106TH CONGRESS, 1st Session | HOUSE OF REPRESENTATIVES | REPT. 106–378 Part 2

PAIN RELIEF PROMOTION ACT OF 1999

OCTOBER 18, 1999.—Ordered to be printed

Mr. BLILEY, from the Committee on Commerce, submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 2260]

[Including cost estimate of the Congressional Budget Office]

The Committee on Commerce, to whom was referred 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, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

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AMENDMENT

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 4, strike line 21 and all that follows through page 5, line 2, and insert the following:

"(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.".

Page 7, strike line 9 and all that follows through line 14 and insert the following:

"(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.".

The following shows the text of the bill as reported:

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.

PURPOSE AND SUMMARY

H.R. 2260, the Pain Relief Promotion Act of 1999 (PRPA) amends the Controlled Substances Act (21 U.S.C. 801, CSA) to promote pain management and palliative care without permitting assisted suicide and euthanasia. The bill provides that the use of controlled substances for alleviating pain and discomfort is a legitimate medical purpose, even where the use of these drugs may have the effect of increasing the risk of death. The bill also clarifies the standard that the use of controlled substances with the intent of assisting in a suicide is not authorized by the Controlled Substances Act and provides that the Attorney General, in implementing the Act, must employ a uniform standard in enforcement of the Act, without regard to State law permitting assisted suicide or euthanasia. PRPA also authorizes an increase in the existing authorization of Health Resources and Services Administration (HRSA) grants for education and training of health care professionals, and creates a new Agency for Health Care Policy and Research (AHCPR) research program aimed at improving the quality of care for patients suffering from chronic or end-of-life pain.

BACKGROUND AND NEED FOR LEGISLATION

Two critical events have led to the call for legislation addressing palliative care and assisted suicide. First, on October 27, 1997, Oregon became the first and only State to legalize physician assisted suicide by lethal doses of controlled substances. Second, the Attorney General of the United States ruled on June 5, 1998, that such usage is now part of the ordinary practice of medicine in Oregon and, therefore, exempt from the Controlled Substances Act of 1970 and Drug Enforcement Agency (DEA) jurisdiction.

On April 30, 1997, after a vote of 398–16 in the House and a unanimous vote in the Senate, the President signed the Assisted Suicide Funding Restriction Act of 1997 (Public Law 105–12), which prohibited the use of Federal funds to cause a patient's death. The President, in signing the bill, said it "will allow the Federal Government to speak with a clear voice in opposing these practices," and warned that "to endorse assisted suicide would set us on a disturbing and perhaps dangerous path."

In a letter responding to the inquiry of Judiciary Committee Chairman Henry J. Hyde, dated November 5, 1997, the Administrator of the DEA, Thomas K. Constantine, made a determination that physician assisted suicide with the use of Federally controlled substances violates the CSA. Under the DEA ruling, doctors given the special Federal license under the CSA to prescribe Federally controlled substances could not prescribe them for the purpose of assisting in a suicide. Constantine agreed with the sentiment of many Members of Congress that administering a drug to deliberately cause someone to die is not a "legitimate medical purpose" within the meaning of the Controlled Substances Act.

However, in a letter dated June 5, 1998, Attorney General Janet Reno made a determination that, contrary to Mr. Constantine's position, physician assisted suicide falls within the course of professional practice in those States that have legalized assisted suicide. Under the Attorney General's ruling, the Federal CSA is enforceable against the use of controlled substances for assisted suicide only to the extent that States have not authorized assisted suicide. Thus, while Federal law forbids the use of Federal funds for assisted suicide without regard to whether States legalize this practice, critics charged that this ruling rendered Federal law and policy on assisted suicide subordinate to and a mere function of State law and policy.

The CSA provides a uniform national standard for the control of potentially dangerous drugs, and a system of enforcement and penalties. Because some of these drugs can help alleviate pain and treat illness or injury when dispensed under strictly controlled conditions, physicians and pharmacists may apply to the DEA for a special Federal license to administer them. Thus, while physicians receive their licenses to practice medicine from State medical boards, they receive this separate DEA registration to prescribe controlled substances from the Federal DEA. The DEA registration allows them to prescribe these Federally controlled drugs for "legitimate medical purposes." Under the current statutory scheme of the CSA, physicians must be prepared to explain to DEA officials their use of these drugs, and they lose their registration and even risk criminal penalties if they prescribe such drugs for any purpose other than a "legitimate medical purpose."

HEARINGS

The Committee on Commerce has not held hearings on the legislation.

COMMITTEE CONSIDERATION

On October 13, 1999, the Full Committee met in open markup session and proceeded to the immediate consideration of H.R. 2260 without objection. The Full Committee ordered H.R. 2260 reported to the House, amended, by a voice vote, a quorum being present.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House requires the Committee to list the record votes on the motion to report legislation and amendments thereto. There were no record votes taken in connection with ordering H.R. 2260 reported. An amendment by Mr. Greenwood to strike all after the enacting clause and insert in lieu thereof the text of H.R. 2188, the Conquering Pain Act of 1999, was withdrawn by unanimous consent. An amendment by Mr. Stupak to expand the definition of "palliative care" to include medical conditions other than end-of-life was agreed to by a voice vote. A motion by Mr. Bliley to order H.R. 2260 reported to the House, amended, was agreed to by a voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee has not held oversight or legislative hearings on this legislation.

COMMITTEE ON GOVERNMENT REFORM OVERSIGHT FINDINGS

Pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 2260, the Pain Relief Promotion Act of 1999, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 18, 1999.

Hon. TOM BLILEY,
Chairman, Committee on Commerce, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office (CBO) has prepared the enclosed cost estimate for H.R. 2260, the Pain Relief Promotion Act of 1999.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Mark Grabowicz (for effects on spending by the Department of Justice), Cyndi Dudzinski (for costs to the Health Resources and Services Administration), Jeanne De Sa (for costs to the Agency for Health Care Policy and Research), Lisa Cash Driskill (for the state and local impact), and John Harris (for the private-sector impact).

Sincerely,

BARRY B. ANDERSON
(For Dan L. Crippen, Director).

Enclosure.

H.R. 2260—Pain Relief Promotion Act of 1999

Summary: H.R. 2260 would increase an existing authorization of appropriations to the Health Resources and Services Administration (HRSA) for the purpose of making grants to public and private entities to educate and train health care professionals in palliative care. The bill also would direct the Agency for Health Care Policy and Research (AHCPR) to develop a program to improve palliative care, and would prohibit the use of controlled substances for assisted suicide or euthanasia, regardless of any state law authorizing such activity.

Assuming appropriation of the necessary amounts, CBO estimates that implementing H.R. 2260 would result in additional discretionary spending of about $24 million over the 2000–2004 period. Enacting this legislation could affect direct spending and receipts, so pay-as-you-go procedures would apply; however, CBO estimates that the amounts involved would be less than $500,000 a year.

H.R. 2260 contains both an intergovernmental and a private-sector mandate as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that the bill would result in no costs to state, local, or tribal governments, so the threshold established in UMRA ($50 million in 1996, adjusted annually for inflation) would not be exceeded. CBO also estimates that the costs of the private-sector mandate would fall below the threshold established in UMRA ($100 million in 1996, adjusted for inflation).

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 2260 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal years, in millions of dollars—				
	2000	2001	2002	2003	2004
CHANGES IN SPENDING SUBJECT TO APPROPRIATION					
Estimated Authorization Level	7	7	7	2	2
Estimated Outlays	3	6	7	5	3

Basis of estimate: For the purposes of this estimate, CBO assumes that the bill will be enacted early in fiscal year 2000, that the necessary amounts will be provided for each year, and that outlays will follow historical spending rates for these activities.

Spending subject to appropriation

The estimated change in spending subject to appropriation has two components: (1) an increase in the existing authorization of HRSA grants for education and training of health care professionals, and (2) a new AHCPR research program aimed at improving the quality of care for terminally ill patients.

The existing HRSA grant program received an appropriation of $21 million for fiscal year 1999 (a full-year appropriation for fiscal year 2000 has not yet been enacted). This program is part of a larger HRSA activity which has a current authorization of such sums as necessary through fiscal year 2002. H.R. 2260 would increase the existing target level of $23 million a year (within that "such sums" authorization) by $5 million. The agency would use the additional funds to award grants to public and private entities to de-

velop, implement, and evaluate education and training programs in palliative care.

H.R. 2260 would direct AHCPR to develop a research program to improve palliative care, mainly through the collection and dissemination of guidelines for providing such care. CBO estimates that implementing this provision would cost about $1 million in fiscal year 2000 and $2 million annually thereafter, assuming the appropriation of the necessary amounts. (The agency received an appropriation of $100 million for 1999 and has not yet received a full-year appropriation for 2000.)

Direct spending and revenues

Persons who violate the bill's provisions regarding the use of controlled substances to assist in suicide could face revocation of their license to prescribe controlled substances. Upon revocation of an individual's license, the Drug Enforcement Administration could seize any such substances in their possession. Thus, enacting H.R. 2260 could lead to the seizure of more assets and their forfeiture to the United States, but we estimate that any such increase would be less than $500,000 annually in value. Proceeds from the sale of any such assets would be deposited as revenues into the Assets Forfeiture Fund of the Department of Justice and spent from that fund, generally in the same year. Thus, the changes in direct spending from the Assets Forfeiture Fund would match any increase in revenues to that fund.

Violators of the bill's provisions also could be subject to criminal fines, so the federal government might collect additional fines if the bill is enacted. Collections of such fines are recorded in the budget as governmental receipts (revenues), which are deposited in the Crime Victims Fund and spent in subsequent years. CBO expects that any additional receipts and direct spending would be negligible.

Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. Enacting H.R. 2260 could affect both direct spending and receipts, but CBO estimates that any such effects would be less than $500,000 a year.

Estimated impact on State, local, and tribal governments: H.R. 2260 contains an intergovernmental mandate as defined in UMRA, but CBO estimates that complying with the mandate would impose no costs on state, local, or tribal governments, and thus would not exceed the threshold established in that act ($50 million in 1996, adjusted annually for inflation).

In October 1997, an Oregon law that legalized doctor-assisted suicide for terminally ill patients went into effect. Since that time, the interaction of the Federal Controlled Substances Act with that state law has been controversial. As it currently stands, under both Oregon and federal law, it is acceptable for doctors in Oregon to use federally controlled substances for the purposes set forth in state law. H.R. 2260 would direct the Attorney General to give no force and effect to such a state law when determining whether the federal registration of a doctor under the Controlled Substances Act is consistent with the public interest. This would be a preemption of the Oregon "Death with Dignity Act" because it would limit the

options available to doctors acting under that state law. Because the state would not be required to take any action, the preemption would have no cost. The bill also would authorize $5 million for education and training in palliative care for health care professionals, many of whom are employed by state and local facilities.

Estimated impact on the private sector: H.R. 2260 would create a new private-sector mandate for physicians registered to prescribe or administer federally controlled substances by prohibiting the use of such substances in physician-assisted suicides. The bill would require the Drug Enforcement Administration to treat the use of controlled substances for physician-assisted suicide as a violation of the Controlled Substances Act in all states, including Oregon, which is the only state that currently allows the practice. Doctors who violate the prohibition would lose their registration, would have to give up their stocks of controlled substances, and could face criminal prosecution. Because the bill would affect only doctors in Oregon, the costs associated with the mandate would fall below the $100 million (adjusted for inflation since 1996) threshold established in UMRA.

Previous CBO estimate: On September 24, 1999, CBO transmitted a cost estimate for H.R. 2260, as ordered reported by the House Committee on the Judiciary on September 14, 1999. The two versions of the bill are similar and the cost estimates are identical.

Estimate prepared by: Federal Costs: DOJ—Mark Grabowicz. HRSA—Cyndi Dudzinski. AHCPR—Jeanne De Sa. Impact on State, Local, and Tribal Governments: Lisa Cash Driskill. Impact on the Private Sector: John Harris.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

This section provides the short title of the legislation, the "Pain Relief Promotion Act of 1999".

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

Section 101. Reinforcing existing standard for legitimate use of controlled substances

This section amends the Controlled Substances Act to clarify that doctors and other licensed health care professionals are authorized to dispense, distribute, or administer controlled substances for the legitimate medical purpose of alleviating a patient's pain or discomfort even if the use of these drugs may increase the risk of death. This section also clarifies the current law that the administration, dispensing, or distribution of a controlled substance for the purpose of assisting a suicide is not authorized by the Controlled Substances Act.

This section also provides that the Attorney General in implementing the Controlled Substances Act shall not give force or effect to any State law permitting assisted suicide or euthanasia, and that the provisions of the bill are effective upon enactment with no retroactive effect.

Section 102. Education and training programs

This section authorizes the Attorney General to incorporate the recommendations of the Secretary of Health and Human Services (the Secretary) to carry out educational and research training programs for law enforcement personnel on the necessary and legitimate use of controlled substances in pain management and palliative care.

TITLE II—PROMOTING PALLIATIVE CARE

Section 201. Activities of Agency for Health Care Policy and Research

This section amends the Public Health Services Act (42 U.S.C. 299 et seq.) by authorizing a program responsibility for the Agency for Health Care Policy and Research in the Department of Health and Human Services to develop and advance the scientific understanding of palliative care. The Agency is directed to collect and disseminate protocols and evidence-based practices for palliative care with priority for terminally ill patients.

Section 202. Activities of Health Resources and Services Administration

This section amends the Public Health Services Act by authorizing a program for education and training in palliative care in the Health Resources and Services Administration of the Department of Health and Human Services. This section authorizes the Secretary, in consultation with the Administrator for Health Care Policy and Research to award grants, cooperative agreements and con-

tracts to health professions schools, hospices, and other public and private entities to develop and implement palliative care education and training programs for health care professionals in palliative care.

This section requires the applicant for the award to include three educational and informational components in the program: (1) the program must have a component that addresses a means for alleviating pain and discomfort, especially in terminally ill patients, including the use of controlled substances; (2) the program must provide information and education on the applicable law on controlled substances; and (3) the information and education must provide recent findings and developments in the improvement of palliative care. Health professional schools, residency training programs, continuing education, graduate programs in the health professions, hospices, and other sites as determined by the Secretary will be used as program sites.

This section also requires the Secretary to evaluate the grant, cooperative agreement or contracted programs. Further, it mandates that the Secretary shall include one or more individuals with expertise and experience in palliative care in each peer review group involved in the selection of the palliative care awards. Finally, this section defines the term "palliative care" and authorizes an additional $5,000,000 annually for the palliative care award program with the grant cycle to begin with the Fiscal Year 2000.

Section 203. Effective date

The amendments made by this title take effect October 1, 1999, or upon the date of the enactment of this bill, whichever occurs later.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

CONTROLLED SUBSTANCES ACT

TITLE II—CONTROL AND ENFORCEMENT

* * * * * * *

PART C—REGISTRATION OF MANUFACTURERS, DISTRIBUTORS, AND DISPENSERS OF CONTROLLED SUBSTANCES; PIPERIDINE REPORTING

* * * * * * *

REGISTRATION REQUIREMENTS

SEC. 303. (a) * * *

* * * * * * *

(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.

* * * * * * *

PART E—ADMINISTRATIVE AND ENFORCEMENT PROVISIONS

* * * * * * *

SEC. 502. (a) The Attorney General is authorized to carry out educational and research programs directly related to enforcement of the laws under his jurisdiction concerning drugs or other substances which are or may be subject to control under this title. Such programs may include—

(1) * * *

* * * * * * *

(5) studies or special projects to develop more effective methods to prevent diversion of controlled substances into illegal channels; **[**and**]**

(6) studies or special projects to develop information necessary to carry out his functions under section 201 of this title**[**.**]***; and*

(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.

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PUBLIC HEALTH SERVICE ACT

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TITLE VII—HEALTH PROFESSIONS EDUCATION

* * * * * * *

PART D—INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES

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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.

SEC. [754.] *755.* QUENTIN N. BURDICK PROGRAM FOR RURAL INTERDISCIPLINARY TRAINING.

(a) GRANTS.—The Secretary may make grants or contracts under this section to help entities fund authorized activities under an application approved under subsection (c).

* * * * * * *

SEC. [755.] *756.* ALLIED HEALTH AND OTHER DISCIPLINES.

(a) IN GENERAL.—The Secretary may make grants or contracts under this section to help entities fund activities of the type described in subsection (b).

* * * * * * *

SEC. [756.] *757.* ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.

(a) ESTABLISHMENT.—The Secretary shall establish an advisory committee to be known as the Advisory Committee on Interdisciplinary, Community-Based Linkages (in this section referred to as the "Advisory Committee").

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SEC. [757.] *758.* AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to carry out this part, $55,600,000 for fiscal year 1998, and such sums as may be necessary for each of the fiscal years 1999 through 2002.

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(b) ALLOCATION.—

(1) IN GENERAL.—Of the amounts appropriated under subsection (a) for a fiscal year, the Secretary shall make available—

(A) * * *

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(C) not less than $22,631,000 for awards of grants and contracts under [sections 753, 754, and 755] *section 753, 754, 755, and 756.*

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TITLE IX—AGENCY FOR HEALTH CARE POLICY AND RESEARCH

PART A—ESTABLISHMENT AND GENERAL DUTIES

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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.

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ADDITIONAL VIEWS

The Pain Relief Promotion Act seeks to amend the Controlled Substances Act to promote pain management and palliative care without permitting assisted suicide and euthanasia. Section 101 of the bill specifically states that the use of controlled substances for alleviating pain and discomfort is a legitimate medical purpose, even where the use of these drugs may have the unintended effect of increasing the risk of death. The bill also reinforces the existing standard that the use of controlled substances with the intent of assisting in a suicide is not authorized by the Controlled Substances Act and provides that the Attorney General, in implementing the act, shall employ a uniform standard in enforcement of the Act, without regard to state law permitting assisted suicide or euthanasia.

We do not endorse physician-assisted suicide. However, we have a number of concerns about this bill. The first relates to the lack of a subcommittee hearing or markup on the bill. Palliative care is an important and difficult issue for patients and families across the country, yet the Committee has not given this bill full and thorough consideration. The bill is supported by the American Medical Association and the National Hospice Organization, but opposed by the California Medical Association, the American Nurses Association, the Oncology Nursing Society, the National Association of Orthopaedic Nurses, the American Pain Foundation, and others. This contentious area of public policy demands careful subcommittee consideration and expert testimony by educated witnesses. H.R. 2260 clearly has not gone through the appropriate committee process.

We are troubled that Title I of this bill raises the prospect of the Drug Enforcement Agency (DEA) "second guessing" a physician or a health care professional's intent in prescribing and using large doses of opiates for patients who are in severe pain. Title I of the bill could turn the DEA into a medical oversight body charged with investigating the "intent" and "purpose" of a physician's care for a patient. The threat of investigation alone could scare health care professionals away from providing quality care to the neediest patients. This bill could inadvertently harm the 50 million American patients who suffer from serious pain and other distressing symptoms.

Many sick patients require extremely large doses of pain medications to assure that they are comfortable and can maintain a high quality of life and interaction with their family. These large doses are not prescribed to assist in suicide, but to assure aggressive pain control and quality care. Many patients are able to tolerate the extremely high doses of controlled substances needed to manage their pain and other symptoms, but the same doses in another patient would be lethal.

This gray area poses the problem. H.R. 2260 attempts to end the practice of assisted suicide, but it may just have the opposite effect. Many caregivers believe it could increase suicides, assisted and otherwise, by patients who can no longer bear the unrelieved pain caused when practitioners, threatened by possible DEA investigation into their intent in prescribing pain-killing medication, are deterred from providing necessary pain relief. Other caregivers do not believe this could result. Regular and full consideration by the Subcommittee would have given us an opportunity to resolve these differing views, and to produce better legislation.

JOHN D. DINGELL.
EDOLPHUS TOWNS.
EDWARD J. MARKEY.
TED STRICKLAND.
LOIS CAPPS.
TOM BARRETT.
HENRY A. WAXMAN.
PETER DEUTSCH.
SHERROD BROWN.
ALBERT R. WYNN.
TOM SAWYER.

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