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LIFE, LIBERTY, AND THE PURSUIT OF DEATH OF THE INCONVENIENT OTHER

Jonathan Penn

Said the little boy, "Sometimes I drop my spoon."
   Said the old man, "I do that too."
The little boy whispered, "I wet my pants."
   "I do that too," laughed the little old man.
   Said the little boy, "I often cry."
   The old man nodded, "So do I."
   "But worst of all," said the boy, "it seems
   Grown-ups don't pay attention to me."
   And he felt the warmth of a wrinkled old hand.
   "I know what you mean," said the little old man.¹
   — Shel Silverstein

Paul Clifford, a resident of London, accompanied his mother, Maxine Coombes, to Switzerland for a vacation from which only he would return.² Maxine had been living with motor neuron disease and could not cope with the pain any longer.³ She saved money from her weekly benefits and sold her car to accumulate the needed funds, £10,000,⁴ to pay for the clinic fees and her one-

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³ Id.
⁴ Approximately $14,569.
way trip to Dignitas, the Swiss assisted suicide clinic.\(^5\)

Unknown to Maxine and Paul, Dignitas was located in a graffiti-tarnished, old apartment building that stank of urine.\(^6\) Maxine expected to arrive at a serene location to end her suffering and peacefully close her life.\(^7\) She hoped for assistance that, as the name Dignitas suggests, would provide her with dignity in her death.\(^8\)

Instead of being afforded dignity, Maxine stood outside in the cold for nearly an hour with Paul and her twin sister, Dawn Davis, and waited until a Dignitas employee showed up to let them in the apartment.\(^9\) The employee, Arthur, was dressed in dirty street clothes and briefly asked Maxine on videotape if she knew what she was doing and whether she was being pressured to commit suicide.\(^10\) Maxine mentioned that Paul might struggle coping with her death, and the Dignitas employee offered that he could die at a reduced rate.\(^11\)

Only fifteen minutes after entering the apartment, Maxine ingested a lethal dose of barbiturates.\(^12\) Paul and Dawn were informed that she would remain conscious for forty-five minutes.\(^13\) Her head slouched down to her chest only forty seconds later; no time for goodbyes or parting advice.\(^14\) "Arthur then announced: "Let's make sure we get our stories straight.""\(^15\) They waited outside while Arthur ensured that she was dead, and when they came back in, police and other officials had arrived to investigate Maxine's death.\(^16\) For hours they were

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5. See Koster, supra note 2.
6. Id.
7. Id.
8. Id.
9. Id.
10. Id.
11. Id.
12. Id.
13. Id.
14. Id.
15. Id.
16. Id.
questioned while Maxine was slouched over in her chair.17 Once the officials were satisfied, Paul and Dawn had to leave the room again.18 They were let back into the room where they found Maxine turning blue, covered by a dirty blanket, and her clothes thrown on the floor.19

Maxine’s ashes were mailed to her family in a cheap clay pot with her death certificate and an invoice for postage costs.20 Paul compared the experience to that of a “backstreet abortion place.”21

Some might argue that there was dignity in Maxine’s assisted suicide, but it is even more of a stretch to argue such for Peter Auhagen of Germany. Peter was disabled by a brain hemorrhage—he was not terminally ill, which is required by Swiss law to seek assistance in suicide22—and went to Dignitas for assistance in his suicide.23 Instead of being given the drink of lethal barbiturates like most suicide clients,24 the director of Dignitas decided that Peter was going to be experimented on with a suicide machine made of tubes and valves, which permitted the patient to control the administration of the drugs intravenously.25

Peter started pumping the poison into his body, but the machine was faulty so he was unable to get the full dose.26 Being only partially poisoned, Peter suffered excruciating pain.27 He fell into a coma, foaming at the mouth, sweating, and

17. Id.
18. Id.
19. Id.
20. Id.
21. Id.
23. Id.
24. Id.
25. Id.
26. Id.
27. Id.
thrashing around.\textsuperscript{28} He was still alive after twenty-four hours of suffering.\textsuperscript{29} Because Peter was still alive forty-eight hours later, a nurse called the director requesting that Peter be rushed to a hospital.\textsuperscript{30} The director came to the death room furious that his staff would recommend taking a client to the hospital.\textsuperscript{31} He was worried that the newspapers would report that Dignitas was making inexcusable mistakes.\textsuperscript{32} He was also worried that they were falling behind because there were others waiting to use the room.\textsuperscript{33}

The exact cause of Peter's death is unclear.\textsuperscript{34} The director asserted that Peter had not been injected with suicide drugs, which is illegal in Switzerland.\textsuperscript{35} Others confirmed that he had been administered the drugs through an injection.\textsuperscript{36} Peter's seventy-hour death was far from dignified.\textsuperscript{37}

Dignitas is not concerned with providing dignity in dying, and Peter's terrible death clearly illustrates the devaluing of life that accompanies unrestrained or unchecked ventures in the business of death. Dignity is lost with such a devaluing of life.

While Switzerland has enlarged suicide tourism by legalizing physician-assisted suicide, the United States has not readily accepted physician-assisted suicide at the federal level.\textsuperscript{38} This article looks at end-of-life issues, focusing on physician-assisted suicide, and whether the federal government's numerous responsibilities created by the Older Americans Act and other similar acts, the government's financial limitations, and a growing elderly population will lead to a deterioration of

\begin{footnotes}
\item[28] Id.
\item[29] Id.
\item[30] Id.
\item[31] Id.
\item[32] Id.
\item[33] Id.
\item[34] Id.
\item[35] Id.
\item[36] Id.
\item[37] Id.
\item[38] See Sara Imhof & Brian Kaskie, \textit{How Can We Make the Pain Go Away?: Public Policies to Manage Pain at the End of Life}, 48 \textit{The Gerontologist} 423, 425 (2008).
\end{footnotes}
society's view of elders and a legitimization and acceptance of assisted suicide.

LIFE, DEATH, AND PRINCIPLES

The race to the bottom and the tragedy of the commons are two concepts that shed light on the broad context of human nature and relationships. Stated simply, the race to the bottom is the idea that individuals or entities will comply with only the minimum requirements, or do less than the best, in order to minimize costs. The concept most often refers to cases of industry where an entity will attempt to reduce costs by lowering standards, and a competitor will lower their standards below the standards of the first entity to be more competitive. To be able to compete, the first entity will lower standards again, and the race to the bottom is on. In essence, the race to the bottom is doing the minimum that will still maximize benefits.

The tragedy of the commons is a similar and related concept: if utilization of the commons—defined as freely appropriated finite resources—is not regulated, and individuals are left to their vices, individuals will use the commons without restraint in order to maximize their own benefits. The intemperate collective use of the commons will quickly deteriorate the finite resources to the detriment of the individuals. "Ruin is the destination toward which all men rush, each pursuing his own best interest in a society that believes in the freedom of the commons. Freedom in a commons brings ruin to all."

40. See Schram, supra note 39, at 91.
41. Id.
42. Id.
43. Id.
44. See Hardin, supra note 39, at 1243-44.
45. Id.
46. Id. at 1244.
The race to the bottom and the tragedy of the commons reveal that when individuals seek their own self-interest, it is often to the detriment of others and occasionally to their own loss. There is a strong notion in our society that temperance and restraint, especially when it comes to personal autonomy, are despicable. Yet temperance and self-restraint usually lead to greater freedom with expanded choices.

**Abortion's Correlation to Physician-Assisted Suicide**

In our society, the principle of the inherent dignity—or more accurately, the sanctity—of life has deteriorated. Change in rhetoric has softened the impact of principles and even made the holding of principles unreasonable. This diminished view of the sanctity of life is exemplified in the areas of abortion and physician-assisted suicide.

Interestingly, the abortion movement and the physician-assisted suicide movement find many of their roots in the United States in the same location: New York. In 1970, Constance Cook and Franz Leichter authored and sponsored a bill that would provide for abortion rights in the state of New York. The bill was signed into law on April 10, 1970. Three years later, the U.S. Supreme Court decided *Roe v. Wade* and patterned part of its ruling on the New York law. Much of the abortion rights argument is based on personal autonomy, dignity, and freedom when determining one's course of action regarding life's most personal and intimate choices.

Add approximately twenty years to the *Roe v. Wade* decision and things started to pick up momentum in the physician-
assisted suicide camp. Dr. Timothy Quill, a leading expert on end-of-life issues, was joined by other physicians as he asked courts in New York, and eventually the U.S. Supreme Court, to overturn the state's prohibition against physicians assisting their terminally ill patients in committing suicide. The Court determined that the New York law was constitutional and that there was no right to a physician-assisted suicide, but in a footnote, the Court created an opportunity for progress for physician-assisted suicide proponents by giving traction to the double effect principle.

In considering the correlation between the abortion and physician-assisted suicide movements, the timing provides a hint at the relationship between the two. If proponents of abortion were in their twenties, thirties, and forties at the time of inception of abortion rights (1973), they would have been in their forties, fifties, and sixties when the physician-assisted suicide movement began to take shape in the early 1990s. These proponents' parents likely would have been in their sixties, seventies, and eighties in the early 1990s. Initially, proponents of abortion targeted the fetus as the "inconvenient other" who limited their personal autonomy and choice. Perhaps the target for the "inconvenient other" has shifted to elderly parents who require substantial time and financial commitments, thus limiting personal autonomy and choice.

Not surprising, these movements have been backed by individuals and groups with likeminded ideals and values. Choice rather than ongoing life is supreme. Life is valued less than what might be expected.

53. Vacco, 521 U.S. at 797-98; Quill, 80 F.3d at 716, 718; Quill, 870 F. Supp. at 78, 79-80.
54. Vacco, 521 U.S. at 807-09 n.11 ("Just as a State may prohibit assisting suicide while permitting patients to refuse unwanted lifesaving treatment, it may permit palliative care related to that refusal, which may have the foreseen but unintended 'double effect' of hastening the patient's death.")
56. Id.
Cecile Richards, President of Planned Parenthood, refused to comment on the relationship between abortion and physician-assisted suicide when repeatedly contacted by this author.

Dr. Quill compared abortion and physician-assisted suicide, saying that both are not simple choices and should be last resort choices, but the abortion issue is more difficult to address because it involves the woman making a choice that affects another person if the fetus is viewed as a person; the physician-assisted suicide issue is an easier issue because it involves competent adults making an informed decision for themselves. His view that physician-assisted suicide is an easier issue to address than abortion because of its isolated impact is only partially well-founded. Truthfully, the impact and consequences of the choice to end life are not limited to the ending of that life; there are relational and financial ramifications involving a number of people still living. If it were true that the only impact of abortion and physician-assisted suicide was the ending of one life, then the physician-assisted suicide decision—involving one's self only—would be easier than the abortion decision, but the impact does not end with the person and his or her death. Thus, both are complex and difficult issues to address. For Dr. Quill, both issues simply come down to a choice.

STATUTORY CONSIDERATIONS

When Congress enacted the Older Americans Act, it declared that

"[I]n keeping with the traditional American concept of the inherent dignity of the individual. . . ., the older people of our Nation are entitled to, and it is the joint and several duty and responsibility of the governments of the United States [and] of the several States . . . to

57. Telephone Interview with Timothy E. Quill, Dir. of the Palliative Care Program, U. of Rochester Sch. of Med. (Mar. 25, 2009) [hereinafter Telephone Interview Quill].
58. Id.
assist our older people to secure equal opportunity to the full and free enjoyment of the following objectives: "an adequate income in retirement; the best physical and mental health regardless of economic status; independently-selected suitable housing at affordable costs; full restorative services for those who are institutionalized and support to persons providing long-term voluntary care to older individuals; non-discriminatory employment opportunities; retirement in health, honor, and dignity after years of contributing to the economy; participation in civic, cultural, education and training, and recreational opportunities; access to low-cost transportation; immediate benefit from research that can sustain and improve health and happiness; and freedom and independence in planning and managing their own lives with protection against abuse, neglect, and exploitation."

This long list of congressional objectives to ensure that older Americans are provided for in every aspect of their lives is admirable, but in passing this legislation, Congress established a heavy, and maybe unsustainable, responsibility for the government. Some of the goals may be impossible to fulfill; independently-selected suitable housing at affordable costs cannot be guaranteed. And this Act comes with a large price tag. Funds appropriated to carry out only the family caregiver support section of the Act, which is only a small section of the Act, amounted to $125,000,000 for fiscal year 2001 alone. Other sections of the Act were appropriated "such sums as may be necessary," basically a blank check to fulfill the objectives of the Act. Caring for the older American population is expensive, and the government took upon itself the responsibility to provide.

Oregon's Death with Dignity Act was the first state statute to legalize physician-assisted suicide in the United States, and

60. Id. at § 3023(e)(1) (2000).
61. Id. at § 3023(d).
it removed the reference of "suicide" from any actions taken under the Act. It allows a capable adult who is a resident of Oregon and has been determined by the attending physician and consulting physician to be suffering from a terminal disease to make a written request for medication for the purpose of ending his or her life.

The Act provides safeguards in an attempt to prevent abuse and mistake. The patient must have voluntarily expressed his or her wish to die. There is a fifteen-day waiting period between the initial request and the writing of the prescription. The attending physician must determine that the patient is terminally ill, and a consulting physician must confirm that determination. A right to rescind the request exists, and counseling must occur if either physician suspects that the patient is suffering from depression or any other psychiatric or psychological disorder. The patient must make an informed decision. There is privacy in all of this; no requirement to notify family members exists, and no information is to be made available to the public.

Nearly identical provisions were enacted in Washington and took effect on March 5, 2009. Washington's Death with Dignity Act provides the same rights, immunities, and safeguards as Oregon's Act.

Dr. Quill recommended that procedures be followed before

64. Id. at § 127.805(1).
65. Id. at §§ 127.815-127.880.
66. Id. at § 127.805(1), §§ 3.01-3.14.
67. Id. at § 127.815(1)(h).
68. Id. at §§ 127.815(1)(a), (d).
69. Id. at § 127.825(h), § 3.03.
70. Id. at § 127.820, § 3.02.
71. Id. at § 127.835, § 3.05.
72. Id. at § 127.865, § 3.11(c).
patients receive lethal prescriptions.\textsuperscript{75} He feared that in many cases, though, minimal process is pursued; it is just left to a simple choice.\textsuperscript{76} From a policy standpoint, Dr. Quill viewed Oregon's process and safeguards as reasonable.\textsuperscript{77}

In response to Oregon's passage of the Death with Dignity Act, Congress enacted the Assisted Suicide Funding Restriction Act of 1997.\textsuperscript{78} It prohibited the use of federal financial assistance in support of assisted suicide, euthanasia, and mercy killing and defined the restrictions of funding.\textsuperscript{79} The Act also provided exemptions to the restrictions on federal funding: the restrictions would not apply to withholding or withdrawing medical treatment and care or nutrition and hydration, abortion, or the use of an item or service to alleviate pain and discomfort even if it increased the risk of death so long as the purpose is not to cause death.\textsuperscript{80}

Without using the term "double effect,"\textsuperscript{81} the Act recognized and exempted from restrictions on funding the method of providing pain and discomfort relief even with the attending possibility of hastening or causing death so long as the intent is to relieve pain and discomfort, not to bring on death.\textsuperscript{82} So both Congress and the Supreme Court of the United States gave weight to the principle of double effect.

Back in Oregon, Barbara Wagner was distressed because her lung cancer that had been in remission for two years had returned.\textsuperscript{83} But she was furious because the Oregon Health Plan informed her that it would not pay for the treatment; rather, it

\begin{thebibliography}{9}
\bibitem{75} Telephone Interview Quill, \textit{supra} note 57.
\bibitem{76} \textit{Id.}
\bibitem{77} \textit{Id.}
\bibitem{79} 42 U.S.C. §§ 14401-08 (2000).
\bibitem{80} \textit{Id.} at §§ 11402(b)(1)-(4).
\bibitem{81} See \textit{Vacco}, 521 U.S. at 807-809 n.11.
\bibitem{82} 42 U.S.C. § 14402(b)(4).
\bibitem{83} Tim Christie, \textit{A Gift of Treatment}, REGISTER-GUARD (Eugene, OR), June 3, 2008, at A1.
\end{thebibliography}
would cover the cost of some comfort care options, including a physician-assisted suicide if she chose that option. Barbara's response to the Oregon Health Plan's decision was not positive, "I think it's messed up. . . . To say to someone, we'll pay for you to die, but not pay for you to live, it's cruel. . . . I get angry. Who do they think they are?"

Her oncologist appealed to the company that markets Tarceva, the drug that would have been used for her treatment, to cover her medication. The big pharmaceutical company so concerned with making a profit informed Barbara that it would provide her with a free supply of Tarceva for a year. And as for Oregon, physician-assisted suicide rather than life-sustaining medication was the economical option. As the principle of the tragedy of the commons illustrates, it is impossible to provide everything for everyone with a limited set of resources. And like the race to the bottom indicates, whatever is financially efficient is usually the path that is taken.

The Older Americans Act established greater government responsibility, which strains both federal and state financial resources. Undoubtedly, these financial strains will increase. The elderly population continues to increase. The percentage of Americans age sixty and older in 1900 was 6.4%. This same group had grown to be 16.3% of the total population in 2000.

84. Id.
85. Id.
86. Id.
87. Id.
88. Id.
89. See generally Hardin, supra note 39, at 1243-44.
90. See generally SCHRAM, supra note 39, at 91.
92. Id.
94. Id.
95. Id.
Over the next three decades, this group is expected to grow to be 25.1% of the total population.\textsuperscript{96}

As was demonstrated in Oregon, when the government takes on unmanageable responsibilities and financial resources become exhausted, only the economical options will be provided, and physician-assisted suicide is very economical. With the elderly population and financial strain increasing, physician-assisted suicide will become a more attractive economic option at the federal level and among the states. The problem with an economic analysis is that life is devalued and no reasonable limitation can be set for standards and procedures: euthanasia becomes acceptable, then mercy killing, then involuntary assisted suicide, then genocide. And the race to the bottom is on.

**REVELATION**

In the New York Times, Dr. Quill described the available “last resort” methods for end-of-life care in the order of least to most controversial:

[1] Pain management so aggressive that it may well hasten death, although that is not the primary intention. (This is the doctrine of “double effect.”)

[2] Invoking a patient’s right to forgo life-sustaining therapies or discontinue them.

[3] Voluntarily stopping eating and drinking. Dr. Quill believes this is a “more morally complex” choice because over the last decade the practice has expanded beyond those with end-stage cancer or Alzheimer’s disease — who often lose interest in food or forget how to eat and drink — to people who are not “actively dying” but nevertheless have had enough of disability or dependence.

[4] Sedation to the point of unconsciousness. Although it was endorsed this year by a panel of the American Medical Association, Dr. Quill called it the “last, last resort.”\textsuperscript{97}

\textsuperscript{96} Id.

\textsuperscript{97} Jane Gross, *Landscape Evolves for Assisted Suicide*, N.Y. TIMES, Nov. 11, 2008,
He labeled these four methods as "physician-assisted dying" and then created an interesting distinction between physician-assisted dying and physician-assisted suicide, which is the method of using a self-administered drug that has been prescribed by a physician. A different ordering of the methods may be helpful in understanding the controversy over physician-assisted suicide: (1) invoking a patient's right to forgo or discontinue life-sustaining therapies; (2) voluntarily abstaining from eating and drinking; (3) administering aggressive pain management which may hasten death, although that is not the primary intention; (4) sedation to the point of unconsciousness; and (5) physician-assisted suicide.

Any abuse or mistake of intent or causation would be *de minimis* when using the first two methods. The controversy lies in the intent and causation of the last three methods. The problem with intent based standards is that intent is too easily cloaked and difficult to ascertain. Considering the privacy of the conduct and records in physician-assisted suicide cases, coupled with our lack of omniscience, any construct with similar methods differentiated solely by intent are hard to accept as providing adequate safeguards against abuse and mistake.

If physician-assisted suicide is legalized, then the recognition and legitimization of it will increase among the citizenry. The bedfellows, abortion and physician-assisted suicide, will only lead to an acceptance and legalization of more egregious conduct. And those most vulnerable to this slip will be the disabled, the low-income, and the elderly segments of our population.

Our view of and interaction with the elderly, and all people, should be based on their intrinsic value and inherent dignity, not utilizing a "who cares about them at all" or "what's in it for me" approach.

In an attempt to remove the economic considerations

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98. Telephone Interview Quill, *supra* note 57.
involved in end-of-life decisions, a major solution is for the rising generations to be more responsible individually so as to care for themselves, their aging parents, and their own families, which would provide a better quality of life. This provides for dignity that comes from meaningful work and contributing to family and society. It will remove end-of-life decisions from economic frameworks. Life and death won’t become decisions that are compelled financial “choices.”

If states choose to pass legislation that legalizes physician-assisted suicide, they should include the already established safeguards found in Oregon’s Death with Dignity Act. But an added safeguard would protect against abuses, mistakes, and economic motivation: a disinterested district attorney should be present at all phases of the physician-assisted suicide process.

But perhaps the best solution is to find the proper perspective regarding life and choice.