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The Legal Reality: Flaws and Illusions in Assisted Suicide Legislation
Delivered at the Opposition to Assisted Suicide Educational Conference
Seminary of the Immaculate Conception
February 3, 2016

Good afternoon, everyone.

Thank you all for attending this afternoon and for having me.

I have been asked to discuss today, what have been referred to as the flaws and illusions in various iterations of assisted suicide legislation.

I believe that it is very important when we speak of flaws or illusions not to be giving any impression that such flaws and illusions are fixable. They are not.

When, for example, we rightly criticize the adequacy of certain of the ways this legislation addresses or attempts to address, for example,

- psychological counseling,
- the possibility of coercion,
- the so-called informed consent process,
- conscience protection for objectors and
- patient safety,

we are not suggesting, “fix these things to improve the legislation.” We are not saying

- make counseling requirements more robust and this legislation will be ok or
- require close medical supervision when the patient self administers and this legislation will be ok.

No.

Rather, we are saying, and should be emphasizing that here are examples of practical problems with the legislation, practical problems that necessarily and irremediably flow from this type of deeply flawed endeavor, an endeavor in which a legislature, once again, looks at death as the solution to human suffering, as though human suffering is something science can solve, not merely, to their way of thinking, palliate. These legislators then jerry rig a scheme that will openly encourage healthy living human beings to encourage other living human beings, who are so vulnerable in their suffering, to take their lives by making suicide legal, acceptable, attractive, laudable and indeed courageous.

Be not at all mistaken: the legislation seeks in various ways, some overt and some subtle, to encourage the acceptance by society as a whole of assisted suicide.

The following is a simple example. The legislation invalidates any provision in any will that would condition receipt of a bequest upon natural death, as opposed to death by suicidal ingestion of lethal chemicals under the terms of the law.

This whole picture, ladies and gentleman, is not something that is fixable. And assisted suicide is something with respect to which we are bound to ask the following basic question:

- Is legislatively sanctioned and encouraged death-by-suicide something that a civilized society should pursue?

The grave implications deserve far, far more thought than many of our legislators and fellow citizens are willing to devote, especially in a time when, across so many facets of culture, quick fixes, convenience and perceptions of individual liberty are idolized at the expense of respect for life.

There is a discernible set of false assumptions that almost universally characterizes this type of legislation, not only in New York, but in every place that struggles to make suicide both legally justified and morally acceptable. These assumptions, and the talking points that are trotted out in support of them, are meant to create a halo of respectability and humanity that mixes the truth of human suffering, a truth that will never go away except under a dangerous quick-fix mentality of utopia by planning and convenience, with a lot of falsehood to confuse clear thought.

Today, instead of focusing so much on the practical problems with the legislation, and there are many, I would like to identify and question certain underlying legislative arguments and assumptions, that repeat, time and time again, in both the legislation and supporting rhetoric, and which build a foundation of untruth on which rests this grave wrong, masquerading as humanity.

When the assumptions and arguments are unwrapped, a number of falsehoods embedded in the legislative schemes become apparent. Indeed, when you think about it, all of these schemes turn the Passion of Christ on its head in a number of interesting ways, including, most starkly, the denial of the redemptive power of a degree of voluntary suffering, not only for one's own self, but for others.

Because he himself was tested through what he suffered, he is able to help those who are being tested. (Hebrews 2:18)

Not so with the legislative picture of death and its key features:

- death will take place in six months – **anyway**;
 - the patient knowingly and freely decides that his or her sense of dignity warrants death on his or her own terms;
 - a lucid and rational patient then asks his or her doctor for lethal so-called “medication” in order to avoid further humiliation and suffering;
 - the Patient must self-administer this lethal “medication.” After all, although it is, in the eyes of the legislature, acceptable for the patient to take his or her own life, it is somehow unacceptable for someone else to administer the chemicals – or is it? And why this distinction?; and
 - at some point, to be decided by the patient freely and supposedly without duress, the patient, using the legislative trope, brings about his or her own “peaceful and humane death.” Although apparently, this has to be while the patient has the physical capacity, not only to take the water glass in hand, but to swallow the pills.
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What are the arguments and assumptions built into the legislative narrative of suffering and death?

Assumption #1

In my view, the single most significant operative argument and assumption embedded in the legislative scheme of death is the following: the ending of life as contemplated by the legislation is not suicide.

In their own ways, these bills tell us that the act of self-administration of physician-prescribed lethal doses of so-called “medication” is not suicide.

Here is a quote from one of the bills: “A patient with an illness or condition who self-administers a lethal dose of medication will not be considered suicidal...”

I hinted at it before, but it bears repeating. The manipulative use of the word medication in this context should trouble us deeply. The legislation tells us: this is medication; it is good; it is healing.

The drafters are also clear, for example, that for the purposes of life insurance and death certificates, death by self administration of lethal chemicals shall be considered natural death caused by the underlying condition.

This is clearly contrary to the reality of what has taken place, or, to put it more bluntly, it is simply a lie.

Why is it that the purportedly free and conscious act of hastening death cannot be called what it truly is -- suicide?

As far as I know, still contained in the Merriam-Webster dictionary is the following Definition of Suicide:

“The act or an instance of taking one’s own life voluntarily and intentionally especially by a person of years of discretion and of sound mind.”

Well, we can see a few of the legal reasons as to why death under the legislative scheme cannot be suicide although it falls squarely under the meaning of the word, even by the legislation’s own standards.

- The legislature cannot on the one hand allow, and indeed endorse, these practices and at the same define aiding a patient in his or her own death as being the same as “assisted suicide” under the law, because “assisted suicide” remains a crime and in the eyes of the drafters should remain a crime, but only in certain circumstances and not in others. We’ll come to some of the serious slippery-slope problems and contradictions in a moment
- And the legislature cannot on the one hand allow these practices and at the same time allow life insurance companies to deny coverage under suicide exclusions.

But it all goes much deeper than these legal reasons. The move to change the definition of suicide is a marketing move; it is a move to remove stigma; and to turn something wrongful (the conscious encouragement and aiding of the taking of a life) into something laudatory.

And so convinced are the drafters of one of the bills that assisted suicide is laudatory, that they include a caveat in the very weak conscience protection clause, which says, in sum, that while no health-care professional shall be under any duty to participate in the provision of lethal doses of drugs, the objecting professional MUST make reasonable efforts to refer the patient to professionals who may participate.

So, not unlike what is going on with the HHS mandate (for those of you familiar with that abomination), this is, once again, government attempting to force objecting individuals to partake in practices that violate sincerely held religious belief, all because of a perception that government knows best and that, therefore, governmental views trump religious views.

By the legislation’s own key requirements of sound mind, voluntary action, intentionality and self administration, the situation described in the legislation is the classic definition of suicide. It is suicide plain and simple, and is it suicide to be aided by the medical profession and sanctioned by the government.

But we live in a time don’t we, when we are free to change the meaning of words, particularly in the service of selling falsehoods.

Assumption #2

With all due respect for the medical profession, Assumption #2 is that the medical profession (not to mention the legislature) is both infallible (they don't make mistakes) and omniscient (they know everything).

We should not lose sight of the fact that these bills rely heavily on assumptions about physicians and are explicitly as much about physicians as they are about patients with terminal illnesses.

The bills codify the decriminalization of activity pursuant to which a physician in a so-called bona-fide physician-patient relationship with a terminally ill patient prescribes lethal chemicals to bring about a "peaceful death" in order to put an end to perceived indignity and to stop suffering.

They are all about physicians helping people to kill themselves. They are not about physicians helping people while they are dying.

Necessarily the bills must actually insulate physicians from legal culpability.

What perhaps is more interesting is that the bills also attempt to absolve them from moral culpability through rhetoric.

Let's be clear, in these circumstances, the physicians do not treat patients; they eliminate the need to treat them by helping them kill themselves.

Part and parcel of this dynamic are three assumptions about physicians:

- First – Based on their state of medical knowledge, they infallibly know that unassisted death will occur in six months or so anyway. This six-month period has become the magic number in these types of bills.
- Second – Despite the fact that there is necessarily no empirical or scientific data from any patient, ever, on the level of suffering, discomfort, abject terror, regret etc. endured by the patient in those moments he or she nods off to pre-death sleep, or in the period between sleep and actual death, doctors are empowered by the legislature to say with their unique omniscience that, "I should aid this person's death in order to stop suffering and indignity."
- Third, a physician engaging in the mandated end-of-life versus palliative care risk-benefit discussions with a terminally ill patient would never say anything – would they? -- that would unduly influence one of these very, very vulnerable people or his or her very, very vulnerable loved ones into choosing a hastened death.

The legal reason for decriminalization is clear: if this system and these options are to be implemented and encouraged as viable, open and courageous solutions to human suffering, physicians must be immune from prosecution.

But the justifications for decriminalization and immunization are highly questionable.

Physicians have only half the equation, if that. There are things about which they have no idea and will never have any idea. And do we want our legislature, as a matter of public policy, to be enabling medical doctors to partake in a regulatory scheme built on half an equation and embracing the causation of death as a legitimate solution to suffering.

By the way Stephen Hawking, who was probably never told that assisted suicide was an option, has had 6 months to live for over 50 years. I wonder what he would have done at age 21 if he had been advised of end of life options, and been told he could die in a dignified manner and thus avoid all of the embarrassments that awaited him, knowing what death from ALS typically looks like.

Assumption #3

The third assumption is that a person living with a terminal condition and in the fear of great pain, or in great pain itself, is somehow free from duress.

When looking at the rhetoric, we see that it goes to great lengths to portray these patients as mentally robust and fully capable: A few examples:

- This is about self-determination, mental competence, sound judgment and freedom to choose in a rational manner;
- These bills are not about the unbalanced, the despondent, or the mentally impaired; and
- And there are ample processes in place to protect against choices based upon “impaired judgment.”

The justification portion of the sponsor memo for senate bill 5814 reads as follows:

“The highly publicized planned death of Brittany Maynard has highlighted the need for terminally ill patients to be able to access aid in dying. Patients with a terminal illness or condition seek the ability to choose how and when they die. These patients, **who are mentally competent and without impaired judgment**, should not

be forced to relocate to another state or to leave the country to control how they end their lives and to die with the dignity, peace and comfort they seek and that they **believe** will come with shortening the dying process.” (emphasis added)

The memo goes on

“According to HealthDay/Harris poll findings released in December 2014, 74% of American adults believe that terminally ill patients **in great pain** should have the right to end their lives.” (emphasis added)

It is to be noted that a good portion of the rhetoric assumes a slow and painful death at some point, and notwithstanding justifications in legislative memoranda that speak about self-administration when “suffering becomes unbearable,” the law does not require the patient to be in any pain at all, let alone great pain, at the time prescription and distribution is made, or at the time the patient supposedly self-administers.

It is not only legitimate, it is imperative, to ask at least, the following two questions:

1. Do we want a person who is feeling relatively well, but is fearful of what may be to come, to be persuaded by fear and to have been assisted in death through the mechanisms of state government? There may be a concept for this somewhere, but it is most certainly NOT free choice.

and

2. Is it acceptable to persist in fictional narratives about persons who transition from some discomfort to great pain in a short time within a six-month period (which I recently saw firsthand with my sister in law, who passed two weeks ago from pancreatic cancer). Is it acceptable to persist in the fiction that these patients remain free of duress and mentally capable of deciding to kill themselves at any point in that six-month period. There may also be a concept for this somewhere, but it is NOT free choice.

The point is that in law making, where the State is promoting so called aid-in-dying to such vulnerable people, mythmaking, sloppy thought, marketing and misrepresentation are unacceptable and immoral.

Assumption #4

Assumption #4 is that death by **secobarbital or pentobarbital** is humane.

I am not a pharmacologist. Nor am I a physician. But I do think it is at least the fair and responsible thing to do to question this assumption, especially when we are being told, and the vulnerable are being told, that this aid in dying is the key to a humane death, which will stop indignity and pain.

Have the legislators who are prepared to vote yes to this legislation been properly informed about material issues with the use of these chemicals?

- How is it that death by these chemicals has been deemed cruel and unusual by opponents of capital punishment, but is lauded by the proponents of aid in dying as humane?
- What do botched executions look like?
- What actually happens in an aided suicide?
- How does the FDA view these drugs and the need to regulate them?

And what is the content of the information on which the purported informed consent of the patient is based?

Is it something like the following?

“Mr. Jones, as with all drugs, there are risks of side effects , but in most cases they cause a painless drifting into sleep followed by a cessation of life functions.”

Or should it be more like the information contained in an October 16, 2015 article in US News and World Report entitled *“Drug Used in Death With Dignity is the Same Used in Executions: A Closer Look at the Drugs that Kill.”*

In that article, it is pointed out that death penalty opponents argue that lethal injection drugs are inhumane and can cause gruesome, unimaginable suffering.

Tamara Tabo, head of the Center for Legal Pedagogy at Thurgood Marshall School of Law at Texas Southern University, is quoted in the article as follows:

“I don’t think many people who are casual supporters of the Death with Dignity movement are aware that there are these sorts of risks... Everyone has a picture that it’s simple, clean, easy, and you fall asleep...That’s unfortunately not always so.”

Assumption #5

Understandably, the legislators assume that legislative safeguards are as flawless as the medical profession, adequately addressing all legitimate concerns. The legislative rhetoric says “Look at all the safeguards we’ve added.”

The drafters point to things like

- mandatory forms for requesting the medication;
- the requirement of informed consent;
- the fact that attending MDs must act as gatekeepers to ensure that every person whose judgment may be impaired by mental disorder or depression will get counseling and will be appropriately cleared before any aid-in-dying may be given; and
- the fiction that objectors need not participate.

When closely examined, however, the safeguards are flimsy. Not because the legislators are not well meaning; but because it is not possible to address adequately the parade of problems without undoing entire house of cards on which the misguided goals of the legislation are based.

Not one of the purported safeguards protects against:

- exploitation of the fears and suffering of highly vulnerable populations;
- surrogate decision making;
- administration of lethal chemicals by persons other than the patient;
- self administration in fleeting moments of anguish;
- forcing conscientious objecting physicians into facilitation of evil;
- a death that is far more painful, and far less dignified and humane, than death from the natural disease course accompanied by palliative care; and
- the inevitable decline down a slippery slope

This brings me to the last of the assumptions I'd like to point out.

Assumption #6

There is no need to be concerned with a slippery slope.

Some of the most significant objections to this legislation relate to the very real risk of a slippery slope. And we will no doubt hear that there is no need to be concerned.

This is a frequent retort to legitimate concerns about legislative line drawing in areas where legislatures should not be treading.

We saw this and continue to see it in the contexts of contraception and abortion, and the HHS Mandate. How, we might ask, did the relatively benign *Griswold v. Connecticut* holding of 1965, allowing married couples a right of privacy to use contraception, get transformed through the years into an affirmative federal administrative order in 2010 that forces religious persons and organizations, under threat of severe and crippling financial penalty, to participate in a regulatory scheme that facilitates the distribution to their employees of products and services (abortifacients, sterilization and contraception) that certain religious persons and organizations, indisputably and sincerely, find objectionable.

Yet we hear it all the time: the use of the slippery slope argument is unrealistic fear-mongering. They may say, for example, "It's absurd to think that this legislation will lead to state-assisted or state-mandated death." Is it really so absurd?

The denial of the legitimacy of slippery slope fears is a denial of the two-headed dragon of incrementalism and desensitization, which combine to get right-thinking persons to a point where, perhaps years later, they have to say "My God what have we done."

In order to expose certain of the false premises and assumptions that are embedded in the aid-in dying legislation, we need not adopt a dissenting point of view. We need only adopt the point of view of classes of persons who are left out of the supposed benefits of the legislation. One is certainly entitled to ask, why not

- the elderly who are alone and scared and who simply don't want to go on;
- the incompetent who are condemned to vegetative lives in institutions;
- chronic depressives;
- persons who, prior to debilitating spinal or head injuries or stroke, demonstrably stated "I would never want to live like that";
- children who, as in Belgium, as of February of 2014, are entitled to be euthanized, as long as they request to be killed with parental consent and as long as they understand the implications of the decision; and
- persons who suffer from horrible but not-immediately fatal terminal conditions, slowly moving rare and devastating neurodegenerative disorders like

- motor neuron disease
- multiple system atrophy
- progressive supranuclear palsy
- alzheimer's disease
- lewy body dementia
- and on and on.

Why can't these people who are doomed to horrible suffering and supposed indignity, not for mere months, but for years and years, avail themselves of aid in dying.

Of course, if the supporters of the aid-in-dying legislation were questioned as to why persons in these classes don't have the same right to choose dignified and humane death in lieu of life beset by relentless suffering and indignity, they no doubt would resort to the very lines they have artificially drawn and murmur something or other about barbarism.

But, ladies and gentlemen, how can it possibly be fair and just to tell a person who has six months to live in great pain and suffering that the state supports aid in dying for him or her, but to tell the person who has 6 to 10 years to live with great pain and suffering that the state does not support aid in dying for him or for her.

And this is the problem.

The purported truth of the legislative premises fails to guarantee the truth of the necessary conclusions, and if one is at all honest, this would have to be acknowledged by the advocates of the current legislation, if they believe their own rhetoric.

In sum, the entire endeavor is horribly misguided and cannot be fixed. The overriding flaw and illusion is that this is a matter for the legislature at all.

Thank you for your kind attention this afternoon.

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