The Linacre Quarterly 82 (1) 2015, 49–54

A template for non-religious-based discussions against euthanasia

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We submit this manuscript as part of the ongoing conversation in society at large about physician-assisted death (PAD) and euthanasia. This outlines an approach used by lay healthcare professionals in arguing against PAD/euthanasia during a 1-hour debate conducted on a secular medical school campus. We have included the elements chosen for the "con" side of the argument (i.e., against PAD) by the medical students and attending physician. The goal of this manuscript is to provide a focused and pithy template upon which to build an approach that honors the dignity of life in all circumstances.

Lay summary: *The discussion over physician assisted death and euthanasia remains ongoing in secular academic medical institutions across the United States and much of the western world. These debates have incentivized efforts to develop a framework for arguments against Euthanasia that will find traction in an environment generally hostile to religion and religious thought. In this essay, we present arguments given by the "con" side in a student-led debate over physician assisted death and euthanasia at Vanderbilt University with the hope that they will provide a foundation for future discussions promoting truth and life without alienating our secular colleagues.*

Keywords: Euthanasia, Physician-assisted suicide, Physician-assisted death, Debate, Apologetics

> Medicine is more than a profession … It is not an occupation for those to whom career is more precious than humanity or for those who value comfort and serenity above service to others. The doctor's mission is prophetic. Abraham Joshua Heschel, 1964 AMA Convention (twentieth-century theologian)

Introduction

In the spirit of Abraham Heschel's comments to the AMA cited, we submit this essay as part of the ongoing conversation in society at large about physician-assisted death (PAD) and euthanasia. The objective of this essay is to share a template for non-religious-based discussions against PAD/euthanasia for healthcare professionals increasingly confronted with the "culture of death" spoken of so prophetically by Blessed John Paul II and others. We want to make *two points* before we begin. First, the stimulus for this essay was the public viewing on our medical school campus of a pro-euthanasia video (Navasky and O'Connor 2013) promoted by a student-led organization and followed by a pro/con debate. This is relevant because it represents a tender watershed on university and medical

 DOI 10.1179/2050854914Y.0000000036

school campuses that should be thoughtfully addressed to inform students and practicing healthcare professionals of both truth and misinformation. Second, there are many scholarly works in this area brimming with rigor and depth. The goal of this essay is to provide a focused and pithy template upon which to build an approach that honors the dignity of life in all circumstances.

In medicine, we talk much these days about a "good death," which is not necessarily one completely free of suffering, but a dying process in which we are attendant to pain and symptom management, optimize clear decision making, and affirm the whole person in as dignified a manner as possible. At a time when "Gladd" helium bags for death by suffocation and hired exit guides are found online (Associated Press 2012; Odgen, Hamilton, and Whitcher 2010; Schon and Ketterer 2007; "The EXIT euthanasia blog" n.d.), and in an American society in which proposals to offer mail-order suicide prescriptions were defeated recently only by a narrow margin (Johnson 2012; Patients Rights Council 2013), medical professionals must come to grips with their own understanding of truth. We should consciously and purposefully train ourselves in nuanced approaches for the successful conduct of conversations about the end of life, which are complicated and deeply personal, especially for people living in an increasingly secular world which often disregards any argument with ties to religion. More importantly, when we encounter patients who are requesting that we help them die through the active process of PAD/euthanasia, and who often do not believe in God, without proselytizing we need to help them navigate away from suicide and toward a comfortable dying process through well-orchestrated palliative care. Let us remind ourselves that

> medicine has as its means diagnosing, curing, saving lives toward the end-goal of preserving and improving health, self-worth, and personal dignity. Do not confuse the "means" as the "end." To accomplish the means at the expense of the end is to fail. (Cohen 1989)

The key to approaching any discussion is to know your audience. In many circumstances, it would be ill-advised to explicitly mention drawing from source material by authors with a distinctly Christian identity, yet in other groups, it would certainly be appropriate and useful to incorporate material from Lewis, Chesterton, and other apologists by name. In the introduction to our on-campus debate, we drew from an excerpt of C.S. Lewis's very challenging book, *The Abolition of Man*, which was ranked by the *National Review* as number 7 on their "100 best nonfiction books of the century" (National Review 2005). In the book, Lewis uses the concept of the Tao to represent natural law, traditional values, and objective truth. Lewis states, "there has never been, and never will be, a radically new judgment of value in the history of the world" (Lewis 1955, 56). That is, truth is truth, timeless and unshakeable. Pope John Paul II, speaking on the Church's teachings on abortion in 1995, spoke similarly:

> No circumstance, no purpose, no law whatsoever can ever make licit an act which is intrinsically illicit, since it is contrary to the law of God which is written in every human heart, knowable by reason itself, and proclaimed by the Church. (John Paul II 1995, 62)

Lewis further discusses the manipulative power of our minds in our attempts to rationalize our desire for control, and speaks to how easily we can trick ourselves into looking the other way when something we do has some element of frayed justification: "We do not look at trees either as Dryads or as beautiful objects while we cut them into beams" (Lewis 1955, 82). In the context of euthanasia and abortion, that denial can be

so powerful that we even fail to see the dying human being as a full person. Furthermore, Lewis goes to great lengths to illustrate that each new power won *by* man is a power *over* man as well, using such examples as the plane, the phone, and the birth-control pill. Indeed, it is not so much man's power over nature, as it is man's power over other men via nature. The overall premise of the book is that as man attempts to gain more and more control over nature or creation, he will move outside of the Tao (leaving natural law) and rapidly toward his own destruction —hence, the abolition of man.

It is exceedingly common in pro-euthanasia circles to hear the argument that patient autonomy is the sole basis for moral decision making. Building on the above-mentioned comments (which are not religiously based), one is on solid ground in pointing out that such a morality (one based exclusively on the ability of individuals to choose whatever they believe is right for them in an effort to exert control over their circumstances) is fundamentally flawed, lacking the foundational virtues that have governed the practice of medicine for a millennia, and ultimately destructive to patient and provider alike. Lewis exhorts the importance of teaching and training, which are the purposes of this essay:

> We make men without chests and expect of them virtue and enterprise. We laugh at honor and are shocked to find traitors in our midst. We castrate and then bid the geldings to be fruitful. (Lewis 1955, 35)

Thus, we must, as apologists, be armed with the ability to argue for truth and life without alienating our secular opponents by resorting to arguments from religion.

Here are the three sets of notes that we brought into the debate. In order to remain brief, we will not elaborate further about how each of them was argued and received, but offer them as building blocks to the reader to strengthen any pro-life debate. As noted, every such debate must be explicitly calibrated to the audience:

EOL Debate Talking Points from the Con Side on Euthanasia/ Physician-assisted Death

Melissa Bloodworth's Opening

In our opening statements, we will first state that the profession of medicine was built upon the foundations of society itself, emphasizing the imperative of life. Secondly, we will declare that in rejecting life, the opposing side is separating itself from the established practice of medicine. Therefore, according to this previously established precedent, those dissenting must not only provide sufficiently compelling causes to justify their separation, but further outline the principles upon which their new profession of medicine will stand and how its powers will be organized.

Similarly to how the three branches of the American government were created, three principles of medical ethics—autonomy, beneficence, and justice—were identified to keep one another in check. An executive branch ruling in isolation is recognized as tyranny. A scientist who clings to the virtue of truth but neglects love and mercy is heartless. The practice of autonomy in isolation reflects a society which has yielded to the reign of indifferent cruelty; indeed, to neglect the virtue of beneficence (to say nothing of justice) is a clear violation of the Hippocratic Oath: *primum non nocere*, first do no harm. It is confused thinking to say that murder is an act of compassion: we do not condone killing when young patients suffer from depression. When suicidal intentions indicate to us that a patient is no longer capable of making autonomous informed decisions, we take the time to reach out to the patient, whose life our society has entrusted to the care of our profession. We constitute a

trustworthy and hopeful profession, which the darkness of death and suffering—physical and mental—cannot erode.

Nathaniel Bloodworth's Opening

Since humans have first begun to write, the recorded wish for a good death has existed, described as a peaceful passing beyond the veil, a way we must all travel one day. Many of us might define such a death as one free from suffering, surrounded by those we love while we drift into a deep and gentle slumber. Such idealizations are rarely the case—very often, death is a painful and distressing process, both physically and mentally. Certainly, it is our role as physicians to do all we can to alleviate the suffering of our patients during this transition—but this role is sharply, firmly, and immutably distinct from apportioning death, even upon request. Such power lies forever beyond our grasp, as it should. Autonomy *alone* can never be a substitute or a foundation for moral reasoning. To claim such would be to equivalently state that what we decide is acceptable for us becomes moral, merely by our deciding. The implications of this are disturbing, and self-contradictory. After all, by what authority can we claim that morality is contingent on our decisions—what makes autonomy moral? And for those who advocate for autonomy above all else, what if this request for release through death was not free? Ben Mattlin, who lives with spinal muscular atrophy, states in his *New York Times* article,

> Perhaps, you can't understand why anyone would push for assisted-suicide legislation until you've seen a loved one suffer. But you also can't truly conceive of the many subtle forces—invariably well meaning, kindhearted, even gentle, yet as persuasive as a tsunami—that emerge when your physical autonomy is hopelessly compromised. (Mattlin 2012)

Concerns similar to his are not hard to find. What, then, is the consequence for us as physicians when we, in all of our goodwill, bring death to one who had, unbeknownst to us, submitted their will to this coercion, and who does not act in accord with true autonomy? For those who advocate this path, is not only consenting to—but contributing to—even one death in this manner a risk worth taking?

Wes Ely's Opening

The Declaration of Independence states that all men are endowed by their creator with the rights to "life, liberty, and the pursuit of happiness." The order here is critical—life, before the others, is the fundamental unalienable right that, without which, no other right can exist. While from an American document, this truth about the inalienability of these rights for humans is not restricted to humans from one country; and this truth is maintained whether these rights are implemented well or poorly. Aristotle, in lectures he gave around 350 B.C. at the Lyceum (which later became the backbone of his *Nicomachean Ethics*), explored the ties between life and the nature of happiness when he asked: "What is happiness; what makes a person happy?" The theme of this work included questions posed by Socrates, and subsequently answered by Plato, making it the culmination of thought by the greatest tandem of philosophers the world has ever known. Aristotle said,

> The activity of intellect, which is contemplative … will be the complete happiness of man, if it be allowed a complete term of life. (Aristotle 1984, bk. 10, ch. 7)

A person committing suicide and a physician aiding in that endeavor are turning *in* on the self and not completing the term of life, and so run directly counter to these ideals.

In contrast, these ideals are beautifully realized in L'Arche, a foundation comprised of hundreds of communities around the world that allow the mentally handicapped to thrive

and embrace all of life as worthy of living. The founder, Jean Vanier, wrote, "The response to despair is a limitless trust and hope" (Vanier 2014). These views regarding life were exemplified by Victor Frankl, a prominent Jewish psychiatrist and neurologist who gave up a visa to America to accompany his parents to a concentration camp, losing his entire family—including his pregnant wife—in the process. In the middle of unimaginable human suffering, Frankl wrote,

> Being human always points, and is directed, to something or someone, other than oneself … The more one forgets himself—by giving himself to a cause to serve or another person to love—the more human he is. (Frankl 1984, 133)

Francis Collins, the leader of the human genome project and appointed by President Obama as the director of the NIH, translated these ideals to the healthcare profession when he wrote,

> The simple act of trying to help just one person, in a desperate situation … turned out to represent the most meaningful of all human experiences. … This was true north. (Collins 2006, 218)

This is referred to as the natural law, and is universal and based on the rational nature of humans. As physicians, we must strive to provide a quality dying process for those with terminal prognoses, making the switch seamlessly and successfully from cure to comfort, and recognizing that, as part of the dying process, conflict resolution and life meaning are often fruits for both patient and physician.

One night many years ago, Taylor, my 7-year-old daughter, ran out of a church in downtown Nashville to chase down a homeless man who was out in the dark, cold night. As I ran after her, she grabbed his hand and was on her way back, offering him food and shelter for the night. When her twin sisters asked her why she had done that, she replied,

> Because we learned in school that every person has his dignity, and we show them that by taking care of one another until life is over.

It is *confused thinking* to believe that helping someone commit suicide or determining that a life is not worth living is somehow an act of benevolence. Those actions cheat life of its fullness. We must maintain the fullness of respect for every life, at every moment, fueled by unending love and kindness no matter its circumstances. Remember the words of Jean Vanier: "The response to despair is a limitless trust and hope." How can we as physicians demonstrate to our patients that they can have limitless trust and hope in us if even one of them knows we are willing to kill him or her? The cornerstone of public trust in the medical profession is that physicians have 100 percent incentive to benefit patients and 0 percent incentive to harm them: *primum non nocere*.

Conclusion

The ongoing debate in the medical community and society at large regarding the role doctors should play in expediting death represents a larger struggle for the heart and soul of medicine. To be silent on these matters would be a grave mistake—physicians and other healthcare professionals should make every effort to engage one another and the wider public. Through this report and discussion, we hope to have imparted some insight on strategies and approaches that might gain traction in an increasingly secular profession. We intend not only to emphasize the unacceptability of PAD/euthanasia, but also to propose that physicians act as healers to our suffering and dying patients by meaningfully engaging them and doing all we can to help them find rest and peace as they approach the end of life.

References

Aristotle. 1984. *Nicomachean Ethics*. Tran. W.D. Ross. Princeton, NJ: Princeton University Press.

Associated Press. 2012. California: Seller of suicide kits accepts plea deal. *The New York Times*. May 7, 2012. http://www.nytimes.com/2012/05/08/us/california-seller-of-suicide-kits-accepts-plea-deal.html?_r=0.

Cohen, Irwin P. 1989. Professor for "Introduction to Public Health" at Tulane University School of Medicine. This quote was taken from a lecture delivered on February 7.

Collins, Francis C. 2006. *The language of God: A scientist presents evidence for belief*. New York: Free Press.

EXIT euthanasia blog. n.d. http://exiteuthanasia.wordpress.com/about/.

Frankl, Viktor. 1984. *Man's search for meaning*. New York: Simon & Schuster Inc.

John Paul II, Pope. 1995. *Evangelium vitae*.

Johnson, C. 2012. Assisted suicide measure narrowly defeated; supporters concede defeat. *Boston Globe*. November 7. http://www.boston.com/2012/11/07/dying/gBqan95E7zK3elChci PBOP/story.html.

Lewis, C.S. 1955. *The abolition of man: How education develops man's sense of morality*. New York, NY: Macmillan Publishing Company.

Mattlin, Ben. 2012. Suicide by choice? Not so fast. *New York Times*. October 31. http://www.nytimes.com/2012/11/01/opinion/suicide-by-choice-not-so-fast.html.

National Review. 2005. The non-fiction 100. *National Review Online*. October 19. http://www.nationalreview.com/articles/215718/non-fiction-100.

Navasky, M. and K. O'Connor. 2013. The suicide plan. *Frontline*. November 13. WGBH Educational Foundation. http://video.pbs.org/video/2304058290/.

Odgen, R.D., W.K. Hamilton, and C. Whitcher. 2010. Assisted suicide by oxygen deprivation with helium at a Swiss right-to-die organisation. *Journal of Medical Ethics*, 36: 174–79.

Patients Rights Council. 2013. http://www.patientsrightscouncil.org/site/massachusetts/.

Schon, C.A. and T. Ketterer. 2007. Asphyxial suicide by inhalation of helium inside a plastic bag. *American Journal of Forensic Medicine and Pathology* 28: 364–67.

Vanier, Jean. 2014. Community and growth. Quoted on L'Arche USA website. http://www.larcheusa.org/learn/jean-vanier/.

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