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

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

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

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

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

I do want to note that a previous bill in 1998 caused concerns that it might inhibit doctors from prescribing adequate pain relief. H.R. 2260 has been drafted to resolve those concerns. I am very pleased that the interested parties have worked together over the past year and have crafted legislation that will not only encourage doctors to prescribe effective pain management but also encourage alternatives to euthanasia.

□ 1045

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

H.R. 2260 makes an effort to delineate the prescribing of narcotics for alleviating pain from that of intentionally killing the patient. There is no way medically, legally, or morally to tell the difference. This law will serve to curtail the generous use of narcotics in a legitimate manner in caring for the dying. Claiming that this law will not hinder the legitimate use of drugs for medical purposes but not for an intentional death is wishful thinking. In fear that a doctor will be charged for intentionally killing a patient, even though the patient may have died coincidentally with an injection, this bill will provide a great barrier to the adequate treatment of our sick and dying who are suffering and are in intense pain.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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