Kosovars. With winter closing in on Kosovo and up to 70,000 ethnic Albanians hiding in the mountains without food or shelter, we are looking at the virtual certainty of a humanitarian catastrophe if something is not done to bring relief to those people and to ensure the safety of the other 250,000 to 400,000 Kosovars who have been forced from their homes by the fighting.

There is a strong case to be made that dealing with the situation in Kosovo now will help to prevent it from becoming a flashpoint that could draw other nations into the conflict like moths to a flame.

Viewed in that light, Kosovo is much, much more than a humanitarian endeavor. But we in the Congress have no right to wring our hands over the plight of the Kosovars while refusing to even debate whatever role wisdom may dictate that Congress should play. We have no right to be bold when it comes to criticizing NATO's proposed action while being timid when it comes to doing our job. Regardless of what anyone else does, Congress has a constitutional duty to authorize whatever action it deems necessary. We do no one any favor by surrendering our duty to the executive branch.

Mr. President, we cannot adequately address the crisis in Kosovo in the time we have remaining in this Congress, but that does not mean we ought to completely abandon our responsibility. NATO is prepared to conduct airstrikes in the event the agreement reached in Belgrade falls apart. Congress should be equally prepared in its sine die adjournment resolution. Congress should be ready and should manifest that it is ready to reconvene on the call of the bipartisan joint leadership of the two Houses of Congress if the situation warrants it.

BREAST CANCER AWARENESS MONTH

Mr. BYRD. Mr. President, October is Breast Cancer Awareness Month, a time when we work to heighten people's awareness of breast cancer and the importance of early detection through mammography and self examination.

Breast cancer is the most prevalent cancer among women with one in nine women at risk of developing breast cancer over her lifetime. That is up from a risk that, in 1960, was just one in fourteen! In West Virginia, the American Cancer Society estimates that this year 1,200 women will be diagnosed with breast cancer, while nearly 300 women in the State will die from the disease. Across the country, more than 43,000 women will lose their battle with the disease this year, while more than 178,000 women will just begin their fight. Too many people know the pain of losing a loved one to this devastating, terrible disease.

The startling statistics on the incidence of breast cancer call for a strong Federal response, and that is what Congress has worked to provide. Since 1990, the Congress has increased cancer research funding by 54 percent. For this new fiscal year, I believe that the Senate is heading in the right direction with its version of the Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations bill. This measure contains more than $15.5 billion for the National Institutes of Health (NIH), which is an increase of $2 billion over the level appropriated last year. Within that amount, the National Cancer Institute (NCI) would receive almost $3 billion—a 15-percent increase over last year. It is my hope that the final appropriations measure for the NIH, the National Institutes of Health, and the NCI, the National Cancer Institute, will retain these sizable increases. The research performed and funded by NIH is crucial to our Nation, crucial to those suffering from this dreadful disease, and crucial to the families of those who are suffering.

The strong national investment in cancer research is producing some promising results. For instance, an exciting new avenue being tested for breast cancer prevention is the drug tamoxifen. This therapy potentially promises to prevent 50 percent of breast cancer cases in women who run a high risk of developing the disease.

Additionally, there are a number of new treatment options being studied, including such practices as gene therapy and hormonal agents. This combination of research and new therapies is lending hope to the many women and their families who are blighted by this devastating disease. Let us continue to invest in programs to address the scourge of cancer, breast cancer in women in particular.

Early detection of breast cancer is critical, and, according to medical experts, mammography is the best way to find the disease in its early stages. In West Virginia, about 73 percent of women have had a clinical breast examination and mammogram. That is good, but not good enough. West Virginia still lags behind the national median of 77 percent. So we need to do more.

In an effort to boost breast and cervical cancer prevention, I helped to launch the first-ever West Virginia cancer prevention, education, and screening project in 1990. As a result of this effort and other programs that have partnered with it, between 1989 and 1995, West Virginia experienced a 45 percent increase in the number of women receiving mammograms. We need to continue working together to increase the number of women having mammograms.

Mr. President, I ask unanimous consent to proceed for 2 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BYRD. When a breast cancer tumor is found in its earliest stages, a woman has a better than 90 percent chance of long-term survival. Places like the Mary Babb Randolph Cancer center in Morgantown play an important role in early detection and community education. The center proved to be a life-saver for Jorie Florek. She is a professional golfer from New York State who played in a West Virginia golf tournament to raise money for the cancer center. During the tournament, doctors and nurses from the center provided women with breast cancer information, including instructions on how to perform self examinations. Using that information, Jorie detected a lump that, unfortunately, turned out to be malignant. However, through early detection and aggressive treatment at the cancer center, Jorie is now cancer free.

Another West Virginia success story is that of Stephanie Juristy. Stephanie was working, going to school, raising her teenage son, and planning a wedding when she was diagnosed with breast cancer in 1995. She received treatment at the cancer center, undergoing surgery and chemotherapy, and participated in clinical trials of new treatments. Stephanie is now married, working full-time, and preparing to graduate from school. She is also an advocate for patients in Morgantown, sharing her experiences and knowledge with other women.

Early detection, treatment, and research are all important components in the war against breast cancer. Strides are being made in each of these areas, and, hopefully, one day will lead to a cure for all cancer. And that will be a glorious—glorious—day. However, until then, we must remain vigilant and continue to encourage women to get mammograms and to self screen, and we must continue to make a strong investment in cancer research to press forward for a cure. As we recognize Breast Cancer Awareness Month, let us redouble our efforts to tackle this disease that takes such a devastating toll on our Nation.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon is recognized, under the previous order.

Mr. WYDEN. Thank you, Mr. President.

Before he leaves the floor, I thank the Senator from West Virginia for the unanimous consent request that he made that ensured I would have the opportunity to speak now and also to thank him for all that I have learned from him during my first years in the Senate.

It is one thing to take out a book that describes some of the procedures and the rules of the Senate, but it seems to me that there is no better way to learn about the Senate and the very high standards that are so important here than to simply watch the Senator from West Virginia for a few hours on the floor of the Senate.

Mr. BYRD. I thank the distinguished Senator for his very gracious felicitations. He is a far better student than I am a teacher. I thank him.

Mr. WYDEN. I thank the Senator.

OREGON'S ASSISTED SUICIDE LAW

Mr. WYDEN. Mr. President and colleagues, I take the floor this afternoon because it is my understanding that democracy in Oregon has won at least a temporary victory. I have been informed that there will be nothing attached to the comprehensive spending bill that would override Oregon's assisted suicide law.

While I intend to be very vigilant to monitor any further discussions that take place on this matter, I come today to talk about why this issue is so important not just to my constituents but to all Americans. And I also thank the participants in the budget negotiations for their willingness to leave out this matter that is so complicated and controversial.

I had informed the leadership of both political parties that I was prepared to speak at considerable length if there had been an effort as part of the final budget bill to toss Oregon's ballot measure on assisted suicide into the trash can. I was prepared to do this in spite of the fact that I have personal reservations about assisted suicide. I was prepared to do this because I believe that nothing is more important than the people's right to govern themselves.

When the people of our States have made difficult decisions, difficult moral decisions about matters that have historically been within the purview of the State governments, it is out and out wrong for the Congress to butt in and override those decisions of voters in the States.

The voters of my State have spoken clearly. In two separate referendums, the verdict was clear: Physician-assisted suicide should, under limited circumstances, be legal in the State of Oregon. If the Congress of the United States, meeting 3,000 miles away, had tossed those decisions aside, in a last-minute backroom deal, it would have been a great insult to the people of Oregon and in my view would have contributed mightily to skepticism and cynicism about Government.

It would have been a mistake because there were many questions raised about the measure drafted by the Senator from Oklahoma who, it seems to me, is very sincere about his interest in this subject. In addition to overriding the popular will of the people of my State, his measure would have also set back considerably the cause of better pain management for patients in end-of-life care.

That would have had serious consequences for the treatment of patients in severe pain across this country. His measure would have great implications not just for the people of Oregon, but for the people of all our States. More than 55 groups representing the medical community, many of whom oppose physician-assisted suicide, joined together in an unprecedented coalition to oppose the legislation of the Senator from Oklahoma because of their fear that doctors and other medical providers would be hampered. They feared that the cause of providing pain care to their patients would be set back by the way the legislation by the Senator from Oklahoma was written. I thank all of these groups for their commitment to humane care and for their hard work on this issue.

The key groups that led the coalition were: The Americans for Better Care of the Dying, the American Geriatrics Society, the American Pharmaceutical Association, the National Hospice Organization, the American College of Physicians-American Society of Internal Medicine, and the American Medical Association.

One of the reasons that so many of these groups worked so hard with respect to keeping out of the spending bill legislation that would overturn Oregon's law was their sincere belief that the legislation by Senator NICKLES would have harmed the effort to promote good pain management.

The Nickles legislation would have given the Drug Enforcement Administration new authority to look at every prescription of a controlled substance to determine for what it was intended. In addition, doctors and pharmacists under this legislation have had to be mind readers about what their patients were going to do with one of the drugs that was used under the Controlled Substances Act. Was the patient going to take a medication as prescribed for pain management, or would they have sought to use it to kill themselves?

There is ample scientific evidence that pain management is not performed as well as it might be at this time. And to add further complexities and a broader role for an agency like the Drug Enforcement Administration to step into an area where it has never been before would have, in my view, added additional barriers and complexities to the effort to promote hospice care, palliative care, comfort care, and advance the science of pain management.

Recently, the findings of a study in Oregon done in 1997 were published that show that families reported relatively constant levels of moderate to severe pain during their loved one's final week of life. During the final months in 1997, families reported higher rates of moderate to severe pain for those dying in acute care hospitals. There was one exception, which was when a loved one died in an acute care hospital in late 1997. An important study showed a statewide trend indicating that there were in so many cases moderate to severe pain for these individuals in the last week of life who would have required a physician and others to step in and advocate for those patients.

I have received many letters and a great deal of e-mail from chronic pain patients. These stories are heartbreaking. They point out that it could be any one of us or any one of our loved ones or constituents who finds themselves in chronic, excruciating pain as a result of an accident or through the development of some painful, chronic disease.

Unfortunately, pain patients in the current regulatory environment feel in many instances—and they have told me—as if they are treated like junkies, and that their providers are extremely nervous about how to use pain management in a climate where, had the Nickles legislation been adopted, certainly you would have had the Federal Government looking over the shoulders of doctors and pharmacists with respect to their motivation in prescribing drugs for those who are suffering these acute health and chronic ailments.

We need to do a great deal more. We can do it on a bipartisan basis to advance the cause of pain management. I have had a number of discussions on this matter with Senator MACK, who has done, in my view, excellent work on a number of health issues. Senator SMITH of my State is greatly interested in these matters. I believe we ought to work together so that early next year we can bring before the health committees—and I see our friend from the State of Texas, the chairman of the Subcommittee on Health Care, is here; he has a great interest in these issues—a bipartisan package to promote good pain management before the Senate next year. We do need to do more to help the dying and those who suffer from chronic pain.

I believe that the mere threat of legislation would put the Drug Enforcement Administration into such an intrusive role that physicians, pharmacists, and other health providers would be reluctant to use these medications and future medications that promote pain management, comfort care, and hospice care. The mere threat of this legislation would be a real setback to the kind of health care services that the vast majority of Americans want to see expanded.

Certainly Americans can have differences of opinion on the issue of assisted suicide. I voted against our ballot measure once. I voted for the repeal of it the second time. I voted against Federal funding of assisted suicide. My reservations with respect to this topic are clear. But I think it is wrong for the Federal Government to butt in and override the voters of my State, on a matter that has historically been left to the States. It is especially wrong to do it in a way that is going to allow the Federal Government, particularly through the Drug Enforcement Administration, to play such an intrusive role that doctors, pharmacists, and other health providers will feel uncomfortable and reluctant to assist their patients who are suffering chronic and extraordinary pain.

We have heard reports in Oregon from hospices where doctors have been reluctant to prescribe needed amounts of pain medication because they were