

**American Medical Association’s analysis of  
S. 1272 / H.R. 2260 - the Nickles/Hyde “Pain Relief Promotion Act of 1999”**

Summary of Key Provisions

The “Pain Relief Promotion Act of 1999,” S. 1272 / H.R. 2260, contains two Titles. Title I, “Use of Controlled Substances Consistent with the Controlled Substances Act,” would add a provision to the Controlled Substances Act (CSA) acknowledging the legitimate medical purpose of controlled substances in the management of pain or discomfort, even if their use increases the risk of death for the patient (the so-called “double effect”).<sup>1</sup>

The bill states that, as a matter of federal law, any State law authorizing or permitting assisted suicide or euthanasia would be “without force and effect” in implementing the CSA.<sup>2</sup> It would provide for education and training programs for law enforcement personnel regarding the legitimate and necessary use of controlled substances in pain management.

Title II, “Promoting Palliative Care,” would authorize the Agency for Health Care Policy and Research to collect and disseminate protocols and evidence-based practices regarding palliative care, as well as provide for grants from the Department of Health and Human Services for the development and implementation of health professionals’ training in palliative care.

Discussion

The AMA has long-standing policy strongly opposing physician-assisted suicide and believes that participation in such activities is ethically incompatible with the physician’s role as healer. The AMA was active and outspoken in opposing the public initiatives in Oregon that ultimately resulted in passage of the “Death With Dignity Act.” While the “Pain Relief Promotion Act of 1999” would not technically “overturn” the Oregon law, it would severely hamper the ability of patients to invoke it, since physicians would be unable to legally prescribe intentionally lethal doses of federally controlled substances.

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<sup>1</sup> S. 1272, Sec. 101:

...(I)(1) For purposes of this Act [CSA] and any regulations to implement this Act, alleviating pain or discomfort in the usual course of professional practice is a legitimate 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 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.

<sup>2</sup> S. 1272, Sec. 101:

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

It is incorrect to suggest that the “Pain Relief Promotion Act of 1999” is no different than the bill introduced by the same sponsors in the last Congress, the “Lethal Drug Abuse Prevention Act of 1998” (S. 2151 / H.R. 4006). Last year’s bill cited participation in physician-assisted suicide as a reason to revoke a physician’s Drug Enforcement Administration (DEA) registration, and specifically permitted revocation or denial of registration if the DEA believed there was reason to suspect a physician’s intention was to assist a suicide.

In contrast, language in the “Pain Relief Promotion Act of 1999” explicitly acknowledges the medical legitimacy of the “double effect” in the CSA and provides a new and important statutory protection for physicians prescribing controlled substances for pain, particularly for patients at the end of life. This significant improvement to the CSA largely rectifies the AMA’s concern about last year’s bill regarding the potential to chill appropriately aggressive prescribing for pain management.

The evaluation of whether a physician’s prescribing is pursuant to a “legitimate medical purpose” exists under the current language of the CSA. This is not a new power vested in the DEA, either directly or indirectly, by the “Pain Relief Promotion Act of 1999.” A quick reference to the United States Code reveals multiple instances of case law in which the question of “legitimate medical purpose” was at issue under the CSA.<sup>3</sup> The value of Section 101 of the bill is in providing, for the first time, a shield for physicians who are subject to such an evaluation under the current authority of the DEA.

Under Oregon state law, a physician who complies with the requirements of the Oregon “Death With Dignity Act” in assisting a suicide might, arguably, be protected from DEA investigation or prosecution under the current CSA because he or she is complying with state law. The AMA concurred with the Attorney General’s June 5, 1998 opinion that provided that neither the language of the CSA nor its legislative history supported the Act’s application to physicians *in compliance with state law*. However, those physicians whose prescribing practice falls outside the bounds of state law *would* be subject to the DEA’s authority. A physician in any other state or jurisdiction attempting the same activity without the protection of such a state law would be exposed to potential DEA investigation and prosecution *under current law*. This also holds true for any Oregon physician who prescribes to assist a suicide outside of the protocols required by the “Death With Dignity Act.”

In fact, this provision is the nexus of the argument as it applies to Oregon physicians. The language of the “Pain Relief Promotion Act of 1999” specifically directs the Attorney General to behave as though no Oregon “Death With Dignity Act” exists, thus putting Oregon physicians on par with every other physician in the country as to their potential exposure under the CSA for using controlled substances to assist a suicide. Oregon physicians will be precluded from prescribing or using controlled substances to help their patients commit suicide under the terms Oregon “Death With Dignity Act.” The bill is not retroactive, so physicians who have previously legally assisted a suicide under the Oregon law would not be affected.

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<sup>3</sup> 21 USC 824, 841; Notes of Decisions.

The bill would not expand existing criminal penalties in the CSA for persons whose unauthorized use of a controlled substance leads to someone's death.<sup>4</sup> Nor would it change the definition of what would be a "prohibited act."<sup>5</sup> Nor would it change the intent standard to establish that a prohibited act had occurred. In fact, as noted above, it would add a new statutory protection for physicians that would acknowledge that legitimate medical use of controlled substances to help alleviate or control pain may, as a secondary effect, hasten death.

We anticipate that some will challenge the bill on constitutional grounds, based on the implicit conflict between state and federal law. Whether the federal government can proceed in the implementation and enforcement of its laws by explicitly ignoring – rather than preempting -- state law is a matter for the courts to decide. This potential conflict does not affect the AMA's policy position regarding the substance of the bill.

The AMA supports the "Pain Relief Promotion Act," but will continue working with the sponsors to strengthen the education and training provisions and to assure that the development of such programs includes input from physicians regularly engaged in pain management practice.

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<sup>4</sup> 21 USC 841(b)

<sup>5</sup> 21 USC 841