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

fact is, all of us, handicapped as we are, have value, whether I agree with the philosophical point of view or not of that other individual, is that all of God's creation, all life has value.

What we are really debating is whether or not the State of Oregon can ignore a law that is 28 years old and decide that, in this country, the freest country of the world, that they will allow other people to decide whether life has value.

We are on a terrible slippery slope. The committee of which I am a member had testimonies about what has happened in Holland. In fact, when euthanasia and assisted suicide started in Holland, it was a very small number. It has grown progressively each year. But most importantly, because of the number of people who have been euthanized against their will, people now carry a card in Holland in their billfolds to say do not euthanize me.

They have had to do that because they are worried that, if they get in a precarious life-threatening situation, somebody might make the decision about their life. Our country cannot go that direction. We must demand and stand for the fact that all life has value.

Whether it is the unborn child just conceived, whether it is the child with multiple anomalies, it all has value. If it has no value, there is no real meaning to life in the beginning or in the end. I throw that off as a Member of this body, somebody who represents the great State of Oklahoma, who was brought up in a tradition that this is the freest country in the land, but it is only free if we preserve the principles of life.

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

Mr. CONYERS. Mr. Chairman, I yield myself 3 minutes.

Mr. Chairman, first of all, I want everyone in the chamber to know that this bill requires that two doctors and a patient, who has the understanding to make the decision, would make this decision for the taking of his life, physician-assisted suicide. So the tragedies and scare stories about other countries has nothing to do with this.

This legislation really represents a new hypocrisy by the majority who claim to support States' rights but would prevent the United States Attorney General from giving effect to State laws that allow physician-assisted suicide. They do not say anything about that.

The Supreme Court has said, quote, ''Americans are engaged in an earnest, profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue.''

This bill prevents and excludes that debate by coming to a Washington-knows-best solution coming from those who claim to support States' right. I support States laws. Although Republicans who have often claimed that citizen initiative is the most revered form of democracy, repeatedly sponsor bills that treat them as a higher form of law than others, they bring a measure to the floor today that would overturn an Oregon initiative that has been approved twice by large margins.

The 10th amendment, well, that is someone else's problem. It has reserved to the States those rights not given to the Federal Government. This is not a Federal issue. So, today, to consider a bill that has no grounding in interstate commerce or any other cause in the Constitution, in direct violation of the 10th amendment, compounded by the fact that they directly intend to override Oregon's law and would not give them a chance to make that exception in the Committee on Rules, this measure intrudes severely upon the essential relationship between a doctor and a patient.

Moreover, numerous medical associations have already told us that this bill, ironically, will deter doctors from treating pain because they fear they may be subject to criminal prosecution at the Federal level if their patients die. So it is especially disturbing considering that doctors are already undermedicating approximately 80 percent of their terminally-ill patients because they believe the current drug laws are too strict.

Let us not move in this direction. I commend to my colleagues the substitute of the gentleman from Massachusetts (Mr. STUPAK) and the gentleman from New Jersey (Mr. ROTHMAN), which will come up later.

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

Mr. CANADY of Florida. Mr. Chairman, I yield 3 minutes to the gentleman from Florida (Mr. WELDON).

Mr. WELDON of Florida. Mr. Chairman, I thank the gentleman from Florida for yielding me this time.

I rise in support of this legislation. I come to this debate today, not only as a legislator, but as well as a physician. I practice internal medicine. About once a month, I see patients. For 15 years prior to coming to the Congress, I practiced internal medicine full time.

One of the aspects of that for me was I had the opportunity to manage many patients with chronic pain and many patients, unfortunately, who were terminal who had, in many instances, metastatic cancer, with disease in their bones, and there was a lot of pain associated with their condition.

One of the experiences I discovered was that, with time and attention from the attending physician, it is possible to manage these patients quite successfully so that there is not suffering. Indeed, one of the things that I discovered was that the patients who suffered with severe pain, whether they were terminal or whether they had severe pain from a chronic disease and they were not necessarily terminal, the patients who were suffering were the patients who were being managed incorrectly. Their physicians essentially were incompetent, and that is why they were suffering.

That, in the hand of a competent physician, these patients can be managed correctly, and that their pain can be dealt with. Their nausea as a complication of their pain medicines can be dealt with. Indeed, even if they were severely depressed as a complication of their illness, one could manage them with medications. There is a whole plethora of drugs available.

Now, the reason why some people believe that physician-assisted suicide is necessary is, in my opinion, the false assumption that there are these cases that we cannot manage and, therefore, we have to euthanize these people.

□ 1200

I argue today, before all my colleagues, that that is a very, very cruel and bogus hoax. In competent hands and in compassionate hands we do not have to resort to the extreme measure of managing a patient like we would Fido or Rover, and simply just put them to sleep; that we are essentially at the limits of what doctors can do.

My colleagues, there are narcotic pain relieving drugs not only available in pill form, there are medications available in suppository form, there are medications available that are transcutaneous patches of narcotic pain relievers, there is even a lollipop that doctors can use that has a pain reliever in it. I have never seen a patient that could not have their pain managed. And the people who would resort to this are people who are lazy or perpetrating a hoax on their patients.

Mr. STUPAK. Mr. Chairman, I yield 2 minutes to the gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Chairman, I thank my colleague for yielding me this time, and I rise in opposition to H.R. 2260, the Pain Relief Promotion Act. This is a cynical title for a bill that is not about pain relief but about overturning State-assisted suicide laws.

H.R. 2260 explicitly preempts State laws that govern the practice of medicine, even if the residents of those States have spoken on the issue. Understandably, this bill is opposed by the California Medical Association and other State medical associations.

I strongly oppose physician-assisted suicide, but assisted suicide and pain management are very distinct things, and this bill blurs that distinction.

Title I of this bill raises the prospect of the Drug Enforcement Agency, nonmedical people, second-guessing a physician or a health care professional's intent in prescribing large doses of controlled substances for patients who have very severe pain. The threat of investigation could scare health care professionals away from providing quality care to people who are living in desperate situations, living with uncontrolled pain. There are medical standards in place now, approved by the Joint Commissions Standards Committee.

This bill is opposed by the American Nurses Association. Nurses are the

health care professionals who are most often at the side of patients helping them to deal with their pain and to continue to live their lives. Nurses are ethically bound to oppose this legislation because it creates barriers to appropriate and compassionate patient care. By making effective pain and symptom relief more difficult to obtain, H.R. 2260 is likely to increase suicide as desperate patients seek relief from unbearable pain.

In providing needed pain management, let us remember that we are not assisting patients to die, but helping them to live. I oppose H.R. 2260 and urge support of the Johnson-Rothman-Maloney-Hooley substitute.

Mr. COBURN. Mr. Chairman, I yield 1½ minutes to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Chairman, I rise in support of the Hyde-Stupak bill.

Sometimes on this floor Members actually have to read the legislation. We had a debate here a few weeks ago on managed care in which part of the biggest problem that we had was to get people to read the legislation. So let me read the pertinent point in here, and that is this. ''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.''

Those are important words that are in this bill. For various reasons, moral, religious, professional, ethical, I am against physician-assisted suicide. I agree with my colleague from Oklahoma, I think this puts us on a very slippery slope, and testimony before the Commerce Committee from the Netherlands demonstrated that.

I would also point out that the problem with pain can be handled. But that is not the most common reason why people request assisted suicide. It is not because they are having severe pain. Surveys have shown this. It is because they fear that they are losing control or they fear that they will be a burden. And I think that there are other ways we can approach that to help those people, but that we ought to pass the Hyde bill.

Mr. ROTHMAN. Mr. Chairman, I yield myself 2 minutes.

Mr. Chairman, a lot of people would like this debate to be about physician-assisted suicide because many of us are against physician-assisted suicide. I am against physician-assisted suicide. That is not what this debate is about.

This debate is about whether the underlying bill, 2260, will so intimidate doctors across America that they will not prescribe the pain medications to the children, men, and women who are begging for it. Not because they want to die but because they do not want to suffer agony. They want to live as long as they can, but not in pain.

But my colleagues who want this bill want to make it a physician-assisted bill. Why? Because they did not like the physician-assisted law in Oregon and, instead of going to the United States Supreme Court to get that referendum in Oregon declared unconstitutional, they have decided to use this route. The question is, is that so bad? Yes, it is bad, because by using this route and the controlled substances Federal law to go after the Oregon referendum that the people passed twice, they are affecting tens of millions of other Americans whose doctors will be inhibited and chilled from prescribing the pain medications that those tens of millions of children, men, and women are asking for.

This is not a debate about physician-assisted suicide. If they wanted to get rid of the Oregon physician-assisted suicide bill, let them go to the Supreme Court and have it declared unconstitutional. Do not intrude in the doctor-patient relationship. There is already an untreatment of pain in America. Do not make it worse. It is not necessary.

We are all against physician-assisted suicide. I urge my colleagues, those who are against physician-assisted but believe there needs to be more care for people in pain, more pain medication, then pass the substitute and reject the bill.

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

Mr. CANADY of Florida. Mr. Chairman, I yield myself 2 minutes.

I think it is very important that the Members of the House focus on what the language of this bill actually does, and I appreciated the gentleman from Iowa (Mr. GANSKE) actually quoting the bill. Much is being said here today that has no relationship to what the bill actually says and what it would actually do.

This bill is not going to do anything to intimidate doctors across America. That is what has been said here today. That is not the impact of this bill. This bill is actually going to provide additional protections for doctors across America. In the language of the bill we give a safe harbor for the appropriate use of controlled substances and palliative care. We are creating additional protection under the law for physicians who use controlled substances to control pain, even in circumstances where the hastening of the death of the patient may occur.

We do draw the critical distinction, and we say that the deliberate taking of life is wrong. But if death is hastened as a consequence of providing appropriate palliative care, the physician will be protected. And that is a very important step forward in this legislation. That is why groups such as the American Medical Association support it.

The focus of this bill is to help ensure that we consistently enforce the Controlled Substances Act. The issue before the House today, as we have said repeatedly in this debate today, is whether we are going to have a consistent Federal policy that does not support assisted suicide or whether we are going to allow a Federal regulatory scheme to be used to support physician-assisted suicide. Are we going to allow physicians who are licensed under the Controlled Substances Act to dispense controlled substances, to use the pads, the prescription pads printed up by the DEA, to provide controlled substances to kill their patients? That is the issue before the House today.

I do not think that is appropriate Federal policy. Let me quote to my colleagues what the President himself said upon signing the Assisted Suicide Funding Restriction Act. He said, ''The ban on funding will allow the Federal Government to speak with a clear voice in opposing these practices.'' We should do the same today.

Mr. STUPAK. Mr. Chairman, I yield 3 minutes to the gentlewoman from Oregon (Ms. HOOLEY).

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

Several months ago, I introduced 2188, the Conquering Pain Act, with the gentlewoman from Connecticut (Mrs. JOHNSON) to address the pain crisis, and we are having a pain crisis in this Nation. Most of the provisions are in this substitute. The Conquering Pain substitute addresses pain management from a medical perspective rather than law enforcement. It also expresses Congress' clear opposition to assisted suicide.

Let me tell my colleagues what is in the substitute. First of all, patients, families, and doctors would have access to help 24 hours a day, 7 days a week. Our goal is to make sure that people, if they have a problem on Sunday, do not have to wait until Monday; that they do not have to be in pain. We want patients to know that they should expect to have their pain managed and to receive quality pain management. No one should have to live or die in pain because a doctor was afraid to give higher doses of pain medication.

As introduced, the Conquering Pain Act also sought to identify any barrier in our regulatory pain system that prevents good access to pain management. We want the Surgeon General to provide us with a report on the state of pain in this country. We create an advisory committee to help us identify gaps in the Federal policy on pain management to force the different parts of government to speak to one another, to talk to each other, so we can create a coordinated agenda that builds on all of our actions of the Federal Government without wasting taxpayers' dollars.

Under the Johnson substitute amendment, Congress again expresses its clear opposition to assisted suicide. Among the groups that sat down with us to help us write 2188, the Conquering

Pain Act, from which this substitute is derived, and endorsed that bill, are the American Medical Association, the National Hospice Organization, American Society of Anesthesiologists, American College of Physicians, American Pharmaceutical Association.

Among those who oppose the Hyde-Stupak bill and prefer the Conquering Pain substitute to the Pain Relief Promotion Act are the American Academy of Family Physicians, American Nurses Association, American Pharmaceutical Association, and the American Pain Foundation. And let me tell my colleagues one other group of people that is very important for us to understand. All of those associations that deal specifically with pain management and palliative care are opposed to the underlying bill and support this amendment.

Ultimately, I hope we can agree that the amendment put forth by the gentlewoman from Connecticut (Mrs. JOHNSON), the gentleman from New Jersey (Mr. ROTHMAN), the gentlewoman from New Jersey (Mrs. ROUKEMA), the gentlewoman from New York (Mrs. MALONEY) and myself should be approved because it will make a difference in people's lives every single day who are struggling with these life and death issues.

By improving care rather than by more closely scrutinizing care, we can reduce patients' hopelessness at the end of life. For a medical solution rather than a law enforcement solution, vote for the substitute.

Mr. ROTHMAN. Mr. Chairman, I yield 1½ minutes to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Chairman, I thank the gentleman from New Jersey for yielding me this time, and I rise to support the Scott-DeFazio amendment, and the Johnson-Rothman-Maloney-Hooley amendment, and in opposition to the underlying bill.

Mr. Chairman, I thank the gentleman from New Jersey (Mr. ROTHMAN) for defining what this debate is all about. This debate is not about physician-assisted suicide, which all of us collectively, in many ways, have said that this body, this Congress, does not have the stomach for; in fact, the American people do not have the stomach for, or physicians.

□ 1215

But what this is about is to close the door of the patient's room to the physician before he goes or she goes in the door to serve that patient, and it is a jail-time-for-physicians bill in America. That is the name of this bill.

It is interesting that just a few weeks ago we collectively came together in supporting the patients' bill of rights in reaffirming the relationship between patients and physicians. For once and for all, this Congress stood side by side with the healers of this Nation and said, we want them to engage with their patients.

Now we come back just a few weeks later, and because we have some kind of angst and some kind of disagreement with the Oregon State law, which, in fact, in hearings as I have reviewed is a very good law with double checks, with second opinions, with the right to withdraw, with family members involved, with time frames there, a very strong bill; and yet we in the United States Congress have put ourselves in a God-like position to, one, remove the rights of the people from Oregon but then, as well, tell physicians we lock them up and we do not want them to care for their patients.

Pain is devastating, Mr. Chairman. Pain is devastating. The cancer victims have terrible pain. This is a bad bill. It should be defeated. We should support the amendment.

Mr. Chairman, I rise in opposition to this bill because I am concerned about the negative impact it will have on patient care. This bill enables the Drug Enforcement Administration (DEA) to determine whether a prescription was intended to manage pain or to terminate a life. On its face, this bill may seen like an effort to improve pain management, but instead, this bill will compromise the ability of doctors to relieve patient pain.

I understand concerns that pain management medication may be prescribed for assisted suicides or for euthanasia. Doctors may believe that by prescribing high doses of pain medication, they are easing the suffering of a patient close to death.

For patients who have requested assistance in committing suicide, a physician may prescribe a lethal dose of pain medication as an act of humanity. In both cases, there is considerable debate about the ethics of preserving life in these instances.

However, we already recognize certain rights of patients in determining end of life issues. Terminally ill patients sometimes decide to write living wills that alert medical personnel of their final wishes. People sign organ donor cards and families make life or death decisions concerning on-going treatment in chronically ill cases.

In each of these situations, there is a balancing determination about the quality of life in terms of the wishes of the patient and the interests of society. Included in these decisions are the ethics of end of life pain management.

There is precedent in federal law and state law concerning physician assisted suicide. In Washington v. Glucksberg (1997), the Supreme Court encouraged States to engage in this debate, ''about the morality, legality and practicality of physician assisted suicide.''

The State of Oregon voted in 1994 through a ballot initiative to support physician assisted suicide under specific circumstances and by following specific guidelines.

This bill is an attempt to address this issue by giving the DEA the authority to determine if pain management medication is prescribed in a manner that constitutes a ''legitimate medical purpose.'' Its effect is to take the debate away from the states by regulation on the federal level.

This is problematic because this bill may subject physicians to criminal prosecution when administering pain medication. Physicians who prescribe pain management drugs in large doses that ''may increase the risk of death'' would be in danger of losing their DEA license.

I do not support this bill and I urge my colleagues to vote against it. The Supreme Court has already determined that the States have the right to legislate in this area, and I believe we should defer to that finding. The right of patients to request medication to manage pain, and the responsibility of doctors to manage the pain cannot be compromised.

Mr. COBURN. Mr. Chairman, I yield 1 minute to the gentleman from Florida (Mr. WELDON).

Mr. WELDON of Florida. Mr. Chairman, well, if we wanted to distill this down to the final issue, it is should one of the options be available to a doctor to go in and kill a patient if the patient has determined that their life is not worth living anymore. And if my colleagues think that is a very good law, then perhaps they should not support this bill.

I think this is a cruel hoax. I think anybody who would hold out and say killing them is the best way to go is wrong. I can manage the patients. If they cannot handle them in Oregon, send them to me and I will retire from the House and take care of them in Florida. I mean, this is absurd to say we have to ultimately have the ability to just do that and say bye-bye.

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

Mr. Chairman, this bill merely reinforces current Federal policy that the administration, dispensation, or distribution of a controlled substance for the purpose of assisting a suicide is not authorized by the Federal Controlled Substance Act.

We make clear that the Attorney General, in implementing the Controlled Substance Act, shall not recognize any law permitting assisted suicide or euthanasia.

Now, this legislation has reflected many months of hard work to bring the hospice groups on board to support this legislation. And not only the National Hospice Organization. But the American Medical Association, the American Academy of Pain Management, American Society of Anesthesiologists, the American College of Osteopathic Family Physicians all support this legislation.

Now, despite all the claims made on the floor by the opponents here, this bill really does three things. It promotes pain management and palliative care. It does not create any new Federal standard concerning the controlled substances under the Controlled Substance Act with respect to assisted suicide. We do not put forward any new standard. And it does override reliance on Oregon's Death With Dignity Act as a defense, we do not repeal it, but as a defense to any action pursuant to the Controlled Substance Act.

If I may, one of those who supports this legislation, C. Everett Koop states, and I would like to quote from his statement to us, he says, ''Clearly, controlled substances, such as narcotics, have very legitimate and important uses in modern medicine, not least in alleviating the suffering of dying patients. Just as clearly, Government has

legitimate interests in ensuring that those substances are never intentionally used to take a human life. Physicians who are entrusted by the Federal Government with the privilege of using these potentially dangerous drugs in their practice should be the first to understand the need for laws ensuring their proper use. Their own ethical code instructs them always to use medications only to care, never to kill.''

C. Everett Koop, in endorsing our legislation, goes on and states that this bill strikes the right balance by promoting the much-needed role of federally regulated drugs for pain relief while reaffirming that they should not be abused to assist patient suicide. A better understanding of the difference between trying to kill pain and trying to kill patients will be of great help to law enforcement authorities, to physicians, and especially to patients themselves.

Now, if we take a look at our legislation that we have before us, H.R. 2266, there has been all these claims that law enforcement officials will be questioning the doctor's intent in using controlled substances for pain. That is not the case. That is not even close to what this bill purports to do.

Using drugs to assist suicide is clearly different from using them to control pain. Causing a patient's death usually requires a sudden massive overdose of a potentially dangerous drug. Pain control involves the carefully adjusting dosage until it achieves relief of pain with a minimum amount of side effects for the patient. This gradual adjustment of the dosage is exactly what must be avoided if one's intent is to kill, because patients quickly build up a resistance to side effects, such as suppression of breathing.

The intentional assistance in suicide is already contrary to State law and State licensing practices across this great Nation. This bill creates no new standard, no new law of the States. Even in the few States that do not clearly ban assisted suicide by criminal law, the practice is clearly contrary to medical and also to ethics and licensing standards. And if it is contrary to licensing standards, therefore, it is contrary to the Controlled Substance Act, which denies a license, a registration to anyone who has lost his or her own State license.

So the point being that all this about we are going to put in new intent is simply not true.

Now, let me just make a few comments if I may on the broader issue of federalism that we have heard a lot about. H.R. 2260 does not preempt Oregon's law legalizing assisted suicide. Its only legal effect is we forbid the use of narcotic drugs which are federally controlled for that purpose.

On a broader issue of federalism, Oregon has the right to say that there will be no State penalties for certain conduct. But that does not mean that Oregon can prevent the Federal Government from restricting the use over federally controlled substances.

Registration of a physician under the Controlled Substance Act is a matter entirely separate from a physician's State license to practice medicine. Therefore, the revocation of a registration only precludes a physician from dispensing controlled substances under the Controlled Substance Act. It does not preclude that physician from dispensing other prescription drugs or in his continued medical practice. And because the Federal Controlled Substance Act requires prescriptions to be for legitimate medical purpose to be valid by allowing this practice, the Federal Government is making a judgment that each and every one of those suicides was performed for legitimate medical purpose.

So it is well within the power of the Federal Government to say that these Federal drugs are not being used for the purpose of killing people, notwithstanding State law.

There is no reason why our tax dollars and our Federal law enforcement personnel must be drafted into assisting Oregon's dangerous experiment in assisted suicide.

I hope that our colleagues will reject the arguments and vote for H.R. 2260. Let us end assisted suicide and let us relieve pain. I hope they vote yes.

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

The CHAIRMAN pro tempore (Mr. HASTINGS of Washington). The Chair would advise Members that the gentleman from Oklahoma (Mr. COBURN) has 9½ minutes remaining, the gentleman from New Jersey (Mr. ROTHMAN) has 8½ minutes remaining, the gentleman from Ohio (Mr. CHABOT) has 10 minutes remaining, and the gentleman from Michigan (Mr. STUPAK) has 4 minutes remaining.

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

Mr. Chairman, I would like to just go through and rhetorically ask some questions and answer them so we can really talk about what this bill does. Because we have heard everything except the essence, other than what the gentleman from Michigan (Mr. STUPAK) just outlined, as the truth about what this bill does.

Is it the intent of this bill to undermine States' ability to help patients access appropriate palliative care? No, it is not the intent whatsoever. Is it the intent of this bill to create a fear on the part of physicians so they will not do the proper thing when it comes to caring for end-of-life, pain-enduring patients? No, that is not the intent. And that is not the consequence, regardless of what has been said on the floor. What we actually do is define better so that we do not put physicians at risk and give them a safe harbor.

Are we trying to go around guidelines for end-of-life issues in the State? No, we are not trying to do that at all. What we are trying to say is have whatever guidelines they want, but as far as the use of narcotics, we do not think that those narcotics ought to be used to intentionally take a life.

Some have said we are going to allow the DEA agents to make a decision over what the intent was of the doctor. Well, that is simple. I am for that. I do not have any problem. Because do my colleagues know what? They make that decision about me right now. Whatever my intent is, whether I write a narcotic prescription to alleviate pain associated with a fracture or if I write morphine suppositories for a patient dying of metastatic cancer, they still get a look at it; and they are making a decision right now.

And do my colleagues know what? All they want is to make sure that we are not violating the law. And every physician is trained in that.

Now, what is the real question? The real question is will physicians in this country stand up and put their patients first? That is the real question, will they really go out and help their patient?

As the gentleman from Florida (Mr. WELDON) so eloquently said, we can help patients. We do it all the time. The question is we have to be trained in it, we have to want to do it, and we have to make sure that the extenders of the physicians in this country will in fact carry out our order.

There is no question, the American Medical Association said 2 years ago we have not done a good job in this country in training physicians in end-of-life pain control management. They have redoubled their efforts not only at the American Medical Association but in every medical school in this country.

So what we have heard about the untoward events that will come out of this bill is poppycock; it is not based in fact. The fact is, if they are going to assume everybody is going to do everything wrong, they might be able to do that.

Somehow we changed in this country. We used to assume that people would do things right, that they were honorable, that they had integrity. And then, as we start undermining the values and foundational principles of our country, we have to assume that everybody is going to do everything wrong.

What this bill does is say, if their intent is right, they are safe-harbored and they are protected.

The fact is that every day good physicians are out there making great decisions about pain control for their patients. This bill will enhance their ability to do that, not take away from that.

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

Mr. ROTHMAN. Mr. Chairman, I yield 3½ minutes to the gentleman from Washington (Mr. MCDERMOTT).

Mr. MCDERMOTT. Mr. Chairman, I think that we are passing the ultimate in Murphy's law today. Because a few weeks ago we got out here and talked

about we wanted to have the doctor-patient relationship; and now we, the great medical board of medicine in the sky, are going to decide what goes on between patients and doctors.

What happened in Oregon is really an attempt to deal with a very thorny public issue, and they tried to make explicit and say that that which all physicians know goes on ought to be done within the scope of the law so that there is no question about it.

A patient has to ask, two physicians have to examine for competency. A patient can withdraw. The doctor has to register that he or she is going to administer medication for this purpose. We are not just talking about narcotics here. We are talking about a whole range of psychotropic drugs, everything covered by the DEA. And so now you are going to hand to the bureaucrats, and if I have heard one bureaucrat reviled on this floor, I have heard a thousand of them, so they are going to hand this to the Department of Justice and somebody in the Department of Justice is going to write the rules and regulations for this.

□ 1230

Now, that is where Murphy's law comes, because somebody over there is going to sit and say, well, if a doctor gives this number of pills within this period of time, that is assisting suicide and therefore we are going to swoop in and grab him. They will have to have some standard by which they grab them and take them to court and say you, doctor, were assisting in suicide.

The doctor merely has to take the law out here and say, no, no, no, on page 5 it says here, the purpose of my care was to alleviate pain and other distressing symptoms and to enhance the quality of life, and they are wrong, right? But they are going to have to go through court to prove that that is what they were doing. They would have no defense. If they have 25 pills within 30 days, they will certainly wind up being dragged into court by somebody, maybe a family member, it may be somebody else saying, you were assisting my mother in suicide by giving her those pills.

I am a psychiatrist. I have prescribed many, many, many times amounts of medication that people can use to kill themselves, if they took them all at once. You could say, well, doctor, what you have to do is let the patient have five pills, that is all they get. When they need five more, come in and get five more. I testified in a malpractice suit on which a physician had prescribed 100 Nembutal to somebody which were used for suicide. You are opening a box that you know nothing about, because it occurs in a room between a patient and a physician. And if you think you are smart enough to write a law that will control that situation, you simply do not know what physicians face and what patients face when they are faced with an overwhelming illness. For us to say that we know what should go on in the United States with all 600,000 physicians and the 240 million patients in this country is absolute nonsense.

The locals have worked on an issue here. I think they ought to be allowed to do that because they made it very explicit and made the doctors honest. You are going to make doctors dishonest with this law.

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

I quote, and this testimony was also given before the constitutional subcommittee in the House. I want to give my colleagues the quote of a physician:

''What is the sense of having that woman here? It makes no difference whether she dies today or after 2 weeks. We need the bed for another case.''

This is a recounting of a Catholic nun who did not want to be euthanized but was euthanized anyway in Holland because they needed the bed.

Mr. Chairman, psychiatrists are in lawsuits every day in this country because they give antidepressants that have a lethal dose of 50 and they give too much medicine. One of the things you are taught in medical school is to not give too much medicine, enough medicine that someone could take their life. So we understand that issue and those arguments are fallacious. The fact remains that if we are going to encourage a doctor-patient relationship, I will encourage that all the way up to the point we decide that the doctor has the right to take the patient's life. That is no longer a relationship. That is not a relationship when I as a physician decide I am going to be the giver or taker of life for my patient. And if that is the foundational construct under how we are going to run doctor-patient relationships, we need start completely over. Psychotropic drugs are controlled in this country and for good reason. That is called mescaline, LSD. We use very few. We use antipsychotic drugs and we use narcotics and we use barbiturates. But most psychotropic drugs we do not even allow doctors to write a prescription for because they are significantly mind-altering drugs. The doctor-patient relationship does need to be preserved. This law does nothing to disturb a proper doctor-patient relationship in Oregon. But as soon as a doctor has made the decision that they are the giver or taker of life, they no longer are a physician. They may be called doctor by our society but they no longer are a physician. They no longer have the ethical right to care for that patient.

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

Mr. STUPAK. Mr. Chairman, I yield 2 minutes to the gentlewoman from New York (Mrs. MALONEY).

Mrs. MALONEY of New York. Mr. Chairman, I rise in support of the Johnson–Hooley-Roukema-Maloney-Rothman amendment and against the base bill. The first principle of the Hippocratic oath is to do no harm, yet the base bill before us does harm. The Pain Relief Promotion Act does little to relieve pain. Instead, it focuses on abolishing physician-assisted suicide. It expands the authority of the Drug Enforcement Administration agents to judge the practices of well-meaning doctors. This means that even when death results from sincere efforts to provide appropriate pain relief, a doctor's intent can be questioned.

Last night, I spoke with one of my constituents. Her name is Lisa Pearlman. She was just 22 years old when she developed fibromyalgia. This disease causes pain throughout the body. Lisa said there were days when she could barely function, there were times she could not even pick up her young child. She said she went to at least a dozen doctors before she found one who could manage her pain. Now for flare-ups she takes pain killers to manage the pain so she can take care of her two young children. But what if Lisa's doctor were too afraid of a criminal investigation to order the drugs that changed her life? Where would Lisa and so many patients be?

The American Pain Foundation predicts that the base bill could actually increase the rate of suicide among the terminally ill because people who suffer from severe, chronic pain will no longer have an alternative. By intimidating doctors with pulled licenses and jail sentences, the base bill does more to threaten the lives of those who desperately want to live than those who do not want to live. It gives drug enforcement agents too much control over decisions that should be made by doctors and their patients.

I ask my colleagues to consider the lives of people who depend on aggressive pain medication to live. It is not our place to come between a doctor and their patient in important decisions.

I include for the RECORD the following letter from Memorial Sloan-Kettering in support of the Johnson bipartisan bill. I urge my colleagues to support the Johnson bill.

I am a neuro-oncologist and palliative care physician. On a daily basis, I treat patients with cancer who have pain and other symptoms in the course of their illness, including patients who are dying. I am writing to urge you to oppose H.R. 2260, The Pain Relief Promotion Act of 1999 (Hyde/Nichols). As a palliative care physician, I know that pain is under-treated and that palliative care services are underutilized.

While H.R. 2260 is well intentioned, it is counterproductive. It will likely have a chilling effect on aggressive pain management. As the co-chairman of the Agency for Health Care Policy and Research (AHCPR) expert panel on cancer pain guidelines, I know that physicians often prescribe inadequate amounts of pain medicines, and use less potent pain medications because of fears of regulatory scrutiny. I wish to make it clear that I am opposed to physician-assisted suicide. Furthermore, I feel it is profoundly unfair to provide an option for physician-assisted suicide in circumstances where many patients do not have full access to health care and quality pain management and palliative care. However, in considering the

issue of physician-assisted suicide, Congress should not tamper with the Controlled Substances Act and endanger patients in need of aggressive pain and symptom management. I urge you to support an amendment to strike Title 1 and thereby remove the provisions that turn the Drug Enforcement Agency (DEA) into a medical oversight body charged with investigating the ''intent'' and ''purpose'' in a physician's care for a patient.

I also urge you to support a substitute amendment incorporating the provisions of the Conquering Pain Act (H.R. 2188)—a bill that would constructively promote end-of-life and palliative care—as long as the substitute amendment includes elimination of the changes to the Controlled Substances Act of Title 1 of H.R. 2260. Unless one of these amendments is passed to remove the provisions that would increase barriers to aggressive pain management, I strongly urge you to vote against H.R. 2260 as reported by committee.

Please do not increase the barriers for physicians to provide the pain management, palliative and end-of-life care that the American public needs.

Sincerely,

RICHARD PAYNE, MD,
*Professor of Neurology and Pharmacology,*
*Cornell University Medical College.*

Mr. ROTHMAN. Mr. Chairman, I yield 2 minutes to the gentlewoman from Connecticut (Mrs. JOHNSON).

Mrs. JOHNSON of Connecticut. Mr. Chairman, I would like to respond to my friend and colleague the gentleman from Iowa (Mr. GANSKE) who said, read the legislation. Then he stopped reading the legislation at a very critical point. It is true that this bill allows administering controlled substances to alleviate pain even if they may increase the risk of death. The next sentence: Nothing in this section authorizes intentionally administering a controlled substance for the purpose of causing death, and later on in the definitional section, that causing death must be read as hastening death. So under this law, DEA agents will have to judge whether the intention of the physician was to alleviate pain, even at the risk of death, or whether the physician's intention was to hasten death. This is a judgment that is extremely difficult to make if you are a physician. It should not be made by nonmedical personnel, DEA agents.

This is such a serious matter that Richard Payne, the Chief of Pain and Palliative Care Service, Department of Neurology, Cornell University, Memorial Sloan-Kettering Cancer Center says in a letter, ''Physicians often prescribe inadequate amounts of pain medicines and use less potent pain medications because of fears of regulatory scrutiny.'' Then I have to skip some in the interest of time.

He goes on to say, ''I urge you to support the amendment to strike title I,'' later he goes on to support my amendment, ''and thereby remove the provisions that turn the Drug Enforcement Agency into a medical oversight body charged with investigating the intent and purpose of a physician's care for a patient.''

So if the gentleman from Oklahoma (Mr. COBURN) gets up here and says it is not my intent to discourage alleviation of pain, it does not matter what his intent is when the law says the government is now going to judge the physician's intention in providing care in situations in which there is extremely severe pain and high dosages involved.

Mr. STUPAK. Mr. Chairman, I yield 1 minute to the gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Chairman, I want to follow on to what our colleague from Connecticut had to say. This bill allegedly creates a safe harbor for those who administer pain medications to chronically and terminally ill patients. But I have heard from nurses, family physicians and pharmacists who say the bill will do more harm than good. They believe this legislation will chill their efforts to aggressively treat patients in pain. By raising doubts about the legality of their conduct, this bill will discourage them from easing the pain of AIDS and cancer patients across the country.

I cannot support a bill that will at best further cloud an already uncertain legal environment in which doctors, nurses and pharmacists are trying to do what is best for their patients. This bill will make it harder for them to do their jobs and force them into guessing games over whether the DEA will turn a benevolent or a hostile eye towards their conduct.

We should not gamble the quality of life of patients in pain upon who happens to be Attorney General. Until the bill's safe harbor is truly safe enough for care givers, I unfortunately will oppose this legislation and support the amendments to it.

This legislation was also created as a political attack on Oregon's Death with Dignity Act. It seeks to override the votes of Oregon residents, but it is patients in pain who will pay the price for this legislation.

Finally, H.R. 2260 will put an end to widespread and thoughtful deliberation among the States about physician-assisted suicide. I do not think the Federal government should intrude in these important debates. We should allow states like Oregon to reach decisions which reflect the fundamental beliefs of their residents.

I submit the following material for the RECORD:

SUICIDE BILL'S DEEP FLAWS

The House of Representatives plans to vote today on the most wrenching issue before it: a bill by Rep. Henry J. Hyde (R–Ill.) that is intended to effectively nullify a law in Oregon that allows terminally ill patients to request drugs to end their lives. However, the bill would reach far beyond the Oregon law. Medical societies say it will lead many doctors to under-medicate terminal patients to avoid scrutiny from federal drug agents. For this reason the bill is unacceptable.

Hyde wrote the bill out of rightful concern that the Oregon law, which voters passed in 1994, could lead government down a slippery slope toward sanctioning the state or federal legalization of physician-assisted suicide.

Hyde's bill, however, is by no means the best way to supervise and discipline doctors who stray from their proper role as healers.

The bill has gained broad support in the House largely because of misleading arguments being made by its proponents. Hyde titles his bill. ''The Pain Relief Promotion Act'' and the author of its Senate counterpart, Sen. Don Nickles (R–Oklahoma), insists that ''there's no going after doctors in this.''

In fact, Hyde's legislation imposes civil penalties and a 20-year mandatory prison sentence on doctors who knowingly hasten a terminally ill patient's death. The California Medical Assn., along with physician groups representing a dozen other states, persuasively argue that the harsh sanctions would lead doctors to under-medicate patients to avoid prosecution—thus inhibiting the effective pain management the bill purports to promote.

Some Hyde staffers have said they would consider reducing the bill's penalties if that would persuade President Clinton to sign it. But even if the sanctions were reduced, the bill remains marred by its requirement that the Drug Enforcement Administration define legitimate medical uses of pain medications, then regulate and enforce those subjective determinations. The DEA, basically a policing agency, by its own admission has neither the expertise nor the resources to play doctor.

The best way to prevent medical abuses that drift toward euthanasia is through vigilance by state medical authorities and legislators, not by passing a federal bill with a misleading title and unenforceable aims.

---

AMERICAN PAIN FOUNDATION,
*Baltimore, MD.*

OPPOSITION TO ''PAIN RELIEF PROMOTION ACT'' (H.R. 2260) AS REPORTED BY COMMITTEES

H.R. 2260 is well-intended and an improvement over last year's bill, but it is seriously flawed. Please vote against H.R. 2260 in its present form.

Many doctors and other health care practitioners think H.R. 2260 will have a chilling effect on pain management. Others disagree. It's not worth Congress' taking the risk that people in pain will suffer more under H.R. 2260.

Current law and Drug Enforcement Administration (DEA) regulations protect doctors who aggressively treat pain with morphine and other oploids. Doctors don't need a new law, they need better implementation of existing law.

DEA will investigate physicians' subjective ''intent'' in palliative care with the threat of criminal penalties. Practitioners will incur costs and burden of justifying their medical care to federal authorities. Result: undertreatment of pain.

Assisted suicide should be dealt with in a separate law, not linked to the medical practice of pain management.

Correct H.R. 2260 with floor amendments:

Strike Title I to remove provisions that turn the DEA into a medical oversight body investigating ''intent'' and ''purpose'' in a physician's care for a patient.

Substitute the provisions of the Conquering Pain Act—an effective approach to stopping suicides, assisted and otherwise, by relieving unnecessary pain.

Many patients, physicians, nurses, pharmacists and cancer specialists oppose H.R. 2260:

Patient and Health Care Groups Opposed (partial list): American Academy of Family Physicians, American Alliance of Cancer Pain Initiatives, American Nurses Association, American Pain Foundation, American Pharmaceutical Association, American Society for Action on Pain, American Society of Health-System Pharmacists, American Society of Pain Management Nurses, Hospice and Palliative Nurses Association, National Association of Orthopaedic Nurses, National

Foundation for the Treatment of Pain, Oncology Nursing Society, and Society of Critical Care Medicine.

State Medical Societies Already Opposed or Having Serious Reservations (10/19/99): Arizona Medical Association, Arkansas Medical Society, California Medical Association, Louisiana State Medical Society, Massachusetts Medical Society, Oregon Medical Association, Rhode Island Medical Society, Texas Medical Association, Vermont Medical Society, Washington State Medical Association, and State Medical Society of Wisconsin.

---

DEPARTMENT OF JUSTICE,
OFFICE OF LEGISLATIVE AFFAIRS,
*Washington, DC, October 19, 1999.*

Hon. JOHN D. DINGELL,
*Ranking Minority Member, Committee on Commerce, House of Representatives, Washington, DC.*

DEAR CONGRESSMAN DINGELL: This letter presents the views of the Department of Justice on H.R. 2260, the ''Pain Relief Promotion Act of 1999.''

H.R. 2260 makes two changes to federal drug law as it relates to the use of controlled substances by terminally ill patients. First, the bill clarifies that controlled substances may be used to alleviate pain in the course of providing palliative care to terminally ill patients. The bill also funds research and education on the appropriate use of controlled substances for this purpose. The Department strongly supports these provisions of H.R. 2260.

Second, H.R. 2260 states that the use of controlled substances to assist a terminally ill person in committing suicide is not authorized by federal law. The Department opposes physician-assisted suicide, but is concerned about the propriety of a federal law that would unquestionably make physician-assisted suicide a federal crime with harsh mandatory penalties. Imposing such penalties would also effectively block State policy making on this issue at a time when, as the Supreme Court recently noted in *Washington* v. *Glucksberg,* 117 S. Ct. 2258, 2275 (1997), the States are still ''engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide.''

PALLIATIVE CARE

Section 101 of H.R. 2260 amends section 303 of the Controlled Substances Act (''CSA''), 21 U.S.C. §823, to specify that the use of controlled substances to ''alleviat[e] pain or discomfort in the usual course of professional practice'' is a ''legitimate medical purpose'' under the CSA, 21 U.S.C. §841, ''even if the use of such a substance may increase the risk of death.'' Because a physician who acts with a ''legitimate medical purpose'' is acting in compliance with the Act,[1] H.R. 2260 creates a ''safe harbor'' against administrative and criminal sanctions when controlled substances are used for palliative care. Sections 102, 201 and 202 amend the CSA and the Public Health Service Act (42 U.S.C. §299) to authorize the Attorney General, the Administrator of the Agency for Health Care Policy and Research, and the Secretary of the Health and Human Services Department to conduct research on palliative care, to collect and distribute guidelines for the administration of palliative care, and to award grants, cooperative agreements, and contracts to health schools and other institutions to provide education and training on palliative care.

The Department fully supports these measures. H.R. 2260 would eliminate any ambiguity about the legality of using controlled substances to alleviate the pain and suffering of the terminally ill by reducing any perceived threat of administrative and criminal sanctions in this context. The Department accordingly supports those portions of H.R. 2260 addressing palliative care.

PHYSICIAN ASSISTED SUICIDE

H.R. 2260 would amend section 303 (21 U.S.C. §823) of the CSA to provide that ''[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.'' By denying authorization under the CSA, H.R. 2260 would make it a federal crime for a physician to dispense a controlled substance to aid a suicide.[2] A physician who prescribes the controlled substances most commonly used to aid a suicide would, because he or she necessarily intends death to result, face a 20-year mandatory minimum sentence in federal prison (as well as civil and administrative sanctions under the Act).[3]

The Administration strongly opposes the practice of physician-assisted suicide and would not support the practice as a matter of federal policy. H.R. 2260 side-steps the federal policy question, however, and operates instead by blocking State policy making on an issue that many, including the Supreme Court, think is appropriately left to the States to decide as each chooses.[4]

Moreover, H.R. 2260 would affirmatively interferes with State policy making in a particularly heavy handed way by using 20-year mandatory prison sentences (as well as civil and administrative sanctions) to effectively preclude States from adopting any policy that would authorize physician-assisted suicide, even if that authorization contains carefully drafted provisions designed to protect the terminally ill.

For these reasons, H.R. 2260 is particularly intrusive to State policy making, and the Department accordingly opposes this portion of the bill.[5] The Department would, however, be willing to work with you in formulating a legislative or regulatory solution that obviates the concerns identified in this letter.[6]

Thank you for this opportunity to present our views. The Office of Management and Budget has advised that there is no objection from the standpoint of the Administration's program to the presentation of this letter. Please do not hesitate to call upon us if we may be of further assistance in connection with this or any other matter.

Sincerely,

ROBERT RABEN,
*Assistant Attorney General.*

FOOTNOTES

[1] *See e.g.* 21 C.F.R. §1306.04(a) (authorizing prescriptions only for ''legitimate medical purposes'').

[2] The criminal provisions of the CSA are triggered by the absence of proper authorization. *See* 21 U.S.C. §841(a) (''*Except as authorized by this subchapter,* it shall be unlawful . . .'') (emphasis added).

[3] *See* 21 U.S.C. §841(b)(1)(C) (setting 20 year mandatory minimum sentence when death results from the distribution of a Schedule II substance); 21 C.F.R. §1308.12(a)–(c) (defining Schedule II substances). Schedule III drugs, which are sometimes used, do not carry any mandatory minimum sentence. *See* 21 U.S.C. §841(b)(1)(D).

[4] *Glucksburg,* 117 S. Ct. 2258, 2274 (noting that debate over physician-assisted suicide is underway in the States, ''as it should in a democratic society''); *id* at 2303 (O'Connor, I., concurring) (endorsing majority's result, which left ''the . . . challenging task of drafting appropriate procedures for safeguarding . . . liberty interests . . . to the 'laboratory' of the States''); *id.* at 2293 (Souter, I., concurring) (emphasizing that, in light of current state experimentation, ''[t]he Court should stay its hand to allow reasonable legislative consideration [of this difficult issue]'').

[5] This approach to physician-assisted suicide is consistent with the Department's approach to ''medical marijuana.'' The legality of the latter turns on *factual,* not ethical, questions. That is, the scheduling of controlled substances is based on scientific testing to determine, among other things, whether they have any ''currently accepted medical use for treatment in the United States,'' a ''high potential for abuse,'' and ''a lack of accepted safety for use . . . under medical supervision.'' 21 U.S.C. §812(b)(1) and Schedule I(c)(10). As a result, the CSA appropriately creates a uniform national system of drug scheduling. Where an issue turns solely on ethics, not science, it is reasonable to allow individual states to reach their own conclusions, rather than impose a uniform national standard through implied preemption of state medical standards.

[6] Any solution should also be careful not to make state-authorized assisted suicides more painful, as H.R. 2260 appears to do. H.R. 2260's prohibitions would only reach controlled substances, which are most often used as sedatives and not as the actual agents of death. As a result, H.R. 2260 might well result in physician-assisted suicides that do not use sedatives and pain-controlling substances that are accordingly more painful.

Footnotes at end of letter.

Mr. COBURN. Mr. Chairman, I yield 1 minute to the gentleman from Florida (Mr. WELDON).

Mr. WELDON of Florida. Mr. Chairman, I would like to address two of the criticisms of the bill that have been brought up. Number one, somebody rose and said there is nothing in this bill that will help people with pain. There are two titles in this act. The second title which encompasses most of the bill deals with extensive training so that physicians will get better training on how to manage pain. That is really the problem. That is why people suffer. There are a lot of doctors who are not well trained in how to manage these cases.

Now, the issue that has been brought up as well by the last two speakers, that there will be this gray zone and you will give a few pills and the DEA will start scrutinizing you, in practical effect that never happens. Indeed, under the Oregon statute, which is essentially the focus of all this discussion, you have to register with the State that you are going to execute somebody. It is quite clear what the intent is there. There is not a gray zone at all involved.

I believe if Members take the time to read it as the gentleman from Iowa (Mr. GANSKE) said, this is an excellent bill, an extremely well crafted bill, one of the best ones I have ever seen.

Mr. ROTHMAN. Mr. Chairman, the Oncology Nursing Society and American Nurses Association support the Johnson substitute.

Mr. Chairman, I yield 1½ minutes to the gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. Mr. Chairman, I thank the gentleman for yielding me this time.

We have heard some extraordinary things from the other side. The people who are one day for States' rights today want to preempt it. The people who are for individual decisions want to preempt them. The people who want to sanctify the physician-patient relationship want to put a Drug Enforcement Administration agent in the room with the physician and the patient while they are making these critical decisions. They have talked about the word execute, euthanasia.

Look at the Oregon law. It is something where a physician can only prescribe after there are two diagnoses, a

psychological consultation, the person willingly asks, they have acceded in writing, they have informed their next of kin, there has been a waiting period and the person must self-administer. That is the key. It is not euthanasia. It is not physician-assisted suicide. They write a humane prescription for a person who is dying a horrible, horrible death and who might want relief.

What has happened in Oregon? Fewer people have taken their lives with guns and other things because they just knew it was there if they needed it. They want to turn back the clock to the bad old days when my father is dying and I said, can he not have more pain medication, the doctor said, no, it might depress his breathing. In one line in the bill, they give the doctor that authority. But they take it away five lines later where they say if the doctor intentionally depresses that person's breathing.

□ 1245

Who knows? How are we going to determine intent? Are the drug enforcement administration the best people to determine one's physician's intent and chill their desire to give relief from intractable pain? I would say no, and I do not think on any other day of the week the Republican party would advocate having the Drug Enforcement Administration involved in our personal legal lives.

Mr. COBURN. Mr. Chairman, I yield myself 15 seconds for just a response.

If a doctor writes a prescription that he knows is going to be used to take someone's life, that is doctor-assisted suicide, period, end of sentence.

Mr. Chairman, I yield 1½ minutes to the gentleman from Ohio (Mr. CHABOT).

Mr. CHABOT. Mr. Chairman, I rise in strong support of H.R. 2260, the Pain Relief Promotion Act, 1999. Like many of my colleagues on both sides of the aisle who have spoken here, I have a very profound respect for the sanctity of human life. I also believe that every individual has the right to live and ultimately die with dignity. The Pain Relief Promotion Act goes a long way to ensure that terminally-ill patients receive the palliative care necessary to alleviate chronic pain. In doing so it allows these individuals to die with dignity. This bill prohibits the use of CSA-controlled drugs for assisted suicide and euthanasia, but it gives doctors greater leeway to aggressively treat pain.

In 1997 Congress passed the Assisted Suicide Funding Restriction Act with the support of the current administration. The act forbids the use of Federal funds for assisted suicide whether or not States legalize the practice. The vote in the House on that bill was 398 to 16, and it was unanimous in the Senate. However, since that time we have been confronted with a tragic ruling by the Attorney General, that physician-assisted suicide does not fall under the jurisdiction of the Controlled Substances Act. We, as a body, must now take this opportunity to further clarify our message, and that message is: Congress does not sanction assisted suicide, and federally controlled substances cannot be prescribed for that purpose.

Sadly, we will probably all at one time or another be confronted with a tragedy of personal illness or suffering, and this bill is a good bill, and I would urge its passage.

Mr. STUPAK. Mr. Chairman, I yield our remaining minute to the gentleman from Arkansas (Mr. BERRY).

Mr. BERRY. Mr. Chairman, I rise today in support of the Pain Relief Promotion Act. As a cosponsor of this bill, I know that the Pain Relief Promotion Act would not keep physicians, nurses, or health care workers from providing appropriate pain and symptom control to sick patients. The measure simply clarifies what is already established as case law and common practice. The use of drugs outside of established professional and legal parameters is forbidden, and this bill is very similar to a law already in place in my home State of Arkansas, a law that has proved to be effective and enforceable.

Mr. Chairman, this legislation has been endorsed by a broad spectrum of organizations such as the National Hospice Organization, the American Medical Association, the former Surgeon General, C. Everett Koop. Let us pass this legislation and show that we know the value of human life.

Mr. COBURN. Mr. Chairman, I ask unanimous consent to yield the balance of my time for purposes of control to the gentleman from Florida (Mr. CANADY).

The CHAIRMAN pro tempore (Mr. HASTINGS of Washington). Is there objection to the request of the gentleman from Oklahoma?

There was no objection.

The CHAIRMAN pro tempore. Without objection, 15 seconds is yielded to the gentleman from Florida (Mr. CANADY).

There was no objection.

Mr. ROTHMAN. Mr. Chairman, I yield myself the balance of the time.

The CHAIRMAN pro tempore. The gentleman from New Jersey (Mr. ROTHMAN) is recognized for 1½ minutes.

Mr. ROTHMAN. Here are the facts, Mr. Chairman.

There is an undertreatment of pain in the United States of America because doctors feel inhibited they will be sued civilly in the medical malpractice suit.

What does the underlying bill do? It adds additional fear to doctors that they will be sent to jail and lose their license. How do we know they are fearful of this? Half of the doctors groups have said they do not support this bill. Most of the nurses organizations do not support this bill. Instead, they support the Johnson-Rothman substitute.

So we know doctors and nurses are being chilled now. They are telling us do not pass that underlying bill. If my colleagues do not like physician-assisted suicide, which I do not, which most Members of Congress do not, and they do not like the Oregon physician-assisted suicide bill, go to the Supreme Court and get it thrown out.

But do not chill doctors giving of pain medication to the tens of millions of children, boys and girls, men and women in America and the other 49 states because of not liking Oregon's law. Let us deal with pain for the millions of Americans in pain. Deal with the Oregon constitutional situation in the Supreme Court. They are trying to make this a physician-assisted suicide sanctity-of-life issue. We all believe in the sanctity of life. Address that separately before the Supreme Court. Let us give people in agonizing terminal pain the ability not to kill themselves, but to get the pain medicine they are asking and begging for.

Mr. Chairman, I yield back the balance of my time.

Mr. CANADY of Florida. Mr. Chairman, I yield the balance of my time to the gentleman from Illinois (Mr. HYDE), chairman of the House Committee on the Judiciary.

The CHAIRMAN pro tempore. The gentleman from Illinois (Mr. HYDE) is recognized for 10¼ minutes.

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

Mr. HYDE. Mr. Chairman, let us not make any mistake. The real danger, the real danger if we go down this road, if we leap off the cliff into the abyss is in 10 years, once we make assisted suicide permissible, once we make it possible, once doctors lose the healing, diminish their healing faculty and become an assistant to the hangmen, we put and jeopardize the unwanted people, and we are diminishing the value of human life.

We were told, we pro-lifers, that we do not care about people after they are born; our only concern is when they are born. No, but some of us said, You're starting down a slippery slope; you're devaluing human life, and that is what we see here today. But we are just beginning. The unwanted, the uninsured, the poor, the elderly, the frail, the diseased, the profoundly handicapped, they are at risk. They are watching this today, if only they could, to see if they are going to be put at risk.

They talk about expanding the authority of the DEA. The DEA has this authority already. We are trying to reinstate it in the one State where it has been removed, and that is Oregon. We are not providing any more authority to any law enforcement that they do not have now, and the doctor, the gentleman from Washington (Mr. MCDERMOTT), talked about these tough decisions. Well, if they are so tough, how is a U.S. Attorney going to prove beyond all reasonable doubt that the doctor had a criminal intent? Not so.

This is an important bill because it assures the uniform application of Federal law, and I really ought to thank

the gentleman from Florida (Mr. CANADY), Senator NICKLES, the gentleman from Michigan (Mr. STUPAK), and the gentleman from Oklahoma (Mr. COBURN), and the gentleman from Florida (Mr. WELDON), and so many and all in the hospice and medical communities who have worked so diligently to produce a bill that offers our citizens greater access to palliative care to the management and alleviation of pain and maintains medicine as a healer, a healing force, an alleviator of pain.

The bill has 165 cosponsors in the House and in the Senate. The companion bill cosponsored by Senator LIEBERMAN and sponsored by Senator NICKLES has 31 cosponsors, so there is bipartisan support in the House and in the Senate.

Now we know the Controlled Substances Act was passed in 1970 to establish uniform Federal laws on a uniquely Federal subject, the control, the regulation of controlled substances. Those are drugs that are potentially dangerous. We have got a DEA, we have got a drug car, and we have a national drug problem. The agency's task is to ensure that these potentially dangerous drugs are administered for legitimate medical purposes.

Now it happens that Oregon decided to change the traditional time-honored professional purpose of medicine and give Oregon doctors the option no longer to serve as healing forces but as social engineers, messengers of death. So Oregon has passed a State law that gives doctors the right to assist in the intentional killing of patients, patients who may want to die, families who want their older relatives to die, and so doctors are authorized now by Oregon law to put down their stethoscope and pick up the poison pill and proceed to assist in the execution of their patient.

Very simple. It comes down to this. Do we want to empower our doctors to intentionally kill a patient even if that is the desire of the patient or the family? Do we want to add executions to the list of healing services they provide? Should Oregon law trump the Federal law?

Now some Oregonians resent this Federal intrusion in response to their decision to let doctors do away with the weak, the weary, the fearful of being a burden to their families. Suicide is the ultimate act of despair, and facilitating the intentional killing of a human life is the opposite of healing. The opposite of alleviating pain, it is a surrender to hopelessness when there are other options that reject the culture of death.

Physicians have not been taught what medications to prescribe for a suicide. There is no research or case series in medical literature to which doctors of death can refer to find prescribing information and directions. It is doubtful that one standard will fit all. There is no documented scientific literature or guide book on how to kill one's patient.

The medical profession is concerned about palliative care, and the debate about assisted suicide which takes place now must be at the forefront of our concerns because to focus on the management of pain in the last months, the last days, the last hours of life, hospice doctors and others in the medical profession study and practice medicine with a clear purpose of making their patients more comfortable even while mindful that administering palliative care sometimes can have the unintended side effect of hastening death.

These are difficult decisions faced every day. This bill can help end those decisions by providing what is not there now, a safe harbor, one that is absent in the current law. That safe harbor in this bill protects doctors even if the administration of pain medications result in unintended death.

This bill does something more. It provides money and guidance for training and safeguards now absent in current law to educate doctors, caregivers, medical students, health professions, nurses, State, local and Federal law enforcement officials on the practice of palliative medicine. That is why this is an important bill. It deals with the very nature of man, the value of every life, the definition of a physician. It emphasizes the alleviation and management of pain, not reversing the role of doctor from healer to hangman.

Some of us here today cry Federal preemption of a State law when really what we are dealing with is State preemption of a Federal law. We can advocate the Federal Government look the other way on this issue, play Pontius Pilate, wash our hands, but we have to think about it because there is a sanctity of life that must be respected and defended.

As my colleagues know, there is an insidiousness about the notion of assisted suicide. We make it permissible, then we make it acceptable, and finally it becomes an act of nobility. We plant the idea with the elderly, it is their duty to die, get out of the way. Is that not what the governor of Colorado said a few years ago? The elderly have a duty to die and get out of the way, not to be a burden on the children.

Many times the anguishing words ''I want to die'' really mean I do not want to be a burden on my family. We insist that more be done at the Federal level to promote palliative end-of-life care. There are very effective ways to control pain, and I am confident that doctors will not shy from their duty to alleviate pain, and this bill encourages palliative care. It provides that safe harbor for the physician should the palliative care inadvertently lead to the death of a patient. It provides money for training in pain management and requires caregivers adhere to our national policy of administering controlled substances for legitimate medical purposes, not taking a life.

□ 1300

A doctor should not be asked to play the role of hired gun. His art and science are in the service of life. In this bill, we expressly permit and encourage the use of controlled substances for pain management, even when it might unintentionally hasten death. We supply money and training.

To those who assert we are preempting the laws of Oregon, this bill does not preempt the Oregon law legalizing assisted suicide in specified circumstances. The legal effect of this bill is to forbid the use of certain controlled substances which are federally controlled for the intentional purpose of killing the patient. If you want to use non-controlled substances or some other method to assist the passage of the patient, you can still do so under Oregon law, unfortunately.

The single ethic that has provided the moral backbone for Western civilization is one that insists that every member of the human family has equal inherent moral worth. It is called the Sanctity of Life ethic. That is the core of our belief, that the poor and the powerless deserve equal rights and equal protection.

One of the frequent criticisms of certain acts or omissions by the government is that it will have a chilling effect on some people. How often we hear that phrase. Well, physician assisted suicide has a chilling effect on handicapped people, elderly people, sick people and the unwanted, because it is an aspect of a philosophy from another time and another place that said it was appropriate to get rid of the useless eaters. It starts us down a real slippery slope, where some of us who do not measure up to someone else's standards become vulnerable, expendable and discardable.

Mr. LEVIN. Mr. Chairman, I oppose assisted suicide. I voted against a recent Michigan ballot initiative which would have legalized it in my State. I did so because I believe that it is increasingly evident that with modern pain management techniques doctors can make comfortable patients who are critically ill.

The primary responsibility to handle this issue has traditionally been with the States, which almost universally prohibit assisted suicide. Under current law, assisted suicide is not explicitly listed as a Federal crime. The DEA has never prosecuted a physician for assisted suicide under the Controlled Substances Act (CSA). Instead, the responsibility for enforcing medical standards has historically been a State responsibility.

The effect of H.R. 2260 would be to add assisted suicide to the list of Federal crimes under the CSA which carry a mandatory 20-year jail sentence. For the first time, the Justice Department and the DEA would be required to become involved in determining the intent of doctors when they prescribed pain medication to patients. Associations representing about half of our doctors and almost all of our nurses have said that they believe the fear of being investigated by the DEA would lead many doctors to prescribe less medication for pain.

I support the other sections of H.R. 2260, which would support efforts to educate health professionals about effective pain management. I have long supported pain management

education for health professionals and a comprehensive approach to end-of-life care. I first introduced legislation in this area in 1990. That legislation became law. The most recent version of the legislation would improve upon our earlier efforts by taking steps to provide patients and their families with the information and support they need during the difficult time at the end of life. This legislation would also improve Medicare's coverage of self-administered drugs for pain. All of these issues—pain management, support and information, and the payment policies of Medicare and other insurance payors—should be part of our efforts to prevent suicide and assisted suicide.

Ms. KILPATRICK. Mr. Chairman, today I rise in strong opposition to H.R. 2260, A bill which claims to promote pain relief but actually will increase the pain of many of this Nation's citizens that suffer from debilitating and incurable diseases.

My opposition to this legislation is based on the premise that Federal legislators, most of whom are not doctors, should not delve, dig or pry into the intense and personal decisions made between a doctor and his or her patient. Once again, this Congress is attempting to legislate our lives most private and intimate decisions (the right to die with dignity). It is my belief that the decision to recommend this or any other medical procedure depends on expert medical judgement and therapeutic assessment. Such decisions—much like a women's decision regarding her own reproductive rights—are a physicians responsibility, within the privacy and confidentiality of the doctor-patient relationship.

Like most Members of Congress, I live my life to the fullest. I never take a single moment for granted. For Members of Congress to imply or imagine collectively we know what is best for a family tortured with the final decision of life is pure folly. Again, we need to let doctors in consultation with the patients and the patients family decide what is best in each individual, unique situation.

I am also alarmed by the very reason that we are considering this bill. We are considering this bill to topple the will of the people of the State of Oregon who approved, on two occasions, a measure that would legalize assisted suicide under strict and well deliberated mandates and guidelines. How ironic it is that the Congress, which claims it is the Congress of State rights, is the primary promoter of this legislation?

Congress needs to state focusing on the issues that are most important to the American people. The American people continue to cry out for legislation to address education and health care. How long will the Republicans continue to ignore the citizens call for campaign finance and gun control reforms? We are simply wasting time and energy on a matter that is a decision that will eventually be determined by the Supreme Court, and an issue the States are already effectively addressing.

In this crucial time, when the federal budget is in limbo, it is important that we address the real challenges and problems that need to be, and should be addressed. I am asking that we say ''no'' to the further intrusion on the work of trained, skilled professionals and let doctors, families and patients make the very difficult and hard life and death decisions in private and without the intervention of the Federal Government.

Mr. BURTON of Indiana. Mr. Chairman, as an original cosponsor of H.R. 2260, the Pain Relief Promotion Act of 1999, I think it is important to reiterate the importance of this bill. On October 19, the Committee for Government Reform conducted a hearing entitled, ''Improving Care at the End of Life with Complementary Medicine.'' Pain management is one of the top concerns of palliative care, including those patients who are dying. The need to properly recognize and treat pain is why the Veterans Health Administration added monitoring pain as the fifth vital sign. It is a sad day in this country when some individuals in the medical establishment have determined that one of the options for alleviating pain will be for a doctor to hasten the death. And a sadder day indeed when that option gains so much credibility that the U.S. Congress has to debate a bill clarifying that physician-assisted suicide or the polite term ''euthanasia'' is not an option for pain management.

As we look to provide care for our veterans, including the 32,000 World War II veterans that die each month, we must insure that pain is properly treated. We must also assure that the option to hasten death is not what we look to as a resolution for taking care of veterans and all Americans.

At our October 19, hearing we heard from Dr. Ira Byock, a renowned expert in palliative care. Dr. Byock clarified some of the misconceptions of this bill, including that physicians who use drugs such as morphine to treat pain are already monitored by the Drug Enforcement Administration (DEA) and that this bill will not prevent the prescribing of strong and effective pain drugs. This bill clarifies the importance of pain management and palliative care and asks for further research and the development of practice guidelines for pain management.

We heard from Dr. Byock, who also conducts research in improving care at the end of life, as well as Dannion Brinkley, the chairman of Compassion in Action, an organization that trains hospice volunteers and provides professional and community education, that pain management has to be addressed and that there are other options available to individuals including non-pharmacologic efforts. These treatment options include music therapy, acupuncture, and guided imagery. We heard from Dr. Patricia Grady, Director of the National Institute of Nursing Research that there is research to indicate that these therapies especially when used in conjunction with pain medication allowed patients to have less pain, to rest better, and to go longer between the need for medication.

Dr. Byock also stated something that my colleague from Florida, Congressman WELDON (MD) has reiterated—a doctor knows whether he or she is prescribing a drug to treat pain or to cause death and that pain can be properly treated. Educating health care professionals in pain management and treatment options is vital and this bill will move this forward.

I stand in support of this bill and also suggest that we look at solving the problems of pain in this country by looking to non-controlled substances and complementary therapies as options to treat pain.

Mr. BARCIA. Mr. Chairman, I rise today in support of H.R. 2260, the Pain Relief Promotion Act. I have repeatedly heard today that this bill overturns Oregon's assisted suicide law. This is simply not true. The bill does not prevent anyone in Oregon from assisting in a suicide, nor does the bill establish any new authority to penalize assisted suicide. The bill simply clarifies that assisted suicide may not take place with federally controlled substances. This bill continues to allow States to pass their own laws while clarifying the boundaries of Federal involvement regarding assisted suicide. As Federal legislators, this is our duty. We are in the business of clarifying Federal involvement. Oregon's current experiment in democracy is perfectly within its right, but this does not mean that one State has the right to tell the Federal Government how federally controlled substances should be used.

The essence of H.R. 2660 is that it clarifies the extent to which federally controlled substances can be used in order to relieve the patient's pain. Additionally, by clarifying that drugs under the Controlled Substances Act can be used to relieve pain, even if those drugs hasten death, this bill protects health care providers while allowing them to use the strongest drugs necessary for pain relief.

Mr. Chairman, to the dying we owe our compassion. We have the ability to alleviate the pain of the dying. We must comfort the dying with compassion by voting for H.R. 2260.

Mr. NUSSLE. Mr. Chairman, I rise today in strong support of H.R. 2260. This legislation takes a much needed step toward the Federal protection of all human life. This bill will provide doctors in Iowa's second district and throughout the country the ability to aggressively provide their patients with pain relief while prohibiting the use of federally controlled substances in assisting suicide.

The purpose of this legislation is to encourage the alleviation of pain suffered by patients with advanced disease and chronic illness and pain associated with conditions that do not respond to treatment. H.R. 2260 also encourages the promotion of life of such patients and would prohibit States from enacting laws that permit physician-assisted suicide.

Much of the debate surrounding H.R. 2260 focuses on the affect it will have on those who have severe pain. The opponents to H.R. 2260 worry that this legislation would hinder a doctors willingness to prescribe pain medication to the seriously ill. My home State of Iowa adopted an almost identical provision to H.R. 2260 in 1996, and the statistics show that the use of pain control drugs have almost doubled. Obviously, the Iowa law did not deter doctors from administering pain relief to the seriously ill, neither would H.R. 2260.

H.R. 2260, for the first time, writes into the Controlled Substance Act protection for physicians who prescribe large doses of drugs sometimes necessary to manage intractable pain, even if this may increase the risk of death, so long as the drugs are not prescribed intentionally for the purpose of assisting suicide or euthanasia. Under this bill, a doctor who intentionally dispenses or distributes a controlled substance with the purpose of causing the suicide or euthanasia of any individual may have his license suspended or revoked.

In summary, Mr. Chairman, I hope that my colleagues will join me in supporting H.R. 2260. This legislation provides doctors the ability to use federally regulated drugs for the pain management of the seriously ill.

Mrs. MINK of Hawaii. Mr. Chairman, I rise to express my concerns about H.R. 2260, the Pain Relief Promotion Act.

Although this bill is being represented as if it would improve physicians' abilities to provide pain relief and palliative care, the bill's primary purpose is to criminalize physician assisted suicide utilizing controlled substances. And although I do not condone assisted suicide, exposing doctors to additional criminal and civil liabilities for using controlled substances will curtail the pain relief options available to patients.

H.R. 2260 authorizes the Drug Enforcement Agency to investigate and second-guess the intent of a physician when a death, possibly attributable to a controlled substance, occurs. Such investigations would effectively discourage doctors from dispensing such substances even in the most severe cases. Patients would be left to suffer even more painful and agonizing deaths.

Physicians should not have to fear losing their medical licenses for prescribing pain relief to terminally ill patients. Their responsibilities are complex enough without the additional threat of DEA investigations and criminal and civil law suits questioning their intent. Physicians should have all inventions, treatments and substances, at their disposal to provide care for their patients and to make the last days of a terminally ill patient's life as comfortable as possible.

The DEA should be focusing its efforts on fighting illegal drug activities that are a menace to our society, not on doctors prescribing pain relief for terminally ill patients. And Congress should be focusing its efforts on the issue of what is proper pain management and what are the best ways to treat pain. Accordingly, I support the provisions in the bill that would establish a program within the Department of Health and Human Services to study pain management and distribute pain management information. I also support the grants provided by the bill to train health professionals in the care of patients with advanced illnesses. Still we should not bind the hands of physicians treating terminally ill patients.

I support improving pain management for the terminally ill but I oppose limiting physicians' abilities to practice medicine. I urge a ''nay'' vote on H.R. 2260 as it is currently drafted.

Mr. SMITH of New Jersey. Mr. Chairman, I rise in support of H.R. 2260 because the bill encourages sound medical practice in the relief of pain and suffering of the chronically and terminally ill patients.

This bill would add a provision to the Controlled Substances Act, acknowledging the legitimate use of narcotics for the management of serious pain and discomfort, even if their use increases the risk of death for the patient.

In the Hyde-Stupak bill, the goal is to make the patient as comfortable as possible during that person's terminal or chronic illness. Relief of pain is the contemplated result.

This is not physician-assisted suicide or euthanasia, either in substance or intent. Physicians are not actively and intentionally seeking to end the life of the patient.

But powerful drugs that relieve pain have serious secondary effects. They can cause loss of cognition, depressed respiration, retained secretions, and increased dehydration by depressing voluntary nutrition. The secondary, or unintended effect, may therefore hasten death, through death is not a directly intended purpose.

Organized medicine has recognized the principle of this ''double effect'' as the potential consequence of the legitimate and necessary use of controlled substances for pain management. The AMA calls this principle ''a vital element in creating a legal environment in which physicians may administer appropriate pain care for patients and we appreciate its inclusion.''

The AMA further expands its position as follows. ''Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment, even though it may foreseeably hasten death.''

The bill will promote the training of health professionals to use these drugs appropriately while providing palliative care. This will dovetail with the newly inaugurated AMA program—''Education for Physicians on End of Life Care.'' This program is designed to educate physicians more fully in pain management and to deal more holistically with the patient.

I oppose the Johnson-Rothman-Hooley substitute because it does nothing to prevent or restrict assisted suicide and it does nothing to train physicians and nurses in pain management, which the Hyde bill accomplishes.

Johnson-Rothman-Hooley continues to authorize the use of federally regulated drugs to assist suicides whenever a state law permits this deadly practice. Finally, the substitute never clearly distinguishes pain control from deliberate killing or assisted suicide.

There appears to be much confusion in the debate as to the scope of this proposal and how it might affect individual states. Supervision of controlled substances is a federal prerogative—it always has been. There are no new penalties suggested. Nothing is new. Rather, Hyde-Stupak heightens and reinforces current federal policy.

While the bill will not technically ''overturn'' current Oregon law in this general matter, it will abrogate its use. Since physicians will be unable to legally prescribe intentionally lethal doses of federally controlled substances, the doctors will be encouraged to offer better pain control and not offer death to the seriously ill patient.

Relief of pain with moderate or even substantial doses of drugs is good medical practice. Purposely and intentionally ending human life is inappropriate and antithetical to the role of the physician as healer.

H.R. 2260 clarifies and enables physicians to pursue their legitimate role as healers. Easing pain at the time of the patient's final passage is one of medicine's most noble callings. I urge your support for this important bill.

Mr. HALL of Texas. Mr. Chairman, two years ago I was privileged to be the sponsor of the Assisted Suicide Funding Restriction Act, which passed the House floor by a vote of 398 to 16 before being signed into law by President Clinton.

The Assisted Suicide Funding Restriction Act said that we don't want federal tax dollars going to pay for euthanasia, and we don't want euthanasia going on in federally controlled facilities such as Veterans' Hospitals and Public Health Service facilities. The Pain Relief Promotion Act says we don't want federally controlled drugs being used for euthanasia.

That is a popular position with the American people. In a nationwide poll in June, 64% answered ''no'' when asked whether federal law should allow the use of federally controlled drugs for the purpose of assisted suicide and euthanasia. Only 31% said ''yes.'' That's better than 2 to 1. We are trying to help people live!

One of the parts of the Assisted Suicide Funding Restriction Act that was very important was a rule of construction that made clear that funding and facilities could be provided ''for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as ''the purpose was not ''of causing, or * * * assisting in causing, death * * *.'' The American Medical Association wrote, ''This provision assures patients and physicians alike that legislation opposing assisted suicide will not chill appropriate palliative and end-of-life-care.''

I am glad to see that very similar language is included in the Pain Relief Promotion Act, along with important positive programs to increase the knowledge of health care personnel at the clinical level to be able to control pain.

I am sure that is a large part of why this bill is endorsed by so many medical and end-of-life care groups, including the American Academy of Pain Management, the American Society of Anesthesiologists, the AMA, the National Hospice Organization, the Hospice Association of America, and Aging with Dignity.

Even the Hemlock Society, which works to legalize assisting suicide and of course therefore opposes this bill, concedes that ''the bill encourages aggressive pain relief for the terminally ill.'' Our distinguished colleague, Mr. NADLER from New York, voted against the bill in the Judiciary Committee because he thinks controlled substances should be available for assisted suicide in states that legalize it. But at the Judiciary Committee markup, Mr. NADLER said, ''[M]ost of the secondary reasons for opposing it, the pain issue and so forth, I really don't think are very valid and I think the bill has really been cleaned up in that respect.''

Some of the groups that still oppose the bill, it's important to understand, don't oppose assisting suicide. The American Pharmaceutical Association, for example, has a formal policy that ''opposes laws and regulations that * * * prohibit the participation of pharmacists in physician-assisted suicide.'' Mr. Skip Baker, the head of the Society for Action on Pain, has called the ''Oregon suicide law a much needed law.''

But suicide is not the solution. You don't really solve problems by getting rid of the person to whom the problems happen. Once we accept death as a solution, we begin to lose the incentive and the drive to work on positive alternatives. We can do better than that in America.

This bill is a good start. It will help us end the patient's pain, not the patient's life. Please support it.

Mr. GARY MILLER of California. Mr. Chairman, I believe the Pain Relief Promotion Act is one of the most compassionate and life-affirming bills to come before us this year.

Two years ago, a gentleman came to see me regarding laws on pain relief. At the time, I was working on a ''Pain Patients Bill of Rights'' for Californians who suffer from extreme pain.

The gentleman who visited me is a police officer who had broken his back in the line of duty during an incident with a suspect. As a result of his injury he was in constant, untreatable pain. He had to endure numerous

invasive surgeries, that were not successful. It seemed that he had no choice but to endure chronic pain that most of us cannot even imagine.

He shared with me that because the pain was so unendurable, and because it seemed there was no treatment to stop the pain, he arrived at a point where he wanted to end his life. Pain made life so unbearable, that this protector of the people did not think his life was worth living anymore.

After seeing many different doctors, this police officer finally was referred to a specialist in pain treatment. The doctor was able to prescribe high levels of pain medication, which made the pain manageable, and as a result made this police officer feel that his life was worth living.

Unfortunately, most doctors are afraid to prescribe high levels of pain medication because they do not know if the Drug Enforcement Agency will come after them for diverting drugs or prescribing too much. Doctors are not going to act if they are not sure whether or not they are breaking the law.

Doctors know how to treat their patients, and we need to make sure they have the freedom to prescribe the treatment that will make their patients comfortable. This compassionate piece of legislation will give doctors the legal protection to take care of patients who are experiencing terrible, debilitating pain.

I can testify that the police officer who came to talk with me now has a happy life, and his pain is manageable. He walks with a cane and a limp, but his quality of life is high and he has a passion for life.

For everyone in this room who values life, this is a ''yes'' vote.

Mr. LUCAS of Kentucky. Mr. Chairman, I support the Pain Relief Promotion Act. The Pain Relief Promotion Act will make important strides in giving health care providers around the country better access to the most advanced ways of dealing with patients' pain. It will assure physicians who prescribe federally controlled substances that they can safely authorize adequate amounts to manage pain without jeopardizing their Drug Enforcement Administration registration.

It will also ensure a uniform national application of the existing principle that federally controlled and regulated drugs should not be used to assist suicide or for euthanasia, even if a particular state legalizes the practice as a matter of state law.

This is a good complement to the Assisted Suicide Funding Restriction Act that passed by an overwhelming margin two years ago. That Act said that euthanasia shouldn't be carried out in federal facilities, such as Veteran's Hospitals, and that federal tax dollars shouldn't fund it. This bill says that those narcotics and other dangerous drugs that have long been regulated by the federal government under the Controlled Substances Act should not be used to kill patients.

Congress must not blur the distinction between pain relief and assisted suicide. In order to protect the vulnerable in our society, it is critically important that we maintain the difference recognized by the medical profession and the Supreme Court between treating patients appropriately even if it means risking increasing the likelihood of death and giving patients the means to intentionally kill themselves.

We in Congress must not facilitate turning doctors into killers by giving permission to use federally controlled drugs for assisted suicide and euthanasia. We must enact H.R. 2260, the Pain Relief Promotion Act.

Mr. RAHALL. Mr. Chairman, I support H.R. 2260, a bill to promote pain relief in lieu of promoting assisted suicide for men, women and children suffering from unremitting pain of grievous injury and terminal disease.

The American people oppose euthanasia as a solution to the problem of pain and suffering. They know that is not the humane, decent choice.

I believe that saying yes to people who talk about, threaten or ask for assisted suicide is not respecting that person's choice.

The threat of or request for assisted suicide is a cry for help—not a real request to die.

The yearning for, the love of life, the desire to live, is a part of each and every one of us. When a person—a loved one perhaps—believe they want to die because their pain cannot be or is not being controlled adequately, it is not for us to answer them by allowing controlled substances to be used to bring about their death.

It is our duty and responsibility to let them know we care and that we will do something for them—not to bring about death—but to bring about relief from the pain that causes them to think they would rather die.

It should not be—should not be—the response of the Federal Government to legalize assisted suicide.

Our response should be that we have the medical technology that makes the administration of pain-relieving drugs sufficient to control pain. Our response must be to improve our medical delivery system so that what we know about the cutting edge of medicine becomes a reality at every bedside—and that doctors, nurses and family members are assured that the safe prescription of drugs for pain control is possible without fear that they will be charged with a crime.

Our response must be that we will ensure through authorized federal programs the dissemination of state-of-the-art information to doctors or care-givers in medical settings, about how to control pain. Our response should be to give all care givers the information that our best pain specialists know. Our response is to ensure that this information go out to every general practitioner in every clinical setting—so that no one needs to be put to death—but are made comfortable so that even their final hours are spent in the most pain-free state medically possible.

The Pain Relief Promotion Act before the House today takes those steps—strong steps—in that direction.

Rather than starting down the slippery, dangerous slope of assisted suicide, let us take a higher ground—to a place that tells us it is reasonable—not extraordinary—to expect not to have to kill our loved ones in order to put them out of their misery.

We have the medical technology. We have pain control and management specialists who are ready and willing to impart their knowledge to medical practitioners so it can be used for humane—and safe—purposes.

The relief from pain for those who are suffering from grievous injury or terminal illness is within our capability now—and it can be administered without killing them. No one has a duty to die because they may be a burden to care givers, or a drain on a family's financial resources.

If we do nothing else, we must stop going down that path where we put pressure on those who are vulnerable, who are poor and sick and disabled—that they have a duty to die because they are a burden. To do otherwise is to set a dangerous, inhumane precedent.

I urge my colleagues to vote for alternatives to suicide—not assisted suicide. Vote for the Pain Relief Promotion Act.

Mr. WU. Mr. Chairman, death with dignity is a right which all Americans should have. Currently, only Oregonians have this right. Today, we debate whether Congress will deprive Oregonians of their most fundamental human rights—the right to choose one's destiny.

May God guide this House in its deliberations.

The bill before us today is misnamed the ''Pain Relief Promotion Act,'' a crafty piece of legislation that hides its real intent. Organizations that have taken the time to study the bill, including the state chapters of the American Medical Association, have expressed their opposition. Every day, opposition is growing to this bill because it subjects thousands of doctors across the country to second-guessing by the DEA.

In order to hide the real motive of the legislation, H.R. 2260 alters the Controlled Substances Act—a law intended to deal with drug trafficking and diversion—in an attempt to regulate state medical practice. Frankly, H.R. 2260 amounts to little more than one section that contains non-controversial palliative care measures, and one section that is a thinly veiled attempt to overturn Oregon's Death with Dignity Act.

Terminal illness has nothing to do with drug trafficking or forgery or all the other things that are traditionally the purview of the Office of Diversion Control within the DEA. H.R. 2260 would have this unknown law enforcement agency make determinations regarding a new offense that is inherently intent based, yet without allowing a physician to avoid legal responsibility by establishing that they merely intended to relieve pain, even where death inadvertently results.

The Controlled Substances Act is written as a strictly liability law for both criminal and civil purposes and contains no intent requirement. Sadly, the Judiciary Committee voted down an amendment that would have required the government to prove the doctor's intent, and another which would have allowed health care providers to make an affirmative defense that they had no such intent.

How will the DEA enforce this legislation? The DEA never testified before Congress on either H.R. 2260 or its predecessor in the last Congress, H.R. 4006.

The gymnastics that are required to make this legislation work are mind-boggling.

I am very concerned that there will be vast amounts of new paperwork requirements. Health care workers will be required to report on each other.

Will family members who are sad to see a loved one pass away report the physician?

This bill is fundamentally destructive of patient rights, the physician-patient relationship, and the independent practice of medicine.

Testimony before the Committee indicated that ''this Act subjects physicians who care for dying patients to the oversight of police with no expertise in the provision of medical care.'' I am disappointed that the Committee chose to ignore these words.

While members were not permitted to testify this year in the Judiciary Committee, my state medical association, the Oregon Medical Association, did testify. They said ''Physicians already undermedicate patients for fear of being sanctioned under the current law.''

H.R. 2260 will only exacerbate the current situation, and leave thousands more needlessly suffering. All it will take is one case, in any town in the United States, where the DEA investigates a physician on this issue, and I guarantee that an instant freeze on prescriptions for analgesics across that state will result.

H.R. 2260 will trigger a federal enforcement process that would ruin the careers of physicians and throw them in jail. Physicians, already beset by controversy in local state laws, will be reluctant to prescribe the large doses of pharmaceuticals that are often required to treat incapacitating levels of pain.

The Rules Committee has allowed a substitute by Mrs. JOHNSON, Mr. ROTHMAN, and Ms. HOOLEY, my colleague from Oregon, to be considered on the floor. This substitute will enhance all the non-controversial provisions in H.R. 2260 regarding the need to boost palliative care, but leave out the provisions that have led the American Nurses Association, and American Pharmaceutical Association, the American Academy of Family Physicians, the Association of Health System Pharmacists, the American Pain Foundation, and many other organizations to oppose this bill.

I hope my colleagues will consider the fact that the Johnson-Rothman-Hooley substitute puts Congress on record as opposing assisted suicide, but does not threaten treatment of chronic pain.

There have been instances in our nation's history where it is appropriate for federal law to supercede state law in order to fulfill national imperatives, but this is not one of those occasions.

With this bill today, Congress misses the opportunity to engage in a real debate about end-of-life care, and what our choices should be as individuals in a free society. Today does not represent the kind of open, courageous, and enlightening discussion that Congress is capable of having. Instead, this bill aptly demonstrates what Congress can do in a backhanded way.

I urge my colleagues to oppose H.R. 2260, support the DeFazio-Scott amendment, and support the Johnson-Rothman-Hooley substitute.

The CHAIRMAN pro tempore (Mr. HASTINGS of Washington). All time for general debate has expired.

Pursuant to the rule, an amendment in the nature of a substitute consisting of the bill, modified by the amendments recommended by the Committee on Commerce, is considered as an original bill for the purpose of amendment and is considered read.

The text of the committee amendment in the nature of a substitute, as modified, is as follows:

H.R. 2260

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Pain Relief Promotion Act of 1999''.

**TITLE I—USE OF CONTROLLED SUBSTANCES CONSISTENT WITH THE CONTROLLED SUBSTANCES ACT**

**SEC. 101. REINFORCING EXISTING STANDARD FOR LEGITIMATE USE OF CONTROLLED SUBSTANCES.**

Section 303 of the Controlled Substances Act (21 U.S.C. 823) is amended by adding at the end the following:

''(i)(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 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 enactment of this subsection.''.

**SEC. 102. EDUCATION AND TRAINING PROGRAMS.**

Section 502(a) of the Controlled Substances Act (21 U.S.C. 872(a)) is amended—

(1) by striking ''and'' at the end of paragraph (5);

(2) by striking the period at the end of paragraph (6) and inserting ''; and''; and

(3) by adding at the end the following:

''(7) educational and training programs for local, State, and Federal personnel, incorporating recommendations by the Secretary of Health and Human Services, on the necessary and legitimate use of controlled substances in pain management and palliative care, and means by which investigation and enforcement actions by law enforcement personnel may accommodate such use.''.

**TITLE II—PROMOTING PALLIATIVE CARE**

**SEC. 201. ACTIVITIES OF AGENCY FOR HEALTH CARE POLICY AND RESEARCH.**

Part A of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended by adding at the end the following section:

**''SEC. 906. PROGRAM FOR PALLIATIVE CARE RESEARCH AND QUALITY.**

''(a) IN GENERAL.—The Administrator shall carry out a program to accomplish the following:

''(1) Develop and advance scientific understanding of palliative care.

''(2) Collect and disseminate protocols and evidence-based practices regarding palliative care, with priority given to pain management for terminally ill patients, and make such information available to public and private health care programs and providers, health professions schools, and hospices, and to the general public.

''(b) DEFINITION.—For purposes of this section, the term 'palliative care' means the active, total care of patients whose disease or medical condition is not responsive to curative treatment or whose prognosis is limited due to progressive, far-advanced disease. The purpose of such care is to alleviate pain and other distressing symptoms and to enhance the quality of life, not to hasten or postpone death.''.

**SEC. 202. ACTIVITIES OF HEALTH RESOURCES AND SERVICES ADMINISTRATION.**

(a) IN GENERAL.—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.), as amended by section 103 of Public Law 105–392 (112 Stat. 3541), is amended—

(1) by redesignating sections 754 through 757 as sections 755 through 758, respectively; and

(2) by inserting after section 753 the following section:

**''SEC. 754. PROGRAM FOR EDUCATION AND TRAINING IN PALLIATIVE CARE.**

''(a) IN GENERAL.—The Secretary, in consultation with the Administrator for Health Care Policy and Research, may make awards of grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in palliative care.

''(b) PRIORITIES.—In making awards under subsection (a), the Secretary shall give priority to awards for the implementation of programs under such subsection.

''(c) CERTAIN TOPICS.—An award may be made under subsection (a) only if the applicant for the award agrees that the program carried out with the award will include information and education on—

''(1) means for alleviating pain and discomfort of patients, especially terminally ill patients, including the medically appropriate use of controlled substances;

''(2) applicable laws on controlled substances, including laws permitting health care professionals to dispense or administer controlled substances as needed to relieve pain even in cases where such efforts may unintentionally increase the risk of death; and

''(3) recent findings, developments, and improvements in the provision of palliative care.

''(d) PROGRAM SITES.—Education and training under subsection (a) may be provided at or through health professions schools, residency training programs and other graduate programs in the health professions, entities that provide continuing medical education, hospices, and such other programs or sites as the Secretary determines to be appropriate.

''(e) EVALUATION OF PROGRAMS.—The Secretary shall (directly or through grants or contracts) provide for the evaluation of programs implemented under subsection (a) in order to determine the effect of such programs on knowledge and practice regarding palliative care.

''(f) PEER REVIEW GROUPS.—In carrying out section 799(f) with respect to this section, the Secretary shall ensure that the membership of each peer review group involved includes one or more individuals with expertise and experience in palliative care.

''(g) DEFINITION.—For purposes of this section, the term 'palliative care' means the active, total care of patients whose disease or medical condition is not responsive to curative treatment or whose prognosis is limited due to progressive, far-advanced disease. The purpose of such care is to alleviate pain and other distressing symptoms and to enhance the quality of life, not to hasten or postpone death.''.

(b) AUTHORIZATION OF APPROPRIATIONS; ALLOCATION.—

(1) IN GENERAL.—Section 758 of the Public Health Service Act (as redesignated by subsection (a)(1) of this section) is amended in subsection (b)(1)(C) by striking ''sections 753, 754, and 755'' and inserting ''section 753, 754, 755, and 756''.

(2) AMOUNT.—With respect to section 758 of the Public Health Service Act (as redesignated by subsection (a)(1) of this section), the dollar amount specified in subsection (b)(1)(C) of such section is deemed to be increased by $5,000,000.

**SEC. 203. EFFECTIVE DATE.**

The amendments made by this title take effect October 1, 1999, or upon the date of the

enactment of this Act, whichever occurs later.

The CHAIRMAN pro tempore. No amendment to that amendment shall be in order except those printed in House Report 106–409. 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 read, debatable for the time specified in the report, equally divided and controlled by a proponent and an opponent, and shall not be subject to amendment.

The Chairman of the Committee of the Whole may postpone a request for a recorded vote on any amendment and may reduce to a minimum of 5 minutes the time for voting on any postponed question that immediately follows another vote, provided that the time for voting on the first question shall be a minimum of 15 minutes.

It is now in order to consider Amendment No. 1 printed in House Report No. 106–409.

AMENDMENT NO. 1 OFFERED BY MR. SCOTT

Mr. SCOTT. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 1 offered by Mr. SCOTT:

In title I, strike section 101 and redesignate succeeding sections and all cross references accordingly.

The CHAIRMAN pro tempore. Pursuant to House Resolution 339, the gentleman from Virginia (Mr. SCOTT) and a Member opposed will each control 5 minutes.

The Chair recognizes the gentleman from Virginia (Mr. SCOTT)

Mr. SCOTT. Mr. Chairman, I yield myself 2 minutes.

Mr. Chairman, this amendment strikes section 101 from the bill. That is the part that overturns the Oregon referendum and also exposes doctors to criminal and civil liability.

This bill states that alleviating pain in the usual course of professional practice is legitimate, even if the use of controlled substances may increase the risk of death. However, then it turns around and specifically prohibits the intentional use of such substances for causing death.

Now, the part about alleviating pain being a legitimate practice under the law is legally meaningless because it does not create a legal safe harbor. It does not create an affirmative defense. It does not say if you are consistent with the medical protocol that you can use that as a defense against a charge of intention.

The problem we have is that the case will only arise when you have a terminally ill patient who has died and is full of drugs. DEA comes in and says, well, you killed him intentionally. The DEA has expertise in prohibiting the possession of certain drugs that are totally prohibited, but they have no expertise to know how to prescribe drugs and when too many or not enough drugs have been prescribed.

Now, a doctor may be subject to scrutiny by the state medical board if they inappropriately prescribe drugs, but a law enforcement agency, without any expertise, is inappropriate. Even if the DEA decides not to prosecute a doctor, the fact that this bill is on the books will create civil liability, so that anybody can come in and sue the doctor, contrary to the stated purpose of the bill. Then section 101's expansion of DEA authority, potential civil and criminal liability, will likely increase the doctor's reluctance to prescribe sufficient drugs to relieve pain. This is particularly harmful, because physicians already undermedicate under current law for fear of violating laws, and, if we truly want to encourage aggressive pain relief, we should not expose doctors to additional civil and criminal penalties if they do exactly what we want them to do.

Mr. COBURN. Mr. Chairman, I rise in opposition to the amendment.

The CHAIRMAN pro tempore. The gentleman from Oklahoma is recognized for 5 minutes.

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

Mr. Chairman, what this amendment does is gut the portion of the DEA enforcement that we presently have and is presently law. The real issue we are talking about is how do you defend taking somebody else's life and doing it under the Oregon statute? How do you defend that? How do you say it is okay for me as a physician to take your loved one out?

What, under our Constitution, what would ever give me that right, whether I am in Oregon or Oklahoma? The fact is that Oregon gets the right to pass their laws. As the chairman of the Committee on the Judiciary said, they can still take that; they just cannot do it using the Federal Controlled Substances Act. There is very good reason that we have that act. What the gentleman wishes to do is to make it not apply in this instance.

What about the child that is born, that is severely handicapped and the parents say, ''Oh, no, we can't. You know, we just cannot take care of this child. It is too big of a burden. Will you not please, Mr. Pediatrician, Dr. Obstetrician, won't you relieve our suffering? Please give an injection of respiratory depressant or of a high dose of narcotics so we don't have to handle this burden. Oh, take care of our problem.''

What about the value of that life? It does not have any value, according to the people of Oregon, because only in the context of the people making the decision will it have value. Only in the context of an elderly person that has severe Alzheimer's, is uncontrollable, only if that family desires, and if it is registered to be done, can they do it. That life has no value? There is no value?

In terms of inaccurate statements, the fact is the DEA law is not changed, just clarified, which will make no major change. We could give a safe harbor for physicians. As a practicing physician who gives palliative care for dying cancer patients and others, I welcome this change in the law, because it does clarify, and it does offer safe harbor.

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

Mr. SCOTT. Mr. Chairman, I yield 2 minutes to the gentleman from Oregon (Mr. DEFAZIO)

Mr. DEFAZIO. Mr. Chairman, if you are for States rights, you will support this amendment. But even if you are not for States rights and you are not supportive of what Oregon has done, twice, the people of Oregon by initiative, if you do not want the Drug Enforcement Administration second guessing the intent of every physician providing end-of-life pain care to every American and chilling and destroying that relationship and the capability of people to get relief from pain, you will support this amendment.

The other side is trying to scare people with all sorts of inaccurate statements. Taking someone else's life? The person has to be competent, judged by two doctors, a psychiatrist, and they can only do it by their own hand with a prescription. ''Hangman,'' we heard from the chairman of the committee. ''Euthanasia,'' we heard. Incredibly irresponsible statements by the other side, denigrating the people of Oregon, the 60 percent who supported this, and the people who are suffering horribly at the end of life.

And, finally, the hypocrisy. The chairman of the committee proposed in the last Congress a bill, H.R. 1252, and what he said there is no single Federal judge should be able to overturn a state law adopted by referendum, and that they cannot grant any relief or anticipatory relief on the ground the a state law is repugnant of the Constitution, which they do not say here. It is repugnant to them and their moral structure. Treatises or laws of the United States, unless the application for anticipatory relief is heard and determined by a court of three judges. So he feels so strongly about state referenda that he wants to say a single Federal judge cannot find a violation of the Constitution.

But, in this case, he feels so little about the will of the people of a state and for States rights and for individuals suffering horribly, horribly, at the end of life, that he would overturn it here in a curtailed debate in the House of Representatives, where we get 5 minutes on our side, where the proponents were given three-quarters of the time during the debate. It is a stacked deck. It is not fair.

If you want to preempt the Oregon law, do it straight and honest and straight up and preempt the Oregon law on the floor, and see what the Supreme Court says about that.

Mr. COBURN. Mr. Chairman, I yield 1 minute to the gentleman from Florida (Mr. CANADY).

Mr. CANADY of Florida. Mr. Chairman, I thank the gentleman for yielding me time.

Mr. Chairman, I just want to point out that the whole argument being made by the opponents of this bill is really an argument against the Controlled Substances Act. If you do not like the Controlled Substances Act, that is a position you can take. But this argument that somehow in this particular context we should not be allowed to apply the Controlled Substances Act is based on an argument that undermines the whole regulatory and statutory scheme under the Controlled Substances Act.

It is important for the Members of the House to understand that the question before us is whether we will say that the Federal Government will support and encourage assisted suicide. Now, if you believe that we should support and encourage assisted suicide, you should vote for this amendment and vote against the bill. The question is that, however, and we need to focus on that question: Will we authorize the use of controlled substances for the purpose of killing human beings? If you believe that we should do that, vote for the amendment. If you think that is something we should not do, I suggest you vote against the amendment. That is what is at stake before the House, and Members need to focus on what is really at stake and put aside the scare tactics.

Mr. SCOTT. Mr. Chairman, I yield myself the balance of my time.

The CHAIRMAN. The gentleman is recognized for 1 minute.

Mr. SCOTT. Mr. Chairman, first of all, if a physician intentionally kills someone, they will be subject to all of the state laws, criminal laws. But the point here is that if you have a terminally ill patient who has died and is full of drugs, this bill will allow the DEA to come in to determine what the intent of the physician was. Not medical enforcement, not the medical society full of doctors determining whether the appropriate protocol was followed, but a law enforcement officer. The DEA knows which drugs can be possessed and which drugs cannot be possessed. They know nothing about overprescribing or under-prescribing drugs.

We need to encourage pain relief for patients. We ought not be subjecting the physicians to additional civil and criminal penalties if they do just that.

Now, if this bill passes, we will be subjecting them not only to additional criminal laws, but also the fact that you violated a law makes you exposed to more civil litigation. So even if the DEA has the common sense not to prosecute, anybody else can come in and sue. That is not what we need, and that is why we need the amendment.

□ 1315

Mr. COBURN. Mr. Chairman, I yield myself 1½ minutes, the balance of the time.

Mr. Chairman, this House twice, 2 years in a row, has said we do not think the FDA ought to be in the business of approving drugs that kill babies; we do not find a role for it, that, in fact, we should not spend Federal dollars to figure out the best ways to kill somebody.

If my colleagues want to talk about a slippery slope, pretty soon we are going to figure out the best way to take a senior out, the most comfortable way, the least expensive way, the most efficacious way to end life. Pretty soon, we are going to figure out what is the easiest way to terminate a pregnancy, to eliminate the consequences of a mistake in judgment or a crime. We are going to spend Federal dollars on how to eliminate those segments of our society that are most dependent on us.

I am not a partisan up here. But on this issue, I say that if my colleagues really care about those who cannot care for themselves, they cannot be for anybody in our society to make the final decision about whether they live or not, whether it is me making a decision about my child or us making a decision as a group about a family member or me as a physician making a decision about my patient.

What we are saying was said in Holland 10 years ago. The same statements were said, and it was ignored. Today, they have active euthanasia of newborn babies growing at 20 percent per year. They have active euthanasia of those that are handicapped growing at 20 percent a year. It will happen here, folks.

The CHAIRMAN pro tempore (Mr. HASTINGS of Washington). All time has expired.

The question is on the amendment offered by the gentleman from Virginia (Mr. SCOTT).

The question was taken; and the Chairman pro tempore announced that the noes appeared to have it.

Mr. DEFAZIO. Mr. Chairman, I demand a recorded vote, and pending that, I make the point of order that a quorum is not present.

The CHAIRMAN pro tempore. Pursuant to House Resolution 339, further proceedings on the amendment offered by the gentleman from Virginia (Mr. SCOTT) will be postponed.

The point of no quorum is considered withdrawn.

It is now in order to consider amendment No. 2 printed in House Report 106–409.

AMENDMENT NO. 2 IN THE NATURE OF A SUBSTITUTED OFFERED BY MRS. JOHNSON OF CONNECTICUT

Mrs. JOHNSON of Connecticut. Mr. Chairman, I offer an amendment in the nature of a substitute.

The CHAIRMAN pro tempore. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Amendment No. 2 in the nature of a substitute offered by Mrs. JOHNSON of Connecticut:

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the ''Conquering Pain Act of 1999''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title.
Sec. 2. Findings and purpose.
Sec. 3. Definitions.
TITLE I—EMERGENCY RESPONSE TO THE PUBLIC HEALTH CRISIS OF PAIN
Sec. 101. Guidelines for the treatment of pain.
Sec. 102. Quality improvement projects.
Sec. 103. Surgeon General's report.
TITLE II—DEVELOPING COMMUNITY RESOURCES
Sec. 201. Family support networks in pain and symptom management.
TITLE III—REIMBURSEMENT BARRIERS
Sec. 301. Insurance coverage of pain and symptom management.
TITLE IV—IMPROVING FEDERAL COORDINATION OF POLICY, RESEARCH, AND INFORMATION
Sec. 401. Advisory Committee on Pain and Symptom Management.
Sec. 402. Institutes of Medicine report on controlled substance regulation and the use of pain medications.
Sec. 403. Conference on pain research and care.
TITLE V—DEMONSTRATION PROJECTS
Sec. 501. Provider performance standards for improvement in pain and symptom management.

**SEC. 2. FINDINGS AND PURPOSE.**

(a) FINDINGS.—Congress finds that—

(1) pain is often left untreated or under-treated especially among older patients, African Americans, and children;

(2) chronic pain is a public health problem affecting at least 50,000,000 Americans through some form of persisting or recurring symptom;

(3) 40 to 50 percent of patients experience moderate to severe pain at least half the time in their last days of life;

(4) 70 to 80 percent of cancer patients experience significant pain during their illness;

(5) despite the best intentions of physicians, nurses, pharmacists, and other health care professionals, pain is often under-treated because of the inadequate training of physicians in pain management;

(6) despite the best intentions of physicians, nurses, pharmacists, and other health care professionals, pain and symptom management is often suboptimal because the health care system has focused on cure of disease rather than the management of a patient's pain and other symptoms;

(7) the technology and scientific basis to adequately manage most pain is known;

(8) pain should be considered the fifth vital sign; and

(9) coordination of Federal efforts is needed to improve access to high quality effective pain and symptom management in order to assure the needs of chronic pain patients and those who are terminally ill are met.

(b) PURPOSE.—The purpose of this Act is to enhance professional education in palliative care and reduce excessive regulatory scrutiny in order to mitigate the suffering, pain, and desperation many sick and dying people face at the end of their lives in order to carry out the clear opposition of the Congress to physician-assisted suicide.

**SEC. 3. DEFINITIONS.**

In this Act:

(1) CHRONIC PAIN.—The term ''chronic pain'' means a pain state that is persistent and in which the cause of the pain cannot be

removed or otherwise treated. Such term includes pain that may be associated with long-term incurable or intractable medical conditions or disease.

(2) DRUG THERAPY MANAGEMENT SERVICES.—The term ''drug therapy management services'' means consultations with a physician concerning a patient which results in the physician—

(A) changing the drug regimen of the patient to avoid an adverse drug interaction with another drug or disease state;

(B) changing an inappropriate drug dosage or dosage form with respect to the patient;

(C) discontinuing an unnecessary or harmful medication with respect to the patient;

(D) initiating drug therapy for a medical condition of the patient; or

(E) consulting with the patient or a caregiver in a manner that esults in a significant improvement in drug regimen compliance.

Such term includes services provided by a physician, pharmacist, or other health care professional who is legally authorized to furnish such services under the law of the State in which such services are furnished.

(3) END OF LIFE CARE.—The term ''end of life care'' means a range of services, including hospice care, provided to a patient, in the final stages of his or her life, who is suffering from 1 or more conditions for which treatment toward a cure or reasonable improvement is not possible, and whose focus of care is palliative rather than curative.

(4) FAMILY SUPPORT NETWORK.—The term ''family support network'' means an association of 2 or more individuals or entities in a collaborative effort to develop multi-disciplinary integrated patient care approaches that involve medical staff and ancillary services to provide support to chronic pain patients and patients at the end of life and their caregivers across a broad range of settings in which pain management might be delivered.

(5) HOSPICE.—The term ''hospice care'' has the meaning given such term in section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)).

(6) PAIN AND SYMPTOM MANAGEMENT.—The term ''pain and symptom management'' means services provided to relieve physical or psychological pain or suffering, including any 1 or more of the following physical complaints—

(A) weakness and fatigue;

(B) shortness of breath;

(C) nausea and vomiting;

(D) diminished appetite;

(E) wasting of muscle mass;

(F) difficulty in swallowing;

(G) bowel problems;

(H) dry mouth;

(I) failure of lymph drainage resulting in tissue swelling;

(J) confusion;

(K) dementia;

(L) anxiety; and

(M) depression.

(7) PALLIATIVE CARE.—The term ''palliative care'' means the total care of patients whose disease is not responsive to curative treatment, the goal of which is to provide the best quality of life for such patients and their families. Such care—

(A) may include the control of pain and of other symptoms, including psychological, social and spiritual problems;

(B) affirms life and regards dying as a normal process;

(C) provides relief from pain and other distressing symptoms;

(D) integrates the psychological and spiritual aspects of patient care;

(E) offers a support system to help patients live as actively as possible until death; and

(F) offers a support system to help the family cope during the patient's illness and in their own bereavement.

(8) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

## TITLE I—EMERGENCY RESPONSE TO THE PUBLIC HEALTH CRISIS OF PAIN

### SEC. 101. GUIDELINES FOR THE TREATMENT OF PAIN.

(a) DEVELOPMENT OF WEBSITE.—Not later than 2 months after the date of enactment of this Act, the Secretary, acting through the Agency for Health Care Policy Research, shall develop and maintain an Internet website to provide information to individuals, health care practitioners, and health facilities concerning evidence-based practice guidelines developed for the treatment of pain.

(b) REQUIREMENTS.—The website established under subsection (a) shall—

(1) be designed to be quickly referenced by health care practitioners; and

(2) provide for the updating of guidelines as scientific data warrants.

(c) PROVIDER ACCESS TO GUIDELINES.—

(1) IN GENERAL.—In establishing the website under subsection (a), the Secretary shall ensure that health care facilities have made the website known to health care practitioners and that the website is easily available to all health care personnel providing care or services at a health care facility.

(2) USE OF CERTAIN EQUIPMENT.—In making the information described in paragraph (1) available to health care personnel, the facility involved shall ensure that such personnel have access to the website through the computer equipment of the facility and shall carry out efforts to inform personnel at the facility of the location of such equipment.

(3) RURAL AREAS.—

(A) IN GENERAL.—A health care facility, particularly a facility located in a rural or underserved area, without access to the Internet shall provide an alternative means of providing practice guideline information to health care personnel.

(B) ALTERNATIVE MEANS.—The Secretary shall determine appropriate alternative means by which a health care facility may make available practice guideline information on a 24-hour basis, 7 days a week if the facility does not have Internet access. The criteria for adopting such alternative means should be clear in permitting facilities to develop alternative means without placing a significant financial burden on the facility and in permitting flexibility for facilities to develop alternative means of making guidelines available. Such criteria shall be published in the Federal Register.

### SEC. 102. QUALITY IMPROVEMENT EDUCATION PROJECTS.

The Secretary shall provide funds for the implementation of special education projects, in as many States as is practicable, to be carried out by peer review organizations of the type described in section 1152 of the Social Security Act (42 U.S.C. 1320c–1) to improve the quality of pain and symptom management. Such projects shall place an emphasis on improving pain and symptom management at the end of life, and may also include efforts to increase the quality of services delivered to chronic pain patients.

### SEC. 103. SURGEON GENERAL'S REPORT.

Not later than October 1, 2000, the Surgeon General shall prepare and submit to the appropriate committees of Congress and the public, a report concerning the state of pain and symptom management in the United States. The report shall include—

(1) a description of the legal and regulatory barriers that may exist at the Federal and State levels to providing adequate pain and symptom management;

(2) an evaluation of provider competency in providing pain and symptom management;

(3) an identification of vulnerable populations, including children, advanced elderly, non-English speakers, and minorities, who may be likely to be underserved or may face barriers to access to pain management and recommendations to improve access to pain management for these populations;

(4) an identification of barriers that may exist in providing pain and symptom management in health care settings, including assisted living facilities;

(5) and identification of patient and family attitudes that may exist which pose barriers in accessing pain and symptom management or in the proper use of pain medications;

(6) an evaluation of medical school training and residency training for pain and symptom management; and

(7) a review of continuing medical education programs in pain and symptom management.

## TITLE II—DEVELOPING COMMUNITY RESOURCES

### SEC. 201. FAMILY SUPPORT NETWORKS IN PAIN AND SYMPTOM MANAGEMENT.

(a) ESTABLISHMENT.—The Secretary, acting through the Public Health Service, shall award grants for the establishment of 6 National Family Support Networks in Pain and Symptom Management (in this section referred to as the ''Networks'') to serve as national models for improving the access and quality of pain and symptom management to chronic pain patients and those individuals in need of pain and symptom management at the end of life and to provide assistance to family members and caregivers.

(b) ELIGIBILITY AND DISTRIBUTION.—

(1) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(A) be an academic facility or other entity that has demonstrated an effective approach to training health care providers concerning pain and symptom management and palliative care services; and

(B) prepare and submit to the Secretary an application (to be peer reviewed by a committee established by the Secretary), at such time, in such manner, and containing such information as the Secretary may require.

(2) DISTRIBUTION.—In providing for the establishment of Networks under subsection (a), the Secretary shall ensure that—

(A) the geographic distribution of such Networks reflects a balance between rural and urban needs; and

(B) at least 3 Networks are established at academic facilities.

(c) ACTIVITIES OF NETWORKS.—A Network that is established under this section shall—

(1) provide for an integrated interdisciplinary approach to the delivery of pain and symptom management;

(2) provide community leadership in establishing and expanding public access to appropriate pain care, including pain care at the end of life;

(3) provide assistance through caregiver and bereavement supportive services;

(4) develop a research agenda to promote effective pain and symptom management for the broad spectrum of patients in need of access to such care that can be implemented by the Network;

(5) provide for coordination and linkages between clinical services in academic centers and surrounding communities to assist in the widespread dissemination of provider and patient information concerning how to access options for pain management;

(6) establish telemedicine links to provide education and for the delivery of services in pain and symptom management; and

(7) develop effective means of providing assistance to providers and families for the

management of a patient's pain 24 hours a day, 7 days a week.

(d) PROVIDER PAIN AND SYMPTOM MANAGEMENT COMMUNICATIONS PROJECTS.—

(1) IN GENERAL.—Each Network shall establish a process to provide health care personnel with information 24 hours a day, 7 days a week, concerning pain and symptom management. Such process shall be designed to test the effectiveness of specific forms of communications with health care personnel so that such personnel may obtain information to ensure that all appropriate patients are provided with pain and symptom management.

(2) TERMINATION.—The requirement of paragraph (1) shall terminate with respect to a Network on the day that is 2 years after the date on which the Network has established the communications method.

(3) EVALUATION.—Not later than 60 days after the expiration of the 2-year period referred to in paragraph (2), a Network shall conduct an evaluation and prepare and submit to the Secretary a report concerning the costs of operation and whether the form of communication can be shown to have had a positive impact on the care of patients in chronic pain or on patients with pain at the end of life.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as limiting a Network from developing other ways in which to provide support to families and providers, 24 hours a day, 7 days a week.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $18,000,000 for fiscal years 2000 through 2002.

## TITLE III—REIMBURSEMENT BARRIERS

### SEC. 301. INSURANCE COVERAGE OF PAIN AND SYMPTOM MANAGEMENT.

(a) IN GENERAL.—The General Accounting Office shall conduct a survey of public and private health insurance providers, including managed care entities, to determine whether the reimbursement policies of such insurers inhibit the access of chronic pain patients to pain and symptom management and pain and symptom management for those in need of end-of-life care. The survey shall include a review of formularies for pain medication and the effect of such formularies on pain and symptom management.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the General Accounting Office shall prepare and submit to the appropriate committees of Congress a report concerning the survey conducted under subsection (a).

## TITLE IV—IMPROVING FEDERAL COORDINATION OF POLICY, RESEARCH, AND INFORMATION

### SEC. 401. ADVISORY COMMITTEE ON PAIN AND SYMPTOM MANAGEMENT.

(a) ESTABLISHMENT.—The Secretary shall establish an advisory committee, to be known as the Advisory Committee on Pain and Symptom Management, to make recommendations to the Secretary concerning a coordinated Federal agenda on pain and symptom management.

(b) MEMBERSHIP.—The Advisory Committee established under subsection (a) shall be comprised of 11 individuals to be appointed by the Secretary, of which at least 1 member shall be a representative of—

(1) physicians (medical doctors or doctors of osteopathy) who treat chronic pain patients or the terminally ill;

(2) nurses who treat chronic pain patients or the terminally ill;

(3) pharmacists who treat chronic pain patients or the terminally ill;

(4) hospice;

(5) pain researchers;

(6) patient advocates;

(7) caregivers; and

(8) health insurance issuers (as such term is defined in section 2791(b) of the Public Health Service Act (42 U.S.C. 300gg–91(b))).

The members of the Committee shall designate 1 member to serve as the chairperson of the Committee.

(c) MEETINGS.—The Advisory Committee shall meet at the call of the chairperson of the Committee.

(d) AGENDA.—The agenda of the Advisory Committee established under subsection (a) shall include—

(1) the development of recommendations to create a coordinated Federal agenda on pain and symptom management;

(2) the development of proposals to ensure that pain is considered as the fifth vital sign for all patients;

(3) the identification of research needs in pain and symptom management, including gaps in pain and symptom management guidelines;

(4) the identification and dissemination of pain and symptom management practice guidelines, research information, and best practices;

(5) proposals for patient education concerning how to access pain and symptom management across health care settings;

(6) the manner in which to measure improvement in access to pain and symptom management and improvement in the delivery of care; and

(7) the development of an ongoing mechanism to identify barriers or potential barriers to pain and symptom management created by Federal policies.

(e) RECOMMENDATION.—Not later than 2 years after the date of enactment of this Act, the Advisory Committee established under subsection (a) shall prepare and submit to the Secretary recommendations concerning a prioritization of the need for a Federal agenda on pain, and ways in which to better coordinate the activities of entities within the Department of Health and Human Services, and other Federal entities charged with the responsibility for the delivery of health care services or research on pain, with respect to pain management.

(f) CONSULTATION.—In carrying out this section, the Advisory Committee shall consult with all Federal agencies that are responsible for providing health care services or access to health services to determine the best means to ensure that all Federal activities are coordinated with respect to research and access to pain and symptom management.

(g) ADMINISTRATIVE SUPPORT; TERMS OF SERVICE; OTHER PROVISIONS.—The following shall apply with respect to the Advisory Committee:

(1) The Committee shall receive necessary and appropriate administrative support, including appropriate funding, from the Department of Health and Human Services.

(2) The Committee shall hold open meetings and meet not less than 4 times per year.

(3) Members of the Committee shall not receive additional compensation for their service. Such members may receive reimbursement for appropriate and additional expenses that are incurred through service on the Committee which would not have incurred had they not been a member of the Committee.

(4) The requirements of appendix 2 of title 5, United States Code.

### SEC. 402. INSTITUTES OF MEDICINE REPORT ON CONTROLLED SUBSTANCE REGULATION AND THE USE OF PAIN MEDICATIONS.

(a) IN GENERAL.—The Secretary, acting through a contract entered into with the Institute of Medicine, shall review findings that have been developed through research conducted concerning—

(1) the effects of controlled substance regulation on patient access to effective care;

(2) factors, if any, that may contribute to the underuse of pain medications, including opioids; and

(3) the identification of State legal and regulatory barriers, if any, that may impact patient access to medications used for pain and symptom management.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning the findings described in subsection (a).

### SEC. 403. CONFERENCE ON PAIN RESEARCH AND CARE.

Not later than December 31, 2003, the Secretary, acting through the National Institutes of Health, shall convene a national conference to discuss the translation of pain research into the delivery of health services to chronic pain patients and those needing end-of-life care. The Secretary shall use unobligated amounts appropriated for the Department of Health and Human Services to carry out this section.

## TITLE V—DEMONSTRATION PROJECTS

### SEC. 501. PROVIDER PERFORMANCE STANDARDS FOR IMPROVEMENT IN PAIN AND SYMPTOM MANAGEMENT.

(a) IN GENERAL.—The Secretary, acting through the Public Health Service, shall award grants for the establishment of not less than 5 demonstration projects to determine effective methods to measure improvement in the skills and knowledge of health care personnel in pain and symptom management as such skill and knowledge applies to providing services to chronic pain patients and those patients requiring pain and symptom management at the end of life.

(b) EVALUATION.—Projects established under subsection (a) shall be evaluated to determine patient and caregiver knowledge and attitudes toward pain and symptom management.

(c) APPLICATION.—To be eligible to receive a grant under subsection (a), an entity shall prepare and submit to the Secretary an application at such time, in such manner and containing such information as the Secretary may require.

(d) TERMINATION.—A project established under subsection (a) shall terminate after the expiration of the 2-year period beginning on the date on which such project was established.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

The CHAIRMAN pro tempore. Pursuant to House Resolution 339, the gentlewoman from Connecticut (Mrs. JOHNSON) and a Member opposed will each control 20 minutes.

The Chair recognizes the gentlewoman from Connecticut (Mrs. JOHNSON).

Mrs. JOHNSON of Connecticut. Mr. Chairman, I rise to speak in strong support of aggressive pain management and palliative care. We need the opportunity to oppose physician-assisted suicide and advance the cause of pain management without having to support an aggressive new Federal role in the practice of medicine.

In the next several years, we will see tremendous growth of the elderly population. As we advance medical science to prolong life, we must also do all we can to make people's final months and

days pain free. Too many patients with terminal illness and chronic conditions suffer extreme pain without receiving adequate treatment or even knowing the treatment options. Because acute prolonged pain is a significant cause of people seeking to end their lives, the substitute strikes at a major cause of suicide in an effective and progressive way.

Our substitute amendment clearly opposes physician-assisted suicide. But it would also eliminate the need for such extreme measures by advancing the science of pain management and making it more available to patients.

Our substitute would help broaden access to palliative care through the creation of family support networks and outreach programs. It would also help disseminate information to patients, their families, and physicians through a centralized health and human services Web site specific to pain management and far more accessible information than the existing Web site.

It would also help develop the science of pain management and advance the state of medical practice at the patient's bed side. It would train and educate physicians at the local level through the use of peer review organizations and direct the National Institutes of Health to convene a conference to put new developments in pain research into practice and the health care system.

It would create an 11-member advisory committee to coordinate efforts within the Federal Government to make recommendations about additional research needs, practice guidelines, and other areas of pain management practice.

Finally, the amendment would instruct the Surgeon General to issue a report on the legal and regulatory barriers to pain management, the level of competence in treating pain by physicians around the country, the amount and quality of training received by medical students and residents, and other issues relating to pain management.

I deeply respect the opposition to physician-assisted suicide of the gentleman from Illinois (Chairman HYDE). Congress has already stated its opposition when it overwhelmingly passed legislation to ban Federal funds and Federal health programs from funding assisted suicide.

Most States, including my home State of Connecticut, ban assisted suicide, prohibit it as a matter of State law and as a matter of medical practice.

Our substitute reflects the will of Congress in its clear language opposing assisted suicide, but it goes beyond that to strike at one of the most significant reasons people feel that suicide is the only answer: the sheer desperation and hopelessness that severe pain causes.

Our amendment would address this desperation by promoting the development of pain management, advancing physician knowledge, and increasing patient expectations that their pain should be properly managed.

In contrast, the underlying bill would discourage physicians from prescribing appropriate pain medications. I have a long list of quotes from physicians that demonstrates what a chilling effect this bill would have on current practice.

This is why I have been trying to intervene when my colleagues were saying we do not change the law, because we do change the law, it will have a chilling effect on the willingness of physicians to deliver pain relief care. For the first time, under the Hyde language, DEA agents would be required to judge retroactively the intent of a prescribing physician. With little or no medical training, agents would have to judge if a physician intended to relieve pain even at the risk of death or intended to ''hasten death.''

Now, remember, Mr. Chairman, there is always a risk of death when prescribing controlled substances for extreme pain suffered by very ill patients. Patients build up resistance to medications and require stronger doses for relief. As a result, there is nearly always a risk of death to the patient.

How is a DEA agent to judge whether the stronger dose was appropriate, though it risked death, which is legal under the Hyde language, or it was not appropriate because it hastened death? Does this House want to delegate to nonmedical professionals that kind of authority? Do we want the Federal Government writing regulations to implement this section of law?

Pain management is a developing science and each terminal case has its own tragic reality. Under current practice, the DEA already has clear regulatory authority over physicians who are illegally trafficking drugs and misused controlled substances.

On matters involving questions of medical judgment, however, the DEA defers to the State health agencies and State medical boards which have historically governed the scope and standards of medical practice.

Why would we want to change this? Why would we ask DEA agents to judge the intention of physicians managing extreme pain in very sick patients?

Ironically, a few weeks ago, this body passed legislation to prevent insurance companies from the second guessing of physicians. We should not now require DEA agents to second-guess physicians.

I urge my colleagues to support the substitute amendment that addresses the desperation and hopelessness of suffering severe pain by developing the science of pain management, advancing physician knowledge, and increasing patient expectation and access to proper pain management. I urge support of my amendment.

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

The CHAIRMAN pro tempore. For what purpose does the gentleman from Oklahoma (Mr. COBURN) rise?

Mr. COBURN. Mr. Chairman, I rise in opposition to the amendment in the nature of a substitute.

The CHAIRMAN pro tempore. The gentleman from Oklahoma (Mr. COBURN) is recognized for 20 minutes.

Mr. COBURN. Mr. Chairman, I yield myself 15 seconds so that I might respond.

The gentlewoman from Connecticut (Mrs. JOHNSON) might not recognize that every narcotic prescription that I write today, when it is reviewed and surveyed and sampled, a DEA agent makes a decision whether or not my judgment was appropriate in that. If there is any question, they are in my office looking at my medical records. So the statement to say we do not allow them judgment today is wrong.

Mr. Chairman, I yield 8 minutes to the gentleman from Kansas (Mr. TIAHRT).

Mr. TIAHRT. Mr. Chairman, I thank the gentleman from Oklahoma for yielding me this time.

Mr. Chairman, much of the debate surrounding the Pain Relief Promotion Act focuses on whether it is more likely to have a positive or a negative impact on those who suffer from severe and continuing pain. I believe the experience in my own State of Kansas can shed important light on this question.

Major medical organizations, including the American Academy of Pain Management, the American Society of Anesthesiologists, and the American Medical Association say the bill will live up to its title. They emphasize that, for the first time, the bill writes into the Controlled Substances Act protection for physicians who prescribe the large doses of drugs sometimes necessary to manage intractable pain, even when it may increase the risk of death, so long as the drugs are not prescribed intentionally for the purpose of assisting suicide or euthanasia.

However, a dissident group of State medical societies and some other medical organizations predict that this very provision will lead some physicians to hesitate to prescribe needed drugs, fearing that their intentions may be subject to question by the Drug Enforcement Agency, or the DEA.

Fortunately, there is evidence from a number of States against which we can test these competing predictions. In the period from 1993 through 1998, Kansas and four other States enacted new laws similar in effect to the disputed provision in the Pain Relief Promotion Act.

Like H.R. 2260, these State laws have combined a provision specifically protecting doctors who prescribe medications for pain relief with provisions preventing their use for purpose of assisting suicide or euthanasia. Let us look at what happened at the drug prescriptions following enactment of these laws.

Let us begin with my own State of Kansas. The bill preventing assisted suicide was enacted in our State legislature in 1993 while I served in the

State Senate. Did that cause doctors to be less likely to prescribe high doses? Look at the chart here. Per capita morphine usage increased a little bit for a couple of years, then in 1996, began to rise dramatically. In 1998, the law on assisting suicide was strengthened. At the same time, language specifically protecting prescriptions for pain relief was added.

It read: ''A licensed health care professional who administers, prescribes, or dispenses medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, does not violate this law unless the medications or procedures are knowingly administered, prescribed, or dispensed with the intent to cause death.'' That is very close, indeed, to the language of the Pain Relief Promotion Act.

What happened to the prescriptions for pain killing drugs? Based on the figures for the first half of 1999, per capita use of morphine rose 22 percent in Kansas. The experience has been replicated in State after State after State.

Let us look at a chart for Kentucky. In June of 1994, Kentucky passed a law banning assisted suicide, but specifically allowing pain control that may unintentionally risk death. That year, per capita use of morphine increased. While there was a little dip in 1995, usage was still higher than either of the 2 years before the law passed. Since then, morphine usage per capita has increased over 2,200 grams for every 100,000 people in 1997 and 1998, and projected from half-year figures in 1999.

Next is Iowa. In 1996, Iowa enacted legislation against assisted suicide. The law included language to protect prescriptions for pain relief very similar to that of Kansas and the Pain Relief Promotion Act.

What happened? Again, let us look at the chart. Before the bill, prescriptions of morphine per 100,000 people were almost flat, ranging from 935 to 1,100 grams. With the bill's enactment, the amount of morphine used in prescription soared. By 1997, it had almost doubled.

Next a chart for Louisiana. In 1995, Louisiana passed a law preventing assisted suicide which stated that it did not apply to prescribing medication if the intent is to relieve the patient's pain or suffering and not to cause death. As the chart dramatically shows, in the 4 years preceding the law's effective date, the use of morphine was below 1,000 grams per 100,000 people. In the 4 years since, it has soared. So that, in the first half of this year, it has stood at 3,659 grams per 100,000 people.

Michigan, the home of Jack Kevorkian is next. That chart shows a checkered history of the laws on assisted suicide in their State compared with morphine usage per capita. As my colleagues can see, there is certainly no downward effect on morphine usage associated with the periods the ban was in effect.

□ 1330

Since a permanent statutory ban, which includes language like that in H.R. 2260 promoting pain relief, went into effect in 1998, the trend of morphine usage has been steadily upward.

Rhode Island. Now we will look at this particularly interesting case because the Rhode Island Medical Society is opposing the Pain Relief Promotion Act, saying that preventing the use of drugs to assist suicide will chill prescriptions for pain control.

In 1996, the organization made the same argument against an assisted-suicide bill in the State legislature that passed despite its opposition. That Rhode Island law included the following language: ''A licensed health care professional who administers, prescribes, or dispenses medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, does not violate the provisions of this chapter, unless the medications or procedures are knowingly administered, prescribed, or dispensed to cause death.''

Again, this is quite similar to the language of the Pain Relief Promotion Act.

What happened? As my colleagues can see from the chart, per capita prescriptions of morphine shot up to almost double the highest pre-law rate. Since then they have dropped off a little bit, but remaining far above the pre-law rate.

Next is Tennessee. In July, 1993, a law with language very much like the Pain Relief Promotion Act was enacted. Morphine usage that year and the next year was up from the year before. In 1995, there was a dip, but morphine usage per capita was still greater than that of the year before the law. Since then it has continued up.

Virginia. Briefly let us look at Virginia. In the spring of 1997, the Virginia legislature passed a measure to prevent assisting suicide, which went into effect after reaffirming the vote in the spring of 1998. That law contained language differentiating between the intent to relieve pain, even with the risk of death, and the intent to cause death, just like the Pain Relief Promotion Act.

The result is clear on the chart. Per capita use of morphine has not been deterred. In fact, it went up.

Finally, some of my friends from Oregon make the argument that passing the law legalizing assisted suicide in some cases has freed doctors to provide needed higher doses to accomplish pain relief. But let us look at the Oregon chart.

True, morphine use per capita has increased in Oregon, but virtually all of that increased while the suicide law was not yet in effect, because it had been enjoined by a court order. That means the increase occurred while physicians remained subject to investigation and revocation of their DEA registration if they used federally controlled drugs to assist any suicide. Clearly, that did not deter Oregon doctors from significantly increasing their prescriptions for the pain killing morphine.

Remember, other than Oregon, all of these States' new laws distinguish between the intent to alleviate pain and cause death. Because of experiences in Kansas and other States, we can be confident that a vote for H.R. 2260 will promote and not threaten improved pain relief. I urge a vote of passage and opposition to any substitute or amendments.

Mrs. JOHNSON of Connecticut. Mr. Chairman, may I inquire as to how much time I have remaining?

The CHAIRMAN pro tempore (Mr. HASTINGS of Washington). The gentlewoman from New Jersey (Mrs. JOHNSON) has 13 minutes remaining, and the gentleman from Oklahoma (Mr. COBURN) has 11¾ minutes remaining.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield 3 minutes to the gentleman from Oregon (Mr. WALDEN).

Mr. WALDEN. Mr. Chairman, I rise today in opposition to the Pain Relief Promotion Act and in support of the Johnson–DeFazio amendments.

I share many of my colleagues' discomfort with the issue of assisted suicide, and I certainly respect the desire of the gentleman from Illinois (Mr. HYDE) to improve palliative care and to ensure that the seriously ill receive safe, quality, and effective pain management.

However, I also support States rights. The people of Oregon, not once but twice, through long and through thoroughly debated ballot measure campaigns, affirmed their desire to allow terminally ill people to seek help from their physicians in ending their lives. For most Oregonians, deciding on how to vote on this issue was a deeply personal and moral process. I know, because I too agonized over how to vote on this measure.

I agonized as a father, who watched the life drain from a young son, and who watched as cancer worked its wicked will on a mother. I voted against assisted suicide when it was on the ballot because I personally have serious moral misgivings for it. But I also have a deep respect for the underpinnings of our democracy in our State and our country, and I respect the right of the initiative and the referendum process.

Oregon voters are probably the only ones that have voted both through the initiative and the referendum process to stand up for what they felt was right for their loved ones and for their lives. Now, more than 2500 miles away, a Congress, foreign to many in my State, wants to overturn their will, wants to make that very personal decision for them.

I have to tell my colleagues that in the year that I was out campaigning for this very office there were many times people came up to me and said, ''Are you going to go back there and

undo what we did?'' Not on this issue, but on others. Do my colleagues realize how cynical people are about how they act at the ballot box, only to have some level of government higher or the Judiciary overturn what they seek to do?

So, Mr. Chairman, I stand here today in support of this amendment and of the DeFazio amendment. And I want to close with a quote from Time magazine from a cancer specialist, Dr. Nancy Crumpacker, who said, ''If this bill is passed, doctors will never again be able to treat suffering people without the fear of punishment.''

I do not want them to have to operate under the fear of that kind of punishment. I want this decision, a very personal decision, to remain the way it has been crafted very carefully, not only by Oregon voters but by their legislature as well, so that it is between the terminally ill person, witnessed in that person's physician. So I support the amendments to this legislation.

Mr. COBURN. Mr. Chairman, I yield myself 15 seconds, and I want to quote Herbert Hinden, Professor of Psychiatry at New York Medical College.

''The proposed law provides protection for physicians who prescribe medication with the intention of relieving pain, even if that medication has the secondary effect of causing death.''

Mr. Chairman, I yield 2½ minutes to the gentleman from Alabama (Mr. BACHUS).

Mr. BACHUS. Mr. Chairman, what we are talking about here is the relationship between a doctor and a patient. Most of these patients are dying patients, at least that is what we assume.

These people are at their weakest, they are at their most vulnerable, their complete trust, in fact, their life is in the hands of their doctor. They have every right to expect that their doctor is going to be a healer and not a killer; that their doctor is not going to seek a quick fix. Doctors have the right to prescribe very useful, very strong, very powerful drugs to alleviate pain. But to alleviate pain, not to eliminate patients. It is to eliminate pain.

We, in this country, believe in the sanctity of human life. I can remember my grandmother, very ill in the hospital. I can remember the doctor telling us she would not live through the night. She did live through the night. She came home and she spent 3 more years with my grandfather, and they were productive years. She was not confined to a wheelchair, she was not confined to a bed.

Now, this bill has been misrepresented. I want to commend the gentleman from Illinois (Mr. HYDE) and I want commend the gentleman from Florida (Mr. CANADY) for bringing this bill.

Once again let me repeat what this bill does allow doctors to do. And let me say this, doctors support this bill. The American Medical Association has endorsed this bill. The organization that cares for these dying patients and knows more about them, the American Hospice Organization, has endorsed this bill. Americans support this bill by more than two to one.

This bill allows physicians to do their job effectively and compassionately. Those with terminal illnesses often find themselves in terrible pain, and under current laws many doctors do not have the ability to help those sickest patients. Under this legislation, and it clearly states this, that alleviating pain or discomfort is a legitimate medical purpose consistent with public health and safety, even if the use of such substance may increase the risk of death.''

This bill allows doctors to effectively prescribe medication to control pain of patients and to improve their last few days of life, but at the same time ensures to all of us that they will be healers and that they will conform to their ethical code never to kill, only to cure.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield 1 minute to the gentleman from Maryland (Mr. HOYER).

Mr. HOYER. Mr. Chairman, I thank the gentlewoman for yielding me this time. I want to associate myself with the remarks of the gentleman from Oregon (Mr. WALDEN).

Like the gentleman from Oregon, I too have watched a loved one die of cancer. I did not want her to commit suicide nor be put to death. I wanted her to be healed, as the previous speaker has said, and I believe all the doctors that dealt with her wanted to do that. But anybody who has gone through that experience, I think, is convicted of the fact that they want the doctor to have the latitude to use such means and devices as in the doctor's judgment is best to relieve that patient from the agony of death.

I will vote for this substitute and urge the adoption of this substitute because I believe it gives that latitude. It states as a policy that we are against assisted suicide, but it also goes on to train and to offer counseling and education in this very difficult time for families and individuals.

Mr. Chairman, I rise today in support of the Rothman-Johnson-Maloney-Hooley ''Conquering Pain Substitute'' to H.R. 2260—''The Pain Relief Promotion Act.''

Assisted suicide remains a divisive issue around the nation. For young and old alike who suffer from terminal illness, finding a way to ease excruciating pain is a complex and difficult task.

The ''Conquering Pain Substitute'' provides a viable alternative to the '''Pain Relief Promotion Act.''

Not only does it express this body's opposition to assisted suicide, but it implements a variety of programs to provide information on pain management and learn more about the importance of controlled substances in treating the seriously and terminally ill.

The ''Conquering Pain Substitute'' puts more emphasis into research and insuring that health professions have the information they need in making pain management decisions.

The substitute expands access to pain management by establishing family support networks, a pain guidelines web-site, and insures that all Medicare recipients are informed of their insurance coverage of pain treatment.

The bill also calls for a report by the Surgeon General on legal and regulatory barriers to pain management as well as establishing an advisory committee on pain to coordinate efforts to the Federal Government.

This substitute provides a sensible approach to a difficult and emotional issue and I hope my fellow colleagues will join me in supporting it.

From time to time a few egregious cases, like assisted suicide, lead us to adopt legislation with broad implications and possible unintended consequences.

However, if the substitute fails, I will vote for final passage of H.R. 2260.

Representatives HYDE and STUPAK have made a concerted effort to win wide-spread support of their bill including support by the American Medical Association, and the National Hospice Association. This bill is far superior to the Lethal Drug Abuse Prevention Act that was introduced in the 105th Congress.

Once again I urge my colleagues to support the ''Conquering Pain Substitute''

Mr. COBURN. Mr. Chairman, I yield 2½ minutes to the gentlewoman from New Jersey (Mrs. ROUKEMA).

Mrs. ROUKEMA. Mr. Chairman, I thank the gentleman for yielding me this time, and I rise here today in the first place because I have been wrongly identified as a supporter of the substitute, and secondly I rise in support of the base bill.

But I also wanted to tell my colleagues, that I, too, like the gentleman from Maryland (Mr. HOYER), have had to care for terminally ill members of my family as both a daughter and a mother. I cared for my father at my home during his last weeks as a prostate cancer patient and for my own son, Todd whom I lost to leukemia, and I cared for him. Sincerely and seriously, I address this issue from the memories of the trauma—physical and mental that my loved ones endured.

I have to tell my colleagues that originally I was too focused on only the palliative care questions because the issues had been misrepresented to me. And as I investigated, both with the Justice Department and with the AMA as to their reasons for supporting these portions of the bill, I learned that absolutely this does not interfere with the doctor-patient relationship.

I want to read from the October 19 letter that the Justice Department wrote to the gentleman from Illinois (Mr. HYDE), and I want to be specific about this because there is a lot of rhetoric around here and we are talking about legal questions. The Department of Justice fully supports these measures. ''H.R. 2260 would eliminate any ambiguity about the legality of using controlled substances to alleviate the pain and suffering of the terminally ill,'' and I want to emphasize this, because they go on to say, ''by reducing any perceived threat of administrative and criminal sanctions in this context.'' That gives me the assurance that I believe I need.

Further on, they go on to other questions. But, clearly, the palliative care and the protection of the physician's professional actions are there.

□ 1345

But, in addition, I questioned at length, the AMA. At first I called the AMA with deep concern about their support for the bill. And then after discussing with the AMA, they sent me documentation as to their reasons for support.

Because I am the wife of a doctor and I have had all kinds of contacts with medical provisions, and they specifically explicitly state in black and white that the addition of language explicitly acknowledging the medical legitimacy of the double effect in the CSA provides a new and important statutory protection for the physicians prescribing controlled substances for pain, particularly for patients at the end of life.

It is unambiguous and the AMA supports this because their previous concerns have been addressed quite correctly by the gentleman from Illinois (Chairman HYDE) and the committee.

I strongly support the bill; and oppose the substitute as ambiguous and inadequate.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield myself 10 seconds.

Mr. Chairman, the gentlewoman from New Jersey (Mrs. ROUKEMA) described herself as wrongly identified. I would like the RECORD to note that she asked to be a cosponsor of the amendment, voluntarily signed ''dear colleagues,'' and was part of a letter to the leadership; and while she may have changed her mind, things were not misrepresented and she was not wrongly identified. She has merely changed her position. And I certainly accept and respect that.

Mr. Chairman, I yield 1 minute to my colleague, the gentleman from Texas (Mr. GREEN).

(Mr. GREEN of Texas asked and was given permission to revise and extend his remarks.)

Mr. GREEN of Texas. Mr. Chairman, I oppose assisted suicide. If I had the opportunity either as a Member of Congress or in a referendum, I would vote to make that illegal. However, I am concerned about the unintended consequences that this bill would place on providers and patients at risk, as well as preempt State laws that have already addressed this issue.

All of us have had experience with very dear and close family members who have died and had to have hospice treatment. In my State of Texas, where a physician-assisted suicide is not legal, the definition of ''intractable pain'' and the rules that govern its treatment are carefully worked out and negotiated.

Over the past years, the Texas Board of State Medical Examiners has modified their rules to fine tune them so that they will provide for best care for patients without undue interference. Our pain act was passed to reassure physicians that they would not have enforcement action taken against them if they prescribed a prescription for a controlled substance.

Now I see we have a difference between the AMA and Texas Medical Association. Because before this act was passed by the legislature, many physicians were consciously undertreating patients because of the fear of State disciplinary action. I worried this would happen. That is why I stand in support of the Johnson-Rothman-Hooley substitute.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield 1½ minutes to my colleague, the gentleman from Texas (Mr. PAUL).

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

Mr. PAUL. Mr. Chairman, I thank the gentlewoman for yielding me the time.

Mr. Chairman, I rise in support of this amendment. This will improve the bill. I am very concerned, as a physician, that this bill will do great harm to the practice of medicine. This is micromanaging the palliative care of the dying.

So I strongly support this amendment because it will remove the severe penalties and the threats. Physicians are accustomed to practicing with lawyers over their shoulders. Now we are going to add another DEA agent over our shoulders to watch what we do.

It is said, well, there is not going to be any change in law. Well, if there is not, why the bill? Certainly there is a change in law. This bill does not state that it is dealing with euthanasis. It says it is a pain relief promotion act.

Generally speaking, I look at the names of bills and sometimes intentionally and sometimes just out of the way things happen here, almost always the opposite happens from the bill that we raise up. So I would call this the pain promotion act. I really sincerely believe, as a physician, that this will not help.

Too often physicians are intimidated and frightened about giving the adequate pain medication that is necessary to relieve pain. This amendment will be helpful. This is what we should do. We should not intimidate. The idea of dealing with the issue of euthanasis, euthanasia is killing. It is murder.

I am pro-life. I am against abortion. I am absolutely opposed to euthanasis. But euthanasis is killing. Under our Constitution, that is a State issue, not a congressional issue.

I strongly urge the passage of this amendment.

Mr. Chairman, today Congress will take a legislative step which is as potentially dangerous to protecting the sanctity of life as was the Court's ill-advised Roe versus Wade decision.

The Pain Relief Promotion Act of 1999, H.R. 2260, would amend Title 21, United States Code, for the laudable goal of protecting palliative care patients from the scourge of ''assisted'' suicide. However, by preempting what is the province of States—most of which have already enacted laws prohibiting ''assisted suicide''—and expanding its use of the Controlled Substances Act to further define what constitutes proper medical protocol, the federal government moves yet another step closer to both a federal medical bureau and a national police state.

Our federal government is, constitutionally, a government of limited powers. Article one, section eight, enumerates the legislative areas for which the U.S. Congress is allowed enact legislation. For every other issue, the federal government lacks any authority or consent of the governed and only the state governments, their designees, or the people in their private market actions enjoy such rights to governance. The tenth amendment is brutally clear in stating ''The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.'' Our nation's history makes clear that the U.S. Constitution is a document intended to limit the power of central government. No serious reading of historical events surrounding the creation of the Constitution could reasonably portray it differently.

In his first formal complaint to Congress on behalf of the federal Judiciary, Chief Justice William H. Rehnquist said ''the trend to federalize crimes that have traditionally been handled in state courts . . . threatens to change entirely the nature of our federal system.'' Rehnquist further criticized Congress for yielding to the political pressure to ''appear responsive to every highly publicized societal ill or sensational crime.''

However, Congress does significantly more damage than simply threatening physicians with penalties for improper prescription of certain drugs—it establishes (albeit illegitimately) the authority to dictate the terms of medical practice and, hence, the legality of assisted suicide nationwide. Even though the motivation of this legislation is clearly to pre-empt the Oregon Statute and may be protective of life in this instance, we mustn't forget that the saw (or scalpel) cuts both ways. The Roe versus Wade decision—the Court's intrusion into rights of states and their previous attempts to protect by criminal statute the unborn's right not to be aggressed against—was quite clearly less protective of life than the Texas statute it obliterated. By assuming the authority to decide for the whole nation issues relating to medical practice, palliative care, and assisted suicide, the foundation is established for a national assisted suicide standard which may not be protective of life when the political winds shift and the Medicare system is on the verge of fiscal collapse. Then, of course, it will be the federal government's role to make the tough choices of medical procedure rationing and for whom the cost of medical care doesn't justify life extension. Current law already prohibits private physicians from seeing privately funded patients if they've treated a Medicaid patient within two years.

Additionally, this bill empowers the Attorney General to train federal, state, and local law enforcement personnel to discern the difference between palliative care and euthanasia. Most recently, though, it was the Attorney General who specifically exempted the physicians of Oregon from certain provisions of Title 21, the very Title this legislation intends to augment. Under the tutelage of the

Attorney General, it would thus become the federal police officer's role to determine at which point deaths from pain medication constitute assisted suicide.

To help the health care professionals become familiar with what will become the new federal medical standard, the bill also authorizes $24 million dollars over the next five years for grant programs to health education institutions. This is yet another federal action to be found nowhere amongst the enumerated powers.

Like the unborn, protection of the lives of palliative care patients is of vital importance. So vitally important, in fact, it must be left to the states' criminal justice systems and state medical licensing boards. We have seen what a mess results from attempts to federalize such an issue. Numerous states have adequately protected both the unborn and palliative care patients against assault and murder and done so prior to the federal government's unconstitutional sanctioning of violence in the Roe versus Wade decision. Unfortunately, H.R. 2260 ignores the danger of further federalizing that which is properly reserved to state governments and, in so doing, ignores the Constitution, the bill of rights, and the insights of Chief Justice Rehnquist. For these reasons, I must oppose H.R. 2260, The Pain Relief Promotion Act of 1999.

PREFERENTIAL MOTION OFFERED BY MR. OBEY

Mr. OBEY. Mr. Chairman, I offer a preferential motion.

The CHAIRMAN pro tempore (Mr. HASTINGS of Washington). The Clerk will report the motion.

The Clerk read as follows:

Mr. OBEY moves that the Committee do now rise and report the bill back to the House with a recommendation that the enacting clause be stricken out.

Mr. OBEY. Mr. Chairman, many of us are against assisted suicide. But, in my view, in an attempt to get at that problem, this bill is a blunder and it pushes us away from added protection for patients.

I am for the amendment that is being considered. Because what this bill does is to say that, when a doctor prescribes pain killing agents, the Drug Enforcement Agency could look over the doctor's shoulder and threaten that doctor with 20 years in jail.

That is an outrageous Big Brother intrusion in the doctor-patient relationship. Nobody, not government, not religion, not politicians have the right to tell any individual how much pain they have to endure and how it has to be managed. That is my business and my doctor's business. It is not yours or yours or yours or anybody else's.

Does anybody really believe that today there is too much bias in medicine toward relieving pain? If they think that is the case, they have not been in many hospital rooms lately.

The fact is that today incentives are in the opposite direction to make doctors so careful that they often will err on the side of not enough pain relief. This bill would make that problem worse. That is why I am opposed to it, and that is why I support the amendment.

Mr. COBURN. Mr. Chairman, I seek time in opposition, and I yield to the gentleman from Florida (Mr. CANADY).

Mr. CANADY of Florida. Mr. Chairman, I thank the gentleman for yielding.

Mr. Chairman, I want to bring to the attention of the House why we are here today, and that is because the Attorney General of the United States has made a determination as the Attorney General that physician-assisted suicide is legitimate medical practice. That is what she decided.

Now, that was a break with tradition. That was a break with the policy of the Federal Government. She decided that. And we are here today, as the Congress, to express our view legislatively on whether she was right or wrong. I submit to the House that she was wrong and this House should not endorse the position of the Attorney General that physician-assisted suicide is legitimate medical practice.

That is the real issue before us here today. There has been a lot of things talked about, but I want to thank the gentlewoman from New Jersey (Mrs. ROUKEMA) for bringing out the fact that the Department of Justice has endorsed the provisions of this bill that deal with palliative care.

There have been many things said about those provisions, criticizing them and saying they are going to create additional problems. But the Department of Justice has written in a letter of October 19 that H.R. 2260 would eliminate any ambiguity about the legality of using controlled substances to alleviate the pain and suffering of the terminally ill by reducing any perceived threat of administrative and criminal sanctions in this context. The Department, accordingly, supports these portions of H.R. 2260 addressing palliative care.

This is a very important statement coming from the Department of Justice, and I think the Members should evaluate some of the attacks that have been made on this bill and look at what the Department of Justice, which does not support the overall bill, I hasten to add, they do not support provisions with respect to the effect on Oregon. That is very clear, as well. But palliative care they support.

I suggest that the Members ask themselves as they consider how they are going to vote on this whether we wanted to say that the Federal Government will support and encourage assisted suicide or are we going to authorize the use of controlled substances for the purpose of killing human beings?

It is the Federal Government that authorizes the use of controlled substances. We have a general prohibition on them. But we allow them to be utilized in certain circumstances. Is it going to be the position of this Federal Government that we will authorize them for the purpose of killing human beings? That is the issue that is before us here today, will we allow this well-established regulatory scheme governing controlled substances to be undermined in that way. It is my view that to allow it to be used in that way would be to undermine it.

Now remember, when a physician authorizes the use of a controlled substance, he has to take out a special prescription pad is my understanding, a prescription pad that is authorized by the DEA; and on that special controlled substance prescription pad, he is going to write out a prescription to kill somebody.

Now, do we want to put in place a mechanism where that sort of thing takes place? I do not think so. But we have got to decide today, are we going to go on record supporting the decision of the Attorney General that this is a legitimate medical practice, or are we going to say no?

Now, it is very interesting that each of the proponents of the bill say they are against physician-assisted suicide. Well, if they are against physician-assisted suicide, why do they want to allow a Federal regulatory scheme to be utilized in a way that supports and encourages it? Why do we want to authorize the use of federally controlled drugs for physician-assisted suicide if we are opposed to physician-assisted suicide? I think there is a fatal contradiction.

Mr. HYDE. Mr. Chairman, will the gentleman yield?

Mr. CANADY of Florida. I yield to the gentleman from Illinois.

Mr. HYDE. Mr. Chairman, I would like to ask the gentleman from Oklahoma (Mr. COBURN) a question.

Whenever he prescribes a controlled substance, does not the DEA review that prescription?

Mr. COBURN. Mr. Chairman, reclaiming my time, absolutely.

Mr. HYDE. Mr. Chairman, if the gentleman will continue to yield, now did my colleagues hear that? Every time he writes a prescription for a controlled substance, the DEA, that horrible gestapo, reviews the prescription and the purpose for it.

Now, therefore, the DEA has a role to play today as we speak in the existing law, and this bill does not change it. It just says to Oregon that they are back in with the rest of the 50 States now.

We do not create a gestapo. We simply say that what exists now will continue to exist, but they cannot use controlled substances to execute people, however directly or indirectly.

Mr. CANADY of Florida. Mr. Chairman, the gentleman from Illinois (Mr. HYDE) is absolutely correct.

The CHAIRMAN pro tempore. The question is on the motion offered by the gentleman from Wisconsin (Mr. OBEY).

The motion was rejected.

The CHAIRMAN pro tempore. The Chair would advise that both Members have 6½ minutes remaining in the debate.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield 1 minute to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Chairman, I thank my colleague for yielding.

Mr. Chairman, we should not support H.R. 2260 in its present form. As a physician, I rise in support of the substitute amendment offered by my colleagues, the gentlewoman from Connecticut (Mrs. JOHNSON), the gentleman from New Jersey (Mr. ROTHMAN), the gentlewoman from New York (Mrs. MALONEY), and the gentlewoman from Oregon (Ms. HOOLEY), which tries to lessen the damage that would be done by the underlying bill.

Mr. Chairman, one would believe that the proponents of this bill never have had someone close to them terminally ill, their body taken over by cancer and racked with pain. The only thing that families ask for at times like these is that the last days of their loved ones be as comfortable as possible. And the only thing that we as physicians can offer is palliative treatment or pain relief.

This is not assisted suicide. It is good and caring medical practice. What we need to be doing as a Congress, instead of preventing physicians from providing the care that a person needs, is to do precisely what the amendment asks us to do, allow us to practice our healing arts with compassion and also provide for research and training to expand our options for palliative care so that our loved ones can transition with dignity.

Mr. Chairman, this bill is misguided and it is one more attempt to interfere with the practice of good medicine. Let us pass this amendment. I would want my doctor to be able to provide needed pain relief if I were terminally ill, and so would my colleagues.

□ 1400

Mr. COBURN. Mr. Chairman, I yield 1 minute to the gentleman from Florida (Mr. WELDON).

Mr. WELDON of Florida. Mr. Chairman, I rise in opposition to the substitute. I would like to make it quite clear to all of my colleagues what the substitute does. Both bills have funding and authorization for more education for physicians so that they will more aggressively treat patients with pain. I think the gentlewoman from Connecticut one-ups the authors of the original bill. She has got $19 million in there and a website, et cetera. But she very strategically does not have the language that addresses what is going on in the State of Oregon, and I will again reiterate what I said earlier. When you hold out suicide as an option, it is a fraud. You can take care of these patients.

I practiced treating these people. I took care of them. In proper hands you can manage their pain. You can treat their depression. And to say that in some cases we cannot handle those things and therefore you have to allow them to commit suicide to me is a hoax.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield 1 minute to the gentleman from Oregon (Mr. WU).

Mr. WU. I thank the gentlewoman from Connecticut for yielding me this time.

Mr. Chairman, so much has been said in this debate already. I seek not to restate any of that. I ask my fellow Members of the House to do one thing and one thing only, and, that is, to read the Oregon statute before they vote. Please read the Oregon statute before you vote. There are dozens of protections in the statute. They should be fully informed about what they vote on today, because this body is about to substitute its judgment for the judgment of individuals in small rooms in my home State. Please read the statute before you vote.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield 1 minute to the gentlewoman from New York (Mrs. MALONEY).

Mrs. MALONEY of New York. Mr. Chairman, I rise in support of the bipartisan Johnson amendment. This debate today is not about squashing the Oregon law 3,000 miles away. It is about whether or not people can get appropriate pain relief in our own neighborhoods at home, our parents, our friends.

One of my constituents writes, ''After 5 years and one suicide attempt and my doctor saying he could not legally go any higher on my pain relief medication, I do not want to live anymore. I want to be productive and see my young girl grow up but I really feel I have been sentenced to death.''

I ask my colleagues to consider the lives of people who depend on appropriate pain medication to live. It is not our place or government's place to come between doctors and their patients and potentially criminalize their efforts to ease the suffering of those who need help, who need pain relief.

I urge all of my colleagues to vote for the Johnson substitute and against the base bill.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield 2 minutes to the gentleman from New Jersey (Mr. ROTHMAN).

Mr. ROTHMAN. Mr. Chairman, first let me correct my colleague and friend from New Jersey. On page 3 of the Justice Department's letter to the gentleman from Illinois (Mr. HYDE), they say specifically they oppose the portion of the bill with regards to the Oregon law. They are in favor of the palliative portion but oppose the Oregon portion. That is clear.

Now, let me read from the substitute: ''The purpose of the act is to enhance professional education in palliative care and reduce excessive regulatory scrutiny in order to mitigate the suffering, pain and desperation many sick and dying people face at the end of their lives in order to carry out the clear opposition of the Congress to physician-assisted suicide.''

That is the substitute. We are against physician-assisted suicide but we want to foster palliative care to the tens of millions of Americans suffering chronic, debilitating, horrible pain. Now, the doctors in this Chamber, Democrats and Republicans, are on both sides of this question. The doctors in the major organizations in the United States are on both sides of this question. Most of the nursing organizations are for the substitute. Why? Because they know that there is a chilling effect, a real one, on doctors in prescribing pain medication if the underlying bill is passed and we reject the substitute. If you are against the Oregon law, go to the Supreme Court and throw it out. But do not affect the ability of tens of millions of Americans to get the pain relief that they need. Vote for the substitute that says we are against physician-assisted suicide but we want doctors to be able to prescribe pain medicine to relieve the pain of people suffering horrible, debilitating pain in their last weeks and days of life.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield myself the balance of my time. I rise in strong support of my amendment and urge my colleagues to support it as well.

It is far more aggressive in developing the science of pain management and advancing physician knowledge of pain management and increasing patient expectation of pain management. That is why the National Foundation for the Treatment of Pain, the American Pain Foundation and many other organizations, including the American Academy of Family Physicians, the Society of Critical Care Medicine, the Emergency Room Physicians, the Hospice and Palliative Nurses Association and many others support my amendment. It is also why many State medical societies support this in spite of the AMA's stand.

Furthermore, it is very clear, according to the former counsel of the DEA office of the chief counsel, that under current DEA law and policy, physicians can prescribe controlled substances for pain management, but it is also true that this new bill contradicts the Department of Justice's and DEA's findings that the agency should defer to the medical community on appropriate standards for providing palliative care and that the PRPA would for the first time establish Federal criteria in statute to define ''legitimate medical purposes''. This is a departure from current law that would prevent deferring to State and medical standards and create a conflict with State medical guidelines as to the appropriate standard of medical care. It would create conflict with State law, conflict with State guidelines, conflict with the State agencies that have traditionally implemented this part of the DEA statute. It is a significant change in Federal statute, because for the first time it requires federal criteria as to what is ''legitimate medical purpose'' and requires DEA agents to judge the intent of a physician as he administers to a patient suffering acute pain during the concluding days of serious illness.

I urge support of the amendment.

Mr. COBURN. Mr. Chairman, I yield myself the balance of my time.

I think three points need to be made. There is well-intended thought in the substitute but there are a couple of factual errors. Number one, we would not be here if the Attorney General had not said that physician-assisted suicide is the legitimate practice of medicine. It is not. That is number one.

Number two is the rules and regulations that the Oregon law put up were good. They are intended to make sure the wrong things do not happen, to make sure that if in fact somebody helps somebody die, that they did that when they are not depressed, when they are not coerced, when they are not in a position. But we already have this experiment that has been carried out for us in Holland. They have the exact same rules.

I want to quote to Members the testimony before the Committee on Commerce. There is a substantial practice of euthanasia now, primarily voluntarily, but definitely also not voluntarily. Even 5 years after the regulations were established, the majority of cases of euthanasia and physician-assisted suicide and almost all cases of nonvoluntary euthanasia are not reported, making effective control by the legal authorities impossible in Holland.

In fact, the first publicly reported case of assisted suicide in the State of Oregon involved an out-of-State woman who was found to be depressed by one doctor that she consulted. Within 3 weeks of contacting Compassion in Dying and moving to Oregon, she was dead by lethal overdose. Significantly, while two doctors rendered opinions against the assisted suicide, including a physician who believed the woman was suffering from clinical depression, these opinions were not included in the Oregon Health Division Report of the law's first year after enactment.

So we can be well-intentioned. We can try to design it, but the fact is there are holes. And the very first case in Oregon slipped through the cracks.

Let me read to Members about what we are going to see in the future, and I am not saying this is happening in Oregon today but this is where we are going:

''Thanks to another 'prosecution' of a doctor who euthanized an infant, euthanasia, already practiced on adults in the Netherlands, will soon openly enter the pediatric ward. Dr. Henk Prins killed a 3-day-old girl who was born with spina bifida, leg deformities and hydrocephaly, which all babies who have spina bifida have. The doctor, a gynecologist, not a pediatrician or medical expert in such cases, although experts were consulted, was defended. He testified in the trial court that he killed the child with her parents' permission because of the infant's poor prognosis.''

I am not saying that is going on right now. And I understand and believe the people in opposition to this base bill that they do not believe in physician-assisted suicide. But I beg you to open your eyes to see where we are going. When abortion was first made legal in this country, it was to prevent back alley abortions. The number one reason for abortion today is birth control. That was not the intended purpose when we said we should allow medical abortions. But where are we? Just 50 million babies that are not here for birth control. The lazy birth control. Have an abortion.

So think about what can come out of this. There are legitimate options in the substitute as far as enhancing the treatment of pain control. There is no question. But the fact is this bill will protect physicians. My own experience tells me that. My own gut tells me that. But most importantly we will not violate the State right of Oregon. If Oregon wants to kill somebody not using a Federally controlled drug, they have every right to do it. But what we are saying is, if you are going to use a Federally controlled product, you do not have that right.

The CHAIRMAN pro tempore (Mr. NEY). The question is on the amendment in the nature of a substitute offered by the gentlewoman from Connecticut (Mrs. JOHNSON).

The question was taken; and the Chairman pro tempore announced that the noes appeared to have it.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I demand a recorded vote.

The CHAIRMAN pro tempore. Pursuant to House Resolution 339, further proceedings on the amendment in the nature of a substitute offered by the gentlewoman from Connecticut (Mrs. JOHNSON) will be postponed.

SEQUENTIAL VOTES POSTPONED IN COMMITTEE OF THE WHOLE

The CHAIRMAN pro tempore. Pursuant to House Resolution 339, proceedings will now resume on those amendments on which further proceedings were postponed in the following order: amendment No. 1 offered by the gentleman from Virginia (Mr. SCOTT); amendment No. 2 in the nature of a substitute offered by the gentlewoman from Connecticut (Mrs. JOHNSON).

The Chair will reduce to 5 minutes the time for any electronic vote after the first vote in this series.

AMENDMENT NO. 1 OFFERED BY MR. SCOTT

The CHAIRMAN pro tempore. The pending business is the demand for a recorded vote on the amendment offered by the gentleman from Virginia (Mr. SCOTT) on which further proceedings were postponed and on which the noes prevailed by voice vote.

The Clerk will redesignate the amendment.

The Clerk redesignated the amendment.

RECORDED VOTE

The CHAIRMAN pro tempore. A recorded vote has been demanded.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 160, noes 268, not voting 5, as follows:

[Roll No. 542]

AYES—160

Abercrombie
Ackerman
Allen
Andrews
Baird
Baldacci
Baldwin
Barrett (WI)
Becerra
Berkley
Berman
Bishop
Blagojevich
Blumenauer
Bonior
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Campbell
Capps
Capuano
Cardin
Carson
Castle
Chenoweth-Hage
Clay
Clayton
Clyburn
Conyers
Coyne
Crowley
Cummings
Davis (IL)
DeFazio
DeGette
DeLauro
Deutsch
Dicks
Dixon
Doggett
Dooley
Engel
Eshoo
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gejdenson
Gephardt
Gilman
Gonzalez
Greenwood
Gutierrez
Hastings (FL)
Hilliard
Hinchey
Holt
Hooley
Horn
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson (CT)
Johnson, E.B.
Jones (OH)
Kaptur
Kennedy
Kilpatrick
Kind (WI)
Kolbe
Lampson
Lantos
Larson
Lee
Levin
Lewis (GA)
Lofgren
Lowey
Luther
Maloney (NY)
Markey
Matsui
McCarthy (MO)
McDermott
McGovern
McKinney
Meehan
Meek (FL)
Meeks (NY)
Menendez
Metcalf
Millender-McDonald
Miller, George
Minge
Mink
Moore
Moran (VA)
Morella
Nadler
Napolitano
Obey
Olver
Owens
Pallone
Pastor
Paul
Payne
Pelosi
Pickett
Porter
Rangel
Reyes
Rivers
Rodriguez
Rohrabacher
Rothman
Roybal-Allard
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Scott
Serrano
Shays
Sherman
Slaughter
Smith (WA)
Snyder
Stabenow
Stark
Tanner
Tauscher
Thompson (CA)
Thompson (MS)
Thurman
Tierney
Towns
Udall (CO)
Udall (NM)
Velazquez
Vento
Visclosky
Walden
Waters
Watt (NC)
Waxman
Weiner
Wexler
Wise
Woolsey
Wu
Wynn

NOES—268

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barcia
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bentsen
Bereuter
Berry
Biggert
Bilbray
Bilirakis
Bliley
Blunt
Boehlert
Boehner
Bonilla
Bono
Borski
Boswell
Brady (TX)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cannon
Chabot
Chambliss
Clement
Coble
Coburn
Collins
Combest
Condit
Cook
Cooksey
Costello
Cox
Cramer
Crane
Cubin
Cunningham
Danner
Davis (FL)
Davis (VA)
Deal
DeLay
DeMint
Diaz-Balart
Dickey
Dingell
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Ehrlich
Emerson
English
Etheridge
Everett
Ewing
Fletcher
Foley
Forbes
Fossella
Fowler
Franks (NJ)
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Goode
Goodlatte
Goodling
Gordon
Goss
Graham
Granger
Green (TX)
Green (WI)
Gutknecht
Hall (OH)
Hall (TX)
Hansen
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (IN)
Hill (MT)
Hilleary
Hobson
Hoeffel
Hoekstra
Holden
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Isakson

Istook
Jenkins
John
Johnson, Sam
Jones (NC)
Kanjorski
Kasich
Kelly
Kildee
King (NY)
Kingston
Kleczka
Klink
Knollenberg
Kucinich
Kuykendall
LaFalce
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lucas (KY)
Lucas (OK)
Maloney (CT)
Manzullo
Martinez
McCarthy (NY)
McCollum
McCrery
McHugh
McInnis
McIntosh
McIntyre
McKeon
McNulty
Mica
Miller (FL)
Miller, Gary
Moakley
Mollohan
Moran (KS)
Murtha
Myrick
Neal
Nethercutt
Ney
Northup
Norwood
Nussle
Oberstar
Ortiz
Ose
Oxley
Packard
Pascrell
Pease
Peterson (MN)
Peterson (PA)
Petri
Phelps
Pickering
Pitts
Pombo
Pomeroy
Portman
Price (NC)
Pryce (OH)
Quinn
Radanovich
Rahall
Ramstad
Regula
Reynolds
Riley
Roemer
Rogan
Rogers
Ros-Lehtinen
Roukema
Royce
Ryan (WI)
Ryun (KS)
Salmon
Sanford
Saxton
Schaffer
Schakowsky
Sensenbrenner
Sessions
Shadegg
Shaw
Sherwood
Shimkus
Shows
Shuster
Simpson
Sisisky
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Spence
Spratt
Stearns
Stenholm
Strickland
Stump
Stupak
Sununu
Sweeney
Talent
Tancredo
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Toomey
Traficant
Turner
Upton
Vitter
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Weygand
Whitfield
Wicker
Wilson
Wolf
Young (AK)
Young (FL)

NOT VOTING—5

Delahunt
Hinojosa
Mascara
Rush
Scarborough

□ 1437

Messrs. TANCREDO, PASCRELL, MARTINEZ, BENTSEN, HALL of Texas, BILBRAY, OBERSTAR and Ms. PRYCE of Ohio changed their vote from ''aye'' to ''no.''

Mr. WISE, Mr. BOYD, Ms. JACKSON-LEE of Texas and Ms. SLAUGHTER changed their vote from ''no'' to ''aye.''

So the amendment was rejected.

The result of the vote was announced as above recorded.

ANNOUNCEMENT BY THE CHAIRMAN PRO TEMPORE

The CHAIRMAN pro tempore (Mr. NEY). Pursuant to House Resolution 339, the Chair announces that he will reduce to a minimum of 5 minutes the period of time within which a vote by electronic device will be taken on the additional amendment on which the Chair has postponed further proceedings.

AMENDMENT NO. 2 IN THE NATURE OF A SUBSTITUTE OFFERED BY MRS. JOHNSON OF CONNECTICUT

The CHAIRMAN pro tempore. The pending business is the demand for a recorded vote on Amendment No. 2 in the nature of a substitute offered by the gentlewoman from Connecticut (Mrs. JOHNSON) on which further proceedings were postponed and on which the noes prevailed by voice vote.

The Clerk will redesignate the amendment.

The Clerk redesignated the amendment.

RECORDED VOTE

The CHAIRMAN pro tempore. A recorded vote has been demanded.

A recorded vote was ordered.

The CHAIRMAN pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 188, noes 239, not voting 6, as follows:

[Roll No. 543]

AYES—188

Abercrombie
Ackerman
Allen
Andrews
Baird
Baldacci
Baldwin
Barrett (WI)
Bass
Becerra
Bentsen
Berkley
Berman
Biggert
Bishop
Blagojevich
Blumenauer
Boehlert
Bonior
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Campbell
Capps
Capuano
Cardin
Carson
Castle
Clay
Clayton
Clyburn
Condit
Conyers
Cooksey
Coyne
Cramer
Crowley
Cummings
Davis (IL)
Davis (VA)
DeFazio
DeGette
DeLauro
Deutsch
Dicks
Dixon
Doggett
Dooley
Edwards
Ehrlich
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frelinghuysen
Frost
Gejdenson
Gephardt
Gilchrest
Gilman
Gonzalez
Gordon
Green (TX)
Greenwood
Gutierrez
Hastings (FL)
Hilliard
Hinchey
Holt
Hooley
Horn
Houghton
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson (CT)
Johnson, E. B.
Jones (OH)
Kaptur
Kennedy
Kilpatrick
Kind (WI)
Kolbe
Kuykendall
Lampson
Lantos
Larson
Lee
Levin
Lewis (GA)
Lofgren
Lowey
Luther
Maloney (CT)
Maloney (NY)
Markey
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McKinney
Meehan
Meek (FL)
Meeks (NY)
Menendez
Metcalf
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Moore
Moran (VA)
Morella
Nadler
Napolitano
Neal
Obey
Olver
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Porter
Price (NC)
Rangel
Reyes
Rivers
Rodriguez
Rohrabacher
Rothman
Roybal-Allard
Sabo
Sanchez
Sanders
Sandlin
Sanford
Sawyer
Scott
Serrano
Shaw
Shays
Sherman
Shuster
Sisisky
Slaughter
Smith (WA)
Snyder
Spratt
Stabenow
Stark
Strickland
Tanner
Tauscher
Thomas
Thompson (CA)
Thompson (MS)
Thurman
Tierney
Towns
Udall (CO)
Udall (NM)
Velazquez
Vento
Visclosky
Walden
Waters
Watt (NC)
Waxman
Weiner
Wexler
Wise
Woolsey
Wu
Wynn

NOES—239

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barcia
Barr
Barrett (NE)
Bartlett
Barton
Bateman
Bereuter
Berry
Bilbray
Bilirakis
Bliley
Blunt
Boehner
Bonilla
Bono
Borski
Boswell
Brady (TX)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cannon
Chabot
Chambliss
Chenoweth-Hage
Clement
Coble
Coburn
Collins
Combest
Cook
Costello
Cox
Crane
Cubin
Cunningham
Danner
Davis (FL)
Deal
DeLay
DeMint
Diaz-Balart
Dickey
Dingell
Doolittle
Doyle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Ewing
Fletcher
Foley
Forbes
Fossella
Fowler
Franks (NJ)
Gallegly
Ganske
Gekas
Gibbons
Gillmor
Goode
Goodlatte
Goodling
Goss
Graham
Granger
Green (WI)
Gutknecht
Hall (OH)
Hall (TX)
Hansen
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (IN)
Hill (MT)
Hilleary
Hobson
Hoeffel
Hoekstra
Holden
Hostettler
Hulshof
Hunter
Hutchinson
Hyde
Isakson
Istook
Jenkins
John
Johnson, Sam
Jones (NC)
Kanjorski
Kasich
Kelly
Kildee
King (NY)
Kingston
Kleczka
Klink
Knollenberg
Kucinich
LaFalce
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
Martinez
McCollum
McCrery
McHugh
McInnis
McIntosh
McIntyre
McKeon
McNulty
Mica
Miller (FL)
Miller, Gary
Mollohan
Moran (KS)
Murtha
Myrick
Nethercutt
Ney
Northup
Norwood
Nussle
Oberstar
Ortiz
Ose
Oxley
Packard
Pease
Peterson (MN)
Peterson (PA)
Petri
Phelps
Pickett
Pitts
Pombo
Pomeroy
Portman
Pryce (OH)
Quinn
Radanovich
Rahall
Ramstad
Regula
Reynolds
Riley
Roemer
Rogan
Rogers
Ros-Lehtinen
Roukema
Royce
Ryan (WI)
Ryun (KS)
Salmon
Saxton
Schaffer
Schakowsky
Sensenbrenner
Sessions
Shadegg
Sherwood
Shimkus
Shows
Simpson
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Spence
Stearns
Stenholm
Stump
Stupak
Sununu
Sweeney
Talent
Tancredo
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thornberry
Thune
Tiahrt
Toomey
Traficant
Turner
Upton
Vitter
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Weygand
Whitfield
Wicker
Wilson
Wolf
Young (AK)
Young (FL)

NOT VOTING—6

Delahunt
Hinojosa
Mascara
Pickering
Rush
Scarborough

□ 1449

Mr. HAYWORTH changed his vote from ''aye'' to ''no.''

So the amendment in the nature of a substitute was rejected.

The result of the vote is announced as above recorded.

Stated against:

Mr. PICKERING. Mr. Chairman, on rollcall No. 543, I was unavoidably detained. Had I been present, I would have voted ''No.''

The CHAIRMAN pro tempore (Mr. NEY). The question is on the committee amendment in the nature of a substitute.

The committee amendment in the nature of a substitute was agreed to.

The CHAIRMAN pro tempore. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. HOBSON) having assumed the chair, Mr. NEY, Chairman pro tempore of the

Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration 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, pursuant to House Resolution 339, he reported the bill back to the House with an amendment adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

The question is on the committee amendment in the nature of a substitute.

The committee amendment in the nature of a substitute was agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. BLUMENAUER

Mr. BLUMENAUER. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. BLUMENAUER. In its present form, Mr. Speaker, I am.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. BLUMENAUER moves to recommit the bill H.R. 2260 to the Committee on Commerce with instructions to report the same back to the House forthwith with the following amendment:

Page 3, line 25, before the period insert '', except a law adopted or confirmed through a State citizen initiative or referendum''.

Add at the end of title I the following:

**SEC. 103. EXCLUSION OF CRIMINAL LIABILITY.**

No person shall be held criminally liable for any violation of law based on the effect of the amendments made by section 101.

Mr. BLUMENAUER. Mr. Speaker, this motion to recommit is offered on behalf of myself, the gentleman from Oregon (Mr. WU), the gentleman from Oregon (Mr. DEFAZIO), and the gentlewoman from Oregon (Ms. HOOLEY).

The supporters of this legislation have every right to attempt to ban assisted suicide or to promote the pain management in this country. Unfortunately, the legislation that we have been offered today is the worst of both worlds. It does not just trample on States rights, but it most assuredly does so, effectively overturning legislation that has been approved, not just once, but twice by the citizens of Oregon.

In addition, the physicians that I represent in Oregon tell me that, regardless of their position on physician-assisted suicide, it will make it much, much harder to manage pain, allowing additional second-guessing of their professional judgments as they seek to meet the needs of their patients.

I sincerely believe that virtually nobody outside this Beltway wants to criminalize doctor-patient decisions of this most sensitive manner. Tough decisions are made every day in hospitals all across the country, withdrawing life support, and sometimes, in instances, withdrawing drugs that can, in fact, hasten death.

There are some tragic cases that involve actual suicide. Outside of Oregon, people are often driven to desperate acts alone, seeking to insulate their families from the trauma.

We have heard repeatedly in the course of this discussion that pain management is a serious problem around the country. But most often in this country, as these decisions are made in quiet, most of America looks the other way and ignores the difficulty and the trauma. The citizens of Oregon have taken a difficult decision to help deal with these end-of-life questions, providing the only framework in the United States.

Those of us who listened to the debate on the floor of this assembly heard very eloquent statements by my colleagues about how they arrived as individual citizens in making the decision to vote on that measure themselves, the eloquence of the gentleman from Oregon (Mr. WALDEN) from Hood River talking about very personal instances that affected his family.

Twice Oregonians have decided this is the way they want to go. Despite all the rhetoric about opening the flood gates for physician-assisted suicide, such has not been the case. There are only 15 cases last year in Oregon, and in fact the research suggests and common sense would reinforce that when we give people, their families, and their physicians control over the situation, they are less likely to take desperate and unfortunate action.

The ironic approach that is taken by the supporters of this legislation may actually lead to an increase, if they are successful, in suicide in my State but without the framework.

Mr. Speaker, I strongly urge that Members of this assembly move this bill back to committee to strip away the provisions that would criminalize the decisions that are made by physicians exercising their professional judgment on how best to meet the needs and wishes of their patients and the patients' families, and that we would exempt States which have, by a vote of their citizens, squarely addressed this issue.

Mr. Speaker, I yield the balance of my time to the gentlewoman from Oregon (Ms. HOOLEY).

Ms. HOOLEY of Oregon. Mr. Speaker, I ask for my colleagues' recommittal of this bill. What I have heard around this place today are a lot of people talking about this group supports it, that group does not support it. What we are talking about are real people in every one of our districts.

If that doctor feels a threat of law enforcement, the DEA looking over their shoulder, will they give one's friend, one's neighbor, one's son or daughter, one's wife, one's husband, will they give them adequate pain medication? That is what it is about. It is about whether or not we are going to let people that we care about suffer. Please recommit.

The SPEAKER pro tempore. For what purpose does the gentleman from Oklahoma (Mr. COBURN) rise?

Mr. COBURN. Mr. Speaker, I rise in opposition to the motion to recommit.

The SPEAKER pro tempore. The gentleman from Oklahoma (Mr. COBURN) is recognized for 5 minutes.

Mr. COBURN. Mr. Speaker, this is a difficult issue. End of life issues always are. What the people of Oregon have done, they have every right to do as long as they follow the laws of the United States that do not supersede that.

The fact is, this bill will not keep Oregon from having physician-assisted suicide. What it says is they just cannot use federally controlled drugs to do that.

Now, how did we get where we are? The Attorney General of the United States decided that physician assisted-suicide as far as Oregon's law is concerned is a legitimate practice of medicine.

□ 1500

I am here to tell my colleagues that that is not a legitimate practice of medicine. Matter of fact, even Oregon put great safeguards into their bills to make sure that mistakes were not made. Let me read to my colleagues what happened with one of the first cases.

The first publicly reported case of assisted suicide in Oregon involved an out-of-state woman who was found to be clinically depressed by her doctor. Within 3 weeks of contacting the Compassion in Dying and moving to Oregon, she was dead by lethal overdose. Significantly, two other doctors had rendered opinions against the assisted suicide, including a physician who believed the woman was suffering from a clinical depression. These opinions were not included in the Oregon Health Division report in the law's first year.

The fact is with this motion to recommit what we will be saying, if we follow it in its essence, is that it is okay for a doctor in Oregon to use federally controlled substances to kill a patient, but it is not okay to harm them. So what we will see is, if they harm someone, they are going to be held liable; but if they kill somebody, they will not.

I would put forth to the body of the House that we have a wonderful example of what happens when a group of people follow this logic, and all we have to do is look at Holland. Last year in Holland, a very small country, 80 babies were euthanized by their gynecologists. Now, I know Oregon does not allow euthanasia of babies, but neither did Holland when they first started. The vast majority of people, well over 2,000 people in Holland, were

euthanized against their choice. What is in the testimony is the fact that they are incapable in Holland of knowing how many people were euthanized against their will.

I would ask the Members of this body to throw off the false argument that we are having the DEA look over the shoulder of doctors. In fact, the opposite is true. We have created a safe harbor for doctors that says if their intent is to eliminate pain, then they are held without liability. We also had charts presented and facts presented that showed that in every State that had put in a common-sense approach like this, the use of pain controlled medicines, morphine, has dramatically risen in helping those who are in the pains of dying with manageable pain. And, in fact, we are now moving as a Nation to manage that pain.

I reject this motion to recommit, and I ask the House to support that position.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. HOBSON). Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The motion to recommit was rejected.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. CANADY of Florida. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 271, noes 156, not voting 6, as follows:

[Roll No. 544]

AYES—271

Aderholt
Andrews
Archer
Armey
Bachus
Baker
Baldacci
Ballenger
Barcia
Barr
Barrett (NE)
Bartlett
Barton
Bateman
Bereuter
Berry
Bilbray
Bilirakis
Bishop
Bliley
Blunt
Boehlert
Boehner
Bonilla
Bono
Borski
Boswell
Brady (PA)
Brady (TX)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cannon
Chabot
Chambliss
Chenoweth-Hage
Clement
Coble
Coburn
Collins
Combest
Cook
Costello
Cox
Cramer
Crane
Crowley
Cubin
Cunningham
Danner
Davis (FL)
Davis (VA)
Deal
DeLay
DeMint
Diaz-Balart
Dickey
Doolittle
Doyle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Etheridge
Everett
Ewing
Fletcher
Foley
Forbes
Fossella
Fowler
Franks (NJ)
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gillmor
Gilman
Goode
Goodlatte
Goodling
Gordon
Goss
Graham
Granger
Green (TX)
Green (WI)
Greenwood
Gutknecht
Hall (OH)
Hall (TX)
Hansen
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (IN)
Hill (MT)
Hilleary
Hobson
Hoeffel
Hoekstra
Holden
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hutchinson
Hyde
Isakson
Istook
Jefferson
Jenkins
John
Johnson, Sam
Jones (NC)
Kanjorski
Kasich
Kelly
Kildee
King (NY)
Kingston
Kleczka
Klink
Knollenberg
Kucinich
Kuykendall
LaFalce
LaHood
Lampson
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lucas (KY)
Lucas (OK)
Maloney (CT)
Manzullo
Martinez
McCarthy (NY)
McCollum
McCrery
McHugh
McInnis
McIntosh
McIntyre
McKeon
McNulty
Mica
Miller (FL)
Miller, Gary
Moakley
Mollohan
Moore
Moran (KS)
Murtha
Myrick
Neal
Nethercutt
Ney
Northup
Norwood
Nussle
Oberstar
Ortiz
Ose
Oxley
Packard
Pascrell
Pease
Peterson (MN)
Peterson (PA)
Petri
Phelps
Pickering
Pitts
Pombo
Pomeroy
Portman
Pryce (OH)
Quinn
Radanovich
Rahall
Ramstad
Regula
Reyes
Reynolds
Riley
Roemer
Rogan
Rogers
Ros-Lehtinen
Roukema
Royce
Ryan (WI)
Ryun (KS)
Salmon
Saxton
Schaffer
Schakowsky
Sensenbrenner
Sessions
Shadegg
Shaw
Sherwood
Shimkus
Shows
Simpson
Sisisky
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Spence
Spratt
Stearns
Stenholm
Strickland
Stupak
Sununu
Sweeney
Talent
Tancredo
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Toomey
Traficant
Turner
Upton
Visclosky
Vitter
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Weygand
Whitfield
Wicker
Wilson
Wise
Wolf
Wynn
Young (AK)
Young (FL)

NOES—156

Abercrombie
Ackerman
Allen
Baird
Baldwin
Barrett (WI)
Bass
Becerra
Bentsen
Berkley
Berman
Biggert
Blagojevich
Blumenauer
Bonior
Boucher
Boyd
Brown (FL)
Brown (OH)
Campbell
Capps
Capuano
Cardin
Carson
Castle
Clay
Clayton
Clyburn
Condit
Conyers
Cooksey
Coyne
Cummings
Davis (IL)
DeFazio
DeGette
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Edwards
Ehrlich
Engel
Eshoo
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gejdenson
Gephardt
Gilchrest
Gonzalez
Gutierrez
Hastings (FL)
Hilliard
Hinchey
Holt
Hooley
Horn
Inslee
Jackson (IL)
Jackson-Lee (TX)
Johnson (CT)
Johnson, E. B.
Jones (OH)
Kaptur
Kilpatrick
Kind (WI)
Kolbe
Lantos
Larson
Lee
Levin
Lewis (GA)
Lofgren
Lowey
Luther
Maloney (NY)
Markey
Matsui
McCarthy (MO)
McDermott
McGovern
McKinney
Meehan
Meek (FL)
Meeks (NY)
Menendez
Metcalf
Millender-McDonald
Miller, George
Minge
Mink
Moran (VA)
Morella
Nadler
Napolitano
Obey
Olver
Owens
Pallone
Pastor
Paul
Payne
Pelosi
Pickett
Porter
Price (NC)
Rangel
Rivers
Rodriguez
Rohrabacher
Rothman
Roybal-Allard
Sabo
Sanchez
Sanders
Sandlin
Sanford
Sawyer
Scott
Serrano
Shays
Sherman
Shuster
Slaughter
Smith (WA)
Snyder
Stabenow
Stark
Stump
Tanner
Tauscher
Thompson (CA)
Thompson (MS)
Thurman
Tierney
Towns
Udall (CO)
Udall (NM)
Velazquez
Vento
Walden
Waters
Watt (NC)
Waxman
Weiner
Wexler
Woolsey
Wu

NOT VOTING—6

Delahunt
Hinojosa
Kennedy
Mascara
Rush
Scarborough

□ 1519

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

## OFFERING CONDOLENCES TO FAMILIES OF VICTIMS AND PEOPLE OF ARMENIA

(Mr. GILMAN asked and was given permission to address the House for 1 minute.)

Mr. GILMAN. Mr. Speaker, we were appalled to learn earlier today of the assassination of Armenia's Prime Minister Sarkisian and several other high officials in the Armenian Government. It is tragic that this form of political violence has intruded upon the democratic path to which the Armenian people have committed themselves.

It is our hope and prayer that the people of Armenia not allow this kind of despicable terrorism to deter them from pursuing their democratic ideals and the institutions that provide for a free society.

Armenia has been a good friend of our Nation, and America stands ready to continue to provide the assistance needed to our friends to help them overcome this tragedy. It is our profoundest hope that Armenia will speedily recover from this violence and resume the practices that have provided its people the full measure of political freedom and opportunity.

I want to offer our condolences on behalf of the Congress to the families of the victims and to the people of Armenia.

## SPECIAL ORDERS

The SPEAKER pro tempore (Mr. NEY). Under the Speaker's announced policy of January 6, 1999, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

## TRAGIC EVENTS IN ARMENIA

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New Jersey (Mr. PALLONE) is recognized for 5 minutes.

Mr. PALLONE. Mr. Speaker, it is with profound sadness that I rise today to indicate to my colleagues and the American people the tragic events that