Apostolate of Death

by Aaron Kheriaty

On November 1, after posting a Facebook message stating, "Today is the day I have chosen to pass away with dignity in the face of my terminal illness, this terrible brain cancer," twenty-nine-year-old Brittany Maynard took a lethal dose of barbiturates, prescribed by an Oregon physician, and ended her own life. One newspaper opinion columnist spoke with almost religious awe when she noted that "Maynard has ascended to martyr-saint status as an advocate for the right to suicide in the throes of terminal illness."

In the wake of her death, bills to legalize physician-assisted suicide are being considered in at least twelve states (California, Colorado, Illinois, Indiana, Iowa, Minnesota, Nevada, New Mexico, Pennsylvania, Rhode Island, Wisconsin, and Wyoming). The public is clearly not yet sold, as these efforts follow on the heels of failed attempts to legalize assisted suicide in three other states (Connecticut, Massachusetts, and New Hampshire).

The claim to a right to physician-assisted suicide raises many questions, not the least of which is this: If there is such a right, why would it be restricted to those in the throes of terminal illness? What about the elderly person suffering a slow but nonterminal decline? What about the adolescent or young adult in the throes of depression, demoralization, or despair? Once we adopt the principle that suicide is acceptable, then the fences that legislators might try to erect around it—having six months to live, or having mental capacity, for example—are inevitably arbitrary. These restrictions will eventually be abandoned, as the situation with assisted suicide in Belgium and the Netherlands demonstrates.

In Belgium, assisted suicide has been granted to a woman with "untreatable depression"; in the Netherlands, assisted suicide has been granted to a woman because she did not want to live in a nursing home. We see evidence here of not only a *practical* slippery slope but a relentlessly *logical* slide from a cancer patient with six months to live to people who are merely unhappy, demoralized, dejected, depressed, or desperate. If assisted suicide is a good, why limit it only to a select few?

Recent debates on physician-assisted suicide have largely ignored research in psychiatry and the social sciences. It is important to appreciate what motivates suicidal behavior, which individuals are at risk for suicide, and how suicide risk can be lowered. We know, for example, that suicide is typically an impulsive and ambivalent act.

One suicide "hot spot" is the Golden Gate Bridge in San Francisco, where fourteen hundred people have died, while only a handful have survived the jump. A journalist tracked down a few of these survivors and asked them what was going through their minds in the four seconds between jumping off the bridge and hitting the water. All of them responded that they regretted the decision to jump, with one saying, "I instantly realized that everything in my life that I'd thought was unfixable was totally fixable—except for having just jumped." This small sample is consistent with larger studies of suicide survivors: Ten years after attempted suicide, nearly all survivors no longer wish to die but are pleased to be alive. To abandon suicidal individuals in the midst of a crisis—under the guise of respecting their autonomy—is socially irresponsible: It undermines sound medical ethics and erodes social solidarity.

Suicidal individuals typically do not want to die; they want to escape what they perceive as intolerable suffering. When comfort or relief is offered, in the form of more-adequate treatment for depression, better pain management, or more-comprehensive palliative care, the desire for suicide wanes. We know that the vast majority of suicides are associated with clinical depression or other treatable mental disorders; yet alarmingly, less than 6 percent of the 752 reported cases of individuals who have died by assisted suicide under Oregon's law were referred for psychiatric evaluation prior to their death. This constitutes gross medical negligence.

We also know that there is a "social contagion" aspect to suicide, which leads to copycat suicides. In 1933, on the Japanese island of Izu Oshima, a twenty-one-year-old student named Kiyoko Matsumoto jumped into the volcano of Mount Mihara from an observation point overlooking the molten lava. Her death became a media sensation across Japan as newspapers reprinted her poignant suicide note and turned her into an overnight celebrity. Nine hundred forty-four people subsequently jumped into the

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volcano's crater in 1933 alone. In the years that followed, thousands more made the one-way trip to the volcano, including, every year, dozens of suicide-pact couples who plunged into the lava together. The Tokyo Bay Steamship Company set up a daily line to the island's volcano rim, which became known as "Suicide Point," to ferry victims and spectators: Some passengers bought one-way tickets to the destination, while others traveled there round-trip to watch people jump. This suicide epidemic ended only after officials made it a criminal offense to purchase a one-way ticket to the island and placed a barrier at the observation point.

Many recent commentators have called Maynard's death "courageous" and "inspiring," but we should worry that her death will indeed "inspire" others to follow her example. Assisted-suicide advocates might insist that her death was a purely private decision or merely an exercise in personal autonomy; but given what we know about suicide's social effects, and given the media portrayal of her death, we can anticipate that her decision will influence other vulnerable individuals.

Suicide rates now constitute a public-health crisis: According to the Centers for Disease Control, suicide is currently the third leading cause of death among adolescents and young adults and the tenth leading cause of death overall for individuals over the age of ten. Not all suicides can be prevented, but many can, and our collective efforts have the capacity to save many lives. Studies show that when we intervene during a crisis—for example, during the months of difficult adjustment after a new diagnosis of a serious or terminal disease—we can substantially lower the person's risk of suicide.

Refusing to legitimate suicide helps those in need. The practice of physician-assisted suicide—by whatever name one calls it—sends a message that some lives are not worth living. The law is a teacher: If assisted suicide is legalized, this message will be heard by everyone who is afflicted by suicidal thoughts or tendencies.

While a causal relationship is difficult to establish with the available data, it is perhaps relevant that the overall suicide rates in Oregon rose dramatically in the years following the legalization of physician-assisted suicide in that state in 1997: According to data from Oregon Public Health, after the state's suicide rates declined in the 1990s, they increased significantly between 2000 and 2010, and are now 35 percent higher than the national average.

Many advocates of assisted suicide try to redefine it as something else—indeed, to redefine human dignity and human life itself. Maynard has become a sort of secular saint for the cause, and the media have provided her hagiography. Maynard herself wrote: "If I'm leaving a legacy, it's to change this health-care policy or be a part of this change of this health-care policy so it becomes available to all Americans. That would be an enormous contribution to make, even if I'm just a piece of it." CNN named Maynard one of its "11 Extraordinary People of 2014" for her decision to define death "on her own terms." Another columnist wrote that Maynard in her choice for self-inflicted death employed her "own definitions of life and dignity."

This echoes the famous "mystery clause" of Supreme Court justice Anthony Kennedy: "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." Such a notion of liberty and human dignity can only lead to incoherence and absurdity; life and death are not ours to define, but are objective realities to which we must adapt. There is a great irony in all of this empty talk about controlling the timing and circumstances of our death, since death is the singular event that finally and completely announces our lack of complete mastery and control.

The euphemistically renamed Compassion and Choices (formerly the Hemlock Society) trades on this supposed "right" to redefine human life and death, claiming that "physician aid in dying" is *not really suicide*, simply because the means employed—taking a deadly drug—are "nonviolent" and "peaceful." This Orwellian attempt to manipulate language, and to do an end-run around hard realities, is irresponsible and deceptive.

Evil is always parasitic on, and derivative of, the good: It cannot generate anything of its own, but only distorts and corrupts what is already given. Perhaps this explains the pseudo-religious tones of the assisted-suicide movement's latest iteration. It borrows from mystical or religious language to cast itself as a "compassionate" spirituality.

The most striking example can be seen in Fermand Melgar's prize-winning 2005 documentary film *Exit: Le Droit de Mourir* (Exit: The right to die), recently made available with English subtitles on YouTube. This simultaneously mesmerizing and terrifying film follows the work of the Swiss assisted suicide association EXIT, which provides volunteer "escorts" who help usher people to their deaths. These escorts show remarkable dedication to their work, and demonstrate an intense drive to proselytize. They advocate tirelessly for the legalization of assisted suicide in other countries.

In one striking scene, filmed in a way that evokes Da Vinci's *The Last Supper*, twelve escorts gather around a U-shaped dining table with EXIT's president, Dr. Jérôme Sobel, seated in the center. The seasoned escorts share tricks of the trade and offer guidance to the new recruits. One woman suggests using two large straws for those patients who can no longer hold a glass

to down the pills. The same woman then notes that she cannot take on any new cases as she already has four "self-deliverances" scheduled before the end of the year. Another escort describes the case of an elderly couple who wish to die together by "self-deliverance," which ushers in a conversation about whether the escorts can assist them. One pleads that this couple is "entitled to this departure together because they've spent a lifetime together" and argues that "this forms part of our philosophical mandate," while another regretfully notes that the current law will not allow them to assist because only one member of the couple has a terminal illness.

As the conversation continues, their leader, Dr. Sobel, speaks to his disciples in warm and encouraging tones. He acknowledges that their work is emotionally exhausting—"we have to rest between two missions, recharge our batteries; this is not something you can do as regularly as clockwork." He encourages them to persevere in their work nonetheless: "It is an exceptional act, every single time," he tells them. "I'm exhausted after every assisted suicide." He then states that from now on he will no longer call what they do voluntary work; it is a vocation. The final scene of the film shows Dr. Sobel asking a woman several times whether she is certain she wants to die. After she consents, he prepares the deadly potion and hands her the glass, instructing her to drink it down to the last drop. "May the light guide you and lead you to peace," he tells her as she ingests the poison. Then he bids her farewell: "Bon voyage, Micheline." We watch this woman, on camera, lie back on her bed and die.

Some people thought St. John Paul II was speaking metaphorically when he wrote about our "culture of death." But he meant this quite literally: A culture that honors and exalts those who deliberately reject life is a culture that eventually will come to worship death.

Extreme Makeover: Chartres Edition

by Maureen Mullarkey

While Christianity wanes as an active cultural force in the museum-besotted West, Notre-Dame de Chartres survives as something it was never intended to be: a work of art venerated for its own sake. Once the embodiment of a living French Catholicism—an emblem of the *mentalité* of Christian Europe in its entirety—Chartres has subsided into that signature by-product of jet air travel: a World Heritage Site located amid the bric-a-brac of mass tourism.

Religious services are still conducted within, and the cathedral remains a pilgrimage site for Catholics. Nonetheless, it is a state-owned monument under the jurisdiction of the Regional Directorate of Cultural Affairs. State interest rests in its *symbolic* liturgical function, one that serves the material devotions of a secular twenty-first-century audience. Stripped of transcendent meaning, Chartres exists, in World Heritage language, as a public service "to all people of the world irrespective of the territory in which they reside."

The $18.5 million–overhaul of the cathedral, begun in 2009 and scheduled for completion in 2017, was launched by the French Ministry of Culture with financial backing from the European Union, American Friends of Chartres, and auxiliary fundraisers. The project is well enough along to judge the character of its consummation. Debate over its merits is running full throttle.

Restorers and their critics represent an argument between two disparate philosophies of architectural conservation. The nature of the debate is not new. Popular concern for the preservation of medieval buildings matured in France in the 1830s. Eugène Viollet-le-Duc, whose architectural theory held sway through the nineteenth century and into the twentieth, came to national attention with his work at Notre-Dame de Paris in the mid-1800s. He was the era's new breed of architect-restorer who brought interpretive freedom to the concept of restoration, not simply cleaning and repairing but updating. He added features wherever a creative boost seemed necessary to correct some original deficiency—a flèche here, a tower

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