

## Opinion

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### **Assisted Suicide Becomes a Federal Case**

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In March 1997, the Australian parliament rescinded a Northern Territory law allowing physicians to assist suicides. A similar jurisdictional struggle is now brewing in the United States, where Oregon is the only one of the 50 states to legalize physician-assisted suicide for terminally ill patients.

#### **Background: Oregon's Experiment**

The Oregon law was approved by statewide referendum in November 1994, but its implementation was delayed by court challenges. Ultimately federal courts reinstated the law in late October 1997.<sup>1</sup> A few days later, Oregon voters reaffirmed the 1994 law by defeating a new ballot initiative designed to repeal it.

Oregon's first threatened conflict with federal law arose because the state decided to subsidize assisted suicide for poor Oregonians through Medicaid, a joint program created and substantially funded by the federal government. In April 1997, Congress and President Clinton responded by approving the Assisted Suicide Funding Restriction Act, which forbids any federal health program or medical facility to perform or subsidize assisted suicide or euthanasia.<sup>2</sup> Oregon now plans to support assisted suicides solely with state funds, in a program separately managed from the joint Medicaid program.

#### **Conflict with federal drug laws**

A more direct conflict with federal law was raised last July by Congressman Henry Hyde and Senator Orrin Hatch, chairmen respectively of Congress's House and Senate Judiciary Committees. They asked Thomas Constantine, Administrator of the U.S. Drug Enforcement Administration (DEA), whether the use of controlled substances such as morphine or barbiturates to assist suicides in Oregon would violate the federal Controlled Substances Act (CSA).

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<sup>1</sup> See *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995) Oregon law violates Equal Protection Clause of U.S. Constitution), *vacated*, 107 F.3d 1382 (9<sup>th</sup> Cir. 1997)(plaintiffs lack standing to challenge Oregon law), *cert. Denied sub nom. Lee v. Harclerod*, 118 S.Ct.328 (1997).

<sup>2</sup> Pub. L. No105-12, 111 Stat.23 (1997).

Since 1970 the CSA has established a uniform federal policy for control of addictive or dangerous drugs. It is designed to prevent any use of non-medical drugs such as heroin and cocaine, and to prevent diversion of potentially dangerous prescription drugs for illicit use. To prescribe or dispense a drug listed by the federal government as a controlled substance, each health practitioner must register with the DEA. The DEA may revoke the registration if it is misused to prescribe drugs for anything but a “legitimate medical purpose.”<sup>3</sup> Since 1984, federal law has explicitly provided that a physician may lose his or her DEA registration if it has been used to endanger “public health and safety” or in any other manner that is contrary to “the public interest,”<sup>4</sup> even if the practitioner cannot be proved to have violated state laws.

Hence the Judiciary chairmen’s question: If the federal government excludes assisted suicide from medical treatment in all federal programs, how can it register Oregon physicians so they may use federally regulated drugs to help take patients’ lives? How can this one federal agency treat assisted suicide as “legitimate” medicine?

On June 5, immediately after Oregon voters reaffirmed their state’s assisted suicide law, Mr Constantine replied that prescribing controlled substances for assisted suicide would indeed violate federal drug laws. However, his ruling was immediately questioned by U.S. Attorney General Janet Reno, who said the issue required further study by the Justice Department.

On June 5, 1998, Ms Reno announced that “adverse action against a physician who has assisted in a suicide in full compliance with the Oregon Act would not be authorized by the CSA.” In her view, if a state deems assisted suicide to be a legitimate medical practice” within its borders, current federal law provides no basis for disagreement. She said her ruling was confined to assisted suicides which comply with state law: “Adverse action under the CSA may well be warranted... where a physician assists in a suicide in a state that has not authorized the practice under any conditions, or where a physician fails to comply with state procedures in doing so.”

Ms Reno’s proposed federal policy on assisted suicide is simply to add a layer of federal enforcement to whatever policy each state chooses to enact. In 49 states, the DEA can revoke practitioners’ registrations for assisting suicides: in Oregon it will help implement the state’s “guidelines” for assisted suicide by penalizing only practitioners who disobey the procedural requirements for a “legitimate” suicide. This approach contrasts sharply with the DEA’s insistence that federal policy against any “legitimate” use for marijuana must prevail over state referenda seeking to allow “medicinal” use of the drug.<sup>5</sup>

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<sup>3</sup> 21 C.F.R. §1306.04.

<sup>4</sup> 21 U.S.C. §823(f), 824(a).

<sup>5</sup> See *United States v. Cannabis Cultivators Club*, 5 F.Supp. 2d 1086(N.D. Cal.1998)

Ms Reno's ruling also ignores past cases in which practitioners lost DEA registrations for providing drugs used in suicides or other lethal overdoses. These registrations were denied or revoked not merely because such illicit use was contrary to state law, but because providing drugs for lethal use was seen as an objective threat to 'health and safety' under federal law.<sup>6</sup>

On the day of Reno ruling, Congressmen Henry Hyde (R-IL) and James Oberstar (D-MN) introduced the Lethal Drug Abuse Prevention Act (H.R. 4006) to overturn it. Four days later a Senate companion bill (S. 2151) was introduced by Senator Don Nickles (R-OK).

### **Lethal Drug Abuse Prevention Act**

The proposed Act has two stated purposes: To reaffirm a uniform federal policy that use of federally regulated drugs for assisted suicide and euthanasia is not in accord with the "public interest"; and to affirm that health professionals should not hesitate to use such drugs to control the pain and discomfort of serious illness. The House version has been amended in committee to serve both purposes more effectively.

As amended, H.R. 4006 seeks to prevent lethal misuse of drugs while protecting their legitimate use for pain control in several ways:

1. While prohibiting the use of controlled substances for assisted suicide or euthanasia, the bill explicitly allows their use "for the purpose of alleviating pain or discomfort (even if the use of the controlled substance may increase the risk of death), so long as the controlled substance is not also dispensed or distributed for the purpose of causing, or assisting in causing, the death of an individual for any reason." Similar language endorsing the "principle of double effect" received praise from medical groups when it was enacted as part of the Assisted Suicide Funding Restriction Act of 1997.<sup>7</sup>

2. To revoke a registration for assisting suicide, the DEA must have "clear and convincing evidence" that the practitioner's purpose was to cause death. (The DEA's usual burden in such proceedings is to prove the offense by a "preponderance of evidence," an easier burden to meet.) The bill adds: "In meeting such a burden it shall not be sufficient to prove that the registrant knew that the use of the controlled substance may increase the risk of death."

3. The bill establishes a Medical Advisory Board on Pain Relief, whose members are named by the Attorney General in consultation with national medical

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<sup>6</sup> See e.g., 60 Fed. Reg. 56354 (Nov. 8, 1995)(denying application of Dr Hugh Schade for registration); 49 Fed. Reg. 6577 (February 22, 1984)(denying application of Dr Samuel Fertia for registration).

<sup>7</sup> The American Medical Association had said of the language: "This provision assures patients and physicians alike that legislation opposing assisted suicide will not chill appropriate palliative and end-of-life care." Letter of P. John Seward, AMA Executive Vice-President to Senator John Ashcroft, February 12, 1997.

groups with expertise in palliative care. If a practitioner is accused of violating the DEA's ban on assisted suicide, he or she may ask this Board to review the medical facts and issue an opinion on whether his or her use of drugs was "for the purpose of alleviating pain or discomfort in a manner that does not constitute a violation" of the ban. The Board's opinion is admissible as evidence in any DEA proceeding.

It is clear that the bill's sponsors are acutely aware of the delicate but vitally important distinction between assisted suicide and aggressive pain control, and want to ensure that polices against the former do not discourage the latter. The proposed bill would write into federal statutes, for the first time, a policy that the DEA should affirm pain management as a "legitimate medical purpose" for the use of controlled substances.

## **Objections and Responses**

While opposition to this bill by the Hemlock Society and other pro-euthanasia groups is to be expected, medical groups such as the American Medical Association (AMA) and National Hospice Organization (NHO) have also raised objections. Prominent physicians have also voiced support for the bill, including former U.S. Surgeon General C. Everett Koop, suicide prevention expert Herbert Hendin, palliative care expert Carlos Gomez, and NHO ethics committee chairman Walter Hunter. Medical organizations supporting the bill include the Catholic Health Association, Christian Medical and Dental Society, and Physicians for Compassionate Care (representing 1000 Oregon physicians who oppose assisted suicide).

Critics have three objections to the bill:

1. Opponents say the bill is an unprecedented federal intrusion into "states' rights" and medical practice. This objection ignores the history and purpose of the CSA. As the U.S. Senate observed in 1984: "Registration of a physician under the Controlled Substances Act is a matter entirely separate from a physician's State license to practice medicine. Therefore revocation of registration only precludes a physician from dispensing substances controlled under the Controlled Substances Act and does not preclude his dispensing other prescription drugs or his continued practice of medicine."<sup>8</sup> The federal government has long had its own distinct standards for access to potentially dangerous drugs, so that "state licensure is a necessary but not sufficient condition for DEA registration."<sup>9</sup> H.R. 4006 is not so much a new effort to overturn Oregon's law, as a reminder that federal law has its own standards which an individual state has no authority to rescind.

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<sup>8</sup> S.Rep. No.225, 98<sup>th</sup> Cong., 2d Sess., *reprinted in* 1984 U.S. Code Cong. & Admin. News 3182, 3449 n.40.

<sup>9</sup> 63 Fed. Reg. 8477, 8479 (Feb, 19, 1998)(revoking registration of Townwood Pharmacy).

Some critics invoke last year's U.S. Supreme Court decisions upholding state bans on assisted suicide, to argue that the Court specifically assigned this issue to the states. But the Court never excluded Congress from the assisted suicide debate that it said was occurring "[t]hroughout the Nation."<sup>10</sup> In explaining the governmental interests served by bans on assisted suicide, the Court cited both state and federal laws -- noting, for example, the longstanding policy of federal drug laws "to protect the terminally ill, no less than other patients," from dangerous drugs.<sup>11</sup> The Court also offered "no opinion" on whether a state law like Oregon's is constitutionally valid;<sup>12</sup> such a law has yet to reach the Supreme Court on its merits.

2. Ironically, opponents also object that the law would not stop all assisted suicides because it only applies to suicides using federally regulated drugs. Whereas the first objection charged the federal government with stepping beyond its jurisdiction, this one faults Congress for staying within its clear jurisdiction. Congress's authority to override state laws and ban assisted suicide outright is a complex question; its jurisdiction over legitimate use of controlled substances is clear and unambiguous.

In any event, a federal ban on using drugs like morphine and barbiturates to cause death will significantly impact the ability to implement a pro-suicide law at all. Oregon's law authorizes only the use of "medications" which a patient can self-administer to end life in a "humane and dignified" manner, which narrows the range of available lethal agents considerably. In the U.S.'s first confidential national survey of physicians who have assisted suicides, controlled substances were used in 100% of cases (opioids in 75% of cases and barbiturates in the other 25%).<sup>13</sup> In Oregon the prospect of adverse DEA action has discouraged physicians from assisting suicides; apparently there were more assisted suicides in the three months after Ms Reno's June 5 ruling than in the previous seven months, when DEA action against physicians seemed possible.<sup>14</sup>

3. The most serious criticism of H.R. 4006 is that it would have a "chilling effect" on physicians' use of controlled substances for pain control. Physicians already undertreat pain in dying patients due partly to fear of legal liability, goes the argument, and any new restrictions will only increase such fears.

This objection is based not on the language of the bill, which explicitly protects the use of drugs for pain control, but on physicians' broader fear of investigation by federal drug agents. But the objection is based on a fallacy, because Ms Reno's ruling makes it clear that such investigations will occur even in the absence of new

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<sup>10</sup> *Washington v. Glucksberg*, 117 S. Ct 2258, 2275 (1997).

<sup>11</sup> *Id.* at 2272, quoting *United States v. Rutherford*, 442 U.S. 544, 558 (1979)

<sup>12</sup> 117 S. Ct. at 2262 n.7.

<sup>13</sup> D. Meier et al., "A National Survey of Physician-Assisted Suicide and Euthanasia in the United States," 338 *New England J. of Medicine* 1193, 1196 (April 23, 1998).

<sup>14</sup> "Death with Dignity Preliminary Summary Issued," Oregon Human Resources News, August 18, 1998.

legislation. Under the Reno policy, moreover, the DEA has no uniform policy of its own on the issue and so will enforce whatever policy is found in individual state laws – and most state laws are far *less* sensitive to the needs of good palliative care than H.R. 4006 is. State controlled substances acts and state bans on assisted suicide often do *not* acknowledge the legitimate use of controlled substances for pain control or the “principle of double effect.”

Some medical groups oppose H.R. 4006 based on an instinctively protective attitude toward physicians’ freedom and a distrust of federal drug enforcement efforts. If they look beyond these concerns they may begin to appreciate the considerable merits of the legislation.

## **Conclusion**

The Lethal Drug Abuse Prevention Act was approved by the House of Judiciary Committee in August. In the final weeks of this Congress it must be considered by the House Commerce Committee, then by the full House and Senate before proceeding to President Clinton’s desk.

This legislation could mark a turning point in the United States’ debate on assisted suicide. With its approval, Congress could exert a strong counter-weight against Oregon’s “experiment” in physician-aided death. If it is defeated, Oregon’s experiment may spread to other states without further legal impediment – and with the implied approval of a federal government which gives Oregon physicians access to the most effective drugs for suicides.