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Assisted Suicide and the Controlled Substances Act: Legal Issues Associated with the Proposed Pain Relief Promotion Act

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Summary

The Pain Relief Promotion Act, as proposed in the 106th Congress, provided that the Attorney General, in determining whether the registration of a doctor for the administration of controlled substances is in the public interest, should give no force and effect to state law authorizing or permitting assisted suicide or euthanasia. This language would appear to have been designed to abrogate the legal reasoning set forth by the Attorney General in a press release regarding the application of the Controlled Substances Act to acts of physician-assisted suicide. It would not, however, appear to have required the Attorney General to revoke such registrations; nor would it have criminalized assisted suicide or euthanasia. This report will be updated as congressional action warrants.

The proposed Pain Relief Promotion Act would have amended the Controlled Substances Act to provide that the Attorney General, in evaluating a doctor's authority to administer controlled substances, would give no force and effect to state laws authorizing assisted suicide or euthanasia. The proposed Act also provided that palliative care would be a legitimate medical purpose, and some versions provided that a finding that such care was outside of the usual course of professional practice would need to be established by clear and convincing evidence. Finally, the proposed Act provided for pain relief research and education.

One version of the proposed Act, H.R. 2260, was:

- reported by the House Committee on the Judiciary (H.Rept. 106-378, part I) on October 13, 1999;
- reported by the House Committee on Commerce (H.Rept. 106-378, Part II) on October 18, 1999;
- passed by the House on October 27, 1999, 271 to 156 (Roll No. 554); and
- was reported by the Senate Committee on the Judiciary on April 27, 2000 (S.Rept. 106-299).

The text of the bill was also incorporated into the conference report on H.R. 2614, a bill to amend the Small Business Investment Act, but no further action was taken.

Thirty-nine states forbid assisted suicide by statute,[1] and six states prohibit assisted suicide through application of common law.[2] Four states appear to have neither a statute nor common law which prohibits assisted suicide.[3] Although various proposals legalizing the practice have been considered,[4] only the state of Oregon has a statute permitting physician-assisted suicide.[5] Federal law currently does not forbid assisted suicide, although

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[1] Alaska, Alaska Stat. §11.41.120(a)(2) (1978); Arizona, Ariz. Rev. Stat. Ann. §13-1103(a)(3) (1989); Arkansas, Ark. Code Ann. §5-10-104(a)(2) (1987); California, Cal. Penal Code §401 (1998); Colorado, Colo. Rev. Stat. §18-3-104(1)(B) (1990); Connecticut , Conn. Gen. Stat. §§53a, 56(a)(2) (1997); Delaware, Del. Code Ann., tit. 11, 645 (1995); Florida, Fla. Stat. Ann. §782.08 (1992); Georgia, Ga. Code Ann. §16-5-5(b) (1994); Hawaii, Haw. Rev. Stat. §707-702(1)(B) (1988); Illinois, Ill. Comp. Stat. Ann. 5/12-31(1992); Indiana, Ind. Stat. Ann. §35-42-1-2 (1998); Iowa, Iowa Code Ann. §707a.2, 707a.3 (1996); Kansas, Kan. Stat. Ann. §31-3406 (1992); Kentucky, Ky. Rev. Stat. Ann. §216:302 (1994); Louisiana, La. R.S. 14:32.12 (1999); Maine, Me. Rev. Stat. Ann. Tit. 17a, §204 (1983); Maryland, Md. Ann. Code Art. 27, §416 (1999); Michigan, Act of December 15, 1992, 1992 P.A. 270; Minnesota, Minn. Stat. Ann. §609.215 (1998); Mississippi, Miss. Code Ann. §97-3-49 (1994); Missouri, Mo. Ann. Stat. §565.023 (1983); Montana, Mont. Code Ann. §45-5-105 (1981); Nebraska, Neb. Rev. Stat. §28-307 (Supp. 1977); New Hampshire, N.H. Stat. Ann. §630:4 (1997); New Jersey, N.J. Stat. Ann. §2c:11-6 (1995); New Mexico, N.M. Stat. Ann. §30-2-4 (1978); New York, N.Y. Penal Law §120.30 (Mckinney 1997); North Dakota, N.D. Cent. Code §12.1-16-04 (1991); Oklahoma, Okla. Stat. Ann. Tit. 21, §818 (1983); Pennsylvania, 18 Pa. Cons. Stat. Ann. §2505 (1998); Rhode Island, R.I. Gen. Laws §11-60-1, 11-60-3 (1996); South Carolina, S.C. Code Ann. §16-3-1090 (1998); South Dakota, S.D. Codified Laws Ann. §22-16-37 (1998); Tennessee, Tenn. Health & Safety Code Ann. §672.020 (West 1992); Texas, Tex. Penal Code Ann §22.08 (1994); Virginia, Va. Code Ann., 8.01 622.1 (Michie 1999),Washington, Wash. Rev. Code Ann. §9a.36.060 (1998); Wisconsin, Wis. Stat. Ann. §154.11(6) (1998); *see also* Model Penal Code §210.5.

[2] Alabama, Idaho, Massachusetts, Nevada, Vermont, and West Virginia.

[3] North Carolina, Ohio, Utah and Wyoming.

[4] During the nineties, voters in California and Washington defeated assisted suicide ballot proposals. In November 1998, voters in Michigan defeated a ballot measure to legalize doctor-assisted suicide. Also in 1998, proposed legislation legalizing doctor-assisted suicide was defeated in Maine. Although many such measures have been introduced into legislatures, they generally expire in committee, and seldom reach the floor of the full legislative body.

[5] Or. Rev. Stat. 127.800-.995 (1995). The Oregon Death with Dignity Act was adopted as the result of a statewide referendum. The Oregon legislature responded by setting a new referendum proposing repeal of the Act, but the repeal was defeated. Meanwhile, the Act was challenged in a federal court, which struck it down as a violation of the Equal Protection Clause of the Fourteenth Amendment. *Lee v. Oregon*, 891 F. Supp. 1429, 1431 (D. Or. 1995). The United States Court of Appeals for the Ninth Circuit, however, reversed, holding that the plaintiffs were not sufficiently threatened by implementation of the law to obtain standing. *Lee v. Oregon,* 107 F.3d 1382 (9th Cir. 1997).

The core of the Oregon Death With Dignity Act provides that any competent Oregon resident who has been determined by two physicians to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the

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the "Assisted Suicide Funding Restriction Act of 1997"[6] prohibits the use of federal funds to pay for assisted suicide.

In November of 1997, a Drug Enforcement Agency staff report concluded that prescribing a controlled substance with the intent of assisting a suicide would not be a legitimate medical purpose and therefore would violate the Controlled Substances Act. Consequently, the Drug Enforcement Administration issued a warning that under the Controlled Substances Act, doctors could lose their licenses to prescribe drugs if they helped someone commit suicide. On June 5, 1998, however, the Department of Justice (DOJ) issued a press release rejecting this conclusion.

The DOJ press release reads, in part, as follows:

> Physicians . . . are authorized to prescribe and distribute scheduled drugs only pursuant to their registration with the DEA, and the unauthorized distribution of drugs is generally subject to criminal and administrative action. The relevant provisions of the CSA provide criminal penalties for physicians who dispense controlled substances beyond "the course of professional practice," and provide for revocation of the DEA drug registrations of physicians who have engaged either in such criminal conduct or in other "conduct which may threaten the public health and safety." Because these terms are not further defined by the statute, we must look to the purpose of the CSA to understand their scope.
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> The CSA was intended to keep legally available controlled substances within lawful channels of distribution and use. It sought to prevent both the trafficking in these substances for unauthorized purposes and drug abuse. . . . There is no evidence that Congress, in the CSA, intended to displace the states as the primary regulators of the medical profession, or to override a state's determination as to what constitutes legitimate medical practice in the absence of a federal law prohibiting that practice. Indeed, the CSA is essentially silent with regard to regulating the practice of medicine that involves legally available drugs except for certain specific regulations dealing with the treatment of addicts.
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> The state of Oregon has reached the considered judgment that physician-assisted suicide should be authorized under narrow conditions and in compliance with certain detailed

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[5] (...continued)
purpose of ending his or her life. A "terminal disease" is defined as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. The Act also sets forth specific requirements and procedures that must be satisfied before a patient can be prescribed a lethal dose of medication.

The patient must be informed by an attending doctor of his or her diagnosis, prognosis, the potential risks associated with taking the medication, the probable result of taking the medication, and the feasible alternatives, including, but not limited to, comfort care, hospice care, and pain control. A second consulting physician must then confirm the terminal illness and determine that the patient is acting voluntarily. Further, if there is any indication that the patient may be suffering from a psychiatric or psychological disorder, or depression-causing impaired judgment, either physician must refer the patient for counseling. If there is a referral, no lethal medication may be prescribed until the person performing the counseling concludes that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.

[6] Pub. L. 105-12 (1997).

> procedures. Under these circumstances, we have concluded that the CSA does not authorize DEA to prosecute, or to revoke the DEA registration of, a physician who has assisted in a suicide in compliance with Oregon law. . . .

The DOJ press release notes that physicians who dispense controlled substances beyond "the course of professional practice" may be subject to criminal penalties, and that those who engage in "conduct which may threaten the public health and safety" may have their authority to prescribe controlled substances revoked. Although the press release does not provide citations for these standards, the phrase "the course of professional practice" may be found in 21 C.F.R. §1306.04 (1999), which provides that:

> A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. . . . An order purporting to be a prescription issued not in the usual course of professional treatment . . . is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person . . . issuing it shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

Some variation of the other phrase used in the DOJ press release, "conduct which may threaten public health and safety," is relevant to two different sections of the code: 21 U.S.C. §§823 and 824. Under §823, the Attorney General shall "register" or authorize a physician to prescribe or dispense controlled substances if it is consistent with the "public interest."[7] In determining the public interest, a variety of factors may be considered, including whether such registration is "consistent with the public health and safety." Under 21 U.S.C. §824, a registration "may" be revoked for a number of reasons, including whether the physician has committed such acts as would render his registration inconsistent with the "public interest" as evaluated under the factors found in § 823.[8]

Both the House-passed H.R. 2260, the version of H.R. 2260 reported by the Senate Judiciary Committee and S. 1272 would have, among other things, amended 21 U.S.C. §823 by adding the following at the end:

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[7] Factors to be considered include: (1) maintenance of effective control against diversion of particular controlled substances into other than legitimate medical, scientific, and industrial channels; (2) compliance with applicable State and local law; (3) prior conviction record of applicant under Federal or State laws relating to the manufacture, distribution, or dispensing of such substances; (4) past experience in the distribution of controlled substances; and (5) such other factors as may be relevant to and consistent with the public health and safety.

[8] Such factors include whether the physician has: (1) materially falsified any application filed pursuant to or required by this title or title II; (2) been convicted of a felony under this title or title III or any other law of the United States, or of any State, relating to any substance defined in this title as a controlled substance or a list I chemical; (3) had his State license or registration suspended, revoked, or denied by competent State authority and is no longer authorized by State law to engage in the manufacturing, distribution, or dispensing of controlled substances or list I chemicals or has had the suspension, revocation, or denial of his registration recommended by competent State authority; (4) committed such acts as would render his registration under 21 U.S.C.§ 823 inconsistent with the public interest as determined under such section; or (5) been excluded (or directed to be excluded) from participation in a program pursuant to section 1128(a) of the Social Security Act, 42 U.S.C. §1320a-7(a).

> (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 the enactment of this subsection.

Paragraph (2) of this section appears to be the core of the language intended to discourage the practice of assisted suicide. Under this paragraph, the Attorney General, in evaluating registrations, "shall give no force and effect to State law authorizing or permitting assisted suicide or euthanasia." The intended effect of this language, however, is unclear, since the Attorney General does not have the legal authority to enforce Oregon laws. Rather, in her press release, Attorney General Reno indicated that the Oregon state law would be a standard by which she would interpret the phrases "course of professional practice" and "conduct which may threaten the public health and safety." Thus, it is not clear whether "giving force and effect" is an accurate description of how Oregon state law is utilized in the DOJ press release.

It is likely, however, that a court would construe the terms "give force and effect" to be consistent with the obvious congressional intent that such state laws should not be considered in interpreting the meaning of 21 U.S.C. §§832 and 824.[9] The language in question, however, still would not appear to require the Attorney General to deny registration to physicians who have engaged in assisted suicide, or to require that the Attorney General revoke the licenses of such physicians. Rather, it would require the Attorney General to reevaluate whether the "public interest" would be served by allowing the registration of doctors who are engaged in such activity, this time without consideration of existing state laws authorizing or permitting suicide or euthanasia.[10]

Thus, the language in paragraph (2) does not appear to impose a legal standard for registration of doctors, but rather may be an attempt to abrogate the line of legal reasoning which underpins the DOJ press release.[11] As the term "public interest" is broad and

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[9] House Rep. 106-378, 106th Cong., 1st Session (1999).

[10] This legislation does not address how the Attorney General should evaluate states that neither authorize nor forbid assisted suicide. Further, while the Attorney General must ("shall") register physicians to handle controlled substances if it is not inconsistent with public policy, she is not required to ("may") revoke such registration upon a finding that it is inconsistent with the public interest.

[11] It should be noted, however, that this language would not appear intended to affect physicians (continued...)

ambiguous, paragraph (2) would appear to leave the Department of Justice with wide discretion to consider other factors to determine whether the revocation of a doctor's license for engaging in assisted suicide was in the public interest. DOJ has indicated, however, that the Administration strongly opposes the practice of physician-assisted suicide.[12] Thus, absent the concerns raised by DOJ regarding federal government establishment of medical practice policies for the states, the Administration might well conclude that the practice of assisted suicide is not in the public interest, and withholding or revoking the controlled substances registration of physicians engaging in such would be justified.

The other relevant paragraph in the proposed Act, paragraph (1), appears to be of negligible legal impact. The first sentence of paragraph (1) would establish that for purposes of the entire Act, the provision of palliative care is a legitimate medical practice consistent with the public interest. Although welcomed by a large part of the medical community as a clarification, it seems unlikely that the provision of palliative care by itself would be found by the Department of Justice to be either inconsistent with the public interest or an illegitimate medical practice, even absent the language of this bill. Thus, the effect of this language appears merely to reinforce existing practice.

The meaning of the second sentence of paragraph (1) would also appear to be noncontroversial, but questions have been raised as to its impact. At first glance, the language would appear to merely be a rule of construction, making clear that the language in the first sentence (discussed above) does not authorize assisted suicide or euthanasia. In an October 19, 1999 letter to the Honorable Henry J. Hyde, however, the Department of Justice maintains that the sentence "[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," would make it a federal crime for a physician to dispense a controlled substance to aid a suicide, thus exposing him or her to a 20-year mandatory minimum sentence.

Such an interpretation would appear to be suspect. The second sentence of paragraph (1) indicates only that nothing in §823 authorizes assisted suicide or euthanasia, leaving unanswered the question of whether some other portion of the Act might do so. The fact that the first sentence of the paragraph authorizes palliative care under the Act might arguably be seen by a court as implying that the Act does not authorize assisted suicide or euthanasia. However, given the reasoning of the Department of Justice that compliance with state law is generally sufficient to establish "legitimate medical practice," it is unlikely that a court would find this alternate interpretation sufficiently clear to support a criminal prosecution.

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[11] (...continued)
who choose to engage in assisted suicide or euthanasia using prescription drugs that are not listed as controlled substances.

[12] Letter from Department of Justice to the Honorable Henry Hyde, Chairman, Committee on the Judiciary (October 19, 1999).