



Special report

Can we afford “America's Affordable Health Choices Act”?

Rita L. Marker

“America's Affordable Health Choices Act of 2009” (HR 3200) has been more widely debated, discussed and distorted than any legislative proposal in recent memory. Its stated intent is “to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes.”¹ For those who have taken the time to read the bill, there seems to be more emphasis on cost containment and other purposes than on quality health care.

One particular portion of the bill, Section 1233, dealing with “Advance Care Planning Consultation,”² has been particularly contentious.

What, specifically, does that section do?

It provides payment to practitioners (doctors, nurse practitioners, and physicians' assistants) who provide “advance care planning consultations” to Medicare patients. While the consultations are not mandatory (at least for now), if they do take place, their contents are. Among required elements that each consultation “shall include” are an explanation of legal documents such as living wills and durable powers of attorney, orders regarding life sustaining treatments, and an explanation of the continuum of end-of-life services. Patients need not be experiencing a live-threatening situation but, because they are over a certain age, they will be urged to consider how they want their lives to end.

In practice, if Aunt Mildred, a healthy 65-year-old who regularly plays tennis, goes to her doctor, she will be counseled to consider her end-of-life options.

End-of-life information currently available

To hear proponents of Section 1233 talk about it, one would think that people have no access to information about advance directives. However, for years, federal law has required that patients be provided with general information about advance directives.

In 1992, Congress passed the Patient Self-Determination Act (PSDA), intended to give patients' greater control over their own health care. The PSDA mandates that health care facilities and organizations receiving Medicare or Medicaid funds comply with certain record keeping and patient notification requirements related to advance directives. These requirements include:

- At the time of admission, provide a written summary of a patient's rights under state law to make health care decisions, including the right to have an advance directive.
- Ask all adults entering for treatment whether they have an existing advance directive.

- Document the existence of an advance directive in the patient's medical record.
- Make it clear that treatment and care cannot be conditioned on the existence or non-existence of an advance directive.³

Yet those who support Section 1233 claim that physicians won't tell their patients about options regarding available treatments and the right to accept or reject those treatments unless they receive reimbursement for doing so. In fact, a physician already has a responsibility to provide that information to patients so they can give or withhold consent to available treatments. This is known as informed consent.

Nonetheless, some say that, because of their age, Medicare patients need more details about end-of-life planning. They ignore the fact that, beginning in 2009, doctors have been required to discuss end-of-life planning, including advance directives, with all Medicare patients at their initial “Welcome to Medicare” physical exam.⁴

With all of these requirements currently in place, why the push to place even more emphasis on end-of-life consultation? Is it, perhaps, intended to be subtle (or not so subtle) pressure on elderly patients to decide that they will make a decision to forgo treatment for an, as yet, undiagnosed condition? Is this part and parcel of reducing the growth of health care spending?

Given the fact that one component of the advance care consultation will include encouraging patients to have an “order regarding life sustaining treatment” (often referred to as a POLST form), this seems highly likely. The POLST form essentially circumvents the need for any further discussion of what a patient may or may not want in the future. In practice, a physician discusses hypothetical situations with a patient and then writes orders to withhold certain treatments in the future. Those orders are maintained in the patient's medical record and can bypass the need to ask a competent patient for her wishes at the time that the order is carried out.

Section 1233's compulsory discussion about the “continuum of end-of-life services” deserves particular scrutiny. In most

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states that continuum would culminate in such services as palliative care and hospice. However, in Oregon and Washington, the continuum extends to the provision of a lethal drug prescription under those states’ “Death with Dignity” laws. This should be of concern to all.

Laying the groundwork

Section 1233 did not just show up on the doorstep of health care reform. It was packaged and delivered by Compassion & Choices (C&C), the assisted-suicide advocacy group previously known as the Hemlock Society.

According to C&C, it is “part of a great advance in end-of-life care, building upon several years of thoughtful and strategic groundwork.”⁵ C&C proudly acknowledges its leadership role in placing Section 1233 in the bill:

“Compassion & Choices and its supporters have worked tirelessly with supportive members of Congress to include in proposed reform legislation a provision requiring Medicare to cover patient consultation with their doctors about end-of-life choice (section 1233 of House Bill 3200).”⁶

“As Congress debates health insurance reform, Compassion & Choices is leading the charge to make end-of-life choice a centerpiece of any program that emerges. We are working hard to reach our goal to make end-of-life choice a centerpiece of national health insurance reform.”⁷

The organization’s strategy has entailed close cooperation with Oregon Democratic Congressman Earl Blumenauer, who the organization describes as a “longtime supporter of individual choice.”⁸ Indeed, Blumenauer has been an outspoken supporter of Oregon’s assisted-suicide law, the “Death with Dignity Act” (DWDA). During a floor speech in 1998, he stated:

“In Oregon, our legislation, Death with Dignity, is still a work in progress, but the fact is the preliminary evidence suggests that this option may actually reduce the incidence of violent suicide while **easing the burden on both the individual and their family....**”

“As we age as a society, exponentially, **with the increase of the elderly population**, and just the growth in our population, this will become more serious....The evidence suggests that Americans support the principles of Death with Dignity.”⁹

In a 2004 press release, he applauded a court ruling upholding the assisted-suicide law. “This is a great victory for the people of Oregon who decided not once, but twice that people should have the right to make personal end-of-life decisions without federal interference,” he said. “Every day people across the country struggle with these end-of-life decisions but Oregon is the only state that has protections and safeguards in place.”¹⁰ (Note that he, like other assisted-suicide activists, refers to assisted suicide as an “end-of-life decision.”)

Blumenauer’s “end-of-life” terminology is part and parcel of Section 1233. Clearly expressing his ownership of the section, he described an incident that took place when he was presiding over House proceedings. Explaining that a colleague admonished people to read the bill, specifically citing Section 1233,

Blumenauer wrote, “Actually, I know a little bit about this section because it’s a bill that I wrote which was incorporated into the overall legislation.”¹¹

His earlier incorporated bill is HR 2911, titled the “Advance Planning and Compassionate Care Act.” In fact, a portion of that bill¹² makes up almost the entirety of Section 1233.

While Blumenauer and other defenders of the advance care planning consultation in Section 1233 vociferously deny that it could have anything to do with assisted suicide, it is important to note that his earlier bill acknowledged that a discussion of assisted suicide would be included in such consultations. Since federal law currently prohibits federal funding from being used for “items and services” related to assisted suicide,¹³ Blumenauer inserted language into his bill stating that advance care planning provided in accordance with the proposal “shall not be construed to violate the Assisted Suicide Funding Restriction Act of 1997.”¹⁴ This exception is not contained in HR 3200, but it is likely that the drafters believed it was not necessary since consultation and explanation merely give information. Even more likely is the fact that they believed any reference to assisted suicide would raise red flags. Also, not contained in HR 3200 is a provision from Blumenauer’s earlier bill to “encourage providers to discuss advance care planning with their patients **of all ages**.”¹⁵

Blumenauer is not the only lawmaker to propose advance care planning consultations. Senator Mark Warner (D-VA) introduced a similar bill, quaintly titled the “Senior Navigation and Planning Act of 2009” (SB 1251).¹⁶ Warner explained that he submitted the legislation because Congress is considering health care reform and he would like to see some of his ideas incorporated into that legislation.¹⁷ His bill would **force** doctors to provide information on advance directives and other end-of-life planning tools in “a form and manner, and at a time, determined to be appropriate by the Secretary [of Health and Human Services].”¹⁸ The consequence for not doing so would be severe. No payment would be made to physicians for any items and services furnished after January 1, 2014, unless they agreed (under a process established by the Secretary of Health and Human Service) to provide individuals with information on advance directives and other end-of-life planning tools.¹⁹

What health benefits will be included under HR 3200?

If a particular intervention is not mentioned in HR 3200, does that mean that it will not be covered under any Qualified Health Care Plan (QHCP)? The answer is a resounding, “No.”

Minimum services to be covered are only very broadly defined,²⁰ with the specifics to be worked out after passage of the measure. For example, a “Health Benefits Advisory Committee” (HBAC), chaired by the Surgeon General and made up of between 18 and 26 members (9 to 17 of whom will be appointed by the President) will “recommend covered benefits.”²¹ Included in their duties would be standards respecting the essential benefits package “including categories of covered treatments” as well as “items and services within benefit classes.”²² Recommendations by the Committee would be reviewed by the Secretary of

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Health and Human Services who could propose their adoption. Standards would not be subject to Congressional approval but would, instead, be adopted through the rulemaking process.²³

The HBAC, other committees and appointed officials would essentially be in charge of telling doctors what they can and cannot provide for their patients.

Could this eventually include the actual provision of, rather than just information about, assisted suicide? That depends. The Assisted Suicide Funding Restriction Act specifically prohibits use of federal funding for “any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia or mercy killing.”²⁴ It is likely that those who eventually determine the details about what will be a covered benefit will claim that merely explaining or offering assisted suicide is solely information and does not fall within the definition of an “item or service” and, thus, would not fall within that prohibition. Less likely, but possible, is the prospect that physician-assisted suicide could be redefined as an “end-of-life option” that does not constitute assisted suicide, euthanasia or mercy killing. In fact, this type of redefinition has been done in Oregon and Washington where a death that takes place under those states’ “Death with Dignity” laws is considered a medical treatment, not assisted suicide.²⁵

In the final analysis, any particular “treatment” that is not explicitly prohibited in a health care reform bill could become a covered benefit.

Other curious elements of HB 3200

With the scrutiny on Sec. 1233, other curious additions and omissions in the current proposal have been largely overlooked. For example, much has been made of the need to reduce the incidence of obesity in the United States. But there is no mention in the bill of interventions to address this problem. Undoubtedly, those who make the final determinations of covered benefits will address weight control. However, it does seem odd that, while weight control programs are not explicitly addressed, there are specific and detailed provisions for programs such as nurse visitation services for certain families aimed at “improving... health and pregnancy outcomes or increasing birth intervals between pregnancies”,²⁶ monitored programs for families “to ensure that services are delivered according to the specified model,” including “consulting and coaching on parenting practices”,²⁷ and the establishment of more school-based health clinics.²⁸ (When school-based clinics were first introduced in the 1980s, they were intended for children whose families did not have health insurance. If health care reform will cover everyone, why is an expansion of such clinics necessary?)

There have definitely been heated and passionate debates about HR 3200. Some say that those who express concerns about the health reform bill are alarmists. Is it possible that, rather than being alarmists, those who oppose HR 3200 are realists who recognize the bill as a massive program of social engineering?

Notes

- 1 The “Affordable Health Choices Act of 2009,” Hereafter cited as HR 3200, <http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.+3200>. (last accessed 7/14/09).
- 2 HR 3200, Sec. 1233.
- 3 Omnibus Budget Reconciliation Act of 1991, Pub. L. No. 101-508, §§ 4206 and 4751, 104 Stat. 1388, 1388-115 to 117, 1388-204 to 206 (codified respectively at 42 U.S.C. §§ 1395cc(f) (Medicare) and 1396a(w) (Medicaid)).
- 4 Medicare web site, “Preventative Services: One-time ‘Welcome to Medicare’ Physical Exam,” <http://www.medicare.gov/health/physicalexam.asp> (last accessed 8/19/09).
- 5 “Compassion & Choices Works for Health Care Reform” C&C newsletter, July 2009. <http://www.compassionandchoices.org/newsletter72009> (last accessed 8/19/09).
- 6 “Opponents Distort Health Care Debate,” C&C web site, Aug. 13, 2009. <http://www.capwiz.com/compassionandchoices/issues/alert/?alertid=13786016&type=ME> (Last accessed 8/19/09).
- 7 “Health Insurance Reform,” August 13, 2009. http://www.compassionandchoices.org/act/legislative_work/healthcare_reform (last accessed 8/19/09).
- 8 “Congressman Wants Funding for Doctors and Patients to Discuss Treatment Options,” C & C newsletter, May 2009. <http://www.compassionandchoices.org/newsletter52009> (last accessed 8/19/09).
- 9 Congressman Earl Blumenauer, “Oregon Death with Dignity Law,” Congressional Record, July 14, 1998. Available at <http://www.c-spanarchives.org/congress/?q=node/77531&id=6713674> (last accessed 8/19/09) (emphasis added).
- 10 “Blumenauer Responds to Appeals Court Decision on Death with Dignity Act,” May 24, 2004. http://blumenauer.house.gov/index.php?option=com_content&task=view&id=528&Itemid=170 (last accessed 8/20/09).
- 11 Rep. Earl Blumenauer, “Unhinged,” *Huffington Post*, July 28, 2009. http://www.huffingtonpost.com/rep-earl-blumenauer/unhinged_b_246632.html (last accessed 8/19/09).
- 12 HR 2911, “Advance Planning and Compassionate Care Act of 2009,” Sec. 211. Available at <http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.+2911>; (last accessed 8/24/09).
- 13 Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. 14401 et seq.).
- 14 HR 2911, Sec. 111. This section referred to assistance through the Legal Services Corporation for advance care planning and explicitly exempts advance care planning consultations from activities addressed by the Assisted Suicide Funding Restriction Act of 1997.
- 15 HR 2911, Sec. 121 (emphasis added).
- 16 S 1251, “Senior Navigation and Planning Act of 2009,” <http://thomas.loc.gov/cgi-bin/query/z?c111:S.B.+1251>; (last accessed 8/24/09).
- 17 Thaddeus Pope, “The Senior Navigation and Planning Act of 2009” (S.B. 1251), June 13, 2009. <http://medicalfutility.blogspot.com/2009/06/s1251-senior-navigation-and-planning.html> (last accessed 8/20/09).
- 18 S 1251, Sec. 6.
- 19 S 1251, Sec. 6.
- 20 HR 3200, Sec. 122.
- 21 HR 3200, Sec. 123.
- 22 HR 3200, Sec. 123.
- 23 HR 3200, Sec. 124.
- 24 Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. 14401 et seq.).
- 25 Washington’s assisted-suicide law, the Washington “Death with Dignity Act,” states: “Nothing in this chapter authorizes a physician or any other person to end a patient’s life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. State reports shall not refer to practice under this chapter as ‘suicide’ or ‘assisted suicide.’” (RCW 70.245.180) Similarly, Oregon’s assisted-suicide law, the Oregon “Death with Dignity Act” states: “Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient’s life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. (ORS 127.880. s. 3.14)
- 26 HR 3200, Sec. 1713.
- 27 HR 3200, Sec. 1904.
- 28 HR 3200, Sec. 2511.

New information revealed about Oregon's experience with assisted suicide

Two articles, published in the current issue of *The Journal of Clinical Ethics*, shed new light on Oregon's experience with legalized assisted suicide between 1998 and 2007. The lead author of both articles is Katrina Hedberg, M.D., an epidemiologist with the Oregon Department of Human Services (ODHS) and lead author of most of the state's official annual reports on Oregon's assisted-suicide practice.

- The first article is a study that examines the first 10 years under Oregon's assisted-suicide law, the Death with Dignity Act (DWDA), for trends in doctor and patient participation.

During that period, doctors reported writing 546 prescriptions for lethal drugs that 341 patients took to end their lives. Most of the patients were White or Asian, were younger than 85, had some form of cancer, and were highly educated. In fact, those with a post-graduate education were 9.5 times more likely to opt for assisted suicide than those without a high school education. [Hedberg et al., "The 10-Year Experience of Oregon's Death with Dignity Act: 1998-2007," *Journal of Clinical Ethics*, Summer 2009, p.125; hereafter cited as 10-Year Experience.]

Researchers found "several worrisome trends." Over the 10-year span, there was an increase in patients' concern about "inadequate (current or future) pain control," despite the DWDA's requirement that lethally-prescribing doctors discuss with patients alternatives to assisted suicide, including pain control and comfort care.

Also "worrisome" is the decline in psychiatric evaluation referrals for death-requesting patients. During the first two years under the DWDA, approximately one-third of the assisted-suicide patients were referred for mental evaluations by either the prescribing doctor or the consulting physician. By 2007, not one of the 49 assisted-suicide patients who died that year were referred for evaluation. According to the study's authors, "[T]he decline in formal evaluations raises concerns that depression remains undiagnosed in some patients who request and receive a

prescription under the DWDA." [10-Year Experience, pp. 130-131]

Of the 109 different doctors who wrote lethal drug prescriptions in 2001 through 2007, 72 (66.1%) wrote one prescription and 17 (15.6%) wrote two. However, three physicians (unnamed) wrote 62 death-inducing prescriptions, amounting to almost one-fourth of all the lethal prescriptions written during the seven-year time span. Researchers note that about half of Oregon's doctors are not willing to write assisted-suicide prescriptions and that patients are likely being referred to doctors with more experience with lethal prescriptions or who are "known advocates" of the DWDA. "This may account for why half of the patients knew the prescribing physician for three months or less," researchers conclude. [10-Year Experience, pp. 127 & 131]

During years 1998 through 2007, the ODHS submitted 18 reports to the Oregon Medical Board (OMB) on doctors who had failed to comply with DWDA requirements. Law violations included improper completion of patients written death requests, failure to report assisted-suicide deaths in a timely fashion, incomplete case reports, and failure to wait the mandated 48 hours after receiving the patient's written death request before writing the lethal drug prescription. In all cases, the OMB ruled that the reported doctors had not violated good faith compliance with the assisted suicide law. [10-Year Experience, p. 127]

- The second article is an analysis of the characteristics of the 296,217 Oregonians who died between 1998 and 2007 but did not opt for physician-assisted suicide. "The reality is," the authors wrote, "that the vast majority of Oregon decedents are either not

interested in, or are medically ineligible to participate in DWDA." [Hedberg & Tolle, "Putting Oregon's Death with Dignity Act in Perspective: Characteristics of Decedents Who Did Not Participate," *Journal of Clinical Ethics*, Summer 2009, p 133; hereafter cited as Perspective.]

During the 10-year span studied, not one African-American opted for an assisted-suicide death, a finding that the authors said was consistent with their 2002 interviews of family members who said their deceased African-American relatives never personally considered assisted suicide. The lack of DWDA support and participation was evident in other minority groups as well. While 332 of the 341 patients who died by assisted suicide between 1998 and 2007 were Caucasian (97.4%), only six were Asian (1.8%), two were Hispanic (0.6%), and 1 was Native American (0.3%).

Those with "less formal education" were also less likely to want an assisted-suicide death. While 64.2 percent of those who died by assisted suicide had college and post-graduate educations, 65.8 percent of those who died naturally had high school educations or less.

Reasons cited for patients not choosing assisted suicide include, outright opposition to the DWDA by "a sizable proportion of Oregonians," illnesses where it is difficult or impossible to predict death within 6 months or less as required by law, conditions that render patients cognitively impaired, difficulty in finding a doctor willing to write a lethal drug prescription, and patients who do not live long enough to satisfy the 15-day waiting period or cannot satisfy other requirements of the law. [Perspective, p.135] ■

Oral arguments scheduled in Montana appeal

The Montana Supreme Court will hear oral arguments in *Montana v. Baxter* on September 2, 2009. The state is appealing the December 5, 2008, ruling of Montana's First Judicial District Court Judge Dorothy McCarter, who singlehandedly legalized physician-assisted suicide—a ruling she made effective immediately. When the state requested that she stay her ruling until the state supreme court ruled on the appeal, she refused. "[A] stay pending appeal would deny the fundamental right of Montanans to die with dignity..." she wrote. [*Baxter v. Montana*, Decision & Order, 1/6/09] But Montana physicians have refused to engage in assisted-suicide practice even though it is technically legal to do so. The case has been orchestrated by Kathryn Tucker, the lead litigator for Compassion & Choices (formerly the Hemlock Society). ■

Washington pharmacists & pharmacies required to dispense lethal drugs

When Washington State passed an initiative last November legalizing assisted suicide, many people assumed that pharmacists, like physicians, could opt out of participating in the death-inducing process. But that is not the case.

While pharmacists are considered “health care providers” under the assisted-suicide law, that law only grants the option to not participate in assisted suicides to health care providers who “perform the duties of an attending physician under RCW 70.245.040, the

consulting physician function under RCW 70.245.050, or the counseling function under RCW 70.245.060.” [RCW 70.245.200 (2)(d)(ii); emphasis added] In other words, pharmacists are not explicitly granted the non-participation option.

Moreover, the U.S. Ninth Circuit Court of Appeals recently reversed a preliminary injunction barring Washington from enforcing its rule requiring all pharmacies to deliver and distribute lawfully prescribed drugs or

devices to patients. [*Stormans v. Selecky*, No. 07-36039, U.S. App. LEXIS 15210, July 8, 2009] Consequently, the Ninth Circuit ruling requires pharmacies, not individual pharmacists, to dispense all lethal drug prescriptions lawfully written under the new assisted-suicide law.

According to the reinstated rule, “Pharmacies have a duty to deliver lawfully prescribed drugs or devices to patients...or provide a therapeutically equivalent drug or device in a timely manner...” [WAC 246-869-010] ■



News briefs from home & abroad...

- On August 14, 2009, the **Wisconsin Medical Society's Ethics Committee** rejected a resolution that broadly endorsed physician-assisted suicide (PAS). Resolution 14, which was defeated by a vote of 13 to 5, would have reversed the group's opposition stand on PAS and placed the Society in the position of actively supporting any state legislation that would legalize the practice. It also called upon the group's delegation to the American Medical Association to “submit a resolution to the 2009 AMA House of Delegates Annual Meeting to encourage *all states* to introduce such Death with Dignity legislation.” [Resolution 14 - 2009, lines 31-33; emphasis added]

In requested written testimony submitted to the Ethics Committee, ITF Executive Director Rita L. Marker wrote,

“[Resolution 14] would cause legislators and the public to assume that the Wisconsin Medical Society favors any and all proposals that may seek to permit physician-assisted suicide *even though members of the Wisconsin Medical Society have not examined the contents of such proposals in advance*. The content of those proposals could pose problems for both physicians and their patients, yet the endorsement of the Wisconsin Medical Society could be used to promote their passage.” [ITF, “Testimony: Points for Physicians to Consider,” 8/14/09]

- Australia's “Dr. Death”** and how-to-commit-suicide guru, Phillip Nitschke, is setting up shop in North America. He has chosen Bellingham, Washington, as the American base of operations for his organization, Exit International (aka, Exit US). He's already scheduled Exit's first North America tour, consisting of how-to workshops primarily aimed at senior citizens. Topics he will cover include how to get life-ending barbiturates (from questionable sources in Mexico), how to use his **“Euthanasia Testing Kit”** to test the quality and potency of those drugs, how to make your own death-producing **“Peaceful Pill,”** and how to asphyxiate yourself

using inert gases (like helium) and a tricked out plastic bag. The cities targeted for his workshops are San Francisco, CA (Sept. 8); Vancouver, BC (Sept. 10); Bellingham, WA (Sept. 10); and Anaheim, CA, (Sept. 15). [*e-Deliverance* (Exit International's newsletter), 8/09, p. 4]

- Many British news reports heralded the recent House of **Lord's** ruling in the Debbie Purdy appeal as a victory for legalized assisted suicide. Some even hinted that the ruling mandated that Parliament legalize the practice. But it was hype, generated in part by the right-to-die group Dignity in Dying.

Purdy, a charismatic woman with multiple sclerosis, had earlier petitioned two lower courts to force the director of public prosecutions (DPP), Kier Stamer, to specify whether her husband would be prosecuted under **Britain's Suicide Act** of 1961 if he accompanied her to the Swiss suicide clinic Dignitas to die—even though not one of those who escorted the previous 115-plus Britons to Dignitas were ever prosecuted. The law expressly states that, if convicted, anyone who “aids, abets, counsels or procures the suicide of another” could face a 14-year prison sentence. Both lower courts denied her request, holding that the current law is clear, and only Parliament, not the courts, can change that law. [*Guardian*, 10/30/08; AP, 2/19/09; BBC, 2/19/09] Purdy, with the help of organized assisted-suicide advocates, appealed her case to the Appellate Committee of House of Lords, Britain's highest court.

On July 30, 2009, a panel of five Lords ruled that the DPP must issue a policy outlining the factors he considers relevant in deciding whether to prosecute those involved in another's suicide, and that the absence of such a policy was a violation Purdy's right to respect for private and family life guaranteed under Article 8 of the European Convention of Human Rights. The ruling ordered a clarification of the existing law, not it's reversal. [*R (on the application of Purdy) v the Director of Public Prosecutions [2009] UKHL 44*]

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DPP Starmer is expected to issue an interim policy clarification by the end of September, after which he will ask for input from the public on any permanent guidelines. "This policy is going to cover all assisted suicides," Starmer said. "The same broad principles will apply. They've got to apply to all acts, in the jurisdiction or out of it," he explained. "We won't have separate rules for Dignitas." Making a distinction between assisted suicides that occur in Britain and abroad, he said, would require a change in the law. "We can't change the law, just fill in the policy." [Daily Telegraph, 8/3/09]

Meanwhile, Parliament has shown no interest in changing the law. In March of this year, the House of Commons took no action, not even a debate, on an amendment to exempt those who accompany a loved one abroad to commit suicide from prosecution, and the House of Lords rejected a similar amendment in July. [Daily Mail, 7/17/09]

- On July 10, 2009, a highly respected British conductor and his wife committed suicide together at the Zurich-based suicide clinic Dignitas. The wife, 74 year-old Lady Joan Downes, a former ballet dancer and noted choreographer, was reportedly terminally ill with cancer. Her husband, Sir Edward Downes, 85, was not. His biggest health complaints were losses in hearing and eyesight. According to their children (who were with them when they died), "After 54 happy years together they decided to end their own lives rather than continue to struggle with serious health problems." [Daily Telegraph, 7/14/09]
- Two initiatives aimed at curtailing Dignitas' assisted-suicide business have garnered enough signatures to be voted on by Zurich citizens. One mandates limiting suicide assistance to residents, and the other calls for a change in Swiss law to ban all encouragement of and assistance to suicide. [genevalunch.com, 8/7/09] ■

The International Task Force on Euthanasia & Assisted Suicide is a human rights group formed in 1987 to meet the urgent need for individuals and organizations who oppose euthanasia to work together to: provide information on euthanasia and related issues; promote and defend the right of all persons to be treated with respect, dignity and compassion; resist attitudes, programs and policies which threaten the lives of those who are medically vulnerable.

The Update is available to the general public; suggested minimum donation is \$25.00 [U.S.] a year. Add \$3.00 for foreign postage.

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