes.

PARLIAMENTARY INQUIRY

Mr. DEFAZIO. Mr. Chairman, I have a parliamentary inquiry.

The CHAIRMAN. The gentleman will state his inquiry.

Mr. DEFAZIO. Mr. Chairman, is it not usual that the time is divided equally between proponents and opponents?

The CHAIRMAN. The rule provided for the division of time that was just announced by the Chair.

Mr. DEFAZIO. Mr. Chairman, it specified that three-quarters of the time would go to proponents and one-quarter, 15 minutes, would go to the opponents. Is that correct? Is that what the rule specified?

The CHAIRMAN. No. The rule provided that the time would be divided among the chairmen and ranking minority members of the reporting committees.

The Chair recognizes the gentleman from Oklahoma (Mr. COBURN).

Mr. COBURN. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, we have heard a lot of debate already on the rule. We have heard a debate about the intent of our Forefathers. I would counter what the gentleman from Massachusetts (Mr. FRANK) said during the debate on the rule that, in fact, that every law that we pass has a moral consequence; and that, in fact, if we read the writings of our Founders, they did not see that questions such as this would come up.

The real thing that we are going to be debating is about life. As the freest Nation in the world, are we going to abandon the principle that life has value?

I have come to recognize with all my own deficiencies, and especially how they have been exemplified my last 5 years in Congress, that we are all handicapped in one way or another. Some of us, we can see the external handicap. It is very plain and visible. Others, we hide our handicaps. But the