RESOLVED, that the American Bar Association urges federal, state, and territorial
governments to construe, apply, and if necessary, amend laws regulating the health professions,
controlled substances, insurance, and both public and private health benefit programs so that
these laws do not impose barriers to quality pain and symptom management.

FURTHER RESOLVED, that the American Bar Association urges federal, state, and
territorial governments to support fully the right of individuals suffering from pain to be
informed of, choose, and receive effective pain and symptom evaluation, management, and
ongoing monitoring as part of basic medical care, even if such pain and symptom management
may result in analgesic tolerance, physical dependence, or as an unintended consequence shorten
the individual's life.
Proposed ABA Policy on Legal Obstacles To Effective Pain Management

The rationale for this recommendation is based on four pillars, explained more fully below: (1) pain undertreatment is a strikingly large problem in the United States; (2) there are law-related barriers that contribute to poor pain management practices; (3) all patients have a right to adequate pain and symptom management; and (4) The American Bar Association has an opportunity and a responsibility to seek removal of legal barriers and to support patients’ rights to effective pain and symptom management.

I. Problem: Pain is Widely Undertreated

Pain is prevalent in cancer, especially near the end of life, and in many other diseases and conditions. Unfortunately, pain and other distressful symptoms often are not treated adequately, despite the availability of effective pharmacological and other options for relieving most pain. This was a conclusion of a benchmark review of the state of end-of-life care in the United States, published by the Institute of Medicine in 1997. Inadequate pain relief can impair all aspects of life and sometimes lead to a person’s wish for death.

A growing number of studies confirm the undertreatment of many kinds of pain in a variety of settings and affecting a variety of populations, particularly minority, older, and cognitively impaired patients.

- In 1995, the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) found that among patients with life-threatening illness who were able to speak, half of them, by their families’ report, spent most of their last few days in moderate to severe pain.

- A study published in the Journal of the American Medical Association (JAMA) in 1998, examining the prevalence and predictors of daily pain and pain management in 13,625 nursing home residents age 65 and older suffering from cancer found that daily pain is prevalent among these residents and often untreated, particularly among older and minority patients.

1. Institute of Medicine, National Academy of Sciences, Approaching Death: Improving Care at the End of Life 5 (1997).
2. See, e.g., Victoria Cherrie, “Man Jumps to His Death at Baptist,” Winston-Salem Journal, Jan. 18, 2000, at B-1 (54 year-old man suffering from a painful form of cancer jumped to his death from the window of a hospital).
now renamed the Agency for Health Care Research and Quality) stated in its 1994 guidelines on cancer pain management that 90 percent of cancer pain could be controlled “through relatively simple means” — with existing legal medications.

- A similar study of nonmalignant pain among 49,971 nursing home residents, published in 1999, likewise concluded that daily nonmalignant pain is prevalent among nursing home residents. Even when pain was recognized, men, racial minorities, and cognitively impaired residents were at increased risk for undertreatment.

- In a study of 281 minority outpatients suffering from cancer, Cleeland et al found that 77% reported pain or took analgesics, 41% of those reporting pain had severe pain. Sixty-five percent of minority patients did not receive guideline-recommended analgesic prescriptions compared with 50% of non-minority patients.

- A growing body of literature has also demonstrated widespread undertreatment of pain in patients with AIDS. For example, a 1996 study report by William Breitbart et al of the Memorial Sloan-Kettering Cancer Center in New York evaluated the adequacy of pain management and predictors of pain undertreatment in a sample of 366 ambulatory AIDS patients. Sixty-two percent of the patients reported persistent or frequent pain over the 2 week period prior to the survey. Nearly 85% of the patients were classified as receiving inadequate analgesic therapy, and less than 8% of the patients who reported “severe” pain were prescribed a strong opioid (e.g. morphine) as suggested by published guidelines. Women, less educated patients, and patients who acquired HIV from needle-sharing were most likely to have received inadequate analgesic therapy.

- In a July 1993 report of the attitudes and practices of 897 physicians dealing with cancer pain, researchers found that 86% of the physicians felt that the majority of patients with pain were undermedicated. Only 51% believed that pain control in their own practice setting was good or very good, and 76% reported that poor pain assessment was the single most important barrier to adequate pain management. Sixty-one percent identified physician reluctance to prescribe opioids as a barrier to good pain management.

II. There Are Law-Related Barriers to Effective Pain Management

Apart from the federal Controlled Substances Act, which focuses primarily on drug trafficking and diversion, the prescription, dispensing, and administration of opioid drugs is primarily regulated by the states. States are responsible for regulating medical, pharmacy, and nursing practice. Studies have concluded that state policies are not as balanced as international and federal levels.

---

federal policy. Many state drug anti-diversion laws do not recognize the medical value of controlled drugs as does federal law. States also have laws, regulations, or other governmental policies that place greater restrictions on prescribing and dispensing of opioids than does federal policy. Such policies interfere with decisions about the care of individual patients that require medical expertise rather than government dictum.

Beginning in the mid-1980’s, studies by various groups and individuals have identified regulatory impediments to pain management in state policies. And, a more recent succession of reports addressing pain management has highlighted impediments to pain management in state policies. The impediments include lack of legal recognition of the medical value of opioids, limitations on prescribing and dispensing, exclusion of substance abusers from prescriptions for pain medications, physician concern about discipline, and the confusion of physical dependence with addiction in both policy and practice. Many of the restrictive provisions in state policies date back several years and appear to be based on outdated knowledge about pain, opioids and addiction.

Perception of the law is frequently a more powerful factor in human affairs than the substance of the law. This is nowhere more true than in the field of medicine. Research suggests that physician perception of the risk of disciplinary action or investigation resulting from aggressive pain management is widespread. In 1996, an International Narcotics Control Board survey of impediments to opioid availability reported that: “reluctance to prescribe or stock opiates owing to concerns about legal sanctions ranked third (47%).”

In 1990, the World Health Organization Expert Committee on Cancer Pain Relief and Active Supportive Care recognized that:

---

Health care workers may be reluctant to prescribe, stock or dispense opioids if they feel that there is a possibility of their professional licenses being suspended or revoked by the governing authority in cases where large quantities of opioids are provided to an individual, even though the medical need for such drugs can be proved.1

Studies also confirm that drug anti-diversion policies do have an effect on the rate of prescriptions for, and perhaps increase the use of, less effective or even harmful medications.14 One study reported that when Texas introduced a multiple-copy prescription program, prescriptions for opioids to control pain were halved.15 It is not known whether this dramatic drop resulted from declines in inappropriate prescribing and diversion or whether physicians and pharmacists became reluctant to prescribe appropriate medications. Nonetheless, the magnitude of the change makes it reasonable to expect that the regulation had some impact on patient care.16

Other authors have examined the adverse impact on pain management practices caused by criminal investigations and prosecutions of physicians and nurses in connection with their care of dying patients.17 These analyses conclude that the criminal law has failed to protect patients and families and has significant power to deter appropriate pain management for dying patients.

In the last decade, efforts by a variety of individuals, cancer pain initiatives, patient groups and state agencies have begun to reform state pain policy.18 Especially instructive is an initiative to provide a comprehensive picture of state pain policy by the Pain and Policy Study Group at the University of Wisconsin. This project has published a guide to evaluating state pain policy with

---

comparative information on 17 states. The project is working on a second volume that will cover all 50 states.

A number of states have adopted "Intractable Pain Treatment Acts" (IPTA) or medical board guidelines on prescribing for treatment of pain. In some cases, these changes have produced more balanced state policies; however, some of these changes have also resulted in more restrictions and requirements, especially under some state IPTAs. As an alternative or supplement, many states have looked to improving guidelines or regulations instead. To promote consistency in state medical policy, the Federation of State Medical Boards adopted in May 1998 Model Guidelines for the Use of Controlled Substances for the Treatment of Pain. It is a useful model, not yet adopted by the majority of states. However, the trend to adopt state medical board policy statements on pain management is likely to continue and may also affect pharmacy and nursing practice regulation.

While all these developments provide signs of hope, they are beginning steps that need the support of the legal community if they are to overcome the deeply embedded cultural, social, legal, and medical misunderstanding of pain and symptom management practices.

III. Adequate Pain and Symptom Relief Should Be Considered a Basic Legal Right and Clinical Duty

Recognition of a legal right to pain and symptom relief was given support in the June 1997 decisions of the United States Supreme Court in Washington v. Glucksberg and Vacco v. Quill. Although these cases ruled that terminally ill individuals have no constitutional right to assistance in committing suicide, the Court placed great significance on the fact that, in the two states in question, no laws impeded access by the terminally ill to adequate pain relief, even to the point of causing unconsciousness and hastening death. Justices Breyer, Ginsburg and O'Connor agreed that "were state law to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life...then the Court might have to revisit its conclusions in these cases." The Court's stance has been viewed by many as an endorsement of the doctrine of "double effect."

23 117 S.Ct. at 2303 (J. O'Connor, concurring in Glucksberg and Quill); 117 S.Ct. at 2311 (J. Breyer concurring in Glucksberg and Quill).
24 117 S.Ct. at 2312 (J. Breyer concurring in Glucksberg and Quill).
25 The principle of double effect - whose origin is often attributed to St. Thomas Aquinas - states that an action that has an evil consequence as well as a good one can be justified if it satisfies four conditions: (1) The action from which evil results is good or indifferent in itself; it is not morally evil. (2) The intention of the agent is upright - i.e., the evil effect is sincerely not intended. (3) The evil effect must be equally immediately causally with the good effect,
There are many pharmacologic and non-pharmacologic treatments that may be used to relieve pain. Opioid analgesics in the class of morphine are safe, effective, and essential for the medical management of pain, especially for severe pain. To relieve pain, opioids must be available when and where patients need them and in adequate amounts. Physicians, pharmacists and nurses must be able to prescribe, administer and dispense opioids confidently when needed, according to individual patient needs. The Uniform Controlled Substances Act clearly recognizes that: “Legitimate use of controlled substances is essential for public health and safety, and the availability of these substances must be assured.” Likewise, the Federation of State Medical Boards of the United States “encourages physicians to view effective pain management as part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness.”

One state, California, has recently adopted a “Pain Patient’s Bill of Rights, addressing the use of opiate drugs for treatment of severe chronic pain.” The key provisions are:

(a) A patient suffering from severe chronic intractable pain has the option to request or reject the use of any or all modalities in order to relieve his or her severe chronic intractable pain.

(b) A patient who suffers from severe chronic intractable pain has the option to choose opioid medications to relieve severe chronic intractable pain without first having to submit to an invasive medical procedure, which is defined as surgery, deactivation of a nerve or other body tissue by manipulation, or the implantation of a drug delivery system or device, as long as the prescribing physician acts in conformance with the provisions of the California Intractable Pain Treatment Act...

(c) The patient’s physician may refuse to prescribe opioid medication for the patient who requests a treatment for severe chronic intractable pain. However, that physician shall inform the patient that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opioids.

(d) A physician who uses opioid therapy to relieve severe chronic intractable pain may prescribe a dosage deemed medically necessary to relieve severe chronic intractable pain, as long as that prescribing is in conformance with the California Intractable Pain Treatment Act...

(e) A patient may voluntarily request that his or her physician provide an identifying notice of the prescription for purposes of emergency treatment or law enforcement identification.

The California law represents an attempt to establish by legislative decree widespread awareness and implementation of a legal right to adequate pain relief. It may be debated whether such a legislative approach will prove productive, or possibly even produce unforeseen adverse

---


27 Uniform Controlled Substances Act, Prefatory Note (1990).

28 Federation of State Medical Boards of the United States, supra note 10, at 1.

consequences. The proposed recommendation before the House of Delegates does not propose or oppose this particular solution. The recommendation states the essential components of the right and the domains of public policy that should be examined to ensure support of the right.

IV. Rationale for ABA Action

There are many reasons for the persistence of poor pain management practices – educational, cultural, financial, and legal. As the leader and representative of the legal profession, the ABA has an opportunity and a responsibility to seek removal of legal barriers to good palliative care and to promote respect and support for patients’ rights to effective pain and symptom management. The evidence suggests widespread violation of this right, especially affecting the very old and minorities. This recommendation advances that important objective. Further, it appropriately advances Goal 3 of the Association: to provide ongoing leadership in improving the law to serve the changing needs of society.

V. Relevant Pending Legislation and Related Association Policy

The following three bills in the Congress, as of February 2000, address pain management issues:

A. The Advance Planning and Compassionate Care Act
   S. 628 – by Sen. Rockefeller (D-WV) & Susan Collins (R-ME) introduced 3/16/99.
   Summary: Amends Titles 18 and 19 of the Social Security Act. The bill...
   1. Strengthens Patient Self-Determination Act, requiring opportunity to discuss health care decision making with trained professional;
   2. Requires Advance Directives to be placed in a prominent part of one’s medical record.
   3. Strengthens the portability of Advance Directives across state lines;
   4. Provides for Medicare coverage of self-administered pain medications for life-threatening disease & chronic pain;
   5. Requires the Department of Health & Human Services (DHHS) to study ways to improve Advance Directives and to develop standards/measures to evaluate end-of-life care; funds new initiatives to improve end-of-life care;
   6. Establishes a 24-hour Hotline & Information Clearinghouse.

   Status in Senate: Referred to Senate Commerce Committee’s Subcommittee on Health & Environment. No action as of 4/21/00.

---

31 See Institute of Medicine, supra note 1.
102

B. The Conquering Pain Act
Summary: Amends the Public Health Service Act to provide for a public response to the public health crisis of pain, and for other purposes:
1. Mandates guidelines, satisfaction surveys, quality improvement projects, and Medicare report cards regarding pain control — through the Agency for Health Care Research and Quality, the Health Care Financing Administration (HCFA) & others;
2. Establishes Family Support Networks (through the Public Health Services);
3. Requires studies of reimbursement barriers (by MedPac and the General Accounting Office);
4. Establishes a DHHS Advisory Committee on Pain and mandates an Institute of Medicine report on the underuse of opioids;
5. Authorizes provider performance demonstration projects (Public Health Service).
Status in Senate: Referred to Committee on Health, Education, Labor & Pensions where one hearing was held on 10/13/99. No further action taken as of 4/21/00.
Status in House: Referred to Commerce Committee’s Subcommittee on Health & Environment and Committee on Ways & Means on 6/14/99. No action taken as of 4/21/00.

C. Pain Relief Promotion Act
Summary:
1. Amends the Controlled Substances Act (CSA) to reinforce legitimacy of using opioids for pain & symptom management;
2. Explicitly preempts state laws that permit physician-assisted suicide laws, such as the law in effect in Oregon. The consequence is that physicians in Oregon who assist in a suicide under state law could have their registration under the CSA revoked or denied by the Drug Enforcement Agency, thereby depriving the physician of authority to write prescriptions for controlled substances;
3. Requires Public Health Service to develop palliative care research and collection/dissemination of protocols;
4. Authorizes grants for education of health care professionals.
Status: On October 27, 1999, the U.S. House of Representatives approved HR 2260. The bill is now in the Senate Judiciary Committee. As of 4/21/00, committee mark-up is scheduled for 4/25/00. Meanwhile, the companion bill (S 1272) is in the Committee on Health, Ed, Labor & Pensions, where one hearing was held on 10/13/99, but no further action has been taken as of 4/21/00.

This proposed ABA policy would enable the ABA to support the components of these bills that further pain relief improvement. The ABA already has policy in support of strengthening the use of health care advance directives, as proposed by the Advance Planning and Compassionate Care
Act. The recommendation does not take a position on the controversial provision of the Pain Relief Promotion Act that would override state laws that permit physician-assisted suicide. The ABA neither supports nor opposes physician-assisted suicide. The ABA policy on that subject was adopted in August 1997 and states:

RESOLVED, That any consideration of the matter of physician-assisted suicide which involves personal, religious, emotional, medical, legal and ethical considerations and considerations of appropriate care alternatives, supportive services, pain relief, potential for abuse, legal protection, competency and needed research in many fields, should be left to be resolved by state legislatures and their electorates after extensive and informed public discussion.

FURTHER RESOLVED, That in the event that any state or territory chooses to adopt legislation permitting physician-assisted suicide, it should ensure that information and reporting systems are established to achieve close monitoring of the impact of such practice, especially with respect to vulnerable populations who may be particularly at risk if such practices are authorized.

The American Medical Association was asked to comment on a draft version of this policy and, by letter dated April 10, 2000, from Thomas R. Reardon, MD, President, the AMA made one recommendation that has been accommodated in the final language of this resolution. The draft language in paragraph two had referred to the rights of “individuals suffering from serious and complex illness.” Dr. Reardon’s letter made the following point:

The Draft Recommendation to be submitted to the ABA House of Delegates in not in conflict with applicable AMA policy except that the right to choose and receive effective pain evaluation, management and treatment is extended only to “individuals suffering from serious and complex illness.” My concern is that not all patients who suffer from intractable pain fit within the generally accepted definition of “individuals suffering from serious and complex illness.” I am enclosing a copy of the AMA Council on Scientific Affairs report from the 1999 Annual Meeting with the appendices included so that your Commission can consider whether different wording to describe those individuals included in the class entitled to choose effective pain management might better accomplish the objective of the Commission.

In response to this comment, the Commission on Legal Problems of the Elderly changed the final language of the resolution to delete the phrase “individuals suffering from serious and complex illness...” and replace it simply with, “individuals suffering from pain...”

VI. Detailed Explanation of Recommendation Language

The general principle stated in this recommendation is based upon the premise that decisions about pain management are within the province of doctor-patient decision-making and should not be interfered with by laws or regulators in the normal course of medical care. Inappropriate interference may occur not only from the enactment of restrictive legislation but also from the way existing “neutral” legislation is construed or applied. Therefore, the recommendation calls
for government authority to construe, apply, and if necessary, amend laws regulating the health professions and controlled substances.

The second paragraph positively articulates the goal of the first paragraph: to support fully the right of individuals suffering from pain to be informed of, choose, and receive effective pain and symptom management as part of basic medical care. The recommendation further seeks to dispel the all too common misperception that aggressive pain management poses a risk of addiction. The misperception is in part a consequence of the moral, cultural, and legal war on drug abuse waged by our nation. The confusion can be dispelled but it requires the leadership of both the medical and legal professions together.

Adoption of this policy enables the ABA to take steps if necessary to remedy sometimes unintended consequences of poorly designed public policies. For example:

- In order to ease physician fear of prescribing high opioid doses to treat intractable pain, about a dozen states have enacted Intractable Pain Treatment Acts (IPTAs). These laws typically define “intractable pain” as pain “which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts...” (emphasis added). Although “intractable” has a common dictionary meaning of “hard to manage” or “stubborn,” the term is given more extreme meanings in many IPTAs: it is a pain state in which no relief or cure is possible, or none has been found after reasonable efforts. The implication is that use of opioids as characterized in the IPTAs is beyond “reasonable efforts.” IPTAs that use such language characterize opioids as a “last resort” and as being outside the generally accepted course of medical practice. Thus, while trying to promote the use of opioids for intractable pain, this negative characterization reinforces the very misperception that has discouraged the use of these controlled substances in the first place. Further, it reinforces a generalized fear of culpability, since practices outside the legitimate professional practice of medicine may constitute a violation of federal or state controlled substances law.

- Drug abuse efforts to combat addiction may muddy the waters of clinical practice. According to the survey by the International Narcotics Control Board, the impediment to improving availability and use of opioids for pain management most frequently identified by government narcotic control agencies was concern about opioid addiction. Current science and clinical experience suggest that many commonly held assumptions about the risk of addiction in opioid use for pain need modification. The seminal report of the Institute of Medicine on improving end-of-life care concluded that drug tolerance and physical dependence should be more uniformly and clearly distinguished from addiction. Tolerance occurs when a constant dose of a drug produces declining effects or when a higher dose is needed to maintain an effect. Physical dependence on opioids is characterized by a withdrawal effect following discontinuation of a drug. Such dependence is a common effect in chronic pain management, but it is not restricted to opioids. Neither physical dependence nor tolerance should be equated with addiction or substance abuse. Addiction is a

\[\text{Tex. Rev. Civ. Stat. Art. 4495c, §2(3).} \]
\[\text{International Narcotics Control Board, supra note 12.} \]
psychological and behavioral syndrome characterized by: (1) the loss of control over drug use, (2) compulsive drug use, and (3) continued use despite harm. Some state regulatory policies state that unprofessional conduct can be based on the number of doses or the duration of the prescription. Yet, neither international law nor U.S. federal controlled substances policy limits the dose, amount or duration of prescribing. Some state laws limit the amount of controlled substances that can be prescribed or dispensed at one time, apparently to prevent diversion and addiction. However, these quantity limits may not be sufficient to meet the individual needs of patients under all circumstances, and can result in inadequate treatment of pain.

Similarly, federal law and most state laws do not establish a period of validity for a controlled substances prescription (i.e., the number of days within which the prescription must be dispensed following its issue). However, some states have limited the period of validity to as little as 3 days. Unrealistically short validity periods can make it difficult for a patient to obtain medications without having to make extraordinary and burdensome arrangements.

The Federation of State Medical Boards of the United States declares in its recently developed model guideline:

The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goal is to control the patient's pain. This is consistent with the World Health Organization's recommendation:

Decisions concerning the type of drug to be used, the amount of the prescription and the duration of therapy are best made by medical professionals on the basis of the individual needs of each patient, and not by regulation.

Several states have enacted "prescription monitoring programs" that require the physician to issue prescriptions for controlled substances in certain schedules using only special government-issued single-copy, duplicate or triplicate forms. Studies show that these policies may deter legitimate prescribing of opioids:

Triplicate prescription programs require the prescribing physician to complete detailed, multiple-copy prescription forms. The forms themselves are often difficult to obtain and, if incorrectly filled out, must be completed again by the physician. The triplicate forms also become available to the state medical board, which may choose to pursue disciplinary measures on the basis of such information. Electronic forms and monitoring systems would ease the burden on physicians as well as allow easier monitoring but such systems have not been widely adopted or rigorously evaluated.

---

34 Institute of Medicine, supra note 1, at 193-94.
35 Pain & Policy Studies Group, supra note 10, at 22.
36 Federation of State Medical Boards, supra note 10, at Section I: Preamble.
38 See Institute of Medicine, supra note 1, at 191.
The above examples serve to illustrate some of the specific issues to which the proposed policy is relevant. As already noted, the policy does not propound or oppose a particular legal solution to the problem of inadequate treatment of pain. The recommendation states the essential components of such a right and identifies the domains of public policy that should be examined to ensure support of the right. The ABA is ideally suited to be a leader in any examination of the impact of law and policy on individuals and society. The recommendation enables the ABA to be a part of the discussion and a part of the solution.

Respectfully submitted,

F. Wm. McCalpin, Chair
Commission on Legal Problems of the Elderly
April 2000
GENERAL INFORMATION FORM

Submitting Entity: Commission on Legal Problems of the Elderly
Submitted By: F. Wm. McCalpin, Chair

1. **Summary of Recommendation(s).**
   The recommendation calls for government authority to construe, apply, and if necessary, amend laws regulating the health professions and controlled substances so that these laws do not impose barriers to quality pain and symptom management. Further, the recommendation supports the right of individuals suffering from pain to be informed of, choose, and receive effective pain and symptom evaluation, management, and ongoing monitoring as part of basic medical care. It is emphasized that this right is not abated even where such pain and symptom management may result in analgesic tolerance, physical dependence, or as an unintended consequence shorten the individual’s life.

2. **Approval by Submitting Entity.**
   Approved at the February 4-5, 2000 meeting the Commission on Legal Problems of the Elderly.

3. **Has this or a similar recommendation been submitted to the House or Board previously?**
   No

4. **What existing Association policies are relevant to this recommendation and how would they be affected by its adoption?**
   Generally related ABA policies are:
   - Policy of neutrality toward physician-assisted suicide laws, adopted August 1997.
   - Policy supporting the right of competent individuals to consent to or refuse any suggested medical treatment and for appropriate surrogates to do so on behalf of individuals lacking capacity, adopted February 1990
   - Policy supporting legislation that would provide access for every American to quality health care. Reaffirmed February 1994
   - Policy encouraging the use and recognition of durable powers of attorney for health care, adopted August 1989
   None of these policies are affected by this resolution. The resolution is consistent with all existing ABA policy.

5. **What urgency exists which requires action at this meeting of the House?**
   Three bills supporting improved pain and symptom management are pending in Congress, and palliative care issues are being examined by the majority of states.

6. **Status of Legislation. (If applicable.)**
   Details of the three bills pending in Congress are provided in the report.

7. **Cost to the Association. (Both direct and indirect costs.)**
   None
8. Disclosure of Interest. (If applicable.)
None

9. Referrals.
Sections:
- Administrative Law and Regulatory Practice
- Dispute Resolution
- Family Law
- General Practice, Solo and Small Firms
- Government and Public Sector Lawyers Division
- Health Law
- Individual Rights and Responsibilities
- Judicial Division
- Litigation
- Real Property, Probate and Trust Law
- Science and Technology
- Senior Lawyers Division
- State and Local Government Law
- Tort and Insurance Practice
- Young Lawyers Division

Committees/Commissions:
- Standing Committee on Legal Aid and Indigent Defendants
- Commission on Domestic Violence
- Commission on Homelessness and Poverty
- Consortium on Legal Services and the Public
- Medical Professional Liability
- Commission on Mental and Physical Disability Law

Other: American Medical Association

10. Contact Person. (Prior to the meeting.)

F. Wm. McCalpin, Chair
Cmn. on Legal Problems of the Elderly
c/o Lewis, Rice & Fingerth
500 N. Broadway, Suite 2000
St. Louis, MO 63102
(314) 444-7600
(314) 612-7708 FAX
fmccalpin@lewrisrice.com

Charle Sabatino
Assistant Director
Cmn. on Legal Problems of the Elderly
740 Fifteenth St., NW
Washington, DC 20005
202-662-8686
202-662-8698 (FAX)
sabatino@staff.abanet.org

11. Contact Person. (Who will present the report to the House.)
F. Wm. McCalpin, Chair
Commission on Legal Problems of the Elderly
Same as above.