



SPECIAL REPORT

In the name of health care reform

Rita L. Marker

In an atmosphere where discussion of health care coverage has taken center stage, few people disagree that some type of health care reform is necessary. However, the contents of federal proposals have generated great controversy. For months, facts and myths about those proposals have circulated on YouTube, talk radio, newspapers, letters and television.

The U.S. House of Representatives passed HR 3962, the “Affordable Health Care for America Act,” on November 7, 2009. The U.S. Senate approved HR 3590, the “Patient Protection and Affordable Care Act,” on December 24, 2009. (Full text of both bills is available at: www.internationaltaskforce.org/health_care_reform.htm)

Currently House and Senate leaders are working to build public support and they are working to meld the bills into one which would, if passed, become law. Will this be good? Or will it be harmful?

Most aspects of each bill are open to wide interpretation, and it should be noted that if a piece of legislation can be interpreted in a certain way, it will be—by someone. Therefore, it is important to look at what could be permitted within the boundaries of the language.

A sampling of several aspects of the bills deserves particular scrutiny.

Basic services & basic standards

Both the House and the Senate bill would make basic health care more accessible to many who currently do not have health insurance. For example, H.R. 3962 describes minimum covered services which fall into general categories: hospitalization, outpatient services, professional services of physicians and other health professionals, prescription drugs, rehabilitative services, mental health and substance use disorder services, preventative services, maternity care, well baby care, well child care, medical equipment and supplies.¹

Details about the particular treatments, interventions and care covered within those categories will be dealt with by a new committee (one of many, many new layers of bureaucracy created in each of the bills). The “Health Benefits Advisory Committee,” made up of between 17 and 26 appointed individuals (none of whom are elected or accountable to voters) will recommend specifics about covered benefits and essential, enhanced, and premium plans.² Final determination about benefits and plans will be up to the Secretary of Health and Human Services who will have the authority to

determine which recommendations should be adopted through the rulemaking process.³

But both bills go far beyond providing what is traditionally covered by health insurance, creating or expanding a myriad of wide-ranging social programs.⁴ Furthermore, both contain sections that have caused great concern. One such section deals with advance care planning.

Advance care planning & end-of-life care

Contrary to some emotionally charged statements about advance care planning, it is not mandated in the current bills nor was it an earlier version⁵ of the House bill. Like the earlier bill, the House bill that passed in November will pay physicians and other providers for conducting advance care planning consultations with patients about the “continuum of end-of-life services and supports available.”⁶ Since health care providers will be paid for them, it is virtually certain they will routinely offer such consultations. Because patients—particularly the elderly and those who have been diagnosed with a serious condition—are often reluctant to refuse any service that a doctor suggests, they may feel compelled to accept an advance care planning consultation.

As with the earlier bill, the current House bill’s Section 1233 was written by Oregon Congressman Earl Blumenauer who works in cooperation with Compassion & Choices (Compassion & Choices is the former Hemlock Society. It spearheaded the efforts in Oregon, Washington, and Montana that resulted in transforming assisted suicide from a crime into a medical treatment.)

Following the House bill’s passage, Compassion & Choices acknowledged its work with Blumenauer and, on its website, stated, “As Congress debates health insurance reform, Compassion & Choices is working to make end-of-life choice a centerpiece of any program that emerges. We are making end-of-life choice a centerpiece of national health insurance reform.”⁷

In states where it is legal (Oregon, Washington, and Montana), assisted suicide is considered part of the “continuum of

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end-of-life services.” In fact, in a recent decision,⁸ the Montana Supreme Court treated assisted suicide (which it called “physician aid in dying”) as part of the “legal ethos of honoring the end-of-life decisions of the terminally ill.”⁹ Therefore health care providers in those states, when carrying out an advance care planning consultation, would likely include assisted suicide among the options a patient should consider.

While the advance care planning section states that nothing in it shall “encourage the promotion of assisted suicide,”¹⁰ it does not prohibit discussing it as an option. Informing patients of its availability does not technically constitute encouragement. It is likely that the health care practitioner would inform the patient of assisted suicide as one among many end-of-life options.

Physicians and other health care providers would not be the only ones promoting advance care planning. The House bill requires certain health insurance providers—called “Qualified Health Benefits Plans” (QHBP)—to distribute information about and to facilitate advance directives and other “end-of-life” tools.¹¹

Although the pertinent language states that the QHBP shall not *promote* assisted suicide, it does not preclude—in fact, it appears to mandate—informing individuals about its availability and the “planning tools” to access it. While the bill states that assisted suicide is not to be included as an option,¹² it is followed by a paragraph which includes an exception that clearly obliterates any such prohibition.¹³ Thus, when considered in its entirety, the section requiring QHBPs to provide end-of-life planning permits health insurers to subtly nudge enrollees to consider all end-of-life options including assisted suicide in states where it is permitted.

Key words not defined

It is important to note that “assisted suicide” is not defined in either the House or Senate bill. Because assisted suicide advocates as well as the Washington and Oregon laws and the Montana court decision call the actions that constitute assisted suicide by other names (“physician aid-in-dying,” “death with dignity,” “doctor assisted death,” etc.), the lack of a definition is problematic.

Equally problematic is the lack of any definition of “end of life care,” although it is referred to many times throughout the legislation.

Unless “assisted suicide” is clearly defined and specifically prohibited—without exceptions—and unless the meaning of “end of life care” is narrowly defined, provisions in both the House and Senate bills are cause for serious concern. Otherwise, provisions, such as one in the Senate bill stating that community health insurance options “shall be prohibited from limiting access to end of life care,” could compel all such insurance programs in Washington, Oregon and Montana to provide access to assisted suicide as part of end-of-life care.

Uncertainties about funding & participation

An early draft of a Senate health reform proposal (unveiled by Sen. Max Baucus on October 19, 2009) contained a specific limitation on assisted suicide funding.¹⁴ However, that section was omitted from the Senate bill that passed.

Some commentators state that the Assisted Suicide Funding Prevention Act of 1997 (Public Law 105-12), which has previously prevented federal funding of assisted suicide in Oregon, would apply to assisted suicide under the various health care reform bills. But, since assisted suicide is not defined in this bill and since there is no reference to Public Law 105-12, that may not be the case.

Curiously, another provision that was in the Baucus bill, and which is included in the current bill, states that health care providers and institutions cannot be discriminated against if they *do not provide* assisted suicide.¹⁵ Such wording seems to imply that assisted suicide is acceptable and expected and that those who, for some reason, do *not* participate in it are out of the mainstream—although they will not face sanctions.

Patient decision aids

An additional program to be implemented under the Senate bill provides for the development of “patient decision aids,” described as educational tools to help patients or their representatives and health care providers decide what treatments are best for them.¹⁶ This program is somewhat similar to the House bill's advance care planning provision. However, the Senate version will essentially control what will be included in the decision aids, preventing those not approved by the federal government from use in federally funded “shared decision-making resource centers.”¹⁷ An outside “entity” will establish standards and certify the patient aids¹⁸ which, among other things, “shall address health care decisions across the age span” including children.¹⁹

The provision for an outside entity to establish standards and certify patient aids raises concern about how that entity will be selected, since assisted-suicide advocacy groups have been making concerted efforts to position themselves as the go to organizations regarding end-of-life issues, including health-care decision making.

Reading, writing & comprehensive health services

Over the years health related services in schools have expanded from a part time nurse who would check to see if little Johnny has a fever and should be sent home to full service centers. So rapidly did what became known as a school-based clinic reach into schools across the country that, by the mid-80s, health services on school premises were the subject of national conferences of school based clinic administrators and personnel.²⁰ Caseloads in a school-based clinic located in or near high schools and junior high schools ranged from about 500 to 5,000 students per year.²¹

From the time that clinics began to expand services, parental consent has been requested for clinic services. However, this is

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carried out by requesting general consent²² and parents—knowing that their children can receive immunizations, sports physicals, etc.—rarely refuse such authorization for their children.

Gradually, services expanded from physical health needs to mental health interventions.²³ And, by 1999, school-based clinics were viewed as the primary source of health care for uninsured children and were providing virtually full services including prescribing and, in some cases, dispensing medication.²⁴ Although consent forms were still requested, some services were provided without parental knowledge or consent.²⁵

School-based clinics began to be seen as a necessary source of children's health care. As one policy analyst explained, "School-based clinics are definitely one way to provide health care for children who don't have insurance."²⁶

Since the rationale for passing federal health care reform is to provide health care coverage for the uninsured, it would be logical to expect that school-based clinics would become obsolete. It is, therefore, curious that the very bills that are intended to provide health coverage for *all*, allocate millions of dollars for school-based health clinics²⁷ that will "be integrated into the school environment" and will provide, "at a *minimum*, comprehensive primary health services."²⁸ The expanded clinics will provide on-site access during the academic year and 24 hour coverage through backup health providers to ensure access to services on a year-round basis when school is not in session.²⁹

The federal proposal includes a requirement of parental consent (which, as has been the customary practice, would likely be blanket consent at the beginning of the school year). However, such consent is only required for students who are minors and would not apply to most high school seniors. Federal privacy laws would preclude clinic personnel from even notifying parents if their 18-year-old high school senior was diagnosed with a life-threatening condition.

Thus, if the clinic made such a diagnosis and if the student had a condition qualifying her for assisted suicide in a state where it is legal, the clinic could refer the teenager to an assisted-suicide provider for a prescription for lethal drugs—completely without parental knowledge of what is transpiring.

Would this happen? No one can know for sure.

Could it happen? Yes.

All in the name of health care reform.

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Notes

1 H.R. 3692, Sec. 222, "Essential Benefits Package Defined," pp. 111-112.
 2 H.R. 3962, Sec. 223, "Health Benefits Advisory Committee, pp. 116-118. The HBAC will be chaired by the Surgeon General. Nine to seventeen members will be appointed by the president and nine will be appointed by the Comptroller General.
 3 H.R. 3962, Sec. 223, pp. 121-123.
 4 For example, more than \$750 million is devoted to home visitation programs that funds, among other things, government sponsored home visits to provide parents with "modeling, consulting, and coaching on parenting practices." (H.R. 3692, Sec. 1904, pp. 1194- 1195, 1201) Community Transformation Grants will be made to govern-

mental or non-profit organizations to do just about anything for the purpose of "creating healthier communities." The only activities that are explicitly prohibited with such funding are those "to create video games or carry out any other activities that may lead to high rates of obesity or inactivity." (H.R. 3950, Sec. 4201, p. 1187)

5 H.R. 3200 "America's Affordable Health Choices Act of 2009." For a discussion of H.R. 3200, see: "Special Report: Can we afford "America's Affordable Health Choices Act," *ITF Update*, (<http://www.internationaltaskforce.org/iaa50.htm#1>)

6 H.R. 3962, Sec. 1233, p. 650 - 651. The consultations will be provided "once every five years unless there is a significant change in the health or health-related condition of the individual."

7 http://www.compassionandchoices.org/act/legislative_work/healthcare_reform (last accessed 2/11/10)

8 *Baxter v. Montana*, 2009 MT 449; 354 Mont. 234; Mont. LEXIS 695.

(available at: http://www.internationaltaskforce.org/Montana_Opinion_12_31_09.pdf)

9 *Baxter v. Montana*, 2009 MT 449, ¶37.

10 H.R. 3962, Sec. 1233, p. 652. (emphasis added)

11 H.R. 3962, Sec. 1233, p. 134.

12 H.R. 3962, Sec. 1233, p. 135.

13 "Nothing in this section shall be construed to preempt or otherwise have any effect on State laws regarding advance care planning, palliative care, or end-of-life decision-making." (H.R. 3962, Sec. 1233, p. 136.) For example, in addition to considering assisted suicide (which is called "death under the Death with Dignity Act"), it is listed as one type of palliative care under the Oregon Health Plan.

14 The draft, referred to as the "Baucus bill," contained a provision (Sec. 1921 (a) titled "Protecting Americans and Ensuring Taxpayer Funds in Government Health Care Plans Do No Support or Fund Physician-Assisted Suicide."

15 H.R. 3590, Sec. 1553 (a), p. 360. "The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this act (or under any amendment made by this Act) or any health plan created under this Act (or under any amendment made by this Act), may not subject an individual or institutional health care entity to discrimination on the basis that the entity *does not provide* any health care item or service furnished for the purpose of causing, or the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia or mercy killing." (emphasis added)

16 H.R. 3590, Sec. 3506 "Program to Facilitate Shared Decision-Making," Subsection 636, "Patient Decision Aids," p. 1086.

17 H.R. 3590, Sec. 3506, Subsection 636, pp. 1091 - 1093.

18 H.R. 3590, Sec. 3506, Subsection 636, pp. 1087 - 1090.

19 H.R. 3590, Sec. 3506, Subsection 636, p. 1090.

20 Asta M. Kenny, "School-Based Clinics: A National Conference." *Family Planning Perspectives*, Vol. 18, No. 1, Jan.-Feb. 1986, p. 44 (a publication of the Guttmacher Institute, the research arm of the Planned Parenthood Federation of America). Kenney wrote: "In the fall of 1984, Dryfoos reported there were school-based clinics in only a dozen communities. A year later, at the time of the conference, almost 90 communities in 26 states had a clinic either in operation or on the drawing board. These clinics offer primary health care, including physical exams, treatment for minor accidents and illnesses, immunizations, pregnancy and sexually transmitted disease (STD) testing, counseling on nutrition and weight reduction, gynecological examinations and family planning counseling."

21 Joy Dryfoos, "School-Based Health Clinics: A New Approach to preventing Adolescent Pregnancy?" *Family Planning Perspectives*, Vol. 17, No. 2, Mar.-Apr. 1985, p. 70.

22 "As a general rule, parental consent for a student's participation at the clinic is sought at the beginning of the school year, but is not required for any individual service." Asta M. Kenny, "School-Based Clinics: A National Conference." *Family Planning Perspectives*, Vol. 18, No. 1, Jan.-Feb. 1986, p. 44.

23 Howard S. Adelman and Linda Taylor, "Mental health facts of the school-based health center movement: Need and opportunity for research and development," *The Journal of Behavioral Health Service and Research*, Vol. 18, No. 3, Sept. 1999, pp. 272-283 and R.D. Harold and N.B. Harold, "School-based clinics: a response to the physical and mental health needs of adolescents," *Health Social Work*, Vol. 18, No. 1, Feb. 1993, pp. 65-74.

24 Sona Sharma, "School-based clinics keep uninsured kids healthy," *Nurseweek*, March 1, 1999. Available at: <http://www.nurseweek.com/features/99-2/school.html> (last accessed 2/12/10).

25 "[S]ometimes information is kept from parents, such as an older student's inquiries about birth control or a request for a pregnancy test." Sharma, *Nurseweek*.

26 Sharma, *Nurseweek*.

27 H.R. 3590, Sec. 4101, pp. 1136-1137.

28 H.R. 3590, Sec. 4101, p. 1139. (emphasis added)

29 H.R. 3590, Sec. 4101, p. 1141. ■

Montana Supreme Court rules physician-assisted suicide not illegal in state

Waiting until the very last day of 2009, the Montana Supreme Court handed down a 5-2 ruling making it the first high court in the U.S. to allow physician-assisted suicide. “We find nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy,” the court ruled. [*Baxter v. Montana*, DA 09-0051, 2009 MT 449, MT Sup.Ct., 12/31/09, p. 24. Hereafter cited as *Baxter Sup. Ct.*]

Background

The case involved a lawsuit filed in 2007 by 76-year-old Robert Baxter, a leukemia patient; four physicians from a hospital in Missoula, none of whom were Baxter’s doctors; and the assisted-suicide advocacy organization Compassion & Choices (C&C), formerly the Hemlock Society. C&C’s legal director and veteran litigator Kathryn Tucker spearheaded the lawsuit, arguing that Montana’s law prohibiting assisted suicide violated the state’s constitutionally guaranteed rights to both privacy and dignity. On December 5, 2008, District Court Judge Dorothy McCarter ruled in C&C’s favor, declaring physician-assisted suicide a “fundamental” constitutional right that includes “protection of the patient’s physician” from criminal liability. [*Baxter v. Montana*, Decision and Order, Cause No. ADV-2007-787, Mont. 1st Jud. Dist. Ct., 12/5/08] The state appealed McCarter’s ruling to the Montana Supreme Court.

Supreme Court’s majority ruling

While C&C and other assisted-suicide groups are calling the high court’s ruling a landmark victory, it was not the sweeping constitutional victory they sought. In fact, the court overturned McCarter’s decision that established a constitutional right to assisted suicide and judged the case “guided by the judicial principle that we should decline to rule on the constitutionality of a legislative act if we are able to decide the case without reaching constitutional questions.” [*Baxter Sup. Ct.*, pp. 6-7] The court looked, instead, to existing state statutes, specifically the consent statute and the state’s living will law (the “Rights of the Terminally Ill Act”) as the basis for its ruling.

According to the majority opinion, the consent of a victim can be a defense for a criminal act as long as the person giving consent is competent; able to make a reasonable judgment regarding the nature of the offense; is not being forced, deceived, or under duress; and the act is not against public policy. “This ‘against public policy’ exception to consent applies to conduct that disrupts public peace and physically endangers others,” the court held. “[W]e find no indication in Montana law that physician aid in dying provided to terminally, mentally competent adult patients is against public policy.” [*Baxter Sup. Ct.*, pp. 8 & 10] (Note: Throughout the decision, the court uses C&C’s euphemistic term “aid in dying” instead of the more accurate term “physician-assisted suicide.”)

The court then looked to the state’s living will (advance health care directive) law as “an apt statutory starting point for understanding the legislature’s intent to give terminally ill patients—like Mr. Baxter—end-of-life autonomy, respect and assurance that their life-ending wishes will be followed.” [*Baxter Sup. Ct.*, pp. 13-14] According to the court, there is no significant difference between a physician’s act of withholding or withdrawing life-sustaining treatment in compliance with a patient’s advance directive and the act of writing a prescription for intentionally fatal drugs at the patient’s request:

The Terminally Ill Act, in short, confers on terminally ill patients a right to have their end-of-life wishes followed, even if it requires *direct* participation by a physician through withdrawing or withholding treatment. Section 50-9-103, MCA. Nothing in the statute indicates it is against public policy to honor those same wishes when the patient is conscious and able to vocalize and carry out the decision himself with self-administered medicine and no immediate or direct physician assistance. [*Baxter Sup. Ct.*, p. 15. Emphasis in original.]

The dissenting opinion

In his dissenting opinion, Justice Jim Rice wrote, “[T]he Court has badly misinterpreted our public policy: assisting suicide has been explicitly and expressly

prohibited by Montana law for the past 114 years.” [*Baxter Sup. Ct.*, p. 53]

Furthermore, he argued, “A flaw that underlies the Court’s analysis is its failure to distinguish between the physician’s basic intention in the assisted-suicide case from the physician’s intention while rendering treatment in other cases.” In physician-assisted suicide, the doctor “provides a lethal drug with the *intent* to cause... the patient’s death.” This is “diametrically opposed” to the provision of palliative care, when “the physician does not *intend*” to cause death, but rather “to relieve the patient’s pain and suffering.” [*Baxter Sup. Ct.*, p. 53. Emphasis in original.]

Applying the same reasoning to the Terminally Ill Act, Justice Rice wrote,

A similar distinction arises in the withholding or withdrawal of medical treatment that merely prolongs the dying process, pursuant to the Montana Rights of the Terminally Ill Act. Under the Act, a patient may refuse treatment and allow death to occur naturally, and physicians incur no liability, having not administered any death-causing treatment. Sections 50-9-103, -204, MCA... [*Baxter Sup. Ct.*, p. 54]

Thus, the law accommodating a patient’s desire to die of *natural* causes by withholding treatment does not, as the Court posits, support a public policy in favor of the deliberate action by a physician to cause a patient’s *pre-natural*, or premature, death.” [*Baxter Sup. Ct.*, p. 62. Emphasis in original.]

Majority opinion contrary to other high court rulings

All the previous high court rulings in the U.S. dealing with the issue of assisted suicide are in accord with Justice Rice’s opinion that there is a significant difference between the wanted withholding and withdrawal of life-sustaining treatment and a doctor providing lethal drugs with the intention of ending the patient’s life. In 1997, the U.S. Supreme Court held in *Vacco v. Quill*:

The distinction comports with fundamental legal principles of causation and intent. First, when a patient

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News briefs from home & abroad . . .

- The New Hampshire House of Representatives has killed an expansive bill to legalize assisted suicide. The bill, HB 304 (Death with Dignity Act), was defeated by a full House vote of 242-113 on January 13, 2010. The bill was a hold-over from last year. Rep. Charles Weed (D-Keene), the measure's lead sponsor, had amended the measure twice in the hope of getting it passed by the House Judiciary Committee. Instead, the committee recommended that the House reject the bill in 2010 because of serious abuse concerns. While the measure was patterned on Oregon's assisted-suicide law, it was far more expansive in scope than its prototype.
- According to a February 2010 Angus Reid public opinion poll, American support for legalizing euthanasia has dropped three percentage points since August 2009 (from 45% to 42%), while opposition to legalization has increased by four points (from 32% to 36%). [Angus Reid Press Release, 2/10/10]
- A new book on the history of euthanasia practice in the Netherlands reveals that former Dutch Health Minister Els Borst, who successfully pushed for the passage of the euthanasia law in 2001, now thinks it was a mistake to legalize the practice before good palliative care protocols and programs were developed in the country. Dr. Anne-Marie The, a Dutch anthropologist, lawyer, and author of the book, said palliative care should always come before euthanasia is even considered. [NRC Handelsblad, 11/30/09]
- There is such a thing as the "slippery slope," and it's alive and well in the Netherlands. Once the country legalized

doctor-induced euthanasia for physically suffering adults, courts and medical professionals began expanding the practice to include children, disabled newborns, and those with mental suffering like depression. Now, there is a citizens' initiative being circulated calling for euthanasia deaths for all Dutch people over the age of 70 who are simply tired of living. In just one week, the petition garnered more than the required 40,000 signatures needed to force a debate in the Dutch Parliament. One initiative backer, Dutch lawyer Eugene Sutorious, said there would be virtually no abuse risk for the over 70 set. "No one stands to win or gain personally from it," he explained. When asked about the existence of a slippery slope in the Netherlands, Sutorious replied, "I have seen nothing of the kind happen." [NRC Handelsblad, 2/8/10; Dutch News, 2/14/10]

Recently released figures indicate that the number of reported 2009 euthanasia and assisted suicide deaths increased by 200 cases over the previous year, bringing the total to 2,500. According to the Dutch Right to Die Association (NVVE), six of those cases involved the induced deaths of "people in the early stage of dementia." [NVVE, Relevant Magazine, 2/1/10]

- With support from the Zurich Parliament, a referendum to discourage "suicide tourism" in Switzerland will be held on November 28, 2010. The measure is aimed at curtailing the suicide trade of Dignitas, the clinic near Zurich that has assisted the suicides of over 1,000 people, mostly foreigners.

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refuses life-sustaining medical treatment, he dies from an underlying fatal disease of pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication. [Vacco v. Quill, 521 U.S. 793, 801]

Also in 1997, the Florida Supreme Court ruled in *Krischer v. McIver* (a case, similar to Montana's):

We cannot agree that there is no distinction between the right to refuse medical treatment and the right to commit physician-assisted suicide through self administration of a lethal dose of medication. The assistance sought here is not treatment in the traditional sense of that term. It is an affirmative act designed to cause death—no matter how well-grounded the reasoning behind it. [Krischer v. McIver, 697 So. 2d 97, 102 (Fla. 1997)]

Likewise, in 2001, the Alaska Supreme Court held in *Sampson and Doe v. Alaska*, that the "no difference" claim "overlooks an important distinction between a physician's active participation in a patient's suicide and a physician's willingness to honor a patient's request to cease or withdraw treatment... [T]hese two types of conduct are significantly different." [Sampson and Doe v. Alaska, 31 P. 3d 88, 99 (2001)]

Battle moves to legislature

The Montana Supreme Court's ruling is by no means the final word in the battle for or against legalized assisted suicide in the state. It would have been if the court had declared a constitutional right to "aid in dying." But the court circumvented that issue and instead concluded that there is no statutory basis to prohibit the practice. It will now be up to the legislature to pass new stat-

utes or change old ones to determine whether Montana's physicians will be liable for assisting their patients' induced deaths.

C&C's Kathryn Tucker recently admitted that the legislature has the power to put an end to C&C's efforts to turn assisted suicide into a medical treatment in Montana. "There would be no basis for prosecuting a physician who provides that care [aid in dying] unless and until—and that is a big if—the Legislature were to pass a law that makes a crime of aid in dying," she said. [American Medical News, 1/18/10]

Meanwhile, C&C Executive Director Barbara Coombs Lee is touting the Montana Supreme Court ruling as a "landmark victory" that "will have persuasive influence in other states across the nation." [C&C e-mail message, 12/31/09] ■

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If passed, the referendum would limit legal suicide assistance to those who have lived in Zurich for one year. It would also set a steep fine of up to 50,000 Swiss francs (\$46,000-US) against Dignitas if it violates the year residency requirement. It is expected that Ludwig Minelli, executive director of Dignitas, would pass the fine on to his customers—a huge expense that most could not afford. [World Radio Switzerland, 1/11/10; *London Telegraph*, 1/23/10]

- The debate over whether assisted suicide should be legal in the UK has reached fever pitch, fueled mostly by the British media and its coverage of two court cases—involving mothers who “helped” their children die—and celebrity authors pushing for legalization. The BBC, in particular, has run a number of high-profile, pro-assisted suicide programs. A group of 22 MPs have signed a motion accusing the BBC of having a “persistent bias” in favor of legalization and that it used drama and

news programs to promote its view. The motion also accuses the BBC of ignoring “the rights of the disabled” and calls for the end of the BBC’s public funding. [*Daily Mail*, 2/4/10]

- In Scotland, MSP Margo MacDonald is irate over the **Scottish Parliament’s** decision to route her euthanasia bill to a specially convened ad hoc committee instead of the usual health committee for a hearing. She said it’s a ploy to stall the bill. Titled “End of Life Assistance (Scotland) Bill,” the measure would allow both euthanasia and assisted suicide for those 16 and over who are terminally ill or “permanently physically incapacitated” and unable to “live independently.” [EOL Assistance Bill, § 1 (2) & § 4 (1) & (2)]
- Last November, the French Parliament rejected a euthanasia bill by a vote of 326 to 202. The bill would have legalized “medical assistance to die with dignity.” [Agence France-Presse, 11/24/09] ■

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.

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